

1/27/09

OVERVIEW:

DEPT.

HEALTH

& SOCIAL

SERVICES



Alaska Department of Health and Social Services

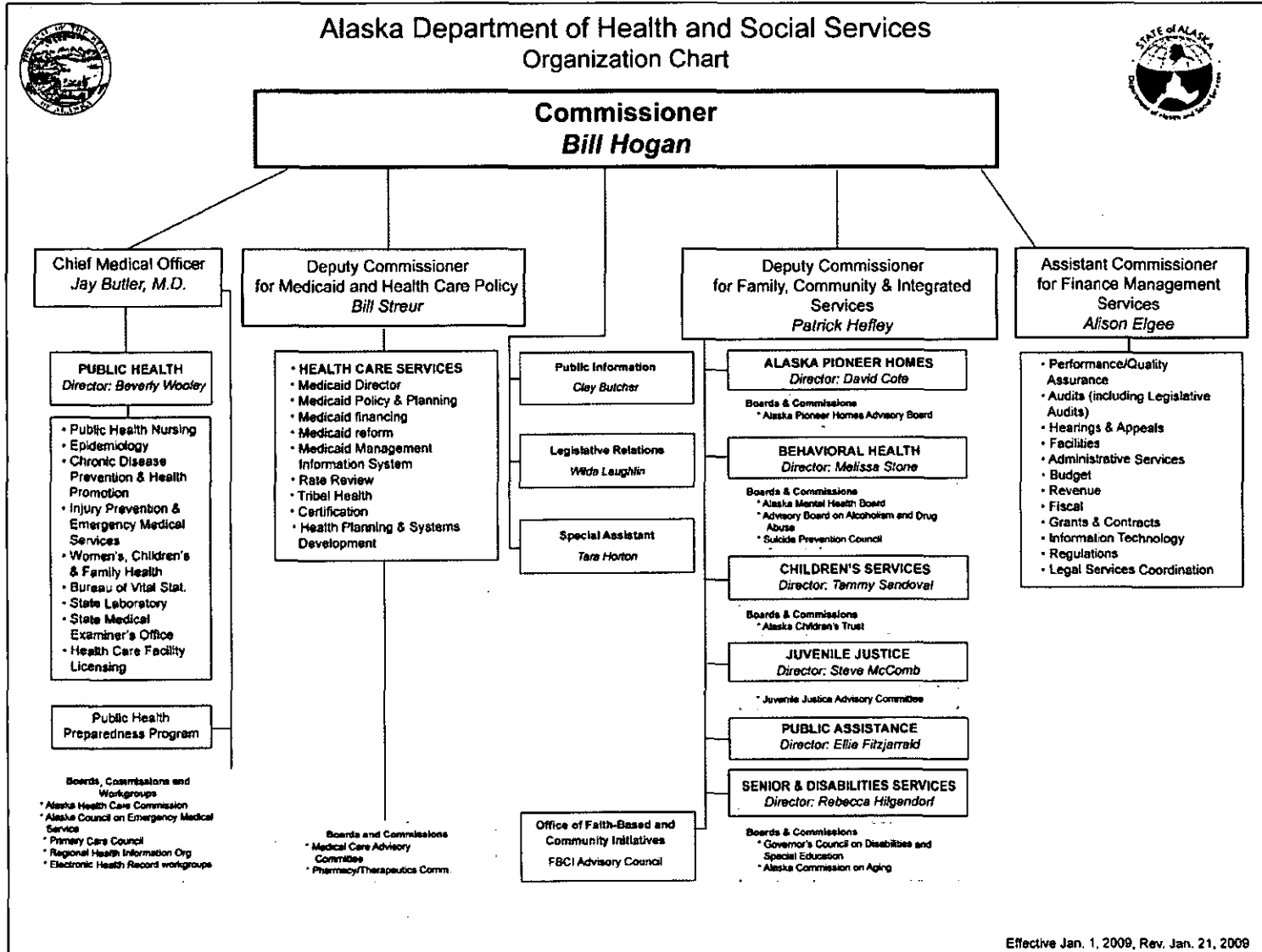
Department Overview



Commissioner
Bill Hogan
January 27, 2009



Department Overview





Department Overview

State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services Search

Health & Social Services

State of Alaska > Health & Social Services



Bill Hogan
Commissioner

- ▶ Contacts
- ▶ 2009 Realignment
- ▶ 2008 Annual Report
- ▶ Organization Chart
- ▶ Priorities
- ▶ Publications

Headlines



- ▶ State Response Team Travels to Emmonak
- ▶ State health department will continue to survey residents over the next year (PDF)
- ▶ State launches FosterWear clothing effort Tuesday (PDF)
- ▶ New database to help doctors, parents track immunizations (PDF)
- ▶ Annual Medicare Drug Plan enrollment window closes Wednesday
- ▶ State issues provisional license to owners of long-term care facility (PDF)
- ▶ State assumes temporary management of long-term care facility
- ▶ State Health & Social Services names

Services



- ▶ Birth & Marriage Certificates
- ▶ Child Care
- ▶ Child Protection Services
- ▶ Denali KidCare
- ▶ Food Stamps
- ▶ Immunization Information
- ▶ Medicaid
- ▶ Public Health Centers
- ▶ Temporary "Cash" Assistance
- ▶ Senior Benefits Program
- ▶ Senior Information Office
- ▶ Substance Abuse Treatment
- ▶ ...view more DHSS services

Divisions





Department Overview

State of Alaska > Health & Social Services > Public Notices > myAlaska

Health & Social Services Search



State of Alaska > Health & Social Services > Alaska Pioneer Homes



David Cote

Division of Alaska
Pioneer Homes Director

*"While preserving dignity and
independence for the Pioneer Homes*

News

- ▶ **Juneau Pioneer Home Celebrates 20 years in 2008!** Sig Olsen and Marritt Andruss dance to the Thunder Mountain Big Band at the 20th anniversary ball. Click to see the picture that appeared in the Juneau Empire Friday June, 6, 2008.
- ▶ **She's Gotta Dance...** Marge Gull is still dancing the night away at a young 95; click here to read the Anchorage Daily News story.
- ▶ **Happy 104th Ura Harp!** Ura Harp celebrated her 104th Birthday on November 29th; click here to see her on the front page of the Anchorage Daily News (pdf 811 KB).

Our Statewide Homes



- ▶ Anchorage
- ▶ Fairbanks
- ▶ Juneau
- ▶ Ketchikan
- ▶ Palmer
- ▶ Sitka

- ▶ Map of locations



Department Overview

State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services Search

Behavioral Health

State of Alaska > Health & Social Services > Behavioral Health



Melissa Witzler-Stone
Director

"Partners promoting healthy communities."

Mission & Values



Current Events & Announcements

Department offers tools to understand, support teens: Alaskans encouraged to reach out to young people in their lives

Meeting Behavioral Health Needs Statewide - Data Analysis of Behavioral Health Disorders Prevalence and People Served in Alaska, FY2008

Presentation - 10/23/08

Comprehensive Behavioral Health Treatment & Recovery (CBHTR) Grant Program SFY09 Funding Summary

Sections

- ▶ Home
- ▶ Division Contacts

Programs

- ▶ Alaska Psychiatric Institute
- ▶ Policy & Planning
- ▶ Prevention & Early Intervention
- ▶ Program Integrity
- ▶ Traumatic Brain Injury
- ▶ Treatment & Recovery

Resources

- ▶ Advisory, Advocacy, &



Department Overview

State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services Search



Health Care Services

State of Alaska > Health & Social Services



William Streur
Deputy Commissioner

vacant
DHCS Deputy Director

**Alaska Medicaid
Recipient Handbook**

School Medicaid

Quick Links

- ▶ [Contacts](#)
- ▶ [Director's Office](#)
- ▶ [Frequently Asked Questions](#)
- ▶ [HIPAA Information](#)
- ▶ [Help Beyond Medicaid](#)
- ▶ [Medicaid State Plan](#)
- ▶ [Medical Care Advisory Committee](#)
- ▶ [Provider Information](#)
- ▶ [Publications/Reports](#)
- ▶ [Prior Authorization](#)
- ▶ [Recipient Help Line](#)
- ▶ [Resources](#)
- ▶ [Useful Links](#)
- ▶ [Payment Error Rate Measurement \(PERM\)](#)

Programs

- ▶ [Adult Dental Care Program](#)
- ▶ [Case Management Services](#)
- ▶ [Chronic & Acute Medical Assistance \(CAMA\)](#)
- ▶ [Denali KidCare](#)
- ▶ [Early & Periodic Screening, Diagnosis & Treatment \(EPSDT\)](#)
- ▶ [Medicaid](#)
- ▶ [Medicare Part "D"](#)
- ▶ [Preferred Drug List](#)
- ▶ [Transportation](#)



[In the News](#)





Department Overview



State of Alaska > Health & Social Services > Public Notices > myAlaska

Health & Social Services

Search



State of Alaska > Health & Social Services > Juvenile Justice



Steve McComb
Director



Of Interest

- ▶ AJJAC Annual Report to the Governor, 2008
- ▶ Juvenile Justice's Year in Review
- ▶ Success Stories
- ▶ *Threat Security and Safety: An Assessment of Security Needs for Alaska's Juvenile Detention Facilities*
- ▶ DJJ FY07 Statistics
- ▶ McLaughlin Youth Center turns 40!
- ▶ Restorative Justice System
- ▶ Information for Victims of Juvenile Crimes
- ▶ Who's Who in the DJJ State Office

The mission of the Division of Juvenile Justice is:

- ▶ Hold juvenile offenders accountable for their behavior.
- ▶ Promote the safety and restoration of victims and

Our Locations

- ▶ Map of DJJ Locations
- ▶ List of DJJ Locations
- ▶ Youth Facilities
- ▶ Probation Services

What We are Doing

- ▶ Statistics
- ▶ Publications
- ▶ Performance Measures
- ▶ Capital Projects
- ▶ Grants

About Us

- ▶ The Director
- ▶ DJJ Report Card



Department Overview

State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services Search

Office of Children's Services



Safe Children, Strong Families

State of Alaska > Health & Social Services > Office of Children's Services



Tammy Sandoval, Director

Mission, Goals & Strategies

- ▶ Strengthening families;
- ▶ Keeping Alaska's children safer;
- ▶ Partnership with tribal leaders;
- ▶ Fostering a high quality and stable workforce; and
- ▶ Building enhanced relationships with community partners.



Alaska Parent Line

Programs

- ▶ Adoption & Guardianship
- ▶ Children's Justice Act
- ▶ Children's Trust

of Interest

- ▶ FosterWear
- ▶ Career Opportunities
 - ▶ The Pipeline - An OCS Newsletter
 - ▶ Radio & PSA Spots
 - ▶ UAA FYSTA Info/Training Calendar
 - ▶ FOSTER Community Partners



Department Overview

State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services Search

Public Assistance



State of Alaska > Health & Social Services



Ellie Fitzjarrald
Director

Director's Office

Our Mission

**Proposed Regulations
and Public Notices**

Fraud Control

Online Manuals

Headlines...

- ▶ State Response Team Travels to Emmonak
- ▶ Need help with your heating bills?
- ▶ Anchorage Adult Public Assistance office moving effective June 10th, 2008
- ▶ PERM Payment Error Rate Measurement - Medicaid A nationwide audit began this winter and promises to have a major impact on Alaska.
- ▶ **SeniorCare program to end following legislative session**
- ▶ Native Family Assistance Program Celebrates Expansion

For Employers

- ▶ Job Start - Money for your Business!
- ▶ Need help hiring?
- ▶ Tax Credits for Employers
- ▶ Calendar of Job Fairs
- ▶ Job Hotline for Employers

For Customers

- ▶ Contact Us!
- ▶ Work for us!
- ▶ AK Job Centers Phone/Fax/TDD
- ▶ Alaska Quest Card
- ▶ Prescription Drug Resource List
- ▶ Printable Application for Public Assistance

Programs

- ▶ Adult Public Assistance
- ▶ Child Care
- ▶ Chronic and Acute Medical Assistance
- ▶ Denali Kidcare
- ▶ Family Nutrition
- ▶ Food Stamps
- ▶ General Relief Assistance
- ▶ Heating Assistance
- ▶ Medicaid
- ▶ SeniorBenefits
- ▶ Temporary Assistance

Get Help...

- ▶ ...finding a job?
- ▶ ...with Child Care?
- ▶ ...with Child Support?



Department Overview

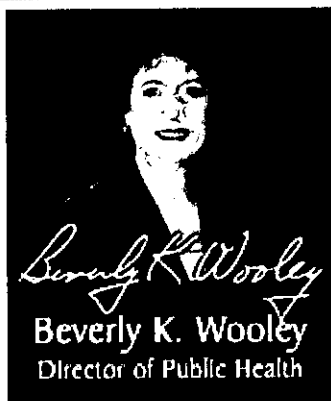
State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services Search

Public Health

Prevention. Promotion. Protection.

State of Alaska > Health & Social Services > Public Health



Fish Consumption
GUIDELINES

BREAST & CERVICAL HEALTH TOPIC
HPV & GARDASIL VACCINE

Seasonal, Avian and
Pandemic Influenza **Flu**

Announcements & Events

- Department offers tools to understand, support teens:** *Alaskans encouraged to reach out to young people in their lives*
- **Your opinion counts. Take this short survey on health care.**
 Results will be forwarded to President-elect Barack Obama's transition team.
- American College of Surgeons lists ways to improve state trauma system
- Trauma System Presentation
- 2007 Alaska Youth Risk Behavior Survey Results
- **View all Department of Health & Social Services Press Releases**

Of Interest

- Certified Copies of Birth, Death, Marriage, &

Public Health

- Public Health Home
- Certification & Licensing
- Chronic Disease Prevention & Health Promotion
- Epidemiology
- Health Planning & Systems Development
- Injury Prevention & EMS
- Laboratories
- Public Health Nursing
- Preparedness
- State Medical Examiner
- Vital Statistics
- Women's, Children's & Family Health



Department Overview

State of Alaska Health & Social Services Public Notices myAlaska

Health & Social Services

Search



State of Alaska > Health & Social Services > Senior & Disabilities Services

Who do we serve? (pdf 234k) : Seniors • Adults with Physical Disabilities and Seniors on Medicaid Waivers • Persons with Developmental Disabilities • Vulnerable Adults • Assisted Living Providers



Rebecca Hilgendorf
Director

About Us

- ▶ [Our Service Principles](#)

Current Training

BASIC Care Coordinator Training:

Details and the registration form

Of Interest

- ▶ [2008 Waitlist Report](#)
 - ▶ [Recommendations for a Rate Methodology for Home and Community-Based Services](#)
 - ▶ [1st Quarterly Report 2009](#)
 - ▶ [Contractors Wanted for the Environmental Modification Home Accessibility Program](#)
 - ▶ [Recommendations for the Alaska Long Term Care Plan Final Report](#)
 - ▶ [Provider Cost Survey](#)

Sections

- ▶ [Adult Protective Services](#)
- ▶ [Care Coordination Training and Resource Materials](#)
- ▶ [Developmental Disabilities](#)
- ▶ [Personal Care Assistant Program](#)
- ▶ [Quality Assurance Program](#)
- ▶ [Reports & Publications](#)
- ▶ [Rural Long-Term Care Development](#)
- ▶ [Grant Services](#)
- ▶ [Nursing Facility](#)



Department Overview

State of Alaska > Health & Social Services > Public Notices > myAlaska

Health & Social Services Search

Finance and Management Services

State of Alaska > Health & Social Services > Finance and Management Services



Quicklinks...

- ▶ Capital Grants Status Report 08
- ▶ Legislative Reports
- ▶ StreamLine - November 2008
- ▶ Facilities Funding Allocation Plan



Alison Elgee
Director

Current Projects....

**H&SS FY-09
Budget
Overview**

Headlines...

- ▶ Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2007-2027
- ▶ Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2006-2026
- ▶ Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2005-2025



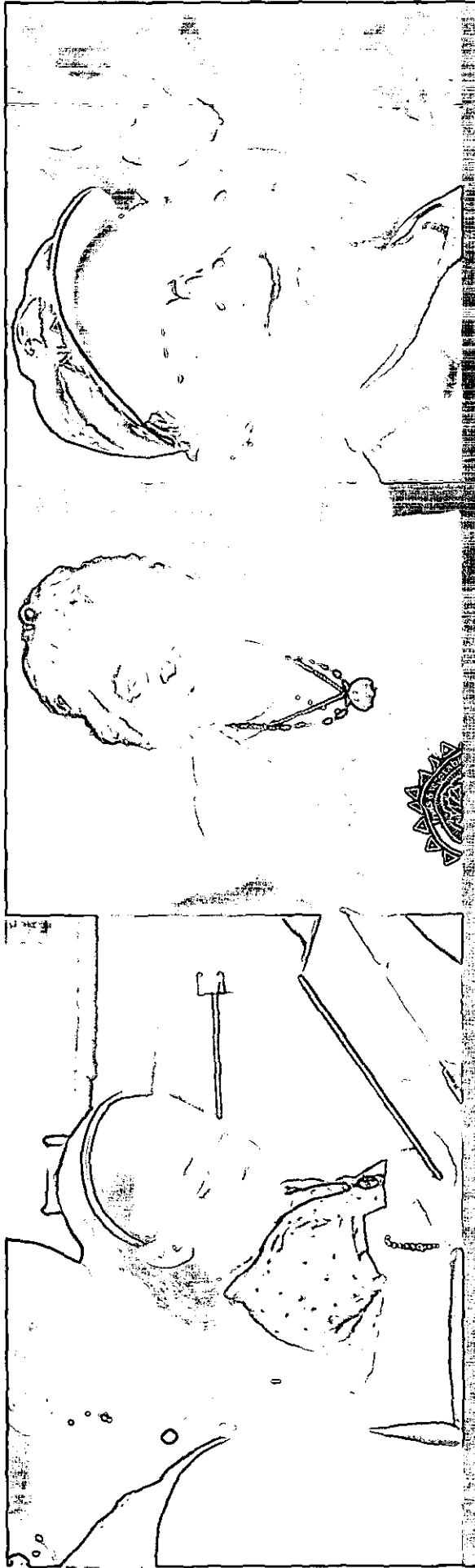
View the DHSS FY08 Operating Grants (PDF 3.6 MB)

Sections

- ▶ Home
- ▶ Assistant Commissioner
- ▶ Audit
- ▶ Budget
- ▶ Facilities
- ▶ Grants & Contracts
- ▶ Human Resources
- ▶ Information Services
- ▶ Revenue & Finance
- ▶ Hearings & Appeals

Links

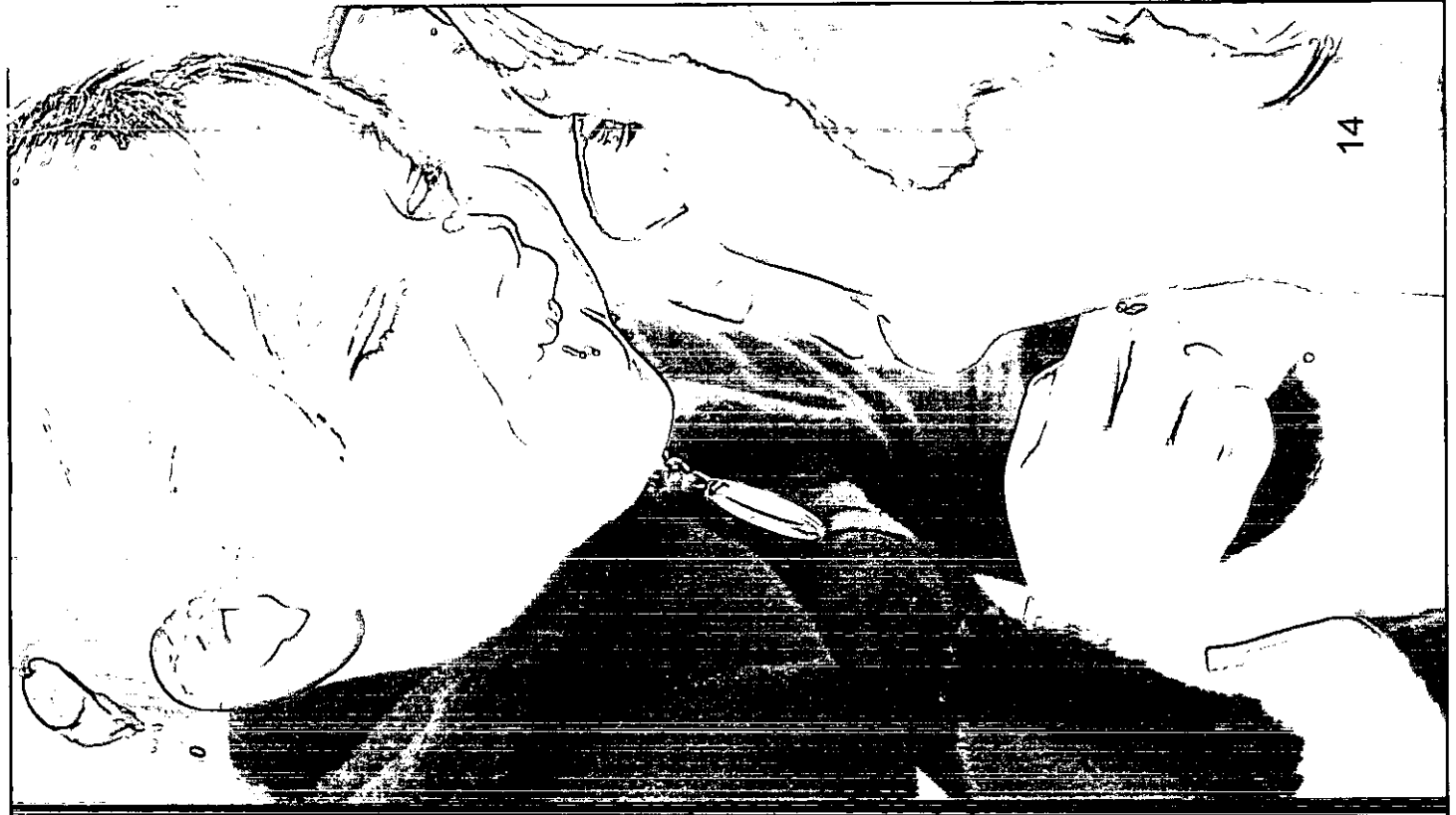
- ▶ Commissioners Office
- ▶ Division Contacts
- ▶ Program Overview
- ▶ Safety Plan



The overriding theme for future
direction of the Alaska
Department of Health and Social
Services is *helping individuals
and families create safe and
healthy communities.*

Priorities

- Substance abuse
- Health and wellness
- Health-care reform
- Long-term care
- Vulnerable Alaskans



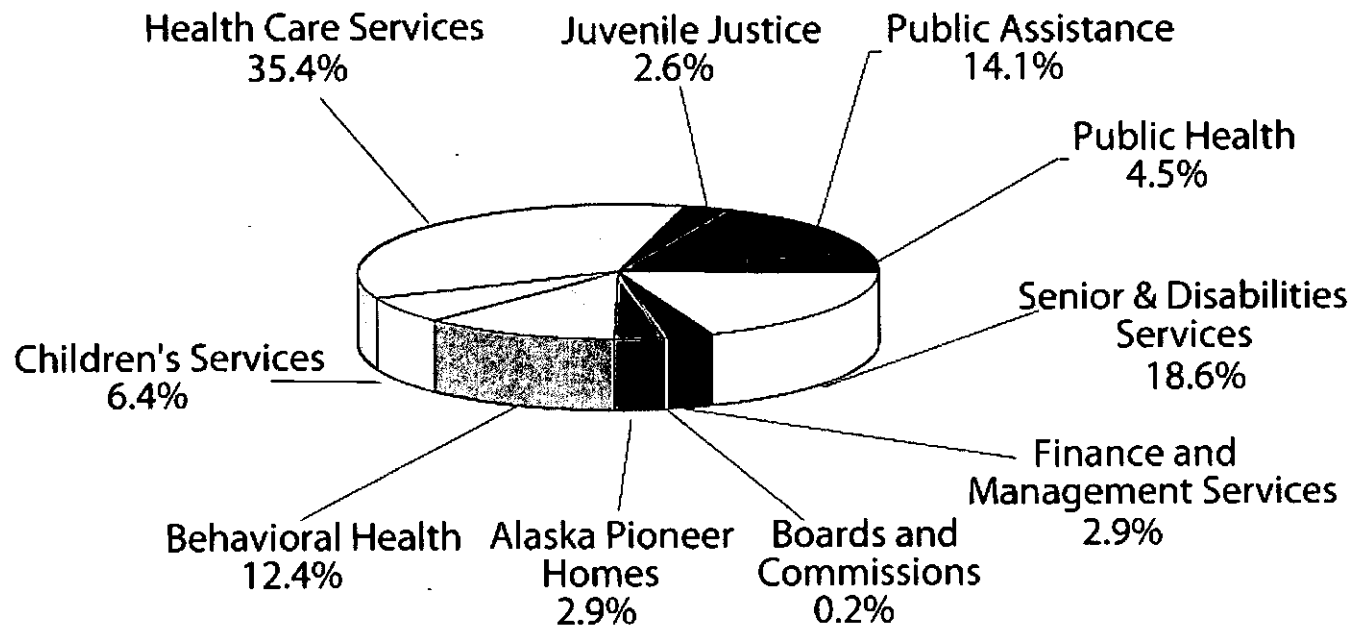


Department Overview

Budget Highlights

DHSS FY2008 Actual Expenditures by Division

(Total Funds)





Department Overview

Budget Highlights

- Medicaid
- Denali KidCare
- Child Care
- Substance Abuse
- Heating Assistance
- Governor's Health Initiative
- Capital Projects



Department Overview

Other

- Measuring Performance
- Community Partners
- Stimulus Package



Department Overview

Conclusion

- Questions?

1/28/09

**WHAT YOU
NEED TO
KNOW:
HEALTH
REFORM**

Alaska State Legislature

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
Fax: (907) 465-3756



Committee Members:
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Senate Health & Social Services Committee

January 27, 2009

To: Sen. Davis, Sen. Paskvan, Sen. Ellis, Sen. Thomas
Sen. Dyson, Rep. Keller, Rep. Herron

From: Lynda Zaugg, Aide Sen. Davis

Please find attached the back up information provided by The Primary Care Association in preparation for their presentation to the joint Senate and House H&SS meeting on Wednesday 1/28/09.

Alaska Behavioral Health Association
Alaska Center for Public Policy

Alaska Health Care Roundtable
Alaska Mental Health Trust Authority
Alaska Native Health Board

Alaska State Hospital and Nursing Home Association
American Cancer Society Cancer Action Network -
Alaska
American Heart Association - Alaska
Anchorage Project Access

WHAT YOU NEED TO KNOW: HEALTH REFORM FOR ALASKA
BRIEFING AGENDA

Wednesday, January 28, 2009

Choice of Briefing Sessions: Morning Session 7:30 – 9:30 a.m.
Afternoon Session 1:15 – 3:15 p.m.

~~AFTERNOON SESSION - CAPITOL BUILDING~~ Butrovich-Fahrenkamp Room 203 (refreshments served)

1:15 p.m. Welcome Wayne Stevens, Alaska State Chamber of Commerce
Moderator Rod Betit, Alaska State Hospital & Nursing Home Assn

1:25 p.m. Picture of Alaska Alice Rarig, PhD Health Planning & Systems
Development

1:45 p.m. What You Need to Know: Health Reform for Alaska
- Lessons from Other States and Issues to Consider -

Keynote Speaker: Enrique Martinez-Vidal
Vice President, AcademyHealth
Director, State Coverage Initiatives

2:45 p.m. Questions & Answers

Panel: Bill Hogan, Commissioner, DHSS
Linda Hall, Director, Division of Insurance, DCCED
Enrique, Martinez-Vidal, Vice President, Academy Health
Alice Rarig, PhD, Health Planning & Systems Development, HSS
Rod Betit, CEO/President, ASHNHA

3:15 p.m. Adjournment

Hosted by:
Senate President, Sen. Stevens; House Speaker, Rep. Chenault; Senate HSS
Chair,
Sen. Davis; House HSS Co-Chairs, Rep. Keller and Rep. Herron

Sponsored by AHAAT, Alaska State Chamber of Commerce, Alaska Primary
Care Association, Alaska State Hospital & Nursing Home Association and
AARP-Alaska.



Co-Chairs:
Kip Knudson, Alaska State Chamber of
Commerce

Shelley Hughes, Alaska Primary Care Association

Vice-Chair: Pat Luby, AARP-Alaska

Members:

AARP - Alaska
Alaska Association of Health Underwriters
All Alaska Pediatric Partnership
Alaska Behavioral Health Association
Alaska Center for Public Policy

Alaska Health Care Roundtable
Alaska Mental Health Trust Authority
Alaska Native Health Board

Alaska Native Tribal Health Consortium
Alaska Primary Care Association
Alaska State Chamber of Commerce
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MORNING SESSION - BARANOF HOTEL Gastineau Suite (breakfast served)

7:30 a.m. Welcome Wayne Stevens, Alaska State Chamber of Commerce
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7:40 a.m. Picture of Alaska Alice Rarig, PhD Health Planning & Systems
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8:00 a.m. What You Need to Know: Health Reform for Alaska
- Lessons from Other States and Issues to Consider -

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Vice President, AcademyHealth
Director, State Coverage Initiatives

9:00 a.m. Questions & Answers

Panel: Bill Hogan, Commissioner, DHSS
Linda Hall, Director, Division of Insurance, DCCED
Enrique, Martinez-Vidal, Vice President, Academy Health
Alice Rarig, PhD, Health Planning & Systems Development, HSS
Rod Betit, CEO/President, ASHNHA

9:30 a.m. Adjournment

Hosted by:
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Sponsored by AHAAT, Alaska State Chamber of Commerce, Alaska Primary
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Members:

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Alaska Native Tribal Health Consortium
Alaska Primary Care Association
Alaska State Chamber of Commerce

Enrique Martinez-Vidal
Vice President, Academy Health
Washington, D.C.

Keynote Speaker January, 28, 2008
What You Need to Know: Health Reform for Alaska

Enrique Martinez-Vidal is a Vice President at AcademyHealth and the Director of the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program which works with state policy leaders to develop strategies to improve insurance coverage and foster broad health care reform. Enrique joined AcademyHealth in February 2005 as the deputy director of SCI.

He is currently the project director for the State Quality Improvement Institute, a project of the Commonwealth Fund to assist states that are ready to make substantial commitments to quality improvement and to facilitate development of concrete action plans for further progress. He also has worked on various projects under a contract with the federal Agency for Healthcare Research and Quality (AHRQ) including the oversight of a state-level environmental scan of quality initiatives to help determine how a partnership could be developed between AHRQ and states regarding quality improvement; and a pilot project that presented AHRQ's State Snapshots to four states in an effort to create an ongoing dialogue about how these reports can be used for state-level quality improvement.

Previously Mr. Martinez-Vidal was the deputy director for performance and benefits at the Maryland Health Care Commission, an independent state agency. There he was responsible for the oversight of Maryland's small group insurance market reforms; the annual evaluation of Maryland's mandated health insurance benefits; the collection and public dissemination of quality and performance information for hospitals, nursing homes and health plans; providing primary assistance on all legislative issues; and working on numerous other projects related to the affordability of health care, quality improvement, and patient safety.

Mr. Martinez-Vidal was formerly a policy analyst with the Maryland Department of Legislative Services for five years. During that time he staffed the House Economic Matters Committee and was involved with a number of health-care related issues. He has a B.A. in political science and international studies from Dickinson College and a master's degree in public policy from Georgetown University.

State Coverage Initiatives



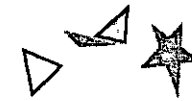
Robert Wood Johnson Foundation

What You Need to Know: Health Reform for Alaska Lessons Learned from Other States

A Briefing for Alaska Legislators and Staff

Juneau, AK
January 28, 2009

Enrique Martinez-Vidal
Vice President, AcademyHealth
Director, State Coverage Initiatives



AcademyHealth

Overview of Presentation

- Background
- What is driving state reform?
- State Reform Strategies
- States & the Health Workforce
- State Quality Reporting Activities
- State Health Policy Commissions and Authorities
- Lessons Learned from State Reforms
- Concluding Thoughts



State Coverage Initiatives (SCI)

- An Initiative of the Robert Wood Johnson Foundation

Community of State Officials

- Convening state officials

Resources and Information

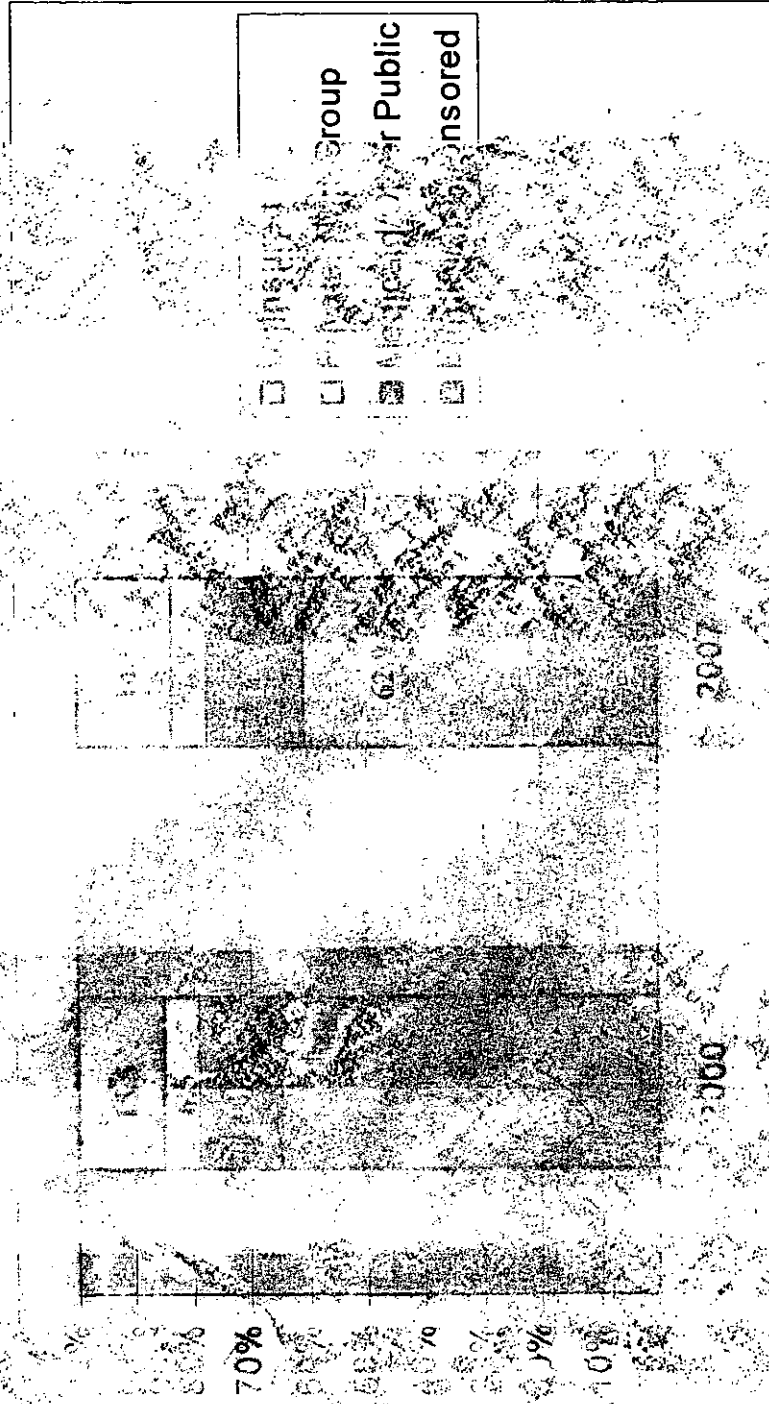
- Web site: www.statecoverage.org
- State Profiles
- Publications/*State of the States*

Direct technical assistance to states

- State-specific help, research on state policymakers' questions
- Grant funding/Coverage Institute



Health Insurance Coverage Changes Among Non-Elderly, 2000-2007



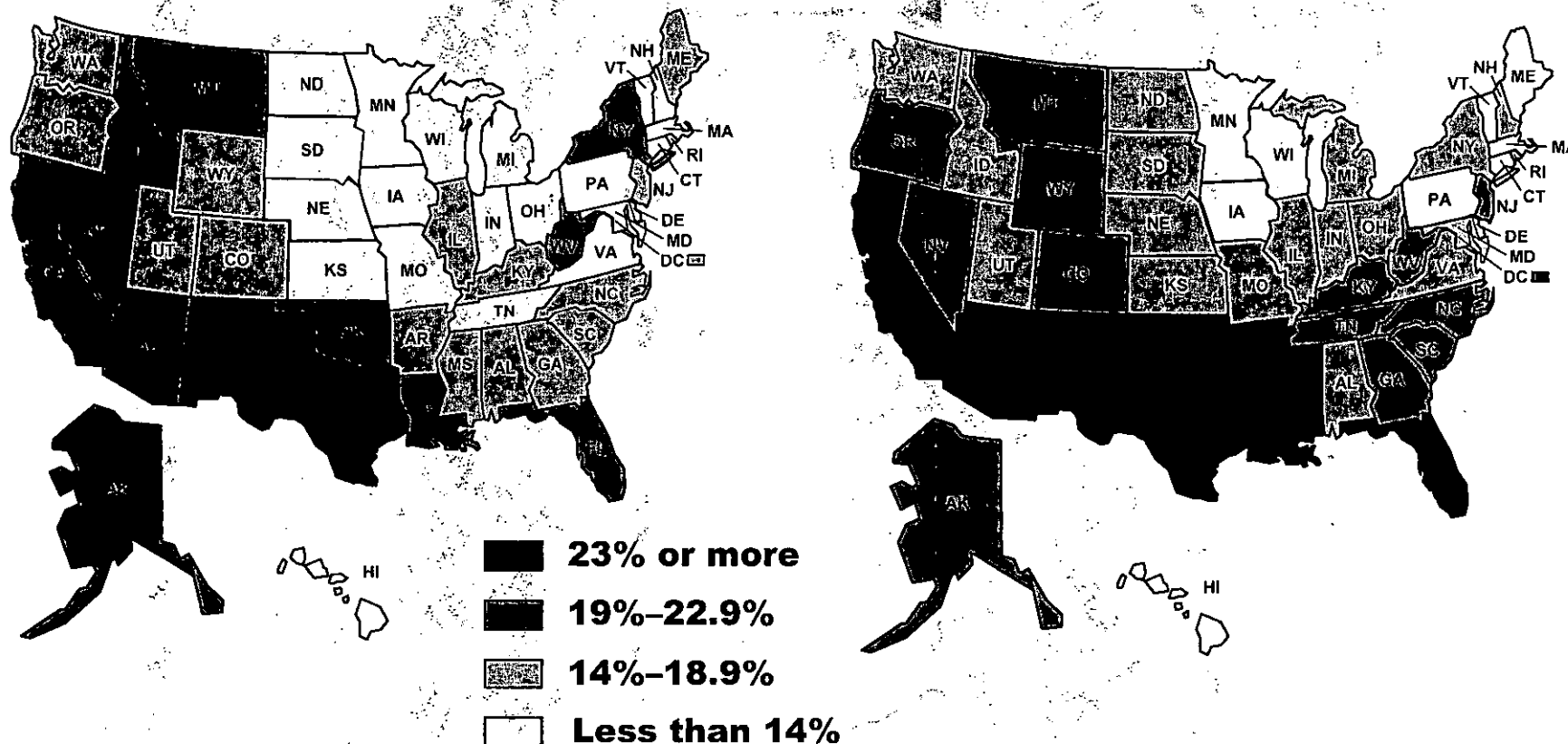
Census Bureau,
Tables, August 2008.

Percent of Uninsured Adults Ages 18–64

(Source: The Commonwealth Fund, 2008)

1999–2000

2006–2007



State Coverage Initiatives



Robert Wood Johnson Foundation

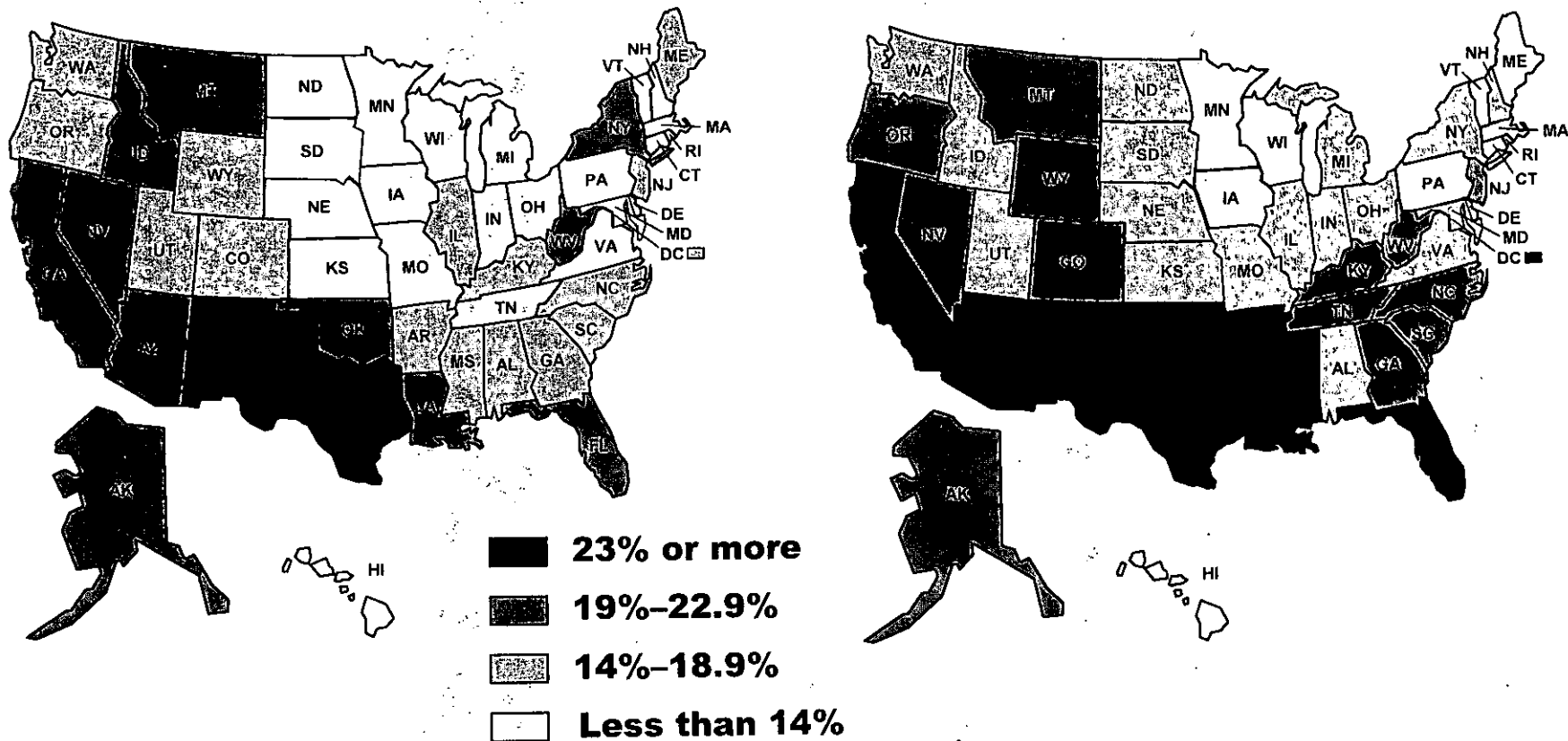
Data: Two-year averages 1999–2000, updated with 2008 CPS correction, and 2006–2007 from the Census Bureau's March 2000, 2001 and 2007, 2008 Current Population Surveys.

Percent of Uninsured Adults Ages 18–64

(Source: The Commonwealth Fund, 2008)

1999–2000

2006–2007

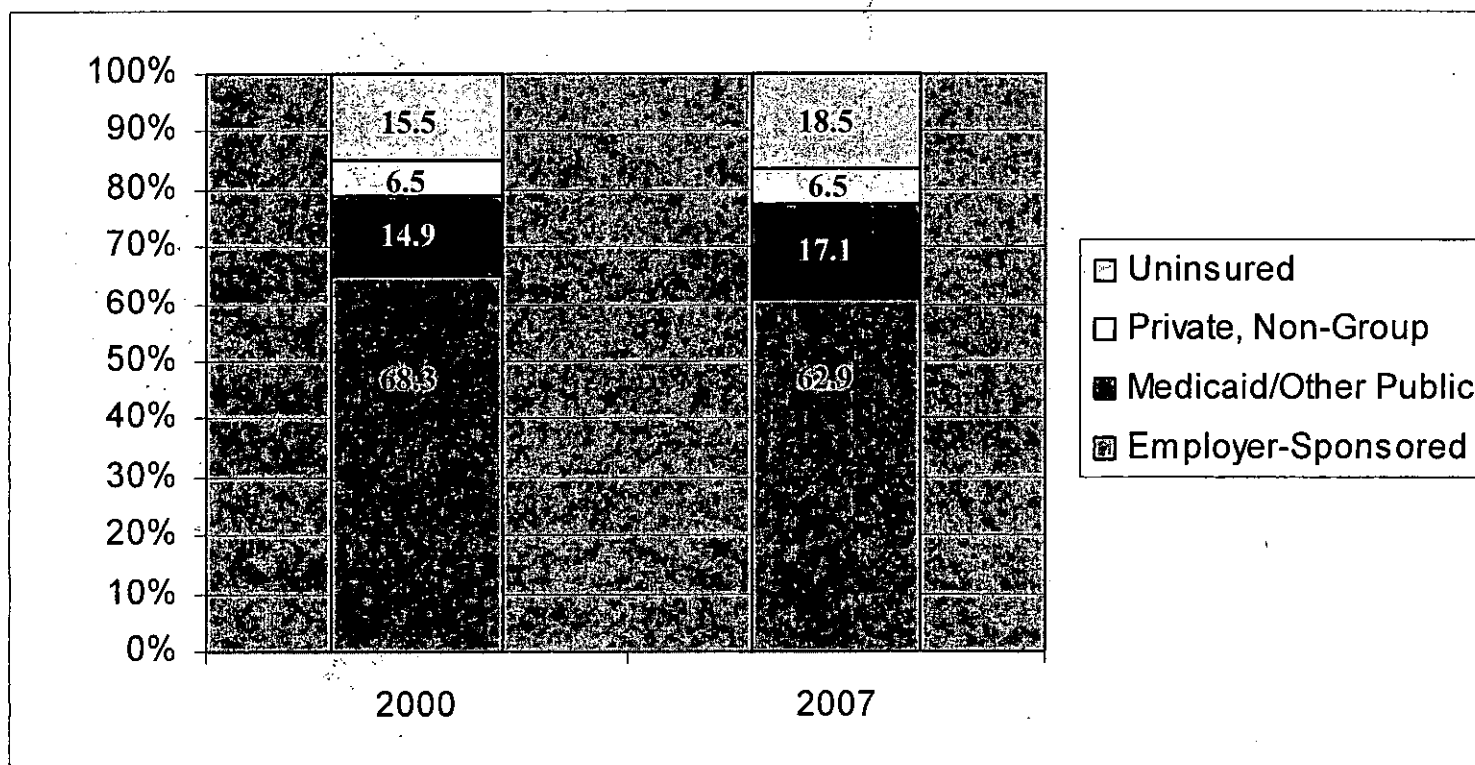


State Coverage Initiatives

Robert Wood Johnson Foundation

Data: Two-year averages 1999–2000, updated with 2008 CPS correction, and 2006–2007 from the Census Bureau's March 2000, 2001 and 2007, 2008 Current Population Surveys.

Health Insurance Coverage Changes Among Non-Elderly, 2000-2007



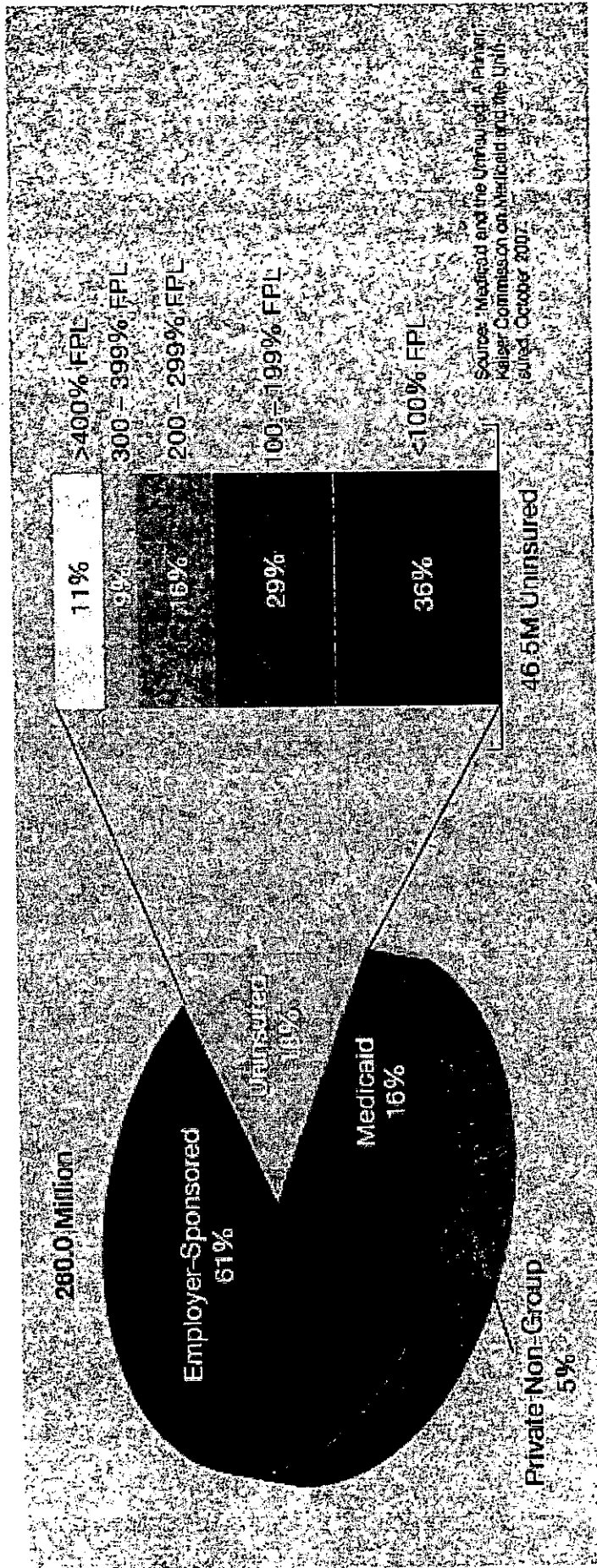
State Coverage Initiatives



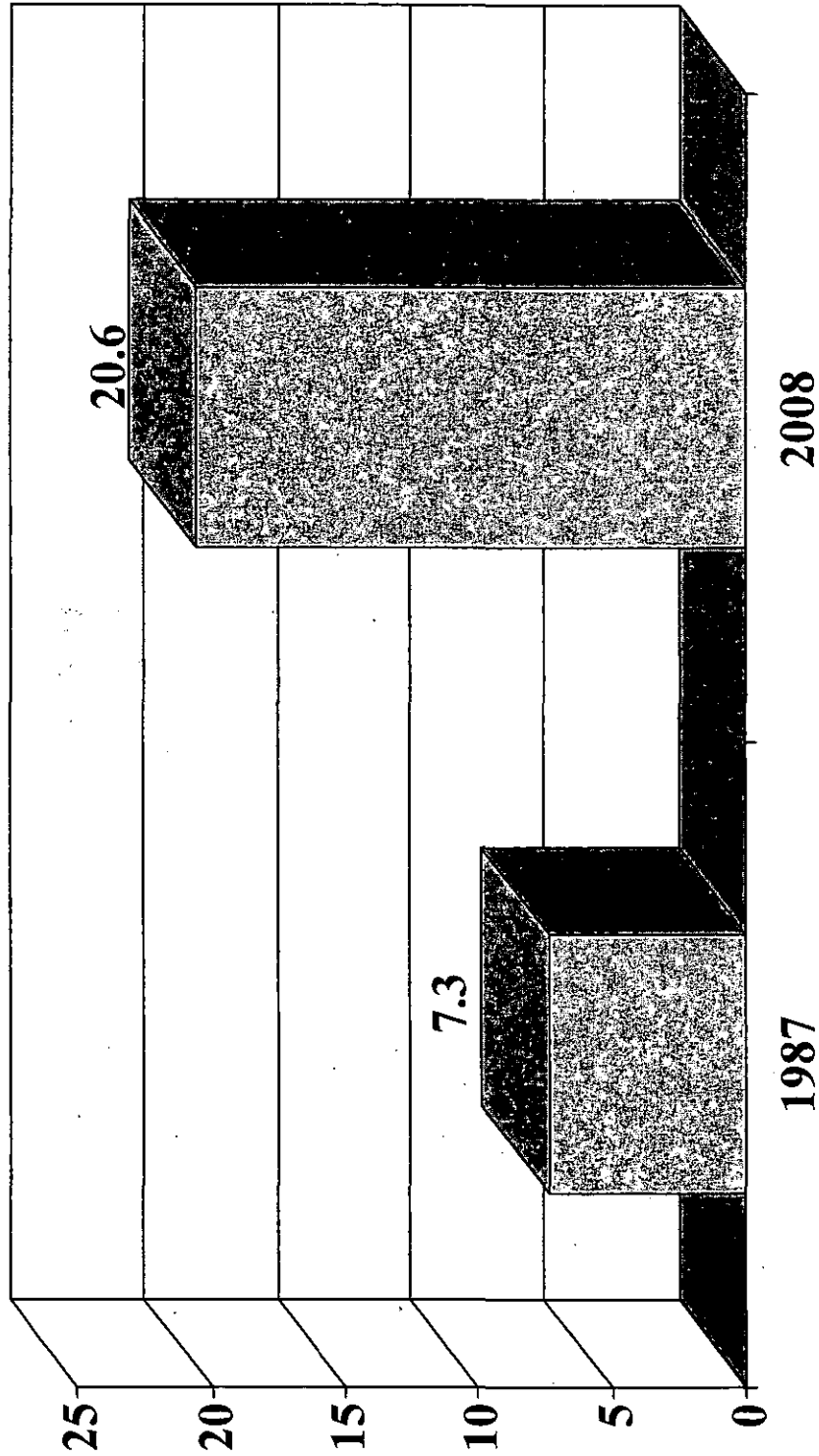
Robert Wood Johnson Foundation

Note: Data from Current Population Survey, Census Bureau, Historical Health Insurance Tables, August 2008.

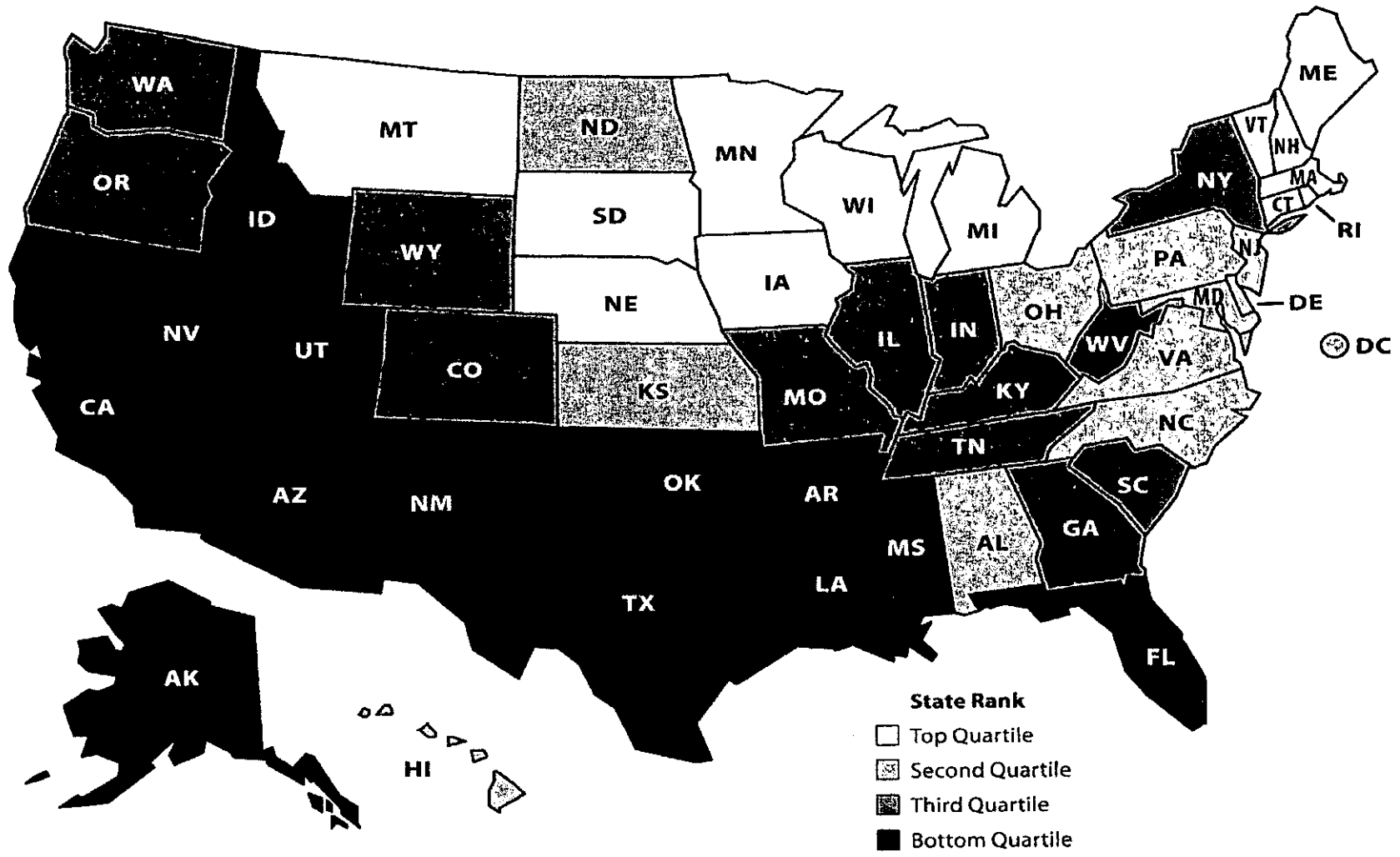
The Non-Elderly as a Share of the Population and by Poverty Level, 2006



Percent of Median Family Income Needed to Buy Family Health Insurance



State Ranking on Quality Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Drivers of State Health Reform Efforts

- Uninsured still high
- Employer-sponsored insurance down
- Costs/premiums increasingly unaffordable – Individ; Families; Govt
- Coverage needed for effective and efficient health care system
- Lack of national consensus – future?
- Greater political will at state level



Key Policy and Design Issues

- Different Populations Require Different Solutions
- Subsidies and Financing: Who will pay? Who will benefit?
- Should Health Insurance Coverage Be Required?
- What is Affordable Coverage?
- What is the Most Appropriate Benefit Design?
- Do Insurance Markets Need to be Reformed/Reorganized?
- Best Mechanisms for Cost Containment/Systems Improvement



“One size fits all” approach won’t work

- Those with few resources to bring to private insurance market
 - Ceiling = eligibility for public programs
 - Children: 100-300% FPL
 - SCHIP Parents/Childless Adults: Vary from 12-275% FPL
- Those with some resources but cannot bear the full cost of insurance premiums
 - Subsidies and other methods to reduce premiums
- Those who have sufficient incomes to participate in market on their own
 - Encourage voluntary participation or mandate coverage



No Free Solutions: Who Will Pay? Who Will Benefit?

- Shared responsibility – Who will help cover the costs?
 - Individuals; Employers; Federal government; State government; Health plans/insurers; Providers
- Enough money in current system?
 - If yes, then – Redistribution (Who will pay? Who will get paid?)
 - If not, then need new forms of revenue: Sin taxes; Provider taxes; Payroll taxes; Lease the lottery; Slots revenues; Gross Receipts Tax



Should Health Insurance Coverage Be Required?

- Unenforceable? Impingement on individual freedom?
- Does your state have money for subsidies to help lower-income uninsured (or an exemption process)?



What is Affordable Coverage?

- Related to overall benefit design
- Related to subsidies being considered
- Could be related to individual mandate
- General agreement that levels of both premium and out-of-pocket costs should somehow be related to income and ability to pay



Benefit Design

- Services included/excluded; cost-sharing; structure of access to providers
- Not just cost of coverage but value of the benefit plan – what set of services are purchased for specific amount of money
- Before – limit benefits; raise cost-sharing; limit networks (value issue)
- Levers within benefit design:
 - reduce premiums
 - encourage efficient/appropriate consumer behavior
 - change carrier and provider behavior
- Evidence-based benefit design? MN
- Consumer-driven health plans? IN
- First-dollar benefits? TN
- Direct consumer behavior change? RI



Don't Forget the Delivery System

- Prevention/primary care/wellness
- Chronic care management and coordination
- Public health initiatives
- Value-based purchasing/payment reforms
- Medical error reduction
- Health-acquired infection reduction/patient safety
- Price and quality transparency
- Health information technology and exchange
- Administrative and regulatory efficiencies



What is a Medical Home?

The Joint Principles of the Patient-Centered Medical Home, developed by the leading physician groups

- **Personal Relationship**
- **Team Approach**
- **Comprehensive**
- **Coordination**
- **Quality and Safety**
- **Expanded Access**
- **Payment for Added Value**

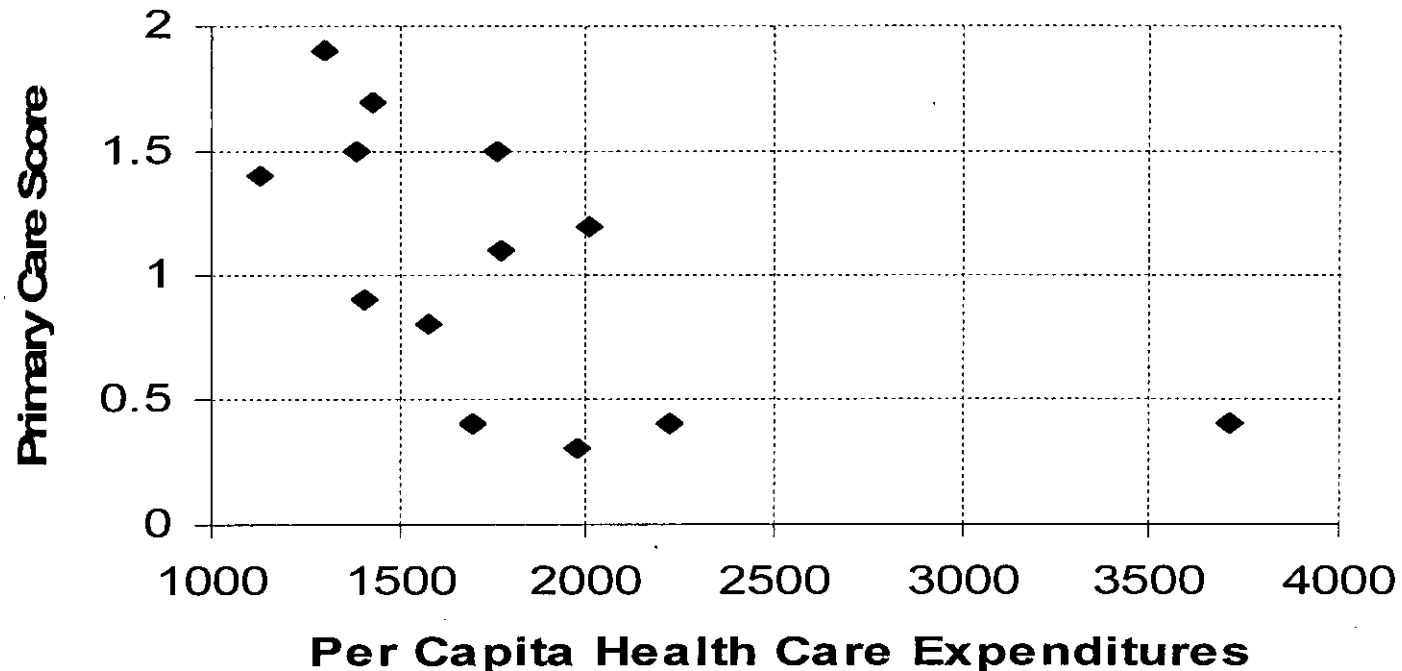


Other “Medical Home” Definitions

- NCQA – Has a 3-level standard being used or adopted by several states
 - Based on the Joint Principles
 - Utilized in Vermont, Rhode Island Medicaid and elsewhere
- Health Disparities Collaboratives, the “Wagner Model” or chronic disease management programs
 - A system change model that emphasizes:
 - Using best practice standards of care for specific chronic diseases
 - Use of quantitative process and outcome measures
 - Team approach to care
 - Patient education and self-management
 - Implemented in Community Health Centers around the country
 - Implemented in Washington, Rhode Island, Pennsylvania, and elsewhere
- Primary Care Case Management (PCCM)



High Access to Primary Care Correlates with Low Health Care Spending



Source: Based on The Commonwealth Fund 2006 International Health Policy Survey of Primary Care Physicians in Seven Countries

State Coverage Initiatives



Robert Wood Johnson Foundation

State Medical Home Programs

- 31 states have implemented programs to advance Medical Homes in Medicaid
- States working across payers on Medical Homes Programs include Colorado, Louisiana, Maine, New Hampshire, Pennsylvania, Rhode Island, and Vermont
- States with model Medical Homes programs include Vermont, North Carolina, Rhode Island and Pennsylvania



Comprehensive Efforts

Enacted

Maine ('03)

Massachusetts ('06)

Vermont ('06)

Significant Proposals

California – failed

Kansas – some pieces

New Mexico – very small pieces

Pennsylvania – in process



Strategies for Comprehensive Reform

	Maine	Massachusetts	Vermont
Individual Mandate	No	Yes	No <i>Will consider if coverage targets not met</i>
Purchasing Mechanism	DirigoChoice	Health Insurance Connector	Catamount Health
Subsidies for Low-Income	Up to 300% FPL	Up to 300% FPL	Up to 300% FPL
Public Program Expansion	Parents <200% FPL Childless Adults <125% FPL	Adults <100% FPL Children <300% FPL	<i>Builds upon previous expansions</i> Children <300% Parents <185% Childless Adults <150% FPL
Employer Requirements	<i>Voluntary</i> <i>Participating employers must pay 60% of premium</i>	\$295/employee fee for non-offering. Must offer §125 Plan	\$365/FTE fee for non-offering



Massachusetts Pillars of the Reform

- Employer Responsibilities
 - Section 125 Plan Requirement
 - Offer Coverage or Be Assessed

- Personal Responsibility/Individual Mandate

- Expansion of Publicly-subsidized Programs

- Major Changes to Insurance Market
 - Merged Small Group and Individual Markets
 - Raising age of dependents – up to 25
 - Connector



Current State of the Commonwealth

- More than 439,000 newly-insured between June 2006 and March 31, 2008
- 191,000 more in private coverage (no public \$\$) – more than 40% of all newly covered have no subsidies
- Employer-sponsored insurance remains predominant source of coverage (82% of non-elderly): no crowd-out
- Non-group premiums are down over 40% and membership has grown over 50%
- Approximately 1-2% of the MA population or 60,000 persons may be exempted from the mandate



Vermont - Blueprint Components

Public Policy	<ul style="list-style-type: none"> ▪ Blueprint legislation and funding ▪ Executive Director at Governor's Office level ▪ Integration with Public Health Disease Prevention Programs
Community	<ul style="list-style-type: none"> ▪ Community Grants ▪ Environmental and Policy Strategies, Smart Planning ▪ 211 as statewide resource tool
Self-Management	<ul style="list-style-type: none"> ▪ Healthier Living Workshop—All conditions <ul style="list-style-type: none"> - Over 40 statewide; 500+ enrolled - +60% reduction in MD and ED visits post at one year ▪ Patient portal planned
Information Systems	<ul style="list-style-type: none"> ▪ Statewide RHIO, Health IT Plan ▪ Web-based chronic care information systems ▪ EMR
Physician Practices	<ul style="list-style-type: none"> ▪ Consensus treatment standards—7+ Diseases ▪ Clinical Microsystems support in practices –training, coaching, peer support ▪ 75% participation in 6 Communities (HSAs) □ 200 practices
Health Systems	<ul style="list-style-type: none"> ▪ Required coordination across all payers in 3 pilots in 2008 ▪ Contract with National Payment Reform Consultant



California Proposed Reforms

- **Shared Responsibility**
 - Individual mandate
 - Guaranteed issue
 - Financing: Government, Hospitals, Employers, Individuals

- **Prevention/Health Promotion/Wellness**
 - Tied to preventive health practices
 - Reducing medical errors (e-prescribing)
 - Obesity prevention
 - Tobacco cessation efforts
 - Health Care Cost and Quality Commission

- **Affordability & Cost Containment**
 - Subsidies for low-income adults and children
 - Section 125 plans/HSAs
 - Emphasis on HIT
 - Increase Medi-Cal reimbursement rates ('hidden tax')



Kansas – Summary of 2008 Legislative Action

Transforming Medical Care	Improving Public Health	Expanding Affordable Insurance
<ul style="list-style-type: none"> • Transparency project: Health care cost and quality (Kansas Health Online) • Health literacy • Medical home definition • Medicaid provider reimbursement • Community Health Record (HIE) • Insurance Form Standardization 	<ul style="list-style-type: none"> → Increase tobacco user fee → Statewide smoking ban → Partner with community organizations → Education Commissioner → Collect fitness data in schools → Promote healthy foods in schools → Promote fitness in schools → Wellness for small businesses → Healthier food for state employees → Dental care for pregnant women → Tobacco cessation in Medicaid (for pregnant women only) → Expand cancer screening 	<ul style="list-style-type: none"> → Aggressive outreach & enrollment of eligible children (target pop: 20,000) → Premium Assistance for low income adults without children (target population: 39,000) → Small Business Initiatives (target population: 15,000 young adults and 12,000 employees of small businesses)

Green – Passed with Funding, if Needed; Yellow – Passed with No Funding; Red – Did Not Pass

State Coverage Initiatives



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Health Solutions New Mexico Plan

What was Proposed:

- Insurance Reforms
- Phased-In Health Coverage Participation Reqmt
- Electronic Claims and Records
- Health Coverage Authority
- Evaluation

What Happened:

- Funding for eligible but not enrolled: \$22.5 m.
- Treat developmentally disabled children: \$10 m.



Pennsylvania Proposed Reforms:

Prescription for Pennsylvania

Rx for Affordability

*Cover All Pennsylvanians
(now Access to Basic Care)*

*Coverage for College
Students and Young Adults*

Community Benefit
Requirements

Uniform Admission Criteria

Fair Billing and Collection
Practices

Capital Expenditures

*Small Group Insurance
Reform*

Health Information Exchange
– Exec Order

Rx for Access

Health Care Workforce

**Removing Practice
Barriers – Scope of
Practice**

Cost-Effective Sites

Co-Occurring Disorders

Governor may consider
individual mandate if number
of uninsured does not
decline over next few years

Rx for Quality

**Hospital-Acquired
Infections**

Quality Outcomes

Pay for Performance

Chronic Care – Exec Order

Health Disparities

Child and Adult Wellness

Long Term Living

End of Life and Palliative
Care

State Coverage Initiatives



Robert Wood Johnson Foundation

Source: Presentation by Ann S. Torregrossa, Deputy
Director & Director of Policy GOHCR. Alliance for
Health Reform Briefing, October 26, 2007

Substantial Reforms

Enacted

Indiana - 2007

Iowa - 2008

Maryland - 2007

Minnesota - 2008

New Jersey - 2008

Washington - 2007

Wisconsin - 2007

State Coverage Initiatives



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Indiana: Healthy Indiana Plan (HB 1678)

- Increases tobacco taxes by \$0.44 per pack; \$0.33 will be used for:
 - Covering adults up to 200% FPL + Immunization programs

- The remaining \$0.11 will be distributed as follows:
 - Three cents will increase physician/dentist Medicaid reimbursement rates;
 - Three cents will provide a tax credit to employers that establish Section 125 plans - for employers not offering a fully insured health plan that satisfies Section 125 of the IRS code, the state will provide the lesser of \$50 per employee or \$2,500 for 2 years if the employer establishes Section 125 plan; and
 - The remaining 5 cents will be used to increase tobacco prevention and cessation programs and for other health programs.

- **A key aspect of HIP is that it utilizes the HSA model combined with comprehensive insurance coverage above the deductible. Individuals will annually receive \$500 of pre-deductible, free preventive care and have a \$1,100 deductible.**



Iowa Reforms

- Coverage for children up to 300% of FPL (with a sliding scale premium between 200-300% FPL) + one-year continuous eligibility
- Directs an advisory group to develop a plan for full health coverage in five years
- A Medicaid buy-in option for those with disabilities
- A Medical Homes Initiative
- Healthy Communities Initiative, Quality improvement council, transparency, electronic health plan to be developed



Maryland Working Families and Small Business Health Coverage Act

- Provides subsidies to small employers (2-9 employees) and employees of small employers if the employer:
 - has not offered a health benefit plan within the prior 12 months;
 - meets certain low-wage requirements to be established through regulation;
 - establishes a Section 125 payroll deduction plan to allow for pre-tax premium contributions; and
 - agrees to offer a wellness benefit that is designed to prevent disease, reduce poor clinical outcomes, and promote health behaviors and lifestyle choices.
- Expands Medicaid eligibility up to 116% FPL for parents/caretaker relatives.
- Phase-in over four years of Medicaid eligibility up to 116% FPL for childless adults—enrollment may be capped and benefits may be limited based on available funding.
- Financing: combination of general funds, hospital uncompensated care savings, a one-time surplus from high risk pool, and federal funds.



Minnesota – Coverage and Cost

- **Childless Adults to 250%**
- **Section 125 Plans**
- **“Essential Benefit Set”**
- **Easier enrollment and more seamless transitions**
- **Directs development of proposal to promote access to affordable employer-sponsored health care through tax credits and deductions**

Children	275% FPL
Pregnant Women	275% FPL
Childless Adults	175% FPL
SSI Disabled	100% FPL



Minnesota Payment Reform and Quality Improvement

- Establishes a single statewide transparent system for quality-based incentive payments
 - Public reporting on risk-adjusted quality measures
- Establishes new payment system based on “baskets” of care and then allows consumers to compare prices across providers
- Establishes standards for state certification of health care homes (to receive care coordination payments)
- Administrative Efficiency
 - Requirement that all EHRs [Electronic Health Records] be consistent with federal interoperability standards and that all prescriptions are ordered electronically by 2011
 - Uniform methods of claims process
- Public health programs to reduce obesity and cut tobacco use



New Jersey: Phases of Reform

Phase I

- Familycare Buy-in
 - Passed Into Law – 12/1/07
- “Kids First” Mandate
- Familycare Expansion
- Market Reform
 - Signed by Governor 7/8/8
 - Implementation 9/1/08

Phase II

- Creation of Garden State AllCare
- Individual Mandate
- Sliding Scale Subsidies
- Section 125 Mandate
- Charity care/related hospital subsidies redirected over time to premium assistance
- Collaborative Care System Creation/Medical Homes



Washington State Reforms

- Provides access to coverage for all children by 2010 (SB 5093)
- Intensive education/outreach/admin simplification to enroll the currently eligible
- Expands SCHIP to children up to 300% FPL (now 250%) in 2009
- Children above 300% FPL – full cost buy-in
- Creates Washington Health Insurance Partnership (Connector) (SB 1569)
 - Targets small employers w/low-income workers
 - Sliding scale premium subsidies for those <200% FPL
- Provides high quality, affordable health care based on recommendations of the Blue Ribbon Commission in Health Care Costs and Access (SB 5930)
 - Reimbursement Changes
 - Chronic Care Projects/Medical Homes
 - Washington State Quality Forum
 - Health Information Technology
 - Appropriate Care Settings
 - Wellness Programs



Wisconsin Reforms

- **BadgerCare Plus: Merge Family Medicaid, BadgerCare (SCHIP - covers children and parents to 185 percent FPL), and Healthy Start:**
 - Cover all children (families above 200% FPL can purchase basic health coverage for their children for \$10 to \$68.53 per child per month, depending on income)
 - Provide coverage/enhanced benefits for pregnant women up to 300% FPL
 - Simplify the program
 - Promote prevention and healthy behaviors (member agreements; incentives for MCOs; incentives for individuals; health literacy/education)
 - Financed through increase by \$1 per pack cigarette tax

- **New Policy Goals (2008+)**
 - Ensure 98% of Wisconsin's population has access to health insurance by expanding to childless adults through **BadgerConnect**, a new online gateway to health care
 - One-stop shop for health care access for low-income families
 - Increase business participation and health insurance portability
 - Use evidence-based medicine to design benefits and control costs



Wisconsin's BadgerCare Plus: Streamlining and Outreach

- Simplified & standardized eligibility rules
 - For example, the state reduced the number of earned income disregards and increased the income limit
 - The goal was to make the program easy to understand for both enrollees and staff
- Invested in outreach & focused on the community level
 - 42 agencies within the state received \$25,000 to build the infrastructure needed to help people apply for the program
 - Statewide ad campaign—called the children's coverage expansion an "all kids" program



Wisconsin's BadgerCare Plus: Streamlining and Outreach

- Made online application process easier & more accessible
 - Supported and promoted online applications
 - Simplified the online application and trained community workers around the state to use it
 - During the first few months of the program, online applications increased from about 25 to 50 percent of total applications
- Invested in more staff
 - Increased size of staff statewide, especially in Milwaukee
 - Developed a new processing center in Milwaukee to approve applications and send cards to enrollees within one week



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Substantial Reforms

States with Recommendations for 2009 Session

Connecticut

Kansas

Ohio

Oklahoma

Oregon

Utah

State Coverage Initiatives



Robert Wood Johnson Foundation

HealthFirst Connecticut Authority Recommendations

- Expanded Medicaid/SCHIP eligibility for all residents with family incomes below 300 percent FPL, with sliding scale cost-sharing and premium assistance for those with ESI.
- Access to a restructured Charter Oak program - currently allows families to buy health insurance regardless of their health status at premiums tied to income.
- A Connecticut Health Partnership, using the state employee health benefit plan as a base, will be available to all residents and employers in order to improve employer offer rates and employee take-up rates, and to offer coverage to those in the non-group market.
- Multiple recommendations for containing costs and improving quality.
- Data collection and analysis to drive policy development, implementation, and evaluation.
- Public entity assigned or developed to oversee the proposed reforms and better coordinate state spending on health care.



Kansas 2009 Health Reform Priorities – Kansas Health Policy Authority

- Statewide Clean Indoor Air
- Increased Tobacco User Fees
- Increased Access to Affordable Health Care and Health & Wellness
 - Medicaid Expansion to Parents up to 100% FPL
 - Convene panel to develop proposals to assist small employers and young adults afford health insurance
 - Tobacco Cessation for Medicaid
 - Expand Cancer Screening for Low-Income and Uninsured
 - HIT - Statewide Community Health Record
 - Workplace Wellness Grants for Small Businesses
 - Expand Kansas Coordinated School Health Program



Ohio State Coverage Initiatives Recommendations

- Requiring employers to establish §125 Plans
- Reinsurance for individuals and small businesses
- Extend group coverage to dependents up to age 29
- Premium assistance for low income workers
- Enrolling more Ohioans in Medicaid and expanding Ohio's Medicaid to high income levels
- Allowing non-Medicaid eligible adults to enroll in Medicaid managed care plans
- Reforms to the individual health insurance market (GI; Mandate; Subsidies; Admin Efficiencies)
- Connector



Blueprint for Oklahoma – Draft Report

- Maximizing enrollment in public programs for those eligible but not yet subscribed
- Developing an affordable basic health benefits plan
- Generating sufficient public revenue
- Encouraging the take-up of private coverage



Oregon Health Fund Board Report

- Improve access for children and low-income
- Cost containment and quality improvement mechanisms
- Purchasing strategies and insurance market reforms
- Encourage new models of care delivery
- Ensure health equity for all
- Train new health care workers
- Federal-state relationship



Utah Legislative Health System Reform Task Force Legislation

- Insurance market reforms:
 - Creates new basic benefit plan called the Utah NetCare Basic Health Care Plan
 - Allows mandate-free benefit plans to be offered in certain circumstances
 - Establishes Internet portal for the purchase of these new plans
 - Sole proprietors included in the small group market pool
 - Establishes a reinsurance pool
- Streamlines and standardizes various aspects of provider, insurer, and consumer interactions and communications.
- Framework for demonstration projects for delivery and payment systems reforms.
- Requires certain contractors who do business with the state to offer health insurance to their qualified employees.



Incremental Approaches

Cover All Children

Purchasing Pools/Mechanisms

Increasing Dependent Coverage

New Benefit Design

Reinsurance

Creative Uses of Medicaid
(public/private)

State Coverage Initiatives



Robert Wood Johnson Foundation

Rhode Island ('07): HealthPact

- Includes coverage for physician visits, hospitalization, preventive services, and prescription drugs
- Design is intended to give incentives to enrollees to be more actively engaged in managing their own health care
- Proposes to achieve significant cost savings through financial incentives for enrollees who improve and maintain their health through **five key wellness initiatives**
- For enrollees who choose to participate in the wellness programs, it is proposed that deductibles, co-pays and co-insurance will be reduced to amounts normally seen in plans with much higher premiums



Cover Tennessee ('07)

- Affordable healthcare coverage
 - Premiums shared equally by employer, individual and state
 - Individual's monthly premium share ranges between \$37 and \$109
 - Premiums vary depending on age, tobacco use, and obesity
 - No deductibles; reasonable co-pays
 - Maximum Benefit amount: \$25,000
- Portable – Individual Product
 - Owned by the individual
 - Individual can keep coverage even if they leave an employer
 - Provides continued coverage during brief periods of unemployment
- Basic – Provides most services most people need



States & the Health Workforce

States & the Health Workforce

- States have strong influence over the development and practice of the health workforce.
 - Education, financing and regulation
- State action is critical for current shortages & for the future.
- States are faced with current or imminent health workforce shortages due to multiple factors:
 - Aging population
 - Changing educational & practice environments
 - Limited pipeline of people entering health professions



State Action on Workforce Issues

- Data collection and analysis: State nursing centers, centers for health workforce studies, university centers
- Pipeline development: Health career websites, K-12 outreach programs, scholarships/loan repayment programs
- Retention (geared towards nurses): Career ladder programs, abolish mandatory overtime, pass minimum staffing ratios
- Licensure and Credentialing: Scope of practice changes, Nurse Licensure Compact (currently 23 states)
- Educational capacity building: Faculty scholarships and loan repayments, increasing educational capacity, innovation in educational delivery



Massachusetts (Enacted 8/08)

- Passed comprehensive plan to strengthen primary care infrastructure
 - Creates new Health Care Workforce Center within the Department of Public Health
 - State authority to establish a medical home demonstration project
 - Directs MassHealth Payment Policy Advisory Board to study methods to improve payments or bonuses for primary care providers
- For health care professionals who practice in underserved areas:
 - Loan forgiveness program
 - Affordable housing pilot
- Requires health insurers to recognize and reimburse nurse practitioners as primary care providers



Oregon (11/08 Recommendations)

- Released blueprint for comprehensive health care system reform - one key “building block” is to train a new health care workforce.
- Action steps include:
 - Collecting data through the licensure process to provide an on-going database about current workforce and analyze future workforce needs
 - Implementing strategies to train, attract and retain an appropriate supply of primary care providers in all areas of Oregon
 - Develop direct reimbursement and a certification system for Community Health Workers



Pennsylvania (Enacted 2008)

- Passed a series of measures over the last few years to expand the scope of practice for physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives and dental hygienists
- Generally, the laws allow fewer doctors to oversee these health care providers and expand the types of settings where they can provide health care services



Iowa (Enacted 5/08)

- Requires that the Department of Public Health expand efforts to guarantee a stable & well-qualified workforce
- Creates a Direct Care Worker Advisory Council to continue work on education and certification issues
- Instructs the Department of Human Services (DHS) to maintain an ongoing report that measures direct care worker turnover in nursing facilities
- Directs DHS to design a premium assistance demonstration project to provide health coverage for up to 150 direct care workers and their dependents



Vermont (Enacted 2006)

Workforce measures to increase provider availability:

- Loan repayment program for health care providers & educators
 - Available to primary care doctors, nurses, dentists, and nurse educators/faculty
 - Must agree to serve patients enrolled in Medicare, Medicaid, or other state health benefit plans
- Loan forgiveness program for nurses and dental hygienists
- Tele-psychiatry pilot to fill the state's gap in available child psychiatrists
- Provider reimbursement surveys
 - Examine the adequacy of reimbursement rates and understand impact of rates on recruitment and retention of health care professionals
- Conduct Nurse Authority Study
 - Establish a work group to study and make recommendations on whether an advanced practice nurse need not be required to work in a collaborative practice with a physician



State Quality Reporting Activities

Using Performance Measurement to Improve Quality

- Public Reporting
 - Health Plans
 - Hospitals
 - Nursing Homes
 - Ambulatory Settings

- Purchasing to Improve Quality
 - Value-based purchasing/payment reform
 - Tiered networks
 - To drive delivery system reform

- To Drive Consumer Choice and Internal Quality Improvement



Public Reporting on Health Plan Performance

- Measures
 - HEDIS: Clinical Measures (Administrative/Medical Records)
 - CAHPS: Patient Satisfaction (Survey)
 - Complaints
 - NCQA Accreditation

- **26 States have public reports using HEDIS, CAHPS or both**

- Some Medicaid Programs publicly report as well



Public Reporting on Hospital Performance

- Descriptive Measures: Administrative
 - Volume/Utilization/LOS/Readmission
 - Number of beds; Services available; Financials; etc
- Process Measures: Clinical (CMS/JCAHO)
 - Heart Attack/Congestive Heart Failure/Pneumonia/SIP
- Outcome Measures: Clinical
 - Mortality (CABG/PCI) – risk adjustment
- Patient Satisfaction: Survey
- **15 States publicly report one or more of these measures**



Public Reporting on Nursing Homes

- Structural/Descriptive Measures: Administrative
 - Number of Beds
 - Staffing Info: Number of Nurses; Turnover; Wages
 - Financial/Cost
- Quality Measures: Clinical (CMS)
 - Quality Measures
 - Deficiency/Complaints
- Patient/Family Satisfaction
- **States generally publicly report deficiency/complaint information**



Public Reporting of Healthcare-Acquired Infections (HAI)

- Public Disclosure:
 - 2003: IL (reworked in 2005)
 - 2004: FL, MO, PA
 - 2005: NY, VA
 - 2006: CO, CT, MD, NH, OH, OK, SC, TN, VT
 - 2007: DE, MN, NJ, TX, WA
 - 2008: CA, MA, OR, RI, WV
- Study Bills: TX (2005/public disclosure in 2007), GA (2006), AK (2006 - resolution)
- Pilot Project: NM (2007)
- Confidential Reporting: NE, NV (2005)



Report Card Authors Face Numerous Choices

Choice	Approach	Issues
Source of data	Claims	Easy and cheap to obtain, but less accurate
	Chart review	More accurate, but expensive
	Surveys	Consumers like, but expensive
Level of reporting	Hospital Level	Facility information, not care by specific practitioner
	Large groups of physicians	Heterogeneous, more valid statistically, less useful to patients
	Individual physician	Numbers of procedures too small, hard to do risk adjustment, most useful to patients
Display of data	Stars or bar graphs	Intuitive and familiar to consumers but can be misleading
	Statistical ranges	Closer to "truth," but more difficult to explain



Common Principles in Performance Reporting

- Steering committee of interested parties
- Pilot first then full implementation
- Reduce duplication of effort by carriers, facilities, and practitioners
- Continuous revision and improvement as measurement techniques advance
- Focus on the Positive
- Web-based application



State Health Policy Commissions and Authorities

Delaware Health Care Commission - 1990

- Independent public body reporting to the Governor and the Delaware General Assembly
- Policy-setting body rather than a service-delivery body
- **Mission:** To promote accessible, affordable, quality health care for all Delawareans.
 - **Access-** Promote access to health care for all Delawareans.
 - **Cost-** Promote a regulatory and financial framework to manage the affordability of health care.
 - **Quality-** Promote a comprehensive health care system assuring quality care for all Delawareans.
- Uninsured Action Plan
- Information & Technology
- Health Professional Workforce Development
- Research & Policy Development
- Specific Health Care Issues & Affiliated Groups



Delaware Health Care Commission

- Chair is Lt Gov
- Four government officials (ex officio)
 - Secretary of Finance
 - Secretary of Health & Social Services
 - Secretary of Children, Youth & Their Families
 - Insurance Commissioner
- Six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate
 - Dean, College of Health and Public Policy, Delaware State Univ.
 - Senior VP for Government Relations, DE Chamber of Commerce
 - Chair, Dept of Family & Comm Med, Christiana Care Health Services
 - President, Maritime Exchange for the Delaware River and Bay
 - Two others



Maryland Health Care Commission

- Develop State Health Plan/administer Certificate of Need program
- Oversee certain aspects of small group market reforms
- Develop and publish consumer guides for health plans, hospitals, nursing homes and ambulatory surgical centers
- Establish and develop a medical care data base on health care services rendered by health care practitioners
- Establish standards for the operation and licensing of medical care electronic claims clearinghouses
- Determine the cost of mandated health insurance services
- Promote the availability of information to consumers on charges by practitioners and reimbursements from payors
- Oversee and administer the Maryland Trauma Physician Services Fund
- Other policy studies as requested: patient safety, affordability, etc



Maryland Health Care Commission

- 15 members appointed by Gov with advise/consent of Senate
 - Nine must be individuals with no connection to the management or policy of a health care provider or payor
 - Remaining six members:
 - Two physicians
 - Two payors
 - One nursing home administrator
 - One non-physician health care practitioner
- Also geographic representation requirements
- To the extent practicable, assure geographic balance and promote racial, ethnic, and gender diversity in the Commission's membership



Kansas Health Policy Authority - 2005

- Responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies.
- All health insurance purchasing by the State is now combined under KPHA, including publicly funded programs (Medicaid, State Children's Health Insurance Program, and Medikan) and the State Employee Health Benefits Plan.
- Responsible for compiling and distributing uniform health care data in order to provide health care consumers, payers, providers and policy makers with information regarding trends in the use and cost of health care for improved decision making.
- 2007 Legislation: Directed KHPA to develop health reform options in collaboration with Kansas stakeholders.



Kansas Health Policy Authority

- Nine voting health care, business, and community leaders appointed by the Governor and the Legislature
 - President, Chief Executive Officer and General Counsel for Medicalodges, Inc.
 - Associate Professor, Dept of Public Administration, University of Kansas
 - Senior Vice President, Human Resources at EMBARQ Corporation
 - Chairman of the Board, Midway Wholesale of Topeka
 - Professor of Management Practice, Harvard Business School.
 - Retired Co-President and CEO, Center for Health and Wellness
 - Pediatrician
 - CEO of Pratt Regional Medical Center
 - Retired, Midwest Consortium Administrator, Centers for Medicare and Medicaid (CMS), HHS
- Ex-Officio Members
 - Dept of Health & Environment (Sec & Dir of Health); Dept of Social & Rehabilitation Services; Dept of Administration; Dept on Aging; Insurance Department; Department of Education; KHPA Executive Director

State Coverage Initiatives



Robert Wood Johnson Foundation

Connecticut Office of Health Care Access

- Headed by a Commissioner who is appointed by the Governor
- Mission: To ensure that the citizens of Connecticut have access to a quality health care delivery system:
 - By advising policy makers of health care issues
 - By informing the public and the industry of statewide and national trends
 - By designing and directing health care system development
- **Certificate of Need & Compliance Unit:**
- **Research & Planning Unit:**



Oregon Health Policy Commission - 2003

- **Mission:** To develop and promote policy recommendations to the Governor, the Legislature, and the Oregon Health Policy and Research (OHPR) that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging healthy lifestyles.



Oregon Health Policy Commission

- Ten voting members appointed by the Governor.
 - Exec VP, Corp Services & Chief Legal Officer, The Regence Group
 - Chair, AterWynne LLP (Strategic Legal Advisors)
 - Director, Integrated Clinical Services, Multnomah County Health Dept
 - Senior Consultant, Watson Wyatt Worldwide
 - President, SEIU Local 49
 - Health Care Consultant
 - Director, Oregon Ctr for Health Professions, Oregon Inst of Technology
 - CEO, The Lussier Center (Management Consulting Services)
 - Chairman, Triquint Semiconductor
 - Vice President and Chief Quality Officer, Samaritan Health Services
- Four legislators (one representing each legislative caucus) serve as non-voting advisory members to the Commission



Lessons Learned in State Reform Efforts

Lessons Learned in State Reform Efforts #1

- Successful comprehensive reforms are built on previous efforts, financing mechanisms
- Need ingredients: leadership, opportunity, readiness to act, persistence
- No free solutions
- Successful efforts to enact reforms often need shared financial responsibility
- State expansions in coverage often rely on private insurers to deliver care
- Voluntary strategies will not result in universal coverage
 - some states are beginning to recognize the need for mandatory participation



Lessons Learned in State Reform Efforts #2

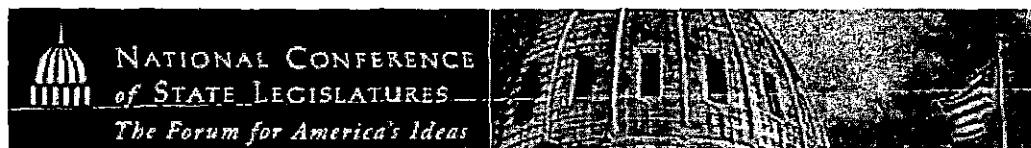
- Hard to get agreement on what is covered (benefit design/affordability)
- Little success so far in addressing underlying cost of health care but a new focus on chronic care management/preventive care holds potential
- Address access, systems improvement, cost containment simultaneously—concern about long-term sustainability of coverage programs and improved population health
- New state reforms can be fairly judged only after several years, allowing a realistic length of time to work through implementation challenges.
- Comprehensive reforms need sequencing
 - Sequential = incremental with a vision



States Can Advance Reform Initiatives But Need Federal Support

- States face growing pressures for reform
 - Uninsurance continues to rise as employer sponsored coverage declines
 - Cost increases threaten state budgets and capacity to sustain Medicaid/SCHIP
- States play critical role in moving the conversations about coverage expansions
 - Testing new ideas (politically and practically)
 - Creating momentum for national policy solution
- States cannot achieve universal coverage without a federal framework and funding
 - Significant variation across states in resources, capacity, and landscape—including uninsured rates, available state funds to invest in coverage, insurance market structures, and other important factors





NCSL Health Committee Roster

[Committee Officers & NCSL Staff](#) // [Committee Members](#) // [Committee Jurisdiction](#)

Committee Description

This committee has jurisdiction over state and federal health programs, legislation, regulations and policies. The committee educates Congress and federal agencies about state concerns regarding developments in federal health initiatives and programs and grants to states. In addition, it serves as a forum for legislators and legislative staff to learn about and share information regarding health programs and health policy initiatives in other states. Recently, the committee has addressed the following issues:

- Medicare prescription drug coverage
- Medicaid
- Health care cost containment
- Health care access
- Public health and prevention

NCSL Health Committee

Chair: Senator Judy Lee, North Dakota

Vice Chair: Senator Ronnie W. Cromer, South Carolina

Vice Chair: Senator Bettye Davis, Alaska

Vice Chair: Representative Keith J. Gillespie, Pennsylvania

Vice Chair: Senator Lisa T. Marrache, Maine

Vice Chair: Senator Patrick Alan Nunnelee, Mississippi

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1/29/09

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Trust Workforce Development Focus Area



Alaska Mental Health Trust Authority

The TRUST
The Alaska Mental Health
Trust Authority

Trust Beneficiaries

- People with mental illness
- People with developmental disabilities
- People with alcoholism
- People with Alzheimer's disease and other dementia

Alaska Scorecard
Key Issues Impacting
Alaska Mental Health Trust Beneficiaries

Alaska Mental Health Trust

Key Population Indicators for Alaska

Indicator	Alaska		U.S. Rate		2007 vs. 2002	
	Rate	U.S. Rate	2007	2002	Change	Trend
Health						
Substance Abuse						
1 Suicide rate per 100,000	29.6	18.9	18	18	0	↔
2 Non-fatal suicide attempts (rate per 100,000)	104.9	54.5	55	55	0	↔
Mental Health						
3 Alcohol-related deaths per 100,000	20.7	7	17	17	0	↔
4 Adults who engage in heavy drinking	6.4%	5.2%	5.2%	5.2%	0%	↔
5 Days of poor mental health in past month (adults)	19.2%	15.7%	18%	18%	0%	↔
6 Days of poor mental health in past month (adults)	11.7%	9.2%	10%	10%	0%	↔
7 Teen who experienced depression during past year	3.7	3.2	3	3	0	↔
8 Population without health insurance	26.9%	28.5%	27.5%	27.5%	0%	↔
Protection						
9 Children abused and neglected (rate per 1,000)	17.4%	15.5%	14.6%	14.6%	0%	↔
10 Injuries to elders due to falls (rate per 1,000)	14.3	12.3	12.3	12.3	0	↔
11 Rate of new fall at traumatic brain injury per 100,000	1,388	1,176	1,176	1,176	0	↔
12 Rate of new fall at traumatic brain injury per 100,000	87.3	not avail	82	82	0	↔
Justice						
13 Percent of incarcerated adults with mental illness or mental disability	4%	28.7%	40%	40%	0%	↔
14 Criminal recidivism rates for incarcerated adults with mental illness or mental disability	26.2%	not avail	34%	34%	0%	↔
15 Percent of arrests involving alcohol or substance abuse (State Troopers)	58.6%	not avail	not avail	not avail	0%	↔
Accessibility, Affordable Housing						
16 Rate of chronic homelessness per 100,000	91.8	41.1	63.5	63.5	0	↔
17 High school graduation rate	83.1	83.1	83.1	83.1	0	↔
18 Percent of youth who received special education who are employed and/or enrolled in post-secondary education one year after leaving school	63%	not avail	not avail	not avail	0%	↔
19 Percent of income wage taxpayer received for average 2-bedroom housing	68.4%	not avail	71.4%	71.4%	0%	↔
20 Average annual unemployment rate	85%	not avail	30%	30%	0%	↔
21 Percent of ESI recipients with children or disabilities who are working	7%	5.7%	not avail	not avail	0%	↔
Trust Beneficiary Population						
Percent of Alaska's Adult Population						
Mental Illness: Alaska Adults with Serious Mental Illness	7%	5.7%	not avail	not avail	0%	↔
Mental Illness: Alaska Children with Serious Emotional Disturbance	12,725	(1.6%)	12,725	(1.6%)	0	↔
Alaskans with Alzheimer's Disease and Related Disorders	6,800	(1.8%)	6,800	(1.8%)	0	↔
Alaskans with traumatic brain injury	11,900	(1.8%)	11,900	(1.8%)	0	↔
Alaskans with developmental disabilities	12,625	(1.8%)	12,625	(1.8%)	0	↔
Alaskan adults dependent on alcohol	12,000	(2.6%)	12,000	(2.6%)	0	↔

Alaska Scorecard, December 2008 | www.hhs.state.ak.us/aph/healthpolicy/scorecard/

Formula for Success

- **Identify a problem or community need**
- **Collaborate with governmental agencies, advisory groups, non profits, service providers, philanthropic organizations and private sector**
- **Develop strategic, sharply focused solutions**
- **Make lasting system improvements for Trust beneficiaries**

committed partners + strategic thinking = results for Trust beneficiaries

Five Focus Areas

- **Bring the Kids Home**
- **Affordable, Appropriate Housing**
- **Disability Justice**
- **Workforce Development**
- **Beneficiary Projects Initiative**

Workforce Development

- **Problem or community need**
 - shortage of health care workers in Alaska at a near-crisis level
 - health services industry fastest growing sector of Alaska's economy, more than 7% of workforce
 - burgeoning demand for increased health services for the state's steadily growing and aging population, some are Trust beneficiaries
 - need to increase pool of qualified employees in Alaska who serve Trust beneficiaries and keep adequately trained
- **Committed partnerships**
 - more than 20 partners -
 - New joint position between Trust, University and DHSS to coordinate workforce development efforts within the focus area (housed in DHSS Commissioner's office – Kathy Craft
 - service providers, Dept. of Health and Social Services, University of Alaska system, Dept. Labor and Workforce Development, non-profit and faith-based organizations,
- **Strategic thinking**
 - key focus area strategies around:
 - recruitment,
 - retention
 - training

Training

- **Trust Training Cooperative**
- **Geriatric Training – Alzheimer's (ADRD)**
- **Credentialing and Quality Standards**
- **Children's Mental Health Certification**
- **Autism Workforce Development Capacity Building**
- **Brain Injury training for professionals**
- **Peer Support Workers**
- **Disability Justice training for professionals**

Recruitment & Retention

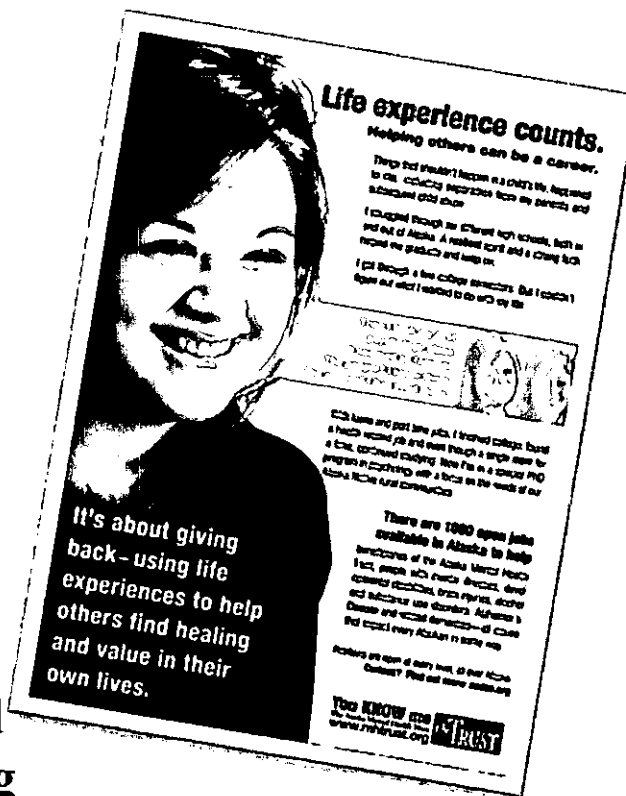
- **Alaska Alliance for Direct Service Careers (AADSC)**
- **Wages and Benefits**
- **“Grow Your Own”**
- **Marketing Strategies**
- **Cash Stipends/Loan Repayment Program**
- **Alaska Psychiatric Residency study**

Administration/Other

- **Behavioral Health Alliance**
- **Workforce Development Statewide Policy Meeting**
- **Workforce Development Manager**
- **Vacancy Study**

FY 2008 Results Highlights

- 990 professionals/providers across Alaska received training and education on behavioral health related topics through the Trust Training Cooperative
- 1,194 providers trained by the Geriatric Education and Training Center on issues regarding Alzheimer's and related disorders
- 1,550 people received behavioral health training through the University of Alaska, a 13% increase in enrollment in beneficiary related degree programs
- 958 professionals across the state received training through the Training and Technical Assistance for Providers program, increasing the number of professionals trained to respond to cases of disability related abuses



Ahead in FY2010

- **Support student loan repayment strategies for health professionals**
- **Support increments for University of Alaska health programs**
- **Researching a psychiatric residency program in Alaska**
- **Finalizing plans for a PhD psychologist internship program in Alaska**

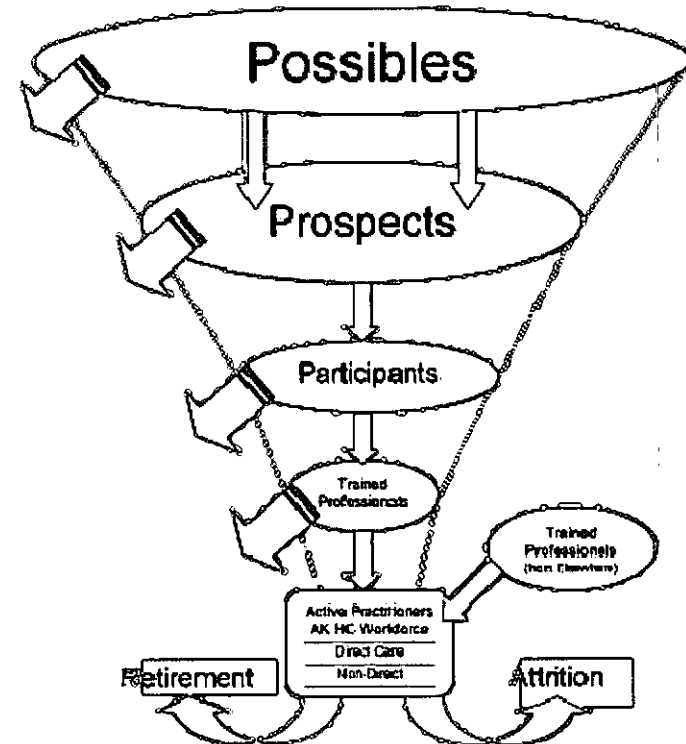


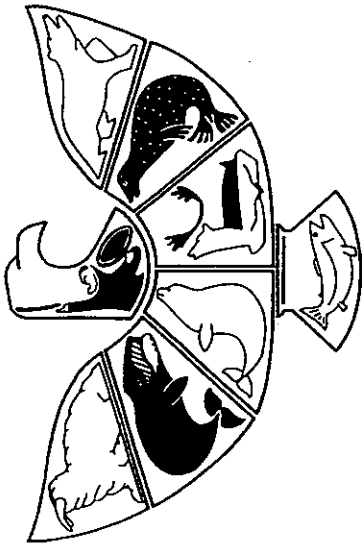
Alaska's Health Care Workforce: Shortage & Solutions

Interagency Presentation — Jan. 29, 2009
House HSS Committee, Alaska State Legislature

Trust Workforce Development Focus Area

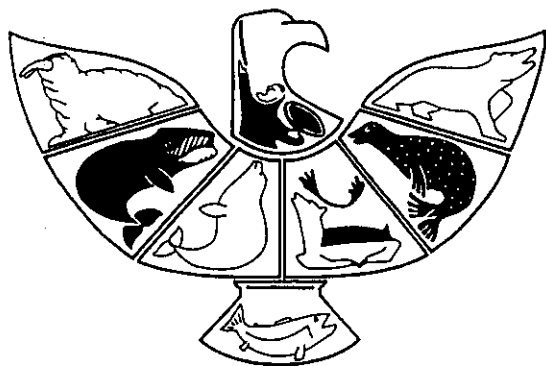
Delisa Culpepper, Chief Operating Officer
Alaska Mental Health Trust Authority





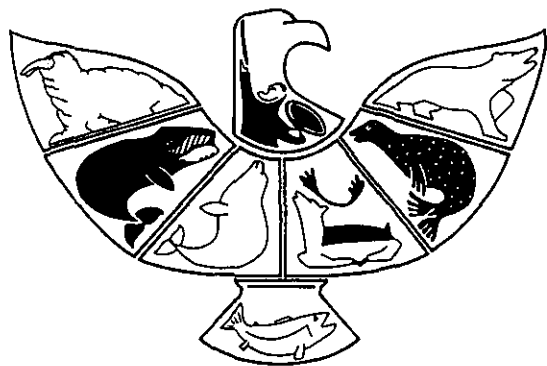
Presented by:
Evangelyn Dotomain,
President/CEO
Alaska Native Health Board

Tribal Workforce Development Update



Topics of Discussion

- Tribal Health System Overview
- Levels of Tribal Health Service Delivery
- Needs in Tribal Health Care
- Tribal Health Care Vacancy Rates
- Tribal Health Care Facts & Actions
- What is Needed?



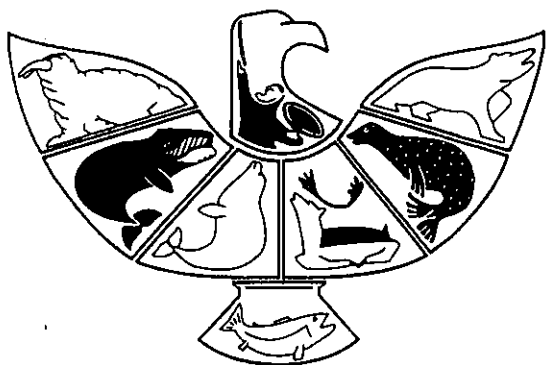
Tribal Health Overview

- Alaska Native Health Board (ANHB) is a 24 member tribal health advocacy organization established in 1968.
 - Regional Tribal Health Organizations
 - Village Tribal Organizations
- We advocate for approximately 130,000 Alaska Natives/American Indians, or 20% of the state population.
- Tribal health consists of :
 - 7 tribally operated hospitals
 - 21 tribally operated health centers in Alaska
 - 161 tribally operated village clinics
 - Over 530 Community Health Aides or Practitioners
- The primary source of funding for this system is derived from the Indian Health Service.



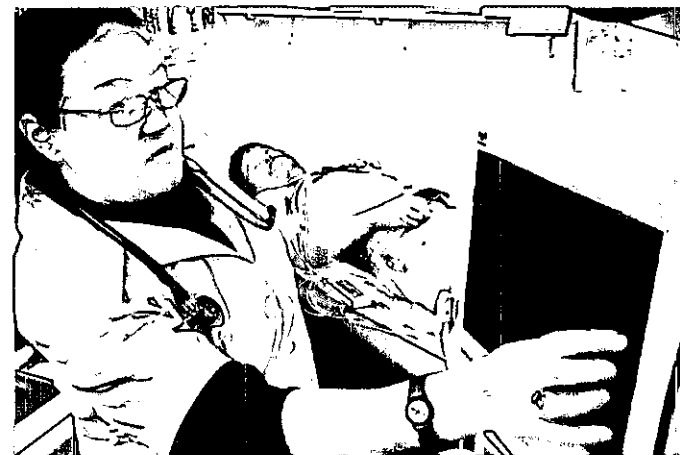
Tribal Health Overview

- **Socio-economic Status**
 - Remote Communities with little economic base
 - High unemployment rates
 - Low income levels
- **Health Care Issues: A Perfect Storm**
 - Travel farther than others to receive health care services
 - With money they don't have
 - Usually much sicker and with more
 - medical issues than the average
 - person by the time they receive
 - care at a health facility
 - Fewer medical resources available
 - Higher costs than other facilities
 - in the United States



Tribal Health Overview

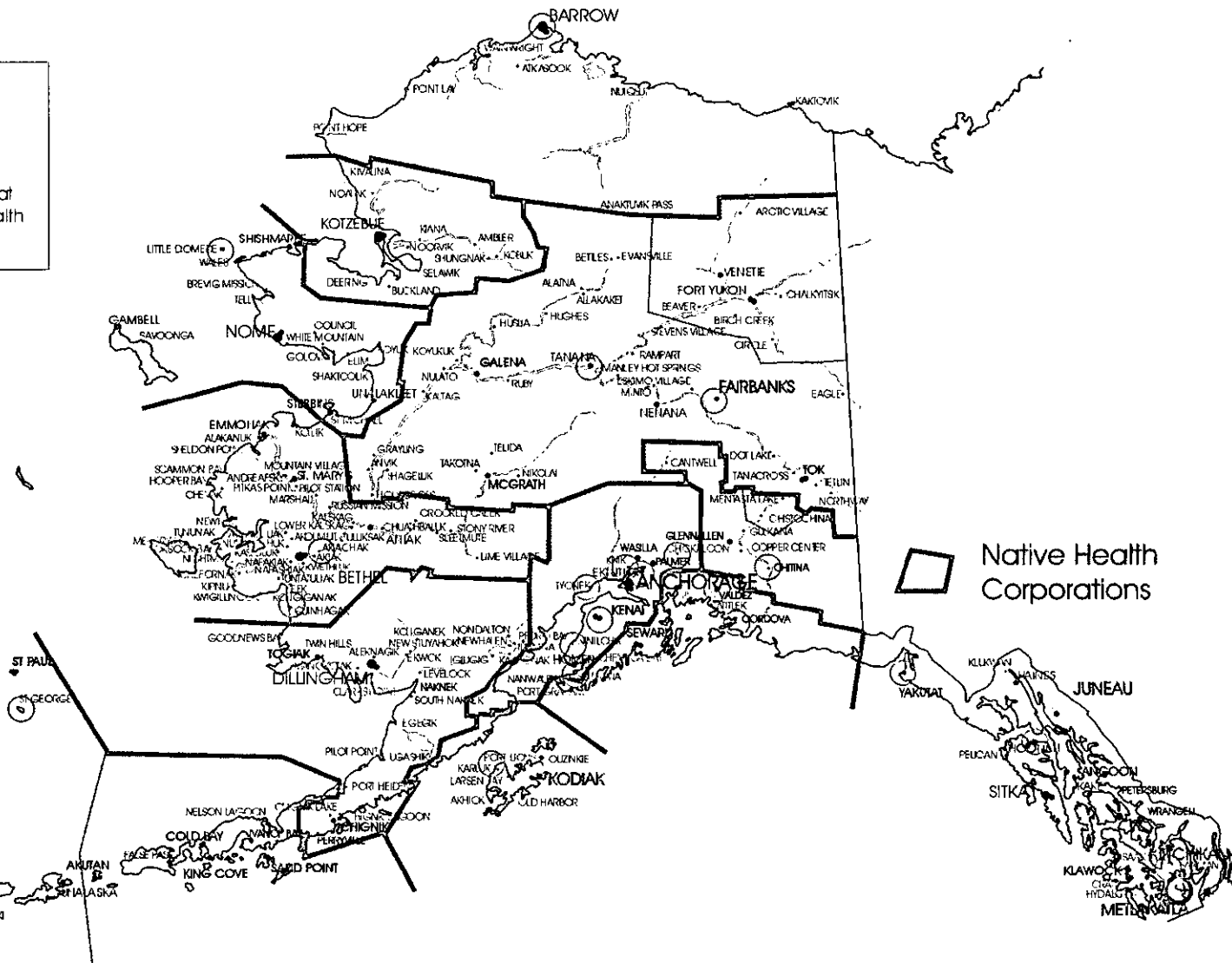
- Tribally delivered health care has improved health for Alaska Natives
- Disease rates have dropped dramatically due to:
 - Improved access to health care
 - Increase in basic public health measures
 - Childhood and Other Vaccines
 - Sanitation and Water Facilities
- However, there are challenges
 - Chronic under-funding
 - Staffing shortages
 - Increasing health care costs
 - Growing Alaska Native population
- Coupled with inadequate funding for Indian Health Service (IHS) for many years — Increases have not kept up with yearly inflation rates or medical cost inflation

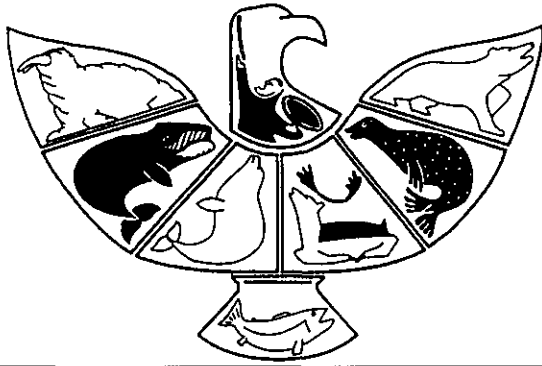


THE ALASKA NATIVE HEALTH CARE SYSTEM

Location Names and Service Level

- HOSPITALS
 - MD HEALTH CENTERS
 - PAVNP HEALTH CENTERS
 - PHN HEALTH CENTERS
 - CHA CLINICS
- Bold Face Names Indicate that a higher level of Contract Health Care is available in that town.

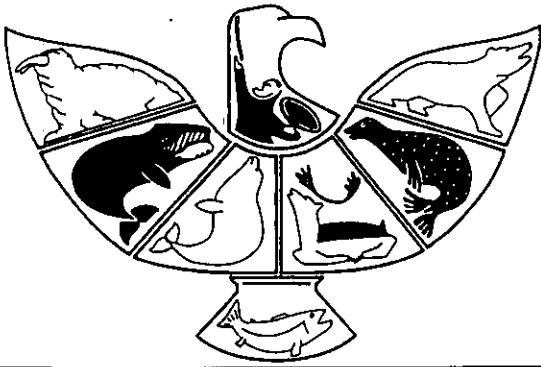




Tribal Health Needs

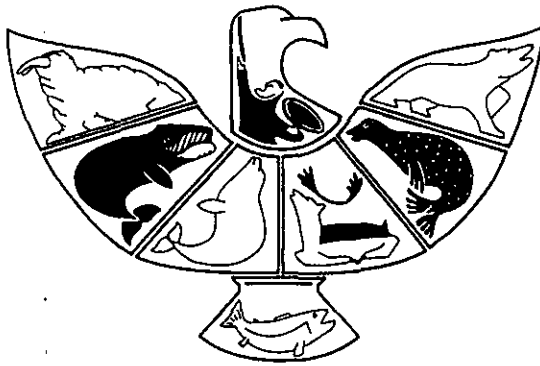
- Village Health Care:
- Primarily provided by Community Health Aides/Practitioners
- Few training sites and limited training slots result in a backlog of those needing training.
- Limited numbers of EMS providers and VPSOs results in high levels of burn-out among Community Health Aides / Practitioners as first responders and limited training time.
- The lack of resources and personnel currently available for rural Elder care means that many geriatric patients receive little or insufficient care.





Tribal Health Needs

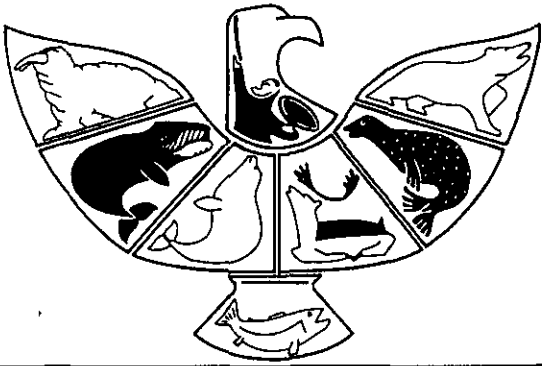
- Behavioral Health
- The need for increased behavioral health services in Alaska is well documented.
 - Alcohol and Substance Abuse
 - Mental Illness
 - Domestic Violence and Child Abuse
- Alcohol and drug abuse account for a substantial number of deaths and approximately 50% of all emergency room visits within Alaska.
- In many regions, behavioral health providers are either in short supply or are less than optimally trained for their duties (or both).



Tribal Health Among Alaska's 100 Largest Employers

	<u>Employees</u>	<u>Ranking</u>
Alaska Native Tribal Health Consortium/ Alaska Native Medical Center	1855	11
<i>Yukon Kuskokwin Health Corporation</i>	<i>1292</i>	<i>15</i>
Southcentral Foundation	1250	16
<i>SE Alaska Regional Health Consortium</i>	<i>826</i>	<i>28</i>
Maniilaq Association	555	44
<i>Tanana Chiefs Conference</i>	<i>485</i>	<i>56</i>
Norton Sound Health Corporation	478	59
<i>Bristol Bay Area Health Corporation</i>	<i>355</i>	<i>70</i>

2007 Alaska Economic Trends



Tribal Vacancy Rates

Contributing Factors:

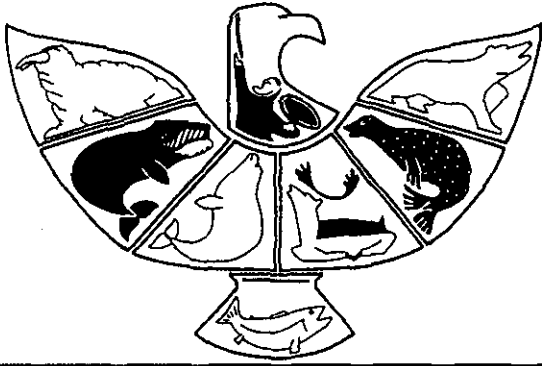
- Remote locations
- Cost of living
- Lack of housing
- Difficulty maintaining competitive salaries due to limited funding
- Fewer graduating Family Practice Physicians
- IHS loan repayment issues
- National Health Service Corp (NHSC) Loan repayment issues



Physicians	27%
Dentists	42%
Pharmacy	30%
Nurses	15%

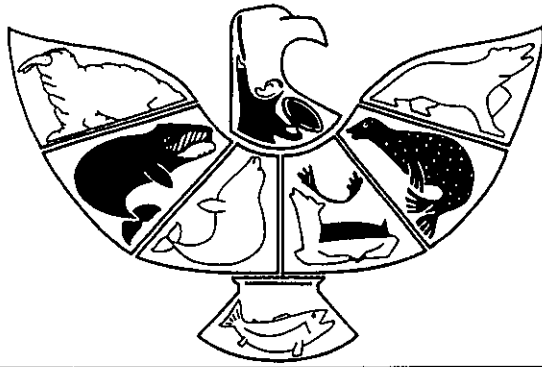
Table 3. Statewide Vacancy Rates

Occupational Groups	Statewide Estimates			Tribal Vacancy
	Positions	Vacancies	Vacancy Rate	
All Occupations	34738	3529	10.2%	16.5%
Physicians	1931	226	11.7%	27.1%
Professional Nurses	7139	696	9.8%	15.5%
CNA/LPN/PCA/HHA	1762	111	6.3%	14.3%
Dentist/Pharmacists/ Therapists	2281	404	17.7%	42.9%
Behavioral Health	7450	1033	13.9%	14.5%
Allied Health	5523	434	7.9%	17.1%
Public Health/Nutrition	189	ND	ND	15.2%
Managers	2947	160	5.4%	7.6%
Health Information/ Reimbursement	4451	253	5.7%	11.3%



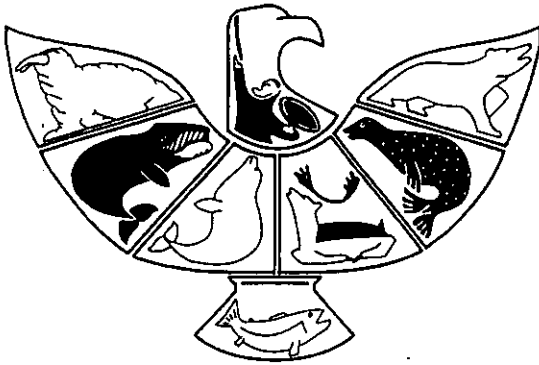
Basic Tribal Recruitment Facts

- Providers are getting more expensive and wanting to work less
- **\$31,000** = Tribal Health Care Cost to Recruit a Primary Care Provider
- **2 years** = Average length of employment stay of a Medical Licensed Professionals (MLP) or a Physician in rural clinic
- **6 months** = Average time to fill MLP vacancy
- **14 months** = Average time to fill a Physician vacancy
- **1 month** = Average notice given to leave rural site
- **150%** = Cost of Locums' coverage compared to direct hire



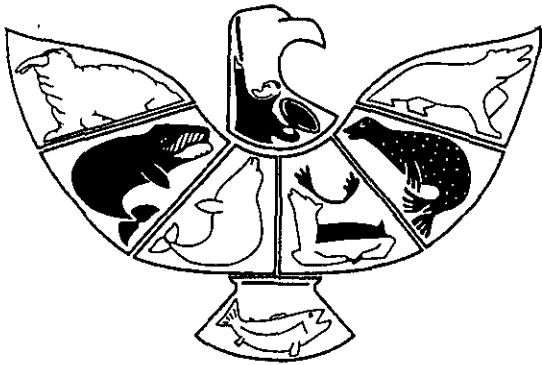
Tribal Health Care Fact

- Alaska Native/American Indian people deserve a high quality health care experience.
- With limited resources, it is getting more difficult to provide this deserved high quality care.



Tribal Health Actions

- Getting more efficient and effective with recruitment efforts
- Increase education and outreach to encourage more Alaska Natives to pursue health careers
- Increase incentives to stay in rural areas
- Continue to explore and adopt technologies to improve access to care in a cost effective manner (example: telemedicine)



What is needed?

- Provide Healthcare Professionals incentives to work at rural sites
- Provide State funded student loan reimbursement
- Increase support for health care professional education
- Support expansion of the number of primary care providers and services in Alaskan communities
- Increased funding for the Community Health Aide/Practitioner Program to increase the number of CHA/Ps and their training opportunities
- Support training for Elder caregivers
- Support for more EMS providers and VPSOs in villages
- Establish a Behavioral Health Aide Program through a statewide training system and certification process





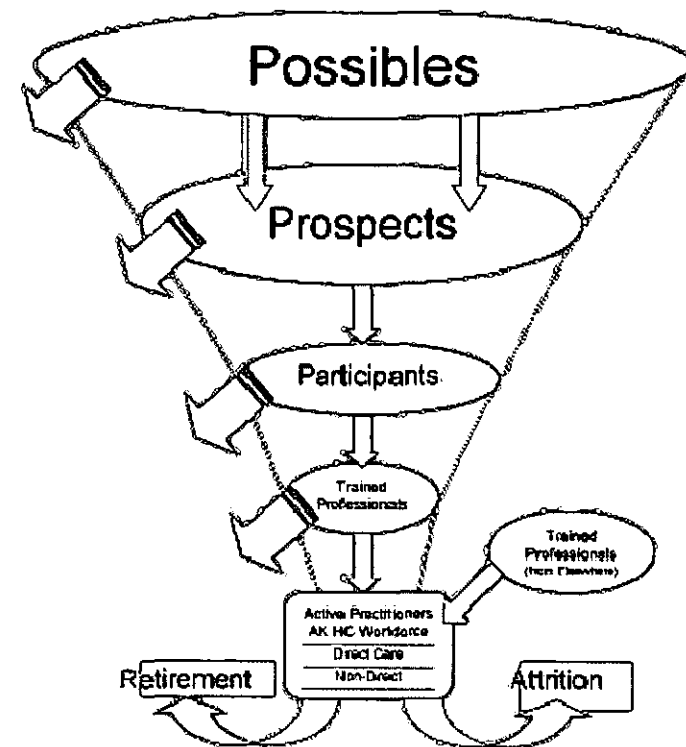
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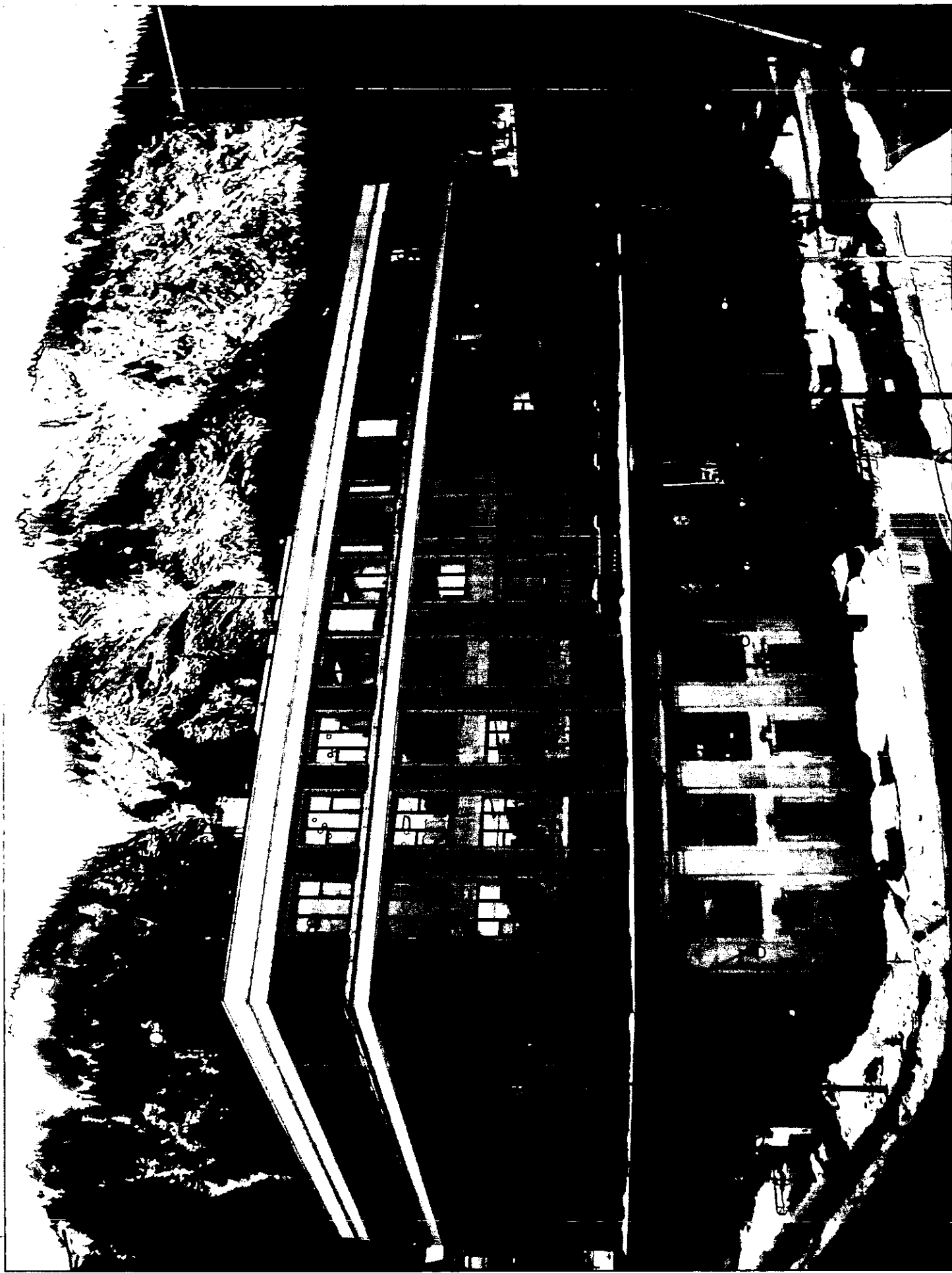


Alaska Department of Health and Social Services

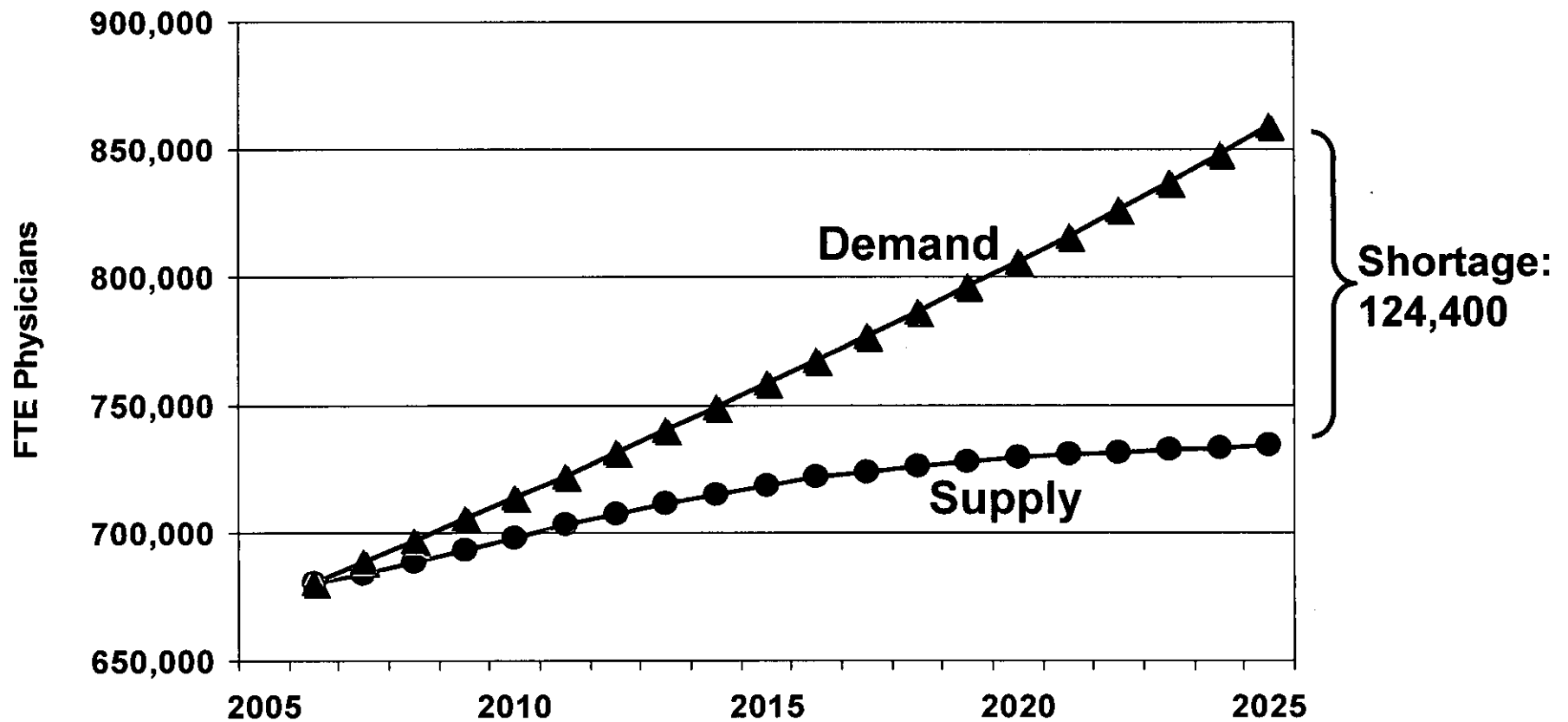
Alaska's Healthcare Workforce

Physician Workforce

Jay C. Butler, MD, FAAP, FACP
Chief Medical Officer



Physician Supply and Demand Projection 2006-2025

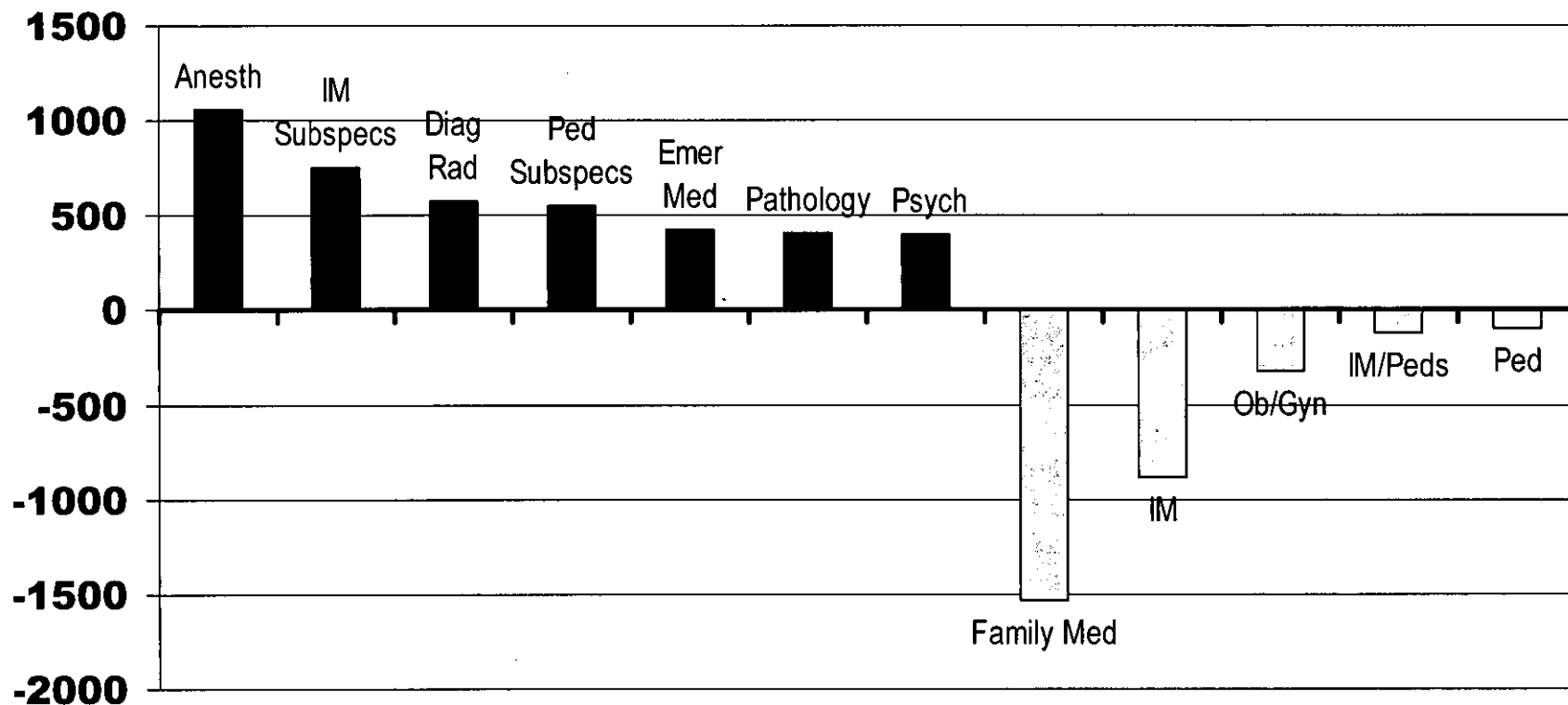


Source: Association of American Medical Colleges

Healthcare Workforce, HSS Hearing 1/29/09

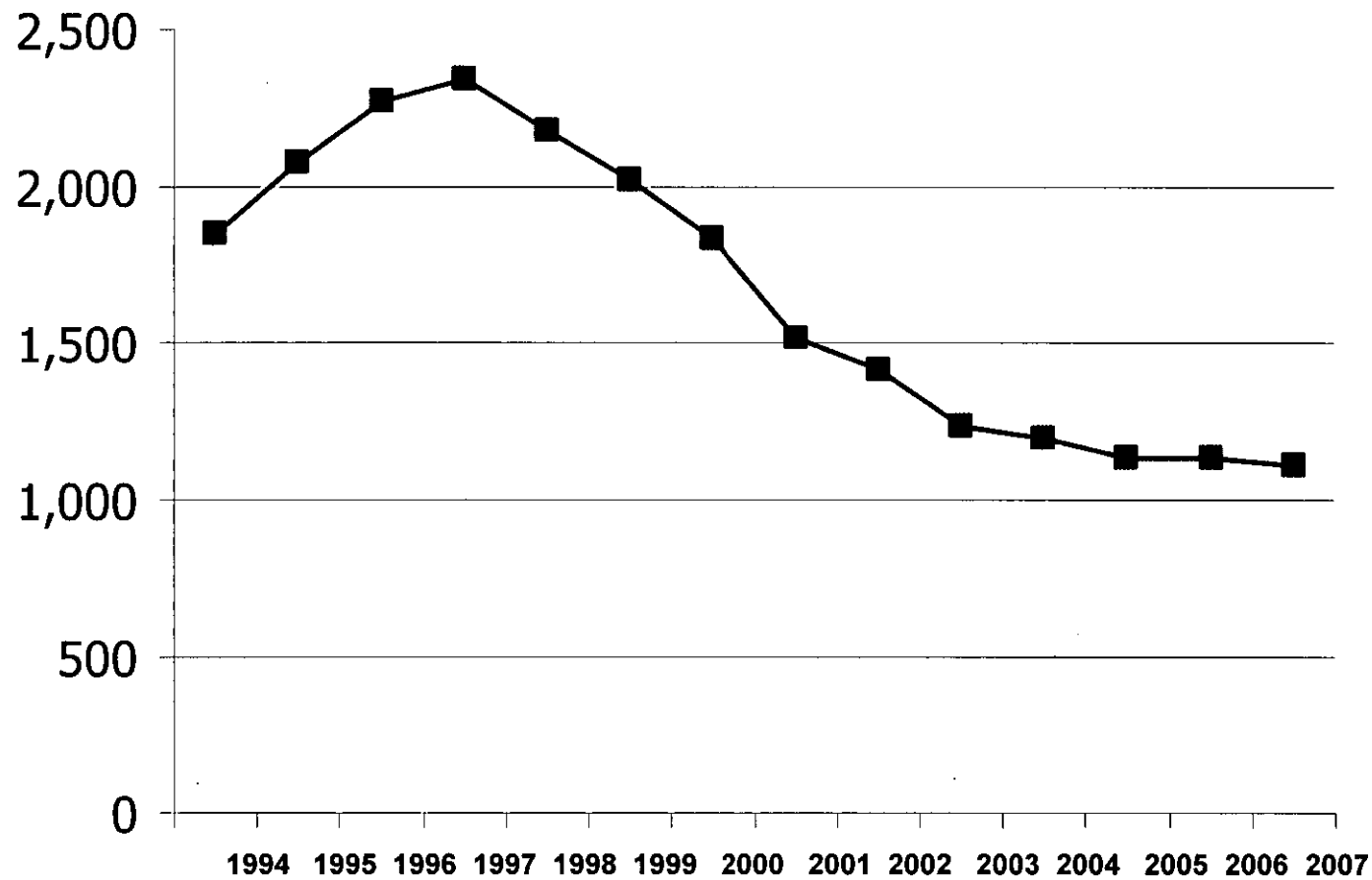
Change in # of U.S. MD Grads Each Year

Training in Various Specialties: 2002-2007

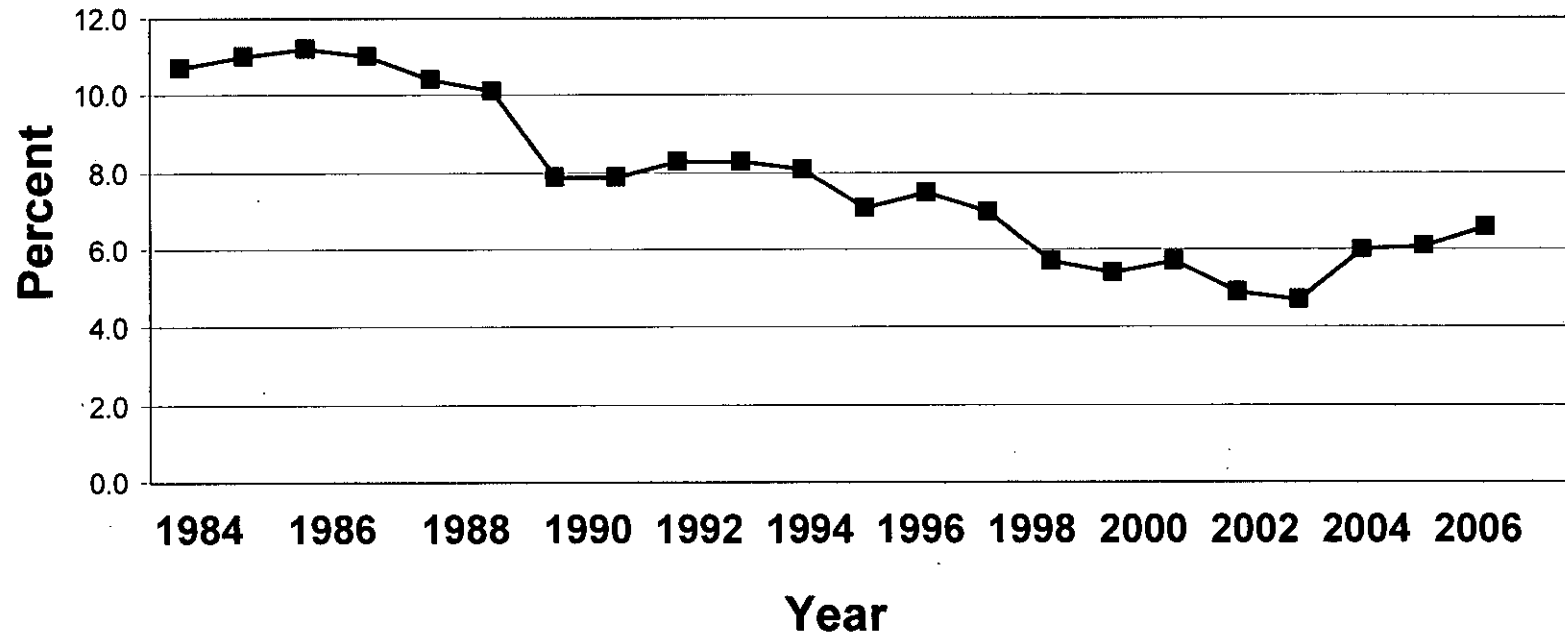


Source: Association of American Medical Colleges

Family Medicine Residency Positions Filled by US Graduates in the Match, 1994-2007



% US Med School Grads Entering General Surgery Residencies



Kirkham JC, Columbia University, 2006

Healthcare Workforce, HSS Hearing 1/29/09

Economic Impact of One Rural Physician on a Local Economy...



23 ← Jobs

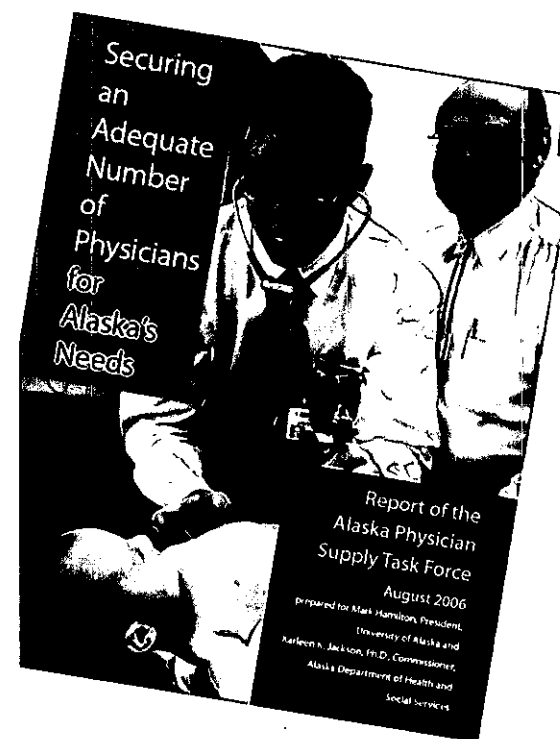
\$ 899,000 ← Wages, Salaries & Benefits

\$1,533,000 ← Total Revenue

Gerald Doeksen (OK State Univ) "Making the Link to Economic Impact & Workforce Development" (at: Rural Health Workforce Trends Conference, Phoenix, AZ; Mar 4-6, 2008)

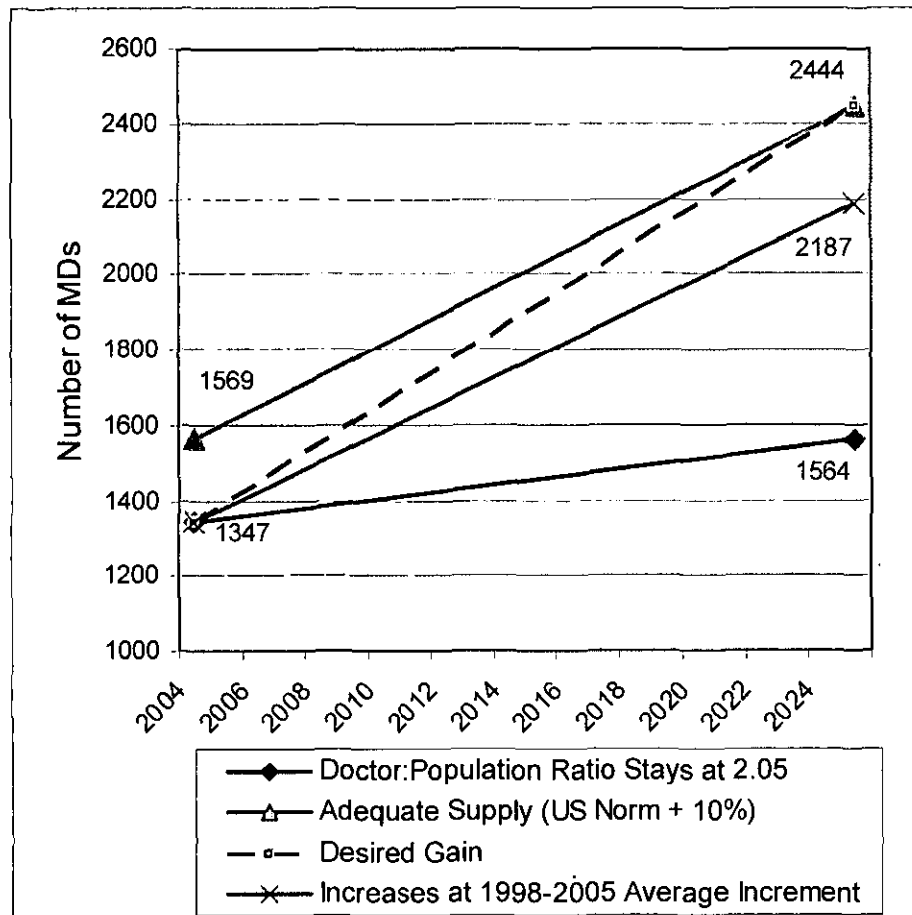
Physician Shortages in Alaska

- **Alaska Physician Supply Task Force (2006)**
 - 1,347 physicians in AK
 - 2.05 per 1,000 population
 - Below national ratio of 2.38
 - Ratio of 2.62 needed
 - Shortage greatest in internal medicine, medical subspecialties, and psychiatry
 - More mid-level providers also needed
- **Job vacancy rate (2007 survey): 12%**

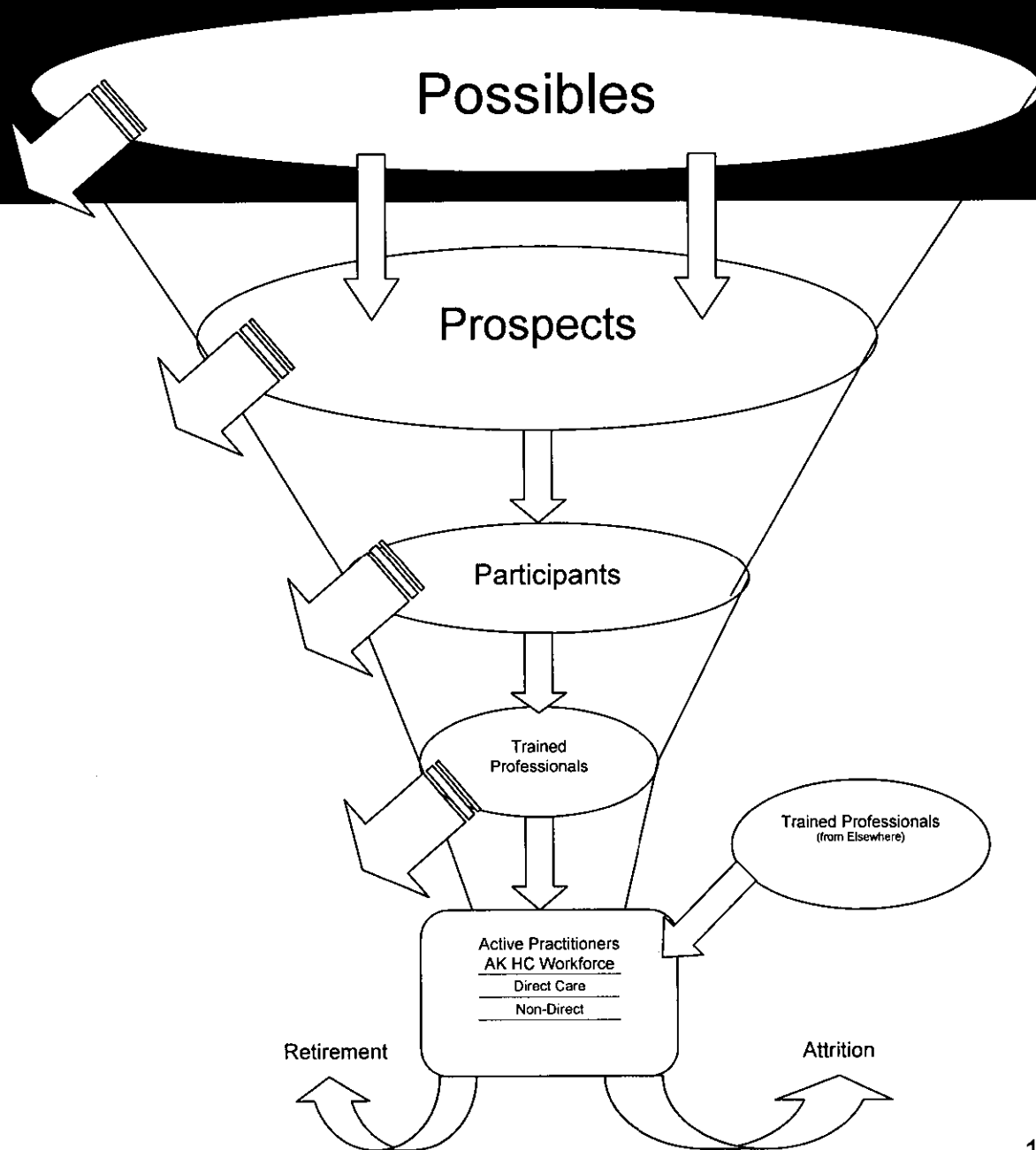


Gain in Alaskan Physicians

Static Doctor to Population Ratio vs. Desired Growth Scenario



- Alaska should have physician-to-population ratio 110% of national average
- Current (2006) shortage: 375 physicians
 - Each year, gain of 78, loss of 40
 - Need increase annual gain from 38 to 59
 - Loss may accelerate

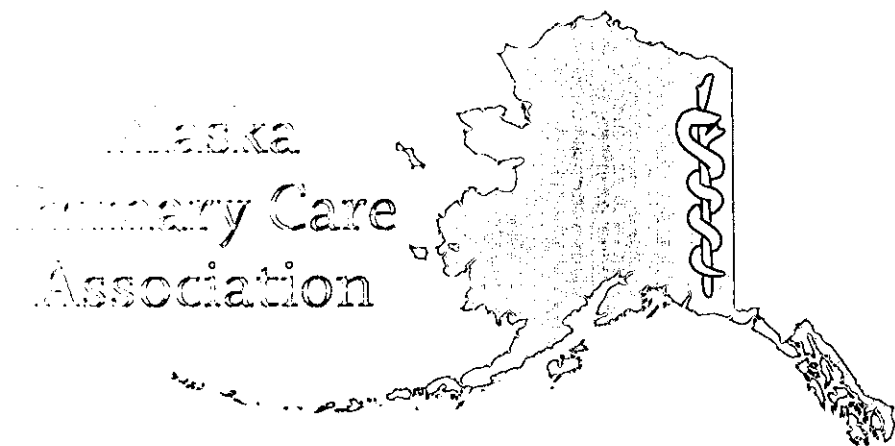


Challenges to Adequate Physician Supply in Alaska

- Aging of population
- Shortage of primary care physicians
- Educational debt
 - 23% of 2008 US medical school graduates carrying >\$200,000 educational debt (*N Engl J Med*, Dec 18, 2008)
- Challenges of practice in Alaska, particularly in rural areas
- Alaska is in competition with other states for recruitment and retention of physicians
 - HRSA: 20 states reporting “scarcities” of physicians

Strategies That Can Enhance Physician Supply in Alaska

- **Initiatives to increase interest in medical careers**
- **WWAMI Medical School**
 - In 2005, 29 of 73 Alaskan applicants were admitted into medical school
- **Loan repayment programs:** Indian Health Service and National Health Service Corps loan repayment programs
- **Utilization of mid-level providers**
- **Residency programs:** Alaska Family Medicine Residency-- 70% of graduates practice in Alaska
 - 43% of physicians in Alaska are in primary care specialties, compared with 34% nationally

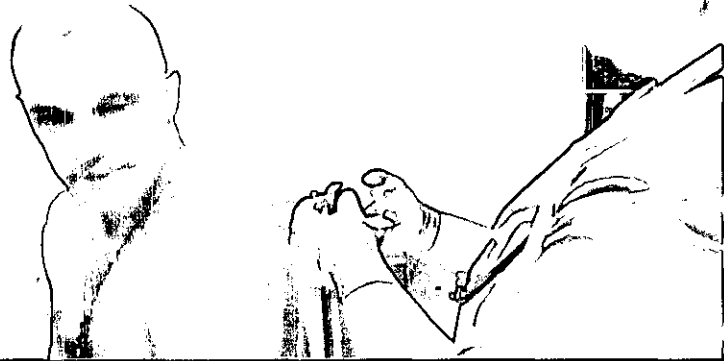


Alaska's Healthcare Workforce:
View from the Safety Net
Marilyn Kasmar, Executive Director
Alaska Primary Care Association



The CHC Model

- Serves all of community residents, without regard for ability to pay or insurance status
- Targeting low income and medically underserved communities
- Local, not-for-profit community managed health care organization



CHC Model: The Safety Net

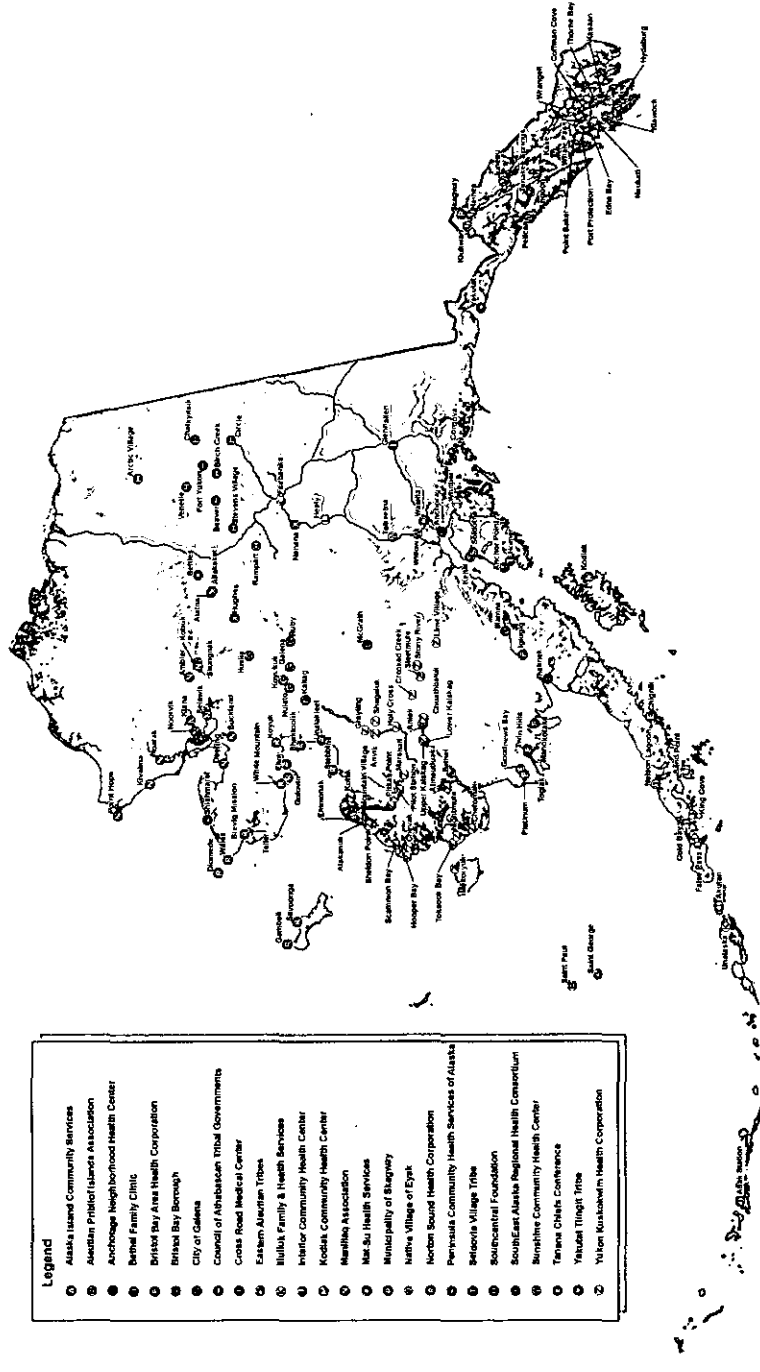
- Provides comprehensive, primary & preventive care
- “Primary Care” => medical, dental & behavioral health
- Sliding fee scale promotes patient accountability
- CHCs reduce use of costly Emergency Room visits



Community Health Centers Alaska — 2009

- Network of 26 CHC Organizations
- 141 Delivery Sites
- Serving 81,000 Alaskans
- Tribal & Non-Tribal Models

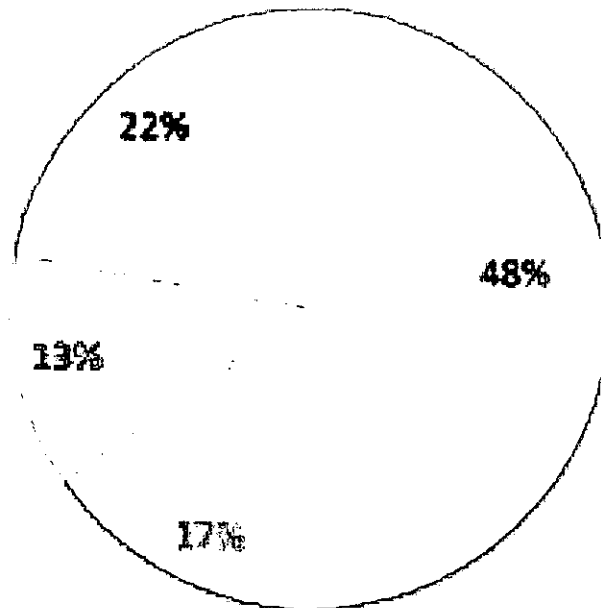
Alaska's Community Health Centers



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Many Alaska CHC Patients are Poor



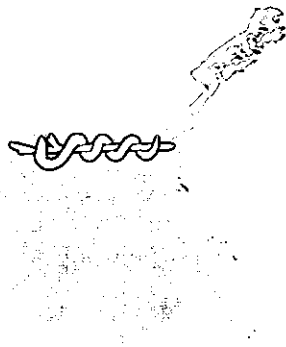
□ 100% and Below FPL

□ 151-200% FPL

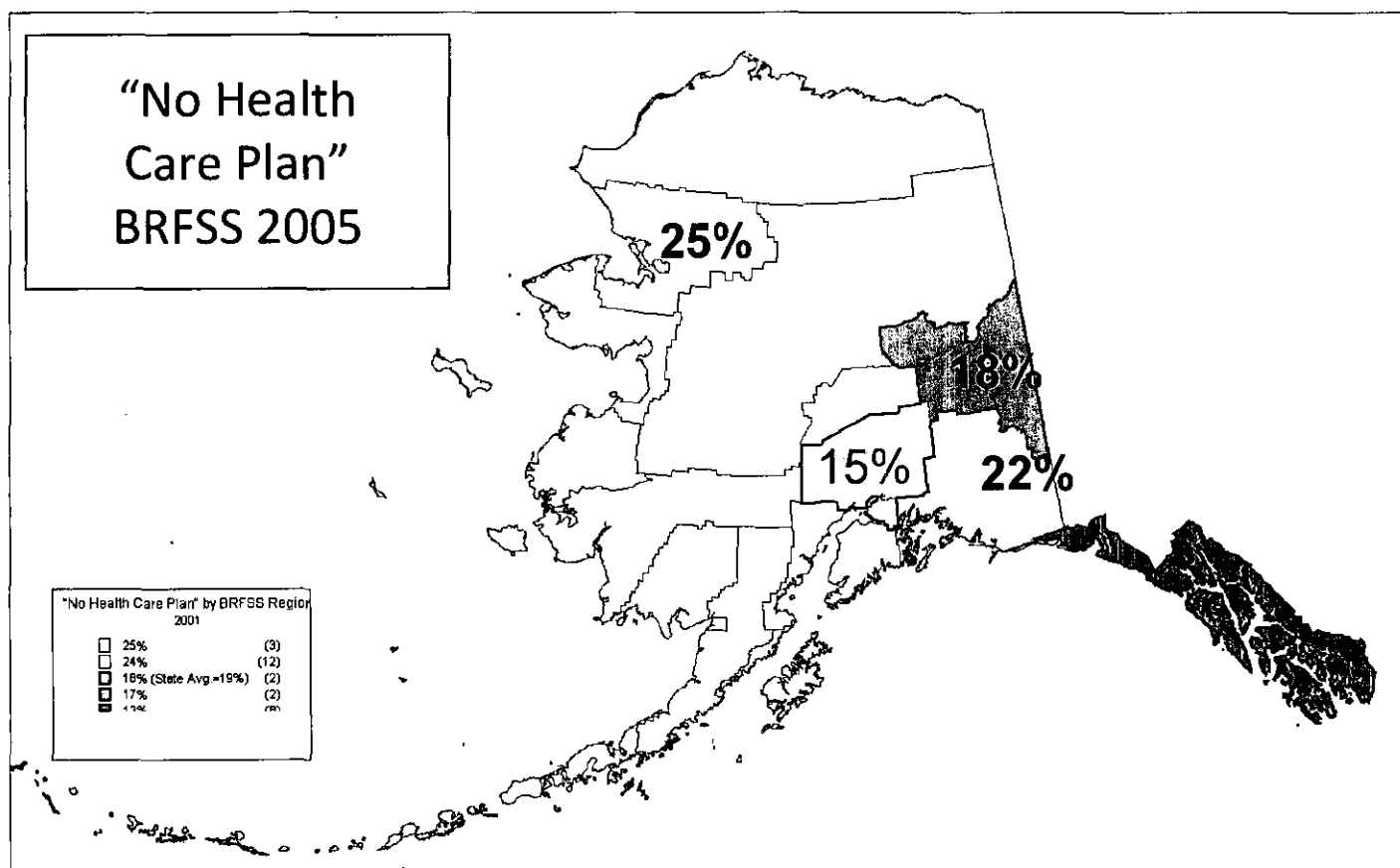
□ 101-150% FPL

□ Over 200% FPL

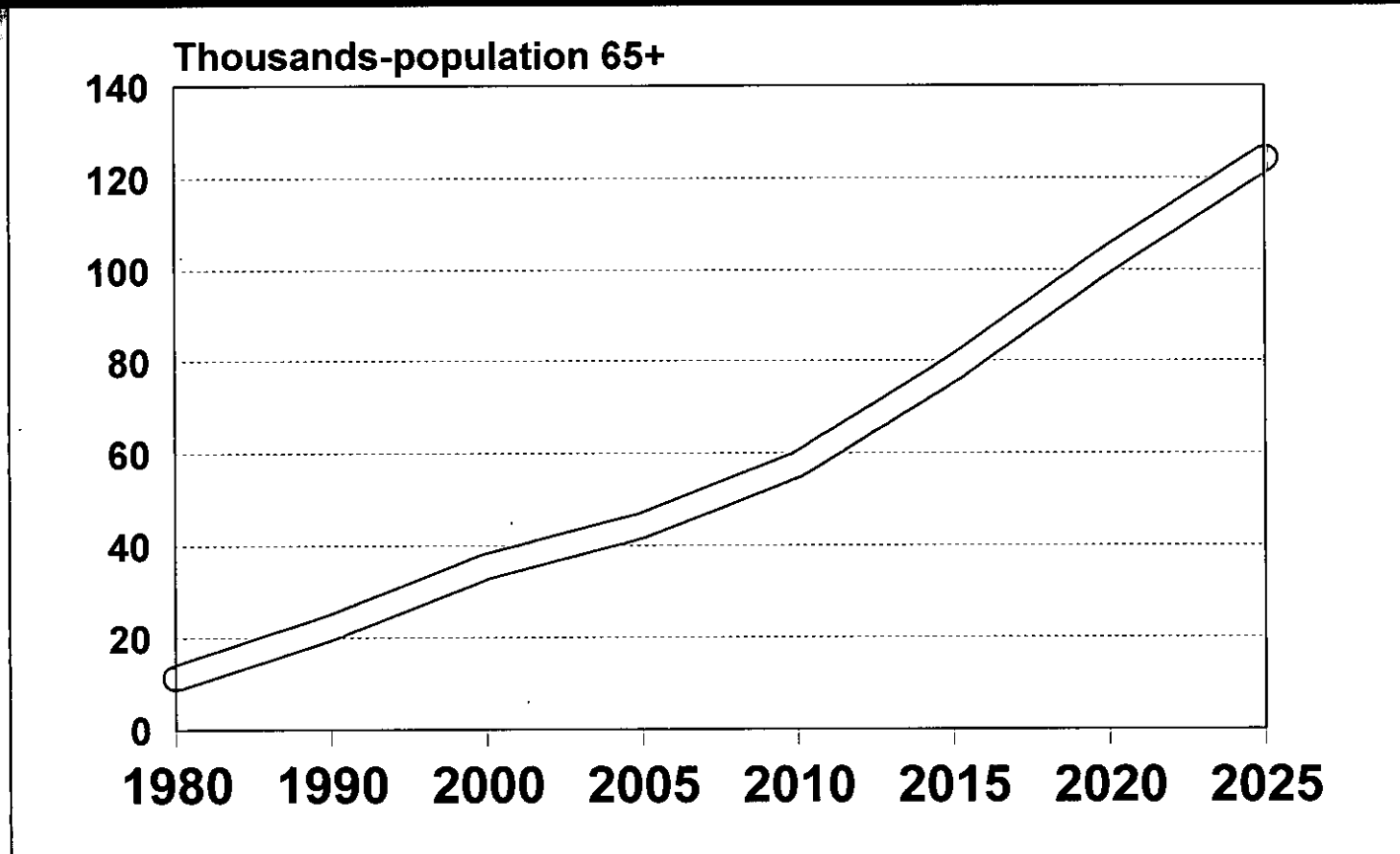
Many Alaska CHC Patients are Uninsured



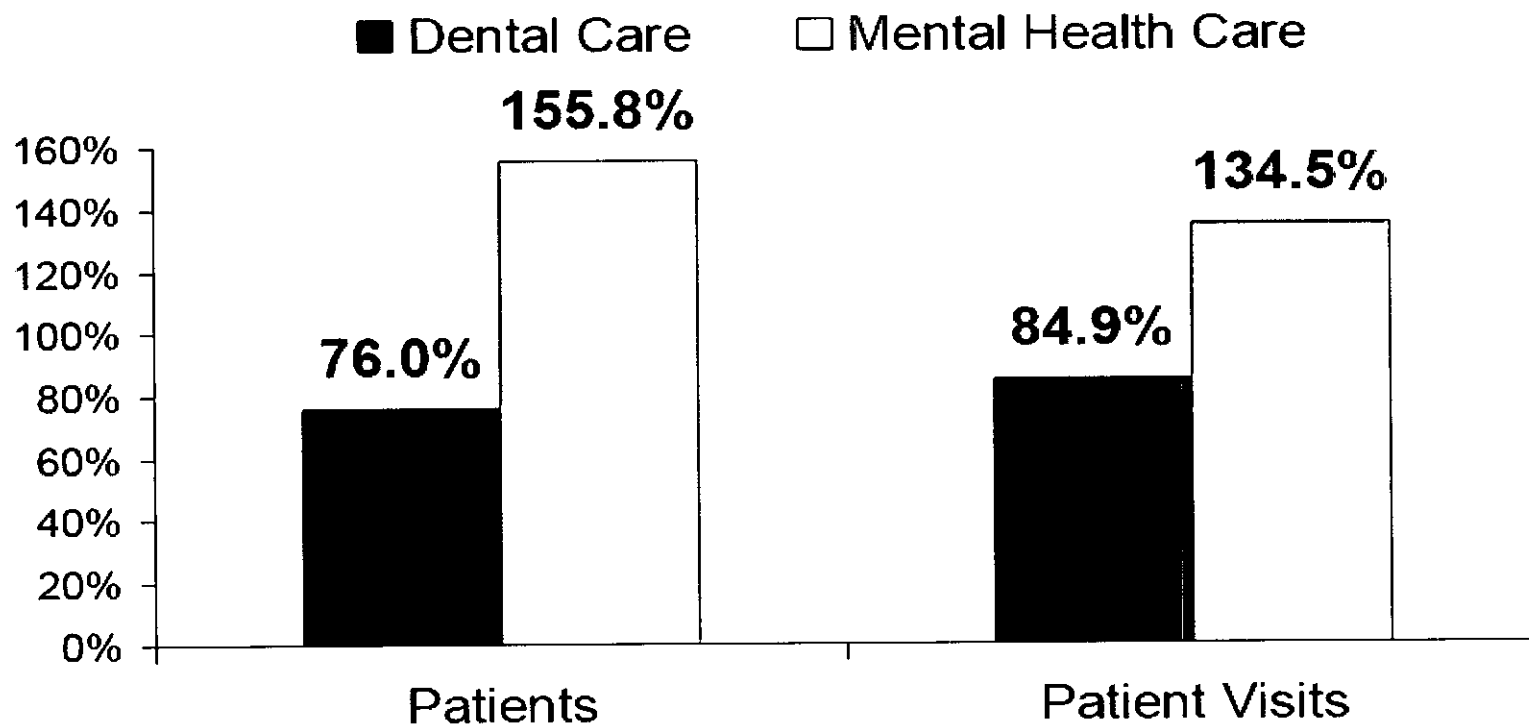
Geographic Disparities in Health Insurance Coverage



The Aging of Alaska's Population Will Continue to Create a Strong Demand for Health Care Services



Growth in Health Center Dental & Mental Health Care, 2000-2005



Note: Mental health does not include substance abuse.

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Healthcare Workforce Shortage: Giant Problem for Alaska's CHCs

- Large
- Unrelenting
- Getting worse
- Disruptive
- Expensive
- Difficult for CHCs to recruit & to retain
- Even more difficult for rural & remote sites

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The Shortage Problem — in the Nation

- Only 9% of physicians practice in rural areas
 - But 20% of the population lives there
- Of 150,000 general dentists in practicing in US
 - But only 14% practice in rural areas
- CHC patients grew 57% from 2000 to 2006

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What are Factors that are Driving this Shortage?

- “States, and especially safety net providers, are facing intense workforce pressures because of
- structural issues related to clinician training,
- difficulty in recruiting and retaining providers to work in health centers, and
- the impending leadership cliff...”

Snyder, Andrew. (2008). Safety Net Workforce in the Context of Health Reform. State Health Policy Briefing (pg. 9)

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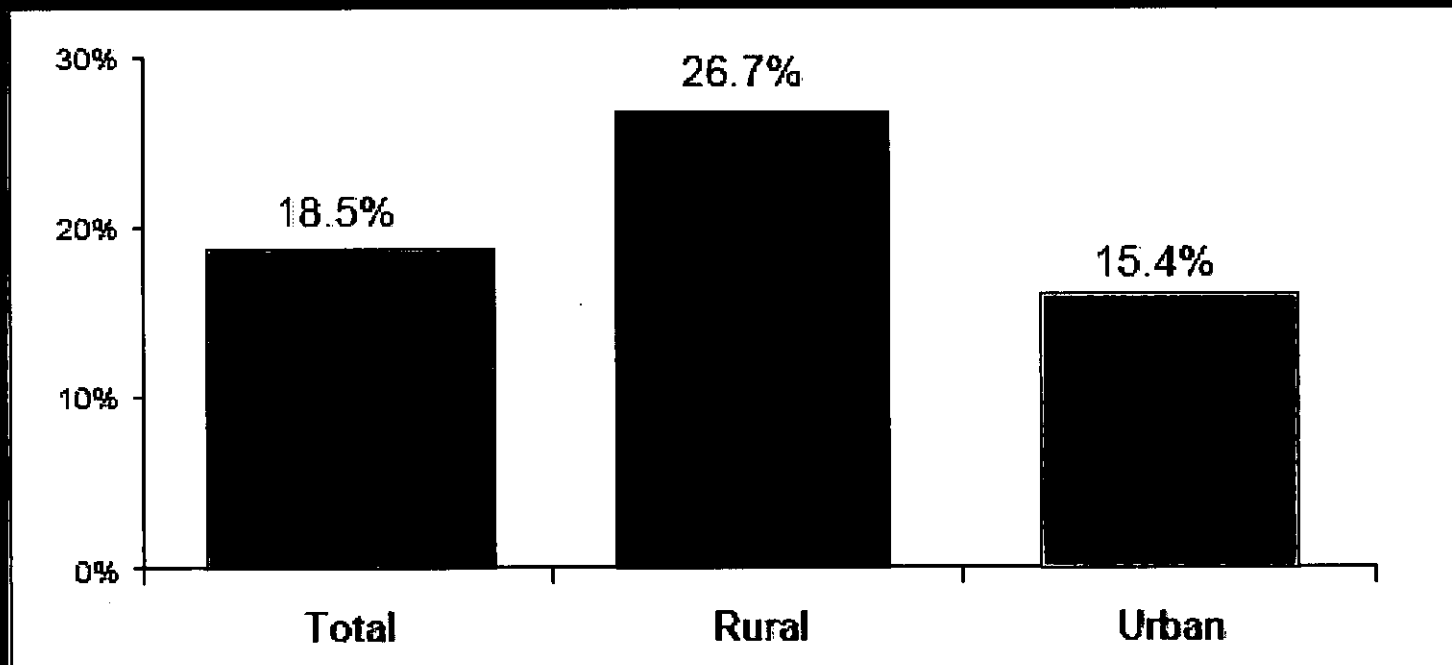
The Shortage Problem — in Alaska Primary Care Occupations

Occupation	Full Sample (n=476)	Statewide Estimate
Family Physician	18.3%	15.8%
General Internist		
Family Nurse Practitioner	23.2%	19.5%
Physician Assistant		

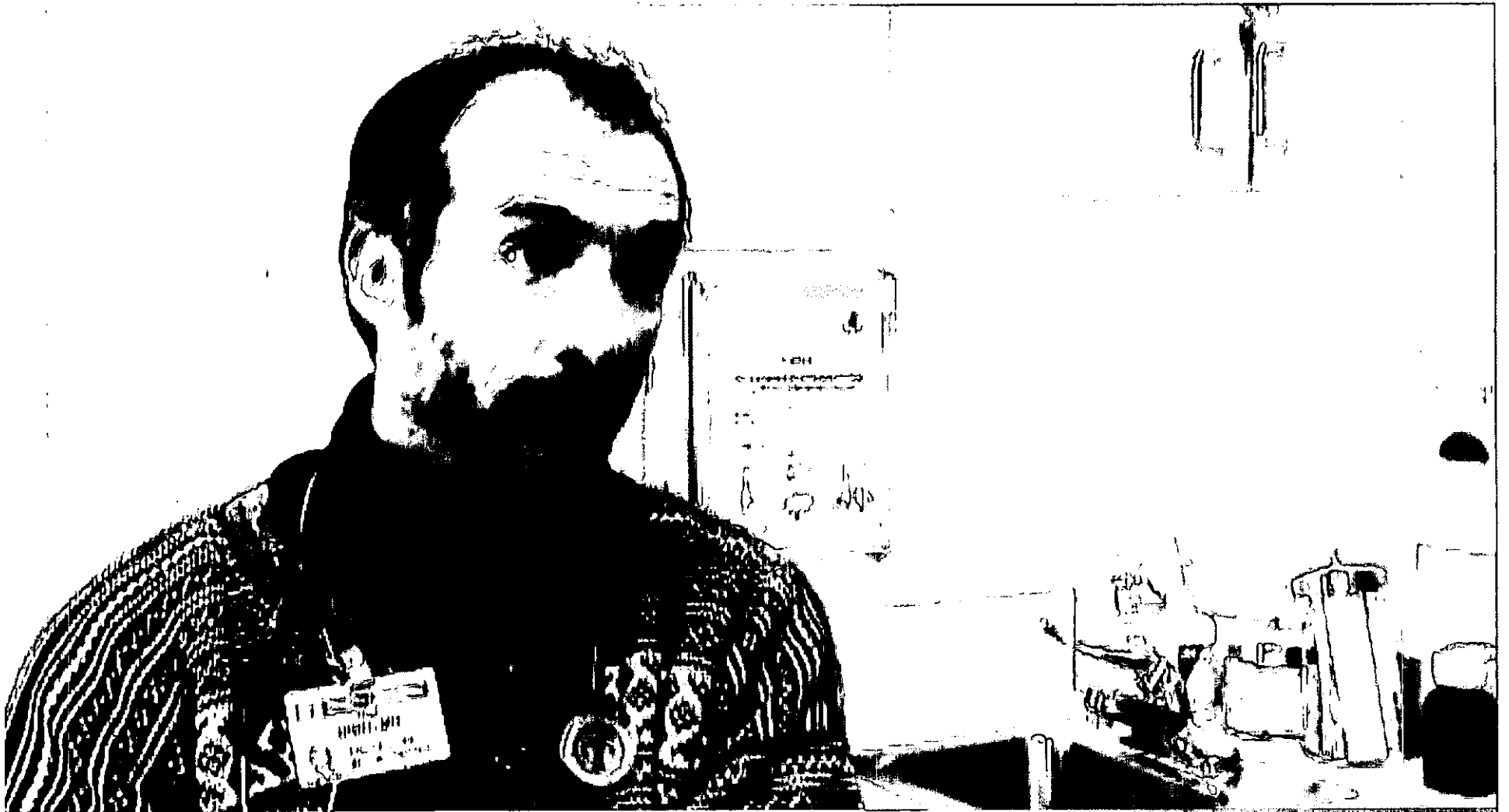
- Long mean vacancy length (7-15 months)
- Higher in rural areas
- Vacancy rate:
 - In rural areas for PAs was 26.8% & for FNPs was 36.4%!



Dentist Vacancy Rates at Health Centers (2004)



Source: Roger Rosenblatt, Holly Andrilla, Thomas Curtin, and Gary Hart. "Shortage of Medical Personnel at Community Health Centers," *Journal of the American Medical Association* 295, No. 9 (2006): 1042-10491.



“Good health care, of course, doesn’t start and stop here in the health center. It’s a community affair.”

- Dr. Tom Hunt, Anchorage Neighborhood Health Center

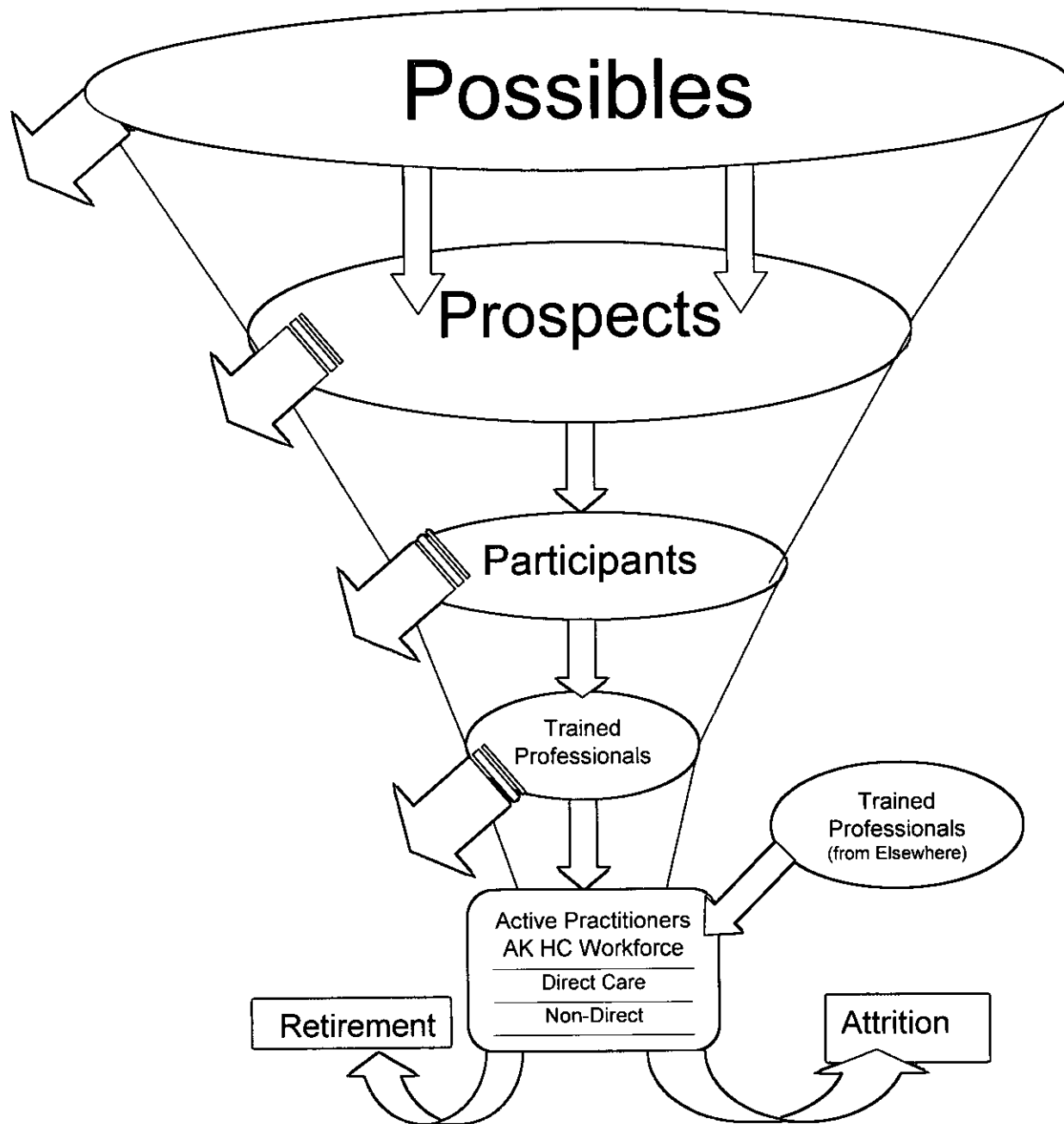
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Will the Shortage Get Better, or Worse?

- “The deficit of health professionals in medically underserved areas will most likely worsen, given the dwindling interest in primary care among medical students.”

Access Transformed: Building a Primary Care Workforce for the 21st Century. National Association of Community Health Centers (Aug 2008, pg. 12)



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A Problem that Must Be Resolved

- We continue to routinely lose candidates
- Every week — and often immediately
- Because... Alaska does not have a State Loan Repayment Option
- Increasingly, it is the candidate's "first question"

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What Does National Expert Opinion Say?

- “Recruitment & retention of health care professionals has been a major problem for CHCs since their inception.”
- “Federal programs such as the National Health Service Corps, augmented by state loan repayment ... remain important sources of CHC clinical personnel, and ... they remain important recruitment tools.”

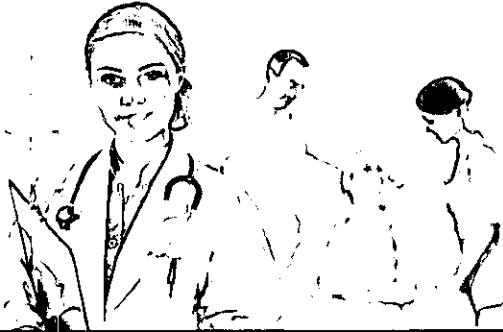
Rosenblatt, et al. (2006). Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion , JAMA, 295(9), pg 1042.

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APCA — 2009 Legislative Priorities Healthcare Workforce

- Workforce Shortage Solutions
 - Health Care Professions Loan Repayment and Incentive Program
 - Medex

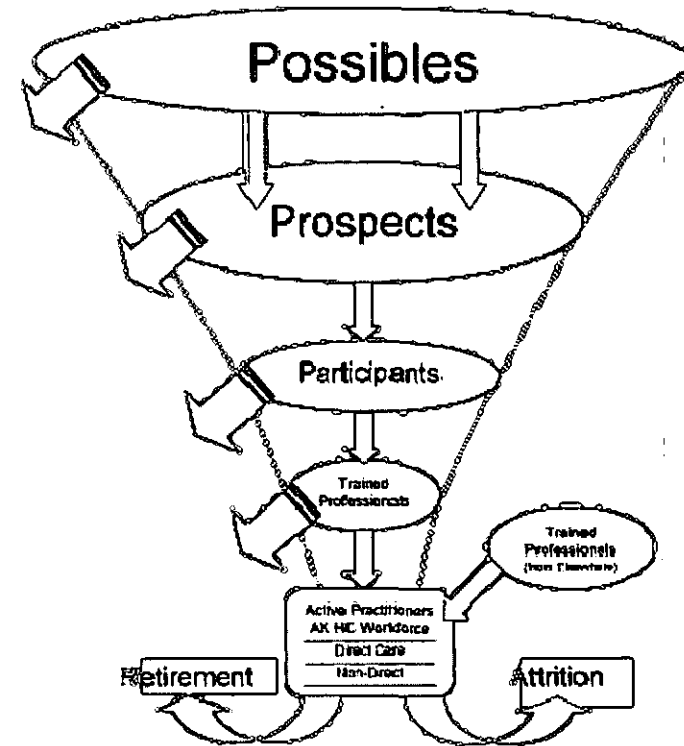


Alaska's Health Care Workforce: Shortage & Solutions

Interagency Presentation — Jan. 29, 2009
House HSS Committee, Alaska State Legislature

Alaska's Healthcare Workforce: View from the Safety Net

Marilyn Kasmar, Executive Director
Alaska Primary Care Association

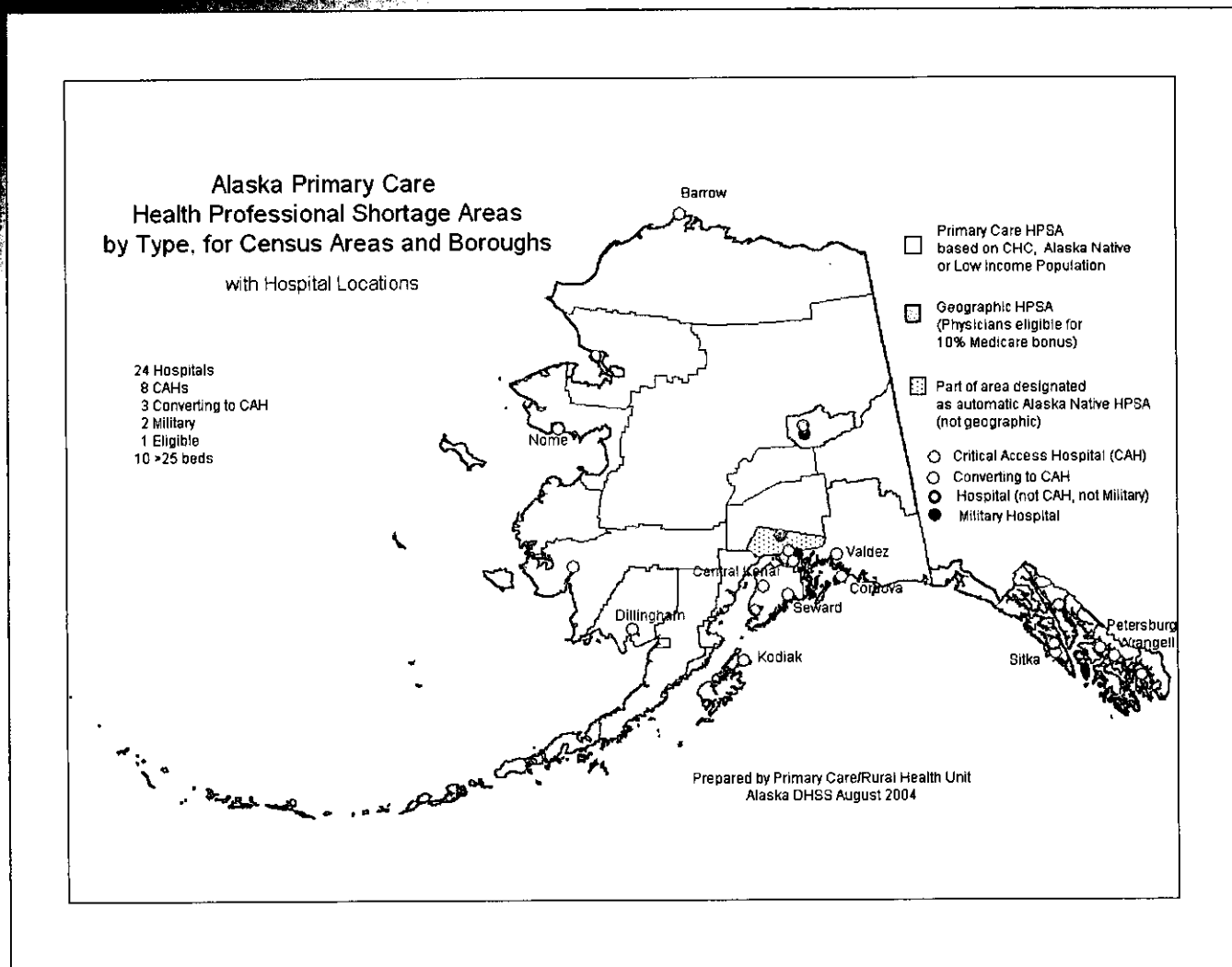


Alaska's Healthcare Workforce:

Rod Betit, CEO

Alaska State Hospital & Nursing Home Association

Hospital and Nursing Facilities



Big Employers

- Providence Health System- Alaska's largest employer since 2001
- Five of top 20 employers are healthcare
- 24 of top 100 employers are health and social services
- Health topped \$5 billion in 2005, 1/3 the value of North Slope oil exports that year

1-3 Data from Alaska Dept of Labor and Workforce Development, Research & Analysis Section
4 Data from Institute for Social and Economic Research, UAA

Industry Perspective

- Itinerant providers mean dollars lost to employers, and resources not invested in local economies. In 2005, we know:
 - 80 hospitals/THOs/Mental Health Centers spent over \$11M in recruitment, \$13M in Itinerants (\$24M total), 16 occupations
 - FMH spent over \$640K in recruitment, and \$920K in Itinerants
 - FMH has saved at least \$1.5M in nurse recruiting since local training started

Nurse Overtime Survey Results

- Temp Nursing Hours Needed to Fill Vacancy:
 - 2006 → 94,166 hours
 - 2007 → 99,748 hours
- Opinion of Facility Administrators (2008)
 - Has gotten “better” → 5
 - Has gotten “worse” → 10

Cromer Report

- The Public's Expectation:
 - Hospitals are supposed to deal with this
 - Real residents want basic services locally
 - Basic services = better distribution of employment

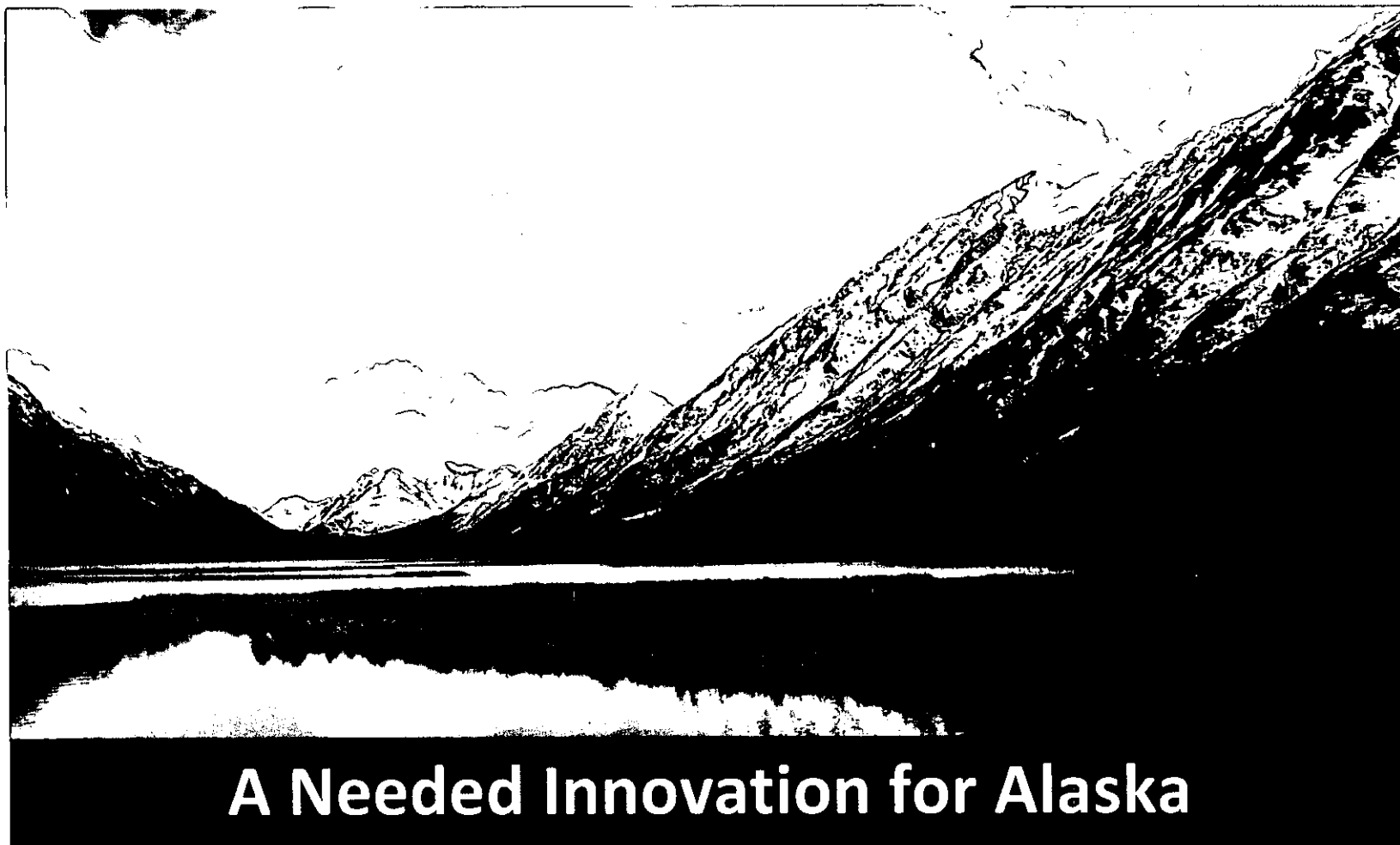
Access to Care: Community Innovations

- This request for workforce improvement is not being done in a vacuum
- Rather – innovations are occurring in several communities – Examples include:
 - Kenai / Soldotna
 - Ketchikan
 - Anchorage

Approaches of Other States To Health Workforce Shortages and Mal-distribution

- Increase number/size of training programs
- Recruit/develop local youth
- Job enhancements
 - salary, benefits, hours
- Malpractice insurance cost relief
- Teamwork, work smarter
- Recruitment and retention enticements
 - pay educational costs in exchange for service

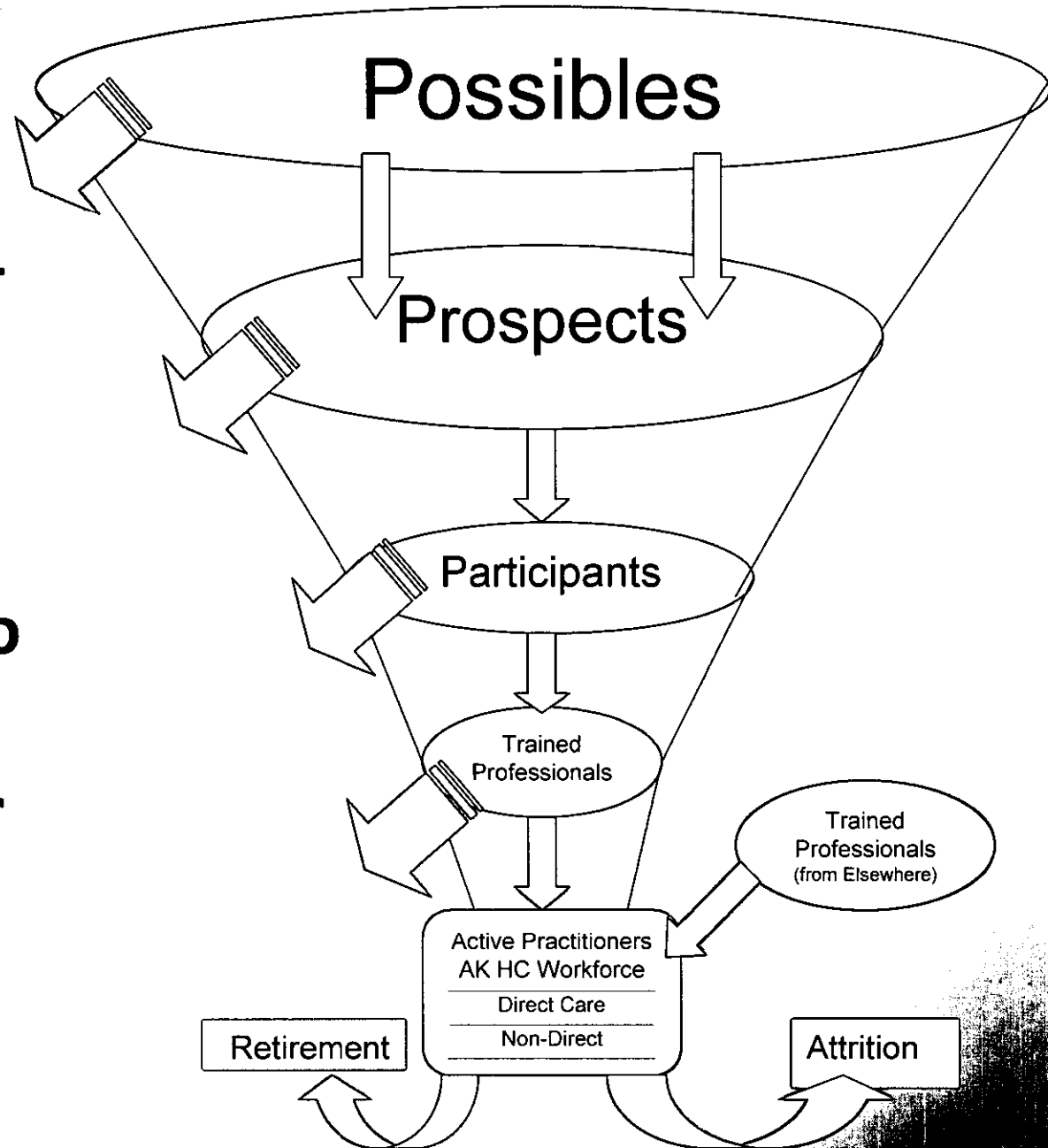
Health Care Professions Loan Repayment & Incentive Program



A Needed Innovation for Alaska

“Support-for-Service Programs”

For those who are farther along in their careers



Support-for-Service Programs

- **Strategy** - Most states have installed “Support-for-Service Programs”, at the state-level
- **Funding** - Four variations on SFSP funding:
 - State-sponsored
 - Blended state-federal (e.g. SLRP’s)
 - Federal-sponsored (e.g. I.H.S., &, NIH)
 - Local contributions to above
- **Outcomes** - SFSP’s – in general – have good outcomes, but there are important program differences -> across types

Support-for-Service Program

- Will remain necessary — regardless of training productivity
- WWAMI has doubled, and, Nursing Program has expanded greatly — but Agencies are still pulling practitioners from elsewhere

SFSP's... Experience of Other States

- Review of 44 states
- Total of 81 state-level SFSP's for HC professions
- Fully 21 states have two or more SFSP's (47%)
- State-level support-for-service programs are a key part of successful recruitment & retention

- Several Strategies: Programs that integrate several strategies have had greater success than have those programs which have relied on single approach

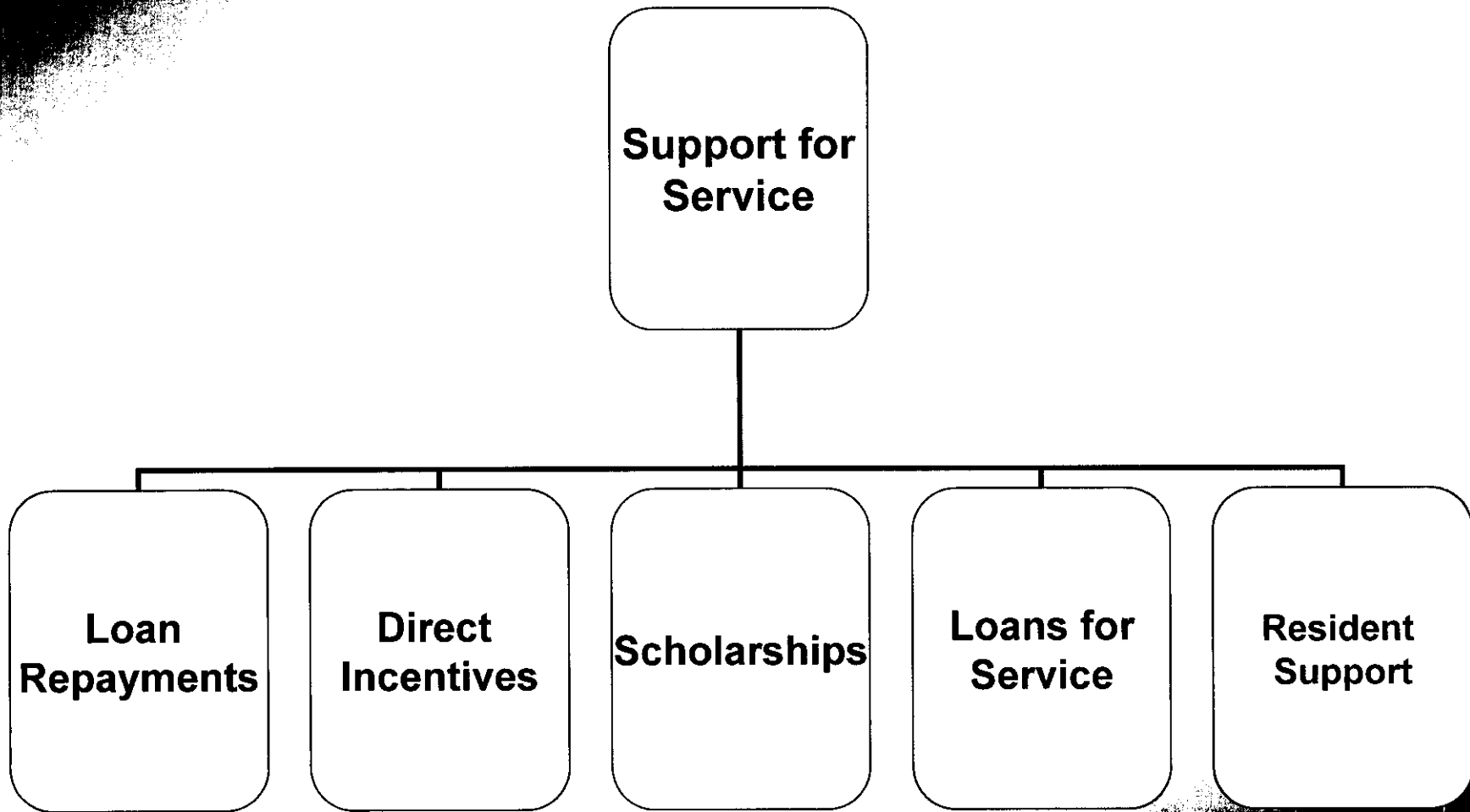
Examples of Other States with Support-for-Service Programs

Arkansas (3)	New Mexico (5)
Iowa (2)	North Carolina (4)
Maine (2)	Oklahoma (3)
Minnesota (7)	Tennessee (2)
Mississippi (2)	Washington (2)
Montana (3)	Wisconsin (2)

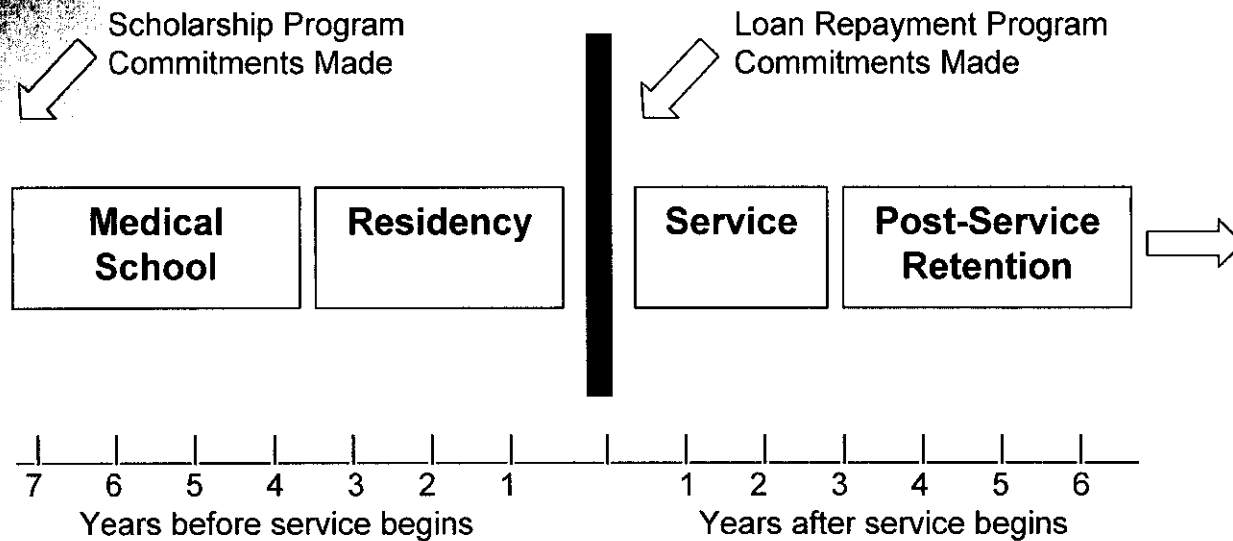
Consequences of Educational Debt

- Like carrying a mortgage on a second home
- Pushes practitioners into more lucrative jobs and specialties
- Discourages poorer students from health careers
- But also - provides a lever to influence practitioners, via loan repayment enticements

SFSP Options...



SFSP -> Timeline Example



- Physicians' training years, commitment-signing, service period, & post-service retention (Pathman, 2006)

Loan Repayment Programs

- Most all other states have these
- They work
- Many states include several professions
- National Health Service Corps → moved to Loan Repayment
- Health Care Professions Loan Repayment & Incentive Program discussed in depth on HPSD site:
www.hss.state.ak.us/dph/healthplanning

Direct Incentive Programs

- Funding is provided to practitioners who agree to work in needy settings — whether or not they have education loans to be repaid
- There is no reason to believe that only young practitioners with debt are suited to work in rural areas and/or with underserved populations

Health Care Professions Loan Repayment & Incentive Program — Interagency Planning Group

- Representatives from:
 - Alaska State Hospital & Nursing Home Assoc
 - Alaska Primary Care Association
 - Alaska Native Health Board
 - Alaska Dental Society
 - Alaska Mental Health Trust Authority
 - Alaska Commission on Post-Secondary Education
 - Health Planning & Systems Development (DHSS)
 - Alaska State Medical Association
 - Alaska Pharmacists Association
 - Alaska Native Tribal Health Consortium
 - Alaska Geriatric Education Center (UAA)

The “Big Ten” Occupations

Tier-1

- Dentists
- Pharmacists
- Physicians

Tier-2

- Dental Hygienists
- Nurses (RN)
- Nurse Practitioners
- Physician Assistants
- Physical Therapists
- Psychologists
- Social Workers

Health Care Professions Repayment & Incentive Program

- Program Elements

- Oversight Entity
- Fiscal Agent
- Practitioner Eligibility
- Site Eligibility
- Payment Details
- Program Evaluation
- Resources & Funding

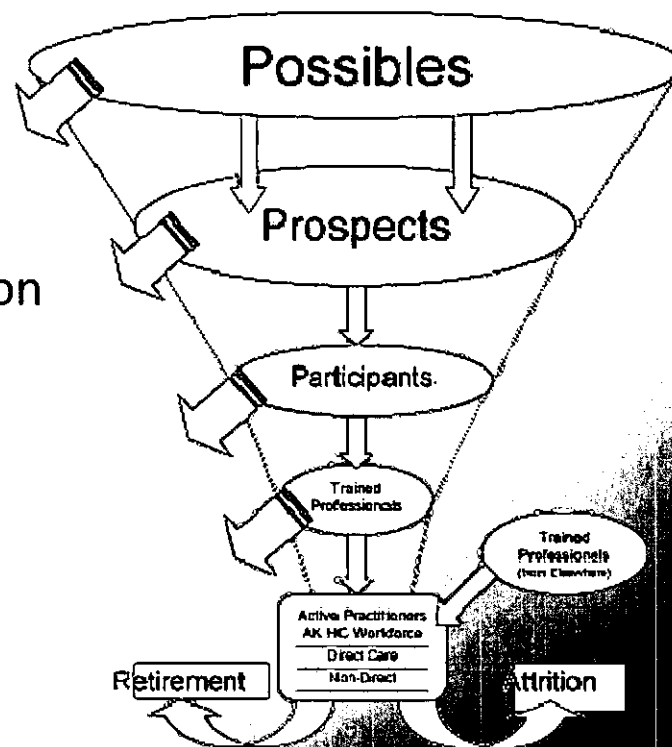


Alaska's Health Care Workforce: Shortage & Solutions

Interagency Presentation — Jan. 29, 2009
House HSS Committee, Alaska State Legislature

Alaska's Healthcare Workforce: Alaska State Hospital & Nursing Home Association

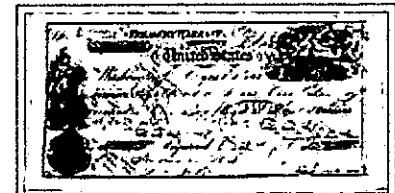
Rod Betit, CEO
Alaska State Hospital & Nursing Home Association



Alaska Purchase

From Wikipedia, the free encyclopedia
(Redirected from Alaska purchase)

The **Alaska Purchase** (otherwise known as **Seward's Folly** or **Seward's Icebox**) by the United States from the Russian Empire occurred in 1867 at the behest of Secretary of State William Seward. The territory purchased was 586,412 square miles (1,518,800 km²) of the modern state of Alaska.



Check used to pay for Alaska, worth \$7.2 million

Contents

- 1 Background
- 2 The viewpoint from Washington
- 3 Ratification and enactment
- 4 Alaska purchase as a propaganda subject
- 5 See also
- 6 Notes
- 7 References
- 8 External links

Background

Russia was in a difficult financial position and feared losing Russian America without compensation in some future conflict, especially to their rivals the British whom they had fought a decade earlier in the Crimean War. While Alaska attracted little interest at the time, the population of nearby British Columbia started to increase rapidly after hostilities ended. The Russians therefore started to believe that in any future conflict with Britain, their hard-to-defend region might become a prime target, and would easily be captured. Therefore Tsar Alexander II decided to sell the territory. Perhaps in hopes of starting a bidding war both the British and the Americans were approached, however the British expressed little interest in *paying* for Alaska.

The Tsar then instructed Russian minister to the United States, Louis Baydalal, to enter into negotiations with Seward in the beginning of March 1867. The negotiations concluded after an all-night session with the signing of the treaty at 4 o'clock in the morning of March 30, 1867^[1] with the purchase price set at \$7,200,000 (about 1.9¢ per acre), equivalent to approximately \$104,000,000 in modern terms.^[2] [Note, however, that \$7,200,000 represented a much more significant portion of federal revenue in 1868, the year the purchase was made, than would an equivalent in today's dollars: the country was less wealthy, and national government taxed that wealth at much lower rates.] American public opinion was generally positive, but some newspaper writers and editors had negative feelings about the purchase of land. Notably, one of those men was Horace Greeley of the *New York Tribune*, for example:

Already, so it was said, we were burdened with territory we had no population to fill. The Indians within the present boundaries of the republic strained our power to govern aboriginal peoples. Could it be that we would now, with open eyes, seek to add to our difficulties by increasing the number of such peoples under our national care? The purchase price was small; the annual charges for administration, civil and

military, would be yet greater, and continuing. The territory included in the proposed cession was not contiguous to the national domain. It lay away at an inconvenient and a dangerous distance. The treaty had been secretly prepared, and signed and foisted upon the country at one o'clock in the morning. It was a dark deed done in the night.... The *New York World* said that it was a "sucked orange." It contained nothing of value but furbearing animals, and these had been hunted until they were nearly extinct. Except for the Aleutian Islands and a narrow strip of land extending along the southern coast the country would be not worth taking as a gift.... Unless gold were found in the country much time would elapse before it would be blessed with Hoe printing presses, Methodist chapels and a metropolitan police. It was "a frozen wilderness."^[3]

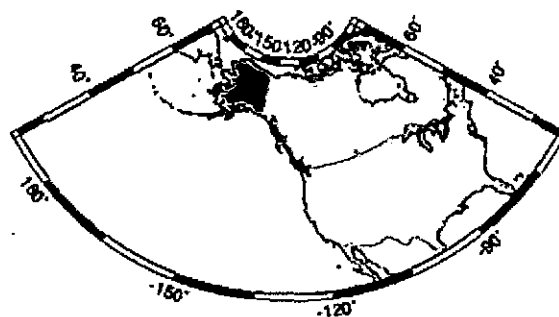
While criticized by some at the time the financial value of the Alaska purchase turned out to be many times greater than what the United States had paid for it. The land turned out to be resource rich and also provided the US a great advantage in the Cold War.

The viewpoint from Washington

The purchase was at the time derided as *Seward's folly*, *Seward's icebox*, and Andrew Johnson's *polar bear garden*, because it was believed foolhardy to spend so much money on the remote region.^[4]

The treaty was promoted by Secretary of State William H. Seward, who had long favored expansion, and by the chairman of the Senate Committee on Foreign Relations, Charles Sumner. They argued that the nation's strategic interests favored the treaty. Russia had been a valuable ally of the Union position during the U.S. Civil War, while Britain had been a nearly open enemy. It seemed wise to help Russia while discomfoting the British. Furthermore there was the matter of adjacent territory belonging to Britain (and now part of Canada). Nearly surrounded by the United States they were of little strategic value to Britain and might someday be purchased. The purchase, editorialized the *New York Herald*, was a "hint" from the Tsar to England and France that they had "no business on this continent." "It was in short a flank movement" upon Canada said the influential *New York Tribune*. Soon the world would see in the northwest "a hostile cockney with a watchful Yankee on each side of him," and John Bull would be led to understand that his only course was a sale of his interests there to Brother Jonathan.

On March 3 Sumner made a major speech advocating the treaty, and covering in depth the history, the climate, the natural configuration, the population, the resources—the forests, mines, furs, fisheries—of Alaska. A good scholar, he cited the testimony of geographers and navigators: Alexander von Humboldt, Joseph Billings, Yuri Lisiansky, Fyodor Petrovich Litke, Otto von Kotzebue, Portlock, James Cook, John Meares, Ferdinand von Wrangel. When he had finished, he observed that he had "done little more than hold the scales." If these had inclined on either side, he continued, it was "because reason or testimony on that side was the weightier." Soon, said Sumner, "A practical race of intrepid navigators will swarm the coast ready for any enterprise of business or patriotism. Commerce will find new arms; the



The signing of the Alaska Treaty of Cession on March 30, 1867. L-R: Robert S. Chew, William H. Seward, William Hunter, Mr. Bodisco, Eduard de Stoeckl, Charles

country new defenders; the national flag new hands to bear it aloft." Bestow American republicanism upon the territory, he urged, "and you will bestow what is better than all you can receive, whether quintals of fish, sands of gold, choicest fur or most beautiful ivory." "Our city," exclaimed Sumner, "can be nothing less than the North American continent with the gates on all the surrounding seas." He argued the treaty was "a visible step" in this direction. By its terms we should "dismiss one more monarch from this continent." One by one they had retired—" first France; then Spain; then France again, and now Russia, all giving way to that absorbing unity which is declared in the national motto — E pluribus unum."^[5]

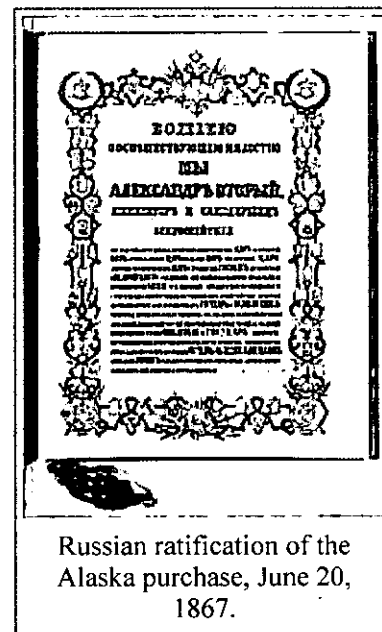
Sumner and Frederick W. Seward.

Seward's Day, in honor of William H. Seward, is a holiday in Alaska on the last Monday of March which celebrates the United States' purchase of Alaska from Russia. Seward's Day is also an alcohol-free day in many cities such as Ketchikan, one of the major cities of the Alaska Panhandle — though the one-day alcohol ban is not observed in all cities.

Ratification and enactment

The United States Senate ratified the treaty on April 9, 1867, by a vote of 37 to 2. However, the appropriation of money needed to purchase Alaska was delayed by more than a year due to opposition in the House of Representatives. The House finally approved the appropriation in July 1868, by a vote of 113 to 48.^[6]

Sumner reported Russian estimates that Alaska contained about 2,500 Russians and those of mixed race, and 8,000 aborigines, in all about 10,000 people under the direct government of the Russian fur company, and possibly 50,000 Eskimos and Native Americans living outside its jurisdiction. The Russians were settled at 23 trading posts, placed conveniently on the islands and coasts. At smaller stations only four or five Russians were stationed to collect furs from the Indians for storage and shipment when the company's boats arrived to take it away. There were two larger towns, New Archangel, now named Sitka, which had been established in 1804 to handle the valuable trade in the skins of the sea otter. It contained 116 small log cabins with 968 residents. The second town was St. Paul in the Pribilof Islands, with 100 homes and 283 people. It was the center of the fur seal industry.



Russian ratification of the Alaska purchase, June 20, 1867.

An Aleut name, "Alaska" was chosen by the Americans. The transfer ceremony took place in Sitka on October 18, 1867. Russian and American soldiers paraded in front of the governor's house; the Russian flag was lowered and the American flag raised amid peals of artillery. Captain Alexis Pestchouroff said, "General Rousseau, by authority from His Majesty, the Emperor of Russia, I transfer to the United States the territory of Alaska." General Lovell Rousseau accepted the territory. A number of forts, blockhouses and timber buildings were made over to the Americans. The troops occupied the barracks; General Jefferson C. Davis established his residence in the governor's house, and most of the Russian citizens went home, leaving a few traders and priests who chose to remain.

Alaska Day celebrates the formal transfer of Alaska from Russia to the United States, which took place on October 18, 1867. Currently, Alaska celebrates the purchase on Seward's Day, the last Monday of

March.

(*October 18, 1867, was by the Gregorian calendar and a clock time 9:01:20 behind Greenwich, which came into effect the following day in Alaska to replace the Julian calendar and a clock time 14:58:40 *ahead* of Greenwich. For the Russians, the handover was on October 7, 1867.)

Alaska purchase as a propaganda subject

The transfer of the Territory of Alaska in 1867 to the United States of America by Tsarist Russia, a transaction historically purported as an intrinsically legal sale, was claimed to be only a lease by Professor Igor Panarin, former KGB analyst^[7], in an interview with *Izvestia* published on Monday, November 24, 2008. However, there is no mention of a time period nor a lease in the original treaty document in which Russia ceded the territory to the United States.^[8]

See also

- Adams-Onís Treaty
- Louisiana purchase

Notes

1. ^ Seward, Frederick W., *Seward at Washington as Senator and Secretary of State*. Volume: 3, 1891, p. 348
2. ^ <http://www.measuringworth.com/ppowerus/>
3. ^ Oberholtzer, Ellis Paxson. *A History of the United States since the Civil War*. Volume: 1. 1917. p. 123
4. ^ Have you been to the "polar bear garden"? The loc.gov Wise Guide
5. ^ Oberholtzer, Ellis Paxson. *A History of the United States since the Civil War*. Volume: 1. 1917. p. 544-5
6. ^ "Treaty with Russia for the Purchase of Alaska: Primary Documents of American History (Virtual Programs & Services, Library of Congress)". Loc.gov. <http://www.loc.gov/rr/program/bib/ourdocs/Alaska.html>. Retrieved on 15 September 2008.
7. ^ Russian Scholar and KGB analyst Panarin predicts USA kaput in 2010
8. ^ "A Century of Lawmaking for a New Nation: U.S. Congressional Documents and Debates, 1774 - 1875 - Treaty With Russia. March 30, 1867 English/French, image". Loc.gov. <http://memory.loc.gov/cgi-bin/ampage?collId=llsl&fileName=015/llsl015.db&recNum=572>. Retrieved on 8 December 2008.

References

- Jensen, Ronald (1975). *The Alaska Purchase and Russian-American Relations*.
- Oberholtzer, Ellis (1917). *A History of the United States since the Civil War*. vol 1.
- *Alaska. Speech of William H. Seward at Sitka, August 12, 1869* (1869; Digitized page images & text), primary source.

External links

- Treaty with Russia for the Purchase of Alaska and related resources at the Library of Congress
- Text of Treaty with Russia
- Meeting of Frontiers, Library of Congress
- Original Document of Check to Purchase Alaska
- US Government article

- Britannica article

Retrieved from "http://en.wikipedia.org/wiki/Alaska_Purchase"

Categories: [History of Alaska](#) | [History of United States expansionism](#) | [Treaties of the United States](#) | [1867 in law](#) | [1867 in the United States](#) | [Russia–United States relations](#)

Hidden categories: [Articles needing additional references from December 2008](#) | [NPOV disputes from December 2008](#) | [All NPOV disputes](#)

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2/3/09

**STRATE-
GIES TO
REDUCE &
PREVENT
SUICIDE**

Strategies to Reduce and Prevent Suicide in Alaska

1

A Presentation to the House Health & Social Services
Committee

Melissa Stone, Director
DHSS, Division of Behavioral Health

February 3, 2009

Background of Suicide Prevention in Alaska

2

- Alaska has a history of high rates of suicide
- In 1987 Senate Resolution No. 19 established a Senate Special Committee on Suicide Prevention.
- Through these efforts, \$600,000 was appropriated for community-based suicide prevention projects (CBSPP).
- The CBSPP focused primarily on rural and remote community-based programs.

Background of Suicide Prevention in Alaska

3

- In FY2006 the CBSPP grant program was integrated into the DBH Comprehensive Prevention & Early Intervention grant programs—with substance abuse prevention, fetal alcohol prevention, youth development & resiliency, connectedness and early mental health.
- This integration was taken to strengthen all behavioral health prevention by promoting comprehensive programming—not separate silos.

Current Suicide Prevention Funding

4

- In FY2009 16 community-based programs are funded with blended suicide prevention funds.
- FY2009 general fund dollars for suicide prevention grant programs is \$715,820 (an increase of 20% since 1989).
- Average grant award is \$44,738 per agency: the largest award is \$140,000 to our statewide 24-hour CareLine/Crisis line and the smallest award being \$8,325 to the City of Nulato.

Current Suicide Prevention Funding

5

- In addition DBH received a one-time FY09 general fund allocation of \$200,000 to begin planning a coordinated statewide strategy to reduce suicide across all age groups.
- Planning grants to regions with rates of suicide exceeding the state rate of 22 per 100,000 are being awarded—Nome, NW Arctic, Yukon Kuskokwim, Bristol Bay.

DBH Long-term Outcomes

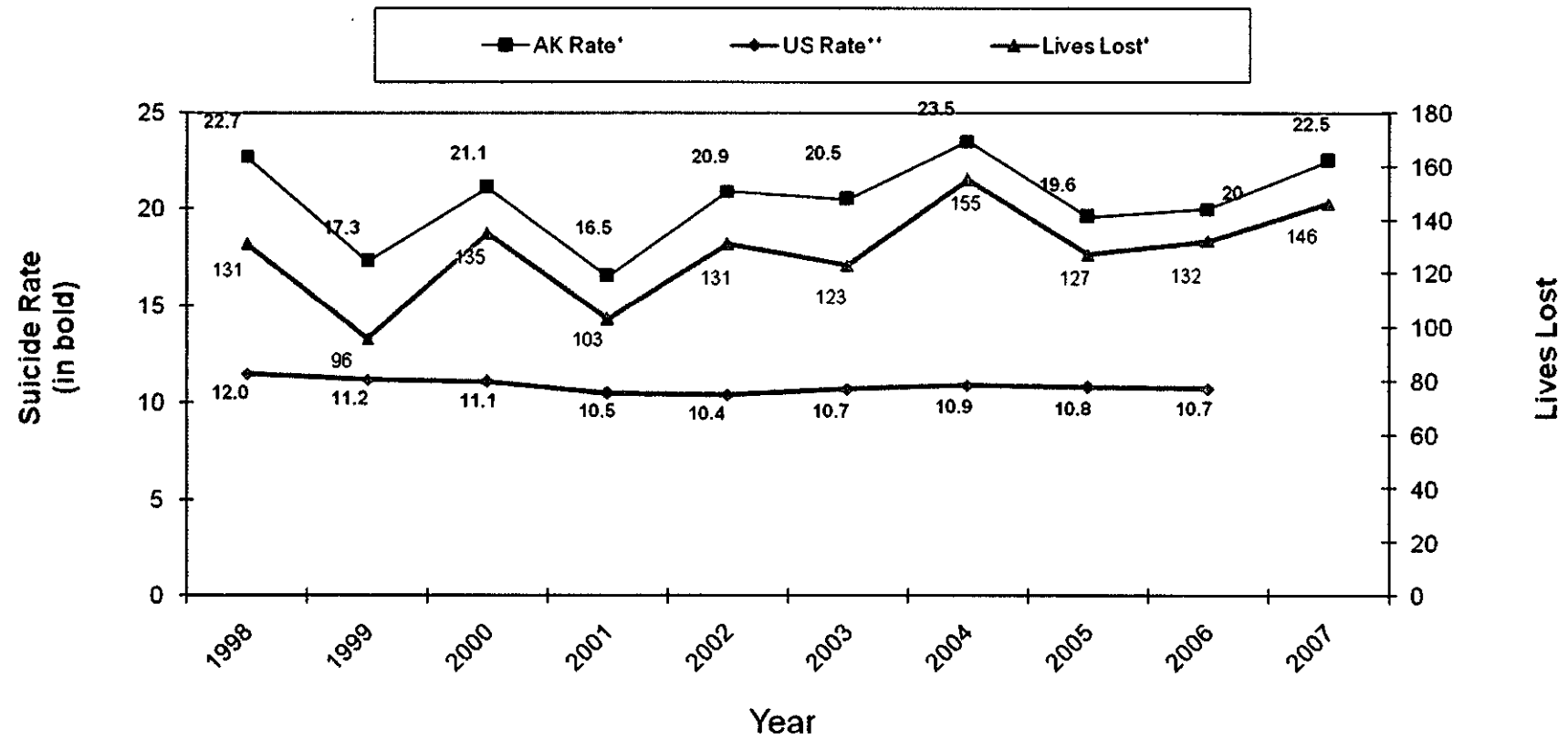
6

- All Alaskan communities, families and individuals free from the harmful effects of substance use, dependency and addiction.
- Alaska children, youth and adults are mentally healthy and living successfully.
- All community members' are connected, resilient and have basic life skills.

What the Data Tell Us...

7

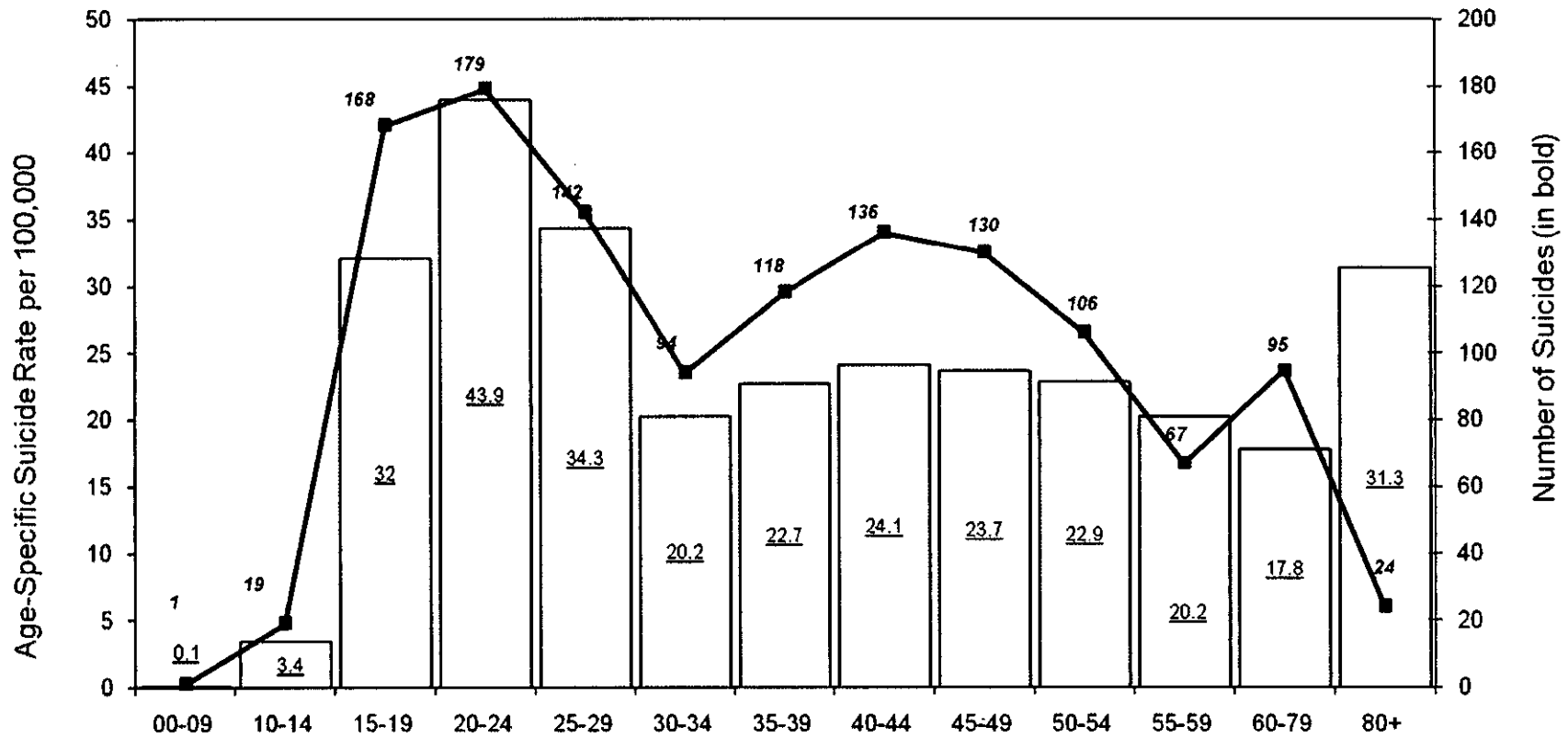
**Alaska Suicide Rates
1998-2007**



What the Data Tell Us...

8

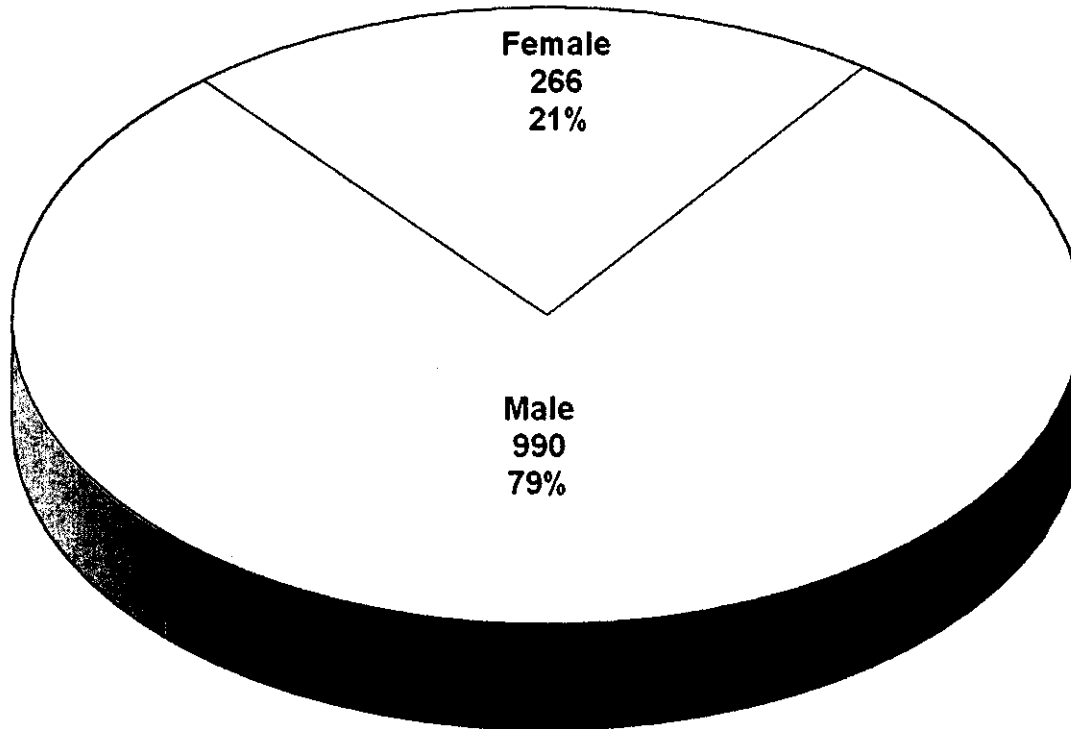
**Alaska Age-Specific Suicide Rates and Numbers
1998-2007**



What the Data Tell Us...

9

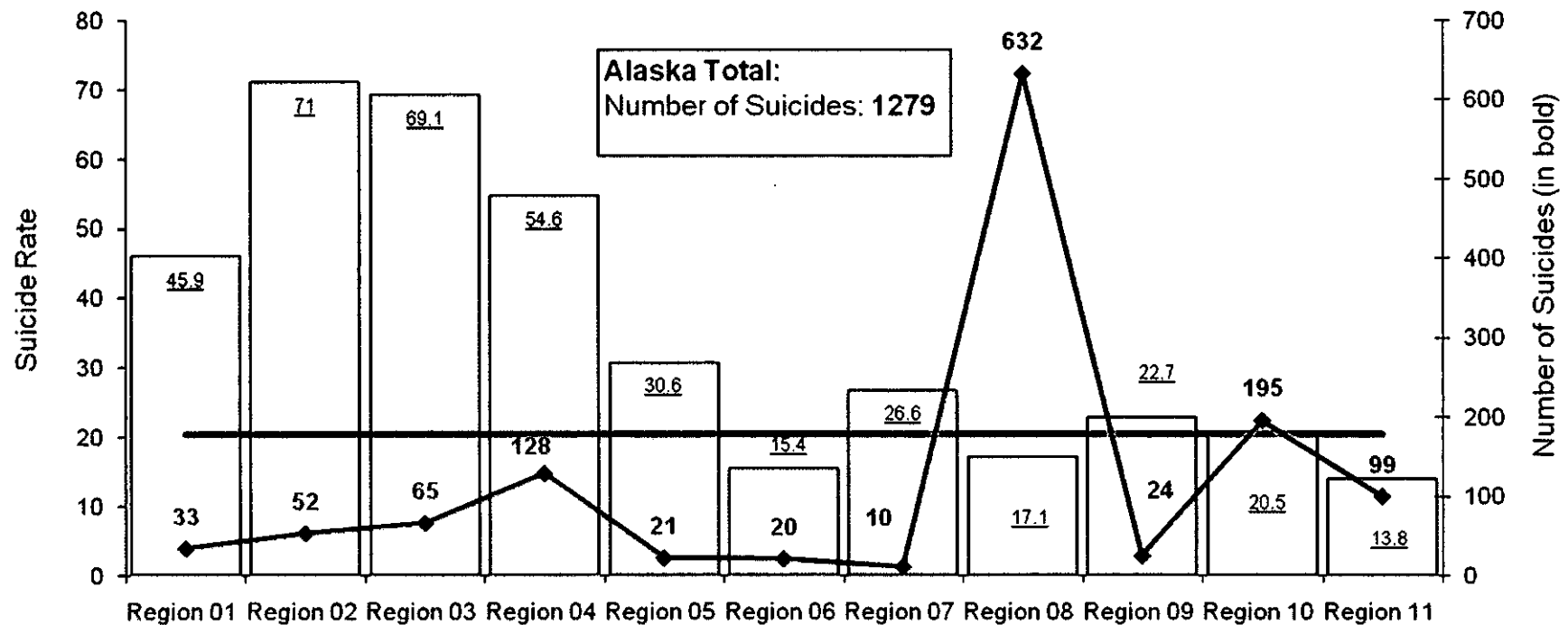
Alaska Suicides by Sex, 1998-2007



What the Data Tell Us...

10

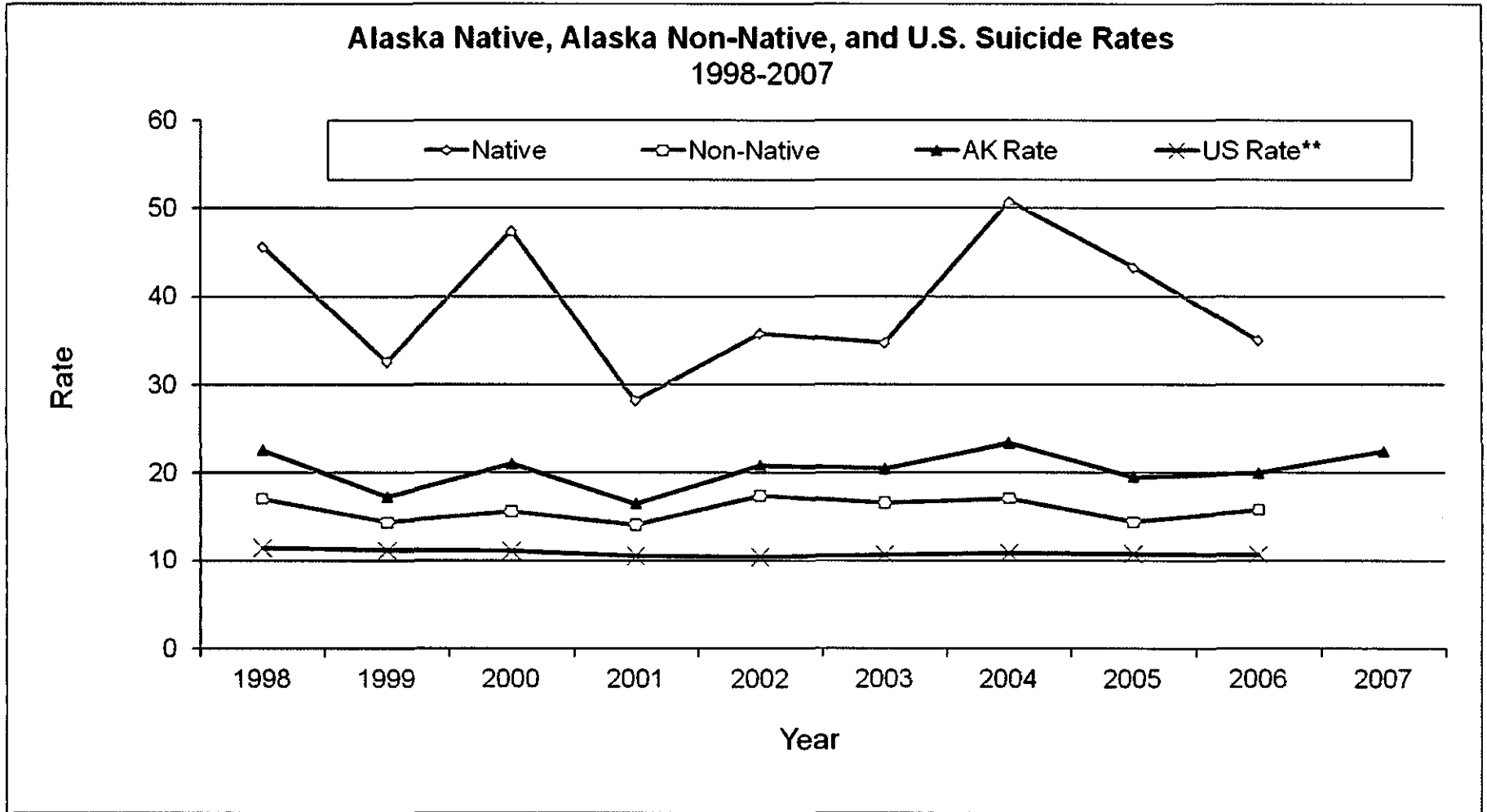
**Alaska Suicide Rates and Numbers by Region
1998-2007**



What the Data Tell Us...

11

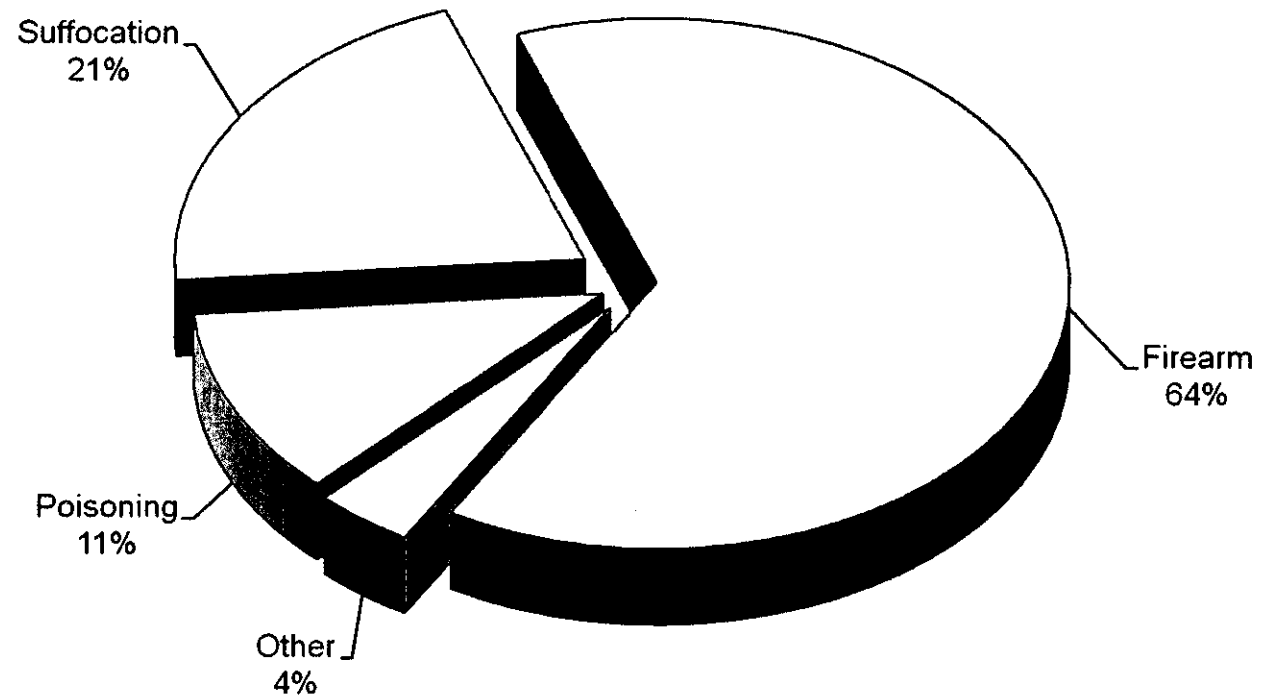
Alaska Native, Alaska Non-Native, and U.S. Suicide Rates
1998-2007



What the Data Tell Us...

12

**Suicide Methods in Alaska
1998-2007**



What the Data Tell Us...

13

- Alaska continues to rank in the top five states for highest rate of suicide across populations.
- According to a recent report from the AK Bureau of Vital Statistics, Alaska's suicide age-adjusted average rate is 21.2 per 100,000 population.
- This equates to 683 suicides between 2003 and 2007.
- In 2008 suicide accounted for two-thirds (68.6%) of all violent deaths in Alaska.

What the Data Tell Us...

14

- The Alaska Youth Risk Behavior Survey (YRBS) shows an increase in the rate of “suicide attempts” among youth grades 9 through 12 from 7.05% in 1995 to 8.05% in 2003, and 10.7% in 2007.
- 2007 YRBS data also indicate a higher rate of suicide attempts among females (12.7%) in comparison to males (8.3%). Males complete more often, but females attempt more often.
- Alaska Native/American Indians have the highest rate of suicide at 47.2 per 100,000.

What the Data Tell Us...

15

- Persons aged 15-24 and 25-29 had the highest rates of suicide (37.6 and 33.6 per 100,000 respectively).
- Between 2003 and 2005 the Anchorage/Mat-Su area had a total of 190 suicides, equaling a rate of 18.3 per 100,000 (low rate/high number).
- In those same years, the Northwest Arctic Borough had a total of 15 suicides, equaling a rate of 43.3 per 100,000 (high rate/lower number).

Current and Recent Activities

Planning & Partnerships

16

- In 2007 the Alaska Injury Prevention Center released the *Alaska Suicide Follow Back Study*.
- The study reviewed what specific factors in Alaska influence suicide by interviewing family and friends of decedents. Results show strong correlations between suicide and:
 - Post traumatic stress disorder
 - Abused as children
 - Substance use problems
 - Problems with law enforcement
 - Loss of job

Current and Recent Activities

Prevention & Early Intervention

17

- In FY2009 16 communities applied for and received grant funds to address suicide prevention and early intervention. A total of \$715,120 were distributed to the following communities:

Wrangell

Haines

Juneau

Kenai

Mat-Su

Mountain Village

Nulato

Petersburg

Nenana

Shaktoolik

Sitka

Fairbanks

Valdez

Nunam Iqua

Current and Recent Activities

Federal Garrett Lee Smith Youth Suicide Grant

18

- In October 2008, DHSS received federal Garrett Lee Smith Youth Suicide Prevention grant award.
- Three-year, \$1.5 million award -- \$500,000 per year.
- 85% of grant funds will be distributed to fund 3-5 Regional Suicide Prevention Teams.
- Focus on Alaska youth ages 10-24 with an emphasis on Alaska Native male teens, pre-teen females, military veterans and youth experiencing mental health disorders/self-destructive behaviors.

Current and Recent Activities

Outreach & Community Engagement

19

- FY2009 one-time increment of \$200,000 assisting 5 regional/sub-regional areas to develop a strategy and implementation plan for suicide prevention in their region.
- Plan development will include town hall meetings, focus groups, key informant interviews and community readiness assessments to identify regional, cultural or other factors unique to their region.

Current and Recent Activities

Planning & Partnerships

20

- July 1, 2008 the Statewide Suicide Prevention Council moved from the DHSS Office of the Commissioner to Behavioral Health—to better align the work of the Council and Behavioral Health.
- In partnership with the Alaska Mental Health Trust and the Suicide Prevention Council, participate in the *You Know Me* campaign to reduce the stigma associated with mental illness and suicide.
- Working in partnership with the Alaska Native Tribal Health Consortium, the YK Community Suicide Prevention Coalition and the Maniilaq *Project Life* (federally funded).

Current and Recent Activities

Outreach & Training

21

- *Suicide Prevention Gatekeeper Training*—a gatekeeper is anyone within a community who can act when someone is contemplating suicide.
- 39 individuals have been trained as “*Gatekeeper trainers*,” able to provide training across Alaska.
- Establishing statewide training in Mental Health First Aide, a first responder training for paraprofessionals and community members to be aware of early signs of poor mental health.

Current and Recent Activities

Outreach & Community Engagement

22

- The Division of Behavioral Health has a strong network of 105 community agencies providing mental health and substance abuse prevention, early intervention, treatment and recovery services through 164 grant programs.
- In addition, we are working in partnership with other community support organizations including faith-based organizations, churches, youth organizations, schools and businesses.

Next Steps

23

- Continue working toward *local solutions for local challenges*—partnering with communities and regional suicide prevention coalitions.
- Focus on 4 intermediate outcomes identified for the Alaska suicide prevention initiative:
 - *Reduce the number of attempted and completed suicides;*
 - *Remove the stigmas associated with depression, mental illness, substance use disorders and suicidal tendencies.*
 - *Increase local responsibility and community action to implement suicide prevention strategies; and*
 - *Increase availability and accessibility of early mental health services.*

- **The Division of Behavioral Health is committed to:**
 - working to reduce the impact of suicide in Alaska;
 - better understand the underlying factors and influences contributing to suicide;
 - assist communities in developing solutions at the community level, with community ownership;
 - develop a cross-disciplinary, research-based approach to reducing the number of suicides in Alaska; and
 - ensuring that Alaska's children, youth and adults are mentally healthy, substance free, connected, resilient and living successfully.

2/5/09
CITIZEN
REVIEW
PANEL
2008
REPORT

ALASKA

Citizen Review Panel



2008
Annual Report

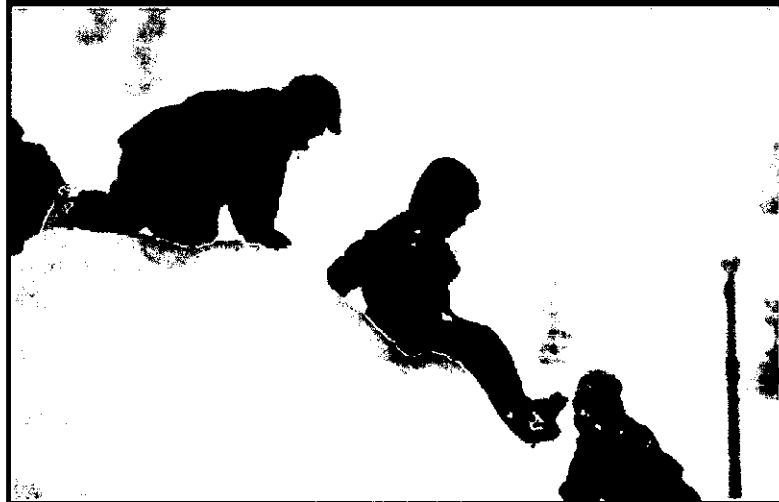


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Mission and Mandate

MISSION

The Alaska Citizen Review Panel (CRP) is committed to reviewing and evaluating the practices and procedures of the Office of Children's Services (OCS) and in making recommendations relative to its findings to insure the safety and the well-being of the children of Alaska.

The CRP will achieve this commitment by examining the policies and procedures of the Office of Children's Services and collaborating agencies; examining, where appropriate, specific cases; evaluating the extent to which agencies are carrying out their child protection responsibilities; and preparing and making available to the public an annual report.

MANDATE FOR THE GROUP

The Citizens' Review Panel (CRP) is federally mandated through the Child Abuse Prevention and Treatment Act (CAPTA); Keeping Children and Families Safe Act of 2003. The CRP is also mandated through Alaska statute Sec. 47.14.205.

"By allowing the Panels to have complete access to child protection cases, by requiring Panels to publicize their findings, and by requiring states to respond to criticisms and recommendations of the Panels, the Committee intends to subject states to public criticism and political repercussion if they fail to protect children." (United States Congress, House Report 104-081, 1995, p.1)

DUTIES ASSIGNED TO THE GROUP

Summary of duties The CRP shall examine the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, to evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities.

CRP duties

- Evaluate OCS compliance with federal and state laws, examine policies and procedures for consistent statewide implementation, review cases with fatalities or near fatalities. The CRP shall evaluate the extent to which OCS is effectively discharging its child protection responsibilities under:
 1. the State Plan submitted to the U.S. Department of Health and Human Services under 42 U.S.C. 5106a(b);
 2. Child Protection Standards under federal and state laws; and
 3. any other criteria that the CRP considers important to ensuring the protection of children, including the level and efficiency of coordination of foster care and adoption programs in the state and a review of child fatalities and near fatalities.

In carrying out the responsibilities listed above, the CRP shall examine the policies, procedures, and practices of OCS, and, where appropriate, evaluate specific cases of child abuse or neglect.
- Maintain confidentiality. A person attending a CRP meeting or a CRP member or CRP staff may not make any disclosure related to information obtained during a review by the CRP. A violation is subject to a civil penalty of up to \$2,500 for each violation.
- Conduct public outreach. The CRP shall conduct public outreach and gather public comment on current OCS procedures and practices involving children and family services.
- Produce an annual report. The CRP shall prepare and make available to the governor, the legislature, and the public an annual report containing a summary of its activities and recommendations for the improvement of child protection services in the state.
- Meet at least every three months. The CRP is required by law to meet every three months. Additional meetings and/or teleconferences are scheduled as needed.

DUTIES ASSIGNED TO OCS RELATED TO THE CRP

HSS support. The Commissioner shall, by regulation, establish policies and procedures necessary to carrying out the duties of the CRP.

- Cooperation with state panel. OCS shall provide the panel access to information on child abuse or neglect cases that is necessary for the CRP to carry out its duties.
- Report response. Not later than six months after the date on which the report is released, OCS shall submit a written response that describes whether or how OCS will incorporate the recommendations of the CRP (where appropriate) to make *measurable* progress in improving the child protection system.

Membership and Staff Support

Required membership The panel shall be composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect.

Current membership

Fred Van Wallinga, Chair, Willow
Carol Olson, Vice Chair, Anchorage
Pamela Dupras, Kodiak
Dana W. Hallett, Soldotna
Arthur S. Hansen, Fairbanks
Susan Heuer, Anchorage
Esperanza Redelfs, Ketchikan
Ralph Taylor, Nome

Desired membership The CRP would like to meet its requirement to be broadly representative of the state by widening the geographic and racial and ethnic diversity of the membership. The group is working to recruit new members from underrepresented areas of the state as well as a greater diversity of child-centered expertise and background.

OCS liaison Tammy Sandoval, Director, is the current liaison between OCS and the CRP. Richard Nault, Deputy Director, was the liaison for much of the previous year.

Staff support Staff support is provided by Sylvan Robb and Nancy Lowe of Information Insights.

Meetings and Activities

Group meetings

September 21-22, 2007	In person — Fairbanks
November 10, 2007	In person — Glennallen
December 12, 2007	Teleconference
January 11, 2008	In person — Anchorage
February 15, 2008	In person — Juneau
March 28, 2008	Teleconference
May 1-2, 2008	In person — Anchorage
June 10, 2008	Teleconference

Other activities

September 20, 2007	Delta Junction: met with local OCS staff and partnering agencies
September 21, 2007	Cantwell and Healy: met with partnering agencies Fairbanks: met with local OCS staff and partnering Agencies
November 8-9, 2007	Chitina, Copper Center, Gakona, Glennallen, Kenny Lake, Northway, Tok and Valdez: met with local OCS
November 13, 2007	Wasilla: Dana Hallett met with James Steele, Children's Services Manager for Southcentral Regional Office and Sue Frisby, Community Care Licensing Supervisor 3 Staff and partnering agencies
November 29, 2007	Anchorage: presented at Alaska Native Indian Child Welfare (Bureau of Indian Affairs) Conference and surveyed attendees
December 19, 2007	Teleconference: Fred Van Wallinga and Sylvan Robb participated in National Citizen Review Panel Conference planning committee
January 9-10, 2008	Anchorage: attended "Pathways to Hope Conference regarding Alaska Native Child Sexual Abuse Anchorage: met with Bethel OCS workers and Paul Burke, Nome Chief of Police and Michelle Krier, Kawerak Child Advocacy Center Director
February 8, 2008	Teleconference: CRP met with Christy Lawton, Children's Services Manager of the Northern Region
February 11-12, 2008	Petersburg, Sitka, and Wrangell: met with local

	OCS staff and partnering agencies
February 13-15, 2008	Juneau: met with local OCS staff and partnering agencies
February 13, 2008	Juneau: met with Lt. Governor Sean Parnell
February 14, 2008	Juneau: met with Commissioner Karleen Jackson, Deputy Commissioner Bill Hogan, and Director Tammy Sandoval
	Juneau: met with Representative John Coghill and chief staffer, Rynnieva Moss
	Juneau: met with Representative Mike Hawker's staff member, Pauly Swanson
	Juneau: testified before House HESS Committee
February 19, 2008	Anchorage: Art Hansen participated in the Community Federal Standards Review
	Glennallen and Gulkana: Fred Van Wallinga and Carol Olson met with current and former OCS workers
February 26, 2008	Teleconference: met with Eileen Lally and Jay C. Bush of the Family and Youth Services Training Academy at the University of Alaska Anchorage regarding TONE training
March 6, 2008	Wasilla: Fred Van Wallinga met with James Steele, Children's Services Manager for Southcentral Regional Office
March 27, 2008	Anchorage: Fred Van Wallinga and Susan Heuer met with Tammy Sandoval, Director of OCS and Christy Lawton, Children's Services Manager for Northern Regional Office
April 8-10, 2008	Anchorage: Art Hansen and Carol Olson attended the Alaska Native Indian Child Welfare Summit
April 14, 2008	Kaltag: Fred Van Wallinga met with school administrator and community resident
April 17, 2008	Fairbanks: Art Hansen attended the Family to Family Conference
	Nulato: Fred Van Wallinga met with school administrator and community residents
	Teleconference: Sylvan Robb participated in National Citizen Review Panel Conference planning committee
April 23, 2008	Fairbanks: Art Hansen attended the Community Cares Conference
	Fairbanks: Fred Van Wallinga met with

May 21-23, 2008

Representative Coghill's staff member, Rynniva Moss
 St. Paul, Minnesota: Fred Van Wallinga and Carol Olson attended the National Citizen Review Panel conference

Annual activities

Although the CRP was formed in May 2002, the core of its current membership has been in place for roughly four years. The group meets approximately every other month, with every third meeting being a teleconference. Panel membership has remained steady this year with eight members, although there were extended absences during the year. One member missed a portion of the year for health reasons and another member missed nearly the entire year due to a military deployment.

The CRP continued to focus this year on the two areas on which it had previously focused. The first was facilitating an improved relationship between OCS and tribal agencies. The second was facilitating an improved relationship between OCS and foster parents. A large part of this effort continued to be the process of educating people about the existence and role of the CRP. To this end, the group continued to maintain a public website at www.crpalaska.org to provide information on Alaska's CRP, as well as citizen review panels in general. The group also distributed its brochures at conferences and made presentations using an existing Power Point presentation to educate more people about the CRP and its mission.

As more people become aware of our existence we receive more calls from dissatisfied citizens. As in the past, we inform people that we do not typically intervene in individual cases, but encourage people to avail themselves of either the OCS grievance process or to open a case with the Ombudsman's Office. When we are aware of cases, we do try to monitor complaints with an eye out for patterns of problems.

Our unofficial theme for this year was data collection. We distributed a survey at the Alaska Native Indian Child Welfare Conference put on by the Bureau of Indian Affairs. We received feedback from over 100 mainly Alaska Native ICWA workers who were attending the conference. Respondents were asked which Native corporation region they were from. There were representatives from all regions except Koniak. Calista had the most representatives among survey respondents with 30%. Calista was followed by 16% from Doyon, 14% from Bristol Bay and 11% from Bering Straits. The other regions each had a handful of respondents.

Respondents were asked if there was good collaboration between OCS and tribal entities in their community. Half of respondents (50%) reported good collaboration, while just under one-quarter (24%) reported that there was not good collaboration. Eight percent of

respondents selected yes and no. Just under one fifth of respondents (18%) selected 'don't know' in response to this question.

Respondents were asked how they would rate the effectiveness of child protection in their community. An equal percentage of respondents selected 'very effective' or 'somewhat effective' and 'very ineffective' or 'somewhat ineffective' with 28% and 27% respectively. Nearly half of respondents (45%) reported that child protection in their community was 'neither effective nor ineffective.'

Respondents were asked to rate the effectiveness of foster care in their community. 'Very effective' or 'somewhat effective' were selected by 27% of respondents. More than forty percent (44%) of respondents report that foster care in their community was either 'very ineffective' or 'somewhat ineffective.' Twenty-nine percent of respondents reported foster care in their community was 'neither effective not ineffective.'

Respondents were asked if had anything else to add and 58% of respondents made an additional comment. Among those comments, 40% of them mentioned foster parent issues. Among the 40% who mentioned foster parent issues, 38% mentioned a lack of Native foster parent homes available and the need for tribes being able to license homes. The other 63% of the foster parent comments mentioned lack of support financially and that becoming a foster parent was cumbersome and standards were too strict.

Based on some of the results from the above survey, we were motivated to try and survey foster parents directly. We continue to work on piloting a survey with current and recent foster parents. Our efforts have been hampered by the lack of a strong foster parent group with whom we can work.

We also collected a great deal of regional data in-person through site visits to 20 communities. We interviewed local OCS staff and staff from the following types of partnering agencies about what is working and what needs improvement in their relationship with OCS and how we can help facilitate those efforts.

- Coast Guard personnel
- Counseling center staff
- District attorneys
- Foster parents
- Health aides & public health nurses
- ICWA workers
- Local police departments
- OCS staff
- School principals, nurses & counselors
- State troopers
- Tribal representatives
- WIC workers

We also learned a great deal from other people in these same job types when we heard from them at several conferences we attended. We attended the "Pathways to Hope" conference on Alaska Native Child Sexual Abuse. Members also attended the Alaska Native Indian Child Welfare Summit conference. Attendance at these conferences provides extremely valuable networking opportunities, especially to hear from rural residents from many communities. Additionally, they are an excellent way to continue to make people aware of our existence.

We had additional training opportunities this year. Several members attended the National Citizen Review Panel Conference in Minnesota. Attendance at the national conference allows us to learn of any legislative changes that impact citizen review panels and to network with members from other states to exchange ideas. We also received a full day tutorial on the OCS budget from the primary person responsible for the budget. After hearing many comments about worker training from interviewees, we had a teleconference with those responsible for providing training for new OCS employees.

This year, for the first time, we asked OCS staff to conduct a case review in a response to reports we had received about a particular community. We were very pleased with the responsiveness and with the resolution of that situation.

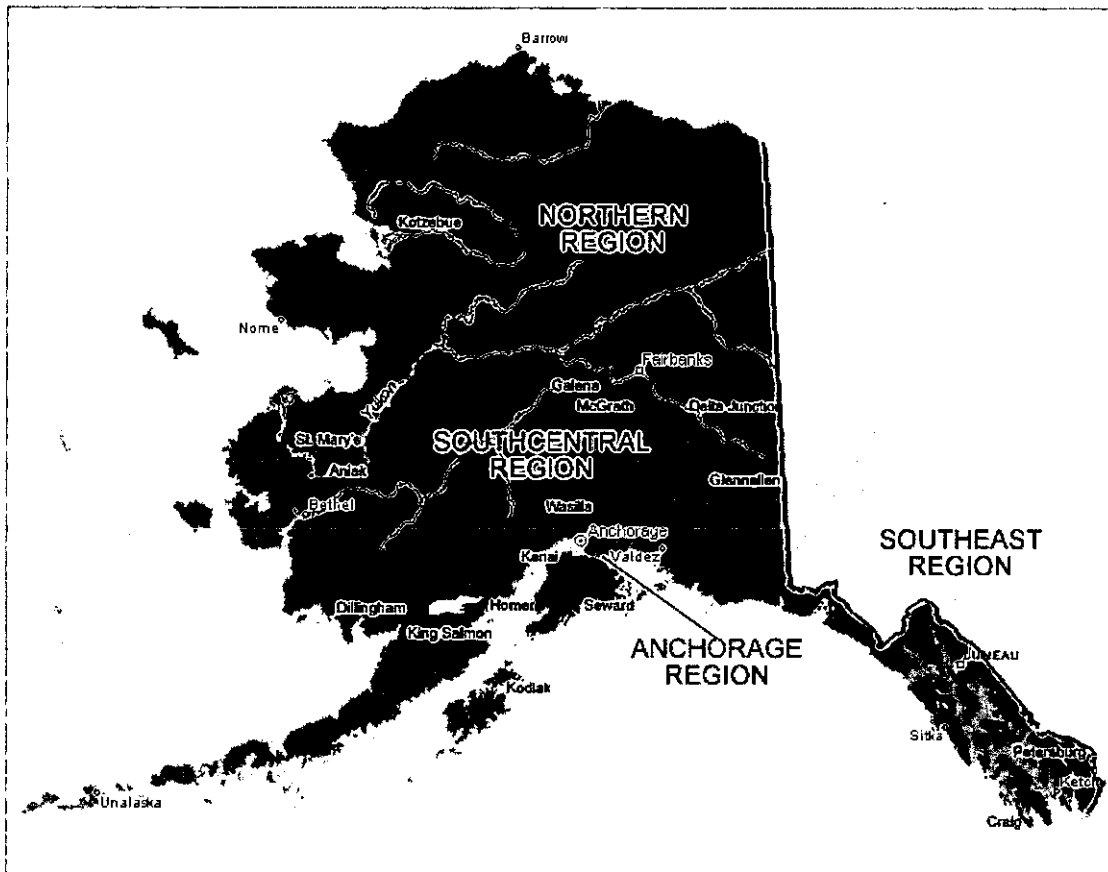
The primary issue we threw ourselves into this year was a recommendation for and strong advocacy of the creation of a fifth OCS region for the state to be headquartered in Bethel. We communicated extensively with Bethel residents involved in the child protection system and presented this recommendation to the House Health, Education, and Social Services Committee. While our request was not immediately acted upon, we continue to feel this is a vital step to enable OCS to provide quality, culturally appropriate services to this region of the state.

Recommendations

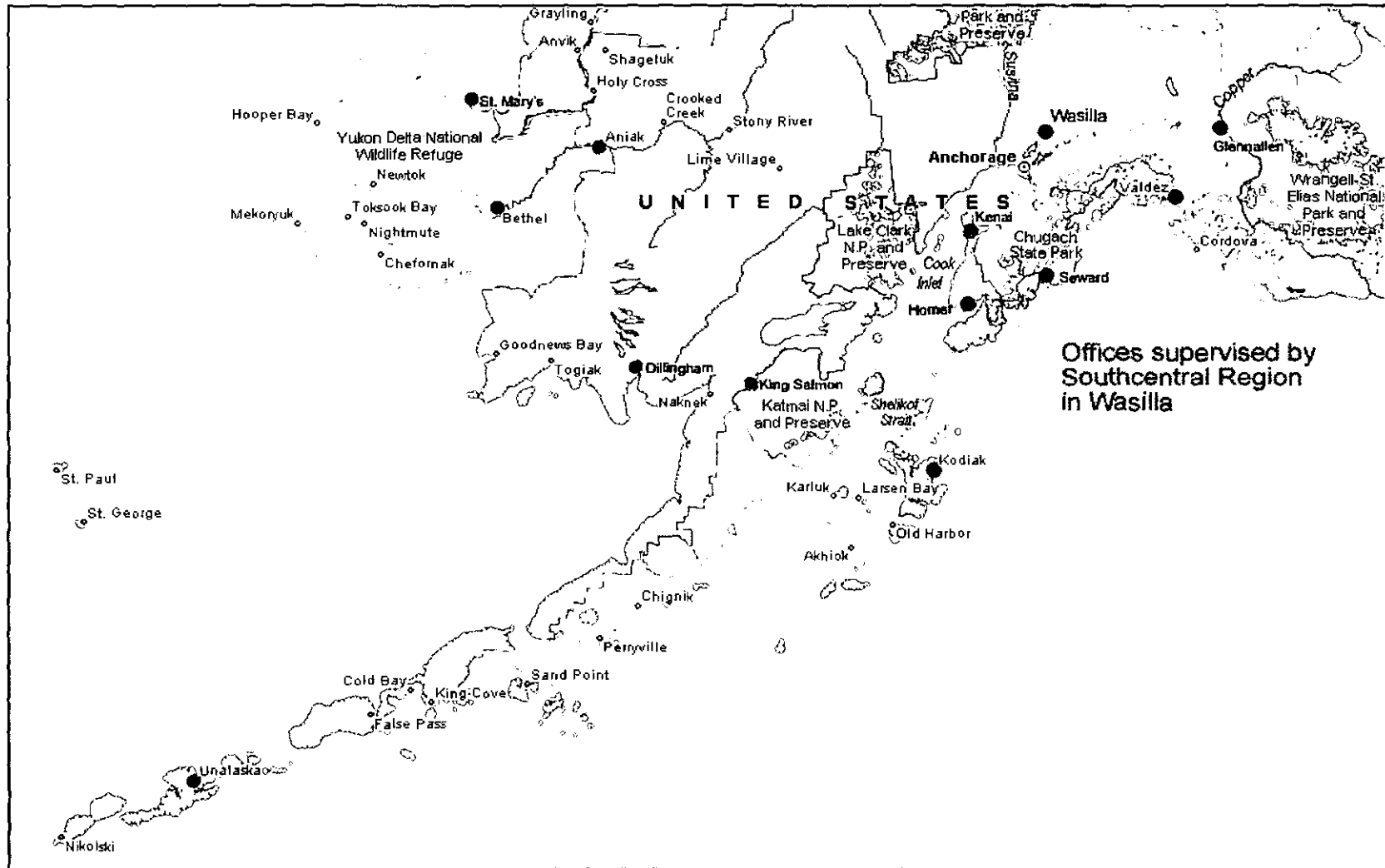
Recommendation 1. Create a fifth region headquartered in Bethel

Population and Land Area

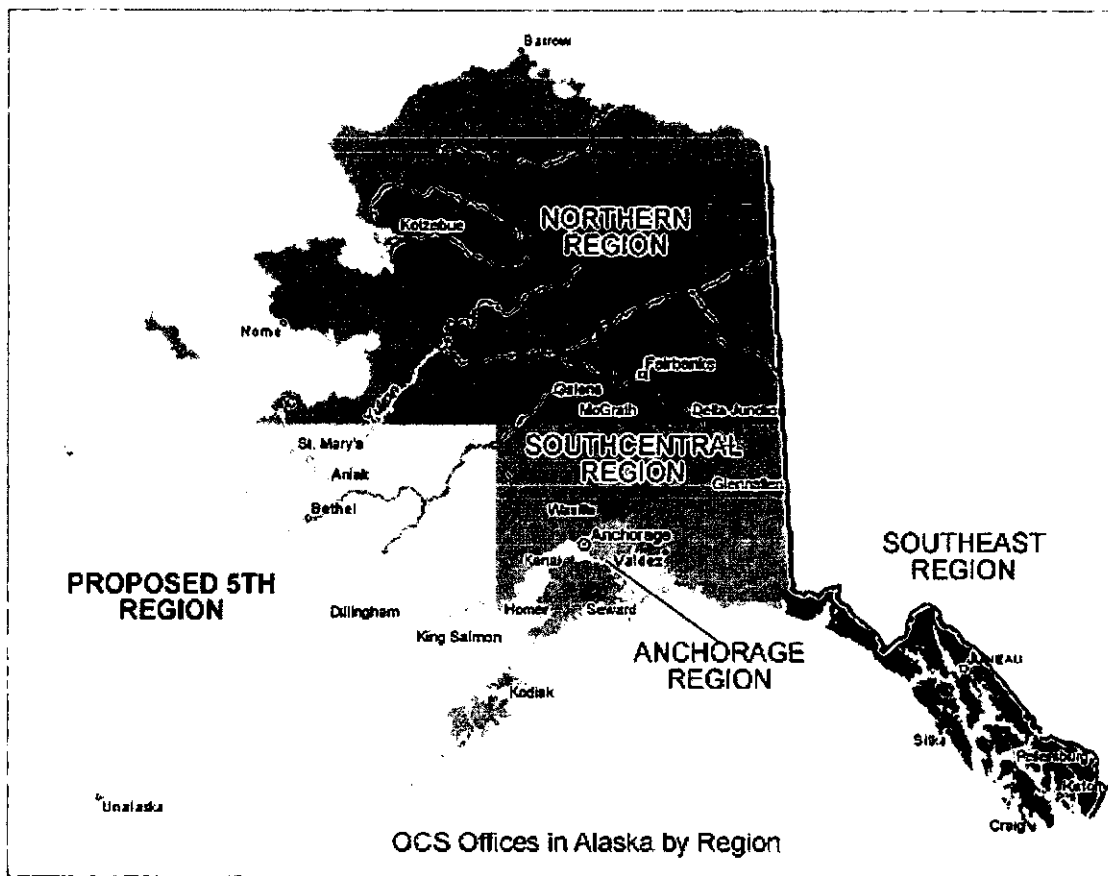
Currently OCS serves the state through four regions: Southeast, Anchorage, the Northern region (which includes the area north of St. Mary's) and the Southcentral region (which is the remainder of the state). The map below shows the existing regions.

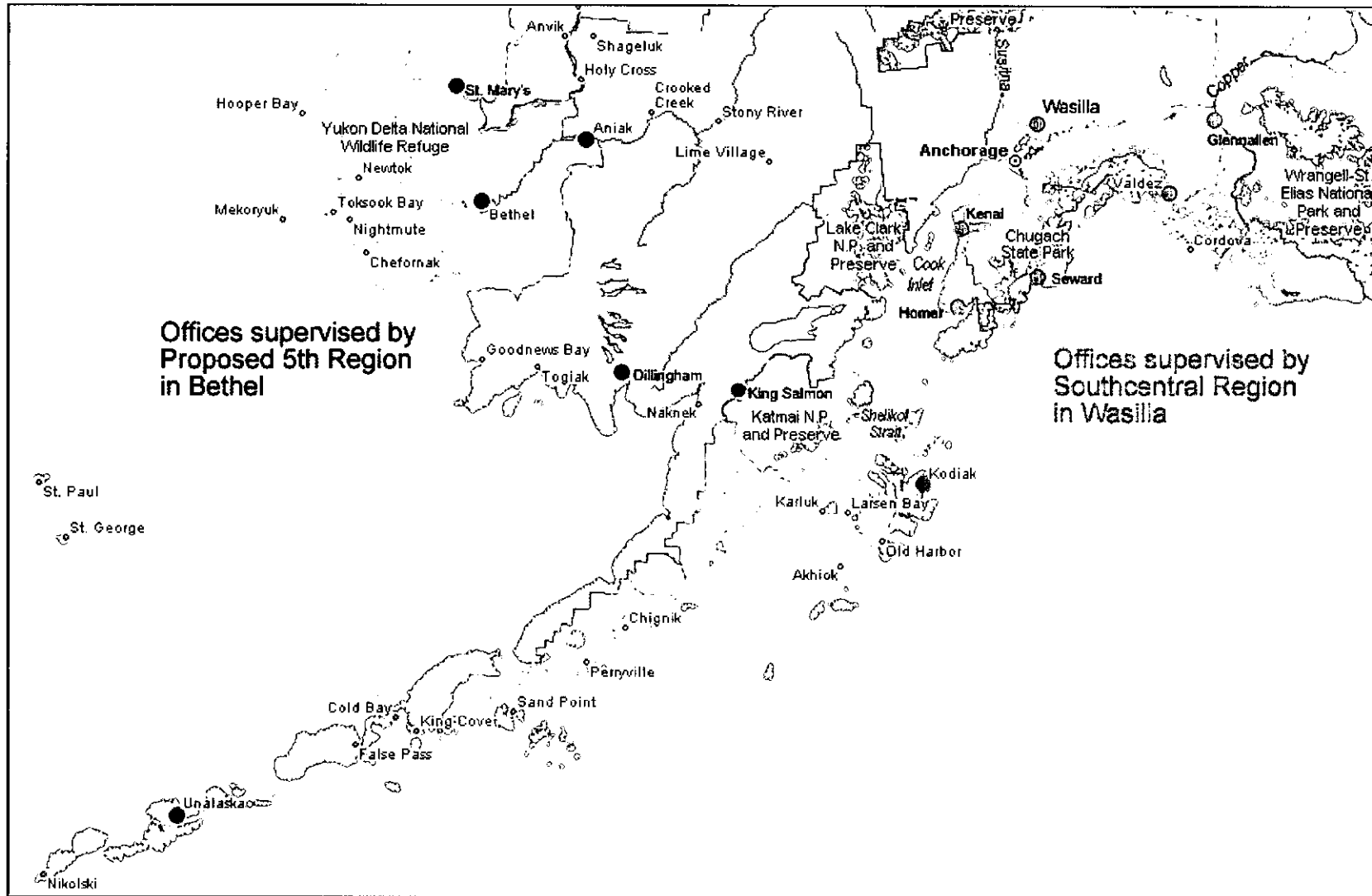


Currently there is one office in the Anchorage region, five offices in the Southeast region, seven offices in the Northern region and 13 offices in the Southcentral region. The existing Southcentral region has 12 field offices which is twice as the region with the next largest number of field offices—six in the Northern region—and three times as many field offices as Southeast (which has four field offices). The following map shows the dozen field offices in the Southcentral region and the regional headquarters in Wasilla.



We propose that in order to better serve the sizable and culturally distinct area of Southwest Alaska, OCS create a fifth region to be headquartered in Bethel. This region would be broken out from the existing Southcentral region (SCRO). It would include the six existing OCS offices in Aniak, Bethel, Dillingham, King Salmon, St. Mary's, and Unalaska. The existing Southcentral region includes 37% of Alaska's land area and 30% of its population. The first map that follows shows the entire state with the proposed five regions. The second map that follows highlights which of the field offices would remain in the Southcentral office and which would become part of the proposed Southwest region.





The table below lists all the boroughs and census areas included in the existing Southcentral region. Those areas above the heavy line are those that would remain in the Southcentral region after the proposed Southwest region is created. Those below the heavy line are the areas that would be in the proposed Southwest region. The existing boundary between the Northern region and SCRO is a straight line east-west across the state, so it does not follow borough or census area boundaries. We have estimated the percentage of the census areas in the proposed Southwest region for those census areas bisected by the boundary.

Borough or Census Area	Population (2006 Census Bureau est.)	% Population Under 5 Years Old	% Population Under 18 Years Old	Land Area (sq. miles)
Kenai Peninsula Borough	52,304	5.8	24.7	16,013
Kodiak Island Borough	13,072	7.7	30.0	6,560
Matanuska-Susitna Borough	80,480	6.4	26.2	24,682
Valdez-Cordova Census Area	9,872	6.2	24.7	34,319
Aleutians East Borough	2,647	3.5	12.1	6,988
Aleutians West Census Area	5,239	3.2	12.8	4,397
Bethel Census Area	17,147	11.2	37.1	40,633
Bristol Bay Borough	1,042	6.5	27.0	505
Dillingham Census Area	4,970	8.7	33.6	18,675
Lake and Peninsula Borough	1,548	8.1	31.2	23,782
Wade Hampton Census Area	6,443*	13.7	42.4	14,614*
Yukon-Koyukuk Census Area	877**	6.5	27.9	21,885**
Total current SCRO	201,745	7.0	27.3	213,053
Total proposed Southwest region	39,913	10.6	36.7	131,479
Total remaining SCRO	155,728	6.3	25.9	81,574
Alaska	670,053	7.4	27.1	571,951

* Estimate 85% of Wade Hampton Census Area in proposed Southwest region, figure is 85% of total.

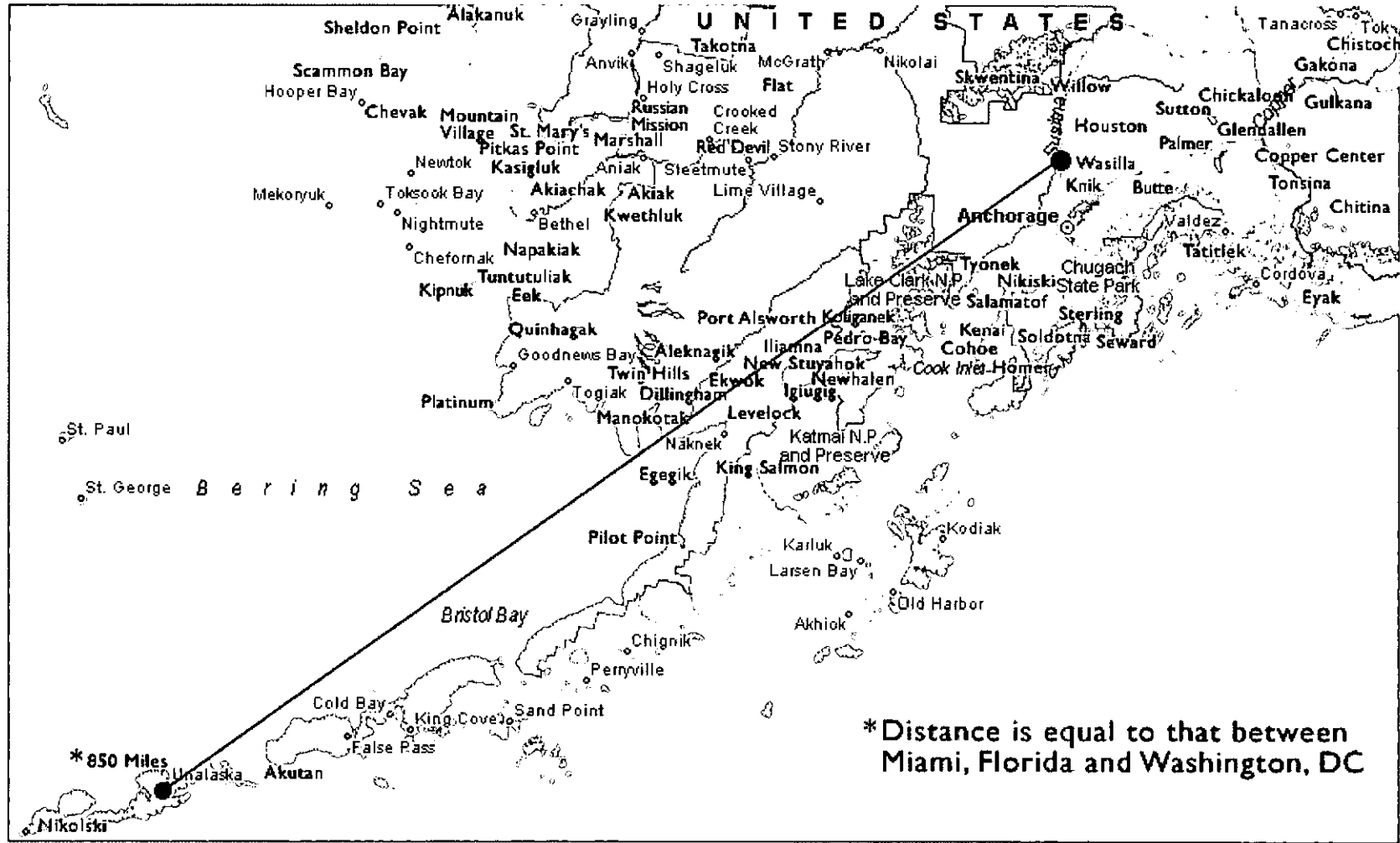
** Estimate 15% of Yukon-Koyukuk Census Area in proposed Southwest region, figure is 15% of total.

The proposed Southwest region would have 6% of Alaska's population, although it would contain 8% of Alaska's children under 18 years old. While the population in the proposed new region is not sizable, 37% of that population is children. The proposed Southwest region would also include 23% of Alaska's land area. This would leave the remaining SCRO with 23% of Alaska's population, 22% of Alaska's children under 18 years old and 14% of Alaska's land area.

The proposed Southwest region has a large number of communities. There are at least 73 communities that would be served by the new region. All of those communities are substantially closer to Bethel than to Wasilla in many ways. The communities are geographically closer, culturally closer and much closer in lifestyle being all off-road small, rural communities.



Currently the distance between Wasilla, where SCRO is headquartered, and Unalaska is equal to the distance between Miami and Washington, D.C.; it is 850 miles. It is 510 miles from Unalaska to Bethel, the proposed headquarters of the Southwest region. Bethel is two-fifths of the way closer to Unalaska than Wasilla is from Unalaska.



Caseloads

In terms of caseload for out-of-home cases the proposed Southwest region would not be the smallest region as shown in the table below. Data in the table cover September 2007 through February 2008.

Region	Total Cases	% of State Caseload	Average Cases Per Month	Highest Monthly Caseload
Anchorage	3,313	42.6	552	557
Northern	1,277	16.4	213	223
Southeast	788	10.1	131	137
Southcentral (existing)	2,397	30.8	400	416
State Total	7,775	100	1,296	1,321
<i>Proposed Southwest</i>	<i>861</i>	<i>11.1</i>	<i>144</i>	<i>146</i>

Data shown below are for opened investigations and also cover the same time period.

Region	Total Cases	% of State Caseload	Average Cases Per Month	Highest Monthly Caseload
Anchorage	1,112	38.1	185	220
Northern	535	18.3	89	109
Southeast	381	13.0	64	74
Southcentral (existing)	893	31.0	149	191
State Total	2,921	100	487	530
<i>Proposed Southwest</i>	<i>270</i>	<i>9.2</i>	<i>45</i>	<i>57</i>

Among in-home cases for that same time period, the Southcentral region had the highest number of cases with 88 of 205 in the entire state. That's 43% of all in-home cases in Alaska. The field office breakdown of these cases was not available, but it can only help the Southcentral region to halve the number of field offices it serves. When investigations and in-home cases are taken together, Southcentral again has the highest number of cases among the regions. Workers in Southcentral have the most cases per worker for these kinds of cases.

Great Need—Troubled Region

As reported in the Anchorage Daily News article, *Slowly, Western Alaska starts to break silence on sexual abuse, Children are often victims of relatives* by Alex DeMarban of the Tundra Drums, Bethel has more sexual assaults than Anchorage in absolute numbers (not per capita). This article was published on January 22, 2008. A portion of the article is excerpted below.

EPICENTER: BETHEL

New statistics from the Alaska State Troopers suggest that Western Alaska leads the state in cases of sexual abuse of a minor -- often when girls are raped or molested by intoxicated adult male relatives and acquaintances -- and cases of sexual assaults against women.

A soon-to-be released study of 989 such cases investigated statewide by troopers in 2003 and 2004 shows that the greatest number -- 476 cases, or 48 percent -- occurred in Western Alaska, said Katie TePas, a troopers program coordinator.

The region is immense -- containing more than one-third of the state's land mass -- and stretches from Kotzebue in the north to Kodiak in the south and out the Aleutian Chain past Unalaska. It's served by 13 trooper posts in what's known as the C Detachment.

But the population is small, represented by dozens of villages -- many with fewer than 500 people -- and a handful of hub communities, such as Kodiak, Bethel or Nome, each with fewer than 6,000 people.

In the vastly more populated regions along the road system -- including Anchorage, Fairbanks and the Matanuska-Susitna Borough -- troopers investigated fewer such cases during the two-year period. Combined, trooper posts in those areas investigated 299 of the studied cases, or 30.2 percent of the total during the two-year period.

Ground zero is the Bethel region, where troopers investigated 17 percent of the cases, more than any other post in the state, TePas said.

"We have an epidemic," she said. "It's a statewide epidemic, but the epicenter, our data shows, is the Bethel region."

CHILDREN MOST VULNERABLE

TePas presented the numbers at a summit on Alaska Native child sexual abuse in Anchorage earlier this month.

The results are highlights from an 102-page study done by the Justice Center at the University of Alaska Anchorage, she said.

Only trooper cases that entered the justice system during the two-year period and reached a conclusion -- cases that did and did not result in a conviction -- are included in the study, TePas said.

The early figures paint a disturbing picture of rapes and other sexual violence against adults and children in Western Alaska, where the population is largely Alaska Native and villages are often loose extensions of family.

In all the 989 cases, family members and friends sexually abuse or assault each other in more than 90 percent of the incidents, she said.

They're especially hurting children. The most common charge during the two years was second-degree sexual abuse of a minor, a class B felony that generally means the rape or other molestation of someone 16 years old or younger, often by an adult.

Almost one-fourth of the child victims were from ages 13 to 15, she said. Nearly the same number were from ages 6 to 12.

Strangers were the perpetrators in less than 1 percent of the cases involving children, TePas said.

Precedent in Other Agencies

There are other state agencies that have more than four regions. The best example is that the Alaska State Troopers divide the state into five detachments (A-E) headquartered in Anchorage, Fairbanks, Ketchikan, Palmer and Soldotna. They have posts in 36 communities. The Troopers are the best agency for OCS to compare itself to because both agencies share a need to be able to respond quickly in emergency situations. Safety requires proximity. Additionally, knowing the community can provide a great benefit in allowing workers to diffuse situations and find the most appropriate outcome. Workers in both agencies need to be culturally competent and familiar with the local services. While the Troopers' detachment C does not mirror exactly the proposed Southwest region, the areas are very similar. This arrangement works well for the Troopers and would work well for OCS. With the Troopers being a primary partner for OCS, it makes good sense to have this region to strengthen the partnership between these agencies.

Community Support

Prior to our testimony before the House Health, Education, and Social Services we received letters from residents and agencies in the Bethel area in support of keeping the Supervisor 5 position in Bethel and for the creation of a new region. We received 15 letters of support which may be viewed in their entirety on our website. Below are excerpts from a few of those letters. We wanted to allow people from the area to speak about the situation.

“...the Native – and dominant – culture in Bethel is radically different than the culture in Wasilla, or in any other region of Alaska. That means that people think about things differently here, and the people here face

very different challenges and expect things to be done in different ways..."

---Lauri Owen, Bethel

"The Bethel OCS office needs the Social Worker V position filled and ideally should be the headquarters of their own region. This would increase the ability and opportunity for local staff to work with the strengths and support identified in each of the 57 villages and 7 different school districts that make up the Yukon Kuskokwim region.

OCS, formerly [*sic*] DFYS, has evolved over the years to be known in a better light than just some agency that "takes your kids away". The region is slowly healing from the negative cultural intervention history in general: forced boarding schools, deadly influenzas that devastated entire communities, priests sexually abusing children, etc. More local hire and higher education and more communication and trust has empowered the people of this region to self determine a better destiny for the next generation. Bethel OCS needs more staff and leadership support to be a proactive part of this. The safety of Alaskan's children is the number one priority; this agency saves lives.

The OCS staff in Alaska are very dedicated people but it is the ones directly in Bethel and the villages that have the greatest insight on this regions strengths and needs."

---Susan Taylor, Bethel

"It cannot be argued that safety is one of the most important issues facing Alaska children and families today, as we look at the distressing numbers of families involved in child protection services. Expedient responses from all members of the protective teams are essential and indeed life-saving for some."

---Alaska Native Indian Child Welfare Association Board of Directors

"Bethel is a unique community that has very high needs for a strong, consistent, locally based child protection work force.

On a recent visit to Bethel I had the opportunity to speak at length with several social workers at OCS about the challenges the community faces with high rates of child neglect and abuse. Bethel is also challenged by some of Alaska's highest rates of traumatic brain injury and substance abuse. Front line child protection workers need direct available supervision in order to effectively do their demanding daily work. Removing the supervisor from this office will only serve to weaken the child protection services provided in this high needs regional hub.

Currently, social workers in the Bethel OCS office travel to more remote villages than any other region in Alaska. Supervisors must be knowledgeable about the culture and values of the communities in which they serve. Supervisors are responsible for infusing their staff with the importance of culturally relevant family interventions.”

---Summer LeFebvre, MSW

“The work that the Office of Children’s Services does can significantly impact the numbers of youth entering BYF as well as the severity of their social-emotional dysfunction and criminal offending. OCS can intervene early in instances of child neglect and abuse, and their involvement can reduce the numbers of youth being detained at BYF. One disturbing development is that we are seeing younger offenders as well as more assaults and sexual offenses. In addition, the severity of personality, behavioral, and emotional impairments is on the rise. The numbers of youth in the BYF that have mental health diagnoses is well over 75%.

It is my professional opinion that to have the Director of OCS held by someone *not* living in our community will only increase the trends mentioned above. The complexities of making child protection decisions is a difficult one at best. The person in that top position needs to have knowledge and respect for the cultures out here as well as the many challenges and difficulties of living in rural Alaska.”

---Dr. Valerie Warren, Bethel

Conclusion

There are many strong reasons for creating this new region.

- The area is 23% of Alaska. If it were a state, it would be the fifth largest state just behind Montana, but ahead of New Mexico.
- The area is entirely off the road system, complicating travel and creating different circumstances than on-road communities face.
- The area has a higher percentage of the population who are children than the state overall.
- The area will have a larger out-of-home caseload than existing regions.
- The area has a great need having the highest rates of sexual assault.
- The area is culturally distinct due to the large, strong Yup’ik population.
- The Alaska State Troopers, who also provide public safety, serve the state through five regions.
- The community supports the effort.
- The OCS offices and staff are already in place. Only four new positions need to be added.

In addition to serving this culturally distinct area that comprises nearly one quarter of Alaska much better, removing responsibility for this area would allow the currently over-stretched SCRO to provide better services to all those children and families remaining in its area. SCRO has many challenges and would greatly benefit from having less on its plate. There are so many good reasons to do this. We have yet to find anyone who does not support the idea.

Recommendation 2. Implement workload study recommendations

In May 2006 OCS received the final report on a statewide workload study conducted by Hornby Zeller Associates, an Outside consulting firm. The study involved a great deal of work examining workers' caseloads and how their time was spent. The study also included four recommendations; the full text of the recommendations is included below. Hornby Zeller Associates' full report on the statewide workload study may be viewed at our website, www.crp.alaska.org.

From Hornby Zeller Associates *Statewide Workload Study*, May 2006.

In response to this study OCS should make a plan for filling existing vacancies and monitoring workloads over time in an effort to increase staff resources as the agency can absorb them. Some aspects of the plan should be:

1. Fill the positions that are authorized but vacant, shifting the bulk of those positions to Anchorage.
2. OCS should recalculate the staffing needs by office every month for a year and plot the results by counting cases and applying the weights each month to identify patterns of under- and over-burden among the offices. These data will provide a reliable direction for shifting current staff to better meet the caseload burden where it is shown to exist over time and for targeting new positions that may be authorized on the weight of this study's results.
3. Once the vacancies are filled, OCS should make an effort to attain additional positions at whatever speed they can be absorbed from both a political and an agency standpoint using the evidence contained in this study. Part of that evidence is the very basic standard used in the study to determine if a case is handled appropriately and the amount of time it takes to handle it appropriately. Those standards are spelled out in Appendix D for each case type.
4. To produce the most equitable distribution of workload for current staff and cases on an ongoing basis, OCS could also provide supervisors making assignments a workload monitoring program through ORCA, as described in Appendix F. These procedures should help supervisors achieve the proper allocation of cases to existing workers based on the case weights or workload standards established by this study.

In the two years since this study was received by OCS, we believe staff have been working to address this problem. However, the situation is still quite grave in many locations. Appendix A of this report is a letter from a guardian ad litem working on the Kenai Peninsula who documents and eloquently makes the case for more workers. As she notes, the Child Welfare League of America recommends caseloads of between 12 and 15 children for social workers doing child protection work. In January 2008 the Kenai permanency social workers were averaging 22.4 families and 38 children. Workers in this one office have caseloads nearly triple the recommended size and are working extraordinary hours trying to make sure no children fall through the cracks. However, inevitably children fall through the cracks and become headline news when a preventable tragedy occurs. A less dramatic, but very harmful outcome is that workers leave when they reach their breaking point.

OCS needs to implement these recommendations immediately. Caseloads must come down so social workers can do social work. During a site visit in Southeast a social worker told us she objected to having her job titled Social Worker since she never got to do social work. She described her job as filling out forms and trying to keep her head above water.

We do want to recognize that the Director of OCS, Tammy Sandoval, is working on these priorities. The Governor approved several OCS increment requests in the fiscal year 2009 operating budget including \$860,900 of funding to comply with the OCS Workload Study. This funding adds seven new caseworker positions and three new support staff positions to the OCS team. Every additional employee is a step in the right direction toward reasonable caseloads and workers with time to do social work.

Recommendation 3. Fix the telephone system

Currently the telephone in a number of small offices is not answered if staff are out of the office. Thus someone calling the Glennallen or Delta Junction office, for example, either get voicemail or are told to hang up and contact another office (e.g., in Glennallen callers are given the number of the Wasilla office while in Delta Junction callers are given the number for the Fairbanks office). The phone system needs to be upgraded in these locations so that the phone transfers automatically to the other office (e.g., Wasilla or Fairbanks). We understand that this may be problematic in very small communities operating with local telephone carriers, however, it should be possible in more places than not. This feature is certainly available and in use in some parts of the state already. If a call to the Director's line is not answered by her in Anchorage the phone is then answered by someone in the main OCS office in Juneau.

The goal is that the main telephone number of every OCS office should be answered by a live person during business hours. People should not have to hang up and place a long distance call if they want to speak with someone. A complaint we have heard from a variety of partners in many locations is that OCS is hard to contact. It should not be

difficult to reach OCS. Some people might be calling to report abuse after having talked themselves into making the call. If told to hang up and call another number, they may feel like they tried and let it go.

Recommendation 4. Publicize and staff the toll free number

The toll free number to report child abuse (1-800-478-4444) is poorly publicized and not well staffed. Several members of the Citizen Review Panel were not even aware of its existence, including a member who is a Guardian Ad Litem. The number is not even prominent on the OCS homepage. OCS should partner with the Alaska Children's Trust to increase publicity for this number. While a large portion of the general public is not likely to have the number memorized, a large portion should know that the number exists. This seems certain to result in increased reporting and yield better protection for children. An advertising campaign that emphasizes that the number is available statewide, 24 hours a day and that callers may be anonymous would help a great deal. Additionally, the advertising should stress that people don't have to *know* whether a child is being abused or neglected. If they have concerns, they should call and professionals will investigate the situation. The ads should stress that it is everyone's business to report suspected abuse.

A good model for the number might be the Alaska Tobacco Control Alliance's Quit Line. The Quit Line phone number is well publicized through television and radio public service announcements and print ads. The Quit Line number is on the front of the Fairbanks ACS Telephone Directory. In reviewing the Information Pages at the front of the Fairbanks ACS Telephone directory, the first page has emergency numbers that includes 911 and the poison control number in large print. In smaller print are numbers for a variety of services including the domestic violence hotline, but nothing for OCS. Further into the Information Pages are two pages of Community Service Numbers. The Family/Youth Services Category of these pages includes listings for 16 agencies, including two 800 numbers (the runaway hotline and the Alaska Center for Resource Families). The only listing for OCS is for the old "Division of Family and Youth Services." When attempting to look up any phone number for OCS, the only listing found was in the Government Listings. There is nothing listed under State of Alaska, Alaska, Department of Health and Social Services, Health and Social Services, Office of Children's Services, or Children's Services. There is a listing in the white pages for Child Abuse Information and Referral that lists the number for the Resource Center for Parents and Children. It should be easier to find a number to call. The number should also be much more prominent on the OCS homepage. It would be nice if the number were listed on the homepage of the Department of Health and Social Services.

Currently staff at the Anchorage office answer the 800 number. If staff are busy, callers are transferred to an auto-attend system and a recording provides the hours of the Anchorage office while they hold. This may confuse callers who thought they had called a hotline. When the phone is answered during business hours, the staffer does not know

that the caller has contacted the hotline. Callers are then transferred to someone in investigations. During several test calls, we were not told that we were being transferred to "John Doe who investigates these cases" and that he would take our information. Additionally, if the individual is not at his/her desk the call goes to 'John Doe's' voicemail. Thus anyone who wishes to make an anonymous report must either continue to call back until the call is answered or leave a message that is not likely to contain all the necessary information, or will not be anonymous.

When the 800 number is called after business hours or on a holiday, a recording answers with the message, "If a child is in danger right now, hang up and call 911." The message then goes on to say, "Your call will be answered in the order in which it was received by a message secretary." This line should be staffed 24 hours a day with someone trained to take a caller's information and to ask the necessary questions.

Recommendation 5. Collocation of OCS Workers

In several locations around the state, OCS workers are collocated with partnering agencies. We have yet to hear anything but positive comments about these situations. Having an OCS worker located in a law enforcement office or at a child advocacy center or school allows OCS workers to collaborate more fully with these partners. OCS workers can be more responsive and develop the strong relationships that will sustain these partnerships through challenging times.

We understand that collocation is not practical in all circumstances; other agencies may not have room to spare. Additionally, we know that OCS has long-term leases in many locations. As these leases end and OCS is revisiting office space, we strongly encourage OCS to pursue collocation wherever feasible. We feel collocation should be a very high priority for OCS offices that have just a single staff person assigned to them. Enabling a lone staffer in an outpost to have the support of the "colleagues" who would be gained through collocation would enable OCS to better retain workers in these especially challenging locations. The OCS office in Glennallen would be an excellent place to start this collocation effort. The Glennallen region is in the process of starting a child advocacy center and it would be ideal for the OCS worker to be located in the CAC facility.

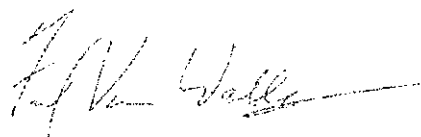
Recommendation 6. Support for Front Line Workers

In the course of talking to many front line OCS workers around the state, we have found workers to be stressed to the point of disability. Many workers are at their breaking point with demanding caseloads and insufficient support services in their areas to offer their clients. Very few OCS offices have enough staff either due to existing positions being vacant or funding that is inadequate to hire the necessary number of workers. Consequently, some workers are stressed to the point of having post traumatic stress disorder. Other workers are losing sleep and are very anxious about the welfare of their clients. Counseling and stress management classes should be available to all workers.

Commendations

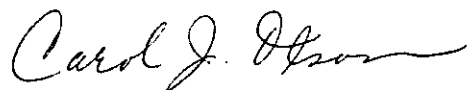
We commend those individuals who courageously spoke up for children when there were potentially negative personal consequences.

Respectfully submitted by the Citizen Review Panel:



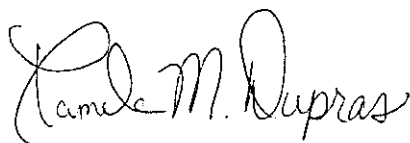
Electronically signed
June 30, 2008

Fred Van Wallinga, Chair



Electronically signed
June 30, 2008

Carol J. Olson, Vice Chair



Electronically signed
June 30, 2008

Pamela M. Dupras, Member



Electronically signed
June 30, 2008

Dana W. Hallett, Member



Electronically signed
June 30, 2008

Arthur S. Hansen, Member



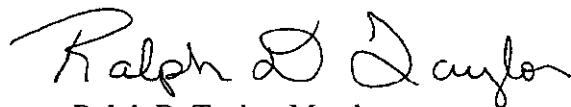
Electronically signed
June 30, 2008

Susan Heuer, Member



Electronically signed
June 30, 2008

Esperanza M. Redelfs, Member



Electronically signed
June 30, 2008

Ralph D. Taylor, Member

*Never doubt that a small, dedicated group of citizens can make a difference.
Indeed, it is the only thing that ever has...
~ Margaret Mead*

Appendix A

KATE TEA, LCSW, GAL
130 Trading Bay Road, Suite 310
Kenai, Alaska 99611
Office 907.283.6551 Fax 907.283.6553
katetea@alaska.net

March 17, 2008

Ms. Tammy Sandoval
Division of Health & Social Services
Office of Children's Services
323 East 4th Avenue; McKay Annex
Anchorage, AK 99501

Ms. Sandoval,

I am a Kenai contract guardian ad litem with the Office of Public Advocacy. We have met on at least two occasions in Anchorage; once for Dianne Olsen's retirement party when we both spoke and again at the last CASA/GAL Conference this past fall. We may have also spoken together at the ICWA training last October. At any rate, I hope that you remember meeting me.

I am writing to you not only as a children's advocate but also in my broader obligation as a social worker to work for change as delineated in the National Association of Social Workers, Code of Ethics. I believe I have a responsibility to my social work colleagues, the families and children we serve, and to advocate for resource allocation when necessary. It is in the spirit mutual concern and sharing common goals as social workers that I am approaching you.

On the occasions that I have had the opportunity to speak with you, I have shared my sincere appreciation for the supervisors and line staff social workers in our Kenai OCS office. I have been a social worker for 20 and guardian ad litem for 10 years. Over this period of time I have experienced many changes in the law, procedures, and personnel in the Department of Law and the Office of Children's Services. Over this same period of time it has been my observation that the quality of social work being performed in the Kenai office has steadily improved. The caliber of social work in the Kenai office is overall excellent in both the intake/investigations and permanency units.

My concern and the purpose of this letter is to bring your attention to the extreme shortage of personnel in the Kenai office which is compromising the ability of the social workers to adequately manage their caseloads. The Kenai caseload numbers have grown to the breaking point and have become intolerable.

I am not as familiar with the intake/investigations unit caseload or staffing needs as I am with the permanency unit due to my duties as a GAL. However, I have observed that all of the intake/investigations social workers are always working at an exhausting pace. I am aware that the intake/investigations unit has been working hard to implement the new "Intake Assessment" model which has placed a significant increase in the demands on their time. These types of changes, while having overall benefit to casework, can become hidden variables that further stretch overworked social workers that are difficult to measure.

At this time, there is "real" social work taking place in the intake/investigations unit with the result that the situations that are more amenable to change never reach the petition/custody stage and only the more complex cases reach the permanency unit. The cases that are transferred into the permanency unit are more complex and the families are much more entrenched in the behaviors that harm their children. The social workers in the permanency unit in Kenai have become completely overwhelmed with the numbers and needs of the families they are serving. The most recent numbers I have obtained from Ms. Abigale Henderson demonstrate what I have been hearing for some time; our social workers in Kenai have caseloads in numbers three times those recommended by the Child Welfare League of America as caseload/workload standards. My research through the NASW web site brought to light information that not only are caseloads high but that "workloads" are even higher due to the growing complexity of the cases. CWLA recommends caseloads of between 12 and 15 children (I have also read 12-14 children) and our Kenai permanency social workers are averaging 22.4 families and 38 children (using figures from January 2008 only).

While every office experiences turnover from time to time, we have been fortunate to have been able to maintain a stable social work staff. This is rapidly changing as the well-trained, committed, and excellent social workers remaining begin to buckle under the extreme burden of so many cases, vacant positions, and the ever increasing number of mandated tasks and procedures that are implemented both internally and most recently externally from the Kenai Court System.

Kenai is at the breaking point. If more positions are not allocated to this office we will begin experiencing more turnover, which will compound every challenge placed upon the remaining social workers leading to the spiral of increasingly compromised casework. There comes a time when no amount of organizational or time management skill can compensate for an unmanageable workload. The dedicated social workers in Kenai have resorted to working late hours, weekends, and holidays in their efforts to address the

demands of their work. Most of them look forward to a holiday as an opportunity to have a “quieter” time to work. The late evenings, weekends, and holiday work schedule has become the norm rather than the exception. We will not be able to retain seasoned social workers or attract new qualified social workers as long as this office remains severely understaffed.

I have been reviewing literature about the impact of social worker turnover on outcomes in child protection. Of interest is an article that can be reviewed at <http://www.uky.edu/SocialWork/cswe/documents/turnoverstudy.pdf> The study looked at the correlation between continuity in the social work relationship and permanency. In this study, the researchers determined that foster children with only one social worker were returned to their family 75% of the time but that this number dropped to about 18% when there were two workers and then to almost zero when there were 6 or 7 workers. I am sure that you are also painfully aware of numerous studies demonstrating the deleterious effects of social worker turnover on outcomes.

There are real overt and covert risks inherent to the conditions that currently exist in the Kenai OCS office. Everyone there is doing all that they can to meet the needs of the families but even with their “regular” extended hours, they are unable to keep up. More positions are needed to maintain even minimally acceptable casework; the current situation is an accident waiting to happen. It is my ethical responsibility as a social worker to advocate for our families and my colleagues; dedicated social workers who are not able to fulfill their obligations and responsibilities due to severe understaffing in their office. We all are responsible for advocating within and outside our agencies for adequate resources to meet clients’ needs. I urge you to please allocate several new social worker positions to the Kenai OCS office as soon as possible.

Thank you for your time and thoughtful consideration of my request.

Sincerely,

Kate Tea, LCSW, GAL
Licensed Clinical Social Worker, #196
Certified Chemical Dependency Counselor, Level II
Guardian ad litem

cc. Mr. James Steele, SCRO Children’s Services Manager
Ms. Abigale Henderson, SW V, SCRO Staff Manager
Ms. Katie Stafford, Kenai Supervisor
Mr. Bill Galic, Kenai Supervisor
Ms. Michelle Higuchi, Kenai Office AAG

Appendix C

Office of Children's Services *Stronger Families, Safer Children*

Manager's Training Outline 2008

According to Team Leadership in the First Ninety Days by Maynard Brusman - *the first weeks are crucial for learning and evaluating. Leaders must maintain the right balance of confidence and humility, while asking probing questions and actively listening. They need a firm support network in place; they must learn everything they can about the organization, its strategies, and customers. Leaders must dedicate a large percentage of learning time to getting to know existing team members in the shortest possible time-frame. Transition from the outside and you face the task of identifying and placing the right people into the right positions, which is a much greater challenge.*

Accordingly, within 90 days of employment new manager will meet with each member of Statewide Management Team for orientation to each domain within the Office of Children's Services. Statewide Management Team members will provide an overview regarding the following:

Director

- DHSS Leadership
- Mission
- Vision
- Values
- 5 Goals
- Prevention
- Quality Assurance
- Citizen Review Panel

Deputy Director

- Role of Deputy Director
- Role of manager in utilizing available human, financial and tangible resources to accomplish OCS' mission
- Philosophy of residential care
- Psych nurses
- Solution focused problem solving
- How this position fits into the OCS manager structure
- DHSS Joint Management Team
- Bring the Kids Home

Appendix C

Administrative Manager

- Organization Structures
 - State, Department, Division, Region, Field
 - Authorities and delegations
 - Budget/Funds
 - When, Where, and How We are Funded
 - Applicable Rules that Follow the Funding
 - Regional Allocations
- Personnel P&P
 - Roles & Responsibility
 - Workplace Alaska & the Hiring Process
 - Use of Non Perms
 - Alternate Work Weeks
 - Reclassifications
 - Disciplinary Actions - Authorization Levels
- Travel Do's and Don'ts/Credit Card Use
- ORCA and Finance - Provider Payments
 - Policy, Procedure, Regulations
 - QA Purpose and Process
 - Matrix Expenditures
 - Audit Exceptions
 - Why ORCA Entries Dictate Allowable Expenditures
 - Your Responsibility/ Accountability for Expenditures Approvals
- Manager's Responsibilities re: Revenue
 - IV-E and the Penetration Rate
 - RMTS
 - Other Revenue Sources

Program Administrator

- Policy
- Child & Family Services Review
- Child & Family Services Plan
- Annual Services Progress Report
- Title IV-E State Plan
- Tribal Title IV-E
- Service Array Section (Programs)
- Resource Family Section (Foster Care & Adoption)
- State office and field offices - one agency

Appendix C

Child Welfare Administrator

- Standardizing Safety Decision Making Practice
Tying safety decision making to division goals
- Family to Family Initiative
- Partnership w/Casey Family Programs & Annie E. Casey Foundation
- Training Academy
- Tips/Lessons learned for management

ORCA Administrator

- ORCA - System of Record
- ORCA as Supervision tool
- ORCA enhancements/improvements
- ORCA Help
- Future of ORCA
- Reports
- ORCA Demonstration

Community Relations/Legislative Liaison

- Legislative Session
- Constituent Relations
- Media responses
- PIT work
- OCS website
- Retention & Recruitment efforts
- The ACT
- The CJA

If the manager comes to OCS with no previous child protective services experience, the manager will make every attempt to attend TONE within their first 60 days of employment.

If the manager comes to OCS with no previous State of Alaska experience, the manager will make every attempt possible to attend the Division of Personnel - Supervisory Training within 120 days of employment.

Appendix B

OCS WORKFORCE GOALS & STRATEGIES

GOAL STRATEGY ACTIVITY	START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS
GOAL #1 - ORGICULTURE / VALUES: Improve public, partner, stakeholder and staff understanding of OCS' mission, vision, values and desired outcomes.					
Strategy A	Increase Public Education Efforts				
Activity 1	Social Norms Marketing Campaign	9/30/2008	3/31/09	25%	Mike R&R Workgroup Developing proposal; schedule meeting with Jeff Linkenback; pursue with Nat'l Alliance/ACT
Strategy B	Develop a comprehensive and consistently implemented New Staff Orientation Plan				
Activity 1	Develop and implement new employee orientation training program.	10/24/08	1/31/2009	25%	Travis; R&R Workgroup Travis presented Anch New EE Orientation program implementation to Mgrs during Mgmt Team Mtg in November
Activity 2	Create a Development Plan for New Staff Mgrs & CSMs.	8/20/08	9/9/2008	100%	SLT Distributed to current CSMs and Staff Managers as an FYI
Strategy C	Communication Plan				
Activity 1	Create a "Communications Guidelines" document for staff use.	6/18/08	9/22/2008	100%	SLT Distributed to Statewide Mgmt Team with directive to discuss / distribute to staff.
Strategy D	Appreciative Inquiry				
Activity 1	Deliver Intro to Appreciative Inquiry presentation	10/6/08	12/31/2008	20%	SLT Senior Leadership Team reviewing

Appendix B

GOAL STRATEGY ACTIVITY	START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS	
GOAL #2 - TRAINING: Provide comprehensive and on-going, culturally-competent and current best practices training.						
Strategy A	Incorporate Mission, Vision and Values into Supervisor's Curriculum					
Activity 1	Train on the importance of supervisory role in supporting MVV among their staff	9/1/2008	11/18/2008	95%	Jay C	In process
Strategy B	Cadre of Supervisors / Facilitators (based on need)					
Activity 1	Canvass supervisors who have completed Supervisor Training to select those who are willing to provide ongoing training for OCS employees.	4/1/2009	7/1/2009	0%	Jay C	Work not yet started
Strategy C	Review Curriculum and Decide Implementation Plan					
Activity 1	Develop proposal				Jay C	
Strategy D	Become a "Learning System Rather Than a Training System"					
Activity 1	Develop proposal				Jay C	
GOAL #3 - RECRUITMENT: Expand the OCS recruitment message, target those applicants most fit for child welfare duty and utilize their talents whenever and wherever possible.						
Strategy A	RJP					
Activity 1	Produce an OCS-featured Realistic Job Profile DVD to be incorporated into OCS hiring procedures.	11/1/07	1/31/2009	50%	Mike; David	Urban taping and staff interviews complete; David Caldwell has yet to interview rural staff and capture 'B Roll'
Strategy B	High School / College Interns					
Activity 1	Implement State of Alaska's Intern Program into OCS offices				Maritt	

Appendix B

GOAL STRATEGY ACTIVITY		START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS
Strategy C	Double Fills					
Activity 1						
Strategy D	On-Calls					
Activity 1						
Strategy E	5 Step Interviewing Process					
Activity 1						
Strategy F	Job Fairs					
Activity 1						
GOAL #4 - RETENTION (cont.): Create a work environment that includes the types of relationships, support, opportunities for growth, workload expectations and compensation that employees do not want to leave.						
Strategy A	AWW Agreements*					
Activity 1						
Strategy B	Telecommuting Agreements*					
Activity 1						
Strategy C	Job Share Agreements*					
Activity 1						

Appendix B

GOAL STRATEGY ACTIVITY		START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS
Strategy D	Lunch and Learns					
Activity 1						
Strategy E	On-going Training					
Activity 1						
Strategy F	Team Building					
Activity 1						
Strategy G	Continue Implementing Workload Study Results					
Activity 1						
Strategy H	Student Loan Forgiveness					
Activity 1	Add OCS caseworkers to any 2009 legislation related to a loan forgiveness program	10/3/08	4/20/2009	10%	Mike	Mike networking with DHSS staff on the DHSS leg proposal
Strategy I	Recognition Program					
Activity 1	Implement and use latest departmental program for all OCS staff	10/1/08		20%	Everyone	DHSS Recognition Program being reviewed by DOA as of 11/10/08
Activity 2	Welcome and congratulate new employees at completion of TONE with OCS t-shirts	10/13/08			Jay C	Funding to come from the contract amount in the FYSTA budget?

Appendix B

GOAL STRATEGY ACTIVITY	START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS	
GOAL #5 - Stipend Program: Create a new employee stipend program that effectively attracts staff, educationally nurtures staff and successfully binds the employee/employer agreement.						
Strategy A	Evaluation of Current Stipend Program					
Activity 1	Contractor Don Schmid will review effectiveness of stipend program for past 3 years.	9/1/08	11/1/2008	90%	Contractor Schmid	D. Schmid has given preliminary findings to N. Rolfzen, T. Sandoval & C. Lawton
Strategy B	Implement Recommendations from Evaluation					
Activity 1	Begin to implement recommendations to revise stipend program beginning 2009	11/1/08	4/1/2009	30%	Christy Lawton	
GOAL #6 - Human Resources: Utilize all tools, knowledge and assistance that is available within the Dept. of Administration, Division of Personnel, and effective in meeting staff recruitment and retention goals.						
Strategy A	Data to Manage / Decisions					
Activity 1						
Strategy B	Competencies for Positions					
Activity 1						
Strategy C	Performance to Appraisals Re: Competencies					
Activity 1						

Appendix B

GOAL STRATEGY ACTIVITY		START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS
Strategy D	Knowledge Transfer Plans					
Activity 1	Develop Knowledge of Transfer Plans per Admin. Order 237 deadline				Maritt	Maritt to provide 'Getting Started' presentation to Mgrs TBA
Strategy E	Performance Coaching					
Activity 1	Expand recent DOP-delivered trainings received in Anchorage & Wasilla to entire agency	11/13/08			Mike	Travis presented to Mgrs at statewide Mgmt Team Mtg in Anchorage in November on 11/13
Strategy F	Union Meetings					
Activity 1	Schedule meetings with Union Reps to help reframe their paradigm of OCS workload	9/23/08	50%		Mike Maritt Tammy	Set meeting with ASEA Business Rep Toya Winton to discuss OCS caseload count and '08 Staff Survey results
GOAL #7 - UAA / UAF: Collaborate with the University system to expand and prepare an applicant pool that is fit for child welfare work in Alaska and exceeds the staffing needs of the OCS program.						
Strategy A	Kentucky's Public Child Welfare Certificate Program					
Activity 1						
GOAL #8 - Other: These must be categorized as 'Other', or miscellaneous goals at this time.						
Strategy A	Review Work Group Membership					
Activity 1	Reestablish membership of the R&R workgroup	11/13/08	12/15/2008	75%	Mike	Mike obtained CSM participation during statewide Mgmt Team Mtg in Anchorage in November; CSMs to appoint others from Region

Appendix B

	GOAL STRATEGY ACTIVITY	START	FINISH	% COMPLETE	STAFF RESPONSIBLE	COMMENTS / PROGRESS
Strategy B	Break Out into Subcommittees					
Activity 1	Direct tasks of R&R workgroup to smaller subcommittees when appropriate				Mike	
Strategy C	"Training" Becomes "Learning"					
Activity 1						

The Office of Children's Services (OCS) wishes to thank the Alaska Citizen Review Panel (CRP) for its work in the past year to ensure the safety and well being of the children of Alaska. We know that we cannot do the work necessary to prevent and reduce child maltreatment without the assistance of all of our community partners. We appreciate the CRP for their diligence in examining policies and procedures and practices that then inform recommendations toward systems improvement of the OCS.

It has been another industrious year for OCS. We continued to work diligently on improving and standardizing practice across the state related to child safety decision making and we were able to roll out *Family to Family* from Anchorage to Fairbanks. We were able to increase new worker training from 2 weeks to 4 weeks to better prepare staff to do child protective services. We were able to implement a competency-based curriculum for supervisors to strengthen their ability to better support their staff. We strengthened partnerships with other divisions within the Department of Health and Social Services to provide a better service delivery system to families that come to the Department's attention through several different doors – Public Assistance, Behavioral Health and Juvenile Justice. We spent more time and effort on the prevention of child maltreatment to combat child abuse and the need for intervention from protective services.

The biggest event to happen within OCS in the past year was the Federal Child and Family Review (CFSR) in September. A great deal of time and effort went into the planning and preparation for the CFRS. That work began with the completion of a Statewide Assessment. A copy of the document can be viewed at - <http://hss.state.ak.us/ocs/Publications/CFSRstateAssessment.pdf>. The final CFRS report has not yet been received from the Administration for Children and Families, but strategic planning for the Performance Improvement Plan has begun.

Again this year, OCS concentrated a lot of effort on Continuous Quality Improvement, including conducting statewide case reviews, quality assurance of our safety assessment implementation and the annual stakeholder surveys. The survey results can be viewed at <http://hss.state.ak.us/ocs/QualityImprovement/QualityImprovement.htm>. The stakeholder surveys also included our annual staff survey. The staff survey produced a 77% response rate this year and a wealth of insightful comments. This year's staff survey truly indicates that OCS staff is committed to the organization's success and invested in improving service delivery to children and families!

The revision of Policy and Procedures (P/P) is a continual process within the OCS. Last year the format of our P/P was revised to become more user-friendly. This year the focus was on revisions to update P/P. A copy of all the revisions is included in Appendix A.

The following are the responses to the specific recommendations made in the CRP 2008 Annual Report:

Recommendation 1 - Create a fifth region headquartered in Bethel.

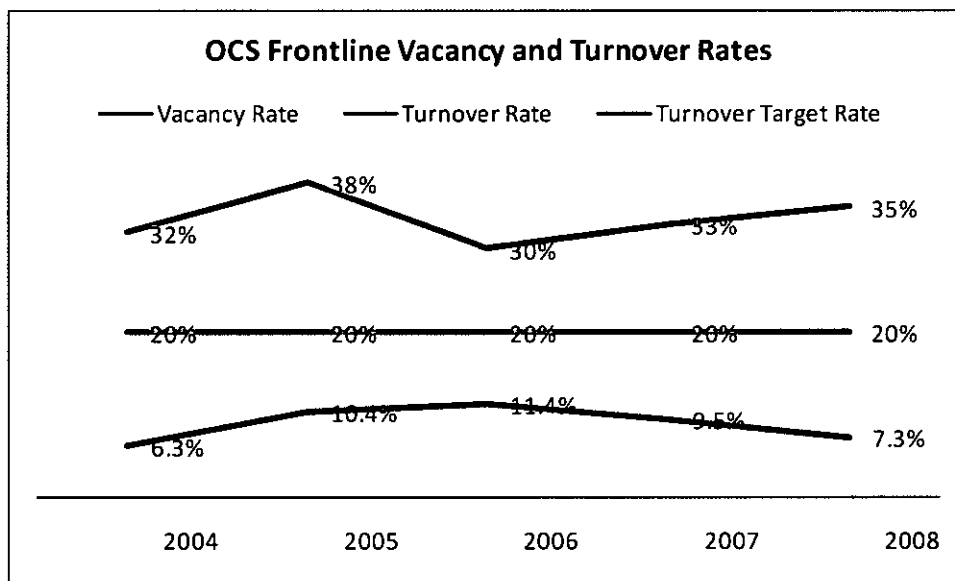
The Governor's Proposed FY2010 Budget was released on December 15, 2008, and does not include a request for funding a 5th region within OCS. OCS has made some changes that are proving to be of assistance though. There is a new Staff Manager in Bethel and a new dynamic South Central Regional (SCRO) Children's Services Manager (CSM) with several years of child protective services expertise. Additionally, an experienced supervisor transferred from Wasilla to Bethel to fill a vacancy. Teamwork within the region is more apparent than ever before and issues are being dealt with as a region, rather than Bethel standing alone as it has at times in the past. The SCRO CSM is soliciting assistance from his co-managers around the state to stand in and help with the work until vacancies can be filled.

In an effort to draw more attention and gain more information, Bethel was selected as a site to be reviewed in the Federal CFSR in September 2008. While the final report has not yet been issued, regional management has begun to follow up on areas in need of most attention. The focus has been on recruitment and hiring of new staff to fill vacancies; strengthening partnerships with tribal organizations; strengthening community partnerships; creating new ways to increase and improve communication between ICWA workers and OCS staff; and planning for cultural awareness training in January of 2009. Additionally, regional management is working with OCS licensing staff to develop a plan to fully train and license foster families in the Bethel region.

Recommendation 2 - Implement workload study recommendations.

The Governor has included 5 new positions for OCS in the proposed FY 2010 budget. Pending approval from the Legislature, the final phase of the recommendations from the Hornsby Zeller Associates workload study report of 2006 will be complete.

Child Protective Services is an emotionally demanding vocation. Across the nation, compassion, fatigue and vicarious trauma lead to high turnover and vacancy rates among caseworkers. In Alaska, fifty percent of the OCS front-line caseworkers have been employed with the agency for less than two years, and 20 percent have less than one year of experience. While vacancy rates have improved since 2006, turnover rates continue to slowly increase.



To institutionalize a mindful and daily focus on workforce development, the OCS formed an internal work group in the fall of 2007 to focus on retention and recruitment strategies. Workforce Goals and Strategies were developed and put into a written work plan that is constantly being revised and added to as the work evolves. (See Appendix B). The workgroup includes a representative from the University of Alaska Family and Youth Services Training Academy, the Division of Personnel, several OCS staff at all levels within the division, and a member from the Annie E. Casey Foundation that is providing technical

assistance. In addition, an executive steering committee was created in August of 2008 to provide guidance and oversight of the workgroup. Two of the members have also joined a DHSS Workforce Development Team created by Commissioner Hogan in November 2008.

The OCS internal work group has begun development of a realistic job profile DVD, intended to minimize turnover through recruitment processes that better inform applicants. A candidate for hire is sent a DVD and asked to sign a simple attestation form which states 1) they have watched the video; and 2) they *still* want to be interviewed and considered for the OCS frontline position. While this is a relatively new technique, states that have already implemented such a process are seeing an increase of new employees that truly have the competencies and the heart to do child protective services work, and a decrease of early resignations/dismissals. The OCS is also adapting its website to include virtual, realistic job profiles of current OCS employees to help job applicants understand what the job entails *before* applying for positions with the division.

A new employee exit survey was created and protocol implemented to help determine why so many workers leave service. Employee incentive techniques are being explored and alternative work weeks are being encouraged. Other strategies related to salaries, student loan forgiveness programs, and telecommuting agreements are also being explored.

The OCS is focusing on several other strategies to increase staff retention. Some of those strategies include increasing new employee training from 2 to 4 weeks to better prepare and equip new front-line workers with the skills and tools they need to do their complicated and demanding jobs. A supervisory competencies curriculum was developed and has begun to be delivered to child protective services supervisory staff. The curriculum has received rave reviews from those in attendance. The Anchorage Field Office has developed and implemented an extensive new employee orientation to supplement new worker training. This new employee orientation model has been shared with the regional managers and is expected to be adapted and implemented in the other regions as well. Due to the number of new field managers coming on board in the past year, an Orientation and Development Plan for New Managers was also developed and implemented. (See Appendix C).

The OCS used its Title IV-E contractor to thoroughly evaluate our current student stipend program with the Universities as the program has not lived up to its expectations for the retention of staff that have been paid to receive an advanced degree. That evaluation has been completed. Based on the contractor's recommendations, revisions and development of policy and procedures is underway so that a stronger and more successful stipend program is in place by the fall of 2009.

The OCS Management Information System, ORCA, is producing more management reports than ever before. One of those reports includes case load data by case worker, office and region. Assignment of new positions and reallocation of existing positions is based on that data and watching the trends of new reports and case assignments each month. Managerial reports have recently been shared with all managers in face-to-face statewide meetings. Managers have been trained how to access and interpret the reports. These ORCA reports have just recently been made available to all staff - not just managers - to encourage all staff to monitor data around the state. OCS has observed that our caseloads have come down over the past year and are far more manageable than in recent years.

The OCS has formed a stronger working relationship with the Division of Personnel (DOP) and has requested Performance Coaching training in field offices. The DOP will accompany OCS to meet with staff and union representatives in an effort to discuss and resolve work load issues. Once the DHSS Employee Recognition Program is approved by the Department of Administration, OCS will adopt and

implement those policy and procedures in their entirety. Retention and recruitment of OCS staff is a systemic challenge. Many of the options determined viable are unattainable by OCS alone and must be supported at the state level.

Recommendation 3 - Fix the telephone system.

In planning for FY09, OCS had put in a capital request specifically to repair/replace antiquated phone systems in field offices. We were allocated \$136,000 to do so and began the repairs in July 2008, once the funding was received. To date, the necessary repairs and/or upgrades have been completed in Barrow, St. Mary's and Aniak. In various stages of being repair and/or upgrade are Kotzebue, Ketchikan, King Salmon, Glennallen, Kodiak, Wasilla, Bethel, Dillingham, Kenai, Seward and Unalaska.

Telephone systems functionality solves many of the issues. However, as is noted in your report, adequate staffing of OCS phones is also a concern. While the preference is that a live voice always responds to the public's calls, protocols about how that happens in each field office, including the small communities with one/two person offices, will be finalized and in place by February 1, 2009.

Recommendation 4 - Publicize and staff the toll free number.

As recommended, the toll free number to report child abuse and neglect has been more prominently displayed on the OCS website. It will also be posted to the DHSS website on a rotating basis with other DHSS divisional information. Additionally, the toll free number has been added to the home page of the Alaska Children's Trust website. To capitalize on cost-free advertising and better inform the public, the OCS shares the toll-free reporting number (as well as the Children's Trust Parent line) with the media whenever the OCS responds to media inquiries about child abuse and child neglect issues.

Currently, the toll free reporting line operates out of Anchorage and was set up to handle primarily Anchorage business. However, if the Anchorage Intake Unit receives a call from another part of the state during business hours, they are able to take the call and transfer the information to the correct field office. After business hours, the calls to the toll-free line are transferred to an answering service. It is agreed that there needs to be continued improvements to all aspects of intake and efforts will continue in the coming year.

In the past year, the entire intake process has been evaluated and is currently under reconstruction. The National Resource Center for Child Protective Services was enlisted to provide technical assistance on this topic. They have evaluated all business processes related to receiving and screening reports of maltreatment. Focus groups were held with staff; intakes were reviewed across the state; and intake workers were shadowed to learn more about our intake processes. We learned that intake has not received the attention and focus it so richly deserves as a separate area in need of expertise. Results from the program evaluation were shared in a face-to-face managers' meeting and planning began to make short term and long term improvements. It was decided that intake policy and procedures needed a major overhaul. Revisions are currently in final draft and will be released as soon as possible in the new year.

Longer term improvements include completely revamping how intake is conducted in the state. OCS staff prefer we move to either a statewide or regional hotline system, whereby all calls would be handled by designated intake staff who specialize in doing the work full time. Case carrying workers would not be expected to perform intake in their individual offices, but rather could concentrate exclusively on their investigative and ongoing work. Ideally, the statewide intake system would be

manned 24 hours a day/7 days a week. However, it will take many more resources, i.e., staff, space and increased information technology, than OCS currently has available.

Recommendation 5 - Collocation of OCS Workers

The OCS wholeheartedly agrees with this recommendation. Collocation is achieved whenever and wherever possible with a variety of different partners, including Child Advocacy Centers, Tribal Agencies, Law Enforcement, Mental Health, Infant Learning Program and others around the state. Whenever there is an opportunity to collocate with our community partners, the opportunity is explored and if feasible, is approved.

Recommendation 6 - Support for Front Line Workers

OCS Administrators and Managers concur that there can never be enough support given to front-line workers. As stated above, in the response regarding the work load study, there has much effort toward the retention and recruitment of staff in the past year.

New efforts to respond to this recommendation include training all managers on the services provided by the Employee Assistance Program (EAP), including the individual counseling and critical stress debriefings that are available to all state employees. The managers were asked to provide the latest information learned about the EAP with all staff in their regions. In response to tragedies involving both clients and a co-worker, OCS made several requests for EAP critical stress debriefings this past year.

In 2008, the Director began attending the last day of new worker training to welcome new staff, share the agency's vision and mission and answer questions. A large part of the Director's welcome to new staff is focused on encouraging them to engage in self care so that they stay mentally fit and capable of performing this demanding work.

The recently (November 2008) unveiled Supervisory Competencies Curriculum training being offered to all social worker supervisors through the Family & Youth Services Training Academy is a very directed effort to ensure that front-line staff are receiving better support through better supervision.

OCS managers and supervisors are increasingly cognizant of the complex personal and familial responsibilities that young workers juggle in today's world. Through our annual staff surveys and employee exit surveys, OCS staff is reporting how much they value the opportunity to work for an employer that offers flexible work schedules.

As stated above, vacancy rates are decreasing. With the number of new staff being added in the past several years, caseload sizes have gone down. Managers have more management reports available to them than ever before with which to equalize caseloads and watch trends within their regions.

In summary, the OCS continues to strive toward improving in its organizational development, better equip its staff with the skills and resources needed for the job, implement best practice standards and streamline processes whenever possible. Retention and recruitment of quality staff remains a top priority. 2008 has been an exceptional year of positive institutional changes, but systems reform will continue within OCS during 2009 and each year thereafter. Alaska's children and their families deserve nothing less.

CPS Manual Revisions Finalized in 2008

2.1.2 Protective Services Alerts.

The title of the section has been changed from "Out of Town Inquiries" to "Protective Services Alerts", and this section now addresses solely the procedures for responding to Protective Services Alerts (PSA) received from other states.

2.2.5 Conducting an Investigation; Assessing for Child Safety

The section has been revised to reflect the safety assessment methodology that is now used by OCS.

2.7 Placement Preferences.

The following requirements have been added:

- When an adult family member or family friend has requested placement of a child in their home, the worker will make every effort to make a placement decision within 45 days of the request.
- If the placement request is denied, the worker will notify the family member or family friend of the denial within five business days following the denial, using a form specified in the policy.
- The worker will document all potential placement resources, consideration of placement resources, and decisions regarding placement in relative/placement search case note in ORCA.

3.5.5 Background Checks for Placement Resources and Interstate Requests for Child Protection Records.

This is a new section that includes the policy and procedures on fingerprinting requirements that were previously located in section 6.8.4. In addition, the revisions address requirements in recent federal legislation (the Adam Walsh Child Protection and Safety Act). The following revisions have been made:

- The requirements has been added that:
 - Child protection records (ORCA and Prober), the Juvenile Offender Management Information System (JOMIS), and the Sex Offender Registry must be checked for each household member 16 or older in the home of an unlicensed placement resource (unlicensed relative and prospective adoptive parents or guardians).
 - If the prospective adoptive parents or any other adult in the home have lived in another state in the preceding five years, OCS must request information from the child abuse and neglect registry from each state of residence during the five-year period.
 - New fingerprint based criminal background checks are required for individuals who previously completed fingerprint based criminal background checks as unlicensed relatives or foster parents and now are applying to become adoptive parents or guardians.
 - OCS is required to respond to requests from other states for child abuse and neglect registry checks.
- It is clarified that:
 - The worker will contact the Resource Family Section in State Office if an individual who is required to be fingerprinted is unable to provide fingerprints due to a medical or physical condition that is documented by a licensed physician.
 - The federal criminal background check requirement for prospective adoptive parents is not met if a name-based criminal background check is completed on a prospective adoptive parent due to rejected fingerprint cards and the cards were rejected solely

Appendix A

because the fingerprint impressions were of low quality due to lack of technological capacity or use of improper technique.

- If a variance is granted to a prospective adoptive parent who has been convicted of certain felonies, a Title IV-E subsidy cannot be approved for a child placed in that home.
- The OCS APSIN Unit handles requests from other states for child abuse and neglect registry.
- Procedures addressing rejected fingerprint cards have been added.
- The section has been updated to reflect ORCA procedures.

3.6.1 Placement Preparation.

It is clarified that issues to be discussed with the care provider prior to placement include:

- The child's mental health needs and ongoing services and supports needed to meet the needs;
- The child's educational needs, including special education services and supports,
- That the child should be maintained in their current school, whenever possible; and
- If known, the child's tribal heritage and tribal resources that may be able to assist the care provider with continuing the child's connection to their culture.

3.7 Change or Termination of Placement/Trial Home Visit/Return Home.

- The section has been reorganized, and updated to reflect ORCA procedures.
- The following requirement has been added:
 - For non-emergency transfers, the worker will provide advance notice to the child, the child's parents or Indian custodian or guardian, the child's foster parents or out-of-home caregiver, GAL, attorney, and tribe by sending a form specified in the policy and will make every effort to provide notification at least ten days prior to the intended transfer.
 - For emergency transfers, the worker will make every effort to notify the parties no later than five working days following the transfer by sending a form specified in the policy.
- It is clarified that when special planning is needed for a developmentally disabled child who is about to be released from custody, the planning will be initiated at least six months prior to the release or as soon as it is known that the child will be released from custody.

3.14.1 Life Skills Assessment.

- The section has been revised to reflect changes in the Ansell Casey Life Skills Assessment (ACLSA).
- It is clarified that OCS' policy requires that all children in custody age sixteen or older who are placed out-of-home complete an ACLSA at least annually, starting at the latest at age sixteen.
- It is also clarified that youth or caregivers who have questions about the ACLSA or need hard copy forms may contact either the Alaska Center for Resource Families or the Regional Independent Living Specialist.

3.14.2 Resources for Youth in Custody and Youth No Longer in Custody

The section has been re-titled and divided into two subsections: **3.14.2.1 Transitioning out of Custody** and **3.14.2.2 Resources for Former Foster Youth**.

3.14.2.1 Transitioning out of Custody: This section addresses resources available to youth in custody who are preparing to transition out of custody.

- It is clarified that OCS's policy requires that an Exit Plan be developed for every 16-year-old in custody. The plan becomes part of the case plan and both the youth's worker and the Regional Independent Living Specialist are involved in developing the plan. An Exit

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Plan outline has been added to the CPS Forms subdirectory of the Statewide Forms Directory.

- For every youth in custody who is approaching the age of majority the worker will assess the youth's ability to live self-sufficiently. If, after the worker has discussed the issue with the youth's GAL or CASA and/or the Office of Public Advocacy, it is decided that a conservator should be appointed, the worker will ask the GAL to initiate a conservatorship proceeding.

3.14.2.2 Resources for Former Foster Youth: This section addresses resources available to youth who have left OCS custody. It is clarified that workers who are contacted by former foster youths about independent living services or funds will refer the youth to either the Independent Living Program Coordinator in State Office or to a Regional Independent Living Specialist.

5.2.3.B Receipt and Acceptance of Completed Home Study.

This is a new section that addresses acceptance of an ICPC home study and the required time lines. It is clarified that if OCS determines that a home study received from another state is insufficient for making a placement decision for a child, OCS must notify the other state within fourteen days of receiving the home study.

5.3.1 Completing the Interstate Compact (ICPC) Home Study.

This section addresses requirements in recent federal legislation (the Safe and Timely Interstate Placement of Children Act), and merges former sections 5.3.1 Time Frames for Completing the Study and 5.3.2 Completing the Home Study. The following revisions have been made:

- The requirement has been added that when another state requests a home study, OCS must respond to the request within 60 days of when the request is received by submitting a report on the result of the home study to the requesting state.
- It is clarified that:
 - The assigned worker will submit a report on the result of the home study before or on the due date regardless of whether it includes a placement recommendation. If a placement recommendation cannot be made by the due date, the worker will list the reason why in the report.
 - If a request for an adoptive home study is referred to an adoptive home study contractor the OCS worker is responsible for ensuring that the report on the result of the home study is received by the Alaska Deputy Compact Administrator by the due date.
 - Supervisors will assign the home study to an OCS worker within three business days of receiving the request packet.
 - Definitions of "home study" and "report on the result of a home study" have been added.

5.3.2 Completing the Home Study.

This section has been deleted.

6.2.1.3 Federal Support – IV-E and Medicaid

The section has been updated to reflect current procedures and current federal rules, definitions and clarifications have been added, and the specific information about the eligibility requirements for Title IV-E adoption subsidies has been moved from section 6.2.2.6.A to this section.

- Changes in the eligibility requirements for Title IV-E Foster include the requirement that the child must now be AFDC eligible
 - in the home from which removed
 - in the month court proceedings are initiated to remove the child from home.

As a result, Parent's Self-Declaration of Income and Resources forms (06-9794) must be

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completed for all children who are removed from home. The form has been revised to reflect the change in eligibility requirements and the CPS Forms subdirectory of the Statewide Forms directory has been updated with the revised form.

- For eligibility for IV-E Adoption Assistance it is no longer required that the child is eligible for AFDC in the month that the adoption petition is filed.
- The following definitions have been added:
 - The AFDC definition of “specified relative”.
 - “Date the child is considered to have entered foster care” – this date determines, for Title IV-E eligibility, the due date of the first annual finding that reasonable efforts have been made to implement the permanency plan.
- The policy on minor parent and baby in placement has been updated to reflect the current federal rules.
- The procedures for IV-E eligibility reviews have been revised to reflect that while the requirement remains that Medicaid eligibility be reviewed every six months, redeterminations of Title IV-E Foster Care eligibility are now completed by the Eligibility Technician at least every twelve months and more frequently when something occurs that effects a child’s eligibility.
- The section has been updated to reflect ORCA procedures.

6.2.2.6.B Guardianship Subsidies

- The definition for “hard to place/special needs child” has been added.
- The section has been expanded to include the policy and procedures for subsidy negotiations.
- Information has been added about the approval process for guardianship subsidies for children under age ten.
- The section has been updated to reflect ORCA procedures.

6.2.2.11 Request for Independent Living Individual Funds for Youth in Custody and Youth No Longer in Custody

- The section has been updated to reflect current procedures:
 - A youth may initiate a request for independent living funds by either completing a request for funds application or by speaking with their caseworker and/or the Regional Independent Living Specialist to determine that a need for funds exists.
 - The application form and instructions for education and training vouchers can be obtained through the Regional Independent Living Specialist.
- It is clarified that for education and training voucher funds a youth can access a maximum of \$5,000 per academic years for a total of eight semesters, and youth may access funds up to age twenty-three if they started their post-secondary education by age twenty-one.

6.3.1 Medical, Dental, Vision, and Mental Health Care

- The requirement has been added that when a child is released from custody due to reaching the age of majority or being emancipated, the assigned worker will ensure that the child’s medical and mental health record is supplied to the child at no cost.
- Examples are provided for what specific kinds of information must be given to the out-of-home care provider.
- It is clarified that:
 - The assigned worker is responsible for ensuring that the child’s medical and mental health records in the case file are kept up-to-date, including records provided by the care provider.
 - Minors have the right to consent to diagnosis, prevention, or treatment of pregnancy, and therefore consent by the child’s parents, OCS, or the out-of-home provider is not required in order for a child in custody to obtain birth control or having an abortion.

Appendix A

6.5.9 Education

- Information has been added about the procedures for appointment of surrogate parents, and their role.
- The requirement has been added that when a child leaves foster care due to reaching the age of majority or being emancipated, the worker will ensure that a copy of the child's education record is supplied to the child at no cost.
- It is clarified that the worker is responsible for ensuring that a child's educational record is reviewed and updated at the time of each out-of-home placement of the child, and that a copy of the record is provided to the foster parent.

6.6.1 Intrastate Case Transfers.

The following revisions have been made:

- It is clarified that transfer between regions will occur only when the judicial venue has changed.
- Procedures for changing judicial venue have been added.
- Time lines have been added for:
 - the receiving supervisor to assign the case; and
 - the assigned worker and the receiving worker to discuss the case.
- The requirement has been added that when a case is transferred to another region the transferring worker will notify the Regional Eligibility Technician of the case transfer to ensure that the Title IV-E and Medicaid case is transferred to the other region.
- The section has been updated to reflect ORCA procedures.

6.6.2 Out-of-Town Requests (OTR).

The section has been reorganized, and the following revisions have been made:

- Timelines for responding to requests have been added.
- The unlicensed relative study outline has been revised to reflect the outline in section 3.5.2 Assessment of Unlicensed Relative Homes (Non-Emergency Placements), and the outline has been added to the statewide forms directory.
- The procedures for background checks for unlicensed relative homes have been updated to reflect current procedures.
- Procedures have been added for responding to requests from non-OCS offices.
- The policy and procedures for changing venue have been moved to section 6.6.1.
- The procedures for placement in a residential facility in another region have been deleted, since a secondary worker is not requested for such placements.

6.8.4 Inquiries to Alaska Public Safety Information Network (APSIN).

This section previously addressed both APSIN checks and fingerprinting. It has been split into two sections, and the APSIN check policy and procedures remains in 6.8.4 and the fingerprinting policy and procedures has been moved to new section 3.5.5. The following revisions have been made to the APSIN check policy and procedures:

- The phone and fax numbers for the Alaska State Troopers has been updated.
- The section has been updated to reflect ORCA procedures.

OCS Forms Changes Finalized in 2008

Revised Forms

- **06-9013 Foster Home Visit Worksheet:** an applicant certification and signature section has been added to ensure compliance with the requirement that licenses are based on a license application.
- **06-9013 Foster Home Visit Worksheet:** The names of children in custody placed in the home have been replaced with the initials of the children.
- **06-9045 Plan for Care:** revised to address requirements in the amended licensing regulations. In addition, questions have been added to address how the foster parent will support the religious, ethnic, cultural heritage and language of foster child's family and how the foster parent will assist a foster child with different practices than the foster family's to attend their own religious or cultural events. The questions were previously located on form 06-9389 Background Information Foster Parent.
- **06-9049 Foster Group Home Report of Inspection:** The form has been revised to reflect the amended licensing regulations.
- **06-9050 Foster Homes with Employees or Volunteers - Report of Inspection:** revised to reflect amendments of the licensing regulations.
- **06-9162 Application for Foster Care License:** revised to address requirements in the amended licensing regulations. In addition, a question has been added that addresses the foster parent's role in supporting and helping to implement the foster child's case plan. The question was previously located on form 06-9389 Background Information Foster Parent.
- **06-9178 Compliance Review:** This form replaces form D084-LIC-07 Compliance Review: Foster Home, and it has been revised to address requirements in the amended licensing statutes and regulations, changes in policy, and ORCA requirements. An additional page has been added to be used for documenting quality assurance findings, actions needed, and follow-up.
- **06-9336 General Variance Application:** The form has been updated to reflect that OCS now only licenses foster homes, foster group homes, and child placement agencies; and the title of the form has been changed from "Variance Application" to "General Variance Application" to avoid confusion, since there now is a separate variance process for the criminal check requirements (based on 7 AAC 10.930-945) with a separate variance application form.
- **06-9350 Notice of Denial of Licensure (Provisional):** a "certification of service" section has been added.
- **06-9351 Notice of Denial of Licensure (Biennial):** a "certification of service" section has been added.
- **06-9352 Notice of Denial of Licensure (Biennial Renewal):** a "certification of service" section has been added.
- **06-9353 Notice of Violation:** a "certification of service" section has been added.
- **06-9354 Initial Notice of Immediate Revocation/Suspension:** a "certification of service" section has been added.
- **06-9355 Warning Notice:** a "certification of service" section has been added.
- **06-9356 Report of Investigation:** a "certification of service" section has been added.
- **06-9357 Request for Hearing:** revised to include the applicant or licensee's address, phone and fax numbers, and e-mail address.
- **06-9371 Foster Care Report of Inspection:** This form was formerly titled "Foster Homes Standard by Standard Evaluation" and it has been revised to reflect the amended licensing statutes and regulations.
- **06-9372 Emergency Shelter Care Health Review:** The revisions consist of minor formatting changes, including the addition of "yes" and "no" checkboxes.

Appendix A

- **06-9389 Background Information Foster Parent:** "Yes" and "no" checkboxes have been added to some of the questions, and some of the questions have been moved to forms 06-9045 and 06-9162.
- **06-9437 Clearance Form:** revised to delete page 2 which contained outdated information about the background check requirements and to add a space for recording Sex Offender Registry History check.
- **06-9437 Clearance Form:** Information about the background check requirements has been added as pages 2 and 3 of the form.
- **06-9712 APSIN Request Form:** The statute citations on the form have been updated.
- **06-9730 Financial Summary Sheet:** This form was originally used only for adoptive applicants, and it has been revised to be used also for foster care licensing.
- **06-9731 Health History:** This form was previously used only for adoptive and guardianship applicants, and it has been revised to be used also for foster care licensing.
- **06-9748 Out-of-Town Request:** revisions include updates to address implementation of ORCA.
- **06-9772 Medical Health Information:** This form was previously used only for adoptive and guardianship applicants, and it has been revised to be used also for foster care licensing. The form is used when the completed Health History or information obtained during the home study process indicates that an applicant has health problems that may affect his/her ability to parent a child.
- **06-9773 Mental Health Information:** This form was previously used only for adoptive and guardianship applicants, and it has been revised to be used also for foster care licensing. The form is used when the completed Health History or information obtained during the home study process indicates that an applicant has mental health problems that may affect his/her ability to parent a child.
- **D084-LIC-17 Employment Application - Foster Home/Foster Group Home:** The title of the form has been changed to reflect that it now applies only to foster homes and foster group homes (it previously applied also to residential child care facilities and maternity homes). In addition, the number of required references has been changed to reflect the requirements in the current licensing regulations.

Added Forms

- **06-9163 Family Characteristics:** completed by foster care applicants and adoptive applicants.
- **06-9179 Referral for Training:** used by OCS staff to refer care providers to the Alaska Center for Resource Families for training.
- **06-9180 Medical, Dental, and Medication Record, and Medication Log:** used by the care provider.
- **06-9181 Fire Drill Log:** This new form replaces form D084-LIC-06 Fire Drill Report and is intended to be used to document fire drills required for foster homes and foster group homes.
- **06-9337 Window Variance Worksheet:** used by licensing workers when a window variance is requested.
- **06-9358 Report of Inspection:** used to document the results of an inspection of a facility.
- **06-9359 Allegation of Compliance:** used by a foster care licensee to notify OCS of completion of a plan of correction.
- **06-9385 Request to Review Licensing Record Log:** used to record requests to review licensing files.
- **06-9386 Provider Emergency Response Information Form:** addresses the requirement in the amended licensing regulations that foster homes must have disaster preparedness and emergency evacuation plans.

Appendix A

- **06-9761 Notice of Emergency Transfer:** used to notify the child, the child's parents or Indian custodian or guardian, attorney, and tribe of an emergency transfer of a child to another placement.
- **06-9762 Notice of Non-Emergency Transfer:** used to notify the child, the child's parents or Indian custodian or guardian, attorney, and tribe of a non-emergency transfer of a child to another placement.
- **06-9763 Notice of Denial of Placement:** used to notify an adult family member or family friend that their request for placement of a child in their home has been denied.
- **06-9798 Child Abuse and Neglect Information Request:** used for requesting information from another state's child abuse and neglect registry about prospective foster or adoptive parents and other adults living in the home, when any of those individuals have lived in another state in the preceding five years.
- **06-9799 Authorization for Release of Information from Child Abuse and Neglect Registry:** used to authorize release of information from another state's child abuse and neglect registry. The form is completed by prospective foster or adoptive parents and other adults living in the home, when any of those individuals have lived in another state in the preceding five years.
- **Unlicensed Relative Study Outline:** (from CPS Manual section 6.6.2) lists issues that must be addressed in an unlicensed relative study.
- **Request for a Superior Court Review Hearing of Placement Denial:** used by adult family member or family friend to request a review hearing when a request for placement of a child in their home has been denied.
- **D084 Orientation Brochures:** These brochures provide information about orientation for licensing and include addresses for the seven OCS field offices that have licensing workers. There are seven different versions of the brochure and the only difference between the seven versions is the contact information regarding orientation.
- **D084-LIC-10 Well Child Exam/Immunization Recommended Schedule:** This document is intended to provide information to care providers.

Deleted Forms

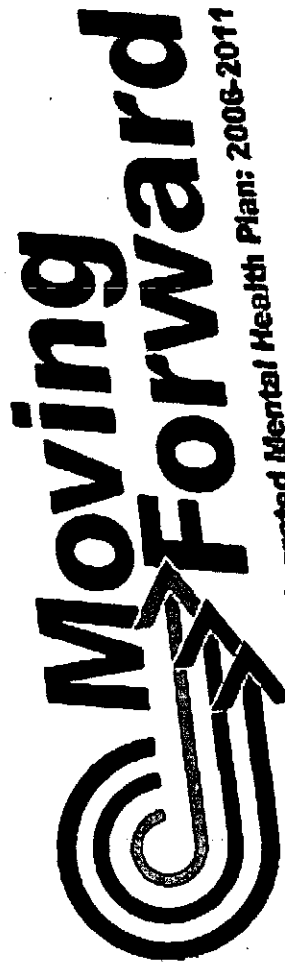
- **06-9444 Second-Hand Smoke Reduction in Foster Home:** The form has been deleted because the content of the form has been incorporated into form 06-9045 Plan for Care.

2/12/09

**MENTAL
HEALTH
COMPRE-
HENSIVE
PLAN**

Comprehensive Integrated Mental Health Plan and Alaska Scorecard

February 12, 2009



Comprehensive Integrated Mental Health Plan: 2006-2011

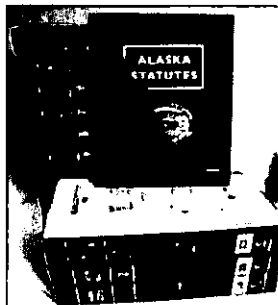
Alaska Scorecard
 Alaska Department of Health and Social Services
 Alaska Mental Health Trust Authority

Area	Target	Actual	Score	Notes
1. Access to Care	95%	92%	95%	
2. Quality of Care	85%	80%	85%	
3. Patient Satisfaction	80%	75%	80%	
4. Financial Performance	90%	88%	90%	
5. Community Engagement	85%	82%	85%	
6. Workforce Development	80%	78%	80%	
7. Research and Innovation	75%	72%	75%	
8. Public Health and Prevention	70%	68%	70%	
9. Health Equity	65%	62%	65%	
10. Overall Performance	80%	78%	80%	



A presentation by the Department of Health and Social Services
and the Alaska Mental Health Trust Authority





Statutory Requirements (AS 47.30.660)

- Department of Health and Social Services must “prepare, and periodically revise and amend a plan for an integrated comprehensive mental health program”
 - in conjunction with The Trust and
 - coordinated with federal, state, regional, local, and private entities involved in mental health services

Comp Plan Leadership Team and Data and Planning Group

- Representatives from:
 - Department of Health and Social Services & its divisions
 - Alaska Mental Health Trust Authority (The Trust)
 - Department of Corrections
 - Governor's Council on Disabilities and Special Education
 - Alaska Commission on Aging
 - Alaska Mental Health Board
 - Advisory Board on Alcoholism and Drug Abuse
 - The Alaska Brain Injury Network

Comprehensive Integrated Mental Health Plan: What is it?

- On-line tool for legislature, executive branch, stakeholders, and partners
- A source of information about the issues impacting all Trust beneficiary populations





Populations Addressed in the Plan

- Comp Plan target population —
Alaska Mental Health Trust beneficiaries
 - People with Alcoholism
 - People with Mental illness
 - People with Developmental disabilities
 - People with Alzheimer's Disease
 - People with Brain Injury
- <http://hss.state.ak.us/dph/healthplanning/movingforward/>



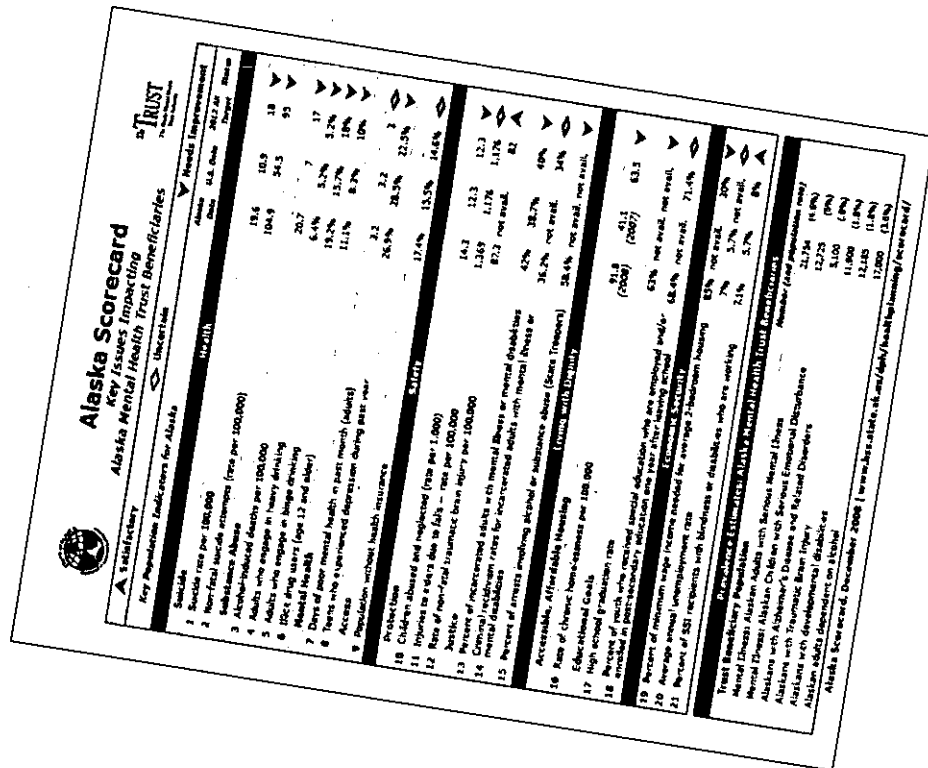
What is in the Comp Plan?

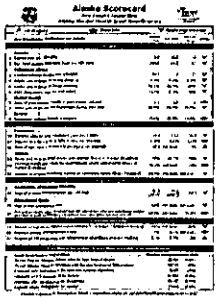
- Prevalence data
- Information about:
 - Substance abuse
 - Suicide
 - Mental Health
 - Safety and Injuries Justice
 - Housing
 - Education
 - Economic Security
- Current system of care
- Initiatives and emerging issues

Category	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Alaska Scorecard

Alaska Scorecard: Key Issues Impacting Trust Beneficiaries

- Provides a snapshot of key issues impacting Trust beneficiaries
- Comparisons to U.S. data
- Targets for 2012



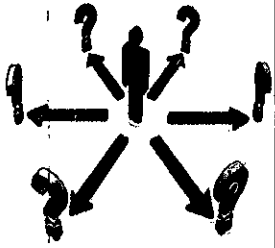


Alaska Scorecard	
Population	650,000
Unemployment Rate	7.5%
Median Household Income	\$28,000
Life Expectancy	77 years
Healthcare Expenditure	\$1,200 per person
Healthcare Access	95%
Healthcare Quality	85%
Healthcare Equity	75%
Healthcare Innovation	65%
Healthcare Sustainability	55%
Healthcare Resilience	45%
Healthcare Leadership	35%
Healthcare Collaboration	25%
Healthcare Transparency	15%
Healthcare Accountability	5%

Alaska Scorecard: How it Works

Information

- Provides links to on-line drilldown information
- Shows trend data
- Links to Comp Plan data, initiatives, and system of care
- <http://hss.state.ak.us/dph/healthplanning/scorecard>

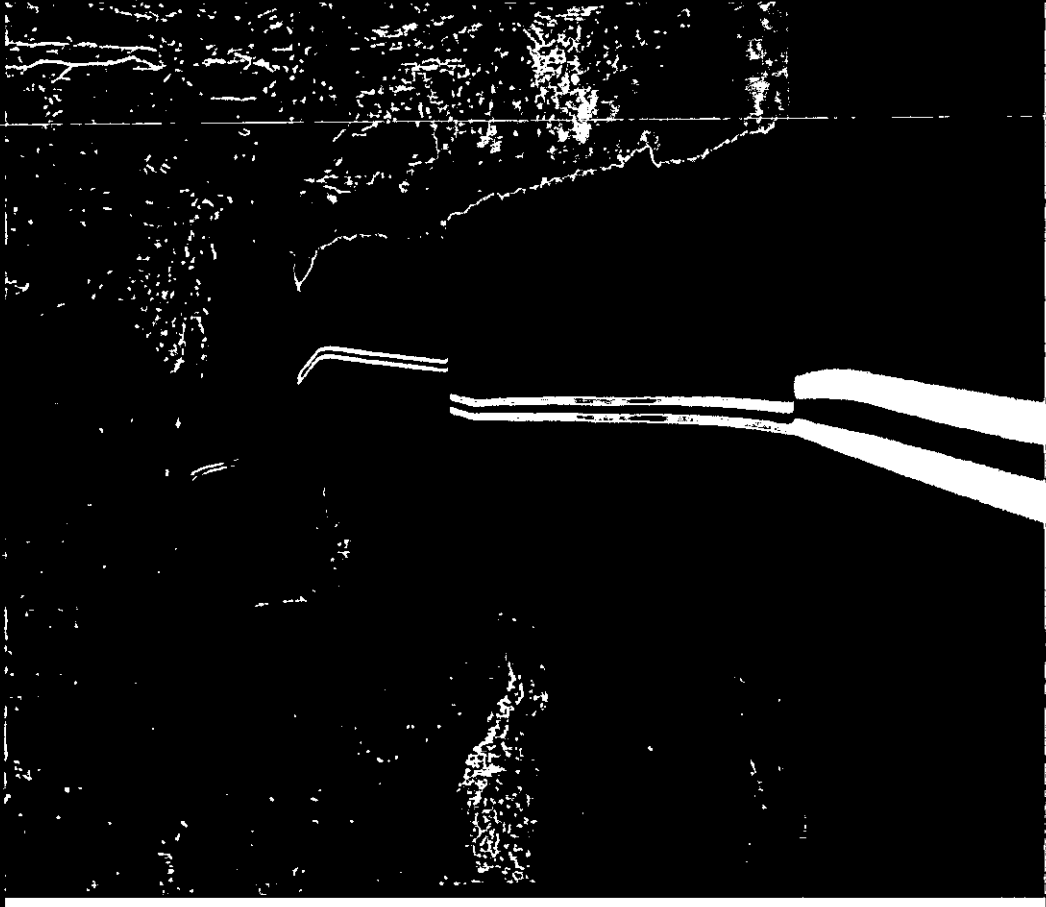


The Comp Plan and Scorecard Guide Policy

- Provide direction for policy and planning efforts
 - Examples:
 - Budget recommendations to The Trust by advisory boards
 - Trust budget recommendations for Mental Health Budget bill
 - New initiatives and focus areas

Comp Plan and Scorecard Serve as Road Maps

- Where we've been
- Where we need to go
- How we plan to get there
- Where we may want to go in the future





FAQ ALASKA - Frequently Asked Questions About Alaska

Question :

When did Alaskan Native people become U.S. citizens?

ANSWER :

- The Alaska Territorial Legislature offered Alaskan citizenship to Native people with a 1915 enabling act, but U.S. citizenship was extended to Alaskan Native peoples in 1924 by the U.S. Congress.

[<< Back to FAQ ALASKA MAIN MENU](#)

Source : Alaska: A History of the 49th State, 2nd ed., by Claus-M. Naske and Herman E. Slotnick. Norman, University of Oklahoma Press, 1987

Last Modified: 27 September 2001

For further information about Alaska, contact [your nearest library](#). For comments or corrections about this site, contact: Alaska State Library:e-mail_asl@eed.state.ak.us

2/17/09

U.S.

**PREVEN-
TATIVE
MEDICINE**

USPM

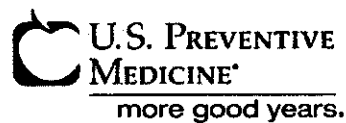
***Prevention - a Concept for State Medicaid
Programs***

Frederic S. Goldstein

President

U.S. Preventive Medicine

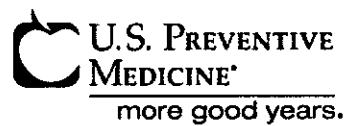
02/17/09



USPM

Agenda

- ◆ USPM Background
- ◆ The Current Health Care System
- ◆ How Prevention Works
- ◆ Ideas for Alaska



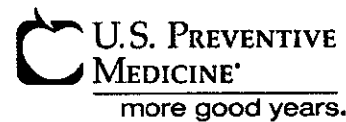
USPM

USPM Background

- ◆ Extensive experience in Health Plans, Hospitals, Chronic Care Management, Medicaid and Commercial

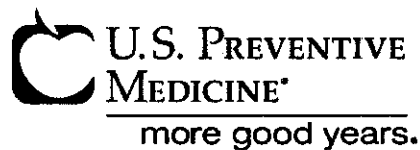
- ◆ Over 10 years of Medicaid Care Management experience
 - ◆ Rural States
 - ◆ Diverse populations
 - ◆ Experience with NA/AI and IHS

- ◆ National and International Services



CREATING NEW PARADIGM

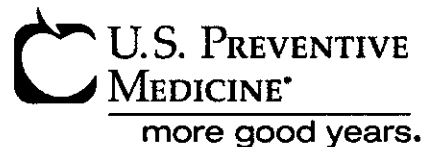
- ◆ Prevention is our only business
- ◆ From the top down, we have all lost family members too soon...we “walk the talk”
- ◆ Every USPM employee is on a mission to create real change in the healthcare system and to help individuals’ improve their long-term health



WHY PREVENTION?

U.S. Preventive Medicine believes the answer is:

- ◆ A systematic approach that identifies those at risk now or in the future based on key clinical indicators
- ◆ Intervention with effective programs of education, behavior modification and care management
- ◆ Periodic measurement of clinical results to improve outcomes and reduce overall health care costs



Gov. Tommy Thompson joins as National Policy Advisor

**“THE PREVENTION PLAN
COULD BE THE BIGGEST
INNOVATION IN
HEALTH CARE IN THE
LAST 30 YEARS.”**

Gov. Tommy Thompson
Former Secretary of the U.S. Department of
Health and Human Services
National Policy Advisor, U.S. Preventive Medicine

INTRODUCING AN EXCITING NEW PRESCRIPTION FOR WELLNESS.

The Prevention Plan™ is a revolutionary new health care concept for employers. Using robust technology and thorough lab work, The Prevention Plan™ identifies the top five risks for an employee and then provides a customized, step-by-step plan to help them lower their personal risks. It's private, secure and completely portable.

The Prevention Plan™ is supported with RN coaching, web tutorials, reminders and reward programs designed to change behavior to improve health. Your prescription for a healthier and more productive work force has arrived. Prevention is powerful medicine, and it's backed by U.S. Preventive Medicine® - the world leader in prevention.

Call 856-713-1180 or visit ThePreventionPlan.com to learn more.



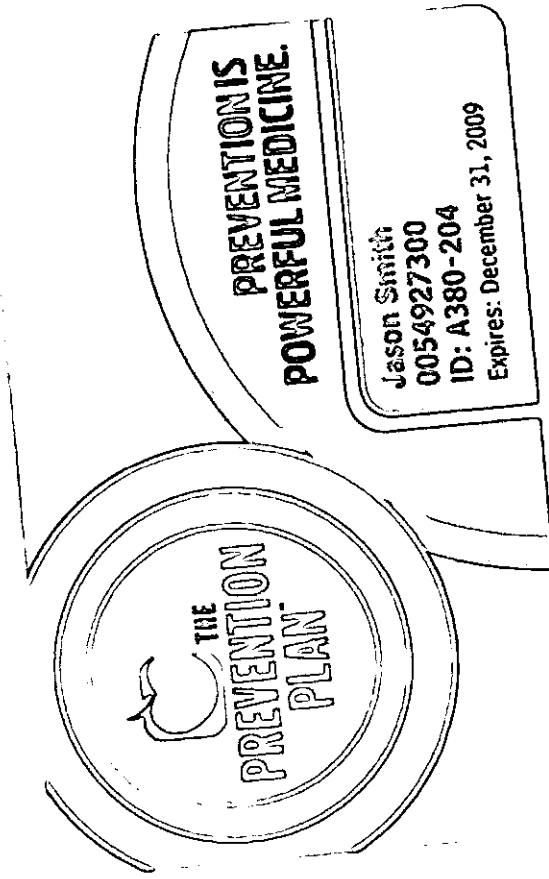
Gov. Tommy Thompson
Former Secretary of HHS

 **U.S. PREVENTIVE
MEDICINE®**
more good years.

Clinical Definition

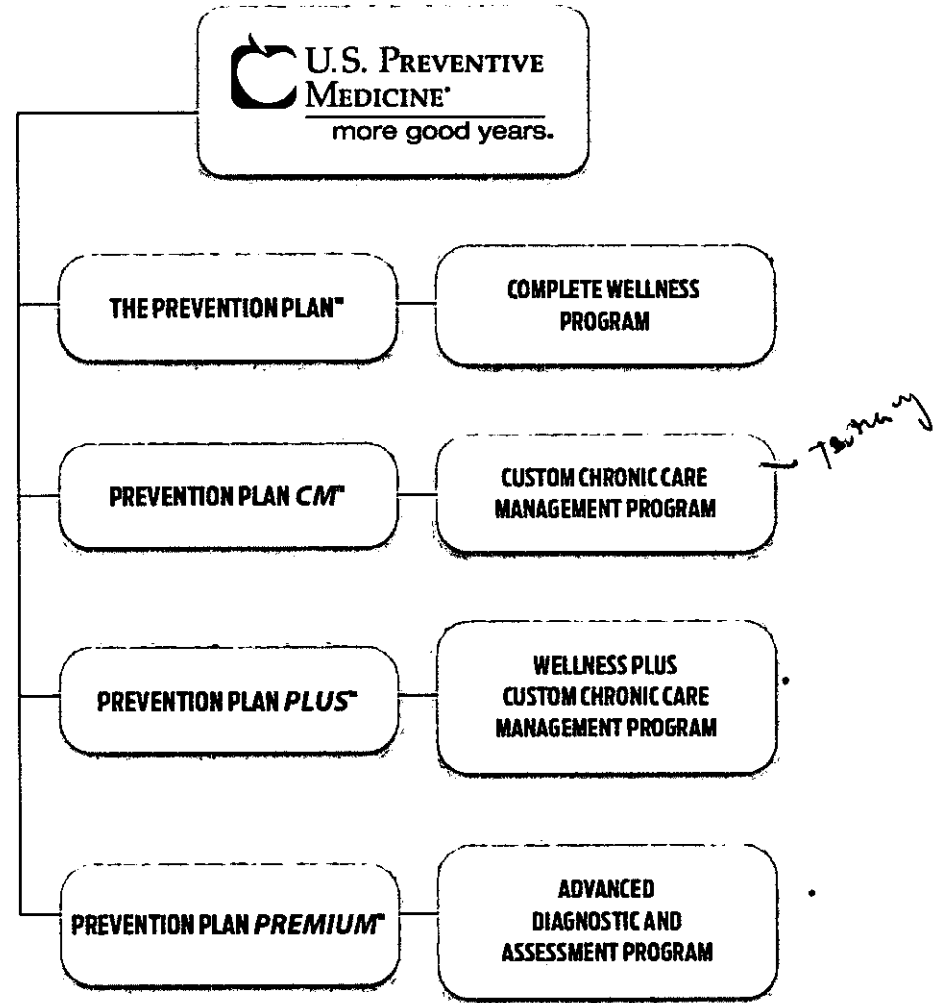
- ◆ Primary
- ◆ Secondary
- ◆ Tertiary - *chronic*

The Prevention Plan™ The Next Generation of Health & Lifestyle Management



Reduce expenses. Increase productivity.

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MANAGING THOSE USING
THE MOST RESOURCES

The Prevention Plan CM

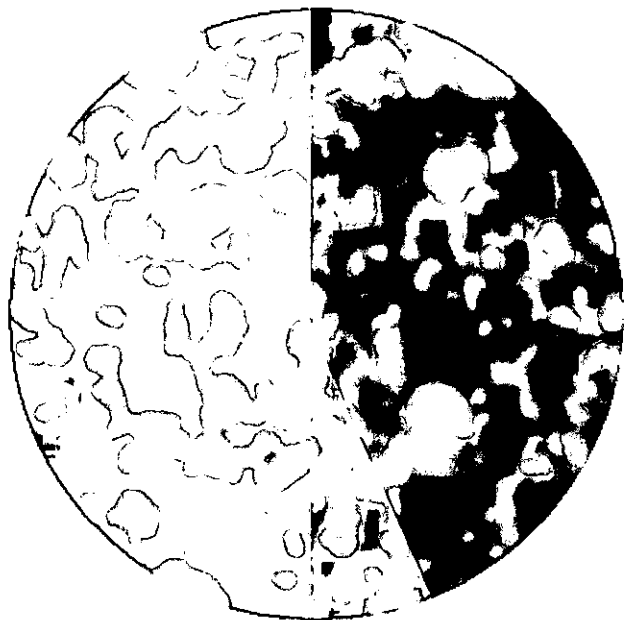
- ◆ Heart Failures
- ◆ Diabetes
- ◆ Asthma
- ◆ COPD
- ◆ CAD
- ◆ Schizophrenia
- ◆ Bipolar disorders
- ◆ High risk maternity
- ◆ Sickle Cell
- ◆ Depression
- ◆ Hepatitis C
- ◆ HIV/AIDS
- ◆ Cancers
 - Breast
 - Cervical
 - Colon
 - Prostate



U.S. PREVENTIVE
MEDICINE®
more good years.

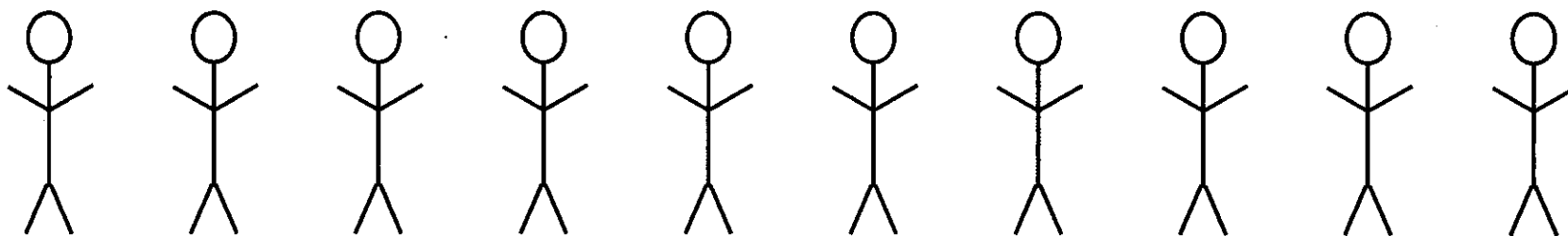
Health Cost Background

Chronic diseases are the #1 cause of death and disability in the U.S.



133 million Americans, representing 45% of the total population, have at least one chronic disease

Chronic diseases kill more than 1.7 million Americans per year, and are responsible for 7 of 10 deaths in the U.S.



Patients with chronic diseases account for 75% of the nation's health care spending

During 2005, the U.S. spent almost \$2 trillion on health care

Of every dollar spent...



...75 cents went towards treating patients with one or more chronic diseases

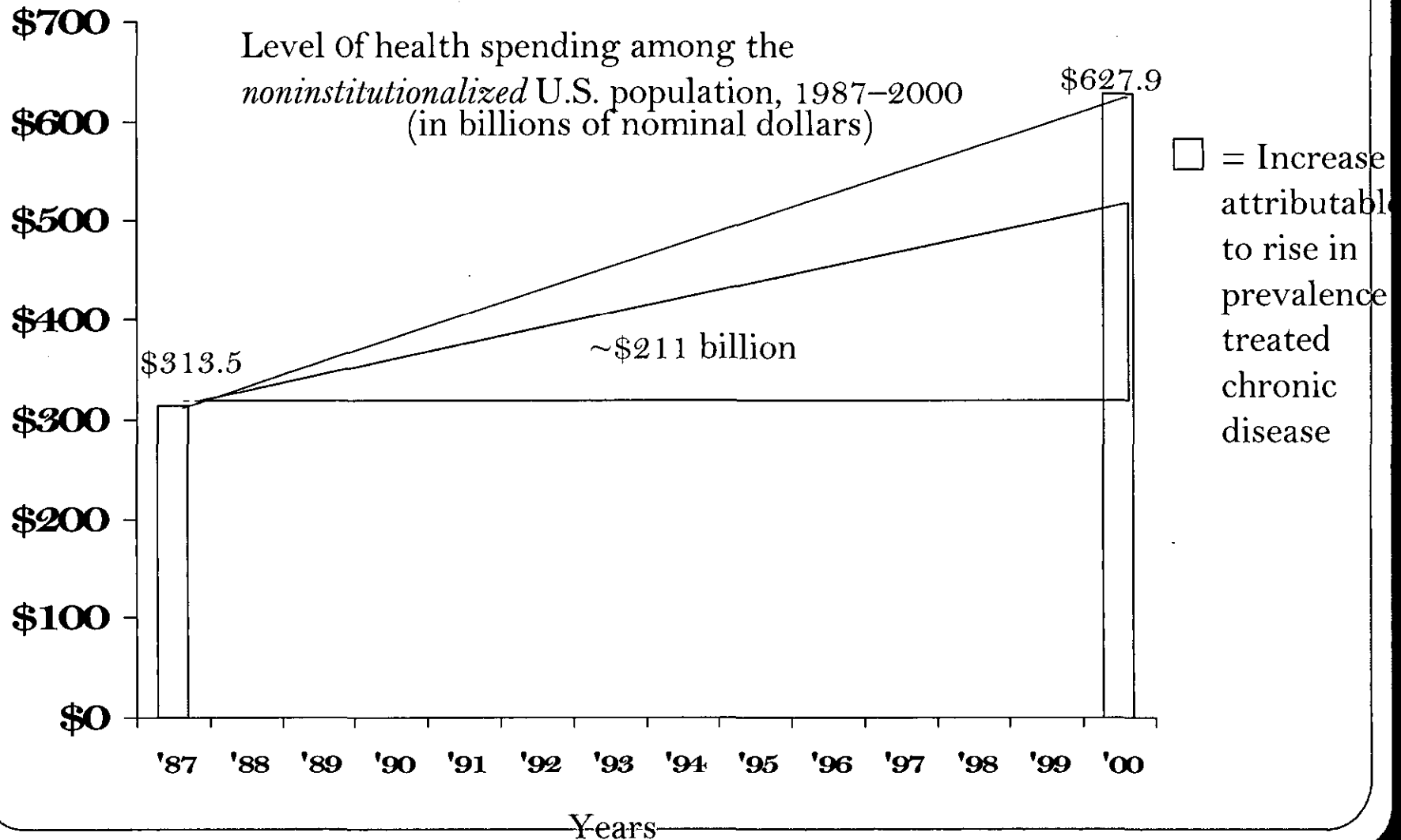
In public programs, treatment of chronic diseases constitute an even higher portion of spending:

More than 96 cents in Medicare... ...and 83 cents in Medicaid

"The United States cannot effectively address escalating health care costs without addressing the problem of chronic diseases."

-- Centers for Disease Control and Prevention

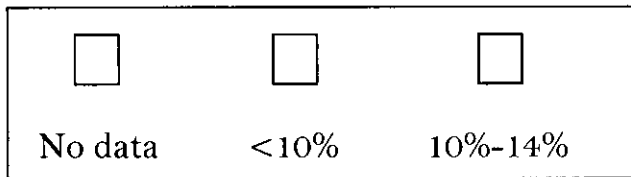
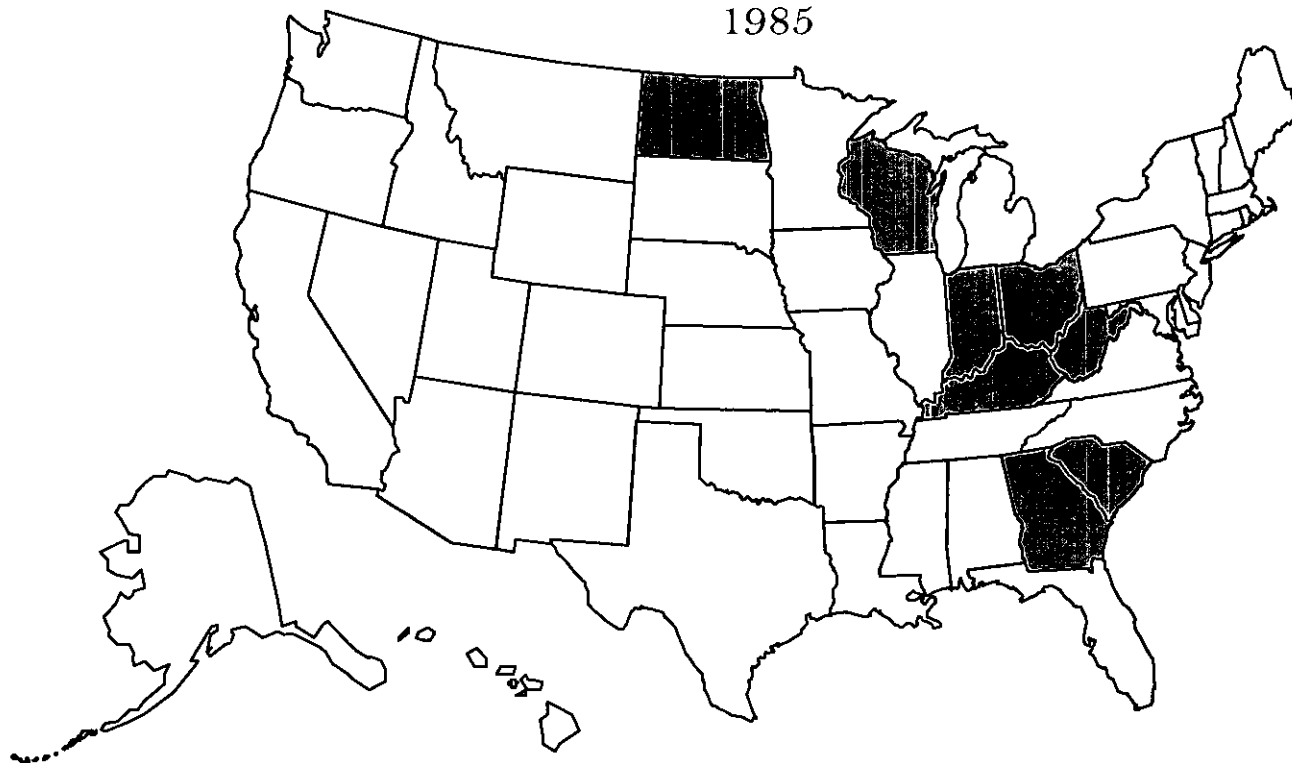
Two-thirds of the increase in health care spending is due to increased prevalence of treated chronic disease



The doubling of obesity between 1987 and today accounts for nearly 30% of the rise in health care spending

Percent of U.S. Adults Who are Obese*

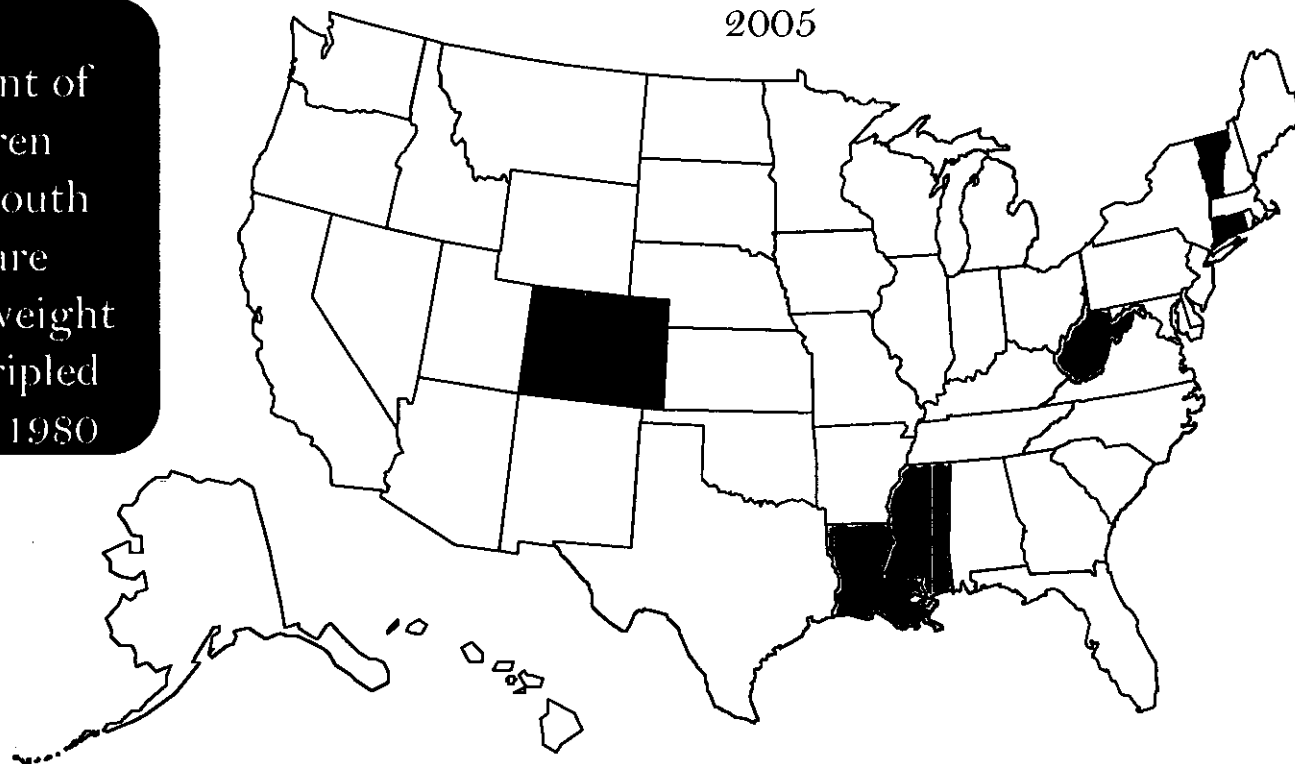
1985



*Data for 1985 based on self-reported weight for 6' 1" person

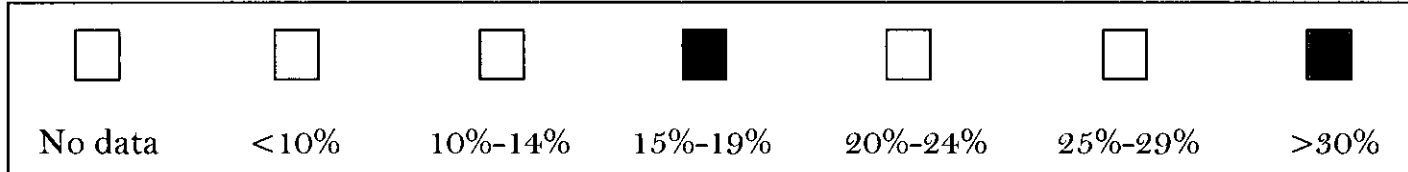
The doubling of obesity between 1987 and today accounts for nearly 30% of the rise in health care spending

Percent of U.S. Adults Who are Obese* 2005



The percent of children and youth who are overweight has tripled since 1980

If the prevalence of obesity was the same today as 1987, health care spending in the US would be 10 percent lower per person—about \$200 billion less



* Data from the Behavioral Risk Factor Surveillance System, CDC

The vast majority of cases of chronic disease could be better prevented or managed

The Centers for Disease Control and Prevention (CDC) estimates...

- 80% of heart disease and stroke
- 80% of type 2 diabetes
- 40% of cancer

...could be prevented if only Americans were to do three things:

- ✓ Stop smoking
- ✓ Start eating healthy
- ✓ Get in shape

Management of chronic disease could also be significantly improved: Chronically ill patients receive only 56% of the clinically recommended preventive health care services



HEALTHCARE 1.0 and 2.0

Business as usual *doesn't* work and Current solutions are *ineffective:*

- ◆ System set up to treat illness instead of prevent it
- ◆ Fragmented and superficial programs don't engage eligible population: 7-12% is the norm
- ◆ Unsuccessful in changing behavior
- ◆ No meaningful incentive for individuals to participate

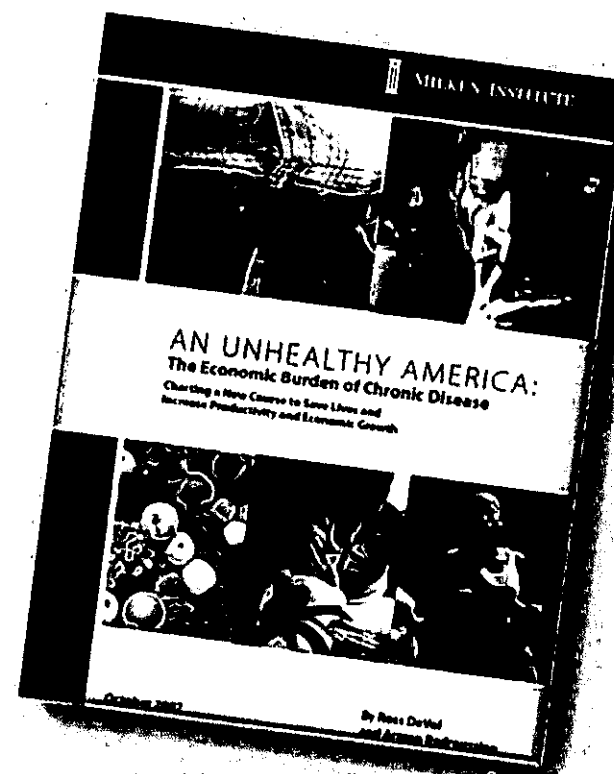
WHAT CAN WE DO ABOUT IT

One solution in sight:

Milken Institute study finds

- ◆ Prevention
- ◆ Early detection
- ◆ Chronic condition management

could save U.S. \$1 trillion annually...



"An Unhealthy America" 2007 study
 Nonprofit, nonpartisan economic think tank

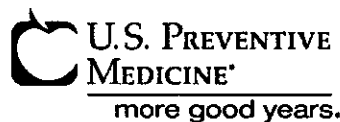
Reforming the Medicaid Program

- ◆ Alaska is unique
- ◆ What has Alaska said they were looking towards
- ◆ Why Reform versus expansion
- ◆ Implementing a Prevention Based Model

ALASKA IS UNIQUE

Alaska's Unique Features

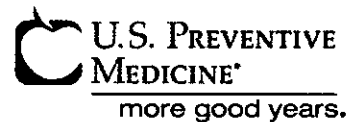
- ♦ Rural to the extreme which is affected by infrastructure (roads, facilities, etc.)
- ♦ Diverse population, AN/AI
- ♦ Issues must be overcome through innovative uses of people, systems and technology.



STATE PRIORITIES

Alaska Dept. of Health and Social Services – 2009 Priorities

- “• **Care Management: Improve care coordination; implement** disease management program for chronic diseases and explore use of primary care case management strategy for most disabled populations; complete planning for the Bring the Kids Home Initiative.
- **Medicaid Reform: Develop legislative and systemic** recommendations for reforming Medicaid aimed at improving Medicaid sustainability.”

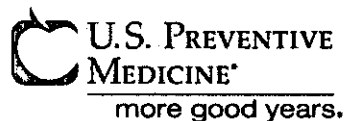


Alaska Health Care Strategies Planning Council

Making Alaskans the healthiest people in the nation...

Goal Five – Prevention and Personal responsibility

The Council believes that government has an obligation to “jump start” healthy choices through incentives, and in addition build the necessary incentive structures for the future.



Reform Versus Expansion

- ◆ The current system is flawed it's a sick care system. Why expand what is not working well?

- ◆ To maximize value, must change incentives for all players

- ◆ Through appropriate reform, one can find savings to expand eligibility (Medicaid funds in Stimulus bill?)
 - ◆ How? Bend the trend on the health status of the Medicaid beneficiaries

MEDICAID

Some Issues to Understand

- ◆ Beneficiaries don't have the knowledge to manage their care
- ◆ Providers don't have the time, expertise, or systems
- ◆ Some states have tried pieces of the concept
- ◆ At the end of the day its about one person changing their behavior.

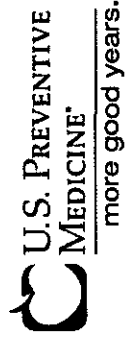
Recommendations

- ◆ Comprehensive Prevention Approach - 1^o, 2^o, 3^o
- ◆ Shared accountability – Incentives and Sticks
 - ◆ Providers
 - ◆ Beneficiaries
 - ◆ Vendors
- ◆ Reform the payment system to providers

MEDICAID

Shared accountability – Incentives and Sticks

- ◆ Providers
- ◆ Beneficiaries
- ◆ Vendors



Reform the payment system to providers

- ◆ Pay for Preventive Services
- ◆ Incent outcomes
- ◆ Pay for data systems (Look to Stimulus package with funding for Heath IT.)

Specific Areas to Consider

♦ **Care Management for Persons with Severe and Persistent Mental Illness –**

♦ This could address Target #3: Reduce 30-day readmission rate for Alaska Psychiatric Institute (API) to 10 percent, which was at 13.5% in 2007

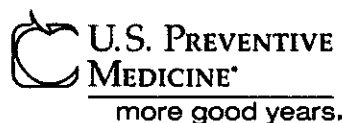
♦ **Implement a comprehensive prevention program to address**

♦ Target #1: 80 percent of all 2-year-olds are fully immunized, which was at 67.3% in 2007.

♦ **Implement a High Risk Maternity Care Management program**

♦ Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010.

Targets from FY 2009 DHSS
Overview



Examples of Success in Medicaid

- ◆ Program examples
- ◆ Some state ideas

MEDICAID RESULTS

High Risk Maternity

- ◆ Preterm babies cost an average of \$32,000 in Medical costs during their first year. (March of Dimes). Medicaid tends to have a higher proportion of pre-term births.
- ◆ USPM high risk mothers experienced a 9.4% preterm delivery rate versus a 14.8% county average. Program cost \$350,000, Estimated gross savings >\$900,000.
- ◆ Another State program experienced a 14.0% preterm delivery rate versus a 20% county average.

MEDICAID RESULTS

Clinical Improvements

- ◆ Mental Illness costs disproportionately fall within Medicaid, particularly for those living with Severe and Persistent Mental Illness.
- ◆ USPM members in a program for Persons with Schizophrenia experienced a 54% reduction in per member per month costs for ER visits.
- ◆ In the same program medication adherence to appropriate antipsychotics improved with fill rates going from 22.9 days per month in year 1 to 27.9 days per month in year 2. (30 days would be 100% adherence to filling medications)

MEDICAID RESULTS

Program outcomes for persons with adult and pediatric asthma, CAD, COPD, diabetes, heart failure, adult and pediatric sickle cell, and adult depression, schizophrenia, schizoaffective and bipolar disorder

Outcome Metric	Aggregate Eligible Population 1 year prior 7/1/05-6/30/06	Cohort 1 year prior 7/01/05-6/30/06	Cohort Year 1 (Enrolled > 6mos) 7/1/06-6/30/07
Average PMPM total medical & pharmacy costs	\$953 PMPM	\$1,191 PMPM	\$892 PMPM
Hospital Admissions per thousand per yr (Adm./K/Yr)	244 Adm./K/Yr	467 Adm./K/Yr	365 Adm./K/Yr
Bed Days per thousand per yr (BD/K/Yr)	4,025 BD/K/Yr	2,955 BD/K/Yr	2,180 BD/K/Yr
ER visits per thousand per yr (ER/K/Yr)	914 Visits/K/Yr	1273 Visits/K/Yr	1007 Visits/K/Yr

MEDICAID RESULTS

Clinical Improvements

- ◆ Chronic Care costs for heart failure, COPD and diabetes are high and these conditions require extensive self management skills

Outcome Metric	Aggregate Eligible Population 2 year prior 8/01/05-7/31/07	Cohort 2 year prior 8/01/05-7/31/07	Cohort Year 1 (Enrolled > 6mos) 8/1/07-7/31/08
Average PMPM total medical & pharmacy costs	\$2,034 PMPM	\$3,252 PMPM	\$2,737 PMPM
Average PMPM inpatient costs	\$872 PMPM	\$1,087 PMPM	\$699 PMPM
Bed Days per thousand per yr (BD/K/Yr)	8,746 BD/K/Yr	12,310 BD/K/Yr	8,291 BD/K/Yr

QUALITY IMPROVEMENTS

Quality Improvements

Quality Measure	At Assessment	At 6 Months
Foot Exams (diabetes)	12%	65%
A1c tests (diabetes)	47%	100%
Monitor blood pressure (hypertension)	14%	32%
Asthma Action Plan	26%	93%

Other State Ideas:

Incentives:

- ♦ a number of States are exploring putting more control into the hands of the beneficiaries with incentives that they can earn by doing the right thing.

Telemonitoring:

- ♦ In home monitoring devices for high cost clients, data managed daily.

E prescribing:

- ♦ Better control of prescriptions, reduces inappropriate utilization, improves safety.

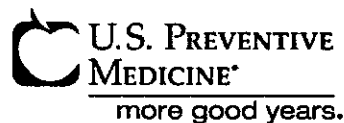


IN CLOSING

What the State says

By improving the place of prevention and personal responsibility in the health and health care decision-making rubric of Alaskans, costs of health care could be lower than they otherwise would be. With concentration on a wellness model of health care, as well as state support for the Community Health Center system and a robust public nursing program, the current access problems could be significantly reduced.

Alaska Health Care Strategies Planning
Council, December 23, 2007



Comprehensive Prevention Approach - 1^o, 2^o, 3^o

- ♦ Baseline assessment of all beneficiaries
- ♦ Shared clinical information system, statewide
- ♦ Comprehensive support/advocacy/coaching for beneficiaries across the continuum
- ♦ Individualized plan for each beneficiary

2/24/09

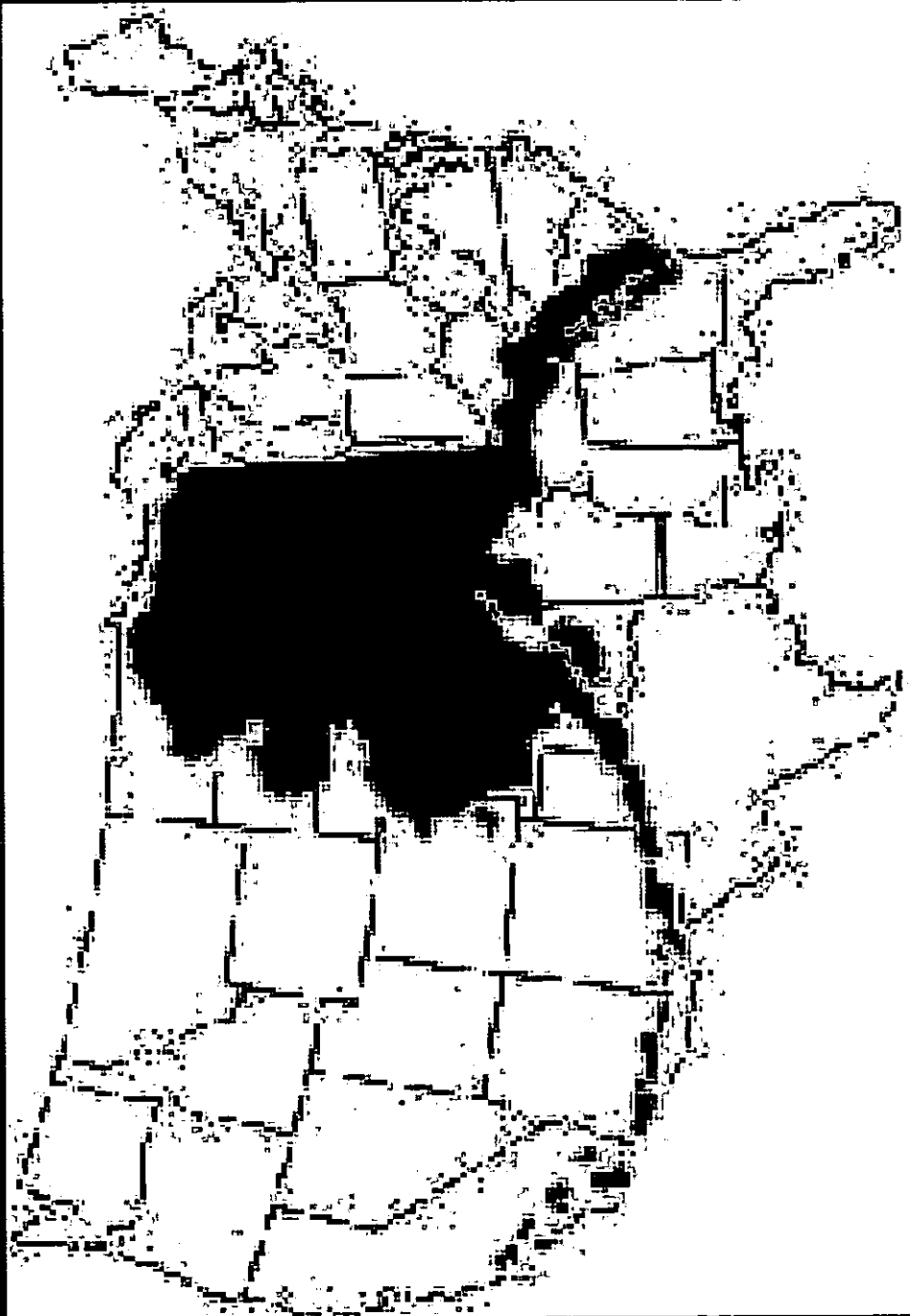
**TELE-
MEDICINE**

SEARHC

Southeast Alaska Regional Health Consortium - TeleBehavioral Health Program

February 24, 2008

Coordinator:
Rand West, Psy.D.



What is TeleBehavioral Health?

TeleBehavioral Health provides Psychiatric, Mental Health, and Substance Abuse Treatment services to remote villages using telephones, televisions and computers to talk face to face with a health provider who is at a distance.

- It is not an internet connection.
- It is not a satellite or broadcast service.
- It is a video signal sent over a dedicated phone line.
- It is confidential and secure.

Mission

Expand psychiatric and behavioral health services and related activities via live videoconferencing to remote villages to provide high-quality behavioral health care.

Vision

A virtual community mental health collaborative that is decentralized and distributed.

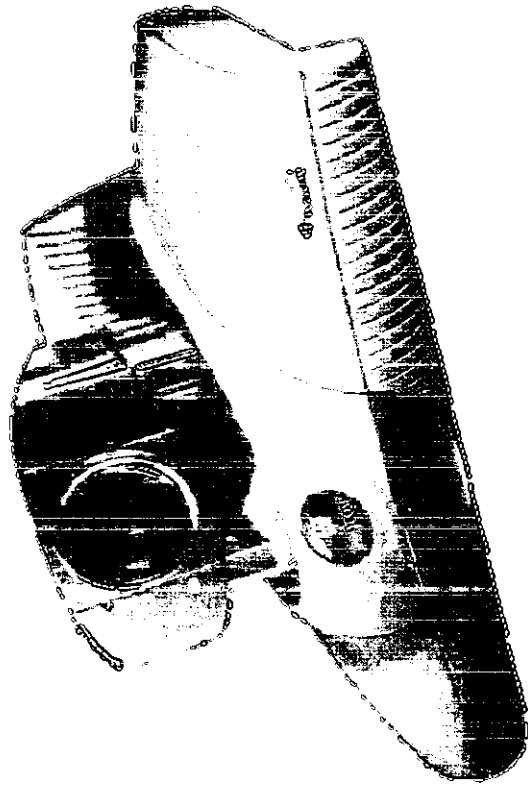
Each site has equal opportunity to contribute to other sites needs, working together as a team to meet behavioral health needs.

Videconferencing Components

- ◆ Cameras
- ◆ Video displays
- ◆ Microphones
- ◆ Speakers

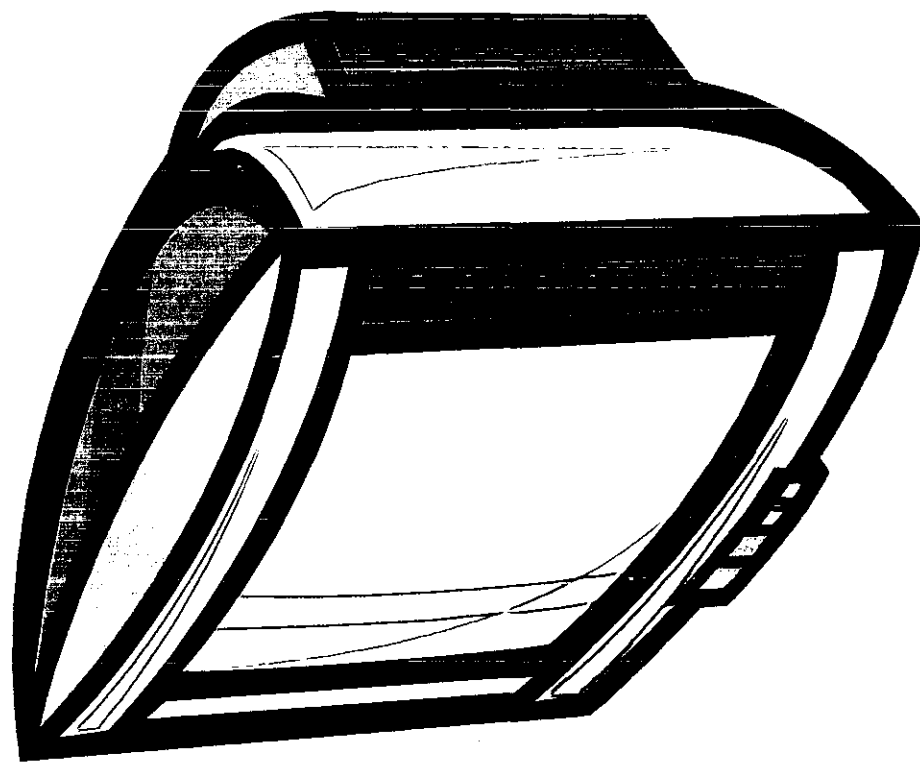
1. Main camera

- ◆ This captures the live movement at one end so it may be sent to the other end points
- ◆ Many sizes, shapes and brands of cameras - use ones certified on ND State Network



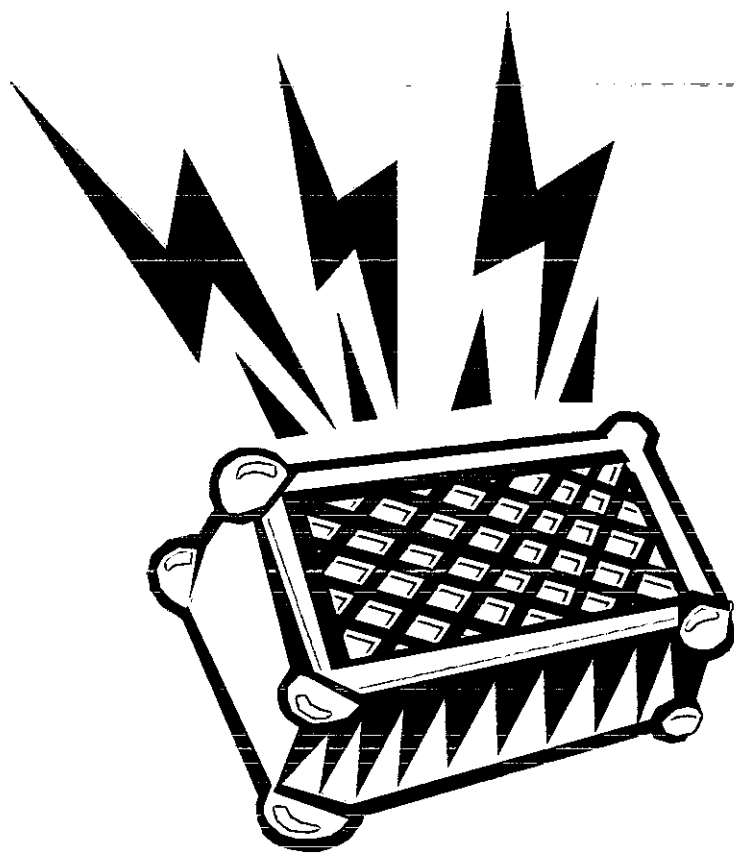
2. The Video display

Television and computer monitors are most often used to display the video.



3. Audio Components

Audio components include microphones and speakers.



4. Add-on components

- ◆ Document camera
- ◆ VCR
- ◆ Specialty cameras
- ◆ DVD players
- ◆ Electronic whiteboards

Why TeleBehavioral Health ?

- ◆ Remote / Rural Areas - Year Round Access Prohibitive.
- ◆ Limited access to Psychiatry
- ◆ Under-served and undiagnosed populations in rural / remote areas.
- ◆ Itinerant Professional Services - Cost vs. Benefit.
- ◆ Rural mental health center staffing issues - Under-staffing, recruitment & retention.

TeleBehavioral Health Services

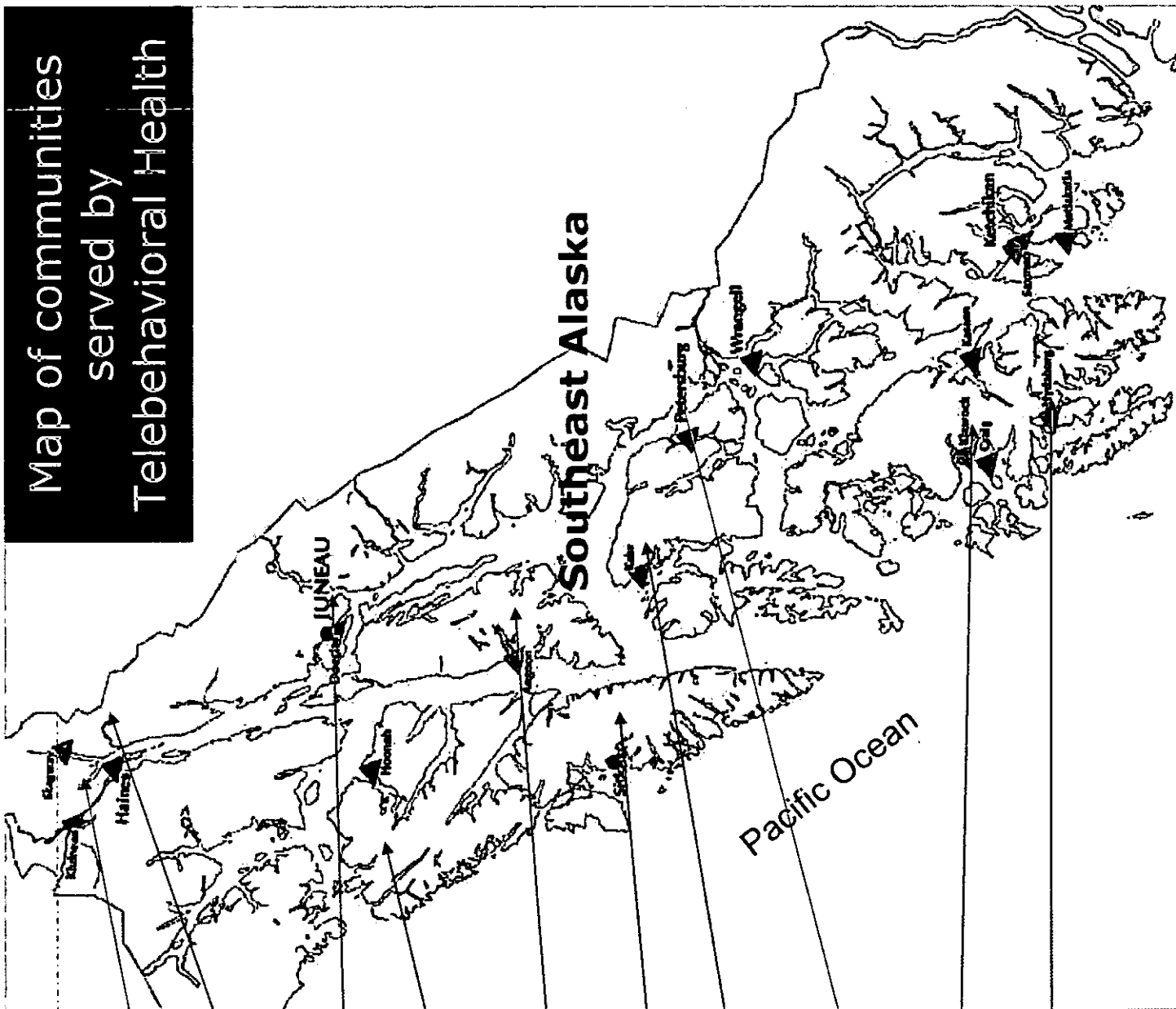
- ✓ Psychiatric Services
- ✓ Psychotropic medication refills
- ✓ Psychiatric consultation with licensed local clinicians
- ✓ Mental Health Assessment/Evaluation and Triage
- ✓ Mental Health and Substance abuse consultation

TeleBehavioral Health Services

Cont.

- ✓ Psychotherapy and Counseling
- ✓ Prevention services
- ✓ Treatment team review/treatment planning
- ✓ Clinical Supervision and Consultation
- ✓ Behavioral Health Education and Training via distance learning
- ✓ Behavioral Health Administration

Map of communities served by
Telebehavioral Health



SKAGWAY*

KLUKWAN

HAINES

JUNEAU

PELICAN

ANGOON

SITKA

KAKE

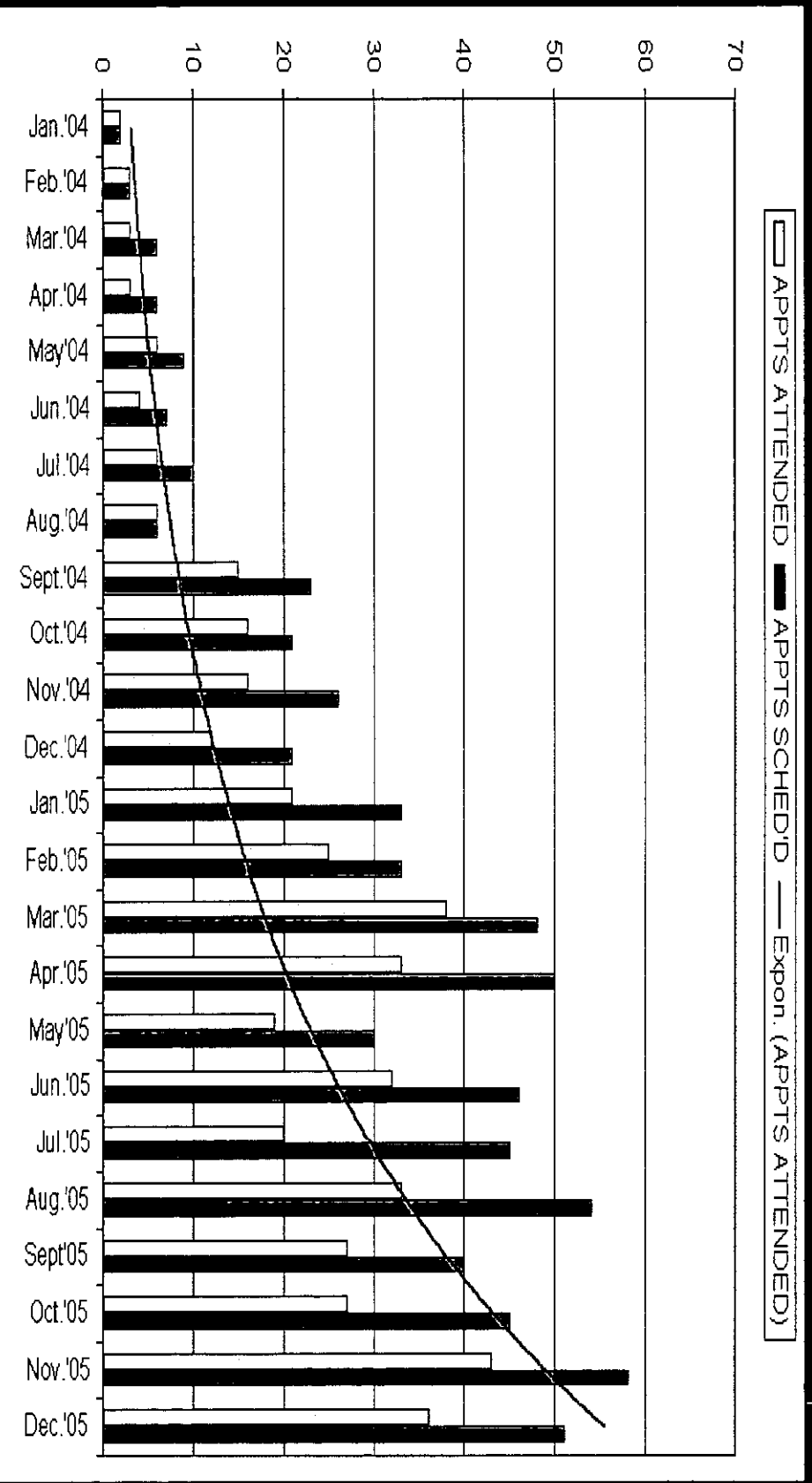
PETERSBURG

KLAWOCK

HYDABURG

1 inch = 60 miles

Jan'04 to Dec'05 TeleBehavioral Health Encounters



- # of Scheduled Appointments = 813
- # of Appointments Patients Kept = 538
- # of person/hours of training = 1530

Telebehavioral Health Program

- ◆ Designed to Empower the remote community:
 - Provide Needed Behavioral Health Services To Residents
 - Enhance Remote Provider's Skills
 - Hub Primarily Is A Resource Center
 - Hub May Provide Specialty Service If Needed

Telebehavioral Health Program

- ◆ Goals:
 - ◆ Increase access to Behavioral Health Services
 - ◆ Increase HRSA Community Expertise
 - ◆ Empower Local Providers
 - ◆ Decrease Costs

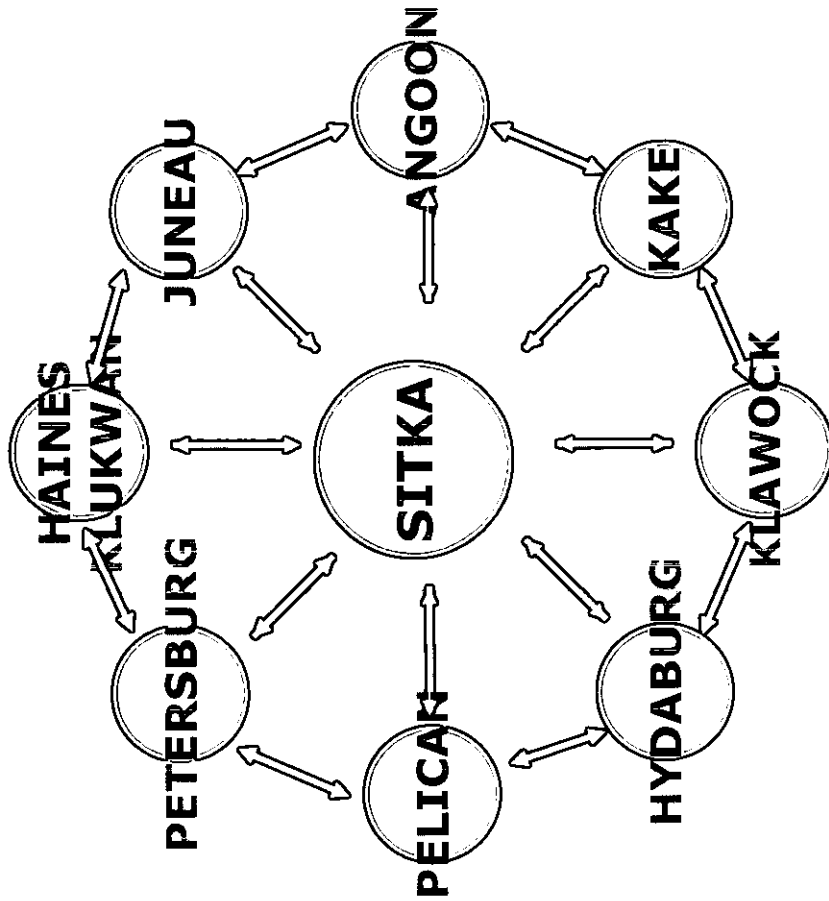
Empower Village Provider's By:

- ◆ Trainings
- ◆ Peer Review
- ◆ Clinical Supervision
- ◆ Consultation

Educational Programming to Village Providers

- ◆ Consultation
- ◆ Grand Rounds
- ◆ Case Conference
- ◆ Monthly Seminars
- ◆ Special programming

A VIRTUAL COMMUNITY MENTAL HEALTH COLLABORATIVE!



“DECENTRALIZED & DISTRIBUTED”

TeleBehavioral Health Program

Additional Goals

- ◆ More and better behavioral health services
- ◆ Determine best practices for Behavioral Health video conferencing
- ◆ Integrate drug, alcohol and mental health services
- ◆ Prevention Mental Health

Best Practices in Video-conferencing

- ◆ Learn the system - feel comfortable
- ◆ Maintain eye contact
- ◆ Maintain appropriate on-camera position
- ◆ Move and gesture slowly
- ◆ Speak in a strong, clear voice
- ◆ Keep noises to a minimum
- ◆ Select clothing appropriately
- ◆ Prepare!

Prepare for the Worst Case Scenario

- ◆ Find out who handles difficult technical problems and how to contact him/her.
- ◆ Designate a remote facilitator.
- ◆ Develop a contingency plan for the remote site and share it with the remote facilitator.

Contact Information

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Tina Lee, M.D.,

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tina.lee@searhc.org



AFHCAN Pathfinder Telehealth & Telemedicine Information

■ Glossaries

Telemedicine Glossary by ATSP -

<http://www.atsp.org/telemedicine/glossary.asp>

emerging arena of health care. This glossary contains definitions for more than 200 words and phrases.

Telehealth and e-health glossary <http://telehealth.net/glossary.html>

Glossary compiled by Marlene M. Maheu, Ph.D. and Ace Allen, M.D. 3/20/2001

■ Associations & Networking Sites

American Telemedicine Association - <http://www.atmeda.org/>

ATA promotes professional, ethical and equitable improvement in health care delivery through the application of telecommunications technology, promoting telemedical research and education, assisting in the development of telemedical policy and standards, providing educational materials to public and professional organizations, etc.

Association of Telehealth Service Providers <http://www.atsp.org/>

The Association of Telehealth Service Providers is an international membership-based organization dedicated to improving health care through growth of the telehealth industry

International Association for Telemedicine <http://www.isft.org>

The ISfT exists to facilitate the International dissemination of knowledge and experience on Telemedicine and e-Health and to provide access to recognized experts in the field worldwide.

TelehealthNet <http://telehealth.net/>

TelehealthNet is a networking site for organizations, associations, professionals and vendors. It is designed to help you share resources and partner in developing telehealthcare solutions to healthcare problems

■ RESOURCES

Department of Veterans Affairs: Telemedicine Initiatives by

State - <http://www.va.gov/telemed/> From this page users can link to a particular State to learn more about the progress of the VA's Telemedicine Initiatives within that State.

Distance Learning and Telemedicine Program - <http://www.usda.gov/rus/telecom/dlt/dlt.htm>

This is the homepage of the USDA's Rural Development and Rural Utilities Service. Includes links to current Distance Learning and Telemedicine awards, press releases, grant funding information, program highlights and overview, success stories, regulations and application guides, and contacts for additional information.



AFHCAN Pathfinder
Telehealth & Telemedicine Information

Federal Telemedicine Update - : <http://www.federaltelemedicine.com/>

Provides reports on expenditures by the Federal Government, which will spend close to one billion dollars this year on research, activities and grants related to telemedicine, telehealth and informatics.

HealthWeb: Telemedicine - <http://www.lib.uiowa.edu/hw/telemed/>

This web site provides links to telemedicine projects worldwide; foundations, associations, professional organizations and learned societies pertaining to telemedicine; telemedicine documents, journals, newsletters; electronic publications; and other similar items of interest.

Lights, Camera, Telemedicine -

http://www.fda.gov/fdac/features/1997/497_tele.html

This article discusses the use of interactive videoconferencing - telemedicine -- by physicians practicing in rural and other remote areas. Telemedicine involves the use of computers and telecommunications equipment to provide health care over long distances.

National Library of Medicine's Telemedicine Projects -

<http://www.nlm.nih.gov/research/telfront.html>

This site contains details of NLM's programs and projects designed to evaluate the impact of telemedicine on health care. Including, the confidentiality of health data transmitted via electronic networks; and the better practice of medicine by physicians using advanced computing and networking capabilities.

NLM National Telemedicine Initiative -

<http://www.nlm.nih.gov/research/telemedinit.html>

The National Library of Medicine, National Institutes of Health supports several telemedicine projects which are intended to serve as models for: evaluating the impact of telemedicine on cost, quality, and access to health care; assessing various approaches to ensuring the confidentiality of health data transmitted via electronic networks; and testing emerging health data standards. This web site provides details related to these projects as well as information about other related programs.

Office for the Advancement of Telehealth <http://telehealth.hrsa.gov>

HRSA has established the Office for the Advancement of Telehealth (OAT) to serve as a leader in telehealth, a focal point for HRSA's telehealth activities and as a catalyst for the wider adoption of advanced technologies in the provision of health care services and education.

Telemedicine Information Exchange - <http://tie.telemed.org/>

An international, quality resource for information about telemedicine and telemedicine-related activities. Resources available include: searchable bibliographic databases of over 4,000 citations; 200 telemedicine programs worldwide; funding sources for telemedicine activity; a database of citations specific to legal issues related to telemedicine; and a "forum" -- experts on various subjects answer questions on telemedicine. This



AFHCAN Pathfinder Telehealth & Telemedicine Information

project is supported by the National Library of Medicine, National Institutes of Health.

Telemedicine Report to Congress -

<http://www.ntia.doc.gov/reports/telemed/index.htm>

This is the on-line table of contents of the Telemedicine Report to the U.S. Congress. Users can link to the history, structure, and overview of the Joint Working Group on Telemedicine; evaluation of Telemedicine projects, legal issues, payment issues, safety and standards, telecommunications infrastructure, privacy, security, and confidentiality.

Telemedicine Resources - <http://icsl.ee.washington.edu/~clau/tmresources.html>

Offers links to sites in the categories of general telemedicine, compression and teleconferencing standards, networking, and medical imaging.

■ Telemedicine Journals & Libraries

Telemedicine Journal and e-Health: <http://www.liebertpub.com/tmj/default1.asp>

A peer-reviewed journal covering all aspects of clinical telemedicine practice, technical advances, enabling technologies, education, health policy and regulation and biomedical and health services research dealing with clinical effectiveness, efficacy and safety of telemedicine and its effects on quality, cost and accessibility of care. Indexed in *Index Medicus*, *MEDLINE*, *Current Contents/Clinical Medicine*, *EMBASE*, *Excerpta Medica*, *Research Alert*, *SciSearch/Science Citation Index-Expanded*, *Science Citation Index*, *PsycINFO*. The official journal of the American Telemedicine Association.

Journal of Telemedicine and Telecare: <http://www.coh.uq.edu.au/jtt/index.html> The Journal of Telemedicine and Telecare is an international, peer-reviewed academic journal which publishes original contributions relating to all aspects of telemedicine and telecare. The JTT is indexed in *Index Medicus/MEDLINE*, *Science Citation Index®*, *SciSearch®*, *Research Alert®* and *Current Contents®/Clinical Medicine*. The JTT is the official journal of the: Finnish Society of Telemedicine, Hong Kong Telemedicine Association, and Telemedicine and eHealth Forum of the Royal Society of Medicine.

Telemedicine Telejournal - <http://www.atsp.org/telejournal/homepage.asp>

ATSP is the sponsoring agency. Presents audio recordings of the Telemedicine TeleJournal. These monthly teleconferences are available to anyone interested in the field of telehealth. Presenters are volunteers from a variety of organizations who share their experiences in this new field. A formal presentation is followed by a question-and-answer period, during which listeners may ask questions of the speakers.

Telemedicine Today <http://www.telemedtoday.com>

Telemedicine Today is the leading news and information source for the telemedicine industry, with a readership that includes telemedicine practitioners, physicians, hospital administrators, healthcare information specialists, vendors, consultants, policy makers, and others interested in this dynamic field. The magazine's coverage includes clinical applications, networking, business models, legal and regulatory updates, telemedicine program profiles, and industry news.



Student Comments about AFHCAN Training

The following quotes are from student evaluations from a recent Train-the-Trainer Workshop.

By far, one of the most organized, thoroughly presented, and fun training classes I have attended. The performance-based approach was right on the mark. You have armed me with all the tools I need to go forward and develop a training program.

Very user-friendly material. Easy to understand.

Strategic planning was one of the most useful segments. This lets us start applying the application to our organizations.

Great job. Excellent instructors all the way around! Liked the hands on, especially the troubleshooting.

Very easy to understand for folks with limited computer skills.

AFHCAN is located on third floor of the new Corporate Office Building (COB) of ANTHC. The COB is located on the Alaska Native Medical Center campus, and includes a number of fully-equipped conference rooms. Our classes always involve hands-on training. The AFHCAN training room includes AFHCAN Carts, desktop computers loaded with AFHCAN software, video teleconferencing capability, and a wall-mounted PC. This allows us to emulate a realistic clinical workflow where cases are sent involving multiple providers and specialties.



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Division of Information Technology
4000 Ambassador Drive,
Anchorage, AK 99508

Visit our website at www.afhcan.org for more information



Alaska Native
Tribal Health Consortium

35-003-0

Total Training and Support Solutions

Let AFHCAN training put you on the fast track to success in using AFHCAN products



AFHCAN

Access Without Limits

TRAINING

New User Training

8 hours

- Teaches a clinical user how to use the AFHCAN Software and the AFHCAN Cart
- Includes coverage of digital camera, otoscope, dental camera, tympanometer, spirometer, and other peripherals
- Assumes no background knowledge

Training Refresher

4 hours

- Introduces the latest hardware and software features
- Provides a quick review of the basics
- Builds on existing knowledge by delving into the fine points of operation
- Assumes some prior training or experience using the AFHCAN Cart and Software



Desktop User

1 hour

- Provides an overview of the software for practitioners who use the AFHCAN software to receive cases for consultation
- Assumes no prior knowledge

Non-Clinical Orientation

1 hour

- Provides an overview of the functions and features of the AFHCAN Cart and Software
- Excellent for anyone who desires a general understanding of the AFHCAN system
- Assumes no prior knowledge

System Administrator

4 hours

- Course covers administrator responsibilities including:
 - Installing AFHCAN Software
 - Adding, editing, or deactivating providers and groups
 - Naming conventions for groups, sites, etc.
 - Understanding the basics of AFHCAN networks
 - Basic troubleshooting
- Tailored for technical staff

Train-the-Trainer Workshop

4 days

- Workshop includes:
 - The New User Training Course
 - Creating a strategic training plan
 - Communicating the value of training to executive staff
 - Assessing telehealth clinical flow for optimal productivity
 - Adult learning tips and tricks
- Tailored for trainers and training managers

Cart Hardware Upgrade Procedure

16 hours

- Trains a technical person to upgrade an existing AFHCAN Cart to the current hardware baseline
- Assumes a basic familiarity with standard hand tools and safety practices

Certification

The Train-the-Trainer course and Cart Hardware Upgrade courses include a Certificate of Completion effective for one year from the date of issue. Certification ensures staff members are authorized to perform certain tasks stipulated in Service Level Agreements.



AFHCAN Support Services

AFHCAN provides Customer Support / Help Desk Services to answer questions and resolve both clinical and technical issues. Telephone, email, and on-site technical support services are available for the installation and use of AFHCAN Products.

Support is available from 8 a.m. to 5 p.m., Monday through Friday, Alaska time. After hours emergency support is available for an additional fee.

On-site support is also available for difficult hardware or software problems. Technical support staff is available to travel to your place of business. Contact AFHCAN for additional details.

"Security at AFHCAN is not just a firewall; it is a process from the design stage through the final implementation and management of the AFHCAN solution."

"Security is built into the software and not added as an afterthought."

"AFHCAN takes extraordinary effort to make sure that servers are hardened and firewalls are configured to provide maximum security."

Statements from a final security review of AFHCAN by a Certified Information Security Auditor (NSA).

The AFHCAN Software will be available in multiple languages in late 2006.

35-002-0, Rev A

**President's Award
American Telemedicine Association (2004)**
Established to recognize a project that has made a substantial contribution toward the advancement of telemedicine.

**Most Innovative New Technology Device
for Diagnostics (2004)**

Presented by The Emerging Technologies and Healthcare Innovations Congress (TETHIC) to a novel diagnostic technology that improves precision, accessibility, turnaround time, or access to diagnosis.



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4000 Ambassador Drive
Anchorage, AK 99508

Visit our website at www.afhcan.org for more information



**Alaska Native
Tribal Health Consortium**

AFHCAN Software
An Enterprise-Wide Telehealth Solution

Add
Comment

Print

AFHCAN
Access Without Limits

A Simple Interface With Powerful Capability

The heart of the AFHCAN store-and-forward telehealth system is the AFHCAN Software. Designed by health care professionals, the system has proven effective in many clinical scenarios.

Access to biomedical peripherals is as easy as 1 – 2 – 3. Users may login, then easily use the peripherals for a patient exam.

- Touchscreen Compatible
- Color coded for easy navigation
- Three (3) clicks to access peripherals once logged in
- Minimal user training required

Integrates With Biomedical Peripherals

Biomedical peripherals offered that are integrated into the AFHCAN Software and may be used to develop a complete telehealth case include:

- | | |
|--------------------|-------------------------------------|
| ■ Audiometer | ■ Spirometer |
| ■ Dental Camera | ■ Stethoscope* |
| ■ Digital Camera | ■ Tympanometer |
| ■ ECG (12-Lead) | ■ Video Otoscope |
| ■ Holter Recorder* | ■ Vital Signs Monitor |
| ■ Scanner | ■ Other scopes (i.e. video sources) |

* Available late 2006

Fits Within Existing Clinical Workflow

The AFHCAN Software supports existing referral patterns and serves as a platform for new clinical relationships. The software enables and facilitates healthcare delivery without generating new business rules. Features accommodate workflow!

- Cases can be sent to an individual or a group (Department)
- Consultants can be advertised locally or shared enterprise-wide
- Cases can be Sent, Archived, Discarded, or placed on Hold
- Trust Relationships can be established between one or many organizations
- Clinicians have options to use drop down menus or free text
- Clinicians have option to receive email notification
- Case Summary, Images and Billing Forms can all be printed

Reliable and Robust for lower Total Cost of Ownership (TCO)

AFHCAN Software supports secure client-to-server and server-to-server connectivity over a wide range of telecommunications infrastructure. This technology typically requires no changes in organizational firewalls, while providing high performance and reliability. AFHCAN has successfully transmitted telehealth data over satellite links on days when storms prevented the transmission of telephony, fax, email, video and browsing.

- Flexible – Self tuning optimizes connectivity over Satellite links, Satellite phones, dedicated lines, POTS or Internet.
- Reliable – Small data packets with retransmission capability to overcome poor connectivity
- Efficient – Users can also create cases when completely disconnected from the server!
- Firewall Friendly and Secure – Appears as browsing (HTTP over port 80) with 3DES encrypted data. Also supports encrypted TCP/IP and SSL options.

Enterprise-Wide Features

The "Enterprise Solution" allows autonomous health care organizations to share multimedia telehealth data in a controlled, secure and robust manner consistent with HIPAA Privacy and Security Requirements. "Server-to-Server" technology allows multiple servers connected to a wide-area network or the Internet to exchange telehealth cases – with Administrative-level security and access controls in place.

Secure - from Design to Deployment

The AFHCAN Software and all preloaded clients and servers are configured and validated for maximum security and functional capability. Continuous, ongoing testing at AFHCAN is used to validate the software design and deployment configuration, and to determine which future software enhancements are needed to maintain secure system (patches, fixes, Service Packs). AFHCAN relies on industry-standards such as PKI (Public Key Infrastructure) and digital certificates from Verisign to provide secure communication and code security.

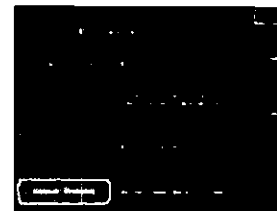
- Supports automatic downloads of authenticated code updates to servers and clients
- Data transmission is encrypted for the "end site" (3DES/SHA1)
- Data is signed by the originating site for non-repudiation purposes and data validation
- External "Hardware Security Modules" store and protect digital certificates outside the Operating System
- Customer controls all server-to-server trust relationships between organizations
- Remote monitoring and alarming built in for proactive management
- Servers are "hardened" to ensure secure deployment
- Role-based Security for users and application administrators
- Fully auditable - tracks all user activities.

Evaluation

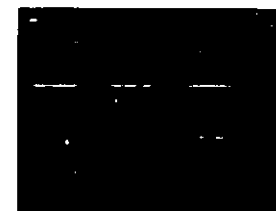
AFHCAN software supports organizational needs for evaluation and utilization reporting requirements. The software provides the capability to pose evaluation questions to users with each telemedicine case, and servers provide reports on response summaries and utilization information.



1. Begin at the login page to start using the software.



2. The user has four choices. Selecting "Create a New Case" provides access to all the biomedical devices.



3. The user may select any peripheral at this point. For example, selecting Video Otoscope starts the next screen.



4. The live image from the Video Otoscope is large enough to view and share with the patient. Controls are easily identified on the right side of the screen.

Continuing Education Units

Alaska Native Medical Center is accredited as a sponsor and provider of Continuing Medical Education credits (CME's) for physicians by the Alaska State Medical Association. Alaska Native Medical Center designates this continuing education activity as meeting the criteria for 9.0 hours of AMA PRA Category 1 Credit™. Each physician should claim only credit commensurate with the extent of participation in the activity.

Alaska Native Medical Center is an Approved Provider of continuing education by the Alaska Nurses Association, an accredited approver by the American Nurses Association Credentialing Center's Commission on Accreditation. Provider Number AP-06-002. Alaska Native Medical Center designates this continuing education activity as meeting the criteria for 9.0 Continuing Nursing Education (CE) credits.

AFHCAN is located on the third floor of the Consortium Office Building (COB) of ANTHC. The COB is located on the Alaska Native Medical Center campus, and includes a number of fully-equipped conference rooms. In addition to our Computer Based Training, our instructor-led classes involve hands-on training. The AFHCAN training room includes AFHCAN Carts, desktop computers loaded with AFHCAN software, videoteleconferencing capability, and a wall-mounted PC. This allows us to emulate a realistic clinical workflow where cases are sent involving multiple providers and specialties.



AFHCAN

Alaska Native Tribal Health Consortium
Health Information and Technology Division
4000 Ambassador Drive
Anchorage, AK 99508

Contact:

Telehealth Training & Support Director
Phone: 907-729-2260
Toll Free: 888-449-4435
Fax: 907-729-2269

Visit our website at www.afhcan.org for more information



**Alaska Native
Tribal Health Consortium**

Computer Based Training Software

*Computer assisted learning is a
powerful alternative to traditional
education approaches*

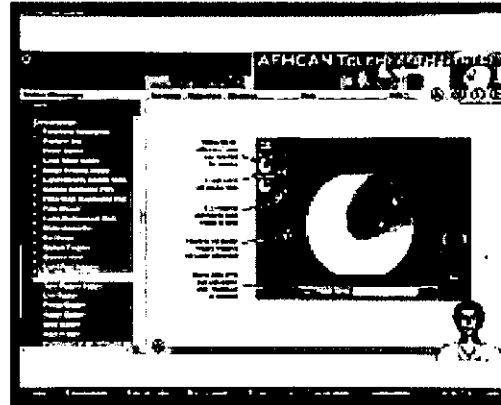


AFHCAN

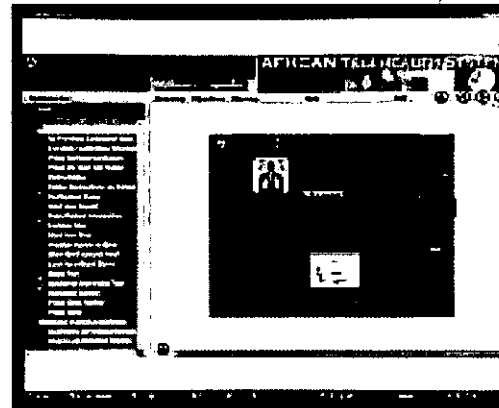
Telehealth Solutions

Benefits

- The AFHCAN CBT Modules actively engage students in the learning process by having them create a test case at the end of every module to demonstrate required skills
- Studies show that students typically retain twice as much information from a CBT course that covers the same material as an instructor-led course. This is due to the intense interaction inherent in the CBT format, the ability to move through the material at the student's own pace and the ability to review material as many times as required
- Students earn Continuing Medical Education (CME) credit for each module by completing the test case and forwarding it to the AFHCAN Telehealth Coordinators
- AFHCAN CBT includes a glossary of relevant terms and short video clips to demonstrate key processes
- Search tools have been built into the program to serve as fast and efficient reference sources
- With CBT each student tailors AFHCAN training to meet their specific needs
- Supervisors can provide the same quality training to shift workers without having to rearrange schedules
- Health care providers can access the CBT during patient care to verify their learned skills



Students can choose to follow the module by listening to the Video professor or using the dialogue box. Either option can be stopped so that learners can take notes, then resume where they left off.



Students can follow the table of contents for a complete version of the module or choose the section that they desire to listen to. This allows the students to concentrate on smaller parts of the module at their own pace.

Convenience

The ability to take the course as time permits, instead of arranging the student's activities around a class schedule, is a major advantage.

- AFHCAN's computer-based training (CBT) is an educational tool designed to give new users a solid introduction to using the AFHCAN Cart. The training covers the same material as our New User Training Course
- The CBT features a multi-media approach to learning that is compatible with a wide range of learning styles
- The user interface puts students in control of their learning by allowing them to select topics of interest and progress through the material at their own pace
- Supervisors now have the flexibility to train new employees quickly and efficiently in as little as an hour a day on various modules
- Students can refresh their skills when needed, instead of when a trainer is available

Cost Effective

Computer based training avoids the expense and loss of work involved in traveling to a central location for training and is cost effective too!

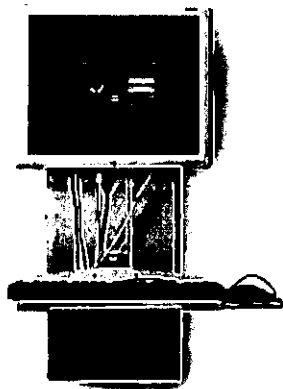
- 24-hour per day/364-day a year trainer often costing less than having an on-site trainer
- The annual fee includes updates and training on new products
- CBT is a cost effective way to get on-demand refresher training as often as you need it

For more information please contact us:
 Phone: 907-729-2285
 Toll Free: 888-449-4435
 Fax: 907-729-2269

OTHER PLATFORMS

Wall Mount System - Video Capture

Save on valuable space using a wall mounted system with adjustable height, integrated CPU, touchscreen monitor and video capture card. Acquire images from endoscopy and other video equipment with simultaneous display on high-resolution monitors.



Portable "Briefcase" Telehealth Unit

This unit has a keyboard and tablet PC with touchscreen. Integrates digital camera, ECG, Spirometer, and videoconferencing. Also, has video and USB interface capability to external devices.



35-004-0



AFHCAN and the Alaska Native Tribal Health Consortium

The Alaska Federal Health Care Access Network (AFHCAN) began as a project of the Alaska Federal Health Care Partnership (AFHCP) in 1998 to improve health care for federal beneficiaries in Alaska using telemedicine technology. During the early years of the project there was overwhelming response for creating a store-and-forward telemedicine system in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) is the managing partner of AFHCAN. ANTHC is a tribal organization, as defined in 25 U.S.C. 450 (b) (c).

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Alaska Native
Tribal Health Consortium

The AFHCAN Telehealth Platforms and Peripherals

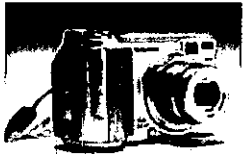


AFHCAN

Access Without Limits



Audiometer plus Tympanometer
The Earscan by Micro Audiometrics provides threshold screening audiometry plus fast and normal speed tympanometry.



Digital Camera
The latest technology in high resolution digital camera and docking station are integrated seamlessly.



Dental Camera
The Evolution M series by Digital Doc is a small dental camera with superior optics, auto focus and excellent color reproduction.



Vital Signs Monitor
The measurement of vital signs plays a fundamental role in medical evaluation and typically includes: blood pressure, pulse, pulse oximetry (O2 saturation), respiratory rate and temperature



ECG (12-Lead)
The IQMark Digital ECG by Midmark Diagnostics is a highly advanced interpretative 12-lead ECG system.

DENTAL EXAMS
 EAR EXAMS
 VITAL SIGNS
 BLOOD PRESSURE
 ECG
 VIDEO OTOSCOPE
 WOUND MANAGEMENT
 DENTAL CAMERA



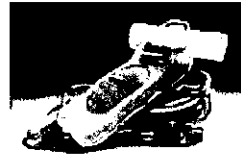
Expansion Capability
Support for TWAIN-compliant devices (e.g. film scanners), digital cameras, and external video devices using composite or s-video auxiliary inputs.



Scanners
Paper and film scanners are accessed through a simple, one touch user interface.



Video Oscope
Integrated camera and light source to provide high resolution, wide angle views for ENT specialties.



Spirometer
The Midmark Diagnostics IQMark Spirometer is an extremely easy to use diagnostic tool and is completely integrated with the AFHCAN software.



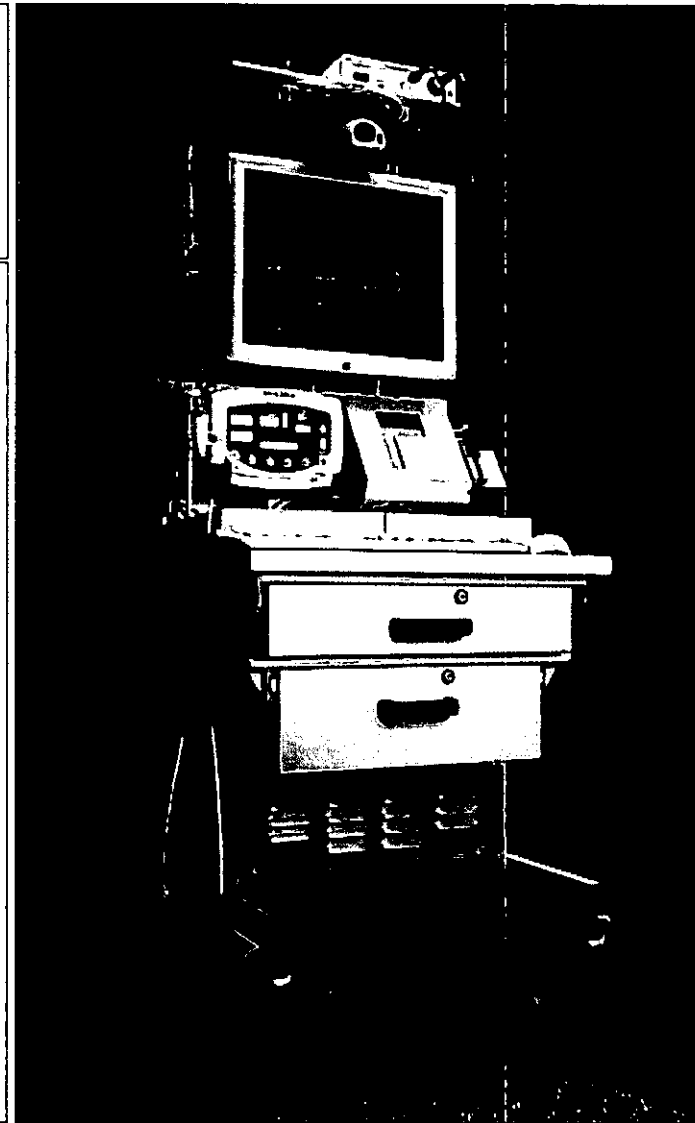
Videoconferencing Add-On
This solution incorporates a high resolution pan-tilt-zoom camera with a software client that support IP-based videoconferencing with the latest H.264 compression for superior image quality.

THE AFHCAN CART

The AFHCAN Cart is a mobile workstation with integrated biomedical peripherals, wireless network capability, and power management hardware that allows health care professionals to:

- Capture patient information using electronic forms and integrated biomedical peripherals.
- Capture information from external imaging devices such as microscopes, ultrasound and surgical scopes.
- Forward the information to another professional or group of professionals at a distant location for review and consultation.

The AFHCAN Cart is small enough to fit through a door, has large rubber wheels to negotiate uneven floor surfaces, has a low center of gravity to minimize instability, and is designed to meet the ergonomic needs of a wide variety of users. The AFHCAN Cart is designed for patient safety with low EMI and an isolated power system.



Videoconference Training for End-Users

AFHCAN training provides significant return on your technology investment and company's bottom line by increasing the skills and knowledge of end-users.

AFHCAN training courses are designed to empower end-users with the practical skills to successfully use videoconferencing equipment for educational, administrative and clinical sessions.

With hands-on exercises and practice opportunities that mirror real life scenarios, AFHCAN training courses benefit the entire workforce.

Training is available onsite or in our Anchorage training facility. Please contact us at (907) 729-4708 or (907) 729-2285 to discuss scheduling options and pricing.

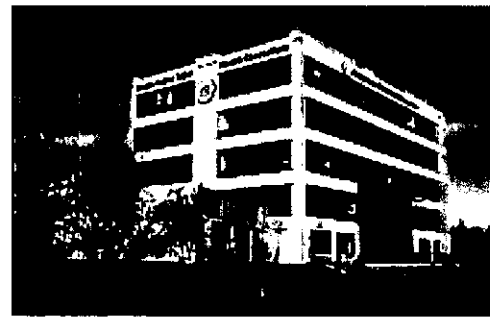
AFHCAN videoconference rooms are all designed differently, with equipment from leading vendors. This gives participants an opportunity to use a variety of equipment and allows us to provide training sessions that involve multiple "sites".

The AFHCAN training room includes AFHCAN carts, desktop computers with AFHCAN software installed, a wall-mounted PC and videoconferencing capability.

The AFHCAN conference room has videoconference capability and is used for small and large group sessions.

The small videoconference room is designed for one-on-one administrative, educational or patient sessions.

AFHCAN is located on the third floor of the Consortium Office Building (COB) of ANTHC. The COB is located on the Alaska Native Medical Center campus.



AFHCAN

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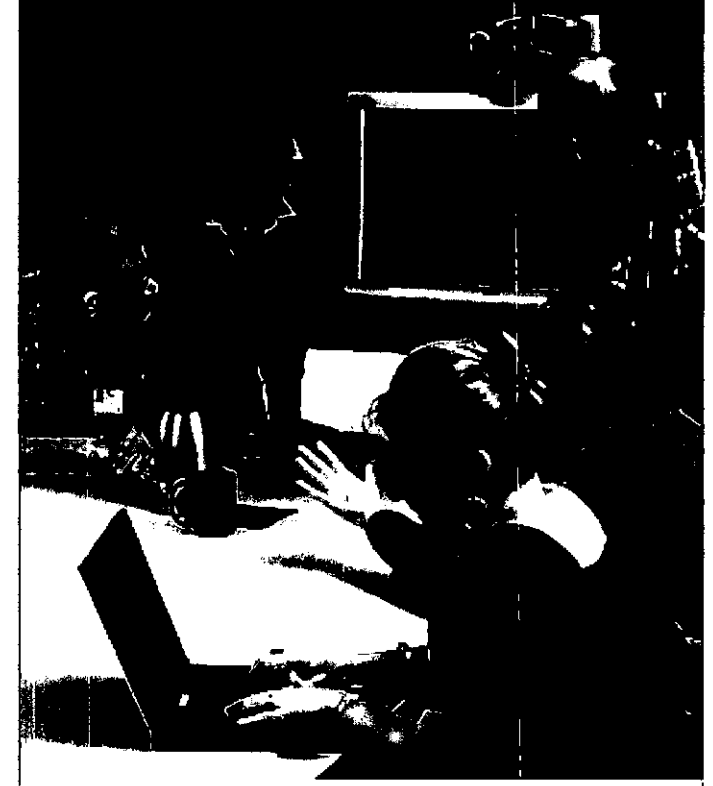


**Alaska Native
Tribal Health Consortium**

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Videoconference Training

Learn how to get optimal usage of your videoconference equipment

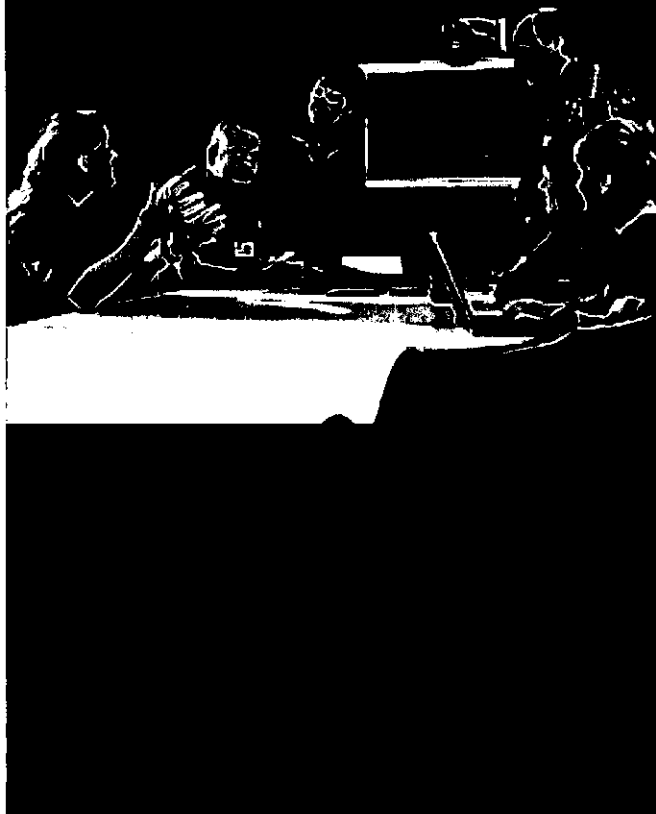


AFHCAN

Telehealth Solutions

Learn How to Videoconference

AFHCAN videoconference training modules are highly interactive. All modules include hands-on practice opportunities with a variety of video equipment.



Module 1: Basics—An Introduction to Videoconferencing equipment

Participants will:

- Gain a basic understanding of components; camera, codec, remote control, and monitor
- Test equipment functionality
- Store and delete presets
- Initiate and terminate point-to-point and multi-point sessions

Module 2: Cameras & Connections

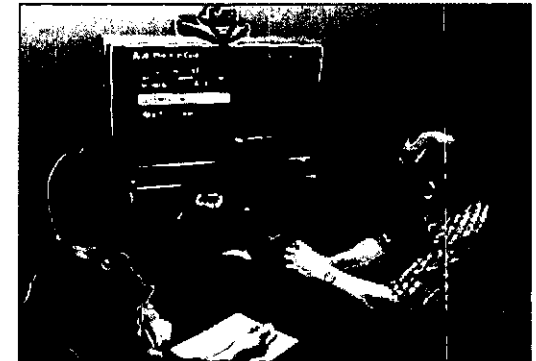
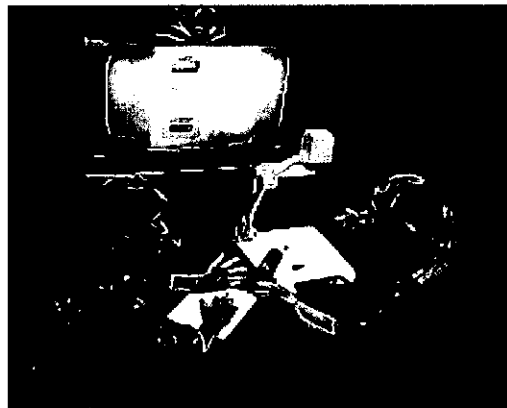
Participants will:

- Use a document camera to project quality images into a videoconference session using printed materials, 3-D objects and an SD card
- Set up and connect to a document camera
- Connect a laptop computer

Module 3: Room Design & Framing Subjects

Participants will:

- Understand elements of room design
- Understand appropriate room arrangement for one-on-one, small and large group sessions
- Practice videoconference etiquette & “tele-presence” for one-on-one, small and large group sessions



Module 4: Troubleshooting

- Participants will learn various troubleshooting techniques for audio/video peripherals, the videoconference unit, TV/LCD panel, and network cables

Module 5: PowerPoint for Videoconferencing

Participants will:

- Learn best practice techniques for creating PowerPoint presentations
- Create or convert a PowerPoint presentation that meets best practice guidelines

Module 6: Orienting Patients

Participants will:

- Plan & prepare for a provider-patient videoconference
- Facilitate a clinical VTC session
- Learn steps to ensure patient privacy, confidentiality & safety

Module 7: Consulting via Videoconference; Best Practices for Providers

Participants will:

- Learn & practice proper “tele-presence” and videoconference etiquette
- Conduct a patient-provider videoconference session
- Discuss document management workflow between referring and consulting sites
- Learn steps to ensure patient privacy and confidentiality

"Access for ENT services has improved dramatically in regions using telemedicine. In some of these regions, wait times for ENT services have decreased from six months to essentially no delay for care."

John Kokesh, MD
Chief of Otolaryngology,
Alaska Native Medical Center



Irene McGlashan at the Oonahaska Wellness Center in Dutch Harbor, Alaska transmits an electrocardiogram (ECG) to a referral physician in Anchorage.

Dutch Harbor is located on Unalaska, a remote island in the Aleutian Chain, 800 air miles from Anchorage.



AFHCAN and the Alaska Native Tribal Health Consortium

The Alaska Federal Health Care Access Network (AFHCAN) began as a project of the Alaska Federal Health Care Partnership (AFHCP) in 1998 to improve health care for federal beneficiaries in Alaska using telemedicine technology. During the early years of the project there was overwhelming response for creating a store-and-forward telemedicine system in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) is the managing partner of AFHCAN. ANTHC is a tribal organization, as defined in 25 U.S.C. 450 (b) (c).

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Alaska Native
Tribal Health Consortium

Access to health care professionals
regardless of where you are...
Telehealth solutions brought to you by AFHCAN



AFHCAN

Access Without Limits

Whole Product Solution

The AFHCAN telehealth platform is a secure and proven "store and forward" technology that increases the quality and accessibility of health care at the point of patient contact. The AFHCAN system provides an innovative approach to ease of use, mobility, support for widely varying clinical workflows, and a robust communication platform. AFHCAN offers a whole product solution that includes:

- Store and Forward Telehealth Software
- Automatic Software Updates
- Application Hosting Services with Third Party ASP's
- AFHCAN Telehealth Cart and other Platforms
- Integrated Biomedical Peripherals
- Clinical Workflow Assessments
- Certified Training for Administrators, Users, and Support Staff
- Service Level Agreements (SLAs)
- Help Desk / Customer Support
- Remote Monitoring

AFHCAN Software

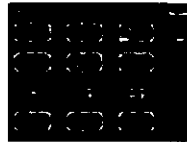
The heart of the AFHCAN store-and-forward telehealth system is the AFHCAN Software designed to support existing clinical relationships between organizations. Our goal is not to require new business rules, but to enable and facilitate healthcare delivery. The "Enterprise Solution" allows autonomous health care organizations to share multimedia telehealth data in a controlled, secure and robust manner consistent with HIPAA Privacy and Security Requirements.



1. Begin at the login page to start using the software



2. The user then has four choices. Selecting "Create a New Case" provides access to integrated biomedical peripherals.



3. The user may select any peripheral at this point. For example, selecting Video Otoscope starts the next screen.



4. The live image from the Video Otoscope is large enough to view and share with the patient. Controls are easily identified on the right side of the screen.



AFHCAN Support Services

Telephone Support

AFHCAN provides telephone support to answer questions and resolve both clinical and technical issues.

Training

Our goal is to provide training opportunities for health care professionals, administrators, and technical staff to expand the skills and knowledge needed to enhance the quality of health care in their communities. We also provide train-the-trainer classes to develop on-site training staff. Training is offered in Anchorage Alaska or at an organization's site.

Software Update Packages

One of the benefits of the AFHCAN Software is that software upgrades are distributed automatically. New features and functionality can be added without the need for user intervention or an expensive IT service call.

Dispatched Technical Support

For complex hardware or software problems, technical support staff is available for hire to perform on-site work.

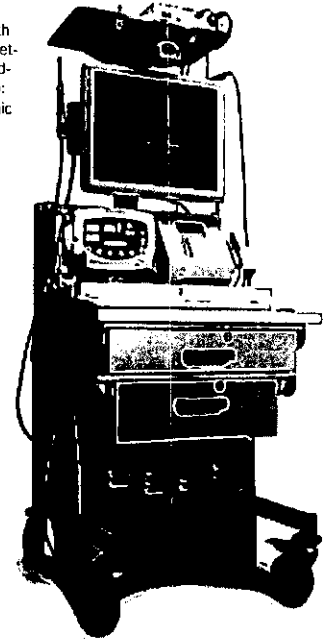
AFHCAN Cart

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Other hardware platforms include wall mounted systems and light weight portable systems.

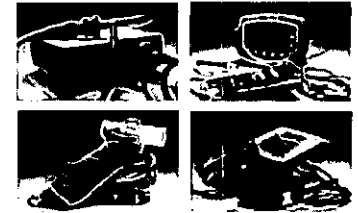


Biomedical Peripherals

Biomedical peripherals that are integrated with the AFHCAN Software and may be used to develop a complete telehealth case include:

- Audiometer
- Tympanometer
- Dental Camera
- Digital Camera
- ECG (12-Lead)
- Holter Recorder*
- Scanner
- Spirometer
- Stethoscope*
- Video Otoscope
- Vital Signs Monitor

* Available late 2006



**3/17/09
OMBUDS-
MAN'S
REPORT
ON OFFICE
CHILD. SER.**



INVESTIGATIVE REPORT

Ombudsman Complaint A2008-0581
Finding of Record and Closure
March 9, 2009

This investigative report has been edited to remove all confidential information and information that would identify the complainants in accordance with AS 24.55.160.

SUMMARY OF THE COMPLAINT

On April 10, 2008, an Anchorage resident complained to the Office of the Ombudsman that an Office of Children's Services (OCS) caseworker interviewed his children on school grounds in the absence of a school official in violation of Alaska Statute.

The ombudsman opened an investigation into the following allegation stated in terms that conform with AS 24.55.150.

Allegation One: OCS interviewed the complainant's children on school grounds arbitrarily without a school official present.

During the course of this investigation the ombudsman added the following allegation:

Allegation Two: OCS unreasonably conducted interviews of the subjects of reports of harm in a manner inconsistent with Alaska Statute 47.17.027 and on occasion in a manner that thwarted the intent of AS 47.17.027.

Ombudsman Linda Lord-Jenkins gave written notice of investigation to OCS Director Tammy Sandoval on July 10, 2008, in accordance with AS 24.55.140. Assistant Ombudsman Kate Shantz investigated this allegation.

BACKGROUND

In April 2008 a mandatory reporter submitted a report of harm concerning the complainant's children to OCS. On April 9, 2008, OCS Children's Services Specialist II Lori Fitzpatrick interviewed the complainant's children, at their school.

Prior to interviewing the children, Ms. Fitzpatrick presented the school with a form letter used by OCS employees to inform the school that a report of harm had been received and that an interview on school grounds was necessary. OCS caseworkers indicate on these forms whether a school official is to be present at the interview. Ms. Fitzpatrick specified that a school official was not to be present. Ms. Fitzpatrick then interviewed both children separately, without a school official present.

After conducting the interview, Ms. Fitzpatrick notified the complainant, per OCS policy, that she had interviewed his children. According to Ms. Fitzpatrick, The father/complainant was uncooperative and would not participate in an interview. The investigation concluded with a finding of unsubstantiated neglect. OCS closed the case and notified the parents via letter.

INVESTIGATION

AS 47.17.027(a)(3) requires that a school official be present during an interview of a child on school grounds. It states, in relevant part:

AS 47.17.027 Duties of school officials.

(a) If the department or a law enforcement agency provides written certification to the child's school officials that (1) there is reasonable cause to suspect that the child has been abused or neglected by a person responsible for the child's welfare or as a result of conditions created by a person responsible for the child's welfare; (2) an interview at school is a necessary part of an investigation to determine whether the child has been abused or neglected; and (3) the interview at school is in the best interests of the child, school officials shall permit the child to be interviewed at school by the department or a law enforcement agency before notification of, or receiving permission from, the child's parent, guardian, or custodian. A school official shall be present during an interview at the school unless the child objects or the department or law enforcement agency determines that the presence of the school official will interfere with the investigation. The interview shall be conducted as required under AS 47.17.033. Immediately after conducting an interview authorized under this section, and after informing the child of the intention to notify the child's parent, guardian, or custodian, the department or agency shall make every reasonable effort to notify the child's parent, guardian, or custodian that the interview occurred unless it appears to the department or agency that notifying the child's parent, guardian, or custodian would endanger the child. [Emphasis Added]

(b) A school official who, with criminal negligence, discloses information learned during an interview conducted under (a) of this section is guilty of a class B misdemeanor.

This statute was passed in 1990 as part of a comprehensive bill addressing child neglect and abuse reporting and investigation. The bill also implemented training requirements for those school district personnel required by law to report suspected cases of abuse or neglect.

As originally introduced, AS 47.17.027 simply required that school districts *allow* OCS (known as the Division of Family & Youth Services at the time the statute was enacted)

[Ombudsman emphasis] or law enforcement to conduct interviews of children on school grounds without prior notification of, or permission from, the child's parents.

A subsequent version of the bill provided that school officials "may" be present during an interview. The final version, passed by the Legislature and signed into law, dropped the discretionary "may" and inserted the mandatory "shall."

A review of the committee minutes pertaining to the bill indicate that this provision was intended to allow OCS access to children for the purpose of conducting an interview where the suspected perpetrator of the abuse or neglect is a person responsible for the child's welfare. It also provides protection to schools that allow the interview without first notifying, or getting permission from, the parent.

Several proponents of the provision testified about the necessity of allowing interviews on school grounds because it is a neutral, safe environment free from potential coercion by the alleged perpetrators. The earlier, discretionary version of the provision appears to have been prompted by a suggestion by Bob Weinstein, then-Superintendent of the South Island School District and chair of the Professional Teaching Practices Commission. Mr. Weinstein also testified that, in his view, it was important for school officials to be present during interviews to protect the rights of the children being interviewed; to ensure that interviews are terminated if the child decides that he or she no longer wishes to participate, for example.

Drafters changed the "may" to "shall" in response to discussion held between interested parties during a subcommittee meeting on this bill. The assistant attorney general who drafted the change later testified that it was intended to reflect "that the intent in most situations was to have the school officials be present." (see April 19, 1990 House Health, Education and Social Services Standing Committee minutes).

OCS Policy and Procedure 2.2.5 addresses how OCS employees are to conduct an investigation and assess a child for safety. The relevant portions state:

The worker will make diligent efforts to contact the child at home, school, childcare, or any other place where the worker believes the child may be found.
(OCS Policy 2.2.5.f.1.C)

After a worker interviews a child, the worker will make every reasonable effort to immediately notify the child's parents, guardian, or custodian that the interview occurred unless the worker believes that notifying the parents, guardian, or custodian would endanger the child or compromise the CPS or criminal investigation. (OCS Policy 2.2.5.f.1.D)

All children will be interviewed separately and away from the alleged perpetrator and/or any other adult that could compromise the investigation process. (OCS Policy 2.2.5.f.1.G)

The OCS manual does not specifically address conducting interviews on school grounds. However, the above-referenced policy does address how its employees are to interact with other third parties, such as tribes, military personnel, law enforcement, and the Department of Law. School personnel are mentioned as sources of collateral information only.

OCS' Standardized Form Letters, presented to school administration staff prior to the interview, provide the statutory authority for OCS to conduct interviews on school grounds. The letter also indicates whether a school official is to be present during the interview. As part of the ombudsman investigation, the investigator contacted 28 OCS caseworkers from all regions of the state and from different offices in those regions. The investigator determined that over the years caseworkers in different offices, apparently on their own volition, have started using several variations of the letter. Some of the variations are quoted below:

In the opinion of OCS, the presence of the District/School representative WILL/WILL NOT (circle one) be detrimental to the interview.

A school official shall or shall not be present during the interview. [AK. Statute Sec. 47.17.027. (a) (3)].

If a school official cannot be present during the interview, it is because the child objects or DHSS determines that the presence of the school official will interfere with the investigation.

A school official shall or shall not be present during the interview. [AK. Statute Sec. 47.17.027 (a) (3)].

If a school official cannot be present during the interview, it is because:

the child objects.

OR

DHSS determines that the presence of the school official will interfere with the investigation.

Lori Fitzpatrick, Children's Services Specialist II, OCS

On May 19, 2008, the ombudsman investigator interviewed Ms. Fitzpatrick about her investigation into the reports of harm OCS received regarding the complainant's children. She acknowledged she didn't allow school officials to be present while she interviewed the children. When asked why she excluded a school official from the interviews, Ms. Fitzpatrick initially said that the children had agreed to speak with her. After the ombudsman investigator explained that, under the statute, the children's consent to be interviewed was not an acceptable reason to exclude a school official from the interview, Ms. Fitzpatrick presented an alternate explanation. She said that, in her experience, children don't open up during interviews when school officials are present. She opined that their reluctance may stem from fear that the school official will relay the information disclosed during the interview to their parents.

In a follow-up interview on August 8, 2008, Ms. Fitzpatrick stated that she did not keep a copy of the letter she presented to the school for the OCS file and again reiterated that she believed she got better answers when officials are not present. Ms. Fitzpatrick's supervisor, Lori Kennell, was present during this interview. Ms. Kennell stated that most caseworkers indicate on the form that a school official is not to be present. She also stated that this topic had been discussed at a recent staff meeting in Anchorage (after the ombudsman served notice of investigation). Caseworkers are now being encouraged to have an official present during interviews that take place at school.

Dr. Eileen Lally, Director, & Jay C. Bush, Program Manager, Family & Youth Services Training Academy (Academy)

The Academy provides ongoing training and education for OCS employees in the areas of child protection services and permanency planning. The Academy conducts a two-week Training and Orientation for New Employees (TONE) course, which all new OCS social-workers and children's services specialists are required to complete. This course addresses the investigation portion of a child protection case.

Dr. Lally and Mr. Bush said that FYSTA training focuses on how the OCS employee engages with people, not the procedural aspects of conducting an investigation. They stated that OCS's regional managers are to instruct employees on the procedures used when conducting interviews at schools. They also said that it would be difficult to address the procedural aspects of conducting an interview on school grounds because each school district operates differently.

Ombudsman's Statewide Survey of OCS Employees

The ombudsman investigator surveyed a random selection of OCS employees from each region of the state on the procedures they use when conducting interviews on school grounds. The survey was intended to determine whether OCS employees were aware of the statutory duty imposed on school officials by AS 47.17.027 and whether they are sufficiently trained to conduct interviews on school grounds.

The investigator surveyed 28 employees in July and August 2008. Both supervisory and subordinate employees were interviewed.

The ombudsman investigator interviewed the Children's Services Manager for each OCS regional office: Southeastern, Anchorage, Southcentral, and Northern. The investigator also surveyed staff from offices within each region: Juneau, Ketchikan, Sitka, Bethel, Kenai, Mat-Su, Valdez, Kotzebue, Nome, Fairbanks, and each of the Anchorage investigations units.

Each participant was asked the same questions regarding conducting interviews on school grounds. The questions are listed below, followed by a summary of the participants' responses.

1. How, procedurally, do you conduct interviews on school grounds?

Participants generally reported using similar procedures when conducting interviews on school grounds. Caseworkers bring their state-issued identification and the form letter explaining OCS's

authority to conduct the interview. They generally present the letter to an administrator at the front desk, who then gathers the child and finds an appropriate space for the interview. Some participants reported that they ask the child if he or she wants a third party, such as the school nurse or counselor, present during the interview.

Several supervisors expressed the opinion that caseworkers in rural areas may not use the form letter at all. The supervisors believed that this may be due to the fact that employees located in the villages may be more familiar with the school staff than those caseworkers located in urban areas of the state.

Survey respondents indicated that their training was limited to the procedures listed above. Participants also reported that, during the school year, the majority of interviews take place on school grounds.

The ombudsman investigator scheduled interviews with eight members of the Anchorage investigations units, as well as the office's Children's Services Manager, over the course of approximately two weeks. The first five respondents reported that the decision to exclude a school official was left to the discretion of the employee. The last four participants indicated that school interviews had been a topic during a recent staff meeting and that Anchorage employees are now being encouraged to have a school official present during interviews. This apparent change in policy may or may not be attributable to the notice of this investigation issued by the ombudsman's office.

2. Have you ever determined that a school official's presence would interfere with the interview?

Responses to this question varied widely. Both of the Bethel respondents said they always indicate that a school official's presence would interfere and, in fact, the form letter that each submitted to the ombudsman investigator had been permanently modified to that effect. Other respondents stated that they generally indicated "shall not be present" on the form letter because the OCS manual instructs investigators to interview children alone.

Several respondents indicated that they rarely excluded school officials.

The most common reasons given for excluding an official was because that official was known to interfere, by asking leading questions or visibly reacting during disclosures of abuse. Another reason given for excluding school staff was because the topic of the interview was unusually sensitive, such as alleged sexual abuse.

Many of the respondents indicated that having a school official present can be helpful when conducting an interview, especially if the official is familiar to the child and can help the child feel at ease. Several participants indicated that they simply leave the choice to the child; if the child wants an official there then the official will be included.

The majority of participants, however, did not appear familiar with the statutory requirement that an official attend an interview unless the child objects or OCS determines that an official's presence will interfere.

One respondent stated that, if parents do not have a right to be present during an interview, he did not know why a school official would be allowed.

3. Does your office utilize specific criteria or guidelines to assist you in making a determination that an official's presence will interfere?

No respondent could identify an established, written policy, either regionally or statewide, that addressed conducting interviews on school grounds, including making a determination that a school official would interfere with an interview.

Several supervisors said that the decision to exclude school officials is left to the discretion and judgment of the investigators.

Several participants said the OCS manual required caseworkers to interview children alone. The ombudsman investigator presumed that these respondents were referring to OCS manual provision 2.2.5. All of these participants interpreted the provision to mean that the interview must be conducted with only the child present.

4. If you have indicated that an official is not to be present during the interview, did you document this in the case file?

None of the participants who have excluded school officials documented the exclusion, or the reasons for excluding, in the case file.

5. Do you feel that your office has a good working relationship with the school districts in your region, and what contributes to the relationship?

Participants overwhelmingly reported a good relationship with the school districts their offices cover. Participants repeatedly mentioned the same factors as contributing to a positive relationship. They mentioned the mandatory reporter training that OCS provides for district employees, maintaining open communication, maintaining a respectful attitude, and regularly keeping in contact with school staff.

However, participants also reported examples of friction between OCS and school districts. One respondent said she has experienced school personnel attempting to get faster responses from OCS by submitting exaggerated reports of harm. Several reported the belief that school personnel need additional education on OCS' purpose and authority. They specifically cited occasions where school personnel, contrary to law, notified a child's parents before allowing OCS to complete an interview. Respondents also mentioned school personnel making reports of harm for issues which, by themselves, may not be appropriate subjects for investigation such as poverty related issues like homelessness or cleanliness problems.

6. Would you, or your co-workers, benefit from additional guidance on how to conduct interviews on school grounds?

Respondents generally favored the idea of a policy or procedure to address interviews on school grounds. However, one respondent stated that the OCS manual is long, caseloads are high, and employees don't have time to read policy. The same respondent stated, however, that it would probably be helpful to have a specific policy addressing school interviews because employees refer to the manual when they have questions. Several participants mentioned high employee turnover as a reason to formulate a policy regarding school interviews. One participant said that a policy would be beneficial because everyone conducts interviews a little bit differently.

Three of the four supervisory staff surveyed expressed support for a specific policy to address interviews on school grounds.

A common concern raised by participants, however, was that an additional policy would lead to additional bureaucracy for OCS staff. Others believed that another policy might be too rigid and constrain OCS caseworkers unnecessarily; they stated that, if adopted, a new policy should be phrased as a guideline, rather than as a strict requirement.

ANALYSIS AND PRELIMINARY FINDINGS

The standard used to evaluate all Ombudsman complaints is the preponderance of the evidence. If the preponderance of the evidence indicates that it is more likely than not that the administrative act took place and the complainant's criticism of it is valid, the allegation is found justified.

The ombudsman investigated the following allegations:

Allegation One: OCS interviewed the complainant's children on school grounds arbitrarily without a school official present.

The Office of the Ombudsman's Policies and Procedures Manual at 4040(5) defines *Arbitrary* in pertinent part as:

(B) the agency's action or decision was based on a delegation of authority to the agency under inadequate standards;

(D) the agency's action or decision was not based on a conscientious consideration of all relevant factors.

Allegation Two: OCS unreasonably conducted interviews of the subjects of reports of harm in a manner inconsistent with Alaska Statute 47.17.027 and on occasion in a manner that thwarted the intent of AS 47.17.027.

The Office of the Ombudsman's Policies and Procedures Manual at 4040(2) defines an administrative act as unreasonable if:

(A) the agency adopted and followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of the program,

(B) the agency adopted and followed a procedure that defeated the complainant's valid application for a right or program benefit, or

(C) the agency's act was inconsistent with agency policy and thereby placed the complainant at a disadvantage relative to all others

AS 47.17.027 requires that a school official "shall be present" at an OCS interview conducted on school grounds unless either:

(1) the child objects, or

(2) the department determines that the official's presence will interfere with the investigation.

This plain language of the statute places the duty on the school official to be present when OCS caseworkers interview children on school grounds. In order for a caseworker to exclude a school official, the caseworker must determine that the official's presence will interfere with the investigation.

Research into the legislative history of the statute revealed that the drafters intended a presumption in favor of school officials being present when children are interviewed. It would therefore negate both the intent and plain language of the statute for OCS workers to make a wholesale determination to exclude school officials from all interviews they conduct on school grounds. Individualized decision making is clearly required under the statute.

However, the statute does not supply any guidelines or criteria to consider when making a determination that an official's presence would interfere with a report of harm interview, and OCS has not created any regulatory or policy guidelines in the 18 years since this statute was implemented.

Further, the plain language of the provision requires that the child be interviewed apart from the alleged perpetrator and anyone who may "compromise the investigation process."

OCS policy 2.2.5 specifies that children are to be interviewed apart from any adult who could compromise the interview process. The manual simply does not require that children always be interviewed alone, as some survey respondents indicated. The policy also does not provide any guidelines for determining whether the presence of a third party may compromise the interview process. Furthermore, while the policy addresses interactions with other third parties, such as law enforcement, medical and military personnel, and tribes, it does not address interactions with school personnel.

Ombudsman standards at 4040(5)(B) define arbitrary, in part, as a delegation of authority under inadequate standards. Because AS 47.17.027 does not contain any standards for OCS employees to employ when making a determination to exclude a school official, it appears that OCS

employees are granted some measure of discretion when making a determination. However in the 18 years since AS 47.17.027 was enacted, OCS has not developed any policy specifically addressing interviews on school grounds. A lack of any standard whatsoever is patently inadequate and, thus, creates the potential for arbitrary actions by OCS employees.

In the complaint that triggered this investigation, the OCS caseworker presented the form letter to the school and specified that an official was not to be present. In her interview with the ombudsman investigator, Ms. Fitzpatrick gave conflicting reasons for why she interviewed the children alone. Initially, she said that the children agreed to be interviewed. She later indicated that she made the decision to exclude a school official because she believes children are more forthcoming without a member of school staff present.

Neither of Ms. Fitzpatrick's proffered reasons for excluding a school official appears to be reasonable exercises of her discretion. That the children agreed to the interview is not an acceptable reason, under the statute, to exclude a school official.

Ms. Fitzpatrick's second rationale for exclusion, that children are unwilling to make disclosures with officials present, may at times have some merit. There may indeed be occasions where children are unwilling to disclose with an official present. However, there may also be occasions where children are more likely to make disclosures when an official *is* present because the child knows and trusts that person. Thus, Ms. Fitzpatrick's second rationale for excluding school officials was not reasonable unless she explained, specifically, why she did not believe the complainant's children would make disclosure with a school official present.

Ombudsman Standards at 4040(5)(D) defines an arbitrary action as an action or decision not based on a conscientious consideration of all relevant factors.

Ms. Fitzpatrick admitted she didn't allow Anchorage School District officials to sit in on her interview with the complainant's children in accord with AS 47.17.027. She instead notified school officials that they would not be allowed in her interview with the complainant's children. The agency provided Ms. Fitzpatrick no standards upon which to base this decision. That opened the way for the caseworker to make an arbitrary decision.

Ms. Fitzpatrick did not make an individualized decision based on the all relevant circumstances of the complainant's children's situation, but rather relied on her assumption that children in general do not disclose instances of abuse when officials are present. A blanket decision to exclude school officials certainly cannot be considered the kind of individualized determination contemplated by the statute at issue. That being said, it does not appear that Ms. Fitzpatrick acted with ill will when she barred school officials from her interviews of the complainant's children.

However, the caseworker did not consider all relevant factors in *this* case involving *these* children. Her decision was arbitrary.

Therefore, the ombudsman proposes to find Allegation One that OCS interviewed the complainant's children on school grounds arbitrarily without a school official present justified.

Allegation Two: OCS unreasonably conducted interviews of the subjects of reports of harm in a manner inconsistent with Alaska Statute 47.17.027 and on occasion in a manner that thwarted the intent of AS 47.17.027.

The complaint at hand is illustrative of a larger problem. When surveyed, OCS employees from all regions of the state appeared to have no knowledge of the statutory requirement placed on school officials by AS 47.17.027.

OCS employees do not have a consistent method for making a determination to exclude school personnel from interviews. Survey respondents espoused many differing views regarding the usefulness of school personnel – some believe that a familiar face puts children at ease and facilitates disclosures while others believe that the presence of a school official prevents full disclosure. Several stated that they always exclude officials, while others said they only exclude if the child does not want an official there during the interview.

Although AS 47.17.027 requires school officials' presence, it also allows for some measure of discretion, yet there are no standards to guide OCS employees in their decision-making process. Employees are unaware of the statutory duty placed on school officials and exercise their discretion inconsistently. Left to their own devices, some have opted to disregard the intent of the statute. This is especially troublesome in light of the survey responses indicating that the majority of interviews take place on school grounds.

The Ombudsman's survey of OCS offices statewide showed that caseworkers either don't know what AS 47.17.027 requires or ignore it. Although OCS years ago issued standard language to caseworkers to help them adhere to the statute, individual offices have amended or now ignore the agency-sanctioned language. Investigation also showed that many OCS caseworkers issue blanket exclusions to school staff without considering the issue on an individual basis, in violation of the spirit of the statute. The agency has failed to establish guidelines to help caseworkers determine when excluding a school official is appropriate. The absence of a statewide policy and procedure addressing school interviews 18 years after the Legislature passed the statute is untenable. This practice is inconsistent with, and fails to achieve, the purposes of the statute. That is unreasonable.

Therefore, the ombudsman proposes to find Allegation Two that OCS unreasonably failed to conduct interviews of the subjects of reports of harm in a manner consistent with AS 47.17.027 and on occasion in a manner that thwarted the intent of the statute **justified**.

Office of Children's Services Director Tammy Sandoval responded on behalf of the agency to the ombudsman's preliminary report. Director Sandoval stated:

Allegation 1 indicates that OCS arbitrarily interviewed the child on school grounds without a school official present. The decision to interview the child on school grounds was not arbitrary but based on statutory requirements. The component that appears to have been arbitrary in nature was the worker's determination of whether a school official should or should not be present.

Allegation 2 indicates that OCS failed to conduct interviews in compliance with statute and in a manner that thwarted the intent of the law. OCS concurs that staff throughout the state have not always adhered to the intent of the statute. However, it is worth noting, that these discrepancies do not generally reflect a purposeful intention to bypass the law, but more so reflect the pervasive lack of understanding on this issue.

Overall OCS concurs with the findings of the investigation and agrees with the proposed recommendations. This is a practice issue that is not sufficiently covered by our policy and procedures. The OCS philosophy supports the role of school officials in the interview process and welcomes increased participation. Additionally, we recognize that it is important to provide education to the appropriate school officials so they are aware of this statutory requirement.

RECOMMENDATIONS

OCS, at some point, developed a form letter for its investigators to present to school administrators when conducting interviews on school grounds. The letter cites OCS's statutory authority to conduct an interview on school grounds and provides a place to make a record of whether OCS has determined that a school official will interfere with the interview.

The letter, however, appears to have been modified by the various OCS offices and several versions submitted to the ombudsman investigator no longer reflect the statutory language of AS 47.17.027. The ombudsman therefore recommends the following:

Recommendation 1: OCS should re-standardize the letter of introduction used by caseworkers and presented to school personnel when interviewing children on school property to mirror the language of AS 47.17.027.

OCS agreed with this recommendation.

The agency response satisfies the intent of the recommendation.

* * * * *

Because multiple survey respondents indicated that a large percentage of interviews occur on school grounds, it is imperative that OCS caseworkers are adequately educated about the statutory duty of school officials to be present during interviews on school grounds. Of equal import is the need to provide caseworkers with appropriate criteria to decide if it appears that an official's presence will interfere with the protective services investigation.

The policy should address the procedure for conducting interviews, such as bringing state-issued identification and the use of the standard form letter. The policy should also address the duty of school officials to be present and include the circumstances in which it may be necessary to exclude an official.

The ombudsman recognizes that school districts operate differently. As such, it would be impossible to address the various nuances that OCS employees may encounter within each district. It is possible, however, to address those aspects of the interview process that are consistent statewide. For example, all employees are instructed to bring their state-issued identification cards and the form letter with them when conducting an interview on school grounds. Additionally, regardless of their location, school officials are required to be present during the interview, absent a finding that their presence will interfere or the child's objection. OCS should develop a policy that addresses, at minimum, these aspects of conducting an interview on school grounds.

The ombudsman also appreciates the concerns voiced by OCS caseworkers regarding the usefulness of an additional policy to address interviews on school grounds. An additional policy certainly could add unnecessary bureaucracy to the investigative process, which often requires quick decision-making. A rigid policy could constrain necessary action. For these reasons, the ombudsman recommends that OCS adopt a flexible, guideline-based policy, rather than a mandate-based policy.

For example, child protective services employees in Portland, Oregon use the following guidelines when assessing whether an official should be present during an interview:

1. The child may be disinclined to disclose the abuse in front of a school official that they see every day for fear of shame or humiliation.
2. The school official is acquainted with or has a relationship with the parent or the offending party.
3. The parent/offending party is well-known or respected within the community.
4. The child already feels "victimized" within the school system because of problems at school, such as academic or disciplinary problems.
5. The school official has a history of interference with (CPS) interviews.
6. Law enforcement is also present so there is no need for the presence of an additional party.
7. The abuse is especially disturbing and horrific and the child is too vulnerable to be aware of boundaries or privacy rights when being interviewed.
8. The case is murky or previous investigations were impossible to substantiate so accurate information is critical, and another presence may cause unintentional influence or interference.

If any of those criteria are met, the CPS employee may choose to exclude the official from the interview.

The ombudsman therefore recommends the following:

Recommendation 2: OCS should develop a policy or procedure to specifically address interviews on school grounds.

OCS Director Sandoval responded:

OCS will revise Policy and Procedure 2.2.5 to provide more specific and detailed guidance to workers about the statutory requirement to specifically address interviews on school grounds and will outline criteria where deviation from this requirement might be appropriate.

The agency response satisfies the intent of the recommendation

* * * * *

By statute, a school official is required to attend protective services interviews taking place on school grounds unless the child objects or OCS determines that the official's presence will interfere. It only makes sense to document in the case file the decision to exclude, and the reasons for doing so, to ensure that the file accurately reflects all actions taken during the course of the investigation. The ombudsman therefore recommends the following:

Recommendation 3: OCS should develop a method for documenting in the case file the reasons why a school official has been excluded from an interview.

Director Sandoval noted:

Included in the policy revision planned as noted in 2 above, guidance will be provided on documenting the justification for why a school official was excluded from an interview.

The agency response satisfies the intent of the recommendation

Many school district personnel are not aware of the duty imposed on them to be present during child protective services interviews. As such, OCS should incorporate information regarding this duty into the training that it already provides to many school districts regarding the duties of mandatory reporters, to foster compliance with AS 47.17.027. This training should include a discussion of OCS's behavioral expectations of school officials who are present at interviews. The Ombudsman therefore recommends:

Recommendation 4: OCS should incorporate information about the duty imposed by AS 47.17.027 into its mandatory reporter training curriculum.

Director Sandoval stated:

OCS does not have a standardized curriculum for educating mandatory reporters about their reporting responsibilities. Every region approaches the training of their communities, schools in particular, in different ways based on that community's norms. OCS shall provide guidance to each regional Children's Services Manager (CSM) about the need to highlight 47.17.027 with the school officials in their community.

The ombudsman understands the need to tailor training to community needs, but remains concerned that allowing each region to tailor training will again end up with inconsistent practice. That reservation notwithstanding, the agency response satisfies the intent of the recommendation.

Several caseworkers stated that outsiders' presence in abuse interviews negatively affect the quality of information gained. If the agency can substantiate that assertion with facts or scientific study, OCS should contact the Legislature to discuss the value of this statutory requirement. The ombudsman takes no stand on this issue other than the recommendation that OCS address the issue rather than ignore the statute. Therefore, the ombudsman recommends:

Recommendation 5: If, after review of these findings and recommendations and its own policy and procedure, OCS believes that the presence of school officials in Report of Harm interviews on school property is detrimental to the quality of the information obtained, OCS should approach the Alaska Legislature's two HS&S committees to discuss a change in the law.

Director Sandoval stated:

OCS does not believe that the presence of school officials is detrimental to the quality of the information obtained, barring rare circumstances. Therefore, OCS will not be advocating to have AS 47.17.027 modified.

The agency response satisfies the intent of the recommendation.

The complainant's children were interviewed by an OCS caseworker without a school official present. The decision to exclude was arbitrary. AS 47.17.027 creates a presumption that school officials will be present during interviews taking place on school grounds – this is the rule, not the exception. Part of the reason this requirement was put into law was to ensure that children's rights are adequately protected during child protective services interviews. The complainant's children were not provided that protection and for that, they deserve an apology. Therefore the ombudsman recommends:

Recommendation 6: OCS should issue a letter of apology to the complainant's and their children.

OCS agreed with this recommendation and will issue a letter of apology. The letter of apology was sent to the complainants in January.

The agency response satisfies the intent of the recommendation

Director Sandoval concluded:

The Office of Children's Services found the Ombudsman investigation and subsequent report to be thorough and accurate overall. We appreciate the opportunity to remedy and improve practice and policy as problematic areas are identified. These changes to practice will serve to further our efforts to standardize practice along the entire case continuum.

OCS will forward copies of the finalized P&P and a copy of the form caseworkers will be expected to use by the end of April 2009.

FINDING OF RECORD AND CLOSURE

Based on OCS's response to the proposed finding of justified, this overall complaint has been closed as justified.

OCS accepted Recommendation One, Two, Three and Six. The agency's response satisfied the intent of Recommendation Four pertaining to notifying school districts of their responsibilities under AS 47.17.027 but the ombudsman remains concerned that the inconsistent practice will result. In answer to Recommendation Five, OCS stated that it sees no need to seek amendment or revocation of AS 47.17.027. The agency response satisfies the intent of the recommendations.

This complaint will be closed with an overall finding of justified and rectified.

PUBLIC VERSION

4/9/09
TRAUMA
CARE
IN
ALASKA

TRAUMA CARE IN ALASKA 2009

Frank Sacco MD, FACS

Alaska Trauma Systems Review Committee



Introduction

“If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped.”

C. Everett Koop, MD, ScDC. ScD
Former US Surgeon General
Former General Chairman, The National SafeKids Campaign

Treating Trauma

- Like heart disease or cancer, trauma is best combated with a strategy that addresses prevention, acute care and rehabilitation.

Introduction

- Injury is a major public health problem
 - ▣ Leading cause of death in 1st 4 decades of life
 - ▣ Leading cause of loss of productivity

- Despite obvious magnitude little public focus
- Significant progress in individual patient care
- Trauma systems shown to save lives

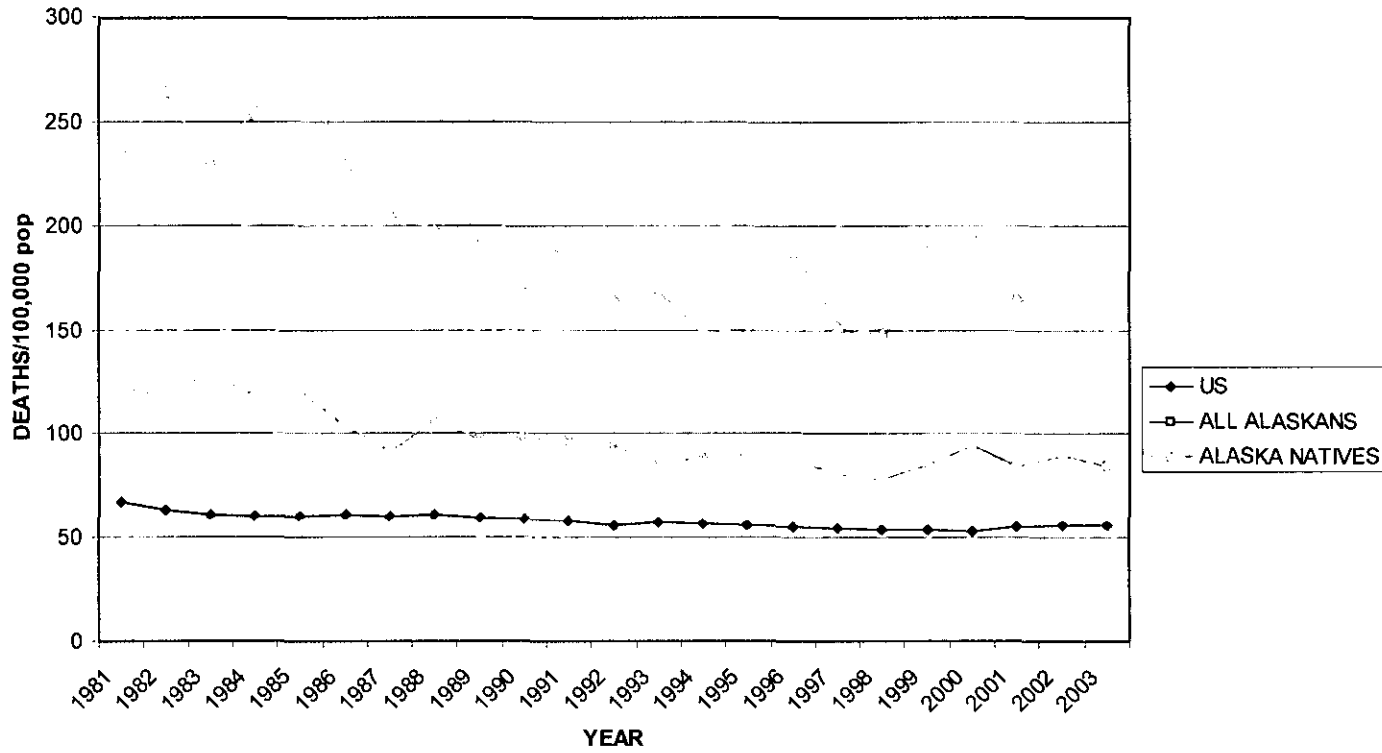
Trauma in Alaska

- Leading cause of death age 1-44.
- 400-500 alaskans die each year.
- Over 5000 admitted to the hospital.
- Over 1000 with permanent disability.
- 800 alaskans hospitalized with brain or spinal cord injuries.

DEATH FROM TRAUMA IN ALASKA



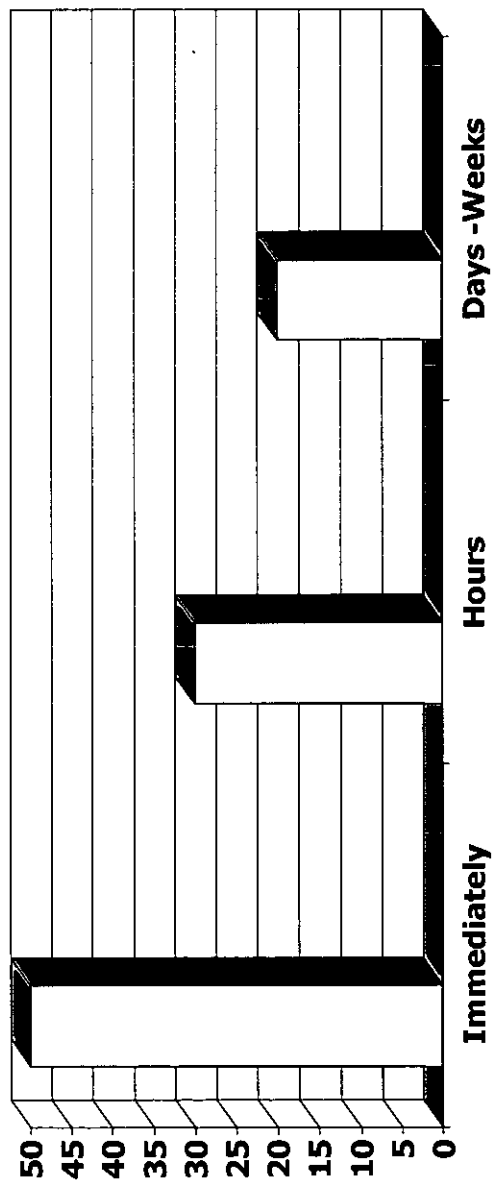
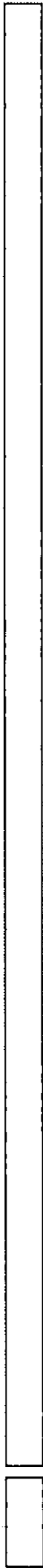
AGE ADJUSTED MORTALITY FROM TRAUMA



Trauma in Alaska

- Motor vehicle crashes leading cause of death.
- Firearm related injuries, second.
- 2004 hospital cost for Alaska trauma patients over \$73 million.
- ~ 25% over trauma admissions uncompensated.

Death from Trauma



Trauma Systems

- u A trauma system consists of hospitals, personnel, and public service agencies with a preplanned response to caring for the injured patient.

Trauma Systems

- u Facilities (trauma center designation)
- u Personnel (training)
- u Patient transport
- u Triage

Facilities-Trauma Centers

- Level I -Definitive subspecialty care, research.
- Level II – Definitive subspecialty care, surgery, ortho, neurosurgery.
- Level III- General surgery, ortho no neurosurgery
- Level IV- Stabilization, limited or no surgical capacity

Personnel



- ATLS
- TNCC
- RTTDC
- ETT first responders

Transport and triage

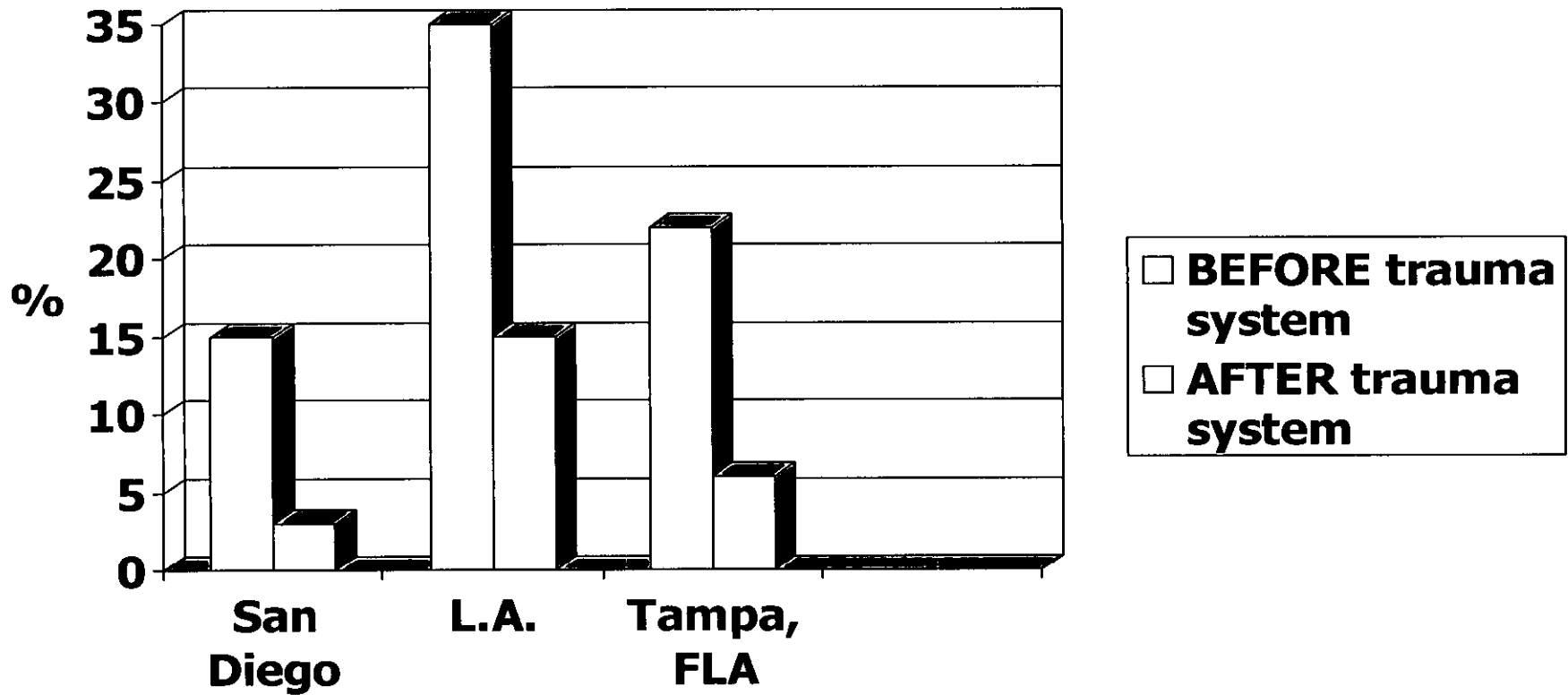


- Guidelines that take into account local resources and capabilities.
- Head Injury Guidelines
- Burn Triage

Trauma Systems

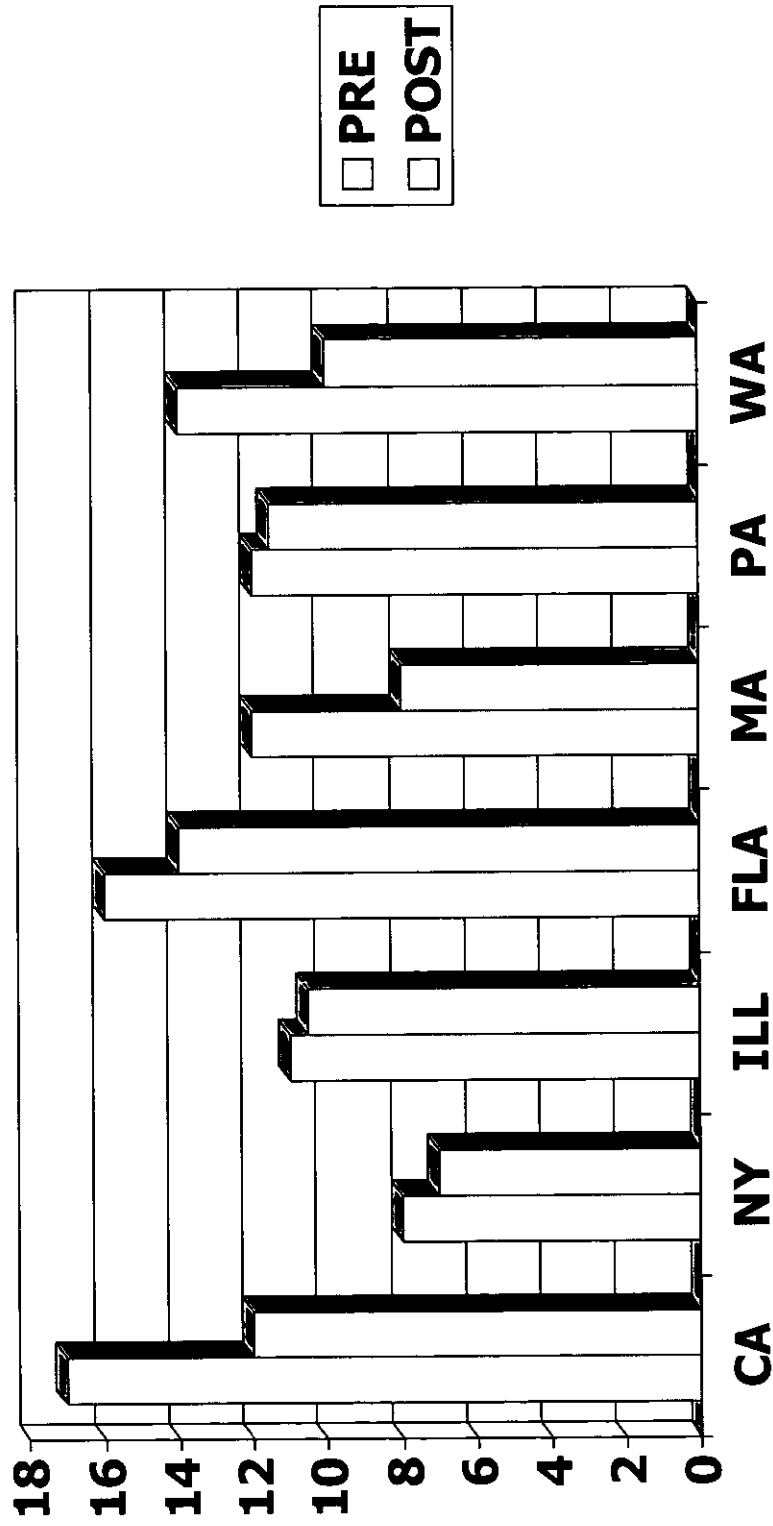
- 15-25% improvement in survival of the seriously injured.
- Increase productive working years
- Improve statewide disaster preparedness.
- Inclusive systems

Preventable Deaths: The impact of trauma systems



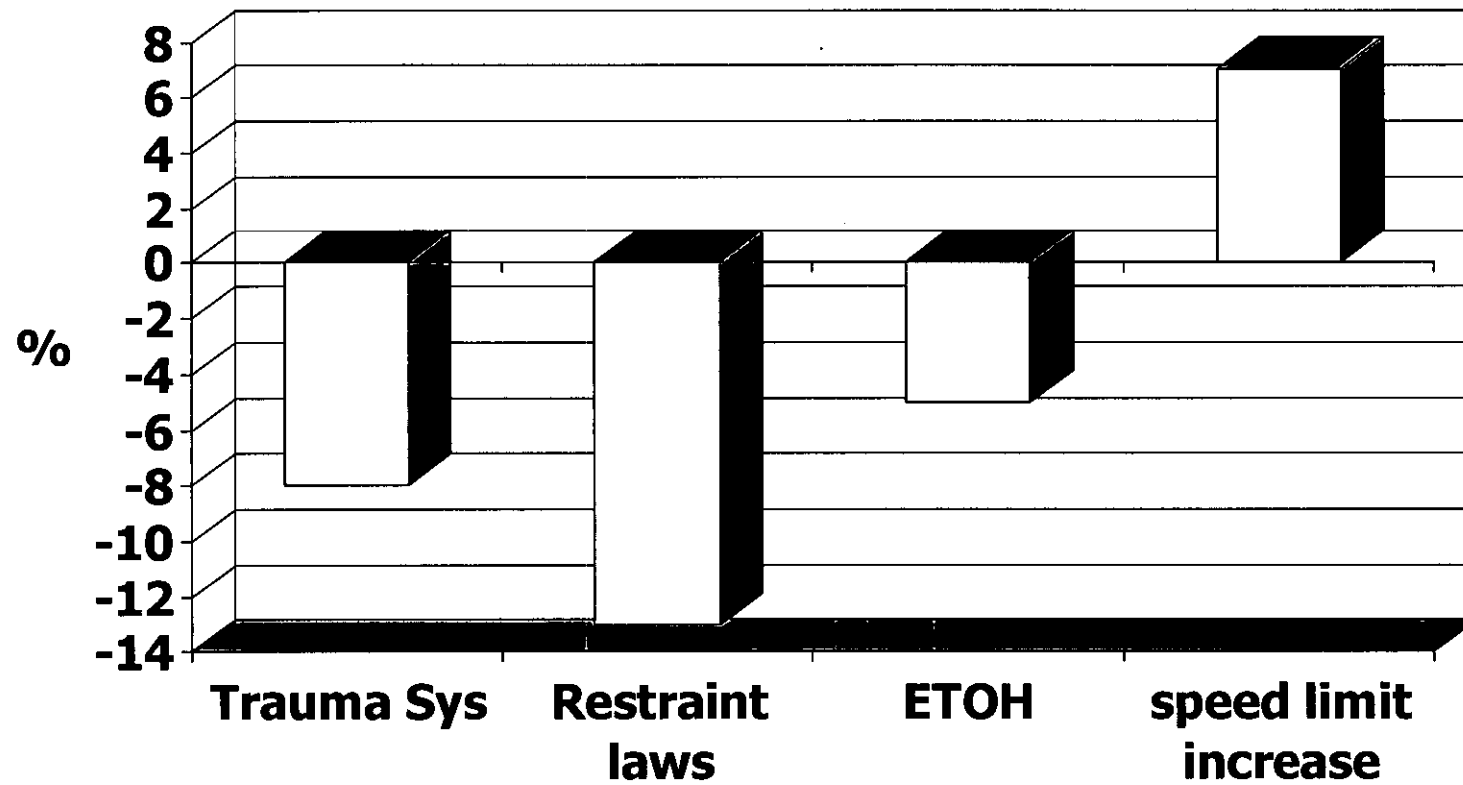
Trauma Systems & crash mortality

Nathens et.al. 2000



Trauma systems & crash mortality

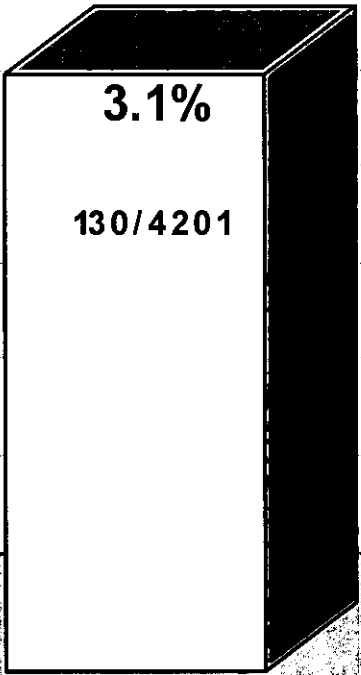
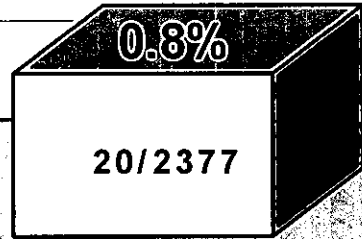
Nathens et.al. 2000



Anchorage Mortality Rate 2005-2007

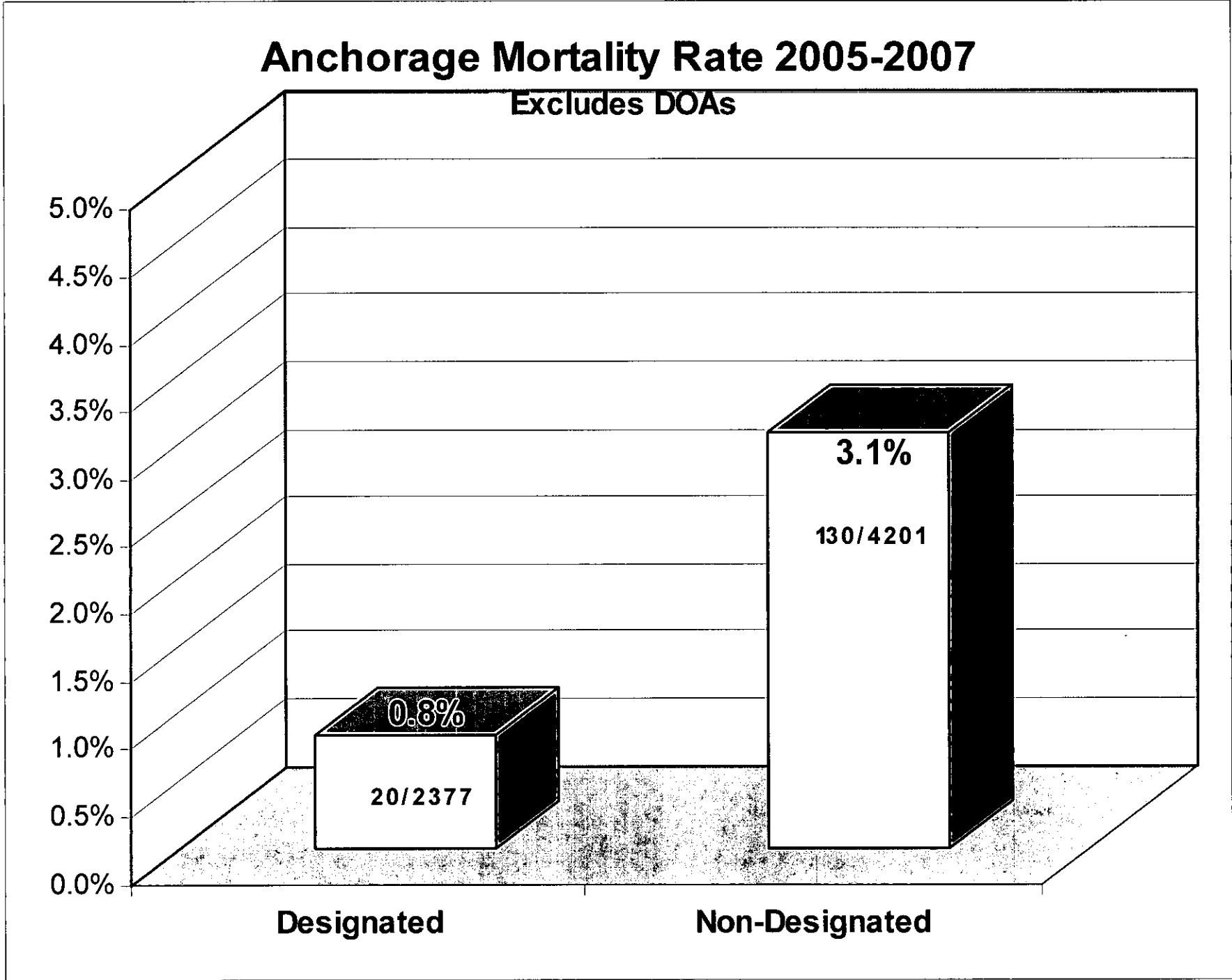
Excludes DOAs

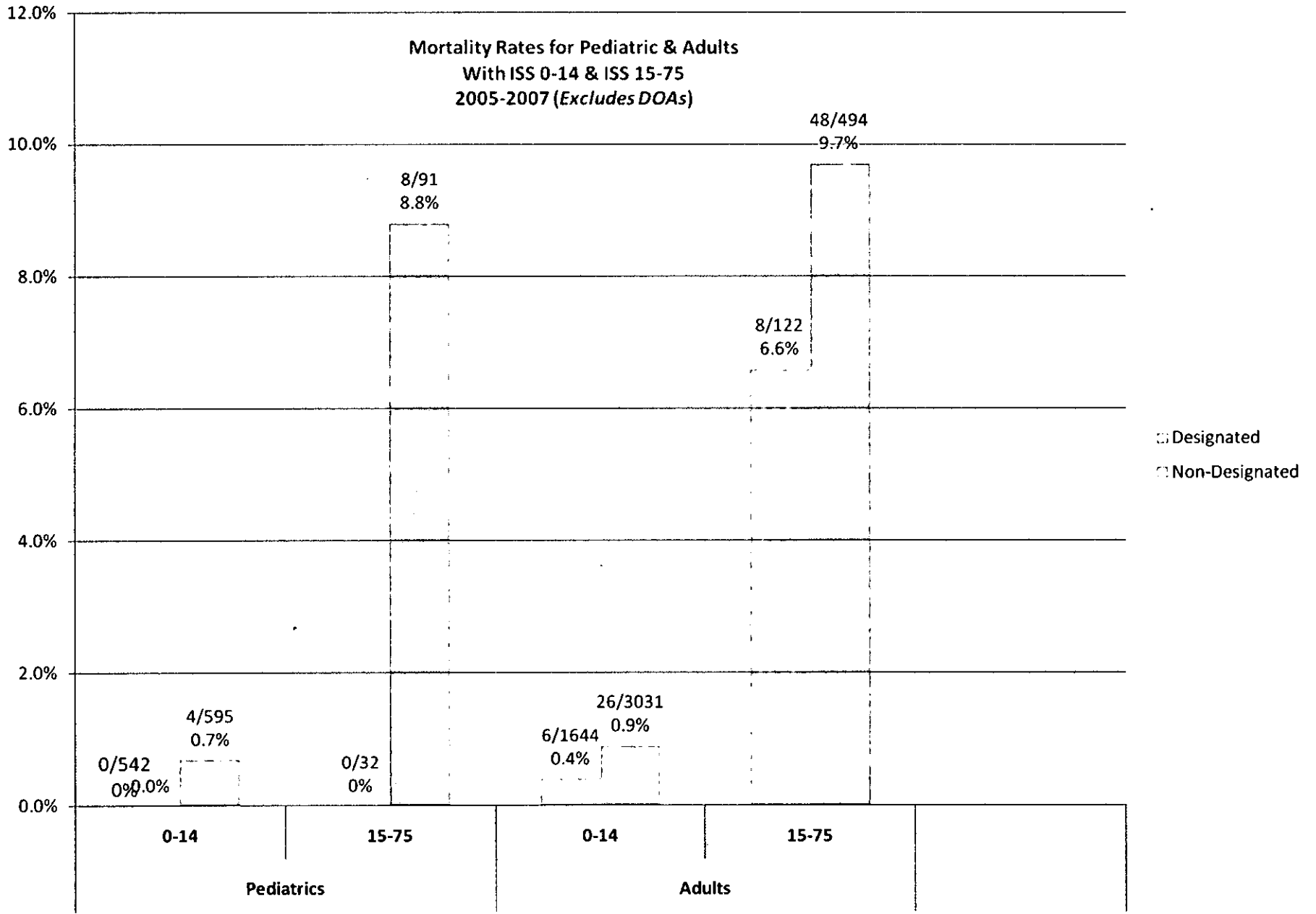
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%



Designated

Non-Designated





Trauma Center and Disaster Preparedness

- Maintain readiness
- Staffed for all types of injury
- Broad communications with regional hospitals and aeromedical resources.
- Surge capacity
- Decontamination
- Resources to facilitate patient recovery

Trauma Systems and the Public

- 2004 Harris poll
- Most people want a trauma system in their area.
- 83% felt it was as important as fire department and were willing to pay extra for it

Trauma Systems and the Public

- 75% of those interviewed “thought” there was a trauma system in their state but only 15% lived in states with comprehensive systems

People think a trauma is very important and they want it.

Most think they already have it and they don't.

Alaska Trauma System

- ❑ **1993 statute- EMS authority for designating trauma centers created.**
- ❑ **Hospital participation voluntary.**
- ❑ **Standards for trauma center designation follow American College of Surgeons criteria.**

Alaska Trauma System

- u **Verification of compliance by outside reviewers for Level I, II, III**
- u **In-state review for Level IV**

Current Status

□ **Twenty–four hospitals in Alaska**

□ **Verified / Certified**

- 1 level II center - ANMC
- 4 level IV centers- NSH -MEH - YKHC –SCH
- 9 other reviews or consultations.

□ **Non-Verified**

- 2 centers providing care for multiple trauma patients
- 6 centers that provide surgical capabilities
- 2 military hospitals

State of Alaska:Trauma System Consultation November 2-5 2008

Site Visit Team

- Reginald A. Burton, MD FACS
Team Leader, Trauma Surgeon
- Jane Ball, RN, DrPH
ACS Consultant
- Samir M. Fakhry, MD FACS
Trauma Surgeon
- Holly Michaels
ACS Program Coordinator
- Drexdal Pratt, CEM
State EMS Director
- Nels Sanddal, PhDc, REMT-B
ACS Consultant
- James D. Upchurch, MD
Emergency Physician

Objective

- To help promote a sustainable effort in the graduated development of an inclusive trauma system for Alaska

Advantages & Assets

- Very committed individuals who use their time and expertise every day to serve Alaska citizens
- Extensive networks for transport
- 3 large medical centers with extensive subspecialty expertise within the state
- Large Level I trauma center in Seattle which freely accepts adult and pediatric trauma patients

Advantages & Assets

- One center maintaining ACS Level II verification standards and other small hospitals working toward Level IV verification
- Alaska Trauma Registry with all 24 acute care hospitals providing data
- Injury prevention activities are well established
- Initial efforts at legislative change

Challenges and Vulnerabilities

- No trauma system plan
- Geography / Weather / Remote and isolated communities
- No trauma standards for scene trauma triage or trauma inter-facility transfers
- Trauma system issues have limited visibility within the DHSS
- Public not aware of trauma system issues
- Limited human resources
- Few incentives for hospitals to participate
- No statewide evaluation of system performance

Trauma Care in Alaska 2009

- “ There are two healthcare systems for injured patients. One for Alaska natives that adheres to national standards and another for the majority of the population”

Definitive Care Facilities

- **Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with ACS COT verification criteria to meet the existing volume and acuity demands.**
- **Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center designation appropriate to their capabilities.**

Definitive Care Facilities

- ❑ **Study pediatric trauma care needs and establish one or more in-state centers of excellence in pediatric trauma care.**
- ❑ **Determine a method of providing financial support for hospitals designated/certified by the state as trauma centers to assist with uncompensated care and the cost of readiness**

System Coordination and Patient Flow

- Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).**

Financing

- **Provide state funding to hire a fulltime trauma system manager.**
- **Determine a method of providing financial support for hospitals designated/certified by the state as trauma centers to assist with uncompensated care and the cost of readiness.**

Alaska Trauma Systems Review Committee

- MDs, nurses, admin, and prehospital. Meet twice a year.
- Oversight- Trauma designation Level IVs
 - EMS/ prehospital triage and interfacility transfer guidelines
 - Trauma system performance improvement.

Head Injury Guidelines for Rural and Remote Alaska

- Developed 2004 by an ad hoc group of the trauma systems review committee.
- Adopted mostly by the tribal system.
- Decreased unnecessary medevacs from the bush 75%. Saving of over \$300,000 medevac costs.
- No adverse consequences.

Current Activity US

- 2008 Georgia \$60,000,000 to create trauma fund.
- 2009 Arkansas \$20,000,000 to develop statewide system of trauma center
- Federal legislation currently being considered in the House and Senate.

Alaska Trauma System: Where do we go now ?

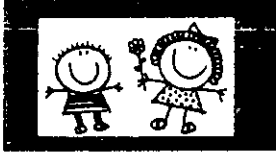
- Increasing facility participation is essential to developing an inclusive system.

- “Carrots and/or sticks”

- The time has come, this legislation can save lives.

2/2/10

**REPORT:
CHILDREN'S
JUSTICE
TASK
FORCE**



Alaska Children's
Justice Act Task
Force

Sara Gray, Coordinator
Cathy Baldwin-Johnson MD, Chair
Jan Rutherford, Co-Chair
Shannon Baergen
John Bioff
BJ Coopes MD
Cyndy Curran
Derek DeGraaf
Bradley Grigg
Judge Charles Huguélet
Thom Janidlo
Lance Joanis
Pam Karakunas
Mike Lesmann
D Owens
Jared Parrish
Diane Payne
Barb Ramos
Cindi Stanton
Fred Van Wallinga
Rob Wood
Doug Wooliver

Visit our website at:
[http://hss.state.ak.us/ocs/
ChildrensJustice/](http://hss.state.ak.us/ocs/ChildrensJustice/)

Contact us at:
Phone: 907-465-3207
Fax: 907-465-3656
Sara.Gray@alaska.gov

Alaska CJATF Legislative Presentation 2/2/10

Overview

Title: Intro to the Alaska CJATF and recommendations for 2010-11
Presenter: Cathy Baldwin-Johnson MD, Chair

Background

- History of CJATF
 - 2009 projects
 - 2010 projects
 - Concerns noted by CJATF
1. Inconsistent interpretation of use of CACs statute
 2. Ability to assure confidentiality of medical and forensic interview peer review
 3. Inability of current assault statutes to adequately protect children

Recommendations

1. Clarification of use of required CACs where possible to include law enforcement
2. Minor revision to medical peer review confidentiality statute to include CAC organizations
3. New statute to allow confidentiality of forensic interviewing peer review
4. Evaluation of current criminal assault statutes as they relate to children with consideration of separate child assault laws



Our Mission: Identify areas where improvement is needed in the statewide response to child maltreatment, particularly child sexual abuse, make recommendations, and take actions to improve the system.

The Alaska Division of Public Health, Section of Women's Children's and Family Health,
Maternal and Child Health Epidemiology Unit
Alaska Surveillance of Child Abuse and Neglect (SCAN)

Overview of presentation

Title: Who, What, and Where of Fatal Child Abuse in Alaska

Presenter: Jared W. Parrish, MS

Background

- The Centers for Disease Control and Prevention recognizes child maltreatment (CM) as a serious public health problem
- Research indicates there are many resulting long-term health effects such as drug addictions, suicidal behavior, teenage pregnancy, obesity, and mental health problems resulting from CM

Public Health Implications

- No single agency has jurisdictional responsibility of all CM.
 - Child protective services address in home CM
 - Law enforcement responds to criminal CM.
- No standardized definition dictates what CM is, thus making comparisons and magnitude assessments impossible.
- The Alaska Surveillance of Child Abuse and Neglect (SCAN) links pre-existing data together to identify unique cases of maltreatment
 - Apply a standardized CDC developed public health definition of CM.
 - Using the Public health model as opposed to the legal model to CM, where prevention not conviction/prosecution is the priority the definition can be very sensitive to ensure all possible cases are captured. Thus the true magnitude of the problem, factors predisposing a child to CM, changes in rates of time, and effectiveness trials can be properly assessed.
 - SCAN is in its third year, and is 100% funded by the Title 5 MCH block grant
 - Currently mortality surveillance linkages multiple data sources and applies a working case definition to identify cases of maltreatment-confirmed, related, or suspected cases.
 - Morbidity surveillance is still being developed and will be implemented statewide, but employ a sentinel surveillance approach using regional hub sites to identify confirmed, related, and suspicious cases.
 - SCAN identifies, parent caregiver factors, incident factors, environmental/family factors, and child factors, and collects CDC developed data elements for epidemiological investigation.

Mortality Data

- Upon investigation of all infant deaths occurring in Alaska from 1992-2005, the death certificate (DC) identified 22 cases of maltreatment/homicide as a cause or contributor to death (0.15 per 1,000 live births). Including the related cases identified by SCAN the number increased to 74, and 133 with suspected cases (0.52 and 0.93 per 1,000 live births respectively). Among the 133 maltreatment-related cases, 35% were abuse (SBS, blunt force trauma), and 65% neglect (Loaded gun left out accessible, unsafe sleep w/intoxicated caregiver).

- For the years 2000-06 among those aged 0-9 years of age
 - Nearly 22% of all deaths are maltreatment-related
 - 70% occurred to infants
 - 63% were neglect related
 - 42% of abuse-related deaths were due to blunt force trauma (including SBS) or gun shot
 - 40% of abuse-related death directly involved substance abuse
 - Alaska Native children have 4 times the risk of a CM fatality compared with Alaska non-Native children.
 - Alaska Native children have 5 times the risk of a NEGLECT fatality compared with Alaska non-Native children.
 - Only 13% of all fatal SBS related deaths occurred to Alaska Native children
- Relative to Anchorage/Mat-Su region (2000 – 2006)
 - Northern region had 3 times higher CM-related infant mortality
 - 3 out of every 10 infant deaths were CM-related (~30%)
 - Interior region has no significant difference in CM-related infant mortality
 - 1 out of every 4 infant deaths were CM-related (~25%)
 - Southwest region had no significant difference in CM-related infant mortality
 - 1 out of every 8 infant deaths were CM-related (~13%)
 - Gulf Coast region had no significant difference in CM-related infant mortality
 - 2 out of every 9 infant deaths were CM-related (~22%)
 - Southeast region had no significant difference in CM-related infant mortality
 - 2 out of every 7 infant deaths were CM-related (~28%)
- For the most part maternal risk factors independently associated with CM vary by Alaska Native status, indicating a need for specific population identification when implementing CM prevention activities.

Take Home Points

- Independent associated factors uniquely differ between Alaska Native and non-Native populations
- Correctly targeted public health prevention programs are need based on evidence based data to impact maltreatment
- Alaska Native children ages 0 – 9 years have higher maltreatment-related mortality rates relative to non-Native infants for all years examined
- Neglect-related deaths account for much of this disparity
- Focus on Neglect-related mortality will have the largest impact on reducing overall maltreatment-related mortality, and is most suited for public health prevention messaging (i.e. positive parenting, risk reduction strategies, community empowerment)

Implications

Using a more sensitive definition and public health model lends the use of epidemiologic investigation that is based on local relevant data. Both appropriate messaging, and population identification will increase the impact of prevention/intervention efforts undertaken by the state and other partners.

Alaska Children's Alliance Update on CACs

February 2, 2010

Pam Karalunas
Statewide Coordinator

Alaska Children's Alliance



The mission of the Alaska Children's Alliance is to promote a culturally appropriate multidisciplinary response to child maltreatment throughout Alaska

ACA - State Chapter of National Children's Alliance which:

- **Sets minimum standards for CACs**
- **Sets minimum standards for State Chapters**
- **Provides**
 - **Limited funding for Chapters**
 - **Support, Training and Technical Assistance**
 - **National recognition**
 - **Accreditation**



**NATIONAL
CHILDREN'S
ALLIANCE**



Alaska Children's Alliance provides:

- **Technical assistance & support to existing and developing:**
 - **Children's Advocacy Centers**
 - **Multidisciplinary Teams**
 - **Child Protection Teams**
- **State representation at the regional and national levels**
- **Limited funding through national grants**
- **Coordination of statewide efforts**
 - **Training**
 - **Data Collection in collaboration w/CJA & SCAN**
 - **Statewide protocols to ensure high & consistent level of service**

Alaskan Child Advocacy Centers

- Anchorage – Alaska C.A.R.E.S.
- Bethel – TWC The Children’s Center
- Copper River Basin – Copper River Basin CAC
- Dillingham – Nitaput Child Advocacy Center
- Fairbanks – RCPC Stevie’s Place
- Kenai Peninsula – Kenai Peninsula CAC
- Juneau – S.A.F.E. CAC
- Kodiak–Kodiak Area Native Assoc. CAC – *Developing*
- Mat-Su – The Children’s Place
- Nome – Kawerak CAC

Child Advocacy Centers provide:

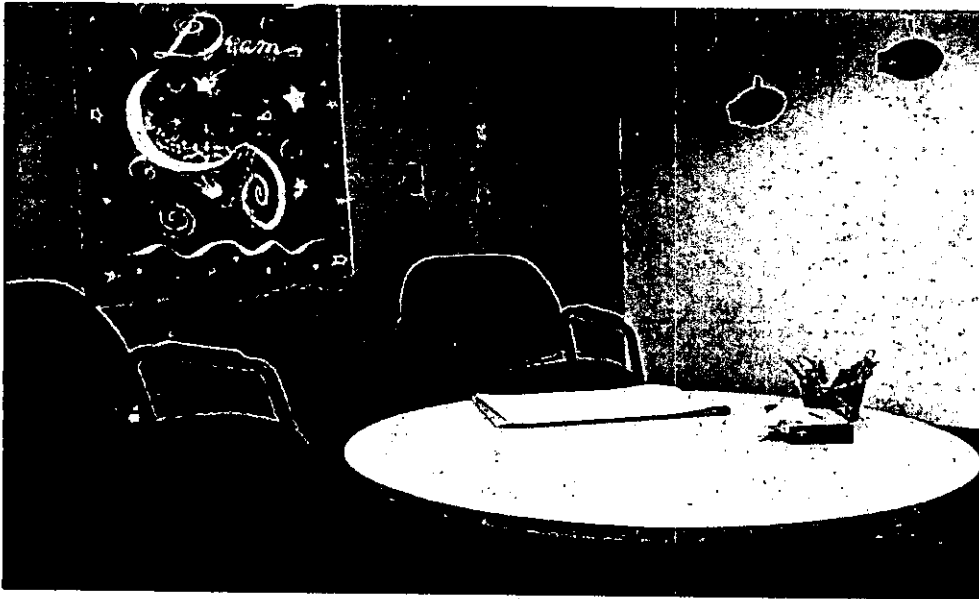
- A child and family friendly environment for coordination of investigative process in child abuse cases, specifically child sexual abuse



"nice people, cozy, homey, - I felt safe here"

Child Advocacy Centers provide:

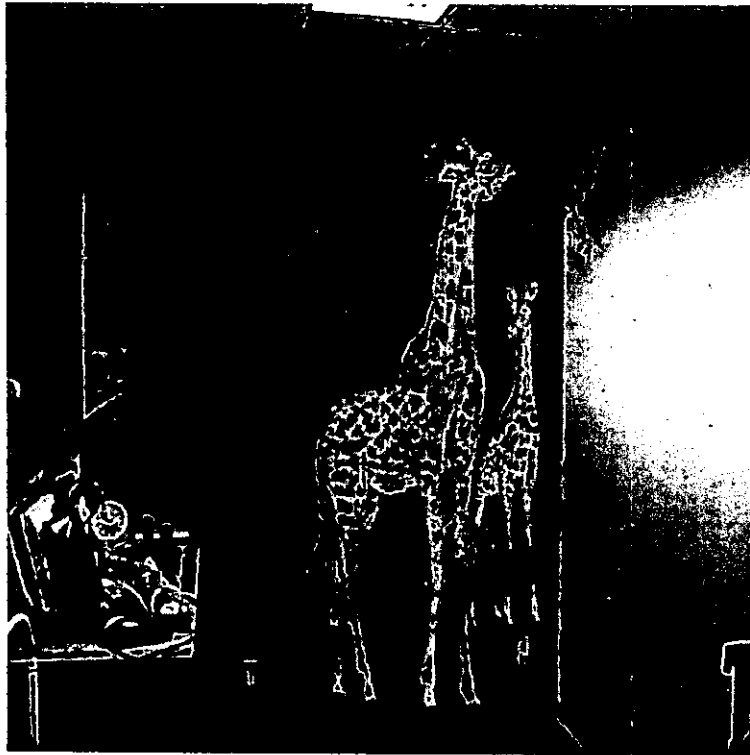
- **Specialized Forensic Interview**



“They said I’m not in trouble and I did do the right thing on telling someone what my uncle was doing.”

Child Advocacy Centers provide:

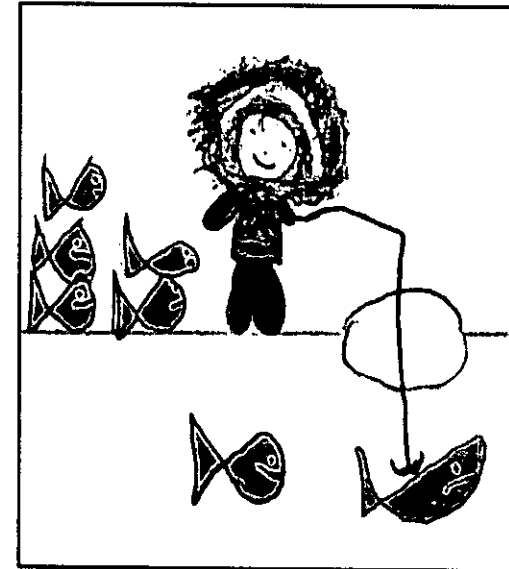
- **Specialized, Non-traumatic Medical Exam**



“My favorite part (of being at the CAC) was finding out my body is OK”

Child Advocacy Centers provide:

- Collaboration with mental health services for earlier response to referrals



Child Advocacy Centers provide:

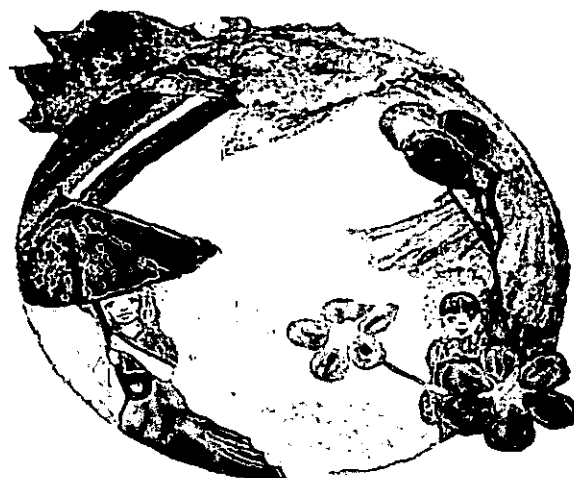
- Identification of risks and assessment of needs of child and family and referrals to address those issues



"Everything was well explained-you guys are doing a great job. Thank you."

Child Advocacy Centers provide:

- On-going support and follow up for family throughout the system process and beyond



“All the caring personalities was very comforting. Everyone kept us apprised of what was happening and were giving us very helpful information. It was nice to be treated so respectfully and I think everyone here helped my daughter find a little peace in this terrible situation.”

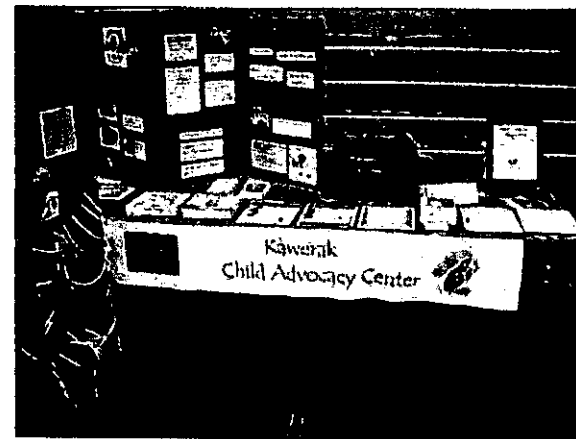
Child Advocacy Centers provide:

CASE TRACKING/DATA COLLECTION:

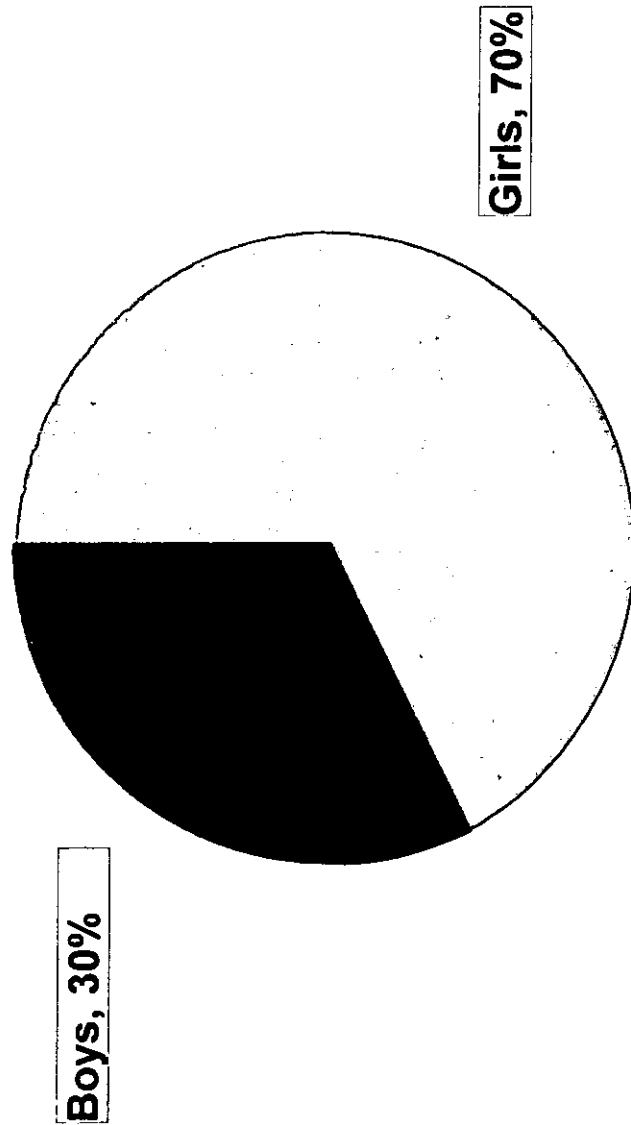
- System for monitoring case progress and tracking outcomes
- CACs in Alaska use a uniform data collection system, NCA Trak which is required for funding
- Helps identify strengths and challenges of the team & the system response

COMMUNITY AWARENESS

- Presentations
- Classes
- Radio Show, Interviews, etc

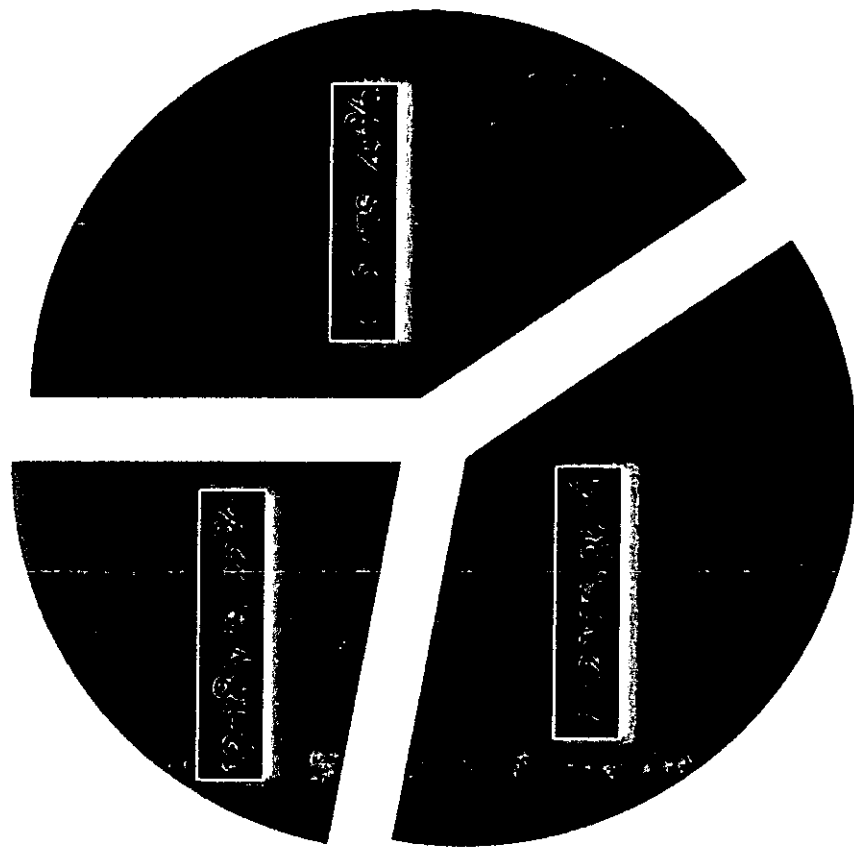


Gender of children seen at Alaska CACs in FY09



Ages of children seen at Alaska

CACs in FY09





CAC Research

Crimes against Children Research Center

University of New Hampshire

1,000 cases of Child Sexual Abuse studied at 4 CACs and 4 communities without CACs showed:

- ❖ More coordination of interviews at CACs – more police involvement in cases
- ❖ Children at CAC less fearful when interviewed
- ❖ Higher satisfaction among parents /caregivers when CAC used
- ❖ More referrals for mental health services through CACs
- ❖ More forensic medical exams when CAC used

Numbers of children seen

Location of CAC & year opened	# of communities served	FY 05	FY06	FY 07	FY08	FY 09	Total seen since open
Anchorage 96	27	601	756	740	921	823	8,017
Bethel 01	35	131	161	137	184	121	935
Copper River Basin 09	17					12	12
Dillingham 03	32	15	28	40	45	28	182
Fairbanks 03	21	126	163	140	142	213	880
Juneau 01	19	102	89	100	90	87	948
Kenai Peninsula 08	30				37	47	84
Mat-Su 99	11	142	98	152	145	167	1,479
Nome 02	17	16	37	24	23	29	196
TOTALS	209	1,133	1,332	1,333	1,587	1,527	12,733

THANK YOU FOR HELPING US MAKE

ALASKA A SAFER PLACE FOR

CHILDREN!



2/3/10
ALASKA
HEALTH
CARE
COMMIS.
REPORT

State of Alaska

Transforming Health Care in Alaska

2009 Report/2010 – 2014 Strategic Plan

Alaska Health Care Commission

2009



Transforming Health Care in Alaska

2009 Report/2010-2014 Strategic Plan

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Prepared for

Governor Sean Parnell and

The Alaska Legislature

Under Administrative Order #246

January 2010

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA HEALTH CARE COMMISSION

SEAN PARNELL, GOVERNOR
Bill Hogan, Commissioner

3601 C Street, Suite 902
ANCHORAGE, ALASKA 99503
PHONE: (907) 269-7800

January 15, 2010

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present this report by the Alaska Health Care Commission in accordance with Administrative Order 246. The Commission was chartered by Governor Palin last winter to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state. This report represents the efforts of the Commission over this past year to identify and analyze problems with Alaska's health care system, develop an initial set of recommendations, and chart a course for the future.

The health care challenges faced by Alaska at this time are daunting. Costs have reached unaffordable levels, more and more Alaskans have difficulty accessing care, the delivery system is fragmented, vacancy rates among the health care workforce are high, financing and payment mechanisms make no sense, variations in medical practice and quality are not well understood, and providers are becoming more and more frustrated as they become buried under layers of government rules intended to help fix these problems.

Action is required, but these problems are complex. There are no magic bullets, there is no one solution, and the improvements required will not occur overnight. A process of transformational change must be implemented that will guide Alaska's health care system down a path to become more patient-centered, more evidence-based, more coordinated, and more efficient. Health care providers need to be supported and provided the appropriate tools they need along the way.

At the same time we need to start getting a handle on cost sooner rather than later. The health care industry represents an important part of our state's economy and we need to be careful about forcing too much change too quickly, but the continuing escalation in health care costs poses a significant and real threat to Alaska's economy and the sustainability of state government. Continuing work on the part of a future Commission must focus on this challenge.

We are optimistic that this report offers hope for the future and will lead to a health care system that focuses on creating health and not just treating illness and injury, will provide value for Alaskans' health care dollar, meets the needs of both consumers and providers, and is sustainable over the long term.

Sincerely,
Ward B. Hurlburt III, MD, MPH
Chair, Alaska Health Care Commission
Chief Medical Officer
Department of Health & Social Services

Deborah Erickson
Executive Director
Alaska Health Care Commission

Acknowledgements

This report represents the contributions of numerous individuals to whom the Commission would like to extend our thanks.

The Commission greatly appreciates the foresight of Governor Sarah Palin in establishing the Commission under Administrative Order 246.

The Commission is grateful for the leadership of our first Chair, Dr. Jay Butler, who was called to duty last spring by the U.S. Centers for Disease Control and Prevention to lead the nation's effort to develop and distribute vaccine to combat the novel H1N1 influenza pandemic. Dr. Butler was instrumental in launching the Commission, laying the groundwork and leading the critical first steps.

Special thanks goes to Department of Health & Social Services Commissioner William Hogan, who supported the Commission by loaning staff and providing information to the effort, and who stepped in as interim Chair on Dr. Butler's departure until the department's new Chief Medical Officer was named. The Commission would like to thank department staff who helped provide administrative and logistical support in their "spare time": Bonnie Caress, Nina Hauptman, Lucy Hansen, Shane Miller, Sherri Stears, and Serafine Bourne.

The Commission is most grateful to the Section of Health Planning and Systems Development in the Division of Health Care Services, who prepared a "primer" on health care in Alaska for the Commission (included as Appendix A of this report), and also supplied additional data, information and guidance in support of health care research and analysis by the Commission, including Deputy DHSS Commissioner William Streur, Pat Carr, Alice Rarig, Faith Allard, Neal Gilbertsen, Mark Millard, Mark Doughty, Karen Lawfer, and Jean Findley.

For the experts who took time out of their busy schedules to prepare presentations and other informational materials and make formal presentations to the Commission at our meetings – we are especially thankful: Dennis McMillian, Dwayne Heyman, Gina Perez, Paul Sherry, Fred Pearce, Donald Pathman, Karen Perdue, Dennis Valenzano, Harold Johnston, Rosyland Frazer, Mark Foster, Tom Hunt, Joan Fisher, George Rhyneer, David Morgan, David Johnson, Valerie Davidson, Stewart Ferguson, William Streur, Doug Eby, Jan Harris, Pat Carr, James Nesbitt, Carl Ekstrom, Kathy Allely, Andrea Fenaughty, Karol Fink, Cathy Giesel, Sharon Cissna, and Alex Cahana.

And finally, the Commission appreciates the many members of the public who were devoted enough to the health of Alaskans to take time to attend Commission meetings in person or over teleconference and testify during public hearing portions of Commission meetings. And a special thanks to those who took the effort to review drafts of the report and provide comments to the Commission.

Alaska Health Care Commission 2009 Report/2010-2014 Strategic Plan

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APPENDICES *Available on the Commission’s Web Site at*
<http://hss.state.ak.us/healthcommission/default.htm>

- Appendix A: Health Care in Alaska**
 - 1. How Health Care in Alaska is Provided
 - 2. How Health Care in Alaska is Funded

- Appendix B: Coordination of Health Care Planning Efforts in Alaska**

- Appendix C: Meeting Summaries & Other Commission Documents**

- Appendix D: Table of Abbreviations and Acronyms**

Executive Summary

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and mental, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the condition of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, and some are private for-profit businesses. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment.

A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of Alaska's health care consumers.

The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health care experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

The Commission also identified four goals for a transformed health care system – that it will:

- I. **Improve access** to health care services and affordable health insurance coverage.
- II. Turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to **contain cost growth**.
- III. Assure that health care services delivered in Alaska meet the highest **quality and safety** standards.
- IV. **Focus on prevention**, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Two aspects emerged as critical to addressing the goals of increased access, improved value (high quality at a reasonable price), and a focus on prevention – 1) individual lifestyle

choices and the impact those choices have on health outcomes and demand for health care services; and 2) the role of primary care in placing the patient at the center of their health care experience.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

To achieve these goals the Commission recommends the following to the Governor and the Legislature:

- A. Strengthen the consumer's role in health and health care
 - Support healthy lifestyles and create cultures of wellness
 - Develop patient-centered primary care models through payment reform, removal of barriers, and support for pilot projects
- B. Foster statewide leadership to support health care transformation
 - Invest in the health policy infrastructure needed to respond to national reform
 - Establish a permanent state health planning and policy body in statute
- C. Develop the health care workforce
 - Make workforce a priority on health care reform and economic development agendas
 - Strengthen the pipeline of future health care workers
 - Support workforce innovation and adaptation as patient care models evolve
 - Direct workforce planning to be more coordinated
 - Increase the supply of primary care physicians by
 - Supporting educational loan repayment and financial incentives for recruitment
 - Expanding the WWAMI Alaska medical school program as resources allow
 - Supporting planning for primary care residency programs
- D. Deploy health information technology
 - Support health information technology adoption and utilization
 - Ensure public health connectivity
 - Ensure resulting information is used for optimization of medical care
 - Ensure privacy and security
 - Facilitate broadband telecommunications service access
 - Improve reimbursement for telemedicine
- E. Improve access to primary care for Medicare beneficiaries
 - Increase the supply of primary care providers
 - Support Federally Qualified Health Centers and Rural Health Clinics
 - Request relief from federal reimbursement inequities and administrative burdens
 - Develop a PACE (Program of All-Inclusive Care for the Elderly) program

The Commission provides in this report an action plan suggesting the operational steps and resources required to implement each of these recommendations. The Commission also lays out a 5-year strategic planning framework designed to facilitate an ongoing comprehensive approach to health care system transformation. Also included is a description of additional strategies for potential inclusion in continued planning efforts, such as cost and quality transparency, evidence-based medicine, payment reform, fraud and abuse control, and public health system support. Finally – as the work represented in this report is only a beginning – a one-year work plan for this or a future health care commission is outlined for 2010 to guide the continuing journey of health care system transformation for Alaska.

PART I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Administrative Order (A.O.) 246. This report is intended to serve as a five-year strategic plan for strengthening Alaska's health care delivery system, and is meant to be a living document that will evolve each year over the course of the coming five years as problems are studied, various approaches are analyzed, and implemented strategies are evaluated. This plan will be updated and conveyed to the Governor and Legislature in subsequent annual reports of the Commission if the Commission is continued beyond this first year.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission's 2009 activities, and a description of the Commission's vision, goals and values;
- Part II: information on the challenges of delivering and accessing health care in Alaska;
- Part III: the Commission's proposed strategy for transformation of Alaska's health care system, including findings and recommendations on key issues analyzed during the year;
- Part IV: a brief explanation of the design elements required for health care system transformation identified this year that are recommended for future analysis;
- Part V: the strategic plan – laying out a framework for the five-year plan, providing a suggested action plan for implementation of the Commission's 2009 recommendations, and setting the Commission's work plan for 2010;
- Appendices: Background information on health and health care in Alaska, and additional documents produced by the Commission.

B. Background on the Alaska Health Care Commission

The Alaska Health Care Commission was established by Governor Palin on December 4, 2008 under A.O. 246 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The duties of the Commission as outlined in the Administrative Order are to:

- I. Serve as the state health planning and coordinating body;
- II. Provide recommendations for and foster the development of a:
 - A. Comprehensive statewide health care policy;
 - B. Strategy for improving the health of Alaskans that includes
 - i. Encouraging personal responsibility in prevention and healthy living for all residents of the state;
 - ii. A reduction in health care costs for all residents of the state to be below the national average;
 - iii. Access in communities of the state to safe water and wastewater systems;
 - iv. The development of a sustainable health care workforce in the state;
 - v. Quality health care being accessible for all residents of the state; and,
 - vi. Increasing the number of residents of the state who are covered by health care insurance; and,
- III. Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the Commission's recommendations and activities.

Commission members were appointed by Governor Palin (with legislative representatives appointed by their respective bodies) January 27, 2009. Short biographies for each of the Commission members are included in Appendix D. The members of the Commission are:

Ward Hurlburt, MD, MPH¹: Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.

C. Keith Campbell: Representing Consumers; Retired; Seward.

Valerie Davidson: Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.

Jeffrey Davis: Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.

Ryan Smith: Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of the Central Peninsula General Hospital; Soldotna.

Wayne Stevens: Representing the Alaska State Chamber of Commerce; President & CEO of the Alaska State Chamber of Commerce; Juneau.

Lawrence Stinson, MD: Representing Alaska health care providers; Anesthesiologist and co-owner of Advanced Pain Centers of Alaska.

Linda Hall (Ex-Officio): Representing the executive branch; Director of the Division of Insurance; Anchorage.

Representative Wes Keller (Ex-Officio): Representing the Alaska House of Representatives; Wasilla.

Senator Donny Olson (Ex-Officio): Representing the Alaska Senate; Golovin.

Creation of the Commission followed from the work of an earlier group convened by Governor Palin – the Alaska Health Care Strategies Planning Council – established under A.O. 232 in 2007. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans. The Council's recommendations included a strategy for creation of a permanent health planning commission established in state statute.

Governor Palin's issuance of A.O. 246 was meant to jump-start the Planning Council's recommendation for a permanent body while legislation to establish the Commission was pending in the Alaska Legislature. There are currently three bills under consideration by the legislature that would create a health care commission in statute – HB 25 (Hawker), HB 75 (Cissna), and SB 172 (Olson)². If one of these bills passes during the 2010 session and is signed into law by Governor Parnell, the work of the current Commission will continue, but potentially with a slightly different charge and different members. If none of these bills pass, and unless Governor Parnell extends the life of the Commission through Administrative Order, the work of this Commission will end, but hopefully their one year of work and this report will add some value to on-going efforts to strengthen Alaska's health care delivery system and improve the health of Alaskans.

¹ Dr. Jay Butler served as Chair of the commission through mid-June. Commissioner William Hogan assumed the role of Chair in June through September. Dr. Hurlburt was appointed Chair of the commission following his appointment as Chief Medical Officer of DHSS in September.

² A table comparing the purpose, duties and membership of the bodies that would be created under each of these bills and A.O. 246 is included in Appendix D of this report.

C. Summary of 2009 Activities

The Commission experienced a number of challenges during their first year, including lack of funding, turnover in the Chairperson's role, temporary reassignment of their one staff person, uncertainties caused by the efforts at the federal level to reform the nation's health care system, and unknowns about the future of the Commission itself. Despite these limitations the Commission was successful in analyzing a number of critical issues and developing the recommendations contained in this report.

The Commission focused this year on:

1. Developing a vision of a transformed health care system for Alaska, including goals and values for guiding decision making;
2. Defining a comprehensive health care system transformation strategy;
3. Identifying, analyzing and developing recommendations regarding a few critical priority issues;
4. Outlining a 5-year strategic planning framework, including identification of:
 - a) a preliminary set of measures for tracking the performance of Alaska's health care system, and
 - b) issues and strategies for future analysis and policy recommendation development.

The Commission identified as their initial priorities for analysis and policy recommendation development for this year the following issues:

- The consumer's role in health care
- Statewide leadership for strengthening the health care system
- Health care workforce development, with a focus on the physician workforce
- Health information technology
- Primary care access for Medicare patients

2009 Accomplishments

Meetings and public hearings: During 2009 the Commission held four face-to-face meetings: February 27-28 in Juneau; and May 1-2, August 25-26, and November 6-7 in Anchorage. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend in person but interested in listening to the meeting or providing public testimony. A number of teleconferences were held during the year as well. Summaries of the meetings and teleconferences are included in Appendix D of this report. Four public hearings were held, three during the May, August, and November meetings, and one on December 14 through the Legislative Information Office teleconference system.

Administration: In their first months the Commission established meeting rules, a set of by-laws, a job description for the Executive Director, and appointed an Executive Director (initially hired by DHSS in February to expedite the first meeting of the Commission). A copy of the Commission's meeting rules, by-laws, and Executive Director job description are included in Appendix D of this report.

Communication and coordination: The Commission developed a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (<http://hss.state.ak.us/healthcommission/>). A listserv was established to maintain communication with system stakeholders and members of the public interested in receiving periodic updates. As an initial step toward assuming the health planning coordination role noted in the Administrative Order, the Commission compiled an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (in Appendix C).

Products: The primary product developed by the Commission is this, their first report to the Governor and Legislature, which includes the Commission's vision, values and goals; findings and recommendations on the priority issues noted above, and a planning framework for the next five years.

D. The Commission's Vision for Transformation of Alaska's Health Care System

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." Benjamin Disraeli

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and behavioral, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the state of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, some are private business. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment. A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of their consumers.

Vision

Alaska's Health Care System

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The first step this year in the Commission's journey toward transformation of Alaska's health care system was to design a picture of the ideal system. The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

Health Care Goals

- I. Improved Access
- II. Contained Cost
- III. Safe, High Quality Care
- IV. Prevention-Based

The Commission also identified four goals for a transformed health care system to support a targeted approach to identification of improvement strategies and performance measurement. The first goal is to improve access to 1) affordable health care insurance coverage, and 2) the services of a health care delivery system that is, itself, healthy. The second goal is to turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to contain cost growth. The third goal is to assure that health care services delivered in Alaska meet the highest quality and safety standards. The fourth goal is to focus on prevention, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission agreed to the following set of values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.

Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.

Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.

Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.

Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

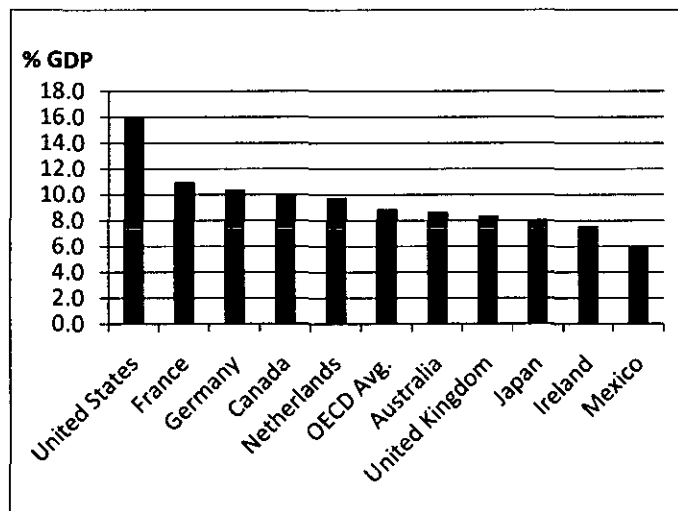
PART II: Health Care Delivery and Access Challenges in Alaska

The effort to transform Alaska's health care system to achieve the Commission's vision requires an accurate and complete understanding of the current condition of the system. A description of health care in Alaska – how it is structured, provided and funded – is included as Appendix A of this report. Here in Part II a discussion of some of the particular challenges associated with delivering and accessing health care in Alaska is discussed.

A. The Cost of Health Care in the U.S.

Health care spending in the United States has been growing faster than the economy for decades, doubling from 8% of the nation's gross domestic product (GDP) in 1970 to 16% in 2006. It is projected to increase to 20% of GDP, with total spending doubling from \$2 trillion in 2006 to \$4 trillion, by the year 2016.ⁱ A comparison of national health expenditures in the United States to other member countries of the Organization for Economic Cooperation and Development (OECD)(Figure 1) illustrates the challenge our nation faces in maintaining a competitive edge in today's global market place, as the increasing cost of health care contributes to higher prices for goods and services produced in the U.S.

FIGURE 1: National Health Expenditures as Percentage of National Gross Domestic Product, 2009

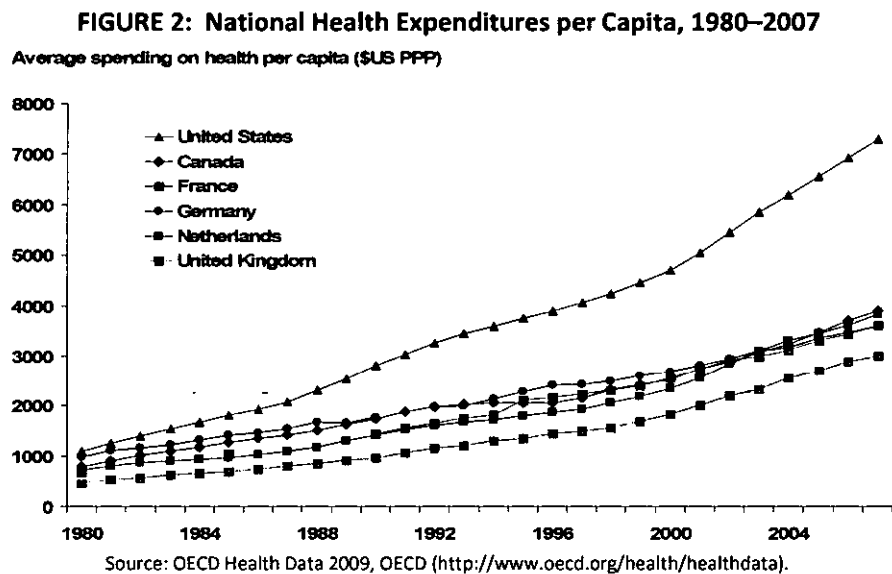


Source: OECD Health Data 2009, OECD (<http://www.oecd.org/health/healthdata>).

Higher costs in the United States do not necessarily reflect greater levels of health care resources. The U.S. has fewer physicians per capita than most other OECD countries, with 2.4 practicing physicians per 1,000 Americans compared to the OECD average of 3.1. The U.S. also has fewer hospital beds, with 2.7 acute care hospital beds per 1,000 Americans compared to the OECD average of 3.8 beds.ⁱⁱ Nor do higher costs mean that Americans have greater access to care. In 2004 97% of U.S. residents reported seeing at least one doctor in the previous 2 years, compared to 95% of Canadians and 98% of Australians. 84% of Americans reported having had a blood test, x-ray, or other diagnostic test in the past 2 years, compared to 84% of Canadians and 83% of Australians.ⁱⁱⁱ

Higher health care spending does not translate into better outcomes in terms of health status. Life expectancy and infant mortality are not necessarily reflective of the quality of health care, but are two general measures of population health that indicate Americans, for all the investment in health care services, are not healthier overall. Life expectancy in 2007 was at 78.1 years in the U.S., placing it 24th among the 30 OECD nations; and the U.S. ranked 28th in infant mortality at 6.7 per 1,000 live births, ahead of only Mexico and Turkey.^{iv}

Health care spending in the United States not only represents a higher proportion of our economy compared to other countries, average spending per person is significantly higher. Per capita national health expenditures in the United States increased 850% over the past three decades to \$7,290 (Figure 2). The average OECD national health expenditure in 2007 was less than half that amount, at \$2,984 per person.^v



Just one result of the escalation in health care costs is the impact on the personal finances of America's families. In 1981 medical problems contributed to just 8% of personal bankruptcies in this country. By 2007 the share of bankruptcies attributable to a medical cause had increased to 62.1%.^{vi}

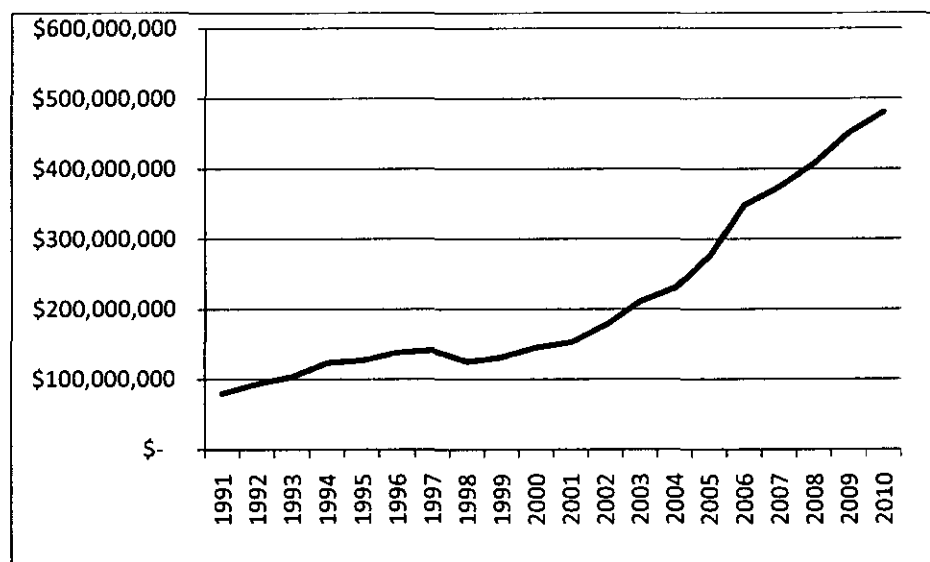
B. The Cost of Health Care in Alaska

The rapid rise in the cost of health care in the U.S. is reflected in Alaska as well. In 1993 the Health Resource & Access Task Force, a group convened by the Alaska Legislature to address questions of health care cost and access, projected health care spending in Alaska would "sky-rocket" from slightly below \$1.6 billion in 1991 to nearly \$5.6 billion in 2003. The HRATF determined that this "alarming" level of spending was inevitable if nothing was done to change the status quo.^{vii} Today in 2009 estimated spending for health care in Alaska is over \$6 billion.

Government (all levels – federal, state and local) pays 64% of Alaska’s health care bill, including public insurance programs (Medicaid and Medicare), government employee and retiree insurance premiums, medical care for military personnel and dependents, Indian Health Service support of tribal programs, medical care provided through the Veterans’ Administration, grants to Community Health Centers, operation of the state psychiatric hospital and Pioneers’ Homes, and care for offenders incarcerated by the Department of Corrections. Private employers pay 17% of Alaska’s health care bill in the form of health insurance premiums, self-insured costs, and Workers’ Compensation medical benefits for their employees. Individual Alaskans pay the remaining 19% through premium contributions, co-payments, deductibles, and direct payment to providers.^{viii}

The high cost of health care presents a significant fiscal challenge for the state of Alaska. State government is currently responsible for administering over \$1.5 billion annually for all health care related expenditures (inclusive of costs for employees and retirees, Medicaid (including federal funds), a variety of grant programs, state health facilities, and services for inmates in state prisons). In 2004 Alaska had the highest annual Medicaid expenditure level per enrollee in the United States, at \$10,417.^{ix} State general fund expenditures for Medicaid grew from a little over \$80 million in FY 1991 to over \$408 million in FY 2008 – an increase of 410% during that 17 year period (Figure 3).^x

FIGURE 3: Alaska State General Fund Medicaid Expenditures, 1991-2010



Source: FY 2010 DHSS Budget Overview
 * FY 2009 and 2010 were estimated expenditures as of Nov 2008

Contributors to health care spending are numerous and varied, but there are two basic components driving total cost – price and utilization. Population increases and inflation are partly responsible for driving upward trends in utilization and pricing, but do not account fully for the rapid rise in health care spending in Alaska – which increased at an average annual growth rate of 8.9% per year between 1990 and 2005. Increased utilization due to a greater number of people living in Alaska made up 1.2% of the average annual spending increase, and general inflation contributed 2.4%. The reasons behind the remaining 5.3% average annual growth rate are not well understood.^{xi}

Increased utilization of the health care system is partly driven by the rising prevalence of health problems and the aging of the state's population. It is also influenced by payment systems that do not present incentives for patients and providers to keep spending in check. New technologies that provide additional diagnostic and therapeutic opportunities are another factor. Also contributing to utilization that may be higher than necessary is the practice of defensive medicine due to concern over medical liability. Fraudulent claims for medical services never rendered also play a role. One factor that may be a key in understanding and controlling utilization is waste in the system – by some estimates as much as 30% of total health care costs are for medical goods and services that are not medically necessary or are ineffective.

Prices of health care services and medical equipment, supplies and pharmaceuticals make up the other component contributing to total spending. The higher cost of living in Alaska contributes somewhat to higher health care prices, but the Consumer Price Index (CPI) for Anchorage increased a total of 38% for all items between 1991 and 2005, while the CPI for medical care in Anchorage increased 98% during that same period. Lack of economies of scale due to Alaska's small, widely dispersed population and also fragmentation and duplication in Alaska's health care system are assumed to contribute to higher prices. Medical liability is a component of price, as the cost of malpractice insurance premiums is passed on to the consumer. New medical technologies also play a role in higher prices, as the cost to providers of implementation is passed on to consumers.^{xii}

One sign that the price of health care in Alaska is higher than in other states is the difference in reimbursement rates between Alaska and Washington State's Medicaid programs. Many of the professional fees paid by Alaska's Medicaid program are nearly three-times higher than those paid in Washington – Figure 4 provides just a few examples from the two states' 2009 Medicaid Fee Schedule.

FIGURE 4: Differences in Medicaid Fees, Washington State and Alaska, 2009

Description	Code	AK Fee	WA Fee	% Difference
Outpatient Office Visit – Lower Level	99212	\$62.46	\$22.69	175%
Outpatient Office Visit – Highest Level	99215	\$221.58	\$76.00	192%
Emergency Department Visit	99283	\$109.14	\$37.48	191%
Knee arthroscopy/Surgery	29881	\$976.77	\$358.08	173%
Gall bladder removal, laparoscopic	47563	\$1,175.10	\$412.29	185%
Cataract Surgery w/ lens implant	66984	\$1,141.23	\$394.44	189%

Source: Alaska Department of Health & Social Services, Division of Health Care Services, December 2009

Another indicator that Alaska's health care prices are generally higher is a comparison of spending for inpatient hospital services. In 2007 the average hospital adjusted expenses per inpatient day was \$2,104 in Alaska – 24% higher than the national average of \$1,696.^{xiii} The average hospital cost per stay in Alaska was \$27,171 compared to the 2007 national average of \$15,455.^{xiv}

And one more example of higher prices and overall costs comes from the Workers' Compensation program. Alaska has ranked 1st in the nation for cost of workers' compensation premium rates since 2005. Medical costs made up 72% of total benefit claims in Alaska in 2008, compared to the national average of 58%. The average medical cost per workers' compensation claim in Alaska was \$40,000 per injury in 2008 compared to the national average of \$26,000. Alaska's Workers' Comp medical fee schedule rates were the highest in the nation in 2006 – on average 3.5 times higher than Massachusetts, the state with the lowest rates.^{xv} Below are a few examples of fees paid by Alaska's program compared to Washington's and Hawaii's.

FIGURE 5: Differences in Workers' Comp Fees, Alaska, Washington and Hawaii 2006

Description	Code	AK Fee	WA Fee	HI Fee
Outpatient Office Visit – Mid Level	99213	\$127.00	\$76.00	\$61.00
Radiology (MRI, spinal canal cervical)	72141	\$2,339.00	\$769.00	\$634.00
General Medicine (nerve conduction)	95904	\$219.00	\$81.00	\$66.00
Knee arthroscopy/Surgery	29881	\$4,181.00	\$869.00	\$693.00
Physical Medicine (therapeutic proc)	97110	\$83.00	\$40.00	\$32.00

Source: November 2009 Report of the Workers' Compensation Medical Services Review Committee, AK Dept of Labor & Workforce Development

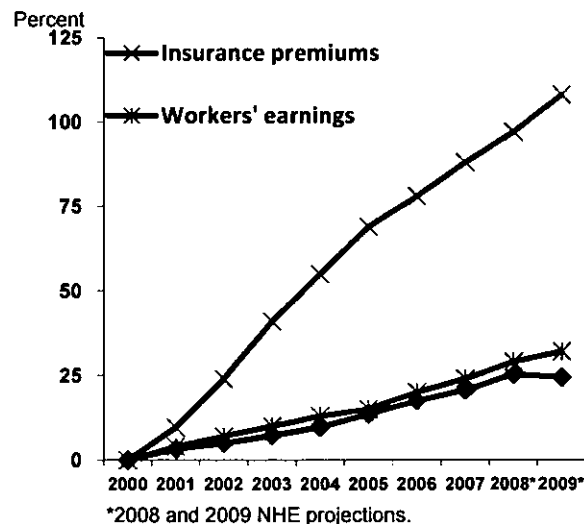
More research is required to understand the disparity in health care prices between Alaska and other states. A more comprehensive analysis of fees paid by all major payers and programs should be conducted. An analysis of variations in fees paid within Alaska as well as comparisons to other states should be included. Note the example from the above two tables in the disparity between fees paid by two different Alaskan programs for the same procedure – Alaska's Workers' Compensation program pays a professional fee for arthroscopic knee surgery (CPT 29881) that is more than four times higher than the fee paid by Alaska's Medicaid program. One other issue related to price and total cost that is not widely understood and should also be investigated is the difference between charges billed by providers and actual reimbursement levels, and how cost shifting occurs as providers adjust to changes in their payer mix and volume.

C. Health Insurance Coverage of Alaskans

Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. Naturally therefore, as the overall cost of health care has increased over the years, the price of health insurance premiums has kept track. Unfortunately workers' wages have not kept pace with the rise in the cost of health insurance (Figure 6), and health care-related expenses are consuming a larger proportion of Americans' household income each year.

FIGURE 6: Premiums Rising Faster than Wages and Inflation^{xvi}

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2009



In Alaska health insurance premiums for working families grew by 90.8% between 2000 and 2009. In comparison, the median earnings of Alaska's workers rose 17% during the same period. The average annual insurance premium for family health coverage in Alaska rose from \$7,456 in 2000 to \$14,226 in 2009. The average annual premium for individual health coverage rose from \$2,923 to \$5,626 during that same period.^{xvii} The percentage of income spent on health care in Alaska (based on per capita averages) increased steadily from 11% in 1991 to 19% in 2004.

14% of Alaskans are uninsured or do not have access to military, Veteran's Administration or Indian Health Service-funded health care services. The following table (Figure 7) illustrates the proportion of Alaskans covered by various types of health care coverage.

FIGURE 7: Health Insurance Coverage by Type of Coverage in Alaska and the U.S.

Health Insurance Coverage Type Average for data years 2006-2008	Alaska		United States
	Count	Percent of Total	Percent of Total
Covered by Any Source	575,269	86.0%	85.0%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Indian Health Service only ³	28,095	4.2%	0.5%
Uninsured all year	93,648	14.0%	15.0%
Total	668,917	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009.

84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed by small businesses that do not offer health benefits or offer coverage they cannot afford. While nearly all firms with more than 100 employees provide health benefits, less than a quarter of Alaska's smallest businesses (those with fewer than 10 employees) offer health insurance. The seasonal nature of Alaska's workforce is an important factor in employer health coverage. The CPS survey data in the Figure 7 table does not capture Alaskans who only have coverage part of the year in the reported uninsured amount. It also does not account for Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still face financial barriers to health care.^{xviii}

³ Figures in this table are adjusted to include as "covered" people of Alaska Native/American Indian race who may have access to IHS-Funded services. The CPS Survey includes IHS beneficiaries in the uninsured category if they have no 3rd-party health insurance coverage. The "Indian Health Service only" amount included here is an estimate based on respondents to the survey identified as "AI/AN only."

D. Health Care Delivery System Challenges

Alaska experiences many health care delivery challenges, including the logistical difficulties and costs involved in providing care for a relatively small number of people spread over vast geographic distances, a delivery system that is highly fragmented, and an inadequate supply and distribution of health care workers.

Logistical Challenges

Alaska is the largest state in the nation geographically, encompassing an area greater than the next three largest states – Texas, California and Montana – combined. At the same time Alaska's population is among the smallest of the states. Alaska has the lowest population density in the U.S. with 1.2 persons per square mile compared to the U.S. average population density of 79.6. 26.1% of the state's population lives in communities of fewer than 2,500 people.^{xx} The dispersion of such a small number of people over such a large area increases the difficulty and cost of delivering care here.

Approximately 75% of Alaska's more than 300 communities are not connected by road to a community with a hospital. Nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.^{xx} Transportation costs are high – air travel between a village and the nearest community with a hospital generally costs more than \$100, with airfare from some of the more remote villages to the tertiary care centers in Anchorage costing as much as \$1,200. Geography and harsh weather conditions pose additional transportation barriers, and can be especially problematic in an emergency situation.

Transportation is not just an issue in terms of patients' ability to reach needed services. The cost of moving supplies, staff and equipment required to operate clinics and hospitals in rural Alaska can be formidable. For example, the price of heating fuel and gasoline in the most remote communities of the state reached as high as \$10.00 per gallon this year – the cost of transporting the fuel to these communities was higher than the cost of the fuel itself.^{xxi}

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state – a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner Program, and the use of telehealth technologies. Many of Alaska's most rural facilities are also highly subsidized by the federal government.

System Fragmentation and Duplication

Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. Health care organizations within the same sector (military, tribal health system, or private sector) do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

Alaska has benefited from a strong military presence due to the state's strategic location, a strong tribal health system presence, and decades of representation in senior leadership in the U.S. Senate. Because of these three factors the federal government has played a lead role in development of Alaska's health care system, especially in rural Alaska as well as for medically underserved Alaskans statewide. And all Alaskans, not just the targeted service population, benefit from the presence of these services in communities where there might not otherwise be any health care delivery system. For example, the tribal health system provides care for non-Native individuals in remote communities where there are no other health care providers.

The downside of heavy federal investment in building the health care infrastructure is there are some communities that have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four hospitals – one military, one tribal, one for-profit, and one non-profit (plus two psychiatric hospitals). The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs.

The duplication and fragmentation in Alaska's health care "system" is inefficient, and potentially unsustainable in the long-run if mechanisms for improved coordination and perhaps integration where appropriate are not implemented.

Health Care Workforce Shortages

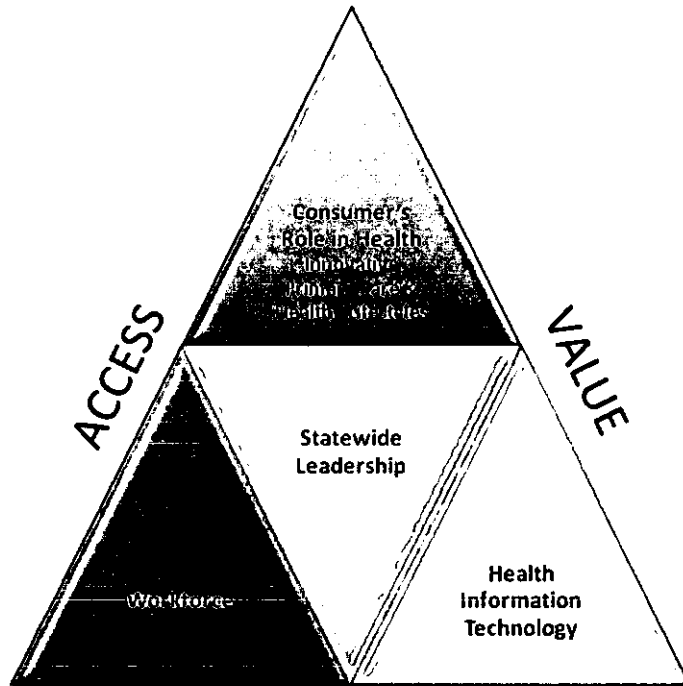
Demand for health care workers rose sharply over the past decade. Alaska's health care employment sector experienced 40% job growth between 2000 and 2007, compared to 13% for all other industries, outpacing the state's population growth during that same period by five times.^{xxii} The supply of new workers produced by Alaska's training and education programs plus those imported from outside Alaska cannot keep up.

Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations are experiencing vacancy rates of 15% - 20%. Pharmacist, therapist and certain nurse specialist positions are also experiencing high vacancy rates. Behavioral health occupations have a somewhat lower vacancy rate overall, but made up the highest proportion of vacancies with 1,033 vacant positions in 2007.^{xxiii}

The costs health care organizations incur associated with recruitment and contracting for the services of temporary employees to cover vacancies is high. 80 Alaska health care organizations surveyed in 2005 reported spending \$24 million in the preceding year for vacancies in 12 key health occupations.^{xxiv} At least a portion of these costs may be passed on to consumers and insurers in the form of higher prices.

Delivery of health care is dependent on an adequate supply and distribution of qualified health care workers. 27 of Alaska's 30 boroughs and census areas contain federally designated health professional shortage areas. Staff shortages are one of the many challenges the Alaska health care delivery system is dealing with as it faces the future.

PART III: 2009 Health Policy Findings & Recommendations



The Commission identified five priority issues for analysis this year:

- A. The Consumer's Role in Health and Health Care
- B. Statewide Leadership
- C. Healthcare Workforce
- D. Health Information Technology
- E. Access to Primary Care for Medicare Patients

PREVENTION-BASED Alaska Health Care Commission's Health Care Transformation Strategy

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Over the course of learning and discussions two aspects emerged as critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered primary care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

The fifth priority issue identified this year is not part of the comprehensive strategy, but was recognized as an immediate crisis worthy of special attention – the problem Medicare beneficiaries in urban Alaska are experiencing with access to primary care. This problem just may be an early indicator – “the canary in the mine” – warning us of the looming health care crisis in our state if we don't take decisive action.

A. The Role of Consumers in Health Care

1. Healthy Lifestyles

Finding A1a: Chronic disease is the leading cause of death and disability in the U.S. and Alaska.

Finding A1b: The majority of health care spending in the U.S. is for chronic disease.

Finding A1c: Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.

Finding A1d: Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.

Finding A1e: Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.

Finding A1f: Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

1.7 million Americans die each year from chronic disease, which cause 70% of all deaths. Cancer, heart disease, stroke, and lung disease are four of the top five leading causes of death in Alaska. 133 million Americans – nearly half our nation's population - live with at least one chronic condition. Individual health behaviors are the leading contributors to chronic disease. The World Health Organization estimates that 80% of heart disease, stroke and type 2 diabetes, and 40% of cancer, would be prevented if Americans stopped smoking, ate a healthy diet, and participated regularly in physical activity.

Complex medical care required over the prolonged course of illness and disability due to these conditions is costly. 75% of all health care expenditures are related to chronic disease. In Alaska, \$600 million is spent annually for hospitalizations due to heart disease and stroke, and \$419 million for all costs due to diabetes. The state of Alaska incurs an estimated \$9-10 million in medical costs due to obesity for state employees alone each year. The doubling in the prevalence of obesity in the U.S. between 1985 and 2004 accounted for nearly 30% of the increase in annual health expenditures.

It is not possible to address the escalation in health care costs without addressing the problem of chronic disease. The Commission began an inquiry into strategies known to be effective at supporting behavior change and learned about the success of Alaska's Tobacco Program, which led to a reduction in adult smoking from 27% in 1991 to 22% in 2008. They also learned about successful worksite wellness programs. There is much more work to be done however - understanding what government, schools, work sites, and communities can do to support healthy choices requires on-going attention.

Recommendation A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Recommendation A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.

2. Primary Care Innovation

Finding A2a: Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Primary care is the foundation of the health care delivery system – providing the main point of entry for secondary and tertiary care, and meeting the majority of patient needs for health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health conditions, and overall management of a patient’s health care services. There is increasing evidence that access to high-quality primary care improves health outcomes and reduces costs. However, the rising demand for services from an aging population and increasing chronic disease, coupled with the decreasing supply of primary care physicians, is sweeping our primary care system toward a crisis.

National health care reform discussions emphasize the importance of primary care, but tend to oversimplify the issues and solutions. Some suggest all that is required to improve access to primary care is increased reimbursement levels for primary care practitioners. Others suggest that primary care practitioners must be paid for additional services that are not currently reimbursable – those services they provide to assist with the coordination and management of a patient’s care and health conditions over and above the time spent during the actual patient encounter. Reimbursement is part of the solution, but increases need to come through a restructured payment system that supports and rewards practitioners for delivering patient care in a new way.

The Commission believes that strengthening the provision of primary care is the key to transformation of the health care system, but they also determined that the current primary care model is antiquated. The traditional medical model based on episodic acute care is no longer the most effective and efficient approach to meeting patients’ needs. They learned about a new patient-centered care model tried in our own backyard, the Southcentral Foundation’s Nuka Model of Care, that’s proven successful - demonstrating reductions in hospital days by 40% and emergency room and specialty visits by 50%.

The “Medical Home Model” is a term meant to describe the ideal concept for how primary care should be provided, but the Commission felt as though this term has become too much of a buzz word in the health care reform debates and that for many it simply implies paying primary care practitioners more for working in the same way. And so the Commission is avoiding use of that term, and is focusing on key characteristics of a modernized high quality primary care model:

- Patient and family centered
- Stable trusting relationship between care team and patient/family that continues over time
- Comprehensive, coordinated, and accessible care provided by integrated multidisciplinary teams
- Focus on health and wellness (physical, behavioral, social) rather than disease care

Alaskans need to be empowered to partner with their health care providers so they can be better stewards of their own health. This will require innovation in patient care at the primary care level.

Recommendation A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.

B. Statewide Leadership

1. Response to National Health Care Reform

Finding B1a: National health care reform proposals under consideration by Congress will have a significant impact on Alaska's state and local governments, health care system, business community, citizens, and families.

Reform of the nation's health care system has been a top priority during 2009. The issue has been politically charged, with proponents stressing the importance of the increased access to health care coverage that would be afforded millions of Americans under the proposed reforms, and opponents decrying the increased national debt burden and inadequate attention to control of health care costs. At the core of the debate is a strong ideological divide over the appropriate role of government in health care.

Emotions are strong on both sides of the argument. The town hall meetings held by Alaska's U.S. Senators this summer and fall drew thousands of Alaskans – many with stories of desperation related to inadequate access to health care, and many others expressing fear and frustration over federal intrusion into what they believe is a personal matter. There's considerable misinformation and rhetoric from either side, with heavy use of popular media to attempt to sway public opinion. Over \$150 million has been spent on TV ads alone this year by both sides.

Unfortunately there is no one entity in Alaska responsible for objectively analyzing the potential impacts of various reform proposals on our state government, health care system, businesses, and citizens. The federal legislation currently under consideration will dramatically change the federal structure within which state health systems operate, and state governments will play a significant role in implementation of federal health care reforms if and when they pass. New responsibilities states can expect to inherit under federal reforms will be both financial and administrative.

State government will incur additional financial responsibilities if Medicaid expansion is mandated. The Alaska Department of Health & Social Services (DHSS) estimates the fiscal impact of the proposed Medicaid expansion at nearly \$450 million over a five year period. One considerable new administrative responsibility that appears likely is creation and operation of a state health insurance exchange. While many of the proposed changes are not slated to take effect until 2013 or 2014, a lot of work will be required during the interim to plan for implementation of new programs and systems.

Except for the ability to evaluate impacts of changes to Medicaid specifically, the state does not have capacity to analyze the effects of federal reform on our state. Regardless of whether federal reforms pass this year or not, the crisis in the nation's health care system will continue to drive federal proposals that will require analysis that could be provided by some form of a state health policy infrastructure.

Recommendation B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.

2. Permanent State Health Planning Board

Finding B2a: The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Over the two decades preceding the creation of the Commission, four groups have been formally convened to address the problems of access to and cost of health care. All of these entities were ad-hoc in nature with a limited lifespan, meeting over periods ranging from 6 months to 2 years. They all had limited time to study the issues and develop recommendations, and in the end no real authority or accountability for following through on their findings and proposed strategies.

In 1987 Governor Cowper created The Governor's Interim Commission on the Status of Health Care and the Health Care Industry in Alaska ("The Governor's Interim Health Care Commission" for short) under Administrative Order (A.O.) #100. The Governor's Interim Health Care Commission had 11 members and four staff, and held eight 2 to 3-day meetings over the course of nine months. The report they published in 1988 made 39 recommendations to the Governor and Alaska Legislature addressing insurance coverage expansion, access to long term care, cost controls, and state health planning.

In 1991 the Alaska Legislature created the Health Resources & Access Task Force. The 17-member HRATF held 14 monthly two-day meetings, producing a report calling for the creation of a single-payer system for Alaska. While their primary recommendation was never adopted, creation of a high-risk pool for Alaskans with pre-existing conditions who cannot otherwise obtain health insurance coverage – the Alaska Comprehensive Health Insurance Association (ACHIA) – followed from their work.

Ten years following the publication of HRATF's final report in 1993, a private group – Commonwealth North – created the Alaska Health Care Roundtable to improve access, quality and cost of health care in Alaska. The Roundtable had a 17-member executive committee representing public and private sector interests. They produced a report in 2005 focused on the improvement of primary care.

In 2007 Governor Palin created the Alaska Health Care Strategies Planning Council under A.O. #232. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans.

The two most recent groups recognized two problems with their ad hoc nature – 1) one year isn't long enough to get a handle on the complexity of the problems in our health care system and come up with a comprehensive approach to solutions; and 2) there was no way to ensure accountability for their efforts. Both groups recommended that a permanent health planning and policy body be established in statute to provide sufficient time for gathering information, studying the issues, and developing comprehensive solutions. The Commission concurred with their recommendation.

Recommendation B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.

C. Health Workforce Development

1. General Workforce Development Findings & Recommendations

Finding C1a: Health care in Alaska is big business and represents a significant employment sector.

Finding C1b: Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

Finding C1c: Health care worker shortages in Alaska are widespread and costly.

Finding C1d: A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).

Finding C1e: Alaskans have been particularly innovative in meeting their health care workforce needs.

Finding C1f: Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Health care in Alaska is a six billion dollar industry, representing 16% of the state's gross domestic product.^{xxv} It is also one of the biggest players in Alaska's labor market. With eight percent of the state's wage and salary jobs it leads all other industries except government, trade, and hospitality. Alaska's top employer is a health care provider – Providence Health & Services – employing over 4,000 people in 2008. Five of the top 20 employers in the state are health care organizations.^{xxvi}

Health care is not only one of the largest employment sectors in Alaska, it is consistently the fastest growing. Between 2000 and 2007 the number of wage and salary jobs in the health care industry grew 40%, from 20,700 to 29,000, compared to just 13% for all other industries. Health care employment grew faster in Alaska than the U.S. overall, with 40% job growth compared to 19% in the U.S. from 2000 to 2007. Health care employment growth has outpaced Alaska's population growth rate by five times.^{xxvii} The Alaska Department of Labor & Workforce Development projects the health care industry will continue to expand in the next decade, increasing by 25% between 2006 and 2016 and adding twice as many jobs as any other industry.^{xxviii}

One other aspect of the health care industry important to the overall economy of the state is that there are health care jobs in virtually every community. There are at minimum paraprofessional health care providers in even the smallest villages. 23% of Alaska's health care workers are employed in rural areas.^{xxix}

A functional health care system cannot be sustained without an adequate workforce. One key measure of access to health care is the supply of health care providers as a ratio to population. But having an adequate workforce goes beyond simple measures of supply. The workforce must be competent to provide high quality care that is culturally appropriate, must be literate in the use of health information

technologies, and must be able to adapt to new patient care settings and models that provide integrated, interdisciplinary, patient-centered care. Having an adequate statewide supply of well trained providers is not enough either – workforce distribution is an important factor as well.

Meeting the demand of Alaska's health care industry for an increasing number of health care workers presents a significant challenge. The supply of new workers produced by Alaska's training and education system plus those imported from outside Alaska cannot keep up. Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations (family physicians, general internists, nurse practitioners, physician's assistants, and community health aide/practitioners) are experiencing vacancy rates of 15% - 20%. 19% of psychiatrist positions were vacant in 2007. Other occupations for which shortages exist include pharmacists (23.7% vacancy rate), and therapists (physical, occupational, speech, and speech-language pathologists with vacancy rates ranging from 15.6 – 29.3%). Key nursing specialties also experience high vacancies, with a 23.4% vacancy rate for nurse case managers. Behavioral health occupations had a relatively lower vacancy rate at 13.9%, but made up the highest proportion of vacancies – with an estimated 1,033 vacant positions. In a 2007 survey of health care organizations conducted by the Alaska Center for Rural Health (and from which the above noted estimates are derived), 54% of respondents cited "inadequate pool of qualified workers" as the top reason for vacancies.^{xxx}

The costs associated with these vacancies are high. 80 Alaska health care organizations surveyed in 2005 reported spending \$24 million in the preceding year for vacancies in 12 key health occupations - \$11 million on recruitment costs plus \$13 million on itinerant temporary workers. They identified three main barriers to recruitment – locating qualified candidates, Alaska's geographic isolation and harsh climate, and the need to satisfy the lifestyle and employment requirements of spouses and other family members.^{xxxi}

The approach to replenishing the health care workforce as the numbers of jobs grow and workers are lost through retirement and attrition includes a combination of "growing our own" strategies – providing training and education in and for Alaska, and importing workers from outside Alaska through a variety of recruitment strategies. There is a history of collaboration in Alaska as the health care industry has partnered with the University system and state and federal funding agencies in the development of health care education and training programs in order to improve our ability to "grow our own."

The University of Alaska (UA), the Alaska Legislature and Alaska's health care industry have demonstrated a commitment to increasing in-state health career training and education opportunities in recent years. The number of students in UA health programs increased 68% between 2001 and 2008. In the fall of 2007 UA had 3,501 students enrolled in health programs. UA now has 80 health programs statewide in various fields including allied and behavioral health, emergency services, health management, medical office management, nursing, primary care, public health, and therapies. In partnership with the health care industry and with financial support from health care organizations and the state Legislature, the UA has recently added or expanded a number of programs, including:

- Doubling the nursing program to more than 220 AAS and BS admissions each year, and providing AAS nursing programs in 12 communities;
- Doubling the number of WWAMI medical school seats from 10 to 20;
- Addition of radiologic technology in six locations;
- Development of cooperative programs with outside universities for occupational, speech and language therapies and audiology;
- Expansion of the distance Master's program in social work;

- Provision of rural allied health training via distance delivery;
- Doubling the Master's of Public Health program to 70 distance students; and,
- Opening the Physician's Assistant program (beginning July 2009).^{xxxii}

Training and education strategies do not begin at the post secondary level however. They include developing the pipeline of potential future Alaskan workers – reaching them early in their K12 education, making sure they have a solid foundation in math and science, and exposing them to potential careers in the health field. One program that helps young people explore health careers is the Area Health Education Center (AHEC). AHECs are federally and state funded programs meant to create formal relationships between university health programs and community partners to support health career education development. Alaska has an AHEC based out of UAA's School of Nursing, administered by the Alaska Center for Rural Health, and serving four regions of the state through partnerships with the Yukon Kuskokwim Health Corporation, Fairbanks Memorial Hospital, the Alaska Family Practice Residency Program, and Southeast Alaska Regional Health Consortium. In addition to encouraging Alaska's youth to pursue health careers, the AHEC facilitates clinical rotation opportunities and continuing education for health professionals in underserved areas. In addition to the AHEC program, Alaska's WWAMI program and also the Alaska Native Tribal Health Consortium administer a number of health career development programs.

Training and education strategies do not end at the post-secondary level either. They also include post-graduate programs such as graduate medical education (GME – residency programs for medical school graduates) and also non-physician programs such as clinical internships for Ph.D. psychologists. Alaska currently has one GME program, the Alaska Family Medicine Residency Program, and groups are in various stages of planning residency programs for pediatrics, psychiatry and internal medicine. Alaska lacks an internship for our Ph.D. doctoral students in psychology.

One other approach to addressing health care workforce shortages that must be noted – one for which Alaska is a proven leader – is innovation in the development of new types of workers and in the utilization of existing provider types. The extreme health care delivery challenges posed by the remoteness and isolation of many of Alaska's Bush communities led to a unique workforce innovation in the middle of the past century that has become a model for other countries with similar challenges – the Community Health Aide/Practitioner. Alaska's tribal health system has used that model to address behavioral health and oral health needs in more recent years, with the development of the Behavioral Health Aide and the Dental Health Aide Therapist Programs. Another innovation is Alaska's use of mid-level practitioners – nurse practitioners and physician's assistants – who have an expanded scope of practice to allow more independent practice by these providers than in many other states. Mid-level practitioners have played an important role in meeting the primary care needs of rural communities not large enough to support a physician practice in Alaska since the 1970s, and play an important role today in urban Alaska as well.

There are a number of collaborative health care workforce planning and development efforts currently underway. Following are some key examples:

- The Alaska Health Care Workforce Coalition (AHCWC) represents a large industry-led partnership that includes not only representatives of health care provider organizations, but also the three state government agencies that play an important role in health care workforce development – Health & Social Services, Education & Early Development, and Labor & Workforce Development, as well as K12 school districts, and the University of Alaska. This

Coalition is in the process of developing a statewide strategic health care workforce plan for Alaska under the auspices of the Alaska Workforce Investment Board (AWIB). A draft of this plan is currently being circulated for public comment, and will be finalized and submitted to the AWIB for endorsement in February 2010.

- The Alaska Diversified Economic Planning Team, established under Administrative Order #249 by Governor Palin, is in the process of developing a statewide strategic comprehensive economic development plan for the state (the "Legacy Plan"). This team has 16 different workgroups currently in the process of addressing various aspects of economic development. One of the workgroups is addressing health care, as it is not only a major employer and driver of Alaska's economic engine; it is also an important support industry for other sectors of the economy. The Legacy Plan Health Care Workgroup, scheduled to produce a report in 2010, is primarily focusing on health workforce issues.
- Last year the Department of Health & Social Services (DHSS) established a position housed at UAF in the Office of the Associate Vice President for Health Programs and supported with funding from the Alaska Mental Health Trust Authority (AMHTA) charged with the responsibility for coordinating the numerous projects under AMHTA's Workforce Development Initiative with DHSS and UA behavioral health workforce projects.
- The Trust Training Cooperative, housed in the University of Alaska Anchorage (UAA) College of Health and Social Welfare's Center for Human Development, includes numerous partners focused on improving training coordination and availability for smaller and rural organizations servicing AMHTA beneficiaries. The Cooperative recently completed a behavioral health training needs assessment.

In addition to these various partnerships, coalitions and workgroups, there are a few entities that contribute routinely to research and analysis of Alaska's health care workforce.

- The Research and Analysis Section in the Alaska Department of Labor & Workforce Development;
- The Section of Health Planning and Systems Development in the Division of Health Care Services, Alaska Department of Health & Social Services; and
- The Alaska Center for Rural Health housed at UAA.

These examples demonstrate that many private and public entities are invested in health care workforce development, but there is no one entity responsible for coordination of all these activities. A single organization charged with coordination of the many health workforce development activities in the state, and designated to provide the organizational home to support implementation of the statewide strategic plan currently under development by the AHCWC, is needed. This would help minimize the possibility that efforts might be duplicated and wasted, or that gaps in important aspects of workforce development go unaddressed. The designated entity could ensure that a comprehensive approach to meeting Alaska's health care workforce needs is taken, including strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of the health care workforce planning, development and support infrastructure.

Recommendation C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.

Recommendation C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.

Recommendation C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.

Recommendation C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.

Recommendation C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.

2. Physician Shortage

Finding C2a: The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.

Finding C2b: Alaska has a shortage of primary care physicians⁴.

Finding C2c: New physicians face disincentives to entering primary care specialties.

Finding C2d: Providers stay to practice where they train.

Finding C2e: Mid-level medical practitioners (Nurse Practitioners and Physician's Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

There are many professions that make up the health care workforce and all are vital to a functional health care delivery system. The Commission chose to focus on the physician workforce in their first year, in part because the one specific health care delivery challenge they chose to study this year is the problem of Medicare access to primary care doctors. For their analysis of the physician workforce the Commission benefited from a recent study by the Alaska Physician Supply Task Force completed in 2006.^{xxxiii} The Task Force was commissioned by the President of the University of Alaska and the

⁴ The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission's definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.

Commissioner of the Department of Health & Social Services to address questions regarding current and future need for physicians in Alaska, and to consider current and potential strategies for meeting estimated physician need.

The United States is experiencing a shortage of physicians which is expected to worsen as the baby boomer cohort of doctors enter retirement, the nation's population ages and requires more intensive medical services, and programs to educate new physicians have insufficient capacity to keep up with demand. A deficit of 96,000 to 200,000 physicians is projected nationwide by 2020.^{xxxiv} In 2006 the Association of American Medical Colleges recommended the number of medical school slots in the country be increased by 30% by the year 2020. As the competition between states increases for a decreasing supply of physicians, it has become increasingly difficult to recruit out-of-state doctors to move to Alaska.^{xxxv}

The Physician Supply Task Force determined that Alaska has a shortage of physicians that is expected to worsen over the next 20 years. They estimated that Alaska should have 375 more physicians today, based on an assumption that Alaska should have 110% of the current national average physician-to-population ratio. The ratio of physicians to population in Alaska is 2.05 doctors per 1000 population compared to 2.38 doctors per 1000 population nationwide. Their recommendation was to increase the number of additional physicians practicing in Alaska each year from the current net average annual increase of 38 (78 new minus 40 lost to retirement and attrition) by more than 50%, to 59 net new physicians per year.

The Commission was impressed by the thorough and professional analysis conducted by the Task Force, but challenged a couple of the assumptions they used to derive estimates of current and future shortages in Alaska. One assumption the Task Force made was that the national average physician to population ratio is representative of the level of need. Another was that Alaska should have 10% more than the national average because of the structural inefficiencies in our state's health care system, and because of the additional administrative and supervisory responsibilities associated with support of paraprofessionals (Community Health Aides/Practitioners) and mid-level practitioners. The Commission felt that this assumption did not account for the fact that these other provider types relieve the actual direct patient care burden for those physicians, nor did it account for the expanded scope of practice of mid-level practitioners in Alaska that allows more independent practice on their part.

Because of questions regarding some of the Task Force's assumptions, the Commission was not prepared to agree at this time that Alaska faces a crisis in total physician supply, but conceded there is evidence pointing to a shortage of primary care physicians. The Alaska Center for Rural Health's 2007 Alaska Health Workforce Vacancy Study estimated a 20% statewide vacancy rate for general internists, a 19% vacancy rate for psychiatrists, and a 15.8% vacancy rate for family physicians. The problem Alaska's seniors are experiencing finding a primary care physician who will accept new Medicare patients is another indicator of this problem. These signs coupled with the Commission's strategic focus on developing and strengthening new primary care patient care models led to a determination that Alaska is experiencing a shortage of primary care physicians, and a recommendation that the state's limited public resources spent on physician supply development should be focused on increasing the supply of primary care physicians specifically.

A consideration of strategies to increase the supply of primary care physicians requires an understanding of the disincentives new medical school graduates face to entering primary care specialties. According to the Association of American Medical Colleges, the average educational debt of

indebted graduates of the class of 2008 was \$154,607, an increase of 11% over the previous year. 87% of graduating medical students carry outstanding loans, and 79% of graduating medical students have debt of at least \$100,000.^{xxxvi} The high level of debt most new physicians have to bear poses a significant disincentive to choosing to enter a primary care specialty, as these are the lowest paid fields. Other disincentives beyond relatively low pay exacerbated by high debt burden include the practice environments that tend to require more work hours, more on-call time, and a higher administrative burden for generalists, and also the higher prestige that is often associated with practicing as a specialist as opposed to a generalist. A combination of strategies for improving education, recruitment, and supporting innovative practice models is required to address the need for an increased supply of primary care physicians.^{xxxvii}

Alaska is one of just 6 states that do not have their own medical school. Instead, Alaska participates in a collaborative medical education program, WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho), that provides a medical school opportunity to rural states in the northwest. Instead of paying to support an in-state medical school, the Alaska Legislature appropriates funds to pay the University of Washington for the government subsidy portion of the WWAMI medical school, which is approximately \$50,000 per student per year. In addition to the government subsidy, Alaska WWAMI students pay tuition of approximately \$20,000 per year (equivalent to Washington in-state tuition for UW medical students).

The number of medical student seats Alaska supports in WWAMI is set in state law (AS 14.42.033). Alaska supported 10 seats since the beginning of the program in 1971, but the legislature doubled support to 20 seats beginning with the 2007 school year. Even after this 2-fold increase, Alaska has less than half the national average medical school capacity. The U.S. average number of medical school seats to population is 26.6 per 100,000, compared to 11.9 for Alaska.^{xxxviii} The 30-member nation OECD average is 39.6/100,000.^{xxxix} The Alaska Physician Supply Task Force recommended that Alaska expand participation in WWAMI to 30 and then eventually 50 seats.

The rate of return of Alaska WWAMI students to medical practice in Alaska is 47%, compared to the national average for all U.S. public medical schools which is 39%. Alaska medical students who participated in WICHE (Alaska's participation in WICHE medical school programs ended in 1995) had an 18% return rate. The actual return on investment for Alaska when the rate of return of all WWAMI students (including those entering Wyoming, Washington, Montana, or Idaho's program) to medical practice in Alaska is 88% of the number of seats Alaska has subsidized.^{xl} As far as quality, the U.S. News & World Report ranked WWAMI as the #1 medical school for primary care in 2009 for the 15th consecutive year, and also #1 for both rural medicine and for family medicine for the 17th consecutive year.^{xli}

The physician training pipeline ends with graduate medical education. Following completion of medical school, graduates have to complete a residency program in order to be licensed and practice in the United States. Residency programs vary in length. A family medicine residency is three years long. According to national studies physicians tend to stay and enter practice in the community where they complete their final residency training. Alaska was the last state in the nation to establish an in-state residency program, but since 1997 has had the Alaska Family Medicine Residency Program (AFMRP). The program expanded capacity from eight to 12 residency slots a few years ago. In the past 12 years AFMRP has graduated 75 family practice physicians. Of those 75 graduates, 80% have stayed to practice in Alaska, and over half of those who have stayed are practicing in rural Alaska. The AFMRP was designed to train physicians for practice in rural Alaska, so it is achieving its original goal.^{xlii}

A number of other residency programs are being considered for Alaska and are at various stages in the planning process. A pediatric residency program is being planned by a collaborative group including Providence, the Alaska Native Medical Center, and a number of private providers. This program would be a branch residency program of the UW Children's Hospital Pediatric Residency Program, with residents practicing in Alaska for four months out of each of the three years in the program. A psychiatric residency program planning process is underway with financial support from the Alaska Mental Health Trust Authority. This program would also be a branch program of UW, which has already developed a similar branch model in Spokane and Boise (these two programs have been successful in terms of retaining residency graduates to practice in their communities). Psychiatric residencies are four years in length, and the Alaska branch program would have the residents spending their first two years in Seattle, and their last two years in Alaska. One other residency program under consideration is for general internal medicine, but an organized planning effort has not quite coalesced at this point due to lack of financial support and leadership.

One barrier to development of residency programs in Alaska is funding. Most residency programs receive a significant portion of their operational funding from Medicare, which since its inception in 1965 considered educational activities in teaching hospitals a reimbursable expense. Because of the substantial growth in costs associated with support of graduate medical education (GME) – which in 2007 cost Medicare \$8.8 billion – Congress imposed a cap in the Balanced Budget Act of 1997 on the number of residency positions Medicare could support. The cap was set at the number of residents who were training in a given teaching hospital as of December 31, 1996, and did not include provisions for making adjustments or redistribution based on need. This cap effectively locks Alaska out of the Medicare GME funding pool.^{xliii}

Medical education expansion is an important strategy for increasing primary care physician supply, but the time it takes to prepare a college graduate to practice medicine is a minimum of seven years. In addition to increasing capacity for education of new physicians, other strategies to improve recruitment and retention of physicians from outside Alaska must be considered. Support-for-Service programs offer an important recruitment and retention tool for states. These programs provide current or future health practitioners with educational scholarships, educational loans, repayment of educational loans, or direct monetary incentives in return for a contractual obligation with the practitioner to serve a period of service in a needy area.

Loan repayment and financial incentive programs are the most popular form of support-for-service programs, as studies document service obligations established at the beginning of a practitioner's educational process (through a scholarship or loan) are less effective in terms of achieving the desired recruitment outcome as are loan repayment and financial incentive programs. Another benefit of loan repayment and financial incentive programs is that the return is immediate. One study documented a service completion rate of 94% and 93% respectively for loan repayment and financial incentive programs, compared to 63% and 41% respectively for scholarship and loan with service option programs.^{xliv}

One last strategy the Commission considered for addressing the shortage of primary care physicians was the use of mid-level practitioners – physician's assistants and nurse practitioners – to help meet Alaska's primary care need. The recent support by the Alaska Legislature for establishing a PA training program at UAA is a significant step, but opportunities for expanding the use of "physician extender" occupations should be further explored.

Recommendation C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.

Recommendation C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.⁵

Recommendation C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.

Recommendation C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.

Recommendation C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.

Recommendation C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing "physician extender" occupations as an additional approach to addressing the primary care physician shortage.

⁵ The Commission's recommendation that an educational loan repayment and direct incentive program be established for Alaska to assist with addressing physician shortage specifically is not meant to exclude other provider types for which shortages are documented from such a program.

D. Health Information Technology

1. General HIT Findings & Recommendations

Finding D1a: Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:

- Increased health care efficiency and effectiveness; and
- Improved clinical quality and patient safety.

Health information technology is a broad concept that encompasses the use of electronic data and communication systems for compiling, maintaining and transmitting health information. The term “health information technology” (HIT) is more commonly used today to refer to electronic health records (EHR), health information exchange (HIE), and related data collection, storage, and management applications. These data and information management applications are dependent on many of the same technologies as telemedicine/telehealth, which is the use of telecommunication technology to provide clinical and other health services when participants are at different locations. For the purposes of this report the Commission includes both EHR/HIE and telemedicine/telehealth under an umbrella definition of HIT.

Broad adoption of interoperable EHR/HIE systems is widely regarded to be an essential element of health reform, necessary to support increased efficiency and effectiveness of health care and also to improve quality and patient safety.^{xlv} Unfortunately the health care industry is far behind other industries, such as banking and commerce, in the adoption of electronic information management tools,^{xlvi} and the United States lags as much as a dozen years behind other industrialized nations in the move from paper to electronic health records.^{xlvii}

Telemedicine/telehealth has been used to improve access to health care in Alaska for decades^{xlviii, xlix}, and continued development, deployment and modernization of technologies supporting distance delivery of care is essential to meeting the Commission’s goals of improved access at a reasonable cost. Alaska is benefiting from early work in telemedicine/telehealth, as collaborative efforts to deploy and support use of telecommunication strategies for expanding access to health care in the state became the catalyst for projects and eventually whole new organizations now devoted to supporting adoption of EHRs and development of a statewide HIE.

The Commission identified HIT – both EHR/HIE and telemedicine/telehealth - as an essential cornerstone of health care delivery system transformation for Alaska because it is required for successful implementation of virtually all potential specific strategies for health care improvement – from cost and quality transparency, to fraud reduction, to supporting evidence-based clinical practice. But it is important to note that HIT is not a magic bullet that will solve all health care system problems – it is a tool – it is not a goal in itself. The Commission also found that, while there is evidence that HIT adoption leads to improved efficiency and quality of health care, there is insufficient research into the question regarding the financial effects.^{i,ii}

Recommendation D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.

2. Health Information Exchange and Electronic Health Records

a) Development and Use of HIE/EHR

Finding D2a: Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:

- Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
- The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers and small practices;
- Systems that are not user-friendly from the provider's perspective, i.e. are difficult, inflexible and time-consuming to use;
- Costs associated with on-going operation and maintenance; and,
- Antiquated and nonstandard eligibility and claims processing systems.

Finding D2b: Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records by providers. Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

Health care providers in Alaska have begun the transition of their medical record systems from paper to electronic format. A statewide survey conducted in 2009 to determine the current usage of EHRs and interest in their adoption among Alaska physician practices found that, of the 378 physicians and 62 clinic managers responding, 50% reported using an EHR and a third reported using ePrescribing.^{6:lii} Survey respondents who did not use an EHR reported that the initial cost and practice disruption are the major barriers to adoption. Uncertainty about which EHR system to buy was also a significant barrier.

Before continuing it may be helpful to define a few key terms. The federal government, in their work to standardize HIT, has developed a compendium of terms.^{liii} The new standardized definitions include:

- Electronic Health Records (EHRs) - "electronic records of health-related information on an individual that conform to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization."
- Electronic Medical Records (EMRs) are distinguished from EHRs as being internal to one health care organization - "electronic records of health related information on an individual that conform to nationally recognized interoperability standards and that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization."
- Personal Health Records (PHRs) are distinguished from EHRs and EMRs as being managed and controlled by the individual patient - "electronic records of health-related information on an individual that conform to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual."
- Health Information Exchange (HIE) is "the electronic movement of health-related information among organizations according to nationally recognized standards."

⁶ The surveyors noted that the percentage of respondents reporting EHR usage could not be ascribed to the total population of Alaska physicians because of the self-selecting nature of the survey methodology.

- Regional Health Information Organization (RHIO) - "a health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community."

The federal government is actively driving the health care industry toward broad adoption of HIT. In April 2004 President Bush established the Office of the National Coordinator for Health Information Technology (ONC).^{lv} The ONC is charged with coordinating and promoting the deployment of interoperable electronic health information systems throughout the nation as well as other related health technology initiatives. This agency has been leading national standards development initiatives and administering related grant programs for the past five years.

In 2009 Congress included more than \$20 billion in the American Recovery and Reinvestment Act (ARRA) for the development and adoption of health information technology under the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH sets a goal of 2014 to increase dramatically the number of health care providers who have and effectively use EHRs and HIEs. The goal is to be achieved through an array of financial incentives, education, training and state-led actions.

Under HITECH Medicare will begin providing incentive payments of up to \$44,000 for individual providers and \$2 million for hospitals starting in 2011 for "meaningful use of electronic health records." Beginning in 2015 providers not using an EHR will be penalized through reductions to their reimbursement rate. CMS and ONC issued regulations on December 30, 2009 setting standards for the Medicaid and Medicare incentive programs, providing a definition of "meaningful use," and setting standards for certification of EHR technology. Under HITECH state governments also play a lead role in planning and implementation of efforts to establish HIE(s) for their state.^{lv}

The Alaska Legislature passed SB 133 during the 2009 session, creating a statewide health information exchange system for Alaska and directing the Department of Health & Social Services to enter into a contract and to designate a qualified entity in the state to assist in the planning and implementation of the network. The Division of Health Care Services (DHCS) is leading this effort, and expects to award the HIE contract and designate the State HIE Entity this month (Jan 2010). DHCS is also responsible for development of a new Medicaid Management Information System (MMIS), and is working to ensure that the Statewide HIE Plan is closely coordinated with the State Medicaid HIT plan.^{lvi}

Two non-governmental organizations active in the advancement of EHR/HIE in Alaska today are spin-offs from the Alaska Telehealth Advisory Council (ATAC), which was created in 1999 with federal funds earmarked to foster telemedicine in Alaska. ATAC's membership included DHSS, hospitals, tribal health organizations, professional provider groups, the insurance industry, the telecommunications industry, and the University of Alaska. The ATAC sunset in 2007, but while the group was active they developed many initiatives that are continuing to support deployment and use of telehealth applications and services. In 2005 the ATAC fostered the creation of the Alaska EHR Alliance (AEHRA), formed to support implementation of EHRs in physician practices, and ChartLink, formed to support development of a statewide HIE. Chartlink was incorporated as a 501(c)(3) in 2008 as the Alaska eHealth Network (AeHN). AEHRA conducted the EHR physician survey earlier in 2009, and is now in the process of selecting two recommended EHR vendors for Alaska's providers based on the results of that survey, and will negotiate reduced prices for Alaska's providers with those vendors.

EHR/HIE-related health information management systems currently in use by state government in Alaska include:

- **MMIS (Medicaid Management Information System):** an electronic information management system the federal government requires all states maintain to process Medicaid claims and store and retrieve data needed to manage and audit the Medicaid program. Alaska's MMIS was implemented more than 20 years ago in 1987, and now new technology and federal requirements dictate the construction of a new system. The process to design, build and operate Alaska's new MMIS began in 2006 with release by DHCS of a Request for Proposal (RFP), and the resulting contract was awarded in 2007 to Affiliated Computer Services, Inc. (ACS). The new system currently under development is known as the Alaska Medicaid Health Enterprise. It expected to be operational by the fall of 2011.
- **RPMS (Resource and Patient Management System):** an information management system administered by the U.S. Indian Health Service that includes clinical, business practice, and administrative information management applications and is in use in most health care facilities within the IHS delivery system. In addition to a number of organizations within the Alaska Tribal Health System, the Alaska Division of Public Health's Public Health Nursing Section uses RPMS as the EHR/HIE for the state's public health centers.
- **AKAIMS (the Alaska Automated Information Management System):** a state government administered web-based management information system and clinical documentation tool for the state's behavioral health provider grantees. AKAIMS provides an EHR function in addition to supporting state and federal data reporting requirements. Behavioral health providers with their own clinical information systems are able to interface electronically to a data repository to allow compliance with state and federal reporting requirements.
- **Several public health monitoring and population health protection systems:** Disease tracking, biosurveillance and epidemiological investigations, and immunization monitoring are some of the governmental public health functions supported by information management systems. Systems currently in use by the Division of Public Health in DHSS include AK-STARS (infectious disease reporting system and database), VacTRAK (vaccine registry), the Alaska Cancer Registry, the Alaska Birth Defects Registry, and the Alaska Trauma Registry.

Financing currently supporting EHR/HIE development in Alaska includes:

- \$10.4 million awarded by the Federal Communication Commission (FCC) Rural Health Care Pilot Program to the Alaska Native Tribal Health Consortium (on behalf of the private/public partnership now represented by AeHN) at the beginning of 2008 to unify electronic health care networks throughout the state and enable connectivity between rural and urban providers within Alaska and to the Lower 48. The FCC funds are supporting the design and construction of a statewide broadband network to facilitate exchange of health information, and to support telemedicine services, video conferencing, and voice-over-internet applications. The Alaska Legislature provided \$500,000 in FY 09 through a capital appropriation to provide required matching funds in support of this project, and the Alaska Federal Health Care Partnership provided an additional \$500,000 in matching funds.

- \$300,000 from ONC to assess Alaska privacy and security laws, and subsequently an additional \$300,000 to develop policies and procedures for the secure and private exchange of health information. Alaska is one of the eight original member states in the Health Information Security and Privacy Collaboration (HISPC), which has been working together to develop inter-organizational privacy agreements. See the Privacy and Security section below for more information on this project.
- \$2.5 million in capital funding was appropriated by the Alaska Legislature for the Alaska Primary Care Association in FY 2009 to support development of the Alaska Community Health Integrated Network, a Wide Area Network for Community Health Centers in Alaska to support development and sharing of electronic health records, practice management software, videoconferencing and telehealth applications.

Recommendation D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.

Recommendation D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.

Recommendation D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.

Recommendation D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.

Recommendation D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.

b) Privacy and Security

Finding D2c: Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

For EHR and HIE efforts to be successful consumers and health care providers must trust their information will be kept confidential and secure. An appropriate balance must be struck between protection of individual privacy violations and breaches in system security, and the need to permit appropriate access to information. Policies that are too strict will decrease the value of electronic availability and exchange of information. Policies that are too lax will erode public trust and lead providers to implement restrictions to protect their patients.

Alaska is an original member state of the national Health Information Security and Privacy Collaboration (HISPC), a multi-state collaborative funded by the U.S. Department of Health & Human Services in 2006 to address the privacy and security challenges presented by electronic health information exchange. Governor Murkowski initially designated the ATAC to be the state's HISPC representative, but a new designee has not been officially named by a Governor since the ATAC sunset in 2007. Alaska ChartLink now incorporated as the Alaska eHealth Network has been filling the role as Alaska's representative to HISPC, providing a coordinated approach to addressing privacy and security issues for Alaska.

In Phase I of the HISPC Privacy and Security Solutions project an assessment of the current privacy and security landscape in Alaska was completed. The assessment included an intensive investigation of current community practices and the legal environment. AeHN facilitated discussions with 250 Alaskan providers and consumers from across the state to identify security and privacy issues related to data sharing, and provided that information to the federal team working on national policy. Since that time AeHN participated representing Alaska on a multi-state collaborative that developed a set of standardized data sharing agreements and policies for the exchange of protected health information between private health entities, and between public health agencies. Other standardized policies and procedures developed under Phase III of HISPC include, a Privacy and Confidentiality Policy, a Policy and Procedure for Addressing Breaches of Confidentiality, an Identification and Authorization Policy, a Provider Participation Agreement, and a Patient Participation Agreement.

Federal efforts to protect privacy and security of electronic health information continues with the implementation of the HITECH Act, which includes a focus on privacy and security and expands current federal privacy and security protections already in place under HIPAA (the Health Insurance Portability and Accountability Act). At the state level, SB 133 requires the HIE State Designated Entity to adopt an opt-out provision which will allow individual Alaskans to request removal from the data sharing system. The next step in HIE development for Alaska may include an update of medical records laws to support privacy and security in the emerging electronic environment.

Recommendation D2f: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.

3. Telehealth/Telemedicine

Finding D3a: Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.

Finding D3b: Barriers to adoption and use of telemedicine include:⁷

- Insufficient telecommunications connectivity in some rural Alaskan communities;
- Inadequate access to training for providers and their staff;
- Medical licensure restrictions across state borders;
- Misalignment of payment systems between costs and benefits.

Telemedicine – literally “medicine across distance” - is the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status. The term “telehealth” encompasses a broader definition of remote health care delivery that is not limited to clinical services.^{vi} Alaska has been a leader in the development and utilization of telehealth applications as a mechanism for improving access to care for nearly a century - from a 674 mile dogsled relay to transport desperately needed diphtheria anti-toxin to the residents of Nome in the winter of 1925⁸ - to CB radio communication between doctors in regional hospitals and Community Health Aides in village clinics during the 1960s – to remote monitoring of ICU patients in rural community hospitals by critical care specialists in urban medical centers today.

The Alaska Federal Health Care Partnership (AFHCP) was founded in 1995 to support collaborative efforts among federal health care providers, including shared training opportunities, service contracts, and technology. The Partnership includes the Department of Defense (Air Force 3rd Medical Group, Bassett Army Hospital), Veteran’s Administration (Alaska Regional Office), US Coast Guard, Indian Health Service, and tribal health organizations. The Partnership has launched a number of telehealth initiatives over the years for beneficiaries of their federal programs, including a home telehealth monitoring and care coordination program, a teleradiology project, and a telebehavioral health initiative.

The AFHCP created the Alaska Federal Health Care Access Network (AFHCAN) in 1998. AFHCAN is federally funded and operated by the Alaska Native Tribal Health Consortium. It provides telehealth solutions to 248 sites throughout Alaska, including tribal health organizations, Army, Air Force, and Coast Guard sites, and state public health nursing centers.^{lviii} They also now serve customers in other states and other countries, including Greenland and Panama. AFHCAN started out with the deployment of store-and-forward applications due to limited availability of broadband connectivity in the state, but has expanded to add video conferencing applications with the increasing access to high-speed lines with greater data capacity.

Other telemedicine programs actively involved in improving access to health care in the state today include the Alaska Rural Telehealth Network, Providence’s REACH system (for remote evaluation of stroke) and eICU, the Alaska Psychiatric Institute’s Telebehavioral Health Care Services Program, and the Southeast Alaska Regional Health Consortium Telebehavioral Health Program.

⁷ The order of the bullets in this finding is not meant to imply priority order of significance.

⁸ Coordination of the relay effort was achieved through communications by Morse code transmitted over telegraph lines.

An essential telecommunication service necessary for meeting today's telehealth and also HIE/EHR needs is broadband - advanced communications systems capable of providing high-speed transmission of services such as data, voice, and video over the Internet and other networks.^{ix} There are 82 communities in Alaska without broadband service, and an additional 31 communities with unknown Internet connectivity levels.^{ix} There are currently a number of federally funded programs supporting expansion and subsidies for broadband service in the state, including:

- The Rural Health Care Program of the FCC's Universal Services Fund (USF), administered by the Universal Service Administration Company, which provides health facilities in rural communities with affordable telecommunication services by subsidizing telecom and Internet access charges related to the use of telemedicine and telehealth. The Health Planning and Systems Development Section in the Division of Health Care Services provides technical assistance to rural health clinics across the state to help with the annual USF application process. 240 health clinics in rural Alaska submitted applications to this program in FY 2009.^{ix}
- The Regulatory Commission of Alaska and the Alaska Department of Commerce, Community and Economic Development have provided federally funded grants for a number of years (since 2003) to telecommunications carriers and cable operators to provide broadband Internet service in rural Alaskan communities. The Rural Alaska Broadband Internet Access Grant Program provides up to 75% of the funding required to expand broadband service into rural communities, and subsidizes rates for these services so that they are comparable to those paid by residents of Anchorage, Fairbanks and Juneau for a period of at least two years after expansion project completion.^{ix}
- The American Recovery and Reinvestment Act of 2009 included \$7.5 billion to increase broadband access in underserved areas of the country, and also included associated funding to create a nationwide map of broadband availability. The Denali Commission received a federal stimulus grant under this initiative in November 2009 to map broadband access in Alaska down to the census block level. The project will identify availability of wireless, cable, fiber optic and telephone services along with connection speeds, and is expected to be completed by 2012. A number of Alaskan telecommunication companies have already applied for stimulus funds to continue the deployment of broadband to rural Alaska.

Recommendation D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.

Recommendation D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.

E. Access to Primary Care for Medicare Patients

Finding E(a): Alaska's Medicare-eligible population is growing.

Finding E(b): Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.

Finding E(c): One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.

Finding E(d): Health care providers report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.

Finding E(e): Care for Medicare patients is often more complex and time-intensive than for the general patient population.

Finding E(f): Mid-level practitioners are increasingly being used to solve the Medicare access problem.

Finding E(g): Health care providers report Medicare's physician and mid-level practitioner reimbursement schemes are not rational and not reliable.

Finding E(h): Health care providers commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

Background

Medicare is the federal government's health insurance program for the elderly (age 65 and older) and disabled. Created by Congress in 1965, it is partially funded with payroll taxes, and is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health & Human Services. Medicare benefits include:

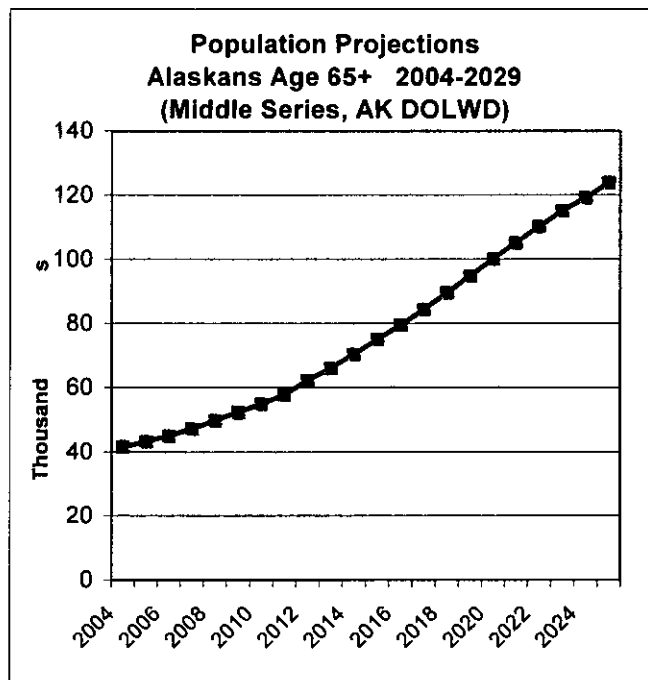
- **Part A (Hospital Insurance)**, covering inpatient hospital stays, some care in skilled nursing facilities, and hospice.
- **Part B (Medical Insurance)**, covering medically necessary services not covered under part A, such as outpatient hospital care, physician services, some preventive services, diagnostic tests, and durable medical equipment.
- **Part C (Medicare Advantage)**, an optional fee-for-service plan that provides Part A and Part B benefits through a private health insurance plan.
- **Part D (Medicare Prescription Drug Plan)**, provides prescription drug coverage.

Medicare premiums are highly subsidized by the federal government, and spending for Medicare has grown steadily since its inception with costs doubling every four years between 1966 and 1980. Medicare costs, now at \$495 billion, accounted for 19% of all health care expenditures in the U.S. in 2009. One strategy the federal government implements to control soaring costs is limiting the physician payment rate.

The sustainable growth rate (SGR) formula for Medicare was created by Congress in 1997 to limit Medicare growth. The SGR, which is tied to the GDP, triggers reductions in the Medicare physician payment rate when costs rise too steeply – which has been the case each year since the SGR was created. Congress has not had the political will to enforce the reductions however, and has intervened each year to block them. While the statutory payment reductions have not been enforced, the SGR has had the effect of limiting potential payment rate increases. This strategy has not had the intended effect however, as reduced or limited payment rates are offset by increased utilization and total Medicare costs have continued to rise.

Another variable in Medicare physician rate setting are geographic differentials. Alaska has benefited from successful efforts by our congressional delegation to enact legislative provisions to boost the reimbursement rate for Alaskan physicians by increasing Alaska’s geographic differential. Effective January 2009 Alaska’s Medicare physician reimbursement rate was set permanently in federal law at 29% above the national average.

In 2008 there were 59,435 Alaskan Medicare beneficiaries, approximately 82% of whom were aged 65 or older with the remainder qualifying due to disability. The number of Alaskans aged 65 and older has more than doubled over the past two decades, from 22,095 in 1990 to 49,455 in 2008. That number is projected to nearly triple again by the year 2030 to 134,391.



The Problem

Many Alaskan Medicare beneficiaries, particularly those in more urban communities, report they have trouble finding a physician to take them as a patient. A study conducted by the Institute for Social and Economic Research (ISER) at UAA in 2008 confirmed there are few primary care physicians in Anchorage who will accept new Medicare patients.^{lxiii} The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.^{lxiv}

Driving this problem is the growing demand for Medicare services due to 1) the aging of Alaska's population, and 2) the need for increasingly complex care to treat and manage chronic conditions. As noted above, Alaska is experiencing significant growth in the Medicare eligible population that is expected to continue over the next two decades. The growing number of Medicare beneficiaries is compounded by the amount of extra time and effort it takes to treat a typical Medicare patient. One study found that for every 100 Medicare patients a primary care physician treats, that physician potentially has to interact with 99 other physicians in 53 different practices as they work to coordinate treatment of multiple and complicated health problems.^{lxv}

The problem of growing demand is compounded by an inadequate supply of primary care physicians. Physicians report Medicare's low reimbursement rates, about one-third less than what private insurance pays in Alaska, as a primary reason behind decisions to not accept new Medicare patients or opt out of the Medicare system entirely. Other factors playing into these decisions include Medicare's burdensome administrative requirements, and a federal government audit process that is onerous and punitive. If there were more primary care physicians they would be able to spread the Medicare patient load and physician practices might more easily be able to absorb losses from lower reimbursement and increased paperwork.

Potential Solutions

Recognizing that the ability to drive changes in federal policy is limited, the Commission felt the most effective state-based strategy for addressing the Medicare access problem is to increase the supply of primary care providers, following similar recommendations to those specified in Part III.C of this report. The Commission was particularly interested in the opportunity to develop an internal medicine residency program for Alaska. One of the few primary care practices in Anchorage that was accepting new Medicare patients until recently was the Family Medicine Residency Program, but they had to cap the number of seniors they could accept as the elder portion of their patient population had grown to the point that the residents were not able to get the amount of experience with younger populations they needed. An internal medicine residency program would provide a dual benefit by producing more primary care physicians who specialize in treating adults and who are likely to stay in Alaska to practice, and by also creating a new clinical practice that would accept Medicare patients.

The Commission heard from a couple of groups proposing to expand clinical capacity. One group proposed starting a new for-profit primary care practice that would see Medicare patients exclusively, and would be staffed by a physician-led nurse practitioner team. The Commission had reservations regarding the proposed care model, which would limit a patient's ability to be seen for multiple conditions at the same time. The complex care needs of this population are too great and require a high level of coordination. The Commission also felt that a for-profit practice should be able to make the business case to investment partners if the proposal was viable, and that government investment would

not be appropriate. A second group suggested that expansion of the Anchorage Neighborhood Health Center (ANHC) would support the ability to expand the Medicare patient population seen there, but a specific request was not made of the Commission, and the ANHC recently received a sizeable state capital grant (\$10 M) to support the planned expansion. The Commission felt that state government strategies for expanding medical clinic capacity are most appropriately targeted at Federally Qualified Health Centers and Rural Health Clinics – which are non-profit safety net providers such as the ANHC.

The Commission determined that it was also necessary to request assistance again from Alaska's congressional delegation with seeking relief from Medicare's inequitable reimbursement rates, burdensome administrative requirements, and onerous audit conditions. There were questions about how the administrative requirements of Medicare compare to Medicaid and other 3rd party insurance providers, and a suggestion was made to investigate that question in order to support the request.

One new program the Commission considered as a potential solution to the Medicare access problem was PACE (Programs of All-Inclusive Care for the Elderly). PACE is a Medicare and Medicaid program that provides community-based care and services for older adults and people over 55 living with disabilities who would otherwise require nursing home level of care. PACE programs are required to provide a comprehensive set of wrap-around integrated medical and social services managed by an interdisciplinary team of health care professionals. Eligible Alaskans on Medicare choosing to participate in this optional program would be guaranteed access to primary care.

Initially started as a Medicare demonstration project in 1978, PACE proved so successful in improving outcomes for families and patients, health care providers, government and other payers, that it has been replicated in 31 states by 69 PACE organizations that serve nearly 18,000 individuals today. An evaluation by the federal government (then HCFA now CMS) conducted during the 1990s that studied the impacts of PACE on a wide variety of outcomes found that it resulted in long-lasting decreases in nurse visits to the home, inpatient hospital admissions, inpatient hospital days, and nursing home days. In addition, this study found that PACE enrollees lived longer and spent more days in the community than did non-PACE participants in a similar demographic control group.

The estimated number of Alaskans dually-eligible for both Medicare and Medicaid living in the Municipality of Anchorage is 7,539.^{lxvi} An estimated 10% may be eligible to participate in a PACE program. Two Anchorage health care organizations, Providence and Southcentral Foundation, have expressed some interest in potentially developing a PACE program in the community.

States may elect PACE as an optional Medicaid benefit through the Medicaid State Plan Amendment process. Approval of a State Plan Amendment by CMS does not obligate the state to implement a PACE program, but provides the option and positions the department and interested providers to move forward with program development.

Because only the frail elderly and disabled are eligible to participate in PACE, and those individuals are likely to be receiving higher levels of specialty care already, eligible participants are not as likely to be among those Medicare patients experiencing problems with access to health care. Developing a PACE program in Alaska would most likely make only a very small impact on the Medicare access problem, but because of the many other benefits a PACE program would offer eligible Alaskans, the Commission determined the state should facilitate development of this program.

Recommendation E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by:

- Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved);
- Supporting development of a primary care internal medicine residency program;
- Supporting WWAMI program expansion as resources allow; and,
- Supporting mid-level practitioner development.

Recommendation E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.

Recommendation E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska's Congressional delegation to improve Medicare's reimbursement scheme to ensure the sustainability of care to Medicare patients.

Recommendation E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.

Recommendation E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.

Recommendation E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.

PART IV: Health Care System Transformation Elements

A number of issues and potential strategies were identified by the Commission as important to a comprehensive approach to health care reform for Alaska. Potential elements of health care system transformation identified for future study are described briefly in this part of the report, and a suggested approach for planning related to these issues is provided in Part V.

A. Access to Health Care

1. Health Insurance Coverage

Because federal health care reform efforts underway during 2009 have focused primarily on increasing health insurance coverage, the Commission decided it would not be prudent to evaluate state options for expanding coverage until Congress completes their work.

Future study of access to health care coverage will require analysis and understanding of:

- **National reforms adopted in and for Alaska.** Strategies for increasing health insurance coverage in pending federal legislation include creation of a new government-administered insurance plan ("public option"), creation of health insurance exchanges, creation of non-profit member-operated health insurance cooperatives ("Co-ops"), expansion of Medicaid eligibility, individual and employer mandates requiring purchase of insurance, subsidies for low income individuals to purchase insurance, and insurance market reforms. If federal legislation passes, future state health commission work should include analyzing options and making recommendations for state policy direction needed to implement federal reforms at the state level. At a minimum, the work of this or a future commission to consider health insurance coverage expansion will require study of the impact of national reforms in Alaska.
- **Alaska's private insurance market.** Only 23% of Alaskans have health insurance purchased on the private market. An additional 32% have insurance through their employers' self-insured plan (exempt from state regulation under federal law (ERISA)). The remaining 45% of Alaskans have insurance through a public plan (Medicaid/Medicare), have health care provided by the military or the tribal health system, or are uninsured. Consideration of insurance market reform strategies will require study of the potential impact on Alaska's health care system since less than a quarter of the population is covered by the state-regulated insurance market.^{lxvii}
- **The challenge small businesses face in obtaining insurance coverage for their employees.** Most of Alaska's smallest businesses (those with fewer than 10 employees) cannot afford to offer health benefits to their employees. 52% of uninsured Alaskans are employed adults (9% are unemployed adults, and the remainders are children and others not in the work force). Those studying this issue in the future can benefit from the work conducted by the Department of Health & Social Services on health insurance coverage in Alaska during 2005-2007 under a grant from the Robert Wood Johnson Foundation. One of the findings from that study is the importance of understanding the seasonal nature of Alaska's workforce. Other results from that study were obtained from surveys and focus groups conducted with Alaska business owners regarding their ability to obtain insurance for their employees and the barriers they face.

2. Health Care Workforce Development

Alaskans' access to quality health care is dependent on the availability of a well trained health care workforce with sufficient numbers of workers in the right occupations and the right locations to meet the needs of the population. The focus by the Commission during their first year on the physician workforce was just a first small step and only one component in what should be a comprehensive and sustained approach to development and implementation of a health care workforce strategy for Alaska. As noted in Part III, Section C of this report, there are numerous organizations collaborating on various aspects of health care workforce planning and development. Future study and improvement of Alaska's health care workforce cannot occur in isolation but must consider and build on these other efforts, and a comprehensive approach to addressing Alaska's health care workforce needs must include strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of health care workforce planning, development and support infrastructure

3. Physical Health Care Services

Individual services and systems of care within the health care delivery system need to be better understood and considered as part of future work to improve the system. During this year the Commission heard specific concerns about access to dental services, and the condition of Alaska's Trauma System. Those two areas could be a starting point for delving deeper into analysis of Alaska's health care system. Additional areas might include pharmacy, vision care, and preventive services.

4. Behavioral Health & Long Term Care

The Commission noted that any effort to transform Alaska's health care system should consider the system from the consumer's perspective. From the individual health care consumer's perspective their behavioral health and long term care needs cannot be separated from their physical health needs. For that reason alone future health care planning and policy development efforts need to consider these other systems and services, and another important factor necessitating their inclusion is that behavioral health and long term care are significant cost drivers in the increasing cost of health care.

The Commission did not attempt in their first year to address issues related specifically to the funding and delivery of behavioral health and long term care in Alaska. In part because there are other groups working on planning for behavioral health and long term care improvement, such as the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, and the Department of Health & Social Services, while there is no other entity charged with examining the broader health care delivery system. Future work must not leave these sectors out however. Recent plans, such as the Comprehensive Integrated Mental Health Plan and the State Plan for Long Term Care Services, should be reviewed.

If this or a future Commission wishes to foster innovation in transforming Alaska's health care system to better support a healthier Alaskan population they will need to coordinate with the behavioral health and long term care planning entities to ensure they are taking an integrated and holistic approach while not duplicating efforts.

B. Cost & Quality (Value)

The trend in state and federal health care reform efforts has been moving away from more simplistic cost control measures, such as caps on fees, towards a focus on improved value, thus most strategies to address the cost of care cannot be separated from strategies to improve quality.

1. Understanding the Cost of Care in Alaska

Information presented in Part II of this report indicates costs are higher in Alaska compared to other states, but a thorough understanding of the underlying reasons why costs vary is required prior to making specific policy recommendations to address the problem. Is it due to an insufficient supply of providers and insufficient competition between providers? Is there higher utilization of medical services in our state, and if so is it due to waste in the system or due to a higher prevalence of complex health conditions? How does fragmentation of the health care delivery system affect overall costs? Are payers unable or unwilling to negotiate the lowest possible price for services?

An important aspect of understanding variations in cost and underlying cost drivers is understanding how cost shifting occurs when one payer or set of payers underpays a health care provider (pays less than the costs the provider incurs to deliver the service). Prices charged are typically higher than the cost of care (and beyond profit margin) to make up for capped reimbursement by some providers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are not able to pay. Further analysis of cost drivers and cost shifting is needed to support development and implementation of successful strategies to control cost and improve value.

2. Primary Care Innovation

One of the Commission's central strategies for improving health care cost and quality is innovation in the patient care model at the primary care level. A lot of work must be done to implement the Commission's recommendation (#A2a) in support of primary care innovation. A collaborative effort with the primary care provider community and the Alaska Department of Health & Social Services needs to be undertaken to define the care model in more specificity beyond the identified characteristics, performance standards and measures must be developed, required internal organization supports for providers must be identified (such as information technology, knowledge management strategies for evidence-based practice, and development of effective teams), as well as requirements for a supportive payment and regulatory environment.

3. Value-Driven Purchasing

The fee-for-service approach to purchasing health care drives up the overall cost of care by incentivizing the provision of more services, and more costly services, while offering no incentives for improved quality or efficiency. "Value-driven purchasing" (VDP) identifies and implements purchasing practices intended to improve the value of health care services by holding providers accountable for both the quality and cost of services delivered to patients. VDP strategies include establishing standardized quality measures and reporting requirements, reporting of health care price and quality information, and use of direct incentives or disincentives to providers and consumers to promote improved quality of care and health outcomes as well as greater value for dollars spent. There are a number of strategies that could be studied to start Alaska on the road to value-driven purchasing.

a) Leverage State Purchasing Power

State government in Alaska represents a substantial payer for health care services. The state spent over \$1.5 billion last year in Medicaid expenditures, payment of state employee and retiree claims (not counting benefit credits paid to union health trusts), payment of state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. Collaboration between these state programs to develop shared value-driven purchasing strategies could provide significant market-share leverage for improving health care quality and cost in this state. This is an area that warrants additional study and potential recommendations.

b) Provider/Payer Cost Sharing Demonstration Projects

Because of the way the fee-for-service payment system is structured, health care providers may face situations where implementing measures that will reduce overall costs in the system and save money for the payer will actually increase the cost the provider incurs while reducing their revenue. This may be particularly true of hospitals, when investing in a costly new technology will improve patient outcomes and reduce hospital bed days. Future work on this issue could involve working with Alaska's hospitals to determine the extent to which these types of situations might delay innovation (and thereby delay improved patient outcomes and overall system costs), and consider the advisability of cost sharing demonstration projects.

c) Cost and Quality Transparency

Consumers need to know the price and quality of their health care options in order to make informed decisions and support their ability to participate more fully in their care. Empowering consumers with information not only supports improved decision-making on their part, but drives the entire system to provide better care for less money. An infrastructure to support transparency of health care cost and quality for Alaskan consumers, compiling and analyzing data on pricing and quality measures for physician services and hospital care and producing public information through an accessible and understandable reporting mechanism, does not currently exist.

Creating a system to provide transparency is not as simple as it may sound however. Pricing of individual services might be misleading without a more comprehensive picture of the total cost of care for a given condition and the expected outcomes of various care options. And transparency to support a market-based approach is not the only solution to the health care cost and quality problem. Health care is different than other goods and services, and all the conditions required for a competitive market do not exist in the health care market. Consumers do not fully control all of their health care dollars, and they cannot participate fully in all aspects of clinical decision-making about their care. In addition, many

health care decisions are made for consumers in urgent or emergent situations when the consumer is severely ill, injured or under too much emotional stress to participate in their care decisions.

The potential benefits of and barriers to developing an information system to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent in order to improve quality and control costs.

d) Evidence-Based Medicine

The Dartmouth Atlas of Health Care^{lxviii} and numerous other studies have consistently demonstrated wide variations in practice patterns and use of health care resources across geographic regions of the United States – the tests and treatment a patient with a given health condition receives varies based on the location in the country where the care is received. The waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending. Moreover, research has documented those regions of the country where there is overuse of health care resources and resulting higher spending actually have lower quality of care and worse health outcomes.^{lxix lxx lxxi}

Decreasing the variability in health care services and spending requires the application of evidence-based medicine, which seeks to improve the decision-making of individual health care providers as they make diagnosis and treatment decisions about individual patients, to engage the patient in making informed decisions about their care, and to improve the policies of payers and health care delivery organizations. Evidence-based medicine is defined as a set of principles and methods intended to ensure that to the greatest extent possible, population-based policies and individual medical decisions are consistent with evidence of effectiveness and benefit.”^{lxxii} The core idea behind evidence-based medicine is that the right care must be provided to the right patient in the right place at the right time and at the right price. And that all the determinations about what constitute these “right” decisions are based on the best available scientific evidence.

Improving evidence-based medical decision making may be the key to increasing value in health care – decreasing cost and increasing quality. There are a number of roles public policy can play in supporting and driving the use of evidence-based medicine. One state government example comes from Washington state, which has enacted a set of statutory provisions authorizing the state’s public payers (Medicaid, Workers’ Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improving quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.^{lxxiii} Continuing work to improve value must include identification of the best approaches to expanding the application of evidence-based medicine in Alaska

e) Payment Reform^{lxxiv}

The current fee-for-service payment system rewards health care providers for volume, not value. The financial incentives in this system lie entirely in the provision of more health care services and the sale of more health care commodities regardless of the quality of care provided, and may actually serve as a disincentive to creating health. Movement away from fee-for-service to new payment methodologies will require capacity for electronic information management, and therefore development and implementation of health information technology.

Reform of payment methodologies to reward quality can evolve in an incremental approach that can be initially pilot tested and gradually implemented to prevent harm to health care providers and their

business interests, and in a way that supports providers as they transform the health care system over time. Research is required to guide implementation of new payment methods, and careful evaluation is required to assess cost-effectiveness, impact on quality of care and patient outcomes, and identification of unintended consequences. Following are three value-driven payment strategies this or a future Commission might choose to analyze and for which they might develop policy recommendations.

- ***Pay-for-Performance***

A pay-for-performance program provides a bonus payment for health care providers meeting certain standards of quality on a predetermined set of clinical measures. One approach would provide incentives for improvement over baseline performance as well. One challenge to developing a pay-for-performance program in Alaska will be the small size of many of Alaska's hospitals and the lack of any large primary care group practices, as sufficient patient volume to provide statistically valid measurement of quality is required.

- ***Patient-Centered Primary Care Enhanced Service Payment***

The Commission in this report recommends the state of Alaska aggressively pursue development of innovative models of patient-centered primary care. Implementation of this recommendation will require further work to develop a detailed definition including the criteria a practice will have to meet in order to be deemed as meeting the new standard of care. The level and source of funding as well as the reimbursement mechanism for enhanced payment to support these new patient care models will need to be identified as well. As Medicaid is the state's largest payer, the Department of Health & Social Services is the logical entity to begin this next level of planning in support of the development of a Medicaid pilot program. DHSS might look to partner with other state agency health care purchasers and also private health insurance companies operating in Alaska to expand the reach of such a program.

- ***Bundled Payment Systems***

Payment bundling provides a global fee for a specified set of services. Development of this payment system could be evolved over time, starting with bundling of a limited set of hospital services related to certain acute care episodes (related to certain illness diagnoses for a specified period of time – for example, coronary artery bypass surgery and extending 30 days beyond discharge); and expanding over time to include physician inpatient care and post-acute care. A particular challenge to implementing this strategy in Alaska is the lack of integrated care networks here. Hospitals would initially have to contract with physicians and other service providers required to deliver the suite of services potentially needed to treat the bundled diagnoses or procedures. Other challenges involve the lack of sophistication of information and accounting systems of many of Alaska's smaller hospitals, the need to identify standards to ensure cost reduction does not negatively impact quality, mechanisms for avoiding "cherry-picking" of patients with the potential for fewer complications, and ways to reduce exposure to risk for providers.

f) Reporting and Non-Payment for "Never Events" and other Health Care Acquired Conditions

"Never events", as suggested by the term, are occurrences of medical errors that should never happen. The National Quality Forum maintains a list of 28 Serious Reportable Adverse Events considered "never events." Examples include surgery performed on the wrong body part, surgery performed on the wrong patient, leaving a foreign object in a surgical patient, patient death or disability due to use of a contaminated device, and patient death or disability due to a medication error.

CMS enacted a policy on July 31, 2008 to deny Medicare payment for medical services provided by a hospital for care required as the result of a never event. The new CMS policy also authorized State Medicaid Directors to enact this same policy in their state Medicaid program. A number of private insurance companies also have non-payment for never event policies.

Health care acquired infections, such as MRSA and C.Diff, are not included on the "never event" list; however the U.S. Centers for Disease Control and Prevention estimate that, in hospitals alone, these infections account for 1.7 million infections and result in 99,000 deaths annually. Many more are estimated to occur in other health care settings such as day-surgery clinics.

Required public reporting of these conditions can serve as an incentive for health care providers to increase efforts to prevent these problems, and also provide the public health system with information needed to assist health care providers with prevention techniques. Statutorily mandated health care acquired conditions reporting has been considered by the Alaska legislature in the past, and a plan for developing a health care acquired conditions reporting system is currently under development by the Alaska Division of Public Health in the Department of Health & Social Services.

Future work on this issue could include an assessment of the incidence of medical errors in Alaska, the extent to which never event payment policies have been adopted in Alaska, and if there are opportunities for expanded and improved use of this policy as well as other strategies for reducing the occurrence of medical errors and improving patient safety.

4. Fraud & Abuse Control

The National Health Care Anti-Fraud Association, a public-private partnership of insurance company and government health care payers, estimates that a minimum of 3% of national health care expenditures is lost to fraud and abuse. Health care fraud - intentional misrepresentation or deception for the purpose of receiving higher reimbursement - can take many forms. One of the more common forms is for criminals to obtain patient information and pose as fictitious doctors, billing public and private insurance plans for service that was never rendered. The increased cost to payers for these fraudulent claims translates into increased premiums for private insurance holders and increased taxes to support Medicaid and Medicare.

It is difficult to determine the actual extent and impact of fraud and abuse in the health care sector - one cannot survey the criminals to determine how much they are making - but future work on this issue could include analysis of the current systems in place for fraud and abuse detection, investigation and prosecution for Alaska's Medicaid program and utilized by the insurance industry here. This analysis could include a look at current capacity, including funding and staffing levels, current practices, and also criminal penalties in state statute.

5. Tort Reform

Costs associated with medical liability (medical malpractice insurance premium costs, malpractice awards, and the practice of defensive medicine) are believed to be one driver of increasing health care costs, and reform of related civil justice laws has been one cost control strategy suggested in health care reform debates at the federal and at state levels. Estimates of potential savings from medical malpractice reform vary, but two very recent studies predict measurable savings. The Congressional Budget Office, in an October 2009 study for Senator Hatch, pegs the potential cost savings at 0.5% of

total national health care spending. The National Bureau of Economic Research estimates, in a September 2009 study, that three different types of medical tort reform could reduce premiums for employer-sponsored health insurance plans by 1 to 2% each.

This is one strategy that has been addressed at least partially in Alaska. In 2005 the Alaska Legislature passed the Alaska Medical Injury Compensation Reform Act, limiting noneconomic damage awards for personal injury resulting from health care services to \$250,000 (limit increases to \$400,000 for wrongful death or injury resulting in permanent physical impairment that is more than 70% disabling). Alaska's court system also plays a role – discouraging frivolous lawsuits through Alaska Civil Rule 82, which requires the losing party to tort litigation to pay attorney fees and court costs to the prevailing party.

Future work related to this issue could include evaluation of the impact of the medical liability reform law passed in 2005 and study of additional strategies, such as regulation of medical malpractice insurance providers and development of programs to encourage alternatives to litigation.

6. Process Innovation Strategies

One other factor driving higher cost and reduced quality is operational inefficiency in the delivery of health care services. Inefficiencies associated with both direct medical services and those associated with administrative and logistical support services can benefit from systematic efforts to streamline work processes and drive out waste.^{lxxv} Health care managers have been successfully applying process-innovation strategies that are popular in the manufacturing industry to improve efficiency and quality of their services. Examples of problems tackled range from reducing the number of mistakes in invoices, to reducing the number of patients requiring intravenous antibiotics, to shortening the length of stay in chronic obstructive pulmonary disease patients.^{lxxvi}

Two popular process-innovation strategies in use in health care systems today are Lean Thinking and Six Sigma. Lean Thinking (also known as Toyota Production System (TPS), or simply "Lean") came out of the Japanese auto industry. Lean provides an integrated set of tools, principles, and practices focused on waste reduction and synchronizing work flow, utilizing an extended process flowchart as a tool for identifying non-value-added steps and bottlenecks. Six Sigma was originally introduced by Motorola as a method for driving company-wide quality improvement. It provides an organizational structure of project leaders and project owners, and a problem-solving strategy similar to medical practice – information gathering followed by careful diagnosis, application of "treatment," and follow-up to determine efficacy.

Future work to improve efficiency in health care service delivery processes in Alaska could include analysis of the extent to which manufacturing industry process innovation strategies are being applied by Alaska's major health care providers. Options and opportunities for fostering the transformation in the culture of Alaska's health care businesses to focus on continuous improvement could be identified. Also methods for spreading the adoption of process innovation strategies, for example by supporting forums for sharing best practices and providing technical assistance, could be considered.

C. Prevention

1. Public Health: Population-Based Health Promotion & Disease/Injury Prevention

Many diseases and injuries are preventable. Simple, non-medical, individual approaches to prevention such as hand washing, eating healthy foods, exercising, not smoking, drinking alcohol in moderation if at all, and wearing bicycle helmets and life jackets go a long way towards avoiding illness and injury. Individuals acting alone cannot create all of the conditions necessary to ensure good health however.^{lxxvii}

Since antiquity societal leaders recognized the importance of communal action to protect and promote the health of community members. Some of the rules described in the Old Testament were intended to prevent illness in the community from contaminated food or to prevent the spread of communicable disease. Today governments act to ensure safe food and water, maintain sanitation systems, provide vaccinations, deliver maternal and child health services, enact public policies such as seat belt laws, and operate programs such as tobacco control in order to optimize the health of the population under their jurisdiction.

Public health is defined as “what society does collectively to assure the conditions for people to be healthy.”^{lxxviii} There are two main characteristics of public health – 1) it is concerned with prevention rather than cure, and 2) it is concerned with population-level rather than individual-level health issues. Public health protects and improves communities by preventing epidemics and the spread of disease, promoting healthy lifestyles for children and families, protecting against hazards in homes, work sites, communities and the environment, assuring high quality health care services, and preparing for and responding to emergencies.

The significant improvements in health status in the United States during the 20th century – such as the increase in life expectancy from 45 years in 1900 to over 75 years in 2000 – are primarily due to public health interventions. Only five years of this 30 year increase in the average lifespan of Americans is attributable to the aggregate effects of improvements in medical care.^{lxxix} 25 years of this gain are due to advances in public health.^{lxxx} Attainment of the Commission’s vision to transform Alaska’s health care system so it focuses on creating health and not simply treating illness and injury requires an understanding of and support for Alaska’s public health system.

A report by the Institute of Medicine published in 2002 found that the nation’s governmental public health infrastructure had been neglected, and an overhaul of its components (e.g., workforce, laboratories, public health law) was needed to ensure quality of services and optimal performance. Governmental public health agencies are the backbone of the public health system but do not work alone. Other organizations and sectors of society – including the health care delivery system, communities, business, the media, and academia are important partners in the public health system.^{lxxxi}

In Alaska the state legislature is charged under the constitution to “provide for the promotion and protection of public health” (Constitution of the State of Alaska, Article VII, Section 4). The legislature has paid attention to the needs of Alaska’s public health infrastructure over the years. For example, by funding construction of two new technologically modern public health laboratories during the past 10 years, and by passing comprehensive reform of the state’s public health laws as they relate to public health functions (AS 18.15) in 2005. But a review of Alaska’s public health system has not been conducted in over a decade, and the capacity of the system to meet the need for population-based health promotion and disease and injury prevention is not well understood.

Future work by the Commission could include analyzing the adequacy of Alaska's public health infrastructure, and developing policy recommendations to ensure the state's public health system is sufficiently supported to deliver population-based disease and injury prevention and health promotion services.

2. Safe Water and Sanitation Systems

Safe water and waste water systems are essential to the prevention of disease. At the turn of the last century infectious diseases such as typhoid and cholera were the leading cause of death in the United States. Today many of those diseases have been virtually eliminated - in large part due to modern sanitation systems.

The association between safe drinking water and gastrointestinal illness has long been recognized, but a recent study conducted in Alaska by the CDC Arctic Investigation Program found a link between in-home water service and higher rates of respiratory and skin infections as well. The CDC team noted as "particularly disturbing" their finding that villages in one region with low in-home water service (less than 10% of homes served) experienced a respiratory infection hospitalization rate that was five-times higher than that of the general U.S. population, and a pneumonia hospitalization rate among infants that was 11-times higher.^{lxxxii} This study demonstrates the importance of having safe water that is not only available in the local community for drinking, but is also readily and easily available in the home for hygiene use.

Nearly every home in the U.S. – 99.4% according to the 2000 U.S. Census – now has running water and flush toilets. Alaska ranks last in the nation, with 93.7% of Alaska homes having these basic services. In rural Alaska however, only 77% of homes have modern sanitation facilities.^{lxxxiii}

Support for improved sanitation systems in rural Alaska has been underway for some time, beginning with efforts of the Indian Health Service in the 1960s. In 1972 the state of Alaska enacted the Village Safe Water Act and began contributing state resources for construction of water projects. In 1994 the Rural and Native Sanitation Development Program, jointly funded by the state and federal government, was implemented. When this program began only 37% of rural Alaska households had adequate sanitation facilities. Today the Alaska Department of Environmental Conservation administers the Village Safe Water Program in partnership with the Alaska Native Tribal Health Consortium, providing state and federal funds totaling approximately \$60 million annually as well as technical assistance to Alaska's smallest communities to design and construct water and wastewater systems.

Future work on the part of the Commission could include developing an understanding of the state's plan for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community, and developing policy recommendations to ensure the state's adherence to that plan.

3. Employee Health Risk Management

Health care spending on individuals with one chronic condition is more than twice that for people without such conditions, and spending is nearly 15 times greater on individuals with five chronic conditions. Employers and their insurance plans are increasingly working to change enrollees' health behaviors as a means of achieving cost savings.

Health Risk Management Programs offer incentives such as lower premiums or contributions to HSAs for employees who agree to participate in the program. These programs generally require a health risk assessment and health improvement goals supported by lifestyle management tools, health coaches, and disease management plans.

Health Risk Management Programs have demonstrated effectiveness in reducing the rate of increase in health insurance premiums over time. The City and Borough of Juneau has a long standing program (since 1989), and over the years their premium rate increases have consistently been below the regional average. Safeway has flat-lined employee health benefit cost increases for four years straight since implementation of such a program. Providence Alaska, which is self-insured, launched a program in November of this year based on findings that the program will reduce costs.

While this strategy has primarily been about cost control, it demonstrates how a focus on prevention can work to make individual Alaskans healthier while achieving the added benefit of lowered costs.

PART V: 2010-2014 Strategic Plan for Transforming Alaska's Health Care System

A. 5-Year Planning Framework

The Commission's recommended five-year strategic planning framework is comprised of six essential elements:

I. Develop a Vision of Alaska's Transformed Health Care System

Accomplished in 2009 – Documented in Part I of this Report.

II. Accurately Describe Alaska's Current Health Care System

Begun in 2009 – Documented in Part II and Appendix A of this Report.

Next Steps:

1. Identify gaps in knowledge (e.g., why are prices for health care services higher in Alaska?)
2. Fill in the gaps and complete the picture
3. Analyze impact of national health care reform on Alaska

III. Build the Foundation for a Transformed Health Care System

- **Statewide Leadership**
- **Workforce Development**
- **Health Information Technology**

Begun in 2009 – Documented in Part III of this Report.

Next Steps:

1. Track implementation of 2009 recommendations
2. Implement 2009 recommendations requiring Commission action
3. Continue analysis and identification of solutions for further recommendations

IV. Design Elements Required for Transformation of Alaska's Health Care System

Begun in 2009 – Documented in Part III and IV of this Report.

Next Steps:

1. Continue working on design elements for primary care innovation and healthy lifestyles
2. Prioritize additional potential strategies (identified in Part IV) for analysis and recommendations

V. Measure Progress of Health Care Transformation

First Steps:

1. Work with system stakeholders to identify and develop consensus on indicators to measure progress (see potential indicator set below).
2. Develop data collection and analysis capacity for indicators that are not currently measurable.
3. Report progress on an annual basis to Governor, Legislature, and the general public.

VI. Communicate with the Public & Engage Stakeholders

Begun in 2009 – Commission Public Communication Plan included in Appendix D of this Report.

Next Steps: Implement Commission Public Communication Plan

Potential Health Care System Transformation Measures

1. Increase Access
 - Percent of Alaskans insured
 - Percent of Alaskans who have a specific source of on-going care
 - *Measure of insurance affordability*
 - *Indicator of workforce supply*
2. Control Costs
 - Annual growth rate in total health system expenditures in Alaska
 - Annual growth rate in Alaska's Medicaid expenditures
 - Impact on Alaska's state budget: new spending, net savings, new revenues
 - *Measure of provider revenues based on value*
3. Safe, High-Quality Care
 - Percent of population receiving key preventive services or screenings
 - Percent of Alaskans with chronic conditions controlled
 - Percent reduction in gap between benchmark and actual levels of quality
 - Percent reduction in gap between benchmark and actual levels of safety
4. Focus on Prevention
 - Percent of Alaskan communities with safe water and wastewater systems
 - Percent of Alaskans reporting health risks
 - Percent of Alaskans who smoke cigarettes
 - Percent of Alaskans who are obese
 - Percent of Alaskans who are binge drinkers
 - Percent of Alaskans with moderate to severe depression
 - Death rate among Alaskans due to injury (intentional and unintentional)

B. Suggested Action Plan for 2009 Recommendations

Recommendation	Responsible Party and Action	Timeline and Resources
<p>A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.</p>	<p>Governor: 2010 - Direct DHSS to investigate and develop recommendations for effective strategies to encourage and support healthy lifestyles of Alaskans. Legislature: 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs variable depending on availability of funding and approach to implementation</p>
<p>A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.</p>	<p>Commission: Include healthy lifestyles strategies analysis and recommendation development on 2010 work plan; Coordinate with DHSS investigation of same question.</p>	<p>Jan 2010 – Dec 2010 Cost: \$0 (assumes funding of Recommendation B2a)</p>
<p>A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.</p>	<p>Governor: Direct DHSS to: 1) collaborate w/the AHCC to define patient-centric care models and identify performance standards and measures; 2) pursue grant opportunities to obtain funding for piloting medical home models of care; and, 3) identify statutory and regulatory barriers to development of such care models. Legislature: Consider future requests for removal of statutory barriers and financial support for pilot projects and new payment methodologies.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; (assumes funding of Recommendation B2a) Future costs variable depending on availability of funding and need for pilot project funding.</p>
<p>B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.</p>	<p>Governor: Direct DHSS to develop proposal for development of health policy analysis capacity.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.</p>	<p>Legislature: Pass legislation to establish a Health Care Commission in statute, and fund associated fiscal note. Governor: Sign passed legislation into law</p>	<p>Jan 2010 – Apr 2010 Cost: \$500,000 annual operating budget (based on DHSS fiscal notes for pending legislation)</p>

<p>C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.</p>	<p>Governor: Direct state agencies to ensure future health care and economic development plans consider health workforce needs and strategies. Legislature: Direct legislative committees to ensure health care and economic development agendas consider workforce needs and strategies.</p>	<p>Jan 2010 – Dec 2014 Cost: \$0</p>
<p>C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.</p>	<p>Governor: 2010 – Direct DEED, DHSS, and DoLWD to collaborate together and with stakeholders on the investigation and development of recommendations for strengthening the health workforce pipeline. Legislature: 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.</p>	<p>Jan 2010 – Dec 2014 Cost: \$0</p>
<p>C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.</p>	<p>Governor: 2010 – Direct DHSS to consider innovative approaches to health workforce development. Legislature: 2011-2014 – Consider future requests for legislation and financing of health workforce innovations.</p>	<p>Jan 2010 – Dec 2014 Cost: \$0</p>
<p>C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.</p>	<p>Governor: 2010 – Direct DHSS to collaborate with system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for health care workforce development planning coordination.</p>	<p>Jan 2010 – Dec 2014 Cost: Estimated \$0 - \$250,000 depending on capacity and needs of designated entity</p>
<p>C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.</p>	<p>Commission: Include health workforce planning coordination, analysis, and recommendation development on 2010 work plan</p>	<p>Jan 2010 – Dec 2010 Cost: \$0 (assumes funding of Recommendation B2a)</p>
<p>C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.</p>	<p>Legislature: Limit future appropriations intended to increase the supply of practicing physicians in the state to utilization for primary care physicians only (Family Physicians, Pediatricians, General Internists, and Psychiatrists).</p>	<p>Jan 2010 – Dec 2014 Cost: \$0</p>

<p>C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.</p>	<p>Legislature: Pass legislation to establish educational loan repayment and financial incentive program to support recruitment and retention of primary care providers. Governor: Sign passed legislation into law</p>	<p>Jan 2010 – Apr 2010 Cost: Estimated \$1.5 - \$7.5M annually</p>
<p>C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.</p>	<p>Legislature: Pass legislation to continue WWAMI expansion as state general fund resources allow. Governor: Sign passed legislation into law</p>	<p>Jan 2010 – Apr 2010 Cost: \$600,000 (estimated annual cost of 4-seat expansion in 4th year)</p>
<p>C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.</p>	<p>Governor: 2010 – Direct UA to collaborate with system stakeholders to develop proposals for development of pediatric, psychiatric and primary care internal medicine residency programs for Alaska. Legislature: 2011-2014 – Consider future requests for state participation in support of residency program development and operation.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs variable depending on availability of funding and approach to implementation</p>
<p>C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska’s congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.</p>	<p>Governor: Send letter to congressional delegation. Legislature: Send letter to congressional delegation.</p>	<p>Jan 2010 – Apr 2010 Cost: \$0</p>
<p>C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing “physician extender” occupations as an additional approach to addressing the primary care physician shortage.</p>	<p>Governor: Direct DHSS to work with health workforce development stakeholders to make planning for physician extender and primary care team worker occupations a high priority. Legislature: Consider future requests for health workforce development targeted at primary care.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs variable depending on availability of funding and approach to implementation</p>
<p>D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.</p>	<p>Governor: Follow development of the state HIE and consider future requests for support of HIT needs. Legislature: Consider future requests for HIT development.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>

<p>D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.</p>	<p>Governor: Direct DHSS to work with the state HIE contractor and AK EHR Alliance on exploration of options for assisting small primary care practices with adoption of EHRs.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.</p>	<p>Governor: Direct DHSS to work with the state HIE contractor and AK EHR Alliance on facilitating identification of EHR systems that are interoperable with the state HIE.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.</p>	<p>Governor: Direct DHSS to work with the state HIE contractor and the Division of Public Health on integration of electronic real-time disease reporting systems in the statewide exchange.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.</p>	<p>Governor: Direct DHSS to work with state HIE contractor to identify potential uses of data from the exchange to support health care quality, safety, and efficiency improvement opportunities.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.</p>	<p>Commission: Include HIE, MMIS and ARRA EHR status review, analysis and recommendation development on 2010 work plan</p> <p>DHSS: Provide quarterly report to the AHCC on status of HIE, MMIS, and ARRA EHR implementation</p>	<p>Jan 2010 – Dec 2010</p> <p>Cost: \$0 (assumes funding of Recommendation B2a)</p>
<p>D2f: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.</p>	<p>Governor: Direct DHSS to collaborate with the state HIE contractor and system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for implementation of health information security and privacy protections.</p>	<p>Jan 2010 – Dec 2010 Cost: \$0</p>

<p>D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.</p>	<p>Governor & Legislature: Jan 2010 – Dec 2011: Follow Denali Commission’s 2-year broadband mapping initiative. Jan 2012 – Dec 2014: Work with local, federal and private sector partners to address gaps in service where identified.</p>	<p>Jan 2010 – Dec 2014 Cost: \$0; Future costs to be determined</p>
<p>D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.</p>	<p>Governor: Direct DHSS to investigate and develop a project proposal for pilot testing innovative reimbursement mechanisms for telemedicine-delivered services through Medicaid.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by:</p> <ul style="list-style-type: none"> ○ Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved); ○ Supporting development of a primary care internal medicine residency program; ○ Supporting WWAMI program expansion as resources allow; and ○ Supporting mid-level practitioner development. 	<p>Same as for Recommendations C2a – C2f</p>	<p>Same as for Recommendations C2a – C2f</p>
<p>E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.</p>	<p>Governor: 2010 - Direct DHSS to investigate and develop recommendations for facilitating support of FQHCs and RHCs. Legislature: 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs variable depending on availability of funding and approach to implementation</p>
<p>E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska’s Congressional delegation to improve Medicare’s reimbursement scheme to ensure the sustainability of care to Medicare patients.</p>	<p>Governor: Send letter to congressional delegation to initiate discussion. Legislature: Send letter to congressional delegation to initiate discussion.</p>	<p>Jan 2010 – Dec 2010 Cost: \$0</p>

<p>E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.</p>	<p>Governor: Send letter to congressional delegation to initiate discussion. Legislature: Send letter to congressional delegation to initiate discussion.</p>	<p>Jan 2010 – Apr 2010 Cost: \$0</p>
<p>E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.</p>	<p>Governor: Direct DHSS to investigate and develop a recommendation for a process to compare public and private insurance administrative requirements.</p>	<p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p>
<p>E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.</p>	<p>Governor: Direct DHSS to develop and submit SPA to CMS adding PACE as an Alaska Medicaid benefit, and to develop capacity to negotiate rates with providers interested in developing a PACE program.</p>	<p>Jan 2010 – Dec 2010 Cost: \$200,000 (estimated by DHSS; for actuarial consultant and Office of Rate Review staff)</p>

C. 2010 Work Plan for the Alaska Health Care Commission

Following is a suggested approach to continuing the work of the Alaska Health Care Commission through 2010. This plan will need to be adapted and more details added based on the level of financial and staff resources allocated to this work once financing is determined.

- **Analyze Variations in Pricing and Resulting Cost Shifting in Alaska's Health Care Delivery System**
 - Contract with consultants who have expertise in health economics and health care business management.
- **Analyze Impact of National Health Care Reform** - If national reform legislation passes:
 - Identify state government roles and responsibilities for implementation
 - Analyze and determine potential impact on Alaska's health care system
 - Develop recommendations for Governor and Legislature for maximizing potential benefits and minimizing potential harms
- **Track Implementation of the Commission's 2009 Recommendations**
 - Monitor status of relevant bills during legislative session
 - Consult with Governor's Office on interest and approach to implementing recommendations requiring Governor's action
 - Commission staff to report quarterly to the Commission on status of implementation
- **Implement 2009 Recommendations Requiring Commission Action**
 - Recommendation A1b: Continue studying and develop additional recommendations to support healthy lifestyles
 - Recommendation A2a: Collaborate with DHSS and primary care provider community on definition of patient-centric care model and development of performance standards and measures.
 - Recommendation C1e:
 - Coordinate with the DHSS/AMHTA/UA Behavioral Health Workforce Partnership, Alaska Health Care Workforce Development Coalition and the Legacy Plan Health Care Workgroup
 - Continue analysis of health care workforce issues and develop additional recommendations
 - Recommendation D1b:
 - Coordinate with DHSS to receive a quarterly report on the development of the new statewide health information exchange, the new Medicaid Management Information System, and the use of ARRA funding for electronic health record deployment
 - Continue analysis of health information technology issues and strategies and develop additional recommendations
- **Prioritize, Analyze and Develop Recommendations on Potential Access, Value (Cost Containment and Quality Improvement), and Prevention Strategies described in Part IV of 2009 Report**
- **Implement the Commission's Public Communication Plan**
- **Develop an Evaluation Plan for Tracking the Performance of Alaska's Health Care System**
 - Work with health care system stakeholders to finalize performance metrics that will provide a snapshot of the efficiency, effectiveness, and safety of Alaska's health care delivery system.
 - Identify system for compiling, analyzing, and reporting performance metrics data.

End Notes

PART II

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**ALASKA HEALTH CARE COMMISSION
2009 REPORT**

**APPENDIX A
HEALTH CARE IN ALASKA**

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Prepared for the Alaska Health Care Commission
by the
**Section of Health Planning & Systems Development
Division of Health Care Services
Alaska Department of Health & Social Services**

APPENDIX A: HEALTH CARE IN ALASKA

I. HOW HEALTH CARE IN ALASKA IS PROVIDED

A. HEALTH CARE DELIVERY SYSTEMS: PRIVATE, TRIBAL, MILITARY AND VETERANS ADMINISTRATION

INTRODUCTION

People in Alaska obtain care for health needs through three different systems: the private sector, the military and Veterans' Administration health system, and the Alaska Tribal Health System. The "private sector" can be defined as any services provided by non-military/VA or non-tribal providers. It includes hospitals, physicians, dentists, mental health and substance abuse professionals, and various kinds of clinics. It also includes a wide array of support services such as pharmacies, imaging centers, renal dialysis centers, medical supplies and equipment sales and service, medical transportation services, nursing homes, rehabilitation centers, residential psychiatric treatment facilities, and home care and hospice.

The tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in other states, since one fifth of the population (about 135,000) is eligible for services in the tribal system, and 14% percent (about 90,000) are covered by the military system. (In the U.S. as a whole the proportions are 2% tribal and 4% military.)¹

In Alaska, services that are provided by federal or state governments directly (rather than through reimbursement or an insurance program) are mostly Veterans Administration and military services for active duty and former service people in the Army, Air Force, and the Coast Guard. State and local government services are limited primarily to state psychiatric hospital, Pioneer Homes, public health services,² and some locally owned and operated clinics. Governments also play a major role in reimbursing private and tribal providers for the costs of providing care (rather than providing care directly) through Medicare, Medicaid and other programs. Governments also contract with or provide grants to private, tribal and for-profit organizations to provide services.

Alaska's health services have evolved in response to many factors including geography, population needs and traditions, and historical events. Many of Alaska's hospitals are former tuberculosis control hospitals built by the U.S. Public Health Service to treat the epidemic of the early 20th century. Then Alaska's location gave it a critical military and communication defense role for the country during World War II and during the Cold War of the 1950s and 1960s. The major role of the federally recognized tribes in planning and implementing a coordinated system

¹ U.S. Bureau of the Census, 2000 Census.

² Services include immunizations, well child care, services related to infectious diseases, sexually transmitted disease screening, treatment and partner management, newborn hearing screening, family planning, and home visits for follow-up on referrals of high risk families with children.

of care for Alaska Natives, through an agreement with the Indian Health Service called “compacting,” has supported and determined the development of care in rural areas of the state.

Health care is a major contributor to the state’s economy. Health care accounted for eight percent of Alaska’s employment in 2006, with 29,000 workers, and payroll of about \$1.2 billion. Most of the jobs were in the private and tribal sectors – 93%. Fully one third of Alaska’s health care employees worked in physicians’, dentists’ and other health practitioners’ offices, with 40% in hospitals, and 9% in nursing home and other residential care. About 9% worked in outpatient care centers such as ambulatory surgery centers, dialysis centers, imaging facilities, and other diagnostic and treatment facilities, 6% worked in home health care, and 2% in other ambulatory care settings. Seven of the twenty five largest health care employers were tribal organizations – they accounted for 6,000 employees of 16,640 in those twenty five firms. Thus employment in the non-tribal private sector was likely about 23,000 in 2007, or at least 6% of the state’s total employment.³

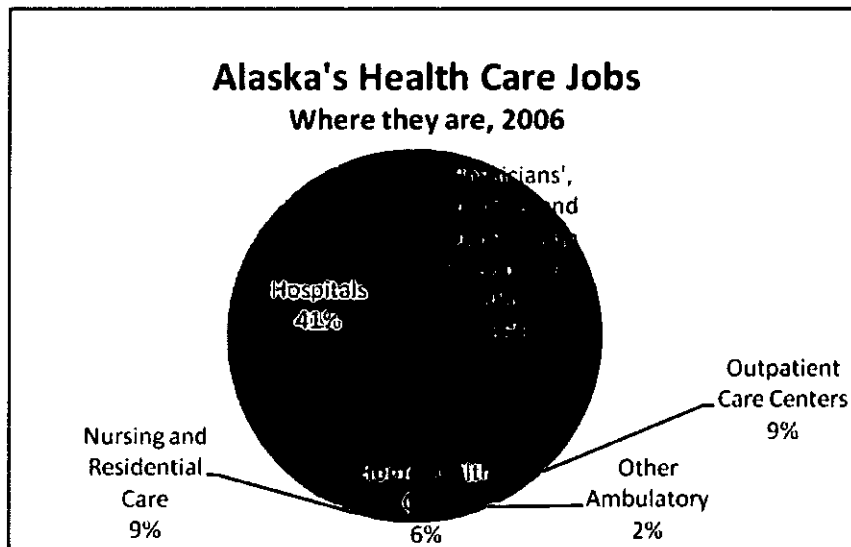
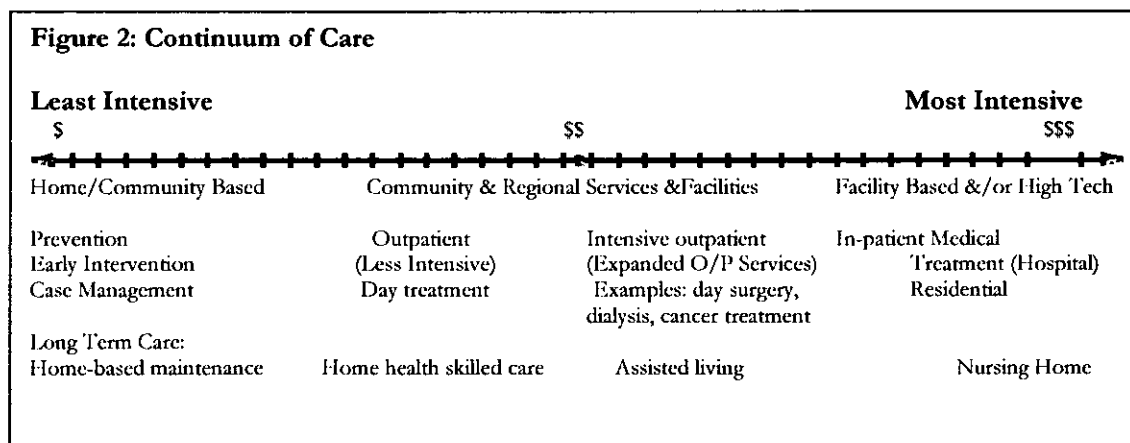


Figure 1: Alaska’s Health Care Jobs, 2006

Thinking of health care services as a “continuum” of care from prevention through treatment, rehabilitation, and maintenance of optimum health can help one comprehend the many different services, facilities and programs. A simplified graphical presentation shows relationships of some of the key components in Figure 2.



³ Fried, N. “Alaska’s Health Care Industry,” Alaska Economic Trends, Anchorage, February 2008.

1. PRIVATE HEALTH CARE SECTOR

The private health care sector includes an array of services from highly specialized diagnosis and treatment to primary care, prevention, and supporting goods and services. Firms range from self-employed professionals, contractors and small businesses to national corporations. Even the not-for-profit health services include very large entities like Providence Alaska Health Systems, the largest employer in Alaska with about 4,000 employees in 2006,⁴ to small community-based community health centers like Bethel Family Health Services with 9 employees. Seattle, Washington is still the nearest source for some highly specialized services such as heart and other organ transplants and severe trauma treatment.

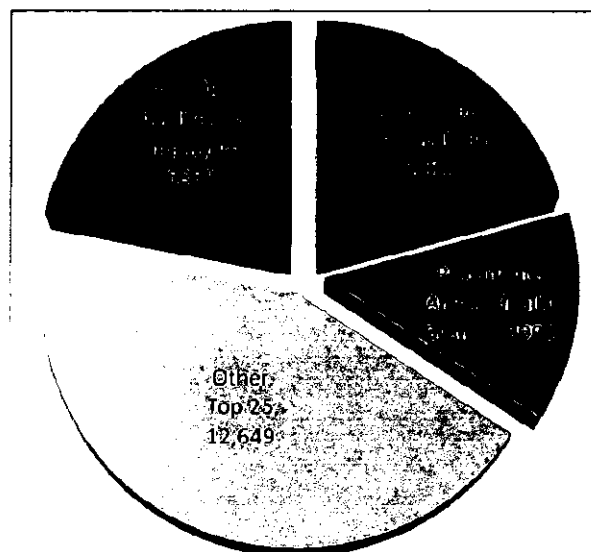


Figure 3: Distribution of Health Care Employment 2006

Only two of Alaska's hospitals are for-profit entities, Alaska Regional Hospital and North Star psychiatric hospital. However many of the free-standing diagnostic, treatment and ambulatory services facilities are for-profit entities. Private sector physicians, dentists, psychologists and other practitioners are either self-employed or have incorporated to pay themselves and staff salaries. Drug stores, medical supply companies, and many other support services are for-profit firms.

Nearly one-third (approximately 10,000) of all health industry jobs in 2007 were in private hospitals. Hospitals are major employers because "they're labor intensive and provide around-the-clock care; three shifts of workers cycle through the hospitals each day."⁵ The Alaska Department of Labor identifies 82 percent of Alaska's non-military employment in hospitals to be in the privately owned and managed facilities rather than local public or tribal facilities.

The private not-for-profit organizations include community-based Community Health Centers and mental health service agencies that receive grants from federal and state government programs. Although these organizations must meet guidelines of public programs, most are not government-run organizations – their boards of directors, employment policies, salary rates, goals and programs are governed by their own bylaws and policies.

⁴ Fried, N., "The Trends 100," Alaska Economic Trends, Anchorage, July 2009. P. 6.

⁵ Ibid., p. 9.

In Alaska, no “managed care organizations” exist in the private sector, and formal provider networks are lacking. However informal referral patterns, and “panels” of preferred providers associated with a variety of insurance programs, result in some structured relationships, and some facilities and groups are affiliated or jointly managed.

2. ALASKA TRIBAL HEALTH SYSTEM

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of nearly 40 tribes and tribal organizations providing health services to American Indians/Alaska Natives (AI/AN) in Alaska. The ATHS is a diverse and multifaceted health care system that has developed over the last 30 years since passage of the 1975 Indian Self-Determination and Education Assistance Act (ISDEA). Each of the tribal health organizations within the ATHS is owned and operated independently, while remaining interconnected via the system’s sophisticated patterns of referrals and their primary and common mission of improving the health status of Alaska’s American Indian/Alaska Native (AI/AN) population.

Alaska has 228 federally recognized tribes, accounting for about 135,000 people. At present, Alaska Native villages are situated mostly along the coast and rivers of Alaska. The dispersal of the communities across a huge, mostly roadless territory accounts in large part for the creation of the innovative statewide health system.

As part of its trust responsibility to Native people, the federal government is required to provide a basic level of health care services to the AI/AN population. The trust responsibility deems these services “pre-paid” with aboriginal lands and authority that tribes ceded to the U.S. government in treaties. In 1975, Congress created a process for transferring Bureau of Indian Affairs and Indian Health Service health programs to tribal governments through the Indian Self-Determination and Education Assistance Act (ISDEA, Public Law 93-638). In doing so, Congress noted the past inadequacies of Native American health care, and reaffirmed its intention to involve tribes in health care programs through tribal self-governance.⁶

⁶From *Jumping Through Hoops: Traditional Healers And The Indian Health Care Improvement Act*, 4 DePaul Journal of Health Care Law 843-860, 844-847 (Summer 1999), accessed on <http://academic.udayton.edu/health/02organ/Indian03.htm> August 10, 2009:

“In passing the Act, Congress noted the government’s “unique legal relationship with, and resulting responsibility to” Indians, necessitated the creation of a comprehensive health care system. The IHCIA set forth the following goals for the IHS:

- (1) to assure Native Americans access to high-quality comprehensive health services in accordance with need;
- (2) to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and
- (3) to be the primary federal advocate for Native Americans with respect to health care matters and to assist them in accessing programs to which they are entitled. Subsequent amendments in 1992 extended the purpose of the IHCIA to raising the health status of Native Americans over a specified period of time to the level of the general United States population. Additionally, the IHCIA sought a high level of participation by Indian tribes in the planning and management of IHS programs, services, and demonstration projects under subsequent self-determination amendments.

The Alaska Native Medical Center (ANMC), a 156 bed facility in Anchorage, serves as the referral center for specialty care. The other tribally administered hospitals (former US Public Health Service hospitals) are located in the six rural communities of Sitka, Barrow, Bethel, Dillingham, Kotzebue and Nome. There are 36 tribal health centers and 176 tribal community health aide clinics. In many rural areas of the state tribal health organizations are the only health care providers available, and serve everyone in the area regardless of race or IHS-beneficiary status.

The federal Indian Health Service (transferred from the Bureau of Indian Affairs to the US Public Health Service in 1955) manages an Alaska Area Native Health Service office (one of eleven Area Offices) that works in conjunction with nine tribally operated service units to provide comprehensive health services to about 135,000 Alaska Native people. Services funded in-part by IHS are delivered by tribal health organizations, or under contract with non tribal service providers. The federal government through the IHS holds title to six tribally operated hospitals⁷ and three tribally operated health centers in Alaska (on St Paul Island, Annette Island and Tanana Village) and is responsible for their maintenance.

Together, the tribal organizations that compose the AHS operate an \$800 million (FY2006) health care sector, and employ more than 7,000 full and part-time staff statewide. Beneficiaries are not charged for most services received within the AHS. Financing for the entirety of the AHS's programs is split between a variety of sources, including federal and state grants and contracts for specific services; Medicaid, Medicare, and private insurance revenue; rural sanitation funding; and other smaller sources of funding. While the Indian Health Service represents the largest funding source, it accounts for only 60% of total revenue.

The Alaska Tribal Health Compact, which authorizes tribes and tribal health organizations to operate health and health-related programs, was formed October 1, 1994. The Alaska Native Tribal Health Consortium (ANTHC) was organized as a statewide non-profit health service organization owned by Alaska Natives and managed by all tribes in Alaska. Other "compact" organizations under P.L. 93-638 include the tribal health corporations that serve regions and specific communities. ANTHC manages all statewide health services formerly provided by the Indian Health Service. ANTHC has responsibility for essential statewide services, including the Alaska Native Medical Center, which it manages in conjunction with the Southcentral Foundation (the regional tribal health organization serving Anchorage and the surrounding communities).

The Compact is the umbrella agreement (also identified as P.L. 93-638, Title-V Self-Governance Compact) that sets forth the terms and conditions of the government-to-government relationship between Alaska Native tribes and/or tribal organizations, and the United States government through the Indian Health Service.⁸ The 23 tribes and tribal organizations that belong to the Compact include:

⁷ The Alaska Native Medical Center in Anchorage, Samuel Simmons in Barrow, Kanakanak in Dillingham, Maniilaq Health Center in Kotzebue, Mt. Edgecumbe in Sitka, and Yukon-Kuskowim Delta Hospital in Bethel. Norton Sound Hospital in Nome is the only tribally managed hospital that is not Federally-owned.

⁸ <http://www.anhb.org/index.cfm?section=Advocacy>

(footnote continued)

- Alaska Native Tribal Health Consortium
- Aleutian//Pribilof Islands Association Inc.
- Annette Island and SU--Metlakatla Indian Community
- Arctic Slope Native Association
- Bristol Bay Area Health Corporation
- Chugachmiut
- Copper River Native Association
- Council of Athabascan Tribal Governments
- Eastern Aleutian Tribes Inc.
- Ketchikan Indian Community
- Kenaitze Indian Tribe
- Knik Tribal Council
- Kodiak Area Native Association
- Maniilaq Association
- Mt. Sanford Tribal Consortium
- Native Village of Eklutna
- Norton Sound Health Corporation
- Seldovia Village Tribe
- Southcentral Foundation
- SouthEast Alaska Regional Health Consortium
- Tanana Chiefs Conference Inc.
- Yakutat Tlingit Tribe
- Yukon-Kuskokwim Health Corporation

In addition, there are 17 tribes and tribal organizations that contract with the Indian Health Services to provide health services under P.L. 93-638, Title I.

ANTHC Maps are available on www.anthc.gov in formats that can be printed to large sheets for more legible readability:⁹

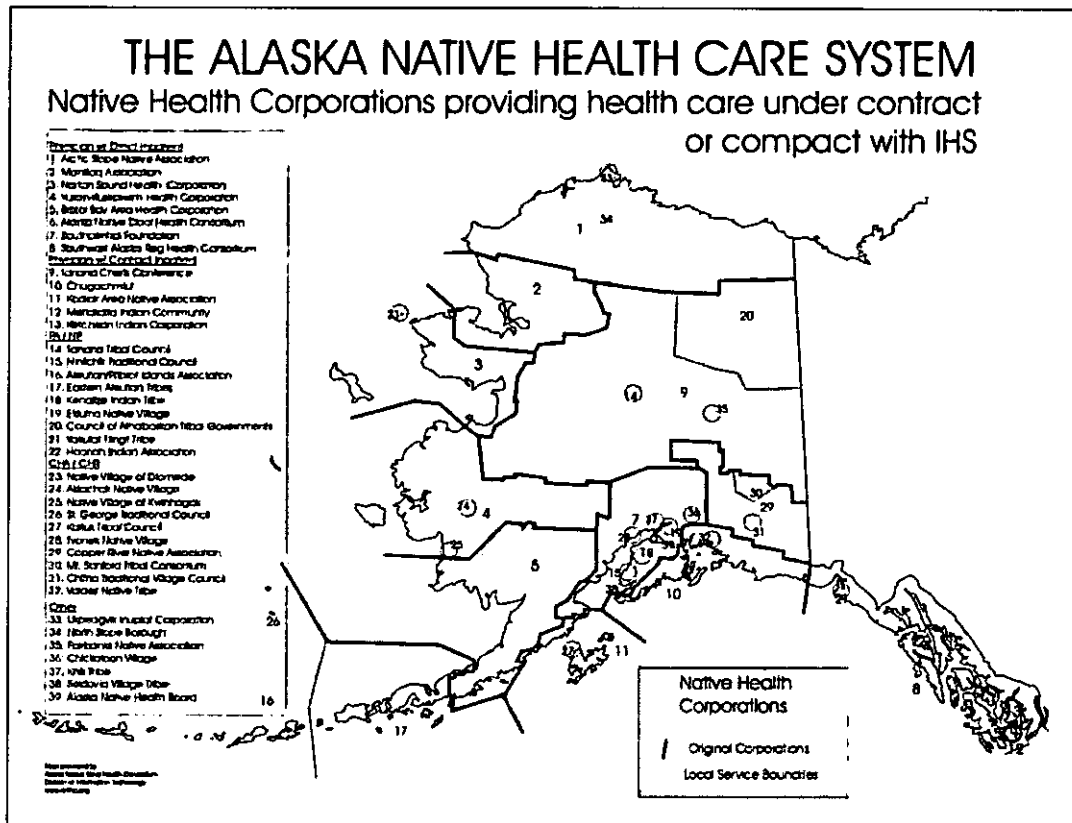


Figure 4: Map of Alaska Native Health Care System

3. U.S. MILITARY AND THE VETERANS AFFAIRS SYSTEMS

U.S. Department of Defense

About 50,000 active duty military and dependent Alaskans are eligible for health care services provided by the Department of Defense. Military retirees and veterans (numbering 76,000¹⁰) have access to certain services. The U.S. Air Force has responsibility for all military, dependents' and veterans' health care in the southern part of the state, and the U.S. Army is responsible for serving these populations in the northern part of the state. A major health center serves each of these areas: Elmendorf AFB Hospital serves the Southern Region,¹¹ and Bassett

⁹ Maps of the Tribal system as well as resource materials about its components are available on the website <http://www.anthc.org/ref/maps/>.

¹⁰ US Department of Veterans Affairs, <http://www1.va.gov/opa/fact/statesum/akss.asp> accessed 8/13/2009

¹¹ **Southern Region:** The 3rd Medical Group, Elmendorf AFB, Alaska is responsible for military services including Air Force, Army, Navy, Marine, Coast Guard, Army/Air National Guard and reserve services units and family members of active duty service personnel. The health care services provided by the 3rd Medical Group include:

a. Primary Care- Pediatrics, Family Practice, Flight Medicine, Internal Medicine and Dental.

(footnote continued)

Army Community Hospital serves the Northern Region.¹² The Veterans' Administration runs an outpatient medical center in Anchorage, and clinics in Fairbanks, Wasilla and Kenai.¹³

When a patient requires highly specialized care, he or she may be referred to a private sector hospital or, more often, to military medical centers out of state. The military has medical centers to serve local military installations in Alaska as well as to provide for surge capacity in times of emergencies. Alaska's military forces have the capability of airlifting complete surgical and hospital facilities to any part of the world or to provide services in times of national emergencies.

The Department of Defense (DOD) TRICARE program (formerly CHAMPUS) is a regionally managed health coverage program for active duty and retired members of the uniformed services, their families and survivors. TRICARE is not an insurance plan, but a health care entitlement program, funded by the U.S. Department of Defense (DoD) for active duty, Guard and Reserve and retired members of the military, and their eligible family members and survivors. TRICARE for Life now provides health care coverage to TRICARE beneficiaries 65 years of age or older. Beneficiaries need to pay the premium for participation in Medicare Part B (physician and other non-inpatient care). TRICARE provides services at military treatment facilities, and supplements that with access to civilian health care networks where necessary (much like the IHS Contract Health Care program).

-
- b. Specialty Care- Women's Health Clinic (OB/GYN), Physical and Occupational Therapy, Optometry/Ophthalmology, Ear/Nose/Throat, Surgery, and Nutritional Medicine
 - c. Ancillary- Pharmacy, Radiology, Laboratory
 - d. Inpatient services including Intensive Care Unit and Labor & Delivery
 - e. Emergency Care- Emergency Room (ER)
 - f. Supplementary Services-Family Advocacy Program/Social Work/Mental Health/Health Promotions and Life Skills.

¹² Northern Region: Bassett Army Community Hospital, Fort Wainwright, Alaska is attached to the Alaska Command, and reports to Chief of All Army Medical Services at Walter Reed Army Hospital. It serves Fort Wainwright, Eielson Air Force Base, Fort Greely and its associated units. Remote army sites are provided with health services through Troop Medical Clinics at Fort Richardson, Fort Greely and Eielson Air Force Medical Clinic. The health care services provided by are:

- a. Primary Care
- b. Women's Health Care
- c. Orthopedics
- d. Audiology
- e. Health Promotion
- f. Medical Laboratory and X-Ray
- g. Mental Health Care
- h. Dental Care
- i. Pharmacy

¹³ Sources:

- 3rd Medical Group Elmendorf AFB website: [www.elmendorf.af.mil/units/3rd Medical Group](http://www.elmendorf.af.mil/units/3rd%20Medical%20Group)
- Alaska VA Healthcare System and Regional Office: www.vishn20.med.va.gov/Alaska and, www.va.gov/hac/forbeneficiaries/champva.asp
- MEDDAC – Fort Wainwright, Alaska website: www.wainwright.army.mil/sites/local

Alaska Veterans Administration (VA) Healthcare System

The Alaska VA Healthcare System and Regional Office offer primary, specialty, and mental health outpatient care. Services are provided at the Anchorage VA Medical Center, on Elmendorf Air Force Base (through a joint venture with the USAF), and through fee-based arrangements with community hospitals in Fairbanks, Wasilla and Kenai.¹⁴ The VA Medical Center in Anchorage also features a comprehensive Homeless Veteran Service consisting of a Domiciliary Residential Rehabilitation Treatment Program, Veterans Industries, Psychosocial Residential Rehabilitation Treatment Program, VA Supported Housing Program and outreach. These health care services are provided and coordinated through the Anchorage VA Medical Center. In addition to this center of care, the Veterans Administration has established a system of Community Based Outpatient Clinics located at Fort Wainwright, Kenai, and Wasilla.

A pilot project announced in September 2009 is intended to enable veterans to get care through community health centers or other local clinics with Veteran's Administration reimbursement so that less travel for care should be involved.

Coast Guard Clinics

The US Coast Guard history of service in Alaska dates back to the Revenue Cutter Service. Coast Guard personnel and their families are stationed throughout Alaska, including remote sites such as Port Clarence, St. Paul, Attu, Dutch Harbor, and Shoal Cove. Coast Guard clinics in Kodiak, Juneau, Sitka, and Ketchikan support the health care needs of the nearly 5,000 Coast Guard members and their families in Alaska.¹⁵

Alaska Federal Health Care Partnership

Alaska Federal Health Care Partnership (AFHCP) is a voluntary partnership of the organizations serving the federal health care beneficiaries in Alaska. AFHCP combines the healthcare resources of the Alaska Native Medical Center, Alaska Native Tribal Health Consortium, Department of Defense, Department of Homeland Security, Department of Veterans Affairs, U.S. Coast Guard, and the Indian Health Service. The combined beneficiary population of these organizations is over 250,000 with some beneficiaries having dual, or even triple, eligibility within the health and wellness provider systems. The Partnership represents over 250 health care facilities across the state-- from isolated village clinics staffed by health aides in the most remote parts of Alaska, to the Alaska Native Medical Center, the military hospitals in Anchorage and Fairbanks, and the extensive VA clinical services in the Anchorage area.¹⁶

¹⁴ About eighty health care providers are paid for by the Veterans Administration at the Elmendorf AFB Hospital, for providing emergency room care, intensive care and staffing for a medical services unit. The Veterans Administration also provides social workers to this hospital.

¹⁵ <http://www.afhcp.org/coast%20guard.html>

¹⁶ Alaska Federal Health Care Partnership website <http://www.afhcp.org/index.html> accessed 8/13/2009

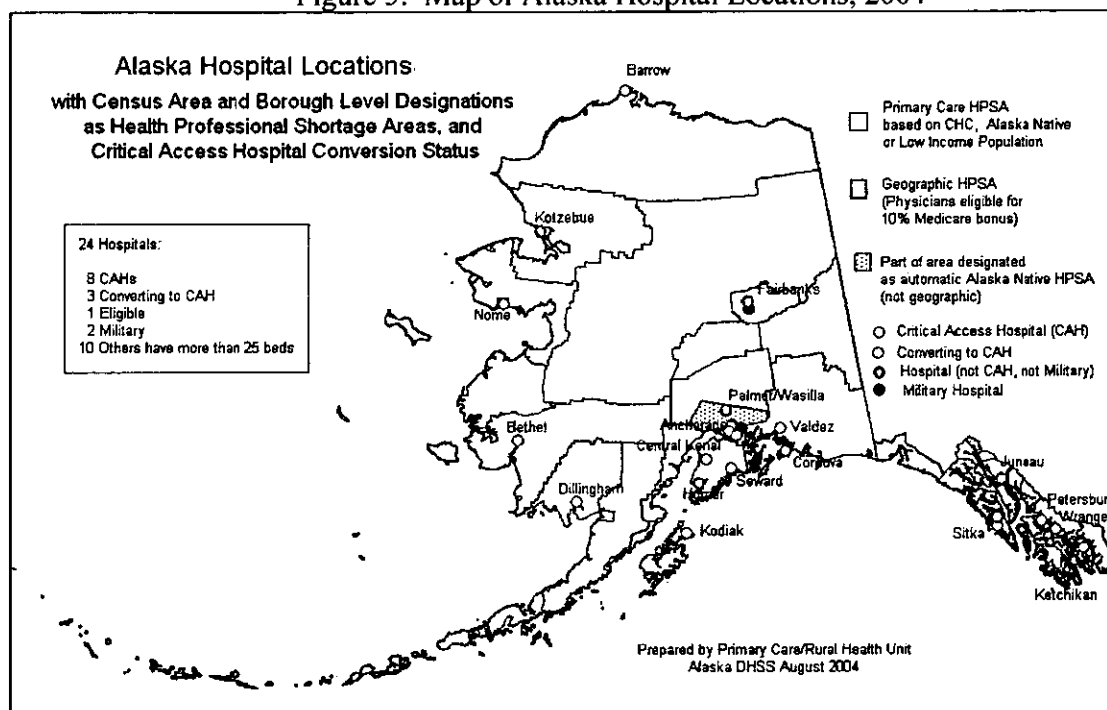
B. FACILITIES

I. MEDICAL FACILITIES

1. HOSPITALS

There are 27 hospitals in Alaska: 24 that provide general acute care (including two military and seven tribally operated hospitals), and three specialized hospitals (one long term acute care and two psychiatric hospitals).¹⁷ The greatest concentration of hospitals is in the Anchorage/Mat-Su region.¹⁸ The relatively large hospitals in Anchorage and Fairbanks serve as referral facilities for providers from rural areas of the state. Hospitals in Seattle also serve as key referral destinations for residents of Alaska in need of “high tech” and specialty services.

Figure 5: Map of Alaska Hospital Locations, 2004



Statewide, there are 1,562 beds in Alaska hospitals, not including those operated by the military. Of those beds, 154 are psychiatric in the two specialized hospitals, 60 are “long term acute care,”

¹⁷ A general acute care hospital must provide surgical, anesthesia, perinatal, medical, nursing, pharmaceutical, dietetic, laundry, medical records, radiological, laboratory, and emergency care services. Such a hospital must also provide speech, occupational, or physical therapy services. A rural primary care hospital or a critical access hospital must provide the services of a general acute care hospital except that the provision of surgical, anesthesia, perinatal, speech, occupational therapy, or physical therapy services is optional. A long-term acute care hospital must provide medical, nursing, pharmaceutical, dietetic, occupational therapy, physical therapy, laundry, medical records, radiological, social work, respiratory, and laboratory services. (7 AAC 12.105)

¹⁸ <http://www.hss.state.ak.us/dph/Healthplanning/publications/healthcare/default.htm> (Alaska Health Care Data Book, figure 4.170)

and 1348 are acute care beds (of which 146 are identified as swing beds that can be used for acute or long term care).

TABLE 1: ALASKA HOSPITALS, 2008

<i>Region/Hospital</i>	<i>Location</i>	<i>Licensed Beds**</i>	<i>Governance</i>
Anchorage Matanuska-Susitna Region			
Providence Alaska Medical Center	Anchorage	326	Private Non-Profit
Alaska Regional Hospital	Anchorage	250	Private For-Profit
Alaska Native Medical Center	Anchorage	150	Tribal Health Corporation; Federal ownership
Air Force Medical Center – Elmendorf	Anchorage	105	Federal Military
Mat-Su Regional Medical Center	Palmer	74	Private Non-profit
St. Elias Long Term Acute Care Hospital	Anchorage	60	Private Non-Profit
Alaska Psychiatric Institute	Anchorage	80	Public State
North Star Hospital	Anchorage	74	Private For-Profit
Interior Region			
Fairbanks Memorial Hospital	Fairbanks	152	Private Non-Profit
Bassett Community Army Hospital	Ft. Wainwright	55	Federal Military
Southeast Region			
Bartlett Regional Hospital	Juneau	71	Public Municipal
Ketchikan General Hospital*	Ketchikan	25	Public Municipal
Petersburg Medical Center*	Petersburg	12	Public Municipal
Mt Edgecumbe Hospital	Sitka	27	Tribal Health Corporation; Federal ownership
Sitka Community Hospital *	Sitka	12	Public Municipal
Wrangell Medical Center*	Wrangell	8	Public Municipal
Gulf Coast Region			
South Peninsula Hospital*	Homer	22	Public Municipal
Providence Kodiak Island Medical Center*	Kodiak	25	Public Municipal
Providence Seward Medical Center*	Seward	6	Public Municipal
Central Peninsula Community Hospital	Soldotna	49	Public Municipal
Providence Valdez Community Hospital *	Valdez	11	Public Municipal
Cordova Community Medical Center*	Cordova	13	Public Municipal
Southwest Region			
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation; Federal ownership
Kanakanak Hospital*	Dillingham	16	Tribal Health Corporation; Federal ownership
Northern Region			
Norton Sound Regional Hospital*	Nome	18	Tribal Health Corporation
Simmonds Memorial Hospital*	Barrow	14	Tribal Health Corporation; Federal ownership
Manillaq Medical Center*	Kotzebue	18	Tribal Health Corporation; Federal ownership

*Critical Access Hospital

** Total beds include licensed and/or certified acute care and swing beds. Many hospitals are operating with fewer beds than the number licensed.

Data Source: Health Facilities List, Licensing and Certification Section, Division of Public Health 2009

The scope of services provided by Alaska's urban hospitals has been changing dramatically. Bed counts have remained quite stable in the last decade, but hospital "campuses" have grown to accommodate an array of emerging technologies and day treatment services that were formerly available only as inpatient services or out-of-state. Examples of services that have been introduced by hospital systems in the last five years include: cardiac catheterization, cardiac electrophysiology ablation, cardiac rehabilitation, chemotherapy and cancer services, renal dialysis, pediatric medicine, birthing centers, outpatient surgery, sleep disorder testing, sports medicine rehabilitation, and expanded hospice and home care. The addition or expansion of these services to Alaska's urban hospitals has provided an incentive to physicians and businesses that support these services to establish residence and to provide care in Alaska, often partnering with the hospital care system. This has allowed Alaskans to receive care in-state.

Alaska's hospitals in communities with populations smaller than 30,000 – that is, outside of Anchorage, Mat-Su, Fairbanks and Juneau – are recognized to be critical "economic engines" of their communities, providing jobs directly, and providing assurance of emergency services and access to care for residents of their service areas, and for employers who want to attract workers. The Balanced Budget Act of 1997 (Public Law 105-33) established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to health care services in rural areas through the development of limited service hospitals and rural health networks. Thirteen Alaska hospitals (see table above) are now certified by Medicare as Critical Access Hospitals (CAH) enabling them to obtain cost-based reimbursement rates from the Federal Medicare program.

Critical Access Hospital Certification

A Critical Access Hospital (CAH) is an acute care facility that provides emergency, outpatient, and limited inpatient services and may be linked to full service hospitals and other types of providers in a rural health network. CAHs generally provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions. CAHs may maintain up to 25 beds to furnish both acute and skilled nursing level care, provided that no more than 15 of these beds are used for acute care at any one time. A CAH may operate nursing home beds or provider-based services like home health. CAHs are reimbursed on a "reasonable cost" basis for services provided to Medicare beneficiaries.

Trauma Center Designation

Alaska's highest level Trauma Center (Level II) is the Alaska Native Medical Center (ANMC). Level II Trauma Centers provide comprehensive trauma care, serving as the lead trauma facility for a geographical area. Emergency physicians and nurses are available in-house to provide direct patient care and initiate resuscitation and stabilization. Prompt availability of general surgeons and certain specialty surgeons is required. A Level II Trauma Center also provides educational outreach and prevention programs, and assumes responsibility for trauma system leadership in the absence of a Level I Trauma Center. Under ACS criteria, Level I centers must conduct trauma research and teach trauma care physicians. Cities in Alaska do not have the patient loads or academic medical centers to support this level of care and the nearest Level I

Trauma Center is located in Seattle. There are four Level IV-designated Trauma Centers in Alaska: Norton Sound Regional Hospital (Nome), Yukon-Kuskokwim Delta Regional Hospital (Bethel), Mt. Edgecumbe Hospital (Sitka), and Sitka Community Hospital (Sitka).

2. Outpatient Facilities

Recent changes in technology and medical practice have allowed patients to receive some services as outpatients rather than being hospitalized. Outpatient services can be performed in a hospital setting or in a freestanding facility. Currently the State of Alaska licenses ambulatory surgery centers, and birthing centers, as authorized by Alaska Statute 47.32. (It also licenses hospitals that may offer ambulatory surgery and ESRD services.)¹⁹ In addition, Alaska has Medicare certified end stage renal disease facilities.

An ambulatory surgical facility provides surgery and anesthesia service, in some cases including pain management and diagnostic services, in an outpatient setting. Ambulatory Surgery Centers (ASC) (which may be called outpatient surgery centers or same-day surgery centers when part of a hospital) perform procedures that are more intensive than those done in the average doctor's office, but not so intensive as to require a hospital stay.

In order for a facility to be licensed as an ASC, services must comply with the state's standards for surgical and anesthesia services in general acute care hospitals. There are also requirements, similar to hospital medical staff regulations,²⁰ for physicians working in these licensed facilities. Currently there are nine licensed Ambulatory Surgery Centers in the state.

Freestanding Birthing Centers are facilities which are not a hospital or in a hospital, where births are planned to occur away from the mother's residence following normal, uncomplicated pregnancy. The state has eight licensed Birthing Centers: one each in Juneau, Soldotna and Fairbanks, and three in Anchorage and two Wasilla.

Alaska also has Medicare certified facilities for treatment of end stage renal disease, commonly referred to as dialysis centers. Dialysis is used to provide an artificial replacement for lost kidney function. It may be used for acutely ill patients who have suddenly but temporarily lost their kidney function and require services for only a short time period; but is used mostly for patients who have permanently lost their kidney function and require dialysis for a long, indefinite period of time. The state currently has seven Medicare certified End State Renal Disease facilities.²¹

Other diagnostic and testing services now being established in some instances as freestanding businesses are imaging (including Magnetic Resonance Imaging and CT Scan), sleep studies,

¹⁹ Per AS 47.32.010

²⁰ Purpose and accountability include that "the provisions of AS 47.05.300 - 47.05.390, regarding criminal history, criminal history checks, criminal history use standards, and a centralized registry, apply to entities listed in (b) of this section, as provided in AS 47.05.300."

²¹ Licensing and Certification Section, Division of Public Health 2009

and laboratories. Such entities are being called “Independent Diagnostic Testing Facilities” (IDTF) when they are not engaged in patient treatment, but perform diagnostic tests by certified non-physician personnel under physician supervision. These facilities are independent of a hospital or physician’s office. The state does not license IDTFs but does monitor the credentials of staff performing tests and the proper functioning of diagnostic equipment used by the facility.

3. Community Health Centers (CHCs) and Special Clinic Certifications

Community Health Centers (CHCs, sometimes referred to as “330 Clinics”) are non-profit, community-based organizations that provide health care to low income and medically underserved areas and populations. The CHC program was established under section 330 of the Public Health Services Act, and federal grant funding is provided through the US Department of Health and Human Services, Health Resources and Services Administration (HRSA).²²

Similar to many outpatient medical clinics, CHCs are required to provide typical primary care services²³ including:

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians, physician’s assistants, nurse practitioners, nurse midwives, and health aides.
- Diagnostic laboratory and radiological services.
- Preventive services (prenatal services; screening for breast and cervical cancer; well-child services; immunizations; screenings for communicable diseases, environmental contaminants, and chronic health conditions; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; family planning services; and preventive dental services.)
- Emergency medical services.
- Pharmaceutical services.

Additionally, community health centers are expected to provide:

- Referrals to providers of health related services including substance abuse and mental health services.
- Patient case management services including counseling, referral, and follow-up services.
- Patient education regarding health conditions and the availability and use of health services.

²² For criteria for designation of Medically Underserved Areas/Populations and health professional shortage areas, see <http://bhpr.hrsa.gov/shortage/index.htm>, www.hss.state.ak.us/dhcs/healthplanning or <http://www.hss.state.ak.us/dph/healthplanning/primarycare/MUA.htm>

²³ Primary care is the provision of professional, comprehensive health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems, and the overall management of an individual’s or family’s health care services. It entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature and care that includes the coordination of other health services.

CHCs differ from privately run physician offices and clinics in several ways. They are required to include a majority of consumer representatives on their Boards of Directors. Their funding is contingent upon demonstration in their funding proposals and utilization reports that they attend to the health status of the entire community in addition to the clinic's patient population. This often means that CHCs participate in prevention program opportunities to address such conditions as diabetes, hypertension, or chronic obesity. Further, chronic care management, medical homes, and the benchmarking of patient outcomes have been the foci of health center activities.

US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care periodically makes US Public Health Service, Section 330 funds available to CHCs to expand their scope of services. Oral health and mental health services are two of the services that have been the focus of additional funding available to CHCs. Many Alaska CHCs have taken advantage of these funding opportunities, and increasingly CHCs are co-locating or otherwise integrating the provision of general dentistry and behavioral health services into their primary care clinics.

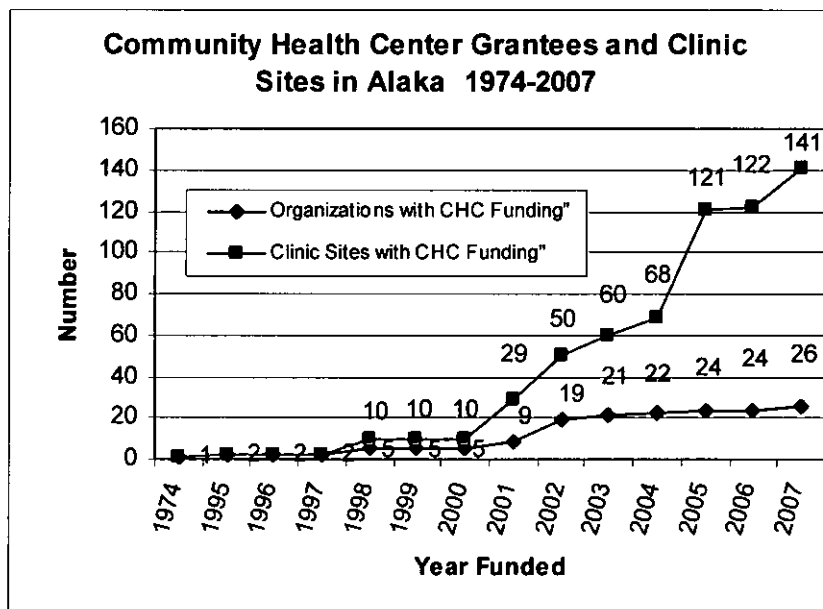


Figure 6: Growth in Number of Community Health Center Grantees and Clinics, 1974 - 2007

Between 1995 and 2009 the number of Community Health Centers in Alaska that were funded in part through Section 330 of the Public Health Service Act grew from two provider agencies – the Anchorage Neighborhood Health Center and Interior Neighborhood Health Center (Fairbanks) who were operating four sites in 1995, to 26 agencies operating 145 healthcare delivery sites.²⁴

Community Health Centers are by definition “Federally Qualified Health Centers,” or “FQHCs,” which are further defined by section 1861 of the Social Security Act.²⁵ Tribally managed clinics are also FQHCs.

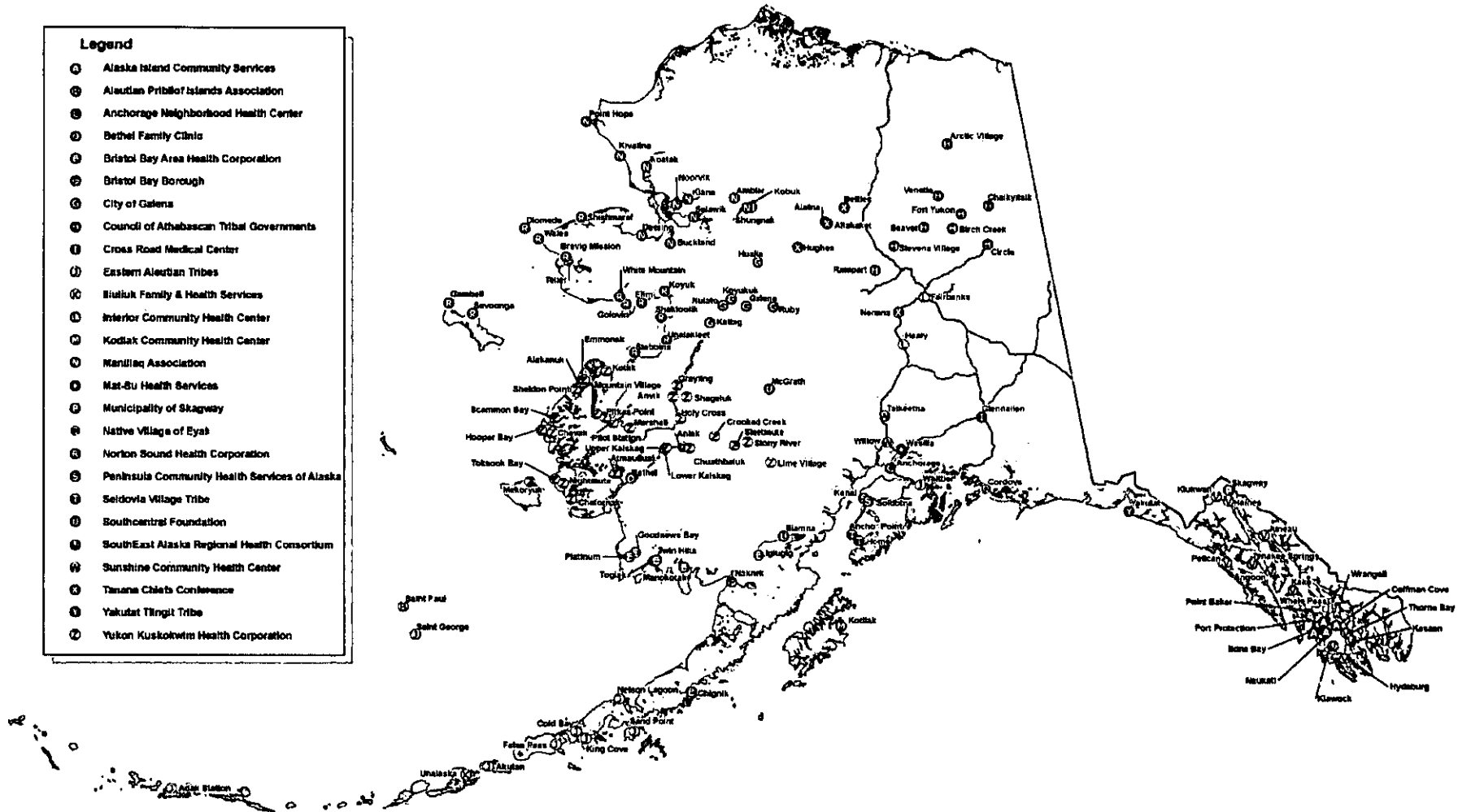
²⁴ Based on the sites listed as reporting to the Bureau of Primary Health Care’s Uniform Data System.

ftp://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateAK_08Jul2008.pdf

²⁵ Section 1861 of the Social Security Act "(4) The term “Federally qualified health center” means an entity which—

- (A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act, or
- (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act;
- (B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;
- (C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or
- (D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[423]."

Figure 7: Map of the Alaska Community Health Centers, Prepared by Alaska Primary Care Association (David Wilson), Jan. 2009



Frontier Extended Stay Clinics

In remote frontier areas of the country weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of these communities providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. A Medicare demonstration project is under development in Alaska in which "Frontier Extended Stay Clinics" (FESCs) would be able to be reimbursed more adequately for the extended services provided to Medicare and Medicaid patients, as Medicare certified providers of these services.

Rural Health Clinics

A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs must provide outpatient primary care and laboratory services, and are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

RHCs can be for-profit or non-profit entities, and can be either publicly or privately owned and operated. Medicare visits are reimbursed based on allowable costs, and Medicaid visits are reimbursed under the cost-based method or an alternative Prospective Payment System (PPS). This may result in an increase in reimbursement over typical Medicare and Medicaid fee-for-service reimbursement rates.²⁶

Rural Health Clinic certification was established under the Rural Health Clinics Act, passed by Congress and signed into law in 1977. The goal of this Act was twofold. First, it encouraged the utilization of physician assistants (PAs) and nurse practitioners (NPs) by providing reimbursement for services to Medicare and Medicaid patients by these health professionals, even in the absence of a full-time physician.²⁷ Second, it created a cost-based reimbursement

²⁶ Downloaded 08-17-09: http://www.raconline.org/info_guides/clinics/rhcfaq.php#whatis

²⁷ A physician assistant (PA) is a licensed health professional who practices medicine under the supervision of a physician. A physician assistant provides a broad range of health care services that were traditionally performed by a doctor. As part of the physician/PA team, a physician assistant exercises considerable autonomy in diagnosing and treating illnesses. What a physician assistant does varies with training, experience, and state laws. In general, PA's can provide approximately 80 percent of the services typically provided by a family physician. They perform physical exams, diagnose illnesses, develop and carry out treatment plans, order and interpret lab tests, suture wounds, assist in surgery, provide preventive health care counseling, and in 39 states, can write prescriptions. A PA can do whatever is delegated to him/her by the supervising physician and allowed by law. The scope of the PA's practice corresponds to the supervising physician's practice. For example, the PA working with a surgeon would be skilled in surgical techniques in the operating room, perform pre- and post-operative care, and be able to perform special tests and procedures.

Nurse Practitioner: The American Academy of Nurse Practitioners defines Nurse Practitioners as licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families, and groups according to their area of practice/specialty. In addition to diagnosing and managing acute episodic and chronic illness, they also emphasize
(footnote continued)

mechanism for services when provided at clinics located in “underserved” rural areas.²⁸ Because of subsequent changes in the Medicare law authorizing Medicare Part B coverage for PAs and NPs in all practice settings (not just RHCs), the original incentive for utilizing PAs and NPs was diminished. However, because a RHC gets reimbursed the same amount from Medicare and Medicaid regardless of whether the patient is seen by a mid-level provider (MLP) such as a PA, NP, Certified Nurse Midwife (CMN), or physician, the clinic continues to have a strong incentive to utilize these practitioners whenever it is clinically appropriate.

In Alaska where a majority of rural primary health care programs have been run with funding from the Indian Health Services (IHS) and Section 330 Community Health Center grants (USDHHS Health Resources and Services Administration), the RHC program has not provided the same financial advantages that it has in other states. Tribally managed clinics have more favorable reimbursement rates than Rural Health Clinics for their Medicare and Medicaid patients. Also, many of the tribal clinics are already within the Community Health Center program.

There are currently three Medicare-certified Rural Health Clinics in Alaska: the Edgar Nollner Health Center in Galena, the Hoonah Midlevel Practice Clinic, and the Yakutat Community Health Center.

4. Physician, Dentist and Other Professional Offices

Many physicians and dentists in Alaska are practicing in solo practice offices, but many share professional office space with others or form group practice offices. Some are primary care physician offices, others include one or more specialties. Physicians and dentists, as well as other specialty service providers, are concentrated in Alaska’s largest communities, likely due to the amenities available, support staff availability, referral resources, and access to other resources. As noted above, about a third of health care jobs are in health practitioners’ offices, according to the industry survey data of the Alaska Department of Labor.²⁹ Thus in terms of practice settings, professional offices are the most common place of work.

Urgent care centers

Some physicians operate their office as an urgent care center or clinic. They have been established in Anchorage, Fairbanks, Juneau, Kenai, and the Matanuska-Susitna Valley. These can be operated by a single physician or group of practitioners, or the center can be affiliated with a hospital based health care system. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care, on an unscheduled or walk-in basis, but who’s condition is not serious enough to warrant a visit to a hospital emergency department. Often urgent care clinics are not open on a continuous basis, unlike a hospital emergency room,

health promotion and disease prevention, incorporating teaching and counseling of individuals, families, and groups as a major part of their practice.

²⁸ “Underserved” means that an area has too few providers to meet the needs of the population. For official designation as an “underserved” area, the area needs to be found to be a “health professional shortage area,” or HPSA, as defined in Federal regulations. The Alaska Primary Care Office in AKDHSS handles designation applications to the USDHHS Health Services and Resources Administration, HRSA.

²⁹ Fried, N. “Alaska’s Health Care Industry,” *Alaska Economic Trends*, February 2008.

but provide extended hours compared to a primary care physicians office. They often provide basic laboratory and imaging services, and referral is made to the appropriate health care provider for follow-up care and treatment. Urgent care centers have the same licensing requirements as that of a primary care physician's office or practice.

5. Mid-Level Provider Clinics

Mid-level providers (MLPs) include Nurse Practitioners, Certified Nurse Midwives, and Physician's Assistants.³⁰ Clinics staffed by MLPs include a handful of private clinics established by these providers. Several community clinics (such as Gustavus and Hoonah) run by communities or tribal organizations have hired mid-level providers as full-time or part-time staff, since the community does not have a population base sufficient to support a physician practice. Another example of mid-level clinic models in use in Alaska is the workplace clinic model used on the North Slope, where oil companies provide contracted physician's assistant services for their employees.

6. Publicly provided clinical medical services

Services provided by state and local health departments include the Municipality of Anchorage and State Public Health Nursing and emergency preparedness immunization programs' services, Early and Periodic Diagnosis and Testing (EPSDT), home visits to high risk newborns and families (upon referral), newborn hearing screening, infectious disease follow-up including follow-up of contacts, Sexually Transmitted Diseases screening and partner management, foodborne outbreak follow-up, and other services.

Alaska Health Fairs and various periodic volunteer programs including the "Northern Edge" training program (sponsored and carried out by the military) bring additional screening, health education, and in some instances treatment services, to selected communities each year. Also, for several years, Anchorage Project Access has organized voluntary donations of services by physicians, especially specialists, and has matched patients with physicians. The Anchorage Neighborhood Health Center (providing primary care services as a Community Health Center) has referred a number of its patients requiring more highly specialized care than the CHC can provide.

7. Comment on Health Care Safety Net

"Health Care Safety Net" is a term used to refer to health care providers who are required by law to see patients regardless of ability to pay. The "health care safety net" includes a wide variety of providers delivering care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. Major safety net providers include public hospitals and community health centers as well as teaching and community hospitals, private physicians, and other providers who deliver a substantial amount of care to these populations.

³⁰ Definition of NPs and PAs in previous footnote.

8. Health Facilities and the “Certificate of Need” Requirement

The Certificate of Need (CON) program as established in statute AS 18.07 is intended to promote the rational planning of health care facilities and health care services, improve citizen access to and choice of health care facility services, review the availability of qualified human resources available to staff facilities and provide services, contain the costs to the state for health care facility services paid for by public funds, and avoid the proliferation of unneeded health care facilities and services in the state through the application of approved standards, review of the needs and activities of an area, and considering input from residents.³¹

The certificate of need requirements of AS 18.07 apply to the following health care facilities licensed under AS 47.32:³²

- an acute care hospital;
- a critical access hospital;
- an ambulatory surgical center;
- an intermediate care facility for the mentally retarded;
- a nursing facility;
- a psychiatric hospital;
- a residential psychiatric treatment center.

The CON requirements also apply to certain health care facilities that are not licensed under AS 47.32: independent diagnostic testing facilities and kidney dialysis centers. For facilities other than nursing homes and residential psychiatric treatment centers, the process is required if costs will exceed \$1.3 million (as of 2009, threshold raised \$50,000 each fiscal year).

II. LONG TERM CARE SERVICES AND FACILITIES

Long term care is distinct from acute care, which focuses on curing an illness or restoring an individual to a previous state of better health. Long term care encompasses a broad range of assistance, services, and supports to meet health and personal care needs over an extended period of time, from nursing home care to home based assistance.

The primary goal of long term care services is to enable senior citizens and disabled individuals to remain in their homes or communities and includes not only health care but services necessary to maintain quality of life including such things as housing and transportation.

Long term care is provided in a range of settings known as a “continuum of care” depending on an individual’s needs and preference (Figure 8).³³ Most long term care is non-skilled personal care assistance, commonly referred to as custodial care, such as help performing everyday Activities of Daily Living (ADL) such as bathing and dressing, in the individual’s home. Another level of care in the patient’s home is home health care provided by skilled and licensed

³¹ As articulated in public notice for regulations 8/12/2009

³² Certificate of Need Program website http://www.hss.state.ak.us/dph/healthplanning/cert_of_need/

³³ Definitions for *Continuum of Care Matrix*, <http://www.hss.state.ak.us/dph/healthplanning/movingforward/matrices/RDdefs.htm>

medical professionals. Alaska currently has 16 licensed Home Health Care agencies which provide skilled medical care to patients in their homes. Of these 16 agencies, nine are hospital based.

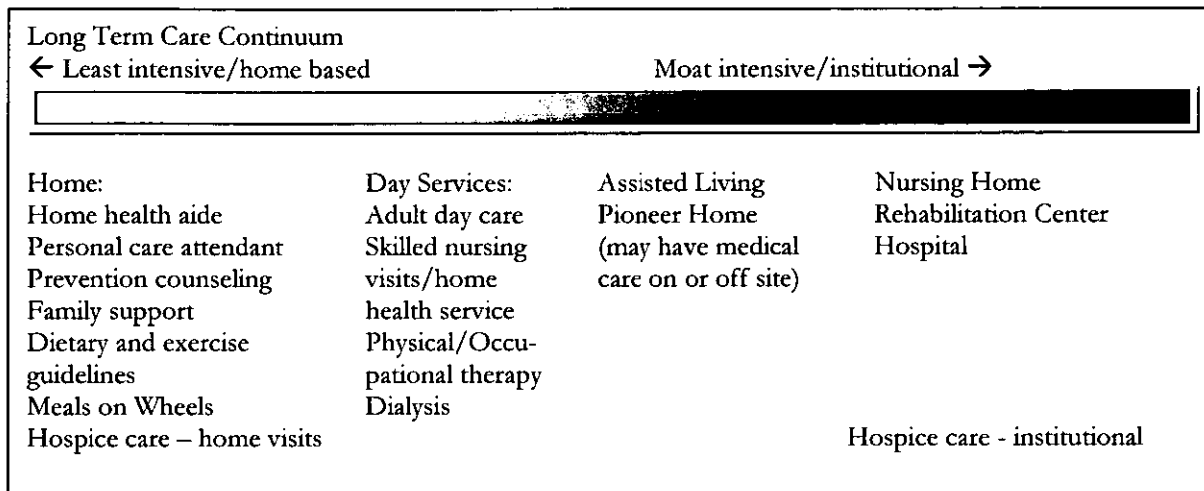


Figure 8: Long Term Care Continuum of Care

When a patient is terminally ill, regardless of age, hospice care can be a choice for the patient and their family. Hospice care provides support by both medical professionals and trained volunteers focusing on the palliation, or relief of symptoms, of a terminally ill patient. This support can be physical, emotional, spiritual, or social. The State currently has 12 licensed Hospice agencies.

Senior housing provides living arrangements designed for handicapped accessibility and convenient access to services. When a senior citizen or disabled individual is no longer able to remain in his or her own home, or with supportive family members, other types of residential care may be available to allow the person to remain in the community. Group homes with assistive services are called “assisted living” facilities. Alaska Pioneer Homes are state-run assisted living homes. Assisted living beds (other than Pioneer Homes) average 2200 annually according to State Certification and Licensing, in about 260 homes.³⁴ The six Pioneer Homes have 508 beds. Skilled Nursing Facilities (SNFs) or nursing homes provide intensive services for those needing a higher level of care. They offer both short and long-term placements for senior who require significant nursing interventions each day. Alaska has 15 nursing homes with 716 beds.³⁵

Assuming that age-specific migration and mortality patterns will remain similar to the current (2000-2005) patterns, it is projected that the population aged 65 and older will nearly triple by

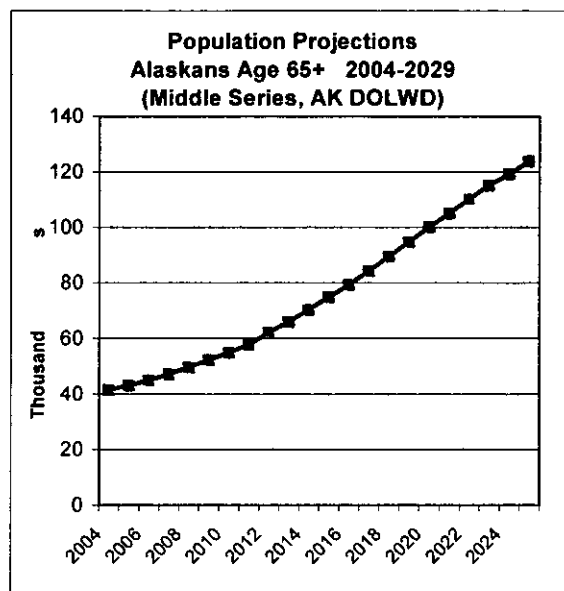
³⁴ 2009 count is 269 licensed senior assisted living facilities with 2,346 beds.

³⁵ Current Facilities List, by email from Certification and Licensing, July 31, 2009

2025, from about 43,000 people in 2005 to about 124,000 in 2025.³⁶ Those who are 85 and over have the highest rates of use of long term care.

The Commission on Aging along with the Department of Health and Social Services, through their 2008-2011 Plan identifies the goal of Alaska seniors staying in their communities, and having access to an integrated array of health and social supports along the continuum of care.³⁷ These goals identify the concern for individuals to be able to maintain quality life through the least invasive and expensive services required in the continuum of care.

Figure 9: Population Projections Alaskans Age 65+, 2004-2029



The goal of keeping people in their homes and communities is also expressed through planning for services for individuals with developmental disabilities, to provide home and community based services where possible, for housing and support for employment.

Table 2: Number of Agencies Providing Long Term Care Services

Selected Agencies Providing Long Term Care Services	Number	Types of Employees	Beds (if applicable)
Home Health	16	PCA, Home Health Aide, RN	n.a.
Hospice	12	RN, LPN, Volunteers, LSW, others	n.a.
Senior Center	45*		n.a.
Pioneer Home	6		550
Assisted Living	269		2,346
Nursing Homes	15	RN, LPN, aides, physician supervision	716

*45 senior centers receive state or tribal funding; several others are known to exist with community funding.

³⁶ Alaska Population Projections, Alaska Department of Labor, 2007

³⁷ <http://www.hss.state.ak.us/acoa/StatePlan.htm>

III. BEHAVIORAL HEALTH FACILITIES

Facilities that offer care to people with mental illness and substance abuse problems range from community clinics (least intensive services) to hospitals for acute psychiatric care (North Star with 74 beds and Alaska Psychiatric Institute with 80 beds). Additional hospitals in Juneau, Fairbanks and regional hubs provide evaluation, stabilization, and short-term treatment and referral. Thirteen (13) non-profit organizations receive grants to provide residential substance abuse treatment.³⁸ Detoxification beds are available in Anchorage, Juneau, and Fairbanks.

Alaska has six Residential Psychiatric Treatment Centers in Anchorage for youth (total 183 beds), and a total of 438 residential psychiatric beds for youth (2009), distributed as follows:

- Northwest: 14
- Southwest: 13
- Anchorage/Mat-Su: 165
- Southeast: 114
- Interior: 117
- Kenai/Kodiak: 15

In addition, there are approximately 320 beds in "Treatment Resource Homes" with behavioral health services for youth. Most are located in the Anchorage Municipality and Matanuska-Susitna Borough.

Agencies across the state receive grant funds from the Department of Health and Social Services and the Alaska Mental Health Trust Authority³⁹ to assist residents with behavioral health needs and help to prevent suicide, substance abuse, and other problems. Approximately 65 organizations are receiving grants from the Department of Health and Social Services Division of Behavioral Health in FY 2010 to provide behavioral health treatment and recovery services. (See Behavioral Health Grantees List).

³⁸ These are:

Sitka Counseling and Prevention
Rainforest Recovery
Southeast Alaska Regional Health Corporation
Salvation Army Clitheroe
Southcentral Foundation
Akeela, Inc.
Volunteers of America - ARCH
Alaska Rehabilitation Services - Nugen's Ranch
Bristol Bay Area Health Corporation
Central Peninsula Hospital - Serenity House
Tanana Chiefs Conference
Fairbanks Native Association
Yukon Kuskokwim Health Corporation

³⁹ The Alaska Mental Health Trust Authority is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of Trust beneficiaries. The Trust operates much like a private foundation, using its resources to ensure that Alaska has a comprehensive integrated mental health program to serve Trust beneficiaries. Detailed elements of the program are included in the Alaska Statutes. (AS 47.30)

By default, the Department of Corrections (DOC) has become the single largest provider of mental health care in Alaska. A 2006 study found that approximately 42 percent (1,524 of 3,628 as of June 30, 2006) of the people incarcerated in Alaska correctional facilities were Trust beneficiaries, with mental illness, substance-related disorders and/or mental disabilities.⁴⁰ Also many youth within the Division of Juvenile Justice system have a co-occurring disorder (substance related disorder accompanied by a mental health disorder). A current alternative to incarceration for adults with severe mental illness is diversion into Anchorage or Palmer Coordinated Resources Projects (therapeutic courts). Therapeutic court programs are also operating in Bethel and Fairbanks.

The DHSS Behavioral Health Integration Project, supported by the Co-occurring State Incentive Grant (COSIG) from SAMHSA, has developed the state's capacity to serve clients with co-occurring disorders. Integration of behavioral health and primary care has been advanced by some Section 330 Community Health Centers that have received special funding from HRSA to include services for mental health and substance abuse.

The Department of Health and Social Services coordinates with the Alaska Mental Health Trust Authority and associated boards to develop the Comprehensive Integrated Mental Health Plan to address the needs of Alaskans with mental and emotional illness, alcoholism and substance use disorders, brain injury, developmental disabilities, and Alzheimer's disease and related dementia. The Department and the Trust convene the interested parties to review and plan for population needs, facilities, workforce, and multiple program initiatives.

IV. EMERGENCY MEDICAL SERVICES

Seven Regional EMS Programs (three non-profit EMS councils, three programs based in regional health corporations, and one program residing in a borough-wide fire department) work with the community-based emergency medical services to be sure that emergency medical services personnel (EMTs) are available to respond to the emergency medical needs of Alaska's citizens and visitors, and to be sure that the personnel and their ambulances and air transport are properly equipped. The State Division of Public Health and Alaska Council on EMS have duties to certify EMTs and work with the EMS programs on their training, reporting and assurance of adequate equipment. "Medevacs" (air rescues) play a major role in Alaska.

⁴⁰ Hornby Zeller Associates, Inc. (December, 2007). *A Study of Trust Beneficiaries in the Alaska Department of Corrections*, p. ii. This does not include individuals in custody in community residential centers or in the contracted facility in Arizona.

C. Health Care Providers

Health care professionals include a variety of specialists and primary care providers in medicine, dentistry, mental health and substance abuse services, and support services. In recent years, concerns about current and potential shortages of health care professionals have led to several studies of supply and demand, recruitment, and retention of physicians and other health care providers in Alaska.⁴¹

Primary Care and Specialty Medical Providers

Primary care services in Alaska are provided by a spectrum of providers, including over 800 primary care physicians, many of about 700 licensed mid-level providers (physician assistants and nurse practitioners), and about 550 Community Health Aides and Community Health Practitioners (see description below). The state licensing database (relying on address listed by the license applicant) shows that most physicians are located in larger communities, those with at least 1,000 people. Some of the physicians and mid-level practitioners practice in Community Health Centers and Rural Health Clinics (RHCs).

Several of the smallest hospitals have hired physicians directly to ensure staffing, and most larger hospitals as well as the tribally managed facilities have hired physician staff members, to serve as emergency room physicians, “hospitalists,” or generalists who work in outpatient, inpatient and itinerant services.

Three quarters of primary care physicians (including family practice doctors, internists, pediatricians and obstetrician-gynecologists) are in the Anchorage-Wasilla, Fairbanks and Juneau areas. Recruitment and retention are difficult in remote areas. Turnover of health personnel is an ongoing problem.

The National Health Service Corps “scholars” program (with six placements in Alaska in 2009) and loan repayment program (with ten placements in Alaska in 2009), and the Indian Health Service loan repayment program, provide financial support in exchange for service for physicians and mid-level providers committed to work in health professional shortage areas.⁴² A federal grant approved in September 2009 for a state-federal loan repayment program will expand the loan repayment opportunities for at least two years.

⁴¹ Securing an Adequate Number of Physicians for Alaska’s Needs, Alaska Physician Supply Task Force Report, August 2006 <http://www.hss.state.ak.us/commissioner/Healthplanning/publications/assets/PSTF-06.pdf>; SORRAS I: Status of Recruitment Resources and Strategies (2004), <http://www.hss.state.ak.us/dph/healthplanning/publications/assets/SORRASreport.pdf>; SORRAS II: Status of Recruitment Resources and Strategies 2005–2006, http://nursing.uaa.alaska.edu/acrh/projects/sorras_report05-06.htm; and Alaska Center for Rural Health, 2007 Alaska Health Workforce Vacancy Study, http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body-final.pdf

⁴² For explanation and criteria for shortage designations, see Alaska Primary Care Office webpage http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_home.htm and USDHHS Health Resources and Services Administration, Shortage Designation Branch, <http://bhpr.hrsa.gov/shortage/>

Specialists are more likely to be in the largest urban areas where they can rely on access for their patients to the tertiary care hospitals (those with more advanced services), the support staff and other support services that can support their practices. Ninety one percent of psychiatrists practice in the Anchorage-Wasilla, Fairbanks and Juneau areas, and 89% of other specialists are located in these urban areas.

Table 3: Licensed Physician, Mid-level and Dental Workforce, by Type, by Region. 2009

Region/Census Area	Medical Doctor	Osteo-path	Physician Assistant	Nurse Practitioner	Dentist	Hygienist
Statewide	1461	122	320	490	486	444
Anchorage/Mat-Su	967	76	179	315	279	287
Gulf Coast	112	15	29	48	53	50
Interior	163	17	55	52	70	50
Northern	19	5	14	9	10	5
Southeast	162	6	22	47	55	48
Southwest	38	3	21	19	19	4
Statewide	100%	100%	100%	100%	100%	100%
Anchorage/Mat-Su	66%	62%	56%	64%	57%	65%
Gulf Coast	8%	12%	9%	10%	11%	11%
Interior	11%	14%	17%	11%	14%	11%
Northern	1%	4%	4%	2%	2%	1%
Southeast	11%	5%	7%	10%	11%	11%
Southwest	3%	2%	7%	4%	4%	1%

*Generalists and Specialists (34 are licensed as specialists, without a "generalist" license)

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

Table 4: Alaska Physicians with Active Licenses, by Region and by Specialty, 2009

Specialty Group:	Anchorage -Mat-Su	Gulf Coast	Interior	North	South- east	South- west	Grand Total
FAMILY PRACTICE	207	57	41	21	67	27	420
INTERNAL MEDICINE	142	12	32	1	19	2	208
PEDIATRICS	91	2	13		13	5	124
OBSTETRICS AND GYNECOLOGY	59	3	9		2		73
GENERAL PRACTICE			1				1
PRIMARY CARE Total:	499	74	96	22	101	34	826
SURGERY	117	17	21		17		172
EMERGENCY MEDICINE	63	9	15		13	2	102
ANESTHESIOLOGY	68	4	12		6		90
PSYCHIATRY	64	5	8		11		88
RADIOLOGY	37	7	8	1	7		60
PATHOLOGY	24	2	3		1		30
OPHTHALMOLOGY	21	2	4		2		29
OTOLARYNGOLOGY	22	1	4		2		29
NEUROLOGY	14	2	2		1		19
UROLOGY	15	1	1		1		18
PHYSICAL MEDICINE/REHABILITATION	13				1		14
CARDIOVASCULAR DISEASE	13						13
DERMATOLOGY	8	1	2				11
MEDICAL ONCOLOGY	5						5
PREVENTIVE MEDICINE	4				1		5
RADIATION ONCOLOGY	4		1				5
AEROSPACE MEDICINE	1	1	1			1	4
ALLERGY AND IMMUNOLOGY	3				1		4
GASTROENTEROLOGY	4						4
NEONATAL-PERINATAL MEDICINE	3						3
OCCUPATIONAL MEDICINE	3						3
RHEUMATOLOGY	3						3
ANATOMIC AND CLINICAL PATHOLOGY	1				1		2
ENDOCRINOLOGY, DIABETES, AND METABOLISM	2						2
INFECTIOUS DISEASE	2						2
NEPHROLOGY	2						2
PEDIATRIC CARDIOLOGY	2						2
INTERVENTIONAL CARDIOLOGY	1						1
PEDIATRIC HEMATOLOGY-ONCOLOGY	1						1
PSYCHIATRY AND NEUROLOGY			1				1
PULMONARY DISEASE			1				1
SPORTS MEDICINE	1						1
Grand Total	1020	126	180	23	166	37	1552
Population (2008 Population Estimates)	367509	75876	104421	23612	69202	39100	679720
Physicians per 1000 population	2.78	1.66	1.72	0.97	2.40	0.95	2.28

Source: July 2009 Occupational Licensing Database. Active (AA status) resident physicians.

Nurses: RNs and LPNs are licensed; Certified Nurse Aides and Personal Care Attendants are not licensed. It should be noted that many nurses cycle into and out of Alaska from out-of-state employment services that help to fill needs for either specialist or generalist nurses, when local supply is insufficient to meet local needs. Data on numbers of such seasonal and/or temporary nurses is not available.

Region/Census Area	RN (Registered Nurse)	Practical Nurse
Statewide	6334	735
Anchorage/Mat-Su	4089	412
Gulf Coast	629	67
Interior	731	150
Northern	90	24
Southeast	660	70
Southwest	135	12
Statewide	100%	100%
Anchorage/Mat-Su	65%	56%
Gulf Coast	10%	9%
Interior	12%	20%
Northern	1%	3%
Southeast	10%	10%
Southwest	2%	2%

Table 5: Licensed Nurses

Physical and Occupational Therapists, active and resident in Alaska, August 2009:

Region/Census Area	Physical Therapists	Occupational Therapists
Statewide	421	186
Anchorage/Mat-Su	269	123
Gulf Coast	49	24
Interior	51	18
Northern	1	1
Southeast	43	20
Southwest	8	0
Statewide	100%	100%
Anchorage/Mat-Su	64%	66%
Gulf Coast	12%	13%
Interior	12%	10%
Northern	0%	1%
Southeast	10%	11%
Southwest	2%	0%

Table 6: Licensed Therapists, 2009

Pharmacists: 471 pharmacists and 1246 pharmacy technicians are licensed in 2009 in Alaska. The vacancy study by Alaska Center for Rural Health suggests that there is a serious shortage of these professionals.

Region/Census Area	Pharmacist	Pharmacy Tech
Statewide	471	1,246
Anchorage/Mat-Su	294	778
Gulf Coast	51	125
Interior	59	160
Northern	3	35
Southeast	55	130
Southwest	9	18
Statewide	100%	100%
Anchorage/Mat-Su	62%	62%
Gulf Coast	11%	10%
Interior	13%	13%
Northern	1%	3%
Southeast	12%	10%
Southwest	2%	1%

Table 7: Licensed Pharmacists and Techs, 2009

Behavioral Health Providers

Many rural Alaska communities have either only part-time workers helping with behavioral health needs or no mental health services other than the occasional itinerant provider. The *2009 Alaska Health Workforce Vacancy Study*⁴³ showed that the vacancy rates for all behavioral health occupations were about 10%, with psychiatrist and clinical psychologist vacancy rates about 16% statewide.

To help bridge the gaps in services, the Alaska Native Tribal Health Consortium has been developing a training certification program for behavioral health aides (BHAs). Currently there are 117 village-based behavioral health aide positions throughout the state, being funded by multiple sources. (Not all of these positions use the title BHA but they all operate within the BHA scope of practice). Where possible, BHA services are integrated into primary care settings.

Behavioral health professionals with current active licenses in Alaska (in August 2009) include 88 psychiatrists; 132 clinical psychologists (PhD); 417 licensed professional counselors; 77 marriage and family therapists; 488 social workers (bachelor's and master's level); and 40 psychological associates. Approximately 480 certified chemical dependency counselors, counselor technicians, and traditional counselors provide services throughout the state; many also have state behavioral health professional licenses. The levels and requirements for certification for the many categories of provider are summarized on the website of the Alaska Commission for Behavioral Health Certification.⁴⁴

⁴³ <http://nursing.uaa.alaska.edu/acrh/>

⁴⁴ [Alaska Commission for Behavioral Health Certification
http://www.nattc.org/getCertified/certification.asp?oldID=sakacbhc](http://www.nattc.org/getCertified/certification.asp?oldID=sakacbhc)

Sixty four of the State's 88 active licensed psychiatrists (73%) are located in Anchorage-Mat-Su area. Seventy percent of psychologists are in this area. Many are in private practice, others work partially or wholly as contractors or employees within the tribal system, the military or not-for-profit service agencies. Several Alaska-based and out of state psychiatrists itinerate to regional medical centers to provide psychiatric assessments and to oversee treatment for residents. Telemedicine has become a tool for increasing access to psychiatric services with links to remote sites across the state, through the tele-behavioral health program based at the Alaska Psychiatric Institute, the telebehavioral health network based at the Alaska Native Health Consortium, and through the Department of Corrections' links to prisons from Anchorage.

Table 8: Active Alaska Resident Licensed Providers in Behavioral Health (August 2009)

Region	Psychiatrist	Clinical Psychologist	Licensed Professional Counselor	Marriage & Family Counselor	Clinical Social Worker (BA, MSW, LCSW)	Psych Associate
Statewide	88	132	417	77	488	40
Anchorage -Mat-Su	64	92	230	51	259	30
Gulf Coast	5	10	30	6	41	3
Interior	9	16	64	9	71	6
North	0	1	10	0	13	0
Southeast	10	12	65	6	68	1
Southwest	0	1	18	5	36	0
Statewide	100%	100%	100%	100%	100%	100%
Anchorage -Mat-Su	73%	70%	55%	66%	53%	73%
Gulf Coast	6%	8%	7%	8%	8%	8%
Interior	10%	12%	15%	12%	15%	16%
North	0%	1%	2%	0%	3%	0%
Southeast	11%	9%	16%	8%	14%	3%
Southwest	0%	1%	4%	6%	7%	0%

ALLIED HEALTH PROVIDERS

Allied health professions are clinical health care professions distinct from medicine, dentistry, and nursing, but generally supporting those services in helping to meet patients' needs. Although they are an integral part of the overall delivery of care and assist in making the health care system function, there is relatively little information tracking these workers, except for the categories of workers for whom licensure is required by state law. Their salaries and other costs are generally rolled into administrative or program costs. The Alaska Center for Rural Health at University of Alaska Anchorage conducted a study called the Alaska Health Care Workforce

Vacancy Study which identified allied health providers employed, positions available and vacancies.⁴⁵ Also, the Occupational Database files posted by the Alaska Department of Labor provide regular reports of employment by quarter, and total workers employed in each occupation each year, by standardized occupational code. Selected allied health occupations are listed in the following table, showing the average quarterly employment in Alaska for 2007 calendar year.

Table 9: Allied Health Employment (Average per Quarter, 2007)

Occupation	Average quarterly employment
Dental Assistant	1079
Dental Hygienist	584
Dental Lab Tech	59
EMT/ETT & Paramedic (308 licensed paramedics '09)	356
Medical & Clinical Lab Technician	297
Medical & Clinical Lab Technologist	238
Medical Records Technician	433
"Other" health technician (SOC code 292099)	401
Optician (74 licensed as dispensing opticians '09)	140
Optometrist (98 licensed, '09)	30
Pharmacy Technician (1126 licensed '09)	544
Psychiatric Technician	253
Physical Therapy Assistant	52
Radiologic Technician	428
Respiratory Therapist	165
Sonographer	39
Surgical Tech	94

Source : Alaska Department of Labor and Workforce Development, Occupational Database, <http://laborstats.alaska.gov/?PAGEID=67&SUBID=212>, accessed 8/10/2009

IV. PARAPROFESSIONALS (CHA/P, DHA, BHA)

The Community Health Aide (CHA) Program was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and high rate of injuries in rural Alaska. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and the tribal health organizations has facilitated improved health status in rural Alaska.

⁴⁵ http://nursing.uaa.alaska.edu/ACRH/projects/archives/ahw_vacancy.htm

The CHA Program now consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual*, which outlines assessment and treatment protocols. There is an established referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The Alaska Area Native Health Service has the responsibility for provision of medical and health related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Tribal Health System. The village based CHA/Ps are a vital link in the delivery system.

Community Health Aides are selected by their communities to receive training. Training centers are located in Anchorage, Bethel, Nome, and Sitka. There are four sessions of CHA training; each lasts three to four weeks. Between sessions, the CHAs work in their clinics completing a skills list and practicum. Completion of the four session training curriculum and successful completion of a clinical skills preceptorship and examination, qualify the CHA as a Community Health Practitioner (CHP). CHA/Ps at any level of training may obtain certification by the Community Health Aide Program Certification Board.

The Community Health Aide Program model is currently being used as a template to develop programs in the areas of dental care, behavioral health, and elder care.⁴⁶

VI. COMPLEMENTARY AND ALTERNATIVE HEALTH PRACTITIONERS

The National Library of Medicine (Medical Subject Headings (MeSH) Section, 2002) classifies alternative medicine under the term complementary therapies. This is defined as therapeutic practices which are not currently considered an integral part of conventional allopathic medical practice. Therapies are termed as *Complementary* when used in addition to conventional treatments and as *Alternative* when used instead of conventional treatment.

The Office of Alternative Medicine, National Institutes of Health (Bethesda, Maryland, April 1995) defined “complementary and alternative medicine (CAM) as a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being. Alternative therapies include, but are not limited to folk medicine, herbal medicine, diet fads, homeopathy, faith healing, new age healing, chiropractic, acupuncture, naturopathy,

⁴⁶ <http://www.akchap.org/GeneralInfo.cfm>

massage, and music therapy. In Alaska, licensed alternative or complementary providers are chiropractors, acupuncturists and naturopaths.⁴⁷

Table 10: Licensed Complementary/Alternative Providers, 2009

Region/Census Area	Licenced Complementary/Alternative Providers		
	Chiropractors	Acupuncturists	Naturopaths
Statewide	220	74	37
Anchorage/Mat-Su	141	48	22
Gulf Coast	25	10	3
Interior	23	7	8
Northern	3	0	0
Southeast	24	9	4
Southwest	4	0	0
Statewide	100%	100%	100%
Anchorage/Mat-Su	64%	65%	59%
Gulf Coast	11%	14%	8%
Interior	10%	9%	22%
Northern	1%	0%	0%
Southeast	11%	12%	11%
Southwest	2%	0%	0%

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

⁴⁷ <http://www.pitt.edu/~cbw/altm.html>

Table 11: Summary of Major Health Occupational Groups' Employment Levels, 2007

Occupational Database: Alaska Health Care Employment	Calendar Year 2007 Employment	
	Total People Employed in the Jobs during 2007	Average Quarterly Employment 2007
("Covered employment" -- does not include self-employed or military)		
Allied Health	13,952	9,422
Nursing	10,088	7,581
Home Health Aides	3,497	2,191
Behavioral Health Professionals	3,480	2,394
Dental	2,805	1,806
Other professionals	2,737	1,941
Administration	1,719	1,304
Physicians	1,070	804
Lab techs	819	552
Pharmacists, Podiatrists & Speech/Language Pathologists	723	533
Mid-Levels (Physician Assistants, Nurse Practitioners)	595	382
EMTs (emergency medical technicians)	553	356
Radiologic Techs	547	428
Chiropractors	62	45
<i>Grand Total</i>	<i>42,647</i>	<i>29,737</i>

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

The worksheet contains the count of workers by occupation for the calendar year. These files are continuously updated and posted to the Web periodically. Six months must pass before data for a particular quarter is considered complete.

The Occupational Database (ODB) contains occupation and place of work information for each wage and salary worker covered by unemployment insurance employed in Alaska. This data series differs from others published by Research and Analysis in that it provides information on each unique worker/employer combination rather than an average monthly employment count or a count of the number of jobs at a particular point in time.

Worker Count Data Limitation: The count of workers is comprised of each unique worker/employer combination. Workers holding jobs with multiple employers are counted more than once.

The worker count is presented for each calendar quarter and summarized for the calendar year. The calendar year totals represent the unique worker/employer count. An employee working all four quarters for the same employer is counted only once.

Occupation codes are based on the Standard Occupational Classification (SOC) system as published by the Office of Management and Budget in October 2000.

Self-employed are NOT included in the figures above. Note that 45 chiropractors were employed on average each quarter in "covered" employment – however there are 218 licensed chiropractors in Alaska with active licenses, so it is likely many are self-employed, not in employment covered by unemployment insurance.

D. HEALTH INFORMATION TECHNOLOGY

HEALTH INFORMATION TECHNOLOGIES IN ALASKA

Health Information Technology (HIT) is expected to be a means to achieve more affordable, safe, and accessible health care. Digital applications available for use by health-care providers and organizations include personal health records (PHRs), electronic health records (EHRs), electronic medical records (EMRs), computerized physician order entry (CPOE) systems, and health information exchange (HIE) systems. All are governed by privacy and confidentiality regulations. Each of these refers to a different set of services:

- Personal health records are records the patient can have in his/her possession, to share with any health care provider seen, and have updated with each visit. Digital PHRs may be kept on a digital memory stick for the patient to carry. They may be self-contained or a copy of a record maintained by a provider.
- Electronic health records and electronic medical records are the mechanisms for replacing paper records with digital ones, that can be easier for doctors or other providers to “search” for medical history, prescriptions and lab results, and that can be stored locally or in a remote location for electronic retrieval or for “exchange” with another provider. Although they are often used interchangeably, there is a difference between EHR and EMR. The EHR is a comprehensive, longitudinal, record of the patient’s medical history or complete medical record. EMR refers to the individual pieces of the EHR such as laboratory results, electrocardiograms, prescriptions, history and physical exams, post operative reports, radiology reports, etc.
- Computerized physician order entry (CPOE) is a process of electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients) under his or her care. These orders are communicated over a computer network to the medical/nursing staff or clinical departments (pharmacy, laboratory or radiology) responsible for fulfilling the order. CPOE has the potential to decrease delays in order completion, reduce errors related to handwriting or transcription, allows order entry at the point-of-care or off-site, provides an opportunity to double check for duplicate or incorrect doses or tests, and simplifies inventory and posting of charges
- Health information exchange systems provide for electronic transfer of patient record information for various possible purposes: to store records in a central place for programs that have multiple service sites; for sending referrals or requested, approved reports between providers. Such information can be limited or comprehensive according to the permissions granted to a potential recipient based on need to know and the patient’s requests and approvals.

Digital telehealth systems, such as teleradiology, laboratory reports, telebehavioral health, telepharmacy, and distance learning systems utilizing videoconferencing equipment are also emerging as ways intended to be cost-effective means to improve health care quality and outcomes.

ELECTRONIC HEALTH RECORD USE IN ALASKA

The Alaska EHR Alliance completed a state-wide survey of physicians (378 respondents) and clinic managers (62 respondents) to assess the status of EHR use in Alaska. 29 communities were represented in the survey.⁴⁸ This survey found that there are currently at least 55 different EHR systems currently being used in healthcare practices across the state. Of those 55 different EHR systems, no single entity holds a significant portion of the EHR market in Alaska with the two leading products being Centricity (11%) and eClinicalWorks (8%). Most (74%) of EHRs in use include a practice management system. Half of the EHRs are connected to labs and one third are connected to one or more pharmacy. One third of the EHRs in the survey did not connect to any other entity.

E-PRESCRIBING

Adoption of e-prescribing has been identified as being critically important to the advancement of e-Health. E-prescribing is recognized as a gateway technology that could speed the development of EHRs and widespread use of other HIT initiatives. Beginning January 1, 2009, CMS will provide an incentive to “successful e-prescribers.” The Medicare e-Prescribing incentive is a new program authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The program begins January 1, 2009, and provides incentives for eligible professionals who are “successful e-prescribers.” Efforts to maximize implementation of e-prescribing systems statewide could result in increase systemic use of other e-health components such as personal health records and electronic health records in both the private and public sectors of health care.

Additionally, there is a disincentive for health-care providers who do not become “successful e-prescribers” by 2012. Under rules adopted by the USDHHS Center for Medicare and Medicaid Services (CMS), eligible professionals who are not “successful e-prescribers” by 2012 will be subject to a differential payment (penalty) for Medicare services beginning in 2012. The differential payment would result in the physician getting 99 percent of the total allowed charges of the eligible professional’s physician fee schedule payments in 2012, 98.5 percent in 2013, and 98 percent in 2014.

HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT

The current “system” of health information exchange for Alaskan healthcare providers is a conglomeration of disparate systems with a variety of capabilities and structural platforms that may or may not be interoperable with each other. An integrated Health Information Exchange HIE system is needed to bring the disparate systems together into one functional product that will improve access to critical health information by healthcare providers and the citizens of Alaska in an interoperable, secure, safe, and efficient manner.

Senate Bill 133 (SB 133), passed in the 2009 legislative session, is intended to modernize Alaska’s health-care IT infrastructure by providing for development of a secure electronic Health Information Exchange (HIE) system that will bridge connections between disparate EHR

⁴⁸ Status of EHR Use In Alaska, 05/11/ 2009:

http://www.aehra.org/images/downloads/summary_of_ehr_survey_findings_52009.pdf retrieved 08/11/2009

systems. A standards-based HIE will allow individual Alaskans to manage their own personal health records and to authorize their personal health-care providers to exchange electronic medical records in a timely, secure manner. The intended outcome of a fully implemented Alaska Health Information Exchange Network is to improve the patients' access to care, reduce unnecessary testing and procedures, improve patient safety, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

The Alaska Department of Health & Social Services is in the process of soliciting proposals for the statewide HIE Entity as authorized by SB 133.

TELEHEALTH

The Alaska Federal Health Care Access Network (AFHCAN) is a telehealth system composed of 248 sites across the state. A total of 44 federal beneficiary organizations participate in the network, including Native and tribal groups, veteran and military providers, and the state of Alaska. AFHCAN initially focused on developing store-and-forward telehealth solution, but has recently expanded into broadband video conferencing telehealth solutions. Store-and-forward solutions were initially developed in response to the limited availability of broadband connectivity in Alaska. Now, however, broadband connectivity supports the larger data payloads and image sets that are often part of an electronic consultation. It has become clear that store-and-forward telehealth offers significant advantages in a distributed multi-organizational health-care environment due to the flexibility it affords providers to respond to cases at their convenience.

Every year, the Alaska Native Medical Center (ANMC) responds to approximately 3,000 telehealth cases and handles 66 percent of these consultations in the same day. Perhaps more impressive is that 50 percent of these cases are responded to within 60 minutes. While store-and-forward was specifically designed to enhance primary care access, approximately 25 percent of all cases today are specialty consultation requests. Video conferencing capacity is also increasing at a rate of three to four times every 12–18 months, with a large deployment of endpoints (funded through the Alaska Federal Health Care Partnership) planned at ANMC in 2009–10 consistent with the growth of video teleconferencing capability at most of the regional health corporations throughout Alaska.

Department of Corrections psychiatric services unit has used video conferencing since [2000], for Anchorage-based psychiatrist and psychologist to provide follow-up and counseling to prisoners in facilities around the state.

The Alaska Psychiatric Institute (API) Tele-Behavioral Health care Services (TBHS) program was originally envisioned under the auspices of the Alaska Telehealth Advisory Council to serve rural communities in south-central and northern Alaska. The API TBHS multidisciplinary team of mental health clinicians provides behavioral health-care services to rural communities throughout Alaska by way of advanced video-teleconferencing technology. The program has continued to grow in the specific number of sites that may access psychiatry because of continuing integration with other information technology, video teleconferencing, and health-care provider networks across Alaska, including the Alaska Native Tribal Health Consortium,

Alaska Federal Health Care Access Network (AFHCAN), the Alaska Rural Telehealth Network (ARTN), and GCI Connect M.D., a medical network that is comprised of over 200 facilities including clinics, hospitals, and medical corporations in the Pacific Northwest and Alaska.⁴⁹

The Alaska Rural Telehealth Network (ARTN) is operational in 11 communities across Alaska, including Soldotna, Cordova, Petersburg, Wrangell, Valdez, Kodiak, Seward, Sitka, Glennallen, Unalaska, and Homer. All sites have digital X-ray capability and most have digital mammography. A Picture Archive and Communications System (PACS) has been implemented system-wide. The PACS is a computer network dedicated to the storage, retrieval, distribution, and presentation of various types of images including ultrasound, mammography, X-ray, computerized tomography (CT), and positron emission tomography (PET). It allows facilities to have their images read from an off-site location (i.e. a Radiologist not located in their facility), which is commonly referred to as teleradiology. The PACS also replaces the need for facilities to maintain hardcopy images on-site by digitally archiving the diagnostic images on the central storage facility – a server located at the Wide Area Network (WAN) core in Anchorage.

⁴⁹ GCI ConnectM.D., Medical Network Overview: <http://www.connectmd.com/mednet.htm> retrieved 04/05/2009.

II. HOW HEALTH CARE IN ALASKA IS FUNDED

A. Introduction

Health care in Alaska is funded by individuals, businesses, and local, state and federal government sources. Individuals pay out-of-pocket costs and contributions to insurance premiums amounting to one fifth of total expenditures. Businesses contribute almost another fifth of the total through purchase of insurance premiums, support for self-insurance programs, and worker's compensation medical benefits. Together the individual and business contributions, "private" sources, account for 38 percent of the total – just under \$2 billion of the \$5.3 billion total expenditures for health care in Alaska in 2005.

The most comprehensive recent Alaska-focused analysis of funding of health care (not including public health activities or facility construction) by ISER (UAA Institute of Social and Economic Research), identified Federal Government programs as the largest purchaser of these services, accounting for another 38 percent of the total -- \$2 billion of the total of \$5.3 billion. Local and state government expenditures for covering employee health benefits, for Medicaid and for other programs, make up the remaining 24 percent of the total.

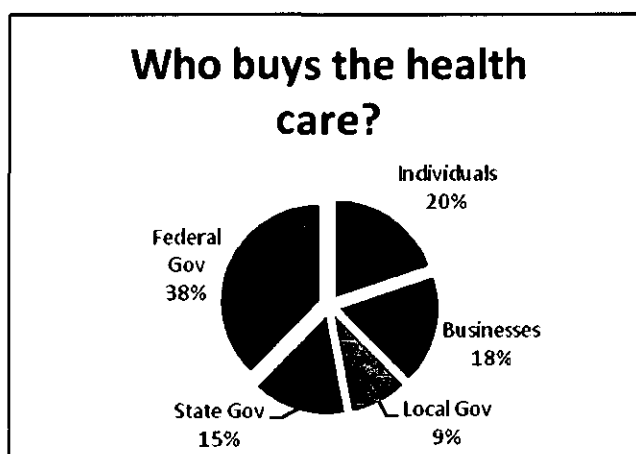


Figure 10: Health Care Purchasers in Alaska, 2005

Table 12: Health-Care Spending in Alaska, FY 2005

Who provides the coverage?	Who Buys the Health Care? (Millions of dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total*
Individuals	\$1,028					\$1,028
Employers		\$922	\$454	\$252	\$411	\$2,039
Government Health Programs			\$38	\$535	\$1,654	\$2,227
Total Spending	\$1,028	\$922	\$492	\$787	\$1,950	\$5,294

Source: *Alaska's \$5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

Nearly a quarter of the Federal share is accounted for by military health services (\$221,000), insurance premiums and self-insured costs. Half of the Federal share is attributable to Medicare and Medicaid claims paid, and another quarter covers Indian Health Service, veteran's benefits, community health centers and payments for services in elementary and secondary schools. ISER's previous study (1991) provides a base for comparison of rate of increase. In the fifteen year period, employer costs quadrupled, while government program expenditures tripled, and individual's contributions almost tripled.

B. Funding Sources: Expenditures, Services and Facilities Supported, and Covered Populations

A summary of "health care coverage" based on responses to the US Census Bureau's annual Current Population Survey (CPS) shows the following types of reported coverage by insurance programs and public programs (Table 13).

Table 13: Health Insurance Coverage of Alaskans, 2006-2008 Average

Health Insurance Coverage Type Average for data years 2006-2008	Alaska		United States
	Count	Percent of Total	Percent of Total
Covered by Any Source	547,203	81.8%	84.5%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Uninsured all year	121,713	18.2%	15.5%
Total	668,917	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009

It is important to note that if otherwise-uninsured American Indians and Alaska Natives are redefined as "covered," then the estimate becomes 14% "uninsured" in Alaska (15% in the US) By CPS definition, "uninsured" includes people of Alaska Native and American Indian Race who may have access to IHS-funded services. In Alaska this is 19% of the uninsured. 63% of

Alaska Natives are covered by private insurance (36%) or public programs (27%), 36% have no health insurance.⁵⁰

Being “underinsured” (lacking insurance coverage or personal resources to pay for specific services, or being required to pay deductibles or co-payments that exceed personal resources) is a major problem to many individuals even though they have some coverage. It is also an issue for their health care providers. How many people are “underinsured” is not known. Data are available from surveys asking people about their perceptions, for example, did you decide not to see a doctor or other health care provider because of cost? Data from hospitals about levels of charity care, “self-pay” patients, and “left against medical advice” may be informative.

- a. **Private Insurance** – including all employment-based except military, and individually purchased policies -- \$2.281 billion (43% of total)
 - Private insurance is generally interpreted to mean both the insurance products sold to employers and employees, and to individuals, whether the employment is for a private for profit or not-for-profit firm. Individuals who pay for private insurance are likely to pay for a policy premium, and then also to pay co-payments, deductibles, and out-of-pocket costs of any services not covered by the insurance policy. The ISER estimates⁵¹ found that about 42 percent of individuals’ costs were for such out-of-pocket expenses .
 - Expenditures for “self-insured” programs include employers’ contributions to such programs. In Alaska, about two thirds of all employers’ (non-military) contributions are to such self-insured plans, while only one third is for “insurance premiums” in the private sector, for the insurance products regulated by the State’s Division of Insurance.
 - Covered lives: the most recent Alaska Division of Insurance survey of health insurers reported 86,645 individuals were covered under comprehensive health insurance plans at year-end 2008. These numbers are reported by the insurers. The estimate suggests that as many as 340,00 individuals are covered through employer-based “self-insured” plans. (See table of Coverage Type above.)
 - Rolling up the expenditures managed by private insurance and “self insured” (private and public) entities, and the premium payments by individuals, the ISER report estimates \$1.685 billion in expenditures for what we generally consider “employment based health insurance.” This accounts for about 32% of health care expenditures in FY2005.

⁵⁰ Tribal contract health care facilities are legally required to serve their tribal members. Other qualified American Indians/Alaska Natives may be eligible to receive care as determined by the organization. This policy makes it difficult or impossible for an American Indian or Alaska Native who leaves his tribal home for education or employment to receive the health care services to which he is legally entitled. This lack of “portability” as well as limitations in some of the services that can be provided is the basis for the Census Bureau determination not to count IHS beneficiary status as “health insurance coverage.”

⁵¹ *Alaska's \$5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

b. Public insurance and coverage

i. Medicare -- \$0.419 billion (Federal)

Medicare provides coverage for health care for about 54,000 individuals in Alaska including 44,000 senior citizens (age 65 and over) and about 10,000 disabled individuals and people with end stage renal disease. Allowable costs include "Part A" (primarily inpatient) services, "Part B" (primarily outpatient/physician/clinic services) for those participating and paying a monthly enrollment fee, and certain prescription drugs under "Part D" for those who have selected that option. With the aging of the baby boomers, a cohort of about 5,000 new "seniors" will join the ranks of the senior population over the next five years, while about 1,800 deaths per year will deplete the population 65 years and over, so the net increase may be over 3,000 Medicare-eligible people per year.

For the individuals with end stage renal disease, benefits include inpatient, outpatient, and home dialysis (including training, equipment and supplies, and drugs) – not paid for are blood, transportation, or dialysis aides or technicians coming to house. Although dialysis facilities reimbursed must be certified by Medicare (CMS), a patient can obtain services at any approved site in the country, so travel is not restricted for individuals who need service usually two or three times a week. Kidney transplant costs are also allowable – organ registration fees, laboratory tests for the patient and potential donors, full cost of care for donor, and immunosuppressant drugs.

Physician participation/availability: Concern about availability of physicians who will accept Medicare patients has emerged in Alaska in the last five years. The issue arose when a two-year special reimbursement rate for Alaska physicians (effective in 2004 and 2005, providing a differential for Alaska physicians 67% above the US average) sunset in January 2006. For the three years 2006-2008, the Medicare differential for Alaska was about 5% above the US average. A new geographic differential for Alaska (29% above the US average) for "physician work" was effective January 1, 2009, but the reports of physician non-participation continue.

First in Fairbanks, then Anchorage, participants at health care forums and articles in newspapers across the state reported that physicians – especially primary care providers - were refusing to accept new Medicare patients, and in some cases were telling established patients they would no longer see them. This selective refusal to see Medicare patients appears generally not to have been followed up by notification to CMS that the provider was "opting out" of the Medicare program, so the officially reported "participation rate" for Alaska providers is still high (11% opt-out rate reported in March 2009 by ISER).⁵²

⁵² Frazier, Rosyland and Foster, Mark, "How hard is it for Alaska's Medicare Patients to Find Family Doctors?" March 2009, UA Research Summary No. 14. Institute of Social and Economic Research, University of Alaska Anchorage.

Provider non-participation has major consequences for patients who may have Medicare as “primary” payer and state retirement benefits or state employment or other insurance as secondary payer, since refusal of the primary payer to pay results in denial of all payers. As a result, individuals who thought they were very well insured found themselves paying out of pocket for all their health care costs or having to seek care from new providers. Medicare patients able to reach a federally funded community health center (CHC) can obtain at least primary care services at such clinics.

The CHCs have experienced very large increases in the number of Medicare patients seen each year since 2000 – from about 3,000 in 2002 to 7,000 in 2007. Some of the increase is attributable to the addition of community health center sites, but most of the increase is believed to have occurred in the urban clinics. In 2007 about 15 percent of all Medicare enrollees were using CHCs as at least one source of care. Anchorage Neighborhood Health Center Executive Director has reported dramatically increased numbers of Medicare patients using the Center, and also increased referrals to the Anchorage Project Access, which matches patients to specialists who have volunteered to see a certain number of charity care cases.

ii. Medicaid - \$0.303 billion State of Alaska, \$0.667 billion Federal (FY 2005)

Medicaid is an “entitlement program” created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting income and asset standards and by fitting into a specified eligibility category. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in “amount, duration, and scope” to satisfy the recipient’s medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Alaska’s Medicaid expansion for these children and pregnant women is called Denali KidCare. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, provisions within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

- iii. Dual Eligibility (for Medicare and Medicaid) – annual expenditure amounts for either program included in above totals

Low income seniors and disabled people may have “dual eligibility” for Medicare and Medicaid coverage, in which case Medicare pays first for what it covers, and Medicaid only pays for services (including beneficiary cost sharing) that are not paid by Medicare. In Alaska, Medicaid generally covers the cost of the Part B (currently \$96.40/month) for all recipients. Part B is the part of Medicare that covers physician, outpatient, some pharmaceutical, and other treatment and rehabilitation services. Part A covers hospital services; few people have to pay premiums for Part A, but Alaska Medicaid will pay those for dual eligibles if necessary.

Also Medicaid recipients do not have to pay a Part D (Pharmacy Benefit) (\$37/month) premium for basic plans, and have greatly reduced cost-sharing.

- iv. Indian Health Service Funds for Alaska Natives and American Indians - \$0.401 billion Federal (FY 2005)

Alaska Natives and American Indians in Alaska from Federally recognized tribes are entitled to health care provided by Indian Health Service, in Alaska primarily through tribal contracts to provide health care services. A portion of these funds are used for “contract health services,” purchase of specialty or out of area care from non-tribal providers for beneficiaries when the services are not available through the tribal system.

- c. Other

- i. COBRA: The *Consolidated Omnibus Budget Reconciliation Act (COBRA)* provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage. Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.⁵³
- ii. ACHIA: The Alaska Comprehensive Health Insurance Association (ACHIA) was created by the Alaska State Legislature in 1992 to provide access to health insurance

⁵³ http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html downloaded 08-17-09

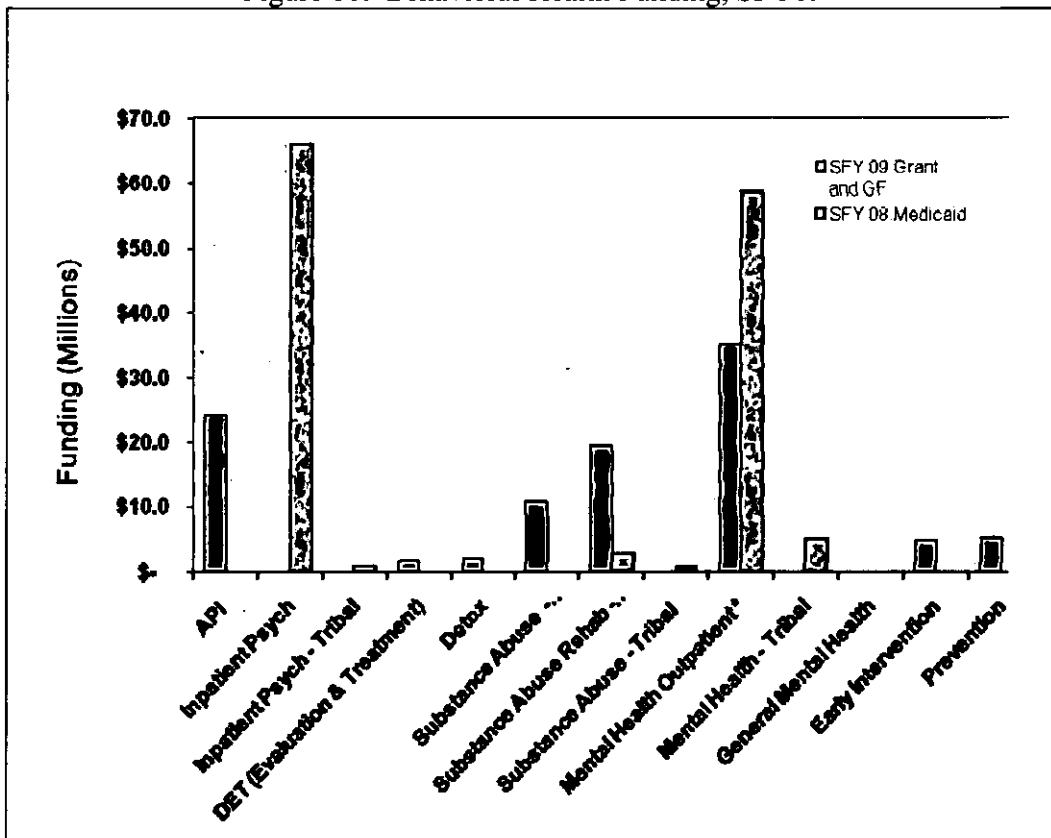
coverage to all residents of the state who are unable to obtain individual health insurance due to a preexisting medical condition and who meet certain eligibility requirements.⁵⁴

- iii. Federal Programs providing care (includes some of the SAMHSA funds)
Military care provision (direct)
Veterans services
Tri-care – insurance-like coverage for dependents
Federal employee benefits
- iv. Federal Grants: support operating costs (fixed grant amounts each year) for Community Health Centers, and support Frontier Extended Stay Clinic demonstration project development – also limited direct services provided by several small demonstration projects – but little actually go to patient care which is covered through the claims-based programs.
- v. Denali Commission: Federal funding of village clinics, regional clinics and hospital clinics, also some behavioral health facilities.
- vi. Anchorage Muni: Maternal Child Health, immunizations (public health activities that relate to provision of health care – there are also many monitoring, assessment, prevention, health education – health promotion, protection and disease prevention activities not addressed here; see <http://www.muni.org/departments/health/pages/default.aspx>.)
- vii. Volunteer activities:
 - Anchorage Project Access (APA) uses a volunteer network of providers to increase access to health care for low-income uninsured members of the Anchorage area. Currently, 333 physicians, 98 mid-level providers, and other support services participate in APA's provider network. Patients are carefully screened for income eligibility, and cannot be eligible for other programs. Since December 2005, APA has processed over 2,035 applications for eligibility, with over 1,110 applicants meeting program eligibility guidelines and receiving medical treatment. See www.anchorageprojectaccess.org.
- viii. State general funds:
 - Public health services that provide direct care – Early and Periodic Screening, Diagnosis and Testing (EPSDT), newborn hearing screening, immunization clinics, other.
 - Division of Juvenile Justice, Department of Corrections, Office of Children's Services, Department of Education each pay for health services for clients to some degree.

⁵⁴ www.achia.com

- **Fishermen's Fund:** Established in 1951, the Fishermen's Fund provides for the treatment and care of Alaska licensed commercial fishermen who have been injured while fishing on shore or off shore in Alaska. Benefits from the Fund are financed from revenue received from each resident and nonresident commercial fisherman's license and permit fee.
- **Division of Behavioral Health funds for provision of behavioral health services** (i.e., not services billable to insurance). Note in the figure below, showing the funding of the continuum of care, that the majority of state funding (both Medicaid and operating API) go to the most intensive mental health and substance abuse treatment services.

Figure 11: Behavioral Health Funding, SFY09



Source: Alaska Division of Behavioral Health, Policy and Planning Unit, March 2009

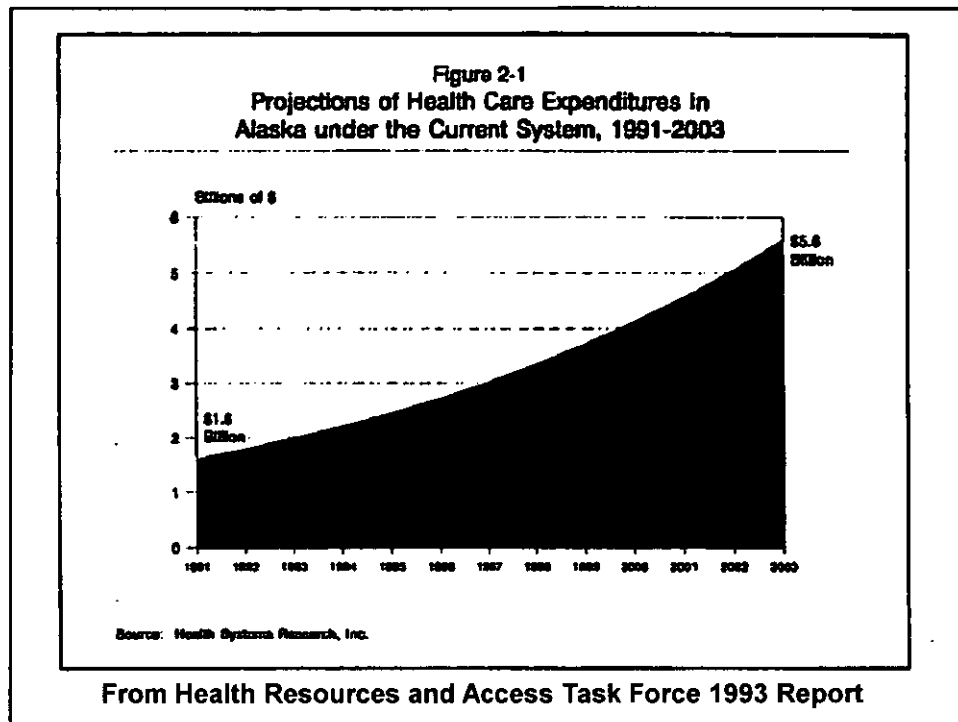
Transforming Health Care in Alaska

Alaska Health Care Commission
2009 Report & 2010-2014 Strategic Plan

Presentation to
House and Senate Health & Social Services Committees
February 3, 2010

A Brief History...

1987-1988	Governor's Interim Health Care Commission
1991-1993	Health Resources and Access Task Force
2003-2005	CWN Alaska Health Care Roundtable
2007	AK Health Strategies Planning Council



And Today...

with AK Health Care Expenditures over \$6 Billion
Health Care Costs Pose a Significant Threat to Alaska's Economy and the Sustainability of State Government

The Alaska Health Care Commission

- Created by Gov. Palin under Administrative Order 246
- Members appointed January 2009
- Purpose: Foster development of statewide plan to address quality and accessibility of health care

Commission Members

- Dr. Ward Hurlburt, Chair – DHSS CMO
- Valerie Davidson – Tribal Health System
- Jeffrey Davis – Insurance Industry
- Keith Campbell – Consumer
- Ryan Smith – ASHNHA
- Wayne Stevens – Chamber of Commerce
- Dr. Lawrence Stinson – Health Care Provider
- Ex-Officio
 - Senator Donny Olson
 - Representative Wes Keller
 - Linda Hall – State Insurance Commissioner

5

Alaska Health Care Commission

Duties

1. State health planning and coordinating body
2. Foster development of a:
 - Comprehensive statewide health care policy
 - Strategy for improving the health of Alaskans
3. Report due to Governor and Legislature
January 15, 2010

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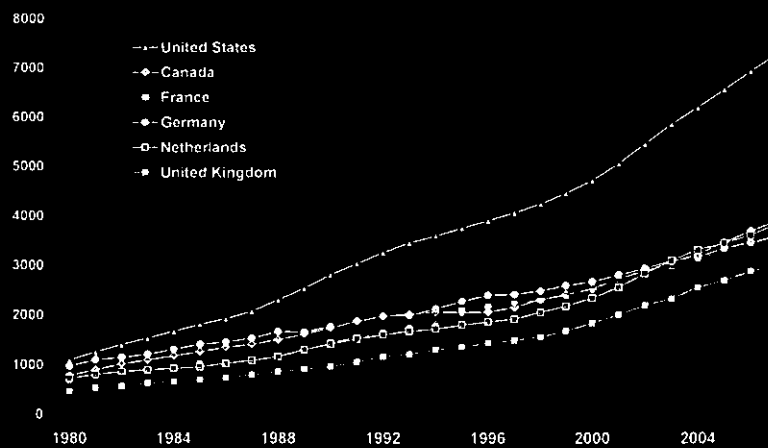
The Elephant in the Room



7

National Health Expenditures per Capita, 1980-2007

Average spending on health per capita (\$US PPP)



Data: OECD Health Data 2009 (June 2009), from the Commonwealth Fund (Nov 2009)

8

Premiums Rising Faster than Wages and Inflation

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000-2009



Commonwealth Fund; November 2009

9

The High Cost of Care in Alaska

- Alaska has the highest annual Medicaid expenditure level per enrollee in the nation at \$10,417 (2004)
- Alaska has ranked first in the nation for cost of Workers' Comp premium rates since 2005
 - Alaska has the highest Worker's Comp medical fee schedule rates in the nation – on average 3.5 times higher than the state with the lowest rates (2006)
 - Medical costs make up 72% of total Worker's Comp benefit claims in Alaska, compared to the national average of 58% (2008)
 - Alaska's average medical cost per Workers' Comp claim is \$40K per injury compared to the national average of \$26K (2008)
- The average cost per hospital stay in Alaska is \$27,171 compared to the national average of \$15,455 (2007)
- The price for medical care in Anchorage doubled between 1991 and 2005, while the Anchorage CPI for all items increased 38% during that same period

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Differences in Medicaid Fees, 2009

Description	Code	AK Fee	WA Fee	% Difference
Outpatient Office Visit – Lower Level	99212	\$62.46	\$22.69	175%
Outpatient Office Visit – Highest Level	99215	\$221.58	\$76.00	192%
Emergency Department Visit	99283	\$109.14	\$37.48	191%
Knee Arthroscopy/Surgery	29881	\$976.77	\$358.08	173%
Gall Bladder Removal, Laparoscopic	47563	\$1,175.10	\$412.29	185%
Cataract Surgery w/Lens Implant	66984	\$1,141.23	\$394.44	189%

Differences in Workers' Comp Fees, 2006

Description	Code	AK Fee	WA Fee	HI Fee
Outpatient Office Visit – Mid Level	99213	\$127.00	\$76.00	\$61.00
Radiology (MRI, spinal canal cervical)	72141	\$2,339.00	\$769.00	\$634.00
General Medicine (nerve conduction)	95904	\$219.00	\$81.00	\$66.00
Knee Arthroscopy/Surgery	29881	\$4,181.00	\$869.00	\$693.00
Physical Medicine (therapeutic proc)	97110	\$83.00	\$40.00	\$32.00

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The 800 lb. Gorilla



12

Determinants of Health



- 40% Behavior
- 30% Genetics
- 15% Social Circumstances
- 10% Health Care
- 5% Environment

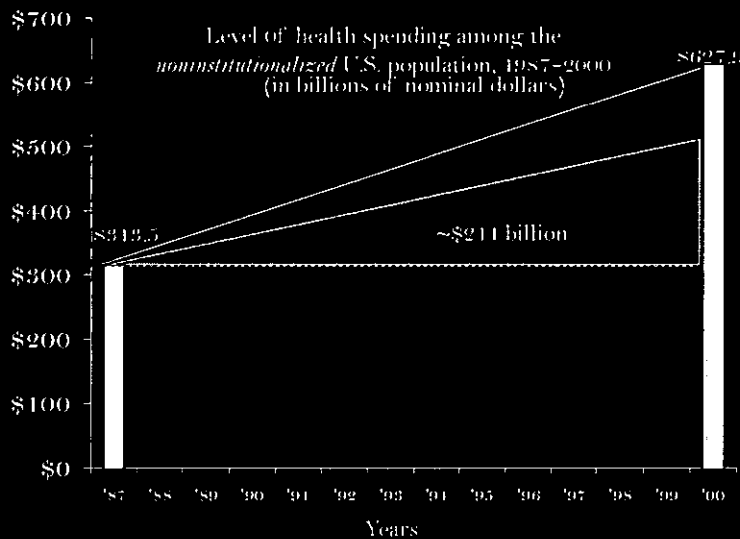
13

Chronic Disease accounts for

- 70% of all deaths in the U.S.
- 4 of the 5 leading causes of death in AK
- 75% of all health care expenditures

14

Health Expenditure Increase Due to Chronic Disease



1
5

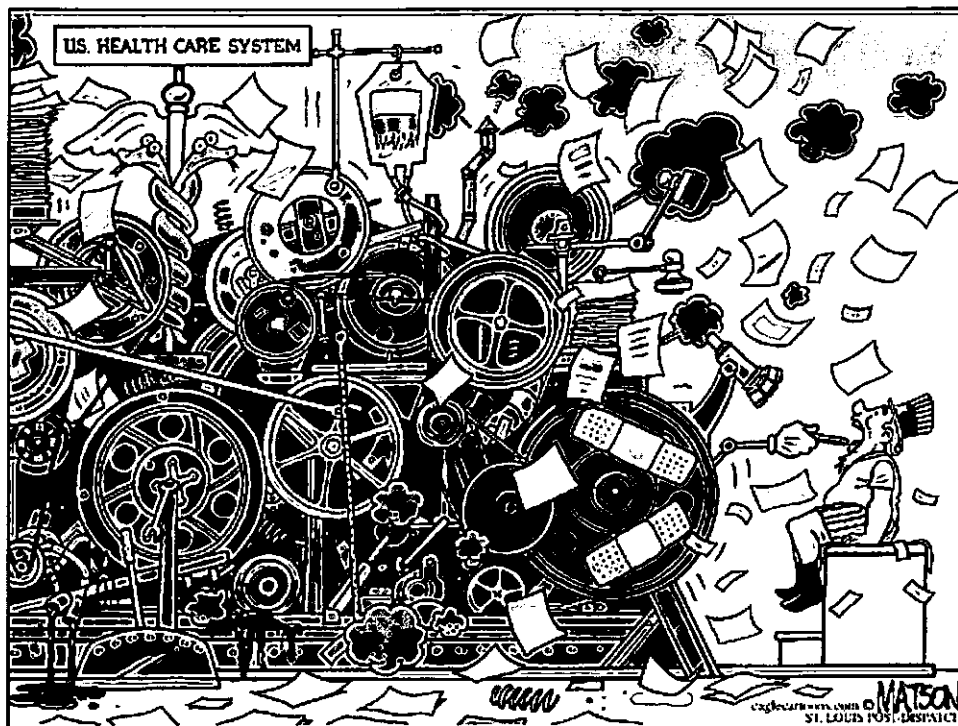
COST =



Price x Utilization

Thank you Mr. Foster

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Diagnosis of Alaska's Health Care System

- ❑ Costs are unaffordably high and continue to climb
- ❑ The delivery of health care services is fragmented
- ❑ Financing and payment mechanisms are complex
- ❑ Many Alaskans lack health insurance
- ❑ Some Alaskans cannot find a doctor to care for them
- ❑ There are high vacancy rates in Alaska's health care workforce
- ❑ Levels and variations in quality of care are not well understood
- ❑ Consumers and health care providers are frustrated
- ❑ The system as currently designed is not sustainable

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Commission's Strategic Plan

- 5-Year Planning Framework
 - I. Develop Vision
 - II. Accurately Describe Current System
 - III. Build the Foundation
 - IV. Design Transformation Elements
 - V. Measure Progress
 - VI. Engage Public & Stakeholders
- Action Plan for 2009 Recommendations
- 2010 Commission Work Plan

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Vision & Values

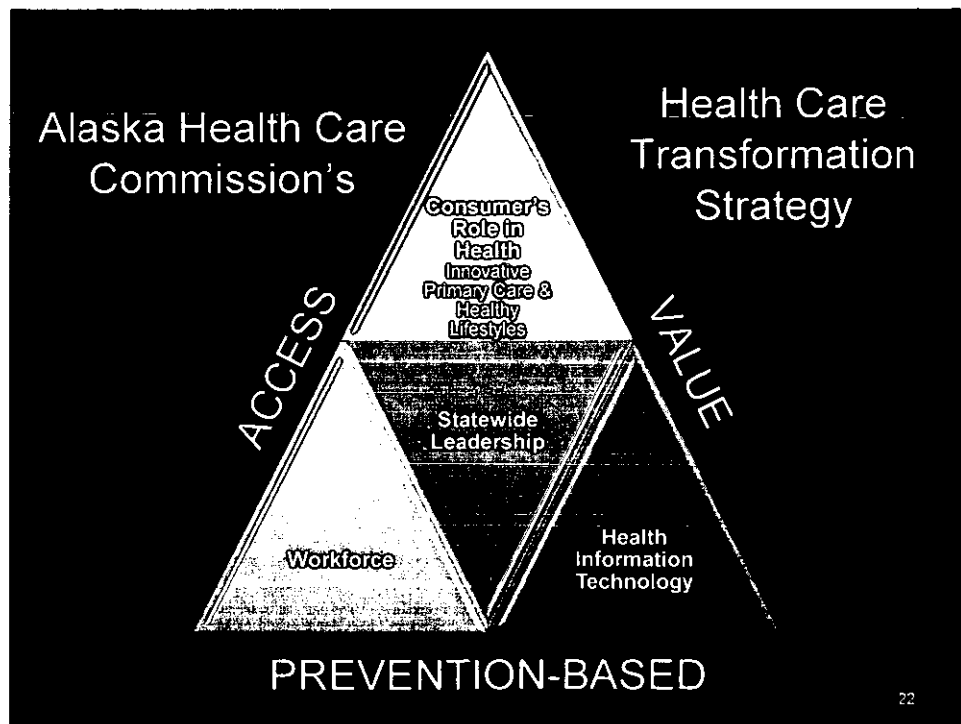
- **Vision**
 - Alaska's health care system produces improved **health** status, provides **value** for Alaskans' health care dollar, delivers consumer and provider **satisfaction**, and is **sustainable**.
- **Reform Goals**
 - Improved Access
 - Controlled Costs
 - Improved Quality
 - Prevention-Based
- **Values**
 - Sustainability
 - Efficiency
 - Effectiveness
 - Individual Choice
 - Personal Engagement

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Year 1 Priorities

- **Consumer's Role in Health Care**
 - Healthy Lifestyles
 - Innovative Primary Care
- **Statewide Leadership**
 - Response to National Health Reform
 - Permanent State Health Planning Board
- **Health Care Workforce Development**
 - Physician Supply and Distribution
- **Health Information Technology**
 - Health Information Exchange/EHR
 - Telemedicine
- **Primary Care Access for Medicare Enrollees**

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Medicare Access Problem - The Canary in the Coal Mine?



23

Recommendations

Strengthen Consumer's Role

- Support Healthy Lifestyles and Create Culture of Wellness
- Develop Patient-Centered Primary Care Model
 - Payment Reform
 - Removal of Statutory/Regulatory Barriers
 - Pilot Projects

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Recommendations

Foster Statewide Leadership

- Invest in Health Policy Infrastructure to Respond to National Reform
- Permanent State Health Planning Board

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Recommendations

Develop Health Care Workforce

- Priority for Health Care Reform and Economic Development Agendas
- Strengthen the Workforce "Pipeline"
- Innovation and Adaptation
- Coordinated Planning
- Target Physician Development \$\$ to Primary Care
 - Loan Repayment & Financial Incentives for R&R
 - WWAMI Expansion as Resources Allow
 - GME for Peds, Psych, and Primary Care Internal Medicine

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Recommendations

Deploy Health Information Technology

- Support HIT Adoption and Utilization
- Ensure Privacy and Security
- Broadband Telecom Infrastructure Access
- Reimbursement for Telemedicine

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Recommendations

Improve Medicare Access

- Increase Supply of Primary Care Providers
 - Loan Repayment & Financial Incentives for R&R
 - WWAMI Expansion
 - GME for Primary Care Internal Medicine
 - Mid-Level Practitioners
- Support FQHCs and RHCs
- Request Relief from Federal Reimbursement Inequities and Administrative Burden
- Develop PACE Program

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Transformation Elements

I. Access to Care

- Health Insurance Coverage
- Health Care Workforce Development
- Physical Health Care Services
- Behavioral Health & Long Term Care

29

Transformation Elements

II. Cost & Quality (VALUE)

- Analyze Cost of Care in Alaska
- Foster Primary Care Innovation
- Move to Value Driven Purchasing
 - Leverage State Purchasing Power
 - Transparency – Cost and Quality
 - Evidence-Based Medicine
 - Pay-for-Performance
 - Bundled Payment Systems
 - Medical Error and Infections Reporting & Non-Payment
- Fraud & Abuse Control
- Tort Reform
- Support Process & Quality Improvement Mgmt Strategies

30

Transformation Elements

III. Prevention

- Public Health & Community-Based Prevention
- Safe Water & Sanitation Systems
- Employee Health Risk Management

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Commission's Future

- ❖ A.O. 246 expires 04/30/10 if not extended
- ❖ Creation of Commission in Statute
 - Bills Pending – 2010 Legislative Session
 - SB 172 Olson
 - HB 25 Hawker
 - HB 75 Cissna

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Thank You

*For more information please visit the
Commission's web site at:*

<http://hss.state.ak.us/healthcommission/>

Question? Comments?

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2/4/10

**BUILDING
ALASKA'S
SYSTEMIC
CAPACITY
TO DEAL...**



Alaskans with Brain Injury: 10 Year Plan for TBI in Alaska, Core Service Assumptions

Alaska has an opportunity to strengthen families and increase the health and safety of Alaska communities through maintaining a State brain injury program.

Brain injury can happen to anyone in an instant; a fall on the playground, a slip on the ice or in the bathtub, a car or off-road vehicle crash, hockey games, and more. Alaska state government has been successful in identifying the needs of Alaskans with brain injury and developing a plan to meet those needs. Because Alaska does not have brain injury specific funding and programs, the current state service delivery system creates an environment where Alaskans who have disability due to brain injury eventually find themselves in homeless camps, chronic inebriate populations, and mental health court and correction institutions. Brain injury is a unique disability and needs a service delivery system that creates a structure where brain injury survivors, who are at risk for challenging behaviors, substance abuse, emotional impulsivity, and more, can learn to manage these behaviors, moods, and emotions. Brain injury case management, post-acute rehabilitation, community re-entry, community clubhouses, and long-term housing arrangements are just a few solutions to freeing up dollars and waiting lists in behavioral health, public assistance, juvenile justice, corrections, long-term care and other existing state programs, while getting people back into the community, school, and work.

It is important to understand the brain injury survivors described above are proportionally small in number when compared to the number of Alaskans that hit their head each year. Many children and adults are being supported in their homes, many have difficulties and challenges at school, work, with their parents or spouses, but continue to work extra hard to maintain the roles that defined them before their injury; mom, dad, teacher, CEO, professor, student, athlete, fisherman, friend, etc. There are many more individuals in the community that do not recognize they have had a brain injury. Many families and individuals are exhausted by the constant struggle, and would benefit from standard brain injury rehabilitation and long-term formal and natural supports.

The State, the Tribal Health System, the hospitals, non-profit/private/public providers, military and other partners have a role in developing this continuum of care. The assumptions listed at the end are not in priority order. They highlight opportunities to develop a full continuum of care for Alaskans with brain injury. The State's role would be to fund and maintain a TBI Program, which includes developing [a portion of] the sustainable funding so providers and community organizations can create and grow community-based services. The brain injury programs that will develop through the state brain injury program would then be utilized by Alaskans with a variety of pay sources.

Alaska state government, through maintaining a TBI Program, will provide the leadership and incentive to create a service delivery system where children, adults, and service members who sustain a brain injury and their families, will have the opportunities that all Alaskans desire; to learn, love and be loved, and find meaningful work or activities.

The Alaska Brain Injury Network worked collaboratively with the Department of Health and Social Services and the Alaska Mental Health Trust Authority to outline a 10 year plan for TBI in Alaska. You can read the full report on the website, www.alaskabraininjury.net.

This document will highlight the following information:

- Why is brain injury a unique disability? (Page 2)
- Current incidence and prevalence of traumatic brain injury in Alaska (Page 2-3)
- Description of populations that are at highest risk for brain injury (Pages 3-5)
- State agency resources currently available for TBI services (Pages 5-6)
- Current Department of Health and Social Services, Alaska TBI Program (Pages 6-7)
- Description of how other States fund TBI services (Pages 7-8)
- 10 Year Plan for TBI in Alaska: Core Service Assumptions (Pages 8-12)

Why is brain injury a unique disability?

It is important to understand that brain injury is a unique disability, and requires the development of brain injury specific programs. A few examples include:

1. Only a few brain injury survivors have a physical sequelae, autonomy often recovers through daily activities.
2. Many brain injury survivors, have a cognitive challenge, and most often have mood and behavior changes
3. Brain injury is an acquired handicap. Most brain injury survivors have a vivid memory of normal life before injury.

Incidence and prevalence of TBI in the State

Every year, the State of Alaska, Department of Health and Social Services (DHSS) reports about 800 traumatic brain injury cases resulting in hospitalization or death. In addition to the 640 seriously injured TBI patients that survive their injuries and are discharged from Alaskan hospitals each year, an estimated three times as many suffer a mild TBI. This is upwards of 3,000 new TBI survivors in Alaska each year, joining the estimated 10,000 to 12,000 Alaskans currently living with brain injury.

The highest rates of TBI in the state of Alaska are among Alaska Natives, residents of rural Alaska, youth aged 15 -19 in motor vehicle crashes, and elderly who suffer injury in some sort of fall. The Alaska Trauma Registry shows that males and females aged 80+ have the highest rates of non-fatal TBI hospitalizations. Falls, motor vehicle crashes, assault, sporting and recreational injuries, and occupational injuries – including war-related injuries – are the primary causes of TBI. Alcohol is often a contributing factor. The crude rate of non-fatal hospitalizations for TBI in Alaska for the five-year period 2001-2005 was 98.6 per 100,000.¹

TBIs are overrepresented among the Alaska Native population. The Alaska Native population comprises about 16% of the Alaskan population; however, Alaska Natives are 34% of the total population of individuals with a TBI. Similarly, the highest rates of TBIs occur in the rural regions of the state with the highest number of Alaska Native residents: the Northwest (81.1% American

¹ T. Ali. AK DHSS Division of Public Health, Section of Injury Prevention and EMS, Alaska Trauma Registry (personal communication, 2009).

Indian/Alaska Native), North Slope (70.1% American Indian/Alaska Native), Norton Sound (75.4% American Indian/Alaska Native) and Interior region (69% American Indian/Alaska Native).²

The Alaska veteran population is 17% of the statewide population, the highest rate among all the states. The Alaska VA Health Systems reports that from September 2001 to October 2008, approximately 146 (11%) veterans receiving primary care screened positive for TBI. Positive screenings are referred for a second screening. Following the second screening, 52 (39%) veterans required further neuropsychological testing to confirm a diagnosis of TBI.³

Because of the non-availability of brain injury rehabilitation in Alaska, service members returning with moderate to severe brain injuries must seek services outside of Alaska. Of active duty personnel returning to Alaska in 2007 and 2008, 1,500 have been screened for mild brain injury and 75 are receiving ongoing TBI care. It is anticipated that in the next six months and over the next few years, several thousand troops will return from Iraq and Afghanistan. Estimates are that between 20 and 30 percent of those troops will need TBI services.

Around 80 community behavioral health centers screen for TBI using the *Alaska Screening Tool*. The data is gathered by behavioral health service providers statewide and entered into the DBH Alaska Automated Information Management System (AKAIMS) database. In 2006, a total of 6,263 individuals were screened using the AKAIMS system. Of that number, just over 1/3 (2,080 individuals) screened positive for a TBI.⁴

A description of groups at high risk for TBI

Military Personnel

A recent study by the Rand Corporation found that approximately 18.5 percent of US Service Members who have returned from Afghanistan and Iraq currently have post-traumatic stress disorder (PTSD) or depression, and 19.5 percent report experiencing a traumatic brain injury during deployment.⁵ Another study provided evidence that screening for depression should be a standard component of TBI assessment protocols. In this study, researchers found that between 30 percent and 38 percent of patients with a TBI were classified as depressed with the NFI Depression Scale and the BDI, respectively.⁶

A study published in the *New England Journal of Medicine* reported on a survey conducted of 2,714 soldiers from two US Army combat infantry brigades – one Active Component and one Reserve Component (Army National Guard) – deployed in Iraq. The study found that mild TBI was strongly associated with PTSD and physical health problems three to four months after the soldiers returned home and concluded that mild traumatic brain injury (i.e. concussion) occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems.⁷

² US Census Bureau (2006)

³ Martin, B. (2009, January 9). Update on mental health issue for returning veterans: Demographics, problems, services, access.

⁴ Michael Walker (personal communication, May 2008)

⁵ Rand Corporation (2008) *Invisible wounds: Mental health and cognitive care needs of America's returning veterans*.

⁶ Seel, RT., & Kreutzer, J.S. (2003). Depression assessment after traumatic brain injury: an empirically based classification method. *Archives of Physical Medicine and Rehabilitation*, 84(11), 1621-8.

⁷ Hoge, C.W., et al. (2008). Mild traumatic brain injury in US soldiers returning from Iraq. *New England Journal of Medicine*, 358, 453-63.

In 2007, the Elmendorf Air Force Base in Anchorage, Alaska established a TBI clinic to diagnose and treat returning military personnel impacted by TBI. Screening of those deployed is mandatory through the Post Deployment Health Reassessment. Military base medics and officials anticipated that a portion of the 3,500 paratroopers with the 4th Airborne Brigade Combat Team, deployed to Iraq from Fort Richardson in Fairbanks, Alaska, would return to Alaska with TBI. Since the clinic's opening, 1,500 patients have been screened for TBI and 75 are currently monitored on a regular basis. The military is currently planning to construct a second TBI clinic in Fairbanks to supplement services offered at the clinic in Anchorage and to serve the Fairbanks-based military population.⁸

Because of the increased recognition of the danger of incurring brain injury while engaged in military duty, the Alaska Brain Injury Network (the state's TBI advisory board) has facilitated a TBI Partnership meeting to coordinate TBI awareness, outreach, and treatment among active duty military personnel, National Guard personnel, Veterans Administration personnel, State personnel, and entities serving Alaska Native Tribal beneficiaries since August 2007. The TBI Partnership military members include the 3rd Medical Unit, Alaska Veterans Administration Health System, Alaska National Guard, VA Vet Centers, and the Alaska Federal Health Care Partnership.

Alaska Native/Native Americans

The CDC Traumatic Brain Injury website identifies Alaska Native/American Indian people as one of the two race categories with the highest rates of hospitalization for this type of injury.⁹ The Alaska Native population comprises about 16% of the total Alaskan population. However, Alaska Natives are 34% of the total population of individuals with a TBI in the state. Similarly, the highest rates of TBI occur in the rural regions of the state with the highest number of Alaska Native residents: the Northwest (81.1% American Indian/Alaska Native), North Slope (70.1% American Indian/Alaska Native), Norton Sound (75.4% American Indian/Alaska Native) and Interior region (69% American Indian/Alaska Native).¹⁰ Thus, the Alaska Native/American Indian population is statistically overrepresented in the numbers of Alaskans impacted by Traumatic Brain Injury in the state.

Currently, available reports on Traumatic Brain Injury (TBI) statistics in Alaska include general demographic categories such as age, race, or region. Due to the elevated rate identified for Alaska Native people, in addition to the regional variance in the topography, environmental risks, and lifestyles, there is a need to identify differences in TBI incidents and risks among the regions of Alaska. This will better inform prevention efforts and help make region-specific assessments about the risk factors, disparities, trends over time, and hospitalization costs for traumatic brain injuries in Alaska Native populations. Additional information on the costs involved in injury, treatment, recovery, and rehabilitation for this population are needed. The Alaska Native Tribal Health Consortium has been contracted to gather this data by September 2010.

As has already been mentioned, many Alaska Native people live in rural parts of the state where there may be a lack of medical and social services, and a lack of awareness about the impacts of TBI and how to treat the injury in the long term. The combination of high prevalence rates and lack of a full spectrum of long-term services and rehabilitation make Alaska Natives a high priority population for services and prevention measures in the state.

⁸ D'Oro, R. (2009, April 5). Growing Elmendorf clinic treats brain injuries. *Anchorage Daily News*. Retrieved from <http://www.adn.com>

⁹ Traumatic Brain Injury. CDC: NCIPC. Retrieved from <http://www.cdc.gov/ncipc/factsheets/tbi.htm>.

¹⁰ US Census Bureau (2006)

Elderly

Accidental and usually preventable falls are the number one cause of injury to Alaskans age 65 and older, often causing serious injury such as TBI or hip fracture. Approximately one third of older Alaskans will fall each year and an average of 579 seniors will be hospitalized as a result. Although the Alaska Trauma Registry reported that during a ten-year period, 680 seniors 65 and older were hospitalized and diagnosed with TBI, research shows that brain injury among the elderly is often misdiagnosed and left untreated. Older Alaskans have the highest prevalence rate of brain injury in Alaska.

Per 100,000 Alaska Residents:

Males age 80+.....	301.3
Females 80+.....	217.2
Males age 15-19.....	215.7
Males age 70-79.....	200.9

Behavioral Health

Substance abuse is often both a cause of brain injury and a symptom after brain injury. Of the 800 Alaskans hospitalized each year, 32 percent were under the influence of alcohol when the brain injury occurred. From 1999 until 2008, the State of Alaska Department of Health and Social Services, Division of Behavioral Health (DBH), was the lead agency responsible for overseeing TBI services in the state. Through its mission to manage an integrated and comprehensive behavioral health system for Alaska, DBH requires its service provider grantees to screen Alaskans seeking behavioral health services for TBI. Around 80 community behavioral health centers screen for TBI using the *Alaska Screening Tool*. The data is gathered by behavioral health service providers statewide and entered into the DBH Alaska Automated Information Management System (AKAIMS) database. In 2006, a total of 6,263 individuals were screened using the AKAIMS system. Of that number, just over 1/3 (2,080 individuals) screened positive for a TBI.

In order to manage and treat substance abuse in clients with a history of brain injury, substance abuse treatment must be a component of a multidisciplinary treatment approach. In order to increase treatment plan success, it is essential to create a brain injury system of care, connecting behavioral health providers to a multidisciplinary team, ultimately ensuring that people who have access to these services can maintain a functional quality of life.

State Agency resources available for TBI services

DBH has made great advances in identifying TBI in those Alaskans who access services through a behavioral health facility. However, because TBI is a condition that does not necessarily present behavioral related effects, it is important that efforts to identify and serve individuals with TBI be expanded to the entire state health and social service system. In this way, an individual with TBI will have access to a spectrum of services such as speech therapy, cognitive therapy, physical therapy, and vocational assistance.

Due to Alaska’s vast geographic area and large number of remote, often inaccessible communities, coordinating brain injury projects and programs among the military, tribal, state, and community

sectors is challenging. DBH has begun the process of raising awareness, identifying individuals in the behavioral health system with brain injury and identifying the need to expand the TBI service system to include a variety of state and community agencies.

Because DBH has mandated TBI screening, grantees have begun to recognize brain injury and are connecting clients to available brain injury supports and resources. Some providers have also begun work within their own programs to respond to the need for service and prevention. In addition, data collected through AKAIMS has been helpful in advocating for increased funding to meet the needs of individuals with brain injury. This important work has provided the foundation for the state's efforts to plan and develop a comprehensive, coordinated service delivery system.

The Alaska Brain Injury Network (ABIN), incorporated in 2003, has been the TBI advisory Board to the State of Alaska, Department of Health and Social Services, and the Alaska Mental Health Board (the Trust) since 2001. ABIN educates, plans, coordinates, and advocates for a comprehensive service delivery system for the survivors of traumatic brain injury and their families. In 2007, ABIN expanded its role by adding a Resource Navigator to provide statewide information and referral for persons with brain injury, their families, providers, friends, and many others interested in brain injury services within Alaska's communities. ABIN's focus on systems improvement and advocacy, as well as its ability to bring a variety of partners together, positions them to coordinate the development of statewide brain injury services among state, tribal, and military systems. The ABIN Board of Directors consists of 18 members representing all regions of Alaska. At least 50 percent of the board members are TBI survivors or their family members.

The State of Alaska Division of Senior and Disabilities Services (SDS) provides access to a continuum of long term services and supports for low-income seniors and people with disabilities. SDS administers four Medicaid waiver programs that provide home and community based services through a network of service providers as an alternative to nursing home placement. In addition to the four Medicaid Waiver programs, SDS administers programs that assist individuals of any age with disabilities to remain safe and independent in their homes and communities. These programs include Older Americans Act programs, Assisted Living Home Certification, Adult Protective services, Personal Care Assistance services, nursing home transition, Medicare Info, and Aging and Disability Resource Centers. The focus of SDS is multi-faceted in nature – serving seniors, adults with physical disabilities, persons with developmental disabilities, vulnerable adults, and assisted living providers. Because of this broad focus, SDS's service population often includes individuals impacted by TBI.

Other State agencies directly serving Alaskan individuals with TBI include Vocational Rehabilitation (VR), Education and Early Development, and Public Health.

Current Department of Health and Social Services TBI Program

Because of the momentum and leadership provided by the State of Alaska in developing a sustainable TBI system, additional staffing was essential to oversee the activities of the developing system. Even though the state was unsuccessful in their bid for a FFY 09 HRSA TBI Implementation Partnership grant, SDS, DBH, ABIN, the Trust, and the Alaska Native Tribal Health Consortium collaborated to fund a temporary TBI Program Coordinator (Project Director) employed by ABIN. That individual was hired and began work in October 2009. During the next year the Program Coordinator will support the development of the state TBI program and research methods to expand access to TBI services in Alaska, including the development of a TBI Medicaid waiver.

During 2008, SDS designated an interim TBI program coordinator to facilitate the transition of the TBI program from DBH to SDS. That individual has been working collaboratively with ABIN on development of an SDS TBI program, which will include a TBI Program Director and Care Coordinator position.

In 2008, the AMHTA Trustees approved MHTAAR funding to support the development of a Brain Injury Care Coordination project to be administered by Senior and Disabilities Services. In spring 2009, the interim TBI Project Director and ABIN Executive Director worked with a consultant to develop this program. The care coordinator position will be hired in the fall of 2009. The Care Coordinator will assist people with traumatic brain injuries and their families to develop a person-centered, goal-oriented plan to achieve short-term and overall life goals and minimize the severity of disabilities through prevention, interventions and compensatory strategies. This position will be responsible for coordinating services to assure that people have access to a full array of needed community services including appropriate health care, medical, rehabilitative, social, educational, in-home supports or other needed services.

Through this project development, SDS has begun an official State TBI Program which, with appropriate resources, is forecasted to better meet the needs of TBI survivors over the next 10 years. The TBI Program is also forecasted to decrease the number of people with TBI who are in the correctional system, juvenile justice facilities, and behavioral health clinics.

How do other States fund and sustain a TBI Program?

States use a variety and combination of funding streams for planning, policy, prevention and research activities, and to serve individuals with brain injuries and their families who have no other access to needed care or supports. Medicaid, Home and Community-Based Services and Medicaid Waivers, and Federal Block Grant programs are used to serve individuals with disabilities and special health care needs including people with brain injury. At the State level, common non-Federal funding sources for TBI service delivery include trust funds, general revenue and special revenue. Often when two or more sources exist, funds from one are used to leverage funds from the other.

There are 24 States that have a Brain Injury Medicaid Waiver (2006). There are 20 states that have General Revenue or Special Revenue specific to brain injury (NASHIA 2005).

Medicaid waivers targeted to individuals with brain injuries operate in half of the states and are small when compared to waivers targeting other groups. These waivers provide significant cost savings, on average \$30,000 annually per person, when compared to institutional facility-based services (Rutgers 2008).

These waivers have been successful both programmatically and financially. In addition to cost savings, these waivers have provided other significant benefits. The existence of these waivers supports the growth of community non-profit brain injury agencies. There is clear evidence of the desirability of home and community-based services among those directly affected by brain injury: there has been growth of these waivers that has resulted in a doubling of the number of persons served over five years; in addition, there is a visible role played by advocates in encouraging states to develop these

waivers. These waivers, over time, have contributed to states' efforts to create and grow an in-state service capacity to provide services to individuals with brain injuries.¹¹

10 Year Plan for TBI in Alaska, Core Service Assumptions

(view the full report at www.alaskabraininjury.net)

Information and Referral

Assumptions:

- Department becomes the lead funder; currently Trust funds Information and Referral (I&R)
- GF/MH expands the program to produce and disseminate educational packets
- Department develops methods for following up with individuals hospitalized and reported to the trauma registry
- Department will coordinate brain injury I & R to ADRC
- Training/workshops to disability, health and social service agencies providing I&R to include TBI information
- Workforce will begin to understand service needs for TBI and will be incorporated into existing programs by FY17

Service Coordination (care coordination)

Assumptions:

- SDS will collect appropriate data during pilot years FY10/11 to determine need for expansion
- 30 clients/ care coordinators at any one time
- Train case managers/care coordinators in other programs regarding TBI and available resources
- Develop and continue protocols with hospitals for linking individuals to services following TBI
- Positions hired internally by SDS or granted out depending on evaluation of demonstration positions in FY10/11

¹¹Hendrickson, L. & Blume, R. (2008). Issue brief: A survey of Medicaid brain injury programs. *Rutgers Center for State Health Policy*

Acute and Post-Acute Rehabilitation

Assumptions:

- State investment will get match from Medicaid, Tribal Medicaid, Insurance, Workman's Comp, etc.
- Data will be developed through TBI Care Coordinator Program to develop service needs and costs associated with those services to direct the writing of a TBI waiver.
- Department will analyze costs of existing services to determine accuracy of forecast.
- Research a post-acute rehab waiver for TBI needs
- Department will develop funding options through general revenue, federal grant, Medicaid to pay for post-acute rehabilitation and therapies
- Community providers; i.e. hospitals or others will develop TBI post-acute and residential programs
- Pool resources for rehabilitation service system (i.e. Veterans Affairs, Department of Defense, Indian Health Services, and Worker's Compensation)
- Adopt program standards, best practices and outcomes
- Determine rehabilitation options for unserved or underserved populations (i.e. children, elderly, Alaskans living in remote areas)
- Support in-state TBI services for children and youth through BTKH

Education and Related Services

Assumptions:

- Training for STAR care coordinators
- Partner with Statewide Positive Behavior Support Initiative to include TBI-specific behaviors
- Partner with Parent Training agencies (i.e Stone Soup Group) to educate families on TBI
- Partner with SESA and Stone Soup Group to train school districts about TBI
- Hospitals and school districts will communicate when a child is hospitalized with TBI
- Develop Project BRAIN, Brain Injury Resource and Information Network for parents, students, teachers, and medical professionals supporting youth with brain injury.

Vocational Training and Rehabilitation

Assumptions:

- Referral to DVR will increase due to service coordination
- Vocational Specialists will be trained in TBI
- By FY12 there will be at least 1 VR specialist with an emphasis in brain injury

- By FY20 there will be several VR specialists depending on the pilot positions in FY12/13
- Increase long-term supported employment programs (job coaching) for persons with TBI
- Expand Mental Health Customized Employment Grant to include TBI
- Provide training to VR counselors and community VR providers on TBI
- Develop pre-vocational options to prepare people for vocational rehabilitation services
- Recruit and provide training to employers on TBI related disabilities
- Provide supports to maintain employment

Long-term Care and Community Supports

Assumptions:

- Expand existing HCBS waivers to include TBI with cognitive and behavioral problems
- Expand existing HCBS waivers to include TBI services, including therapies, behavioral therapies, counseling
- **Develop TBI HCBS Waiver to cover those who are not eligible for existing waivers**
- **Eligibility is determined by Department and available funding**
- **At least 100 Alaskans hospitalized each year are Medicaid eligible.**
- **The number of people eligible can be capped, as well as the maximum amount for each participant. Medicaid funding can be strategically controlled.**
- **Federal government has a 50% match. There is a 100% match for Alaska Native beneficiaries.**
- **State investment will get match from Medicaid, Tribal Medicaid, Insurance, Workman's Comp, etc.**
- **Develop funding for housing and residential**
- **Obtain dedicated funding or general funds to pay for the array of services needed for individuals who are not Medicaid eligible**
- Include TBI in Senior and Disabilities Services efforts to develop person-centered hospital discharge planning model to help transition to community services
- Develop housing alternatives (i.e. supportive living, structured residential, long-term living homes for people with cognitive disabilities)
- Obtain state or MHTA funds as seed money to start clubhouse/day programs for TBI
- Promote technology in activities of daily living (i.e. assistive technology, PDA, etc)
- Develop technology to support TBI survivors in their homes (i.e. online clubhouse model, support groups)

Public Awareness, Prevention, and Advocacy

Assumptions:

- Trust will continue Coordinated Communications
- DPH will expand TBI prevention awareness to rural Alaska and other populations
- Enact booster seat legislation
- Funding for prevention education programs and collaboration among programs
- TBI self-advocates to assist with injury prevention education programs
- Collaboration among injury prevention agencies to coordinate TBI prevention and support best practices
- Funding for "Second Impact Syndrome" training of health professionals and school coaches
- ASAA adopt Impact program for school sports
- Support local helmet use ordinances
- Fund and implement the Alaska Model Helmet program
- Develop and implement teen focused TBI awareness events
- Develop, fund, and implement an elderly fall prevention program
- Public Awareness funding will lead to lower rates of TBI and higher usage of state and community rehab programs

Outreach and Identification

Assumptions:

- Investment in data collection within state government
- Policy decisions
- Develop MOA to share data
- Work with local school districts, Department of Education and Early Development to expand screening to include TBI
- Incorporate TBI into mental health and substance abuse screenings for inmates in correctional facilities
- Improve Behavioral Health Screening Tool to include questions about service-related causes; i.e. blast injuries, etc.
- Improve AKAIMS information to include TBI-specific referrals, duration, costs,
- Include TBI screening questions in existing screening tools in various sectors, to be identified in further research
- TBI screening in primary care settings, schools, etc.

Training and Workforce Development

Assumptions:

- Develop distance delivered TBI curriculum
- Conduct training through existing educational certificate and endorsement programs
- Conduct training through agency sponsored workshops/conferences for direct care providers, educators and other professionals/paraprofessionals.
- Expand core competencies for the workforce to address TBI
- Expand telehealth for training providers and families, particularly in rural areas
- Integrate TBI into college and vocational curriculums
- Develop program for training long-term care and community-based programs serving older adults to identify and screen older adults for TBI.
- Develop and provide training to educators on identifying TBI symptoms.

Statewide Planning and Policy Coordination

Assumptions:

- State Hires TBI Program Coordinator
- TBI Advisory Board to continue role as a planning board for the Department of Health and Social Services and the Trust, maintaining funding eligibility under HRSA TBI ACT
- Alaska to receive Federal HRSA TBI Implementation/Partnership Grant
- Continue to provide a venue for consumer input on the TBI service delivery system.
- Expand data capacity across pertinent programs to evaluate the TBI service delivery system; i.e. individuals served, services provided, expenditures and outcomes.
- Continue TBI participation among the 4 statutory advisory boards
- MOUs to support coordination of program data; individual service planning, including TBI documentation/evaluations, subject to confidentiality release of information
- Consumer Satisfaction Surveys every 2 years

Brain injury rehabilitation and treatment is standard in many states. The following document explains two federal initiatives focusing on TBI rehabilitation research.

NIDRR funds both Rehabilitation Research and Training (RR&T) Centers and TBI Model Systems of Care.

Rehabilitation Research and Training (RR&T) Centers

The National Institute of Disability Rehabilitation Research funds two RR&T Centers on brain injury. Both are housed at The Institute for Rehabilitation and Research (TIRR), Houston, Texas. The two RR&T Centers are: (1) Rehabilitation and Training Center on Community Integration in Persons with TBI and (2) Rehabilitation Research and Training Center on Rehabilitation Interventions Following Traumatic Brain Injury.

The Rehabilitation and Training Center on Rehabilitation Interventions following Traumatic Brain Injury promotes the scientific advancement of rehabilitation research by focusing on several areas identified as needing further research. These include areas of weakness in the current knowledge and future research regarding TBI recovery and rehabilitation effectiveness: improvement of the diagnosis and treatment of persons with mild TBI; development of interventions to assist school-age children with TBI; the needs of minority groups members with TBI; evaluation of the effectiveness of rehabilitation interventions; and treatment for the family members of people with TBI. Activities include publishing an informational and technical assistance resource for consumers and professionals; training for medical and neuropsychological fellows in rehabilitation research; coordinating a state-of-the-science conference on mild TBI; and producing an educational videotape to train family members in effective coping skills. Through representation on the advisory committees, consumers are involved in all aspects of planning and evaluating research and training activities

TIRR's National Database of Educational Resources on Traumatic Brain Injury

This National Database of Educational Resources on TBI is a part of TIRR's Rehabilitation Research and Training Center in Rehabilitation Interventions in TBI grant from the National Institute on Disability and Rehabilitation Research (NIDRR). The database contains information on more than 350 educational videotapes, audiotapes, and written materials that people with TBI, their family members and health care professionals can use. Information can be retrieved directly from the web site or by calling the TIRR Department of Education. To retrieve information from the database or for more information, visit www.braininjuryresearch.org/birc/database.htm.

TBI Model Systems of Care

In 1987 the National Institute on Disability and Rehabilitation Research (NIDRR) in the U.S. Department of Education established the Traumatic Brain Injury Model Systems of Care (TBI Model Systems). NIDRR's multi-center model systems program is designed to study the course of recovery and outcomes following the delivery of a coordinated system of care including emergency care, acute neurotrauma management, comprehensive in-patient rehabilitation and long-term interdisciplinary follow-up services. Each Center systematically collects important data about each individual who meets criteria for inclusion in the TBI National Database and sends this information to the TBI National Data Center. The Centers are currently located at 16 sites throughout the United States that provide comprehensive systems of brain injury care to individuals who sustain a traumatic brain injury, from acute care through community re-entry. The mission of the TBIMS is to improve the lives of persons who experience traumatic brain injury, their families, and communities by creating and disseminating new knowledge about the course, treatment, and outcomes relating to their condition.

The TBI Model Systems serve a substantial number of individuals, allowing the projects to conduct clinical research and program evaluation, which maximize the potential for project replication. In addition, the TBI Model Systems have the advantage of a complex data collection and retrieval program with the capability to analyze the different system components and provide information on project cost effectiveness and benefits. Information is collected throughout the rehabilitation process, permitting long-term follow-up on the course of injury, outcomes, and changes in employment status, community integration, substance abuse, and family needs. The TBI Model Systems serve as regional and national models for program development and as information centers for customers, families, and professionals.

Initially, approximately \$1.5 million funded five centers: Wayne State University in Michigan, Mt. Sinai Hospital in New York, Santa Clara Valley Medical Center in California, The Institute for Rehabilitation Research in Texas, and the Medical College of Virginia in Richmond. For a few years, there were only four (Mt. Sinai left the program), and by 1997, Virginia's center no longer participated, but the Moss Rehabilitation Center in Pennsylvania won a grant for a center as did Ohio State University in Ohio.

In the fall of 1997, the Brain Injury Association of America and others successfully advocated for an additional \$5 million for the program so that more centers could be established. Twelve new sites were awarded funds to establish model systems of care for traumatic brain injury.

Alaska is Combating Traumatic Brain Injury

Jill Hodges

Executive Director

Alaska Brain Injury
Network

Jeff Jessee

Chief Executive Officer

Alaska Mental Health
Trust Authority

Pat Hefley

Deputy Commissioner

Department of Health
and Social Services

Past legislative hearings

2007- What is traumatic brain injury?
What does treatment look like?

Guest presenters: Dr. Tina Trudel (national expert) and partner boards

2008- Impact of TBI on the state.

Military issues related to TBI

Guest presenters: Capt. Richard Barker, Elmendorf; Dr. Russell Cherry, Providence; Stephanie Tanner, military wife of TBI survivor

2009- Importance of Medicaid Waiver to develop coordinated, comprehensive brain injury services in-state

Guest Presenters: Dr. Christie Artuso, Providence Neuroscience Director

Today's presentation- State System Development and Operationalizing

- Jill Hodges, Past 20 years of AK efforts
- Jeff Jessee , Trust Role
- Pat Hefley , DHSS Role
- Public testimony:
 - Martha Moore, ABIN Chair
 - Providers, partnerships essential
 - Consumer, treatment works, family support
- Jill Hodges-Questions and Solutions
 - State and Legislature

TBI Systems Development in AK- 1990-2000

Phase 1: 1990-1995

Advocacy

- Brain injury survivors mobilize
- Early 1990's
 - Testimony to GDCSE, Legislature, AMHTA
- Brain Injury Association of Alaska organizes

Phase 2: 1995-2000

Advocacy Continues

State of Alaska

- State of Alaska-Public Health recognizes TBI
- Public Health awarded CDC grant
 - TBI Registry
- MHDD awarded Federal Grant-systems

TBI Systems Development in AK 2000-2007

Phase 3: 2000-2003

Advocacy

State of Alaska

Federal TBI HRSA Grant

- Needs Assessment
- 1st State Action Plan
- TBI Program Coordinator (FTE)
- Advisory Board

AMHTA-beneficiary group

Alaska Brain Injury Network

- TBI Advisory Board (ABIN) organizes and becomes 501 c3

Phase 4: 2003-2005

Advocacy/TBI Advisory Board

State of Alaska

- Behavioral Health (lead agency)

Data/Surveillance

- DBH mandates screening and data collection
- Consumer Satisfaction Surveys
- AK Trauma Registry Data

Phase 5: 2005-2007

State of Alaska: TBI Dir. turnover

Data- AKAIMS(32% in BH screen TBI)

Workforce: 1st AK Brain Injury Conf

Momentum builds- 2007-2009

Phase 6: 2007-2009

ABIN

- “Service” recommendation
 - Info and Referral
 - Case Management

AMHTA-Funds ABIN recomm.

State of Alaska

- Lead agency transfers to SDS
- TBI Case Management Program developed

Workforce:

Intro to TBI Course

Advance Brain Injury

Workshop

Vocational Rehabilitation

Counselors

Legislation

- SB 118 introduced-medical assistance for TBI

Medicaid Funding: Waivers

- Preliminary research on Medicaid Waivers
- Targeted Case Management

Treatment

- After Hospital/Post-Acute
 - Site Visits
 - AK Providers Coalition
 - Military/Tribal partnerships sought

Key Points

- System Planning—
created framework
and foundation for
action
- Next step:
operationalize
- General Funds or
GF/MH essential
- Phases 1-4 (1990-2005)
 - advocacy, planning,
increasing awareness.
- Phases 5-6 (2005-2009):
 - Direct 'services':
 - info and referral;
 - case management
 - Workforce development
- Phase 7 – 10 (2010-2020)
 - Case Management
 - Treatment: Funding for
Residential and Day Program
 - Workforce

2010 Session: SB 219 and House Companion

SB 219 and House Companion

- Traumatic/Acquired Brain Injury Program
 - Gives statutory authority to develop/improve program.
 - Establishes standards for treatment and services.
 - Defines brain injury.
 - Develops cost/ longitudinal data
 - Planning for Medicaid Waiver/Targeted Case Management

Opportunities

- Positions the state to access federal funding for TBI services.
- The existence of brain injury waivers supports the growth of community-based rehabilitation programs.
- DoD/VA/Tribal/State coordinate planning and implementation of rehabilitation and community re-entry programs.
- Early treatment may reduce future medical and social costs.
- Potential cost savings in acute care, existing state programs; behavioral health, juvenile justice, corrections, homeless activities, and long-term care in institutional facilities.

2010 Session: FY11 Governor's Operating Budget

\$350.0 for TBI Service Coordination Program

- \$200.0 GF/MH
- \$150.0 MHTAAR

Focus: Case Management

- Year 2 of the project
 - (FY10 funded by MHTAAR)
- 2 case managers (serving 60)

Focus: Grant program

- grants funds for specialty services.

Opportunities:

- Reduce emergency dept visits;
- Deter more costly care by keeping people within their own homes;
- increase readiness for vocational rehabilitation/employment.
- Increase independence
- Serve as benchmark for Medicaid Waiver application and funding requests

The Trust's Role- Jeff Jessee

- TBI as a beneficiary group (late 1990's)
- Trust role: planning, demonstration
- Maximize collaboration
- Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State)
- Treatment: General Fund commitment

Past 10 years, Trust has invested \$2.8 million in brain injury systems development

- Trust FY09 Funding specifically for brain injury program: \$628,000
 - Core Services Development
 - Information and Referral
 - Case Management
 - Technical Assistance for planning treatment
 - Systems Development
 - Public Awareness-anti stigma
 - Workforce development
 - Statewide planning- TBI Advisory Board

Department of Health and Social Services Role- Pat Hefley

- Development, now operationalizing.
- 44 States use General Revenue and Medicaid Waivers for brain injury treatment/ services.
- TBI folks are already in the system - need to move them into specialty programs in order to see results.
- Appropriately staged incremental GF/MH budget requests.

Upcoming 2010 Activities

- Federal Grant- \$250.0/year 4 years
 - lead agency: Senior and Disabilities Services
- State of Alaska T/ABI program
 - Case Management
 - Research federal funding opportunities: Medicaid Waiver/Targeted Case Management
- Data/Prevention: regional study, Alaska Native and Non-Native

Public Testimony

- Martha Moore: ABIN Chair
 - Composition of ABIN
 - Recommendation Philosophy
 - Perspective: State role (data collection) and ABIN chair.
- Alaska providers: readiness to partner- TBI post-acute programs
 - Dr. Lester, St. Elias (LTACH)
 - Margaret Carloni, Trauma Nurse, ANMC
- Shannon- Juneau resident, experienced TBI
 - TBI treatment works
 - Family support

Many of Alaska's challenging questions have been asked and answered by other States

- Alaska can learn from 30 years of state system experience; and
- treatment research by the Federal Government, State experiences, military advances

Questions and Solutions

Is brain injury
impacting
State
government?

1980 findings...

- Uninsured or underinsured
- Unemployment
- Trauma/EMS
- Long-term care and support needs
- Family Support

1990 findings...

- Educational System
- Vocational Rehabilitation

2000 findings...

- Criminal Justice
- Behavioral Health

Question and Solutions

How will State
Gov't know
how to develop
TBI systems?

TBI Act of 1996

- Federal Statute
 - Defined TBI in Federal Statute
 - Authorized funding to HHS
 - Established TBI program in CDC
 - Created State grant program (HRSA)
- State experience has broadened program definition to ABI- same service needs.
- National Association of State Head Injury Administrators (1990)
- TBI Technical Assistance Center-specifically for state administrators (since 1996)

Question and Solutions

Is recovery
possible after a
TBI?

Does treatment
work?

- Feds fund TBI model systems since 1987, over 20 years of longitudinal data- yes with specialized support, recovery/ independence is possible
- Research at acute/medical level led to need for community reentry programs
- Military funding is supporting research of community reentry programs and Mild TBI assessment and treatment

Question and Solutions

How will States
pay for brain
injury
treatment?

- 1990's, Centers for Medicare/Medicaid Services (CMS) developed TBI HCBS Waiver prototype
- IDEA 1990 added TBI as disability to report
- State General Funds
- TBI Trust Funds

Question and Answer

How will states
develop treatment
and prepare a
specialty
workforce?

- Many providers have 30 years of experience.
 - Utilize existing models: medical, community reentry, clubhouse, and long-term living..
- TBI specific workforce will build as TBI programs are operationalized.
 - Professional/para-professional specialists have on the job training, does not take special educational training.

Question and Answer

How will rural residents have access to these treatment and services?

- Military and a few states utilize telemedicine for treatment.
- Opportunity for Alaska to become the national leader in providing care to rural areas?

Question and Answer

What type of legislation is/has been successful?

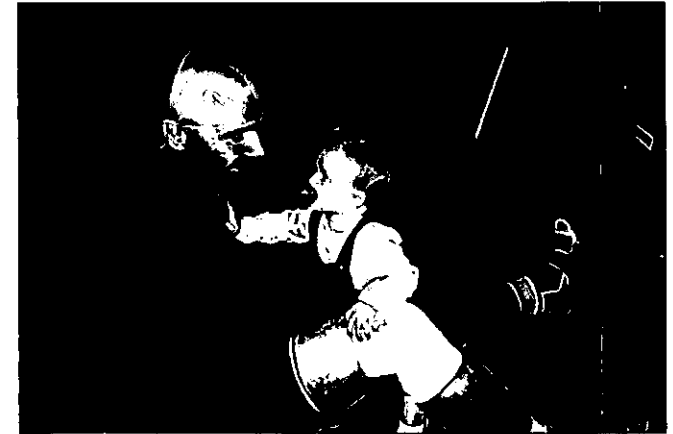
- Resolutions- awareness
 - Last five years
- Prevention
 - AK primary seatbelt law and child safety/ booster seat)
- T/ABI Program into Statute
 - SB 219 and HB Companion
- Interagency Taskforce
- Prevention-concussion management
- Military-screening

Alaska has an opportunity!

- Alaska can operationalize at a faster rate.
- Alaska can become the leader in rural TBI treatment and supports

Alaskans Thank the Legislature...

For recognizing
the 10,000+
Alaskans with
TBI and working
to bring more
services close to
home



Outline for TBI Presentation to House HSS, Feb. 4th 2010. 3:00-5:00 committee hearing
 1 hour presentation, 20 minutes questions/comments

CO-CHAIR: Representative Herron CO-CHAIR: Representative Keller
 VICE-CHAIR: Representative T. Wilson

MEMBER: Representative Lynn
 MEMBER: Representative Seaton
 MEMBER: Representative Cissna
 MEMBER: Representative Holmes

Presenters:
 Pat Hefley
 Jeff Jessee
 Jill Hodges

Invited testimony:
 Martha Moore
 Shannon-consumer
 St. Elias person
 Dr. Groves

Jill Hodges	Do an overview of the 1 hour presentation Review previous presentations Walk through past phases Roles of State, Trust, ABIN, Providers, legislators Highlight 10 Year plan, treatment gap analysis Talk about current bill, FY11 budget recommendation,	15 min.
Jeff Jessee	Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State) Purpose: max collaboration, so everyone comes out a winner History of establishing TBI as a beneficiary group Trust funding has supported planning, pilot projects, technical assistance, workforce Trust role- development, efficacy of programs. Next steps will take General Fund committment	10
Pat Hefley	State of Alaska needs to catch up- 24 States have been utilizing TBI Medicaid Waivers, and 20 states have General Funds/General Revenue for brain injury specific programming. BTKH metaphor TBI folks are in some level of care now, but need specialized type	10

	<p>of care. TBI folks are already in the system-need to move them into specialty programs in order to see results. For several years, been in development mode, now moving into operationalizing. Timeline *As we progress, there will be appropriately staged incremental budget requests. The waiver will have a GF component. Military efforts: ongoing</p>	
Martha Moore	<p>ABIN Chair- different phases met different needs Composition of ABIN Our recommendation philosophy for building system: partnership-adapting successful models-pilot projects perspective State role (data collection) and ABIN chair. ***The amount of work that has been accomplished despite the limited funding due to volunteers/ABIN Board/persistent advocates/Federal Funds/Trust funds</p>	5 min.
Shannon	<p>Share her story- wants everyone to know that improved functioning after brain injury is possible. She wouldn't be here without her mother's support.</p>	5 min.
Dr. Lester or Patti	<p>Post-acute setting to send folks to. Improved outcomes if stay in state. Workforce moral lifted. Families can stay in AK.</p>	5 min.
Dr. Groves	<p>TBI as a chronic condition, need for TBI to be identified and treated. Importance of case management, multidisciplinary treatment team meetings, improved functioning is possible</p>	5 min
Jill Hodges	<p>Take away messages: Though SOA is 30 years behind, we are in a position to move faster with better information due to initiatives in other states, Federally (TBI Model systems-know treatment improved functioning), and in the Military (identification, screening, Mild TBI). future budget recommendations, legislation possibilities Thank you to HSS members Support HB ?? /SB 219, \$350 in Governor's budget</p>	5 min.
HSS members	<p>Questions, Comments</p>	20 min.

Phases/Timeline To Develop Alaska (In-State) Brain Injury Treatment And Services

Advocates	State of Alaska/DHSS	Data/ Surveillance/ Identification	Treatment	Alaska Brain Injury Network	Workforce Development	TBI Resource Navigation (info and referral)	Case Management	Providers to develop direct services	Military efforts
Identifying where the needs are	Vocational Rehabilitation	Educational System	Criminal Justice	Prevention	Legislation				
Phase 1: 1990-1995		Advocates speak out, organize, increase awareness among state government and anybody else willing to listen							
Phase 2: 1995-2000		Advocates come together. Brain Injury Association of Alaska formalizes			State of Alaska hired TBI Program Director Federal HRSA funds Lead Agency: DHSS, Division of Mental Health/Developmental Disabilities	Data and Surveillance- CDC federal grant. Public Health reports ATR data to lead agency (projected findings: Alaska has a high rate of hospitalizations, higher than national average) Federal Funds		Treatment: Trauma/EMS- mostly available in urban settings	
Phase 3: 2000-2003		ABIN: Alaska Traumatic Brain Injury Advisory Board organized (now ABIN), funded by MHTAAR Trust funds			State of Alaska: Federal requirement Alaska multidisciplinary committee develops needs assessment and 1 st state action plan (findings: <i>TBI is public health issue, access to after hospital/long-term rehab is limited, TBI Waiver recommendation</i>)				
Phase 4: 2003-2005		ABIN: Alaska Traumatic Brain Injury Advisory Board (ATBIAB) gains non-profit status (501 c3) Trust Funds			State of Alaska: Lead Agency: DHSS, now DBH designs and implements TBI Screening tool (TBI Project Director turnover) Federal Funds		Data/Surveillance-Alaska Trauma Registry analysis continues		

<p>Phase 5: 2005-2007</p>	<p>ABIN: ATBIAB changes name and receives grant from Trust to develop TBI information and referral service (<i>projected findings: there are hundreds of Alaskans living in the community (statewide) being discharged to inappropriate facilities or home, case management will be a key service, post acute services needed, TBI Waiver</i>)</p>	<p>State of Alaska: TBI Program Director (staff turnover) Federal HRSA funds.</p>	<p>Workforce- 1st Alaska Brain Injury Conference, training for BH clinicians Federal HRSA funds.</p>	<p>Data/Surveillance-in addition to ATR data (, now have AKAIMS (BH screening tool shows 32-34 % clients screening positive for TBI)</p>
<p>Phase 6: 2007-2009</p>	<p>ABIN and partners develop 10 year plan for TBI in Alaska (Plan has been recognized nationally) TBI lead stage agency transitions to Senior and Disabilities Services- utilize strengths in that division which focuses on Aging and Disability Resource Centers. Hospital Discharge, care coordination, Medicaid Waivers State Capital Funds</p>	<p>State of Alaska: DHSS does not receive Federal funds for the TBI Systems project. No TBI Project director Workforce capacity building- Intro to TBI (distance delivered 40 students) Trust Funds Legislation: SB 118 introduced for Medicaid Brain Injury Waiver. Waivers: Preliminary research on 24 TBI Waivers in other states. Information gathering.</p>	<p>ABIN TBI Resource Navigation program develops TBI Resource Directory, provides information/referral to nearly 600 Alaskans, 'callers' or 'cases studies' <i>show need for case management, instate after hospital/community re-entry/long-term rehab/supportive living/clubhouse</i> Trust Funds</p>	<p>Data/Surveillance: Additional data collection includes: Vocational Rehabilitation, Special Education, Nursing Homes, and Hospital Discharge Data. Opportunity for Longitudinal data: Case management to identify: types of referral to the program, service needs, duration of services, costs associated, societal costs and indirect social costs (family, financial, etc)</p>
	<p>Case Management Demonstration Project: MHTAAR funds approved for TBI Service Coordination (1state employee, serving 30-50 clients)Purpose : provide framework to gather longitudinal data on persons with brain injury (money available</p>	<p>Treatment/Direct Service: Preparation/Research on post-hospital treatment (post-acute, community reentry, continuum included neurobehavioral, neuroresidential, supportive living, clubhouses, home supports,)</p>	<p>Providers: Identify providers to deliver post-hospital services (identified agencies include Providence, St. Elias, Mat Su Health Services, supportive living home in valley, "outside" brain injury programs.</p>	<p>Military brain injuries recognized; DHSS highlights need to partner with military to identify needs, coordinate planning. DHSS Commissioner, Trust, and ABIN meets-monthly with Elmendorf, VA, Vet Centers, etc.</p>

	<p>July 1, 2009, Department is interviewing first week in February) <i>(expected findings, need additional case managers, utilize federal funds to support expansion)</i></p> <p>Trust Funds</p>	<p>3 separate site visits to TBI rehabilitation programs (20 programs in New Hampshire, Wisconsin, Virginia, Texas, Kentucky, Illinois) (Funded by Trust)</p> <p>Trust Funds</p>	<p>Coalition grows to include all Alaska providers interested in seeing post-acute options available in state: Providence, St. Elias, Mat Su Health Services, Regional, community providers, supported living programs.</p>	<p>ABIN hosts Defense and Veterans Brain Injury Center and National Intrepid Centers for Excellence for Psychological Health and TBI directors. Col Michael Jaffee and Dr. James Kelly. Sen. McGuire and Rep. Craig Johnson co-host roundtable discussion.</p>
<p>Phase 7: 2010</p>	<p>TBI Case management will be hired (care coordination): 1 FTE hired 30-40 people served</p> <p>Trust Funds</p> <p>Case Management: FY11 Governor's budget includes \$350.0 (\$200.0 GF and \$150.0 MHTAAR) for TBI Service Coordination to include additional care coordinator with small grant program. Grants to support funding services needed. Positions the state to bring in federal funds (through Targeted Case Management in Medicaid State Plan)</p>	<p>ABIN: Full Time TBI Program/Project Director hired- ABIN/SDS/Trust/ANTHC funds</p>	<p>TBI Resource Navigation partners with Aging and Disability Resource Centers (250 new callers/year)</p>	<p>Waivers: More in depth research on Waivers (see additional document for timeline of activities)</p>
	<p>General Funds/Mental Health</p> <p>Trust Funds</p> <p>Research and recommend utilizing targeted case management to expand the program using federal dollars (instead of growing general funds).</p> <p>Federal Funds</p>	<p>Workforce capacity building continues-funded by Trust and ABIN- advanced course, course for vocational rehabilitation counselors</p> <p>Trust and ABIN funds</p>	<p>Prevention: TBI Study-regional information (Alaska Native and non-native) to identify priority communities for prevention efforts ABIN Funds</p>	<p>Legislation: T/ABI Program introduced by Senator McGuire</p>

Phase 8: 2010-1012	Case Management: Amend state plan to include brain injury as a target population to expand number of case managers. <i>Projected findings: case management is key for coordinating services (efficiency and cost savings)</i>	Waiver: TBI Program Director to draft first waiver based on information from Alaska Trauma Registry, ABIN TBI Resource Navigation program, SDS TBI Care Coordination project, department/agency data, research on other State waivers	Data/Surveillance-systematically improves identification through screening; criminal justice systems, corrections, juvenile justice, primary care, schools. <i>(projected findings, need to increase awareness in systems that TBI exists; message is recovery is possible, appropriate supports make a difference, identification is key to appropriate referrals and services)</i>	Workforce capacity building-increase awareness and prepare workforce through a Brain Injury Conference. (ABIN/DHSS/Trust/Partner funds)
		Federal or GF (projected purpose of 1 st waiver and projected findings- purpose-residential rehabilitation program for those who have opportunity for recovery; findings-need a clubhouse for those in the community (not a good fit for behavioral health and/or not available to work); Apply for waiver that focuses on residential neurorehabilitation. Start with 8-16 Medicaid eligible persons. <i>(Projected findings-will learn there is a need for a transitional program (supported living) from the neurorehabilitation to home)</i>	State of Alaska: DHSS/SDS applies for Federal HRSA funds to support TBI program/project director, ANTHC TBI director, workforce (\$250/year 4 years)	Additional awareness building/training to VR counselors
Phase 9: 2012-2015	TBI Info and Referral –additional grant dollars needed to support volume of callers (400 callers)	Treatment: Increase direct services: Apply for additional waiver with focus on supportive living services.	Case management- grows depending on first 3 years of the project.	Educational System: Increase awareness in educational system
	GF and Trust	General funds (aggregate funds) to pay for Medicaid brain injury services (30-40 people served) General funds to support brain injury clubhouses.	GF and Federal	Prevention: Funds requested to implement prevention programs in pilot communities
				Data Surveillance-implement screening tools in criminal justice systems <i>(expected findings higher percentage of offenders will screen positive)</i>

Phase 10: 2015-2020	TBI Info and Referral- going strong	Case management, est. to serve 60-100 people	Treatment: Providers improve post-acute services: residential neurorehabilitation, supportive living, clubhouses Decide how to deal with neurobehavioral.	Criminal Justice System-early identification leads to appropriate trials and treatment
	Vocational Rehabilitation counselors specialize in TBI	Educational System- early linkage from hospital to 504 or special education accommodations		
Projected Outcomes of a coordinated, comprehensive, interdisciplinary State TBI Program	<u>Individual outcomes:</u> increase in recovery, intact family structures, increases in return to work and school <u>Family outcomes:</u> strengthens families, supports family to support their loved one (decreases burnout), decreases divorce rate	<u>State of Alaska outcomes:</u> less strain on behavioral health system, lower recidivism in corrections/juvenile justice, decrease in discharges to nursing homes.	<u>Provider outcomes:</u> increase in jobs, improved work moral, economic gains.	<u>Community outcomes:</u> decrease in homeless population, chronic inebriation, domestic violence/sexual assault.
Key Points	<p>All activities stated above relate to unofficial State of Alaska TBI Program (systems change). Community, Tribal, Military, Individual and other activities are not included.</p> <p>All activities in the state have been funded by Federal grants administered by Behavioral Health and Senior and Disabilities Services, Alaska Mental Health Trust Authority Funds, Federal Earmark, Alaska Native Tribal Health Consortium, State Capital funds No General Funds or GF/MH</p> <p>Phases 1-4: Funding has been directed towards advocacy, planning, increasing awareness, workforce development.</p> <p>Phases 5-6: Funding (Trust funds and FY11 GF/MH Gov. budget) for Information and Referral and Case Management, the first 'direct service' projects. They are both demonstration projects with a research focus.</p> <p>Phases 7-10 Will need General Funds to support activities, move into treatment/direct services</p>			

2/9/10

MAT-SU

SUBSTANCE

ABUSE

PREVEN-

TION...



**MAT-SU SUBSTANCE ABUSE PREVENTION
COALITION**

Data Project



MISSION

“Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.”

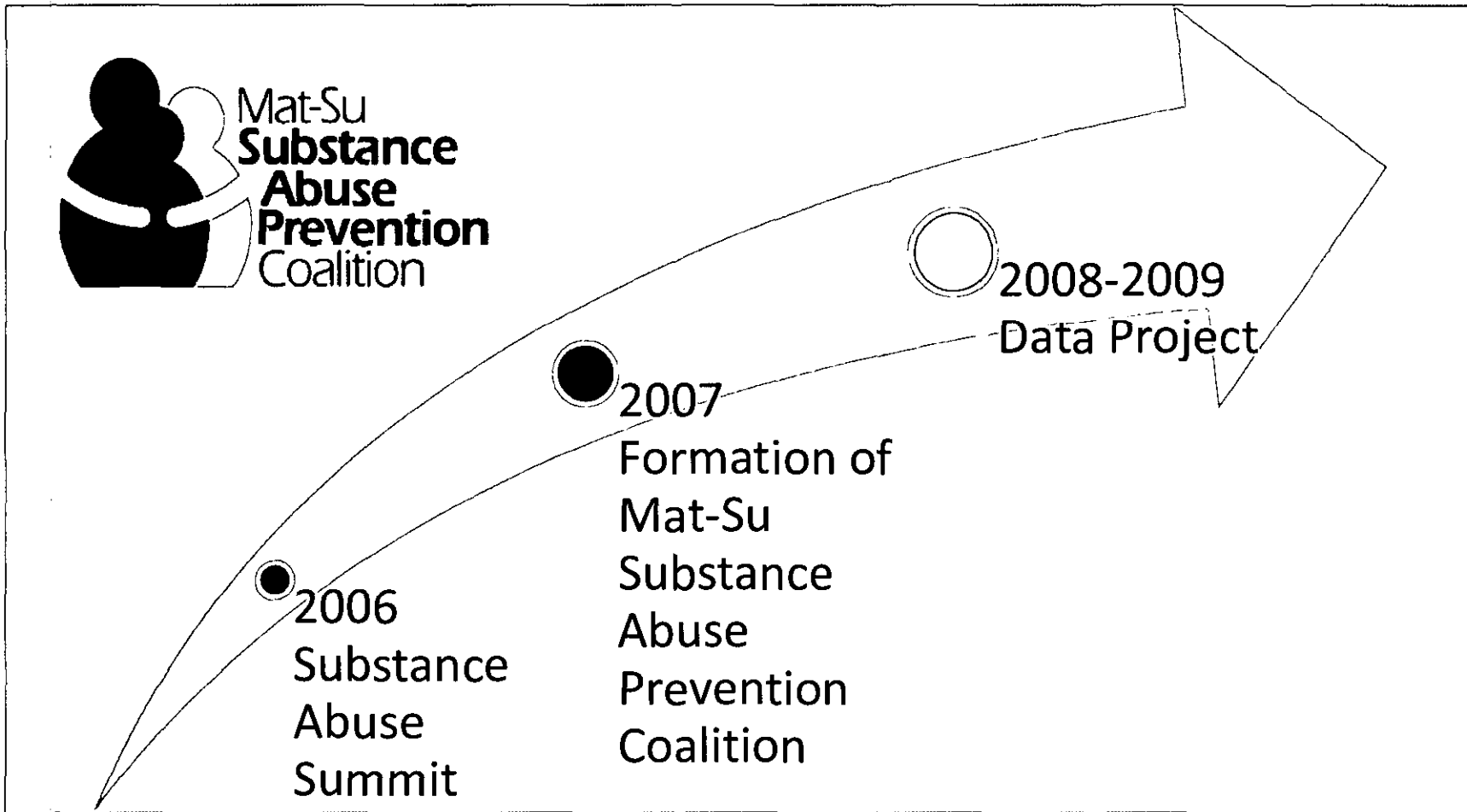
-Mat-Su Substance Abuse Coalition

Overview

1. Brief history of the coalition.
2. Description of our data project.
3. Summarize major findings and corresponding recommendations.
4. Demonstrate coalition effectiveness and describe our work.
5. Call to action.



1. BRIEF HISTORY



METHOD

Data Review

- Collection of available local data from years 2002-2007

Community Assessment

- Analysis of community data
- Development of community database
- Trends in youth substance use survey

Alaska Healthy Kids Survey



Demographic Information



Alcohol, Tobacco, and Other Drug Use



ATOD Use Correlates



Violence, Harassment, Safety & Crime



External Assets



Emotional/Physical Health

Survey Demographics

Surveys sent to 4000 youth

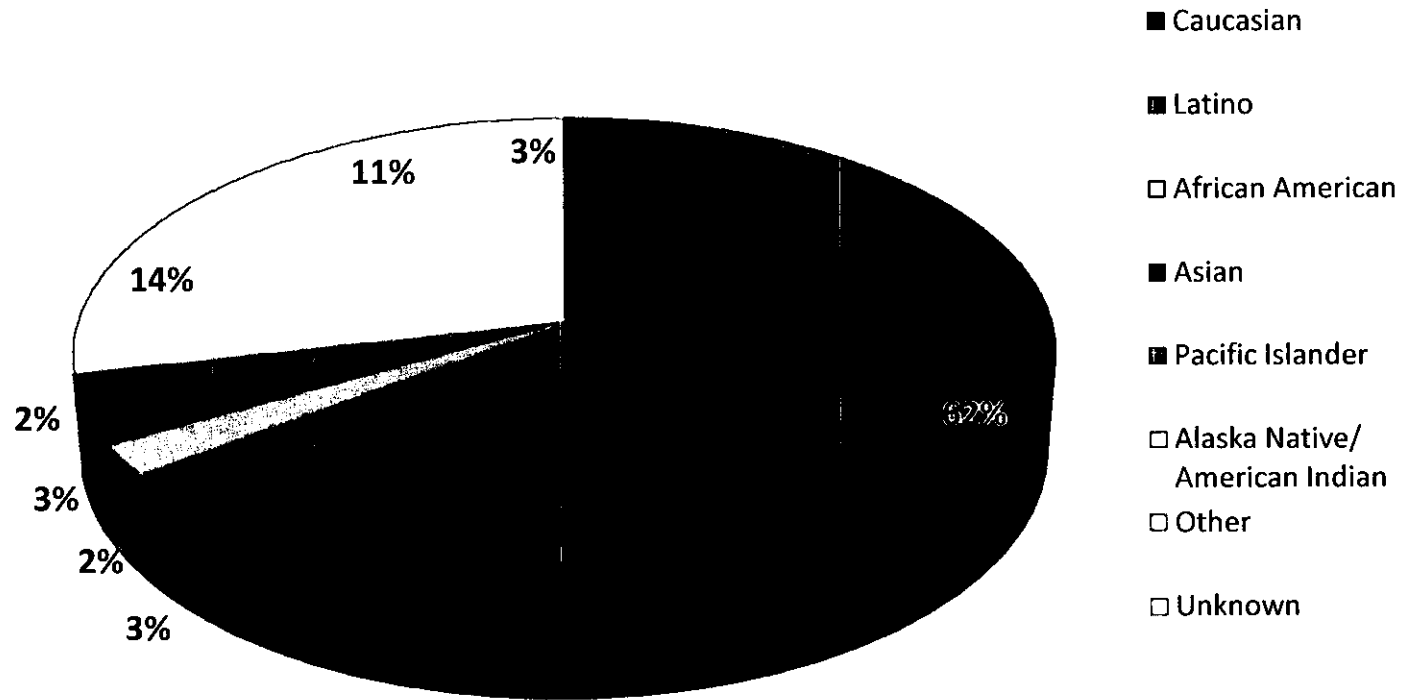
- Mat Su School District
- Christian Schools
- Non-District Home schools
- Homeless and At-Risk youth

2524 surveys received (61% response rate)

- 2435 valid responses
 - High School: n = 1650
 - Middle School: n = 800
 - Male: n= 49.7%
 - Female: n = 50.3%

Demographics

Ethnicity



Results



After receiving the 2008 Data Report which included the Alaska Healthy Kids Survey and other information about the Mat- Su Borough the Coalition decided to utilize the feedback from stakeholder groups:

1. School Groups (Students, Nurses, Principals)
2. Law Enforcement
3. Providers (Treatment)
4. Medical (Nurses/Docs)
5. Faith based Groups

(Input from over 130 community members)

Meaningful participation from adults in the community

- As defined by the following items:
 - Outside of my home and school, I am involved in music, art, literature, sports, or a hobby.
 - Outside of my home and school, I help other people.
 - Outside of my home and school, I am part of clubs, sports teams, church/temple, or other group activities.

Meaningful Participation in Community: Percentage of students by grade

Grade	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
Middle School	24.6	55.3	20.1
High School	29.8	51.9	18.3

Meaningful participation with adults at home

- As defined by the following items:
 - At home I do fun things or go fun places with my parents or other adults.
 - At home I do things that make a difference.
 - At home I help make decisions with my family.

Meaningful Participation at Home: Percentage of students by score

Grade	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
Middle School	24.7	50.4	25
High School	32.3	46.1	21.6

Meaningful participation with adults at school

- As defined by the following items:
 - At school I do interesting activities.
 - At school I help decide things like class activities or rules.
 - At school I do things that make a difference.

Meaningful Participation at School: Percentage of students by score

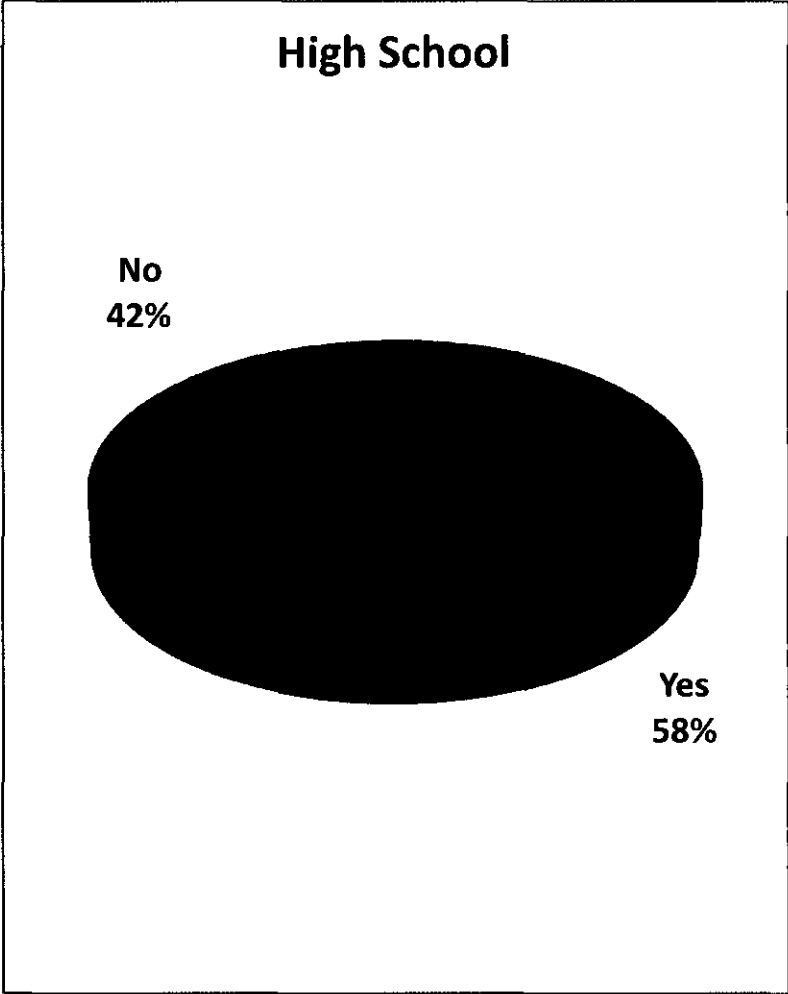
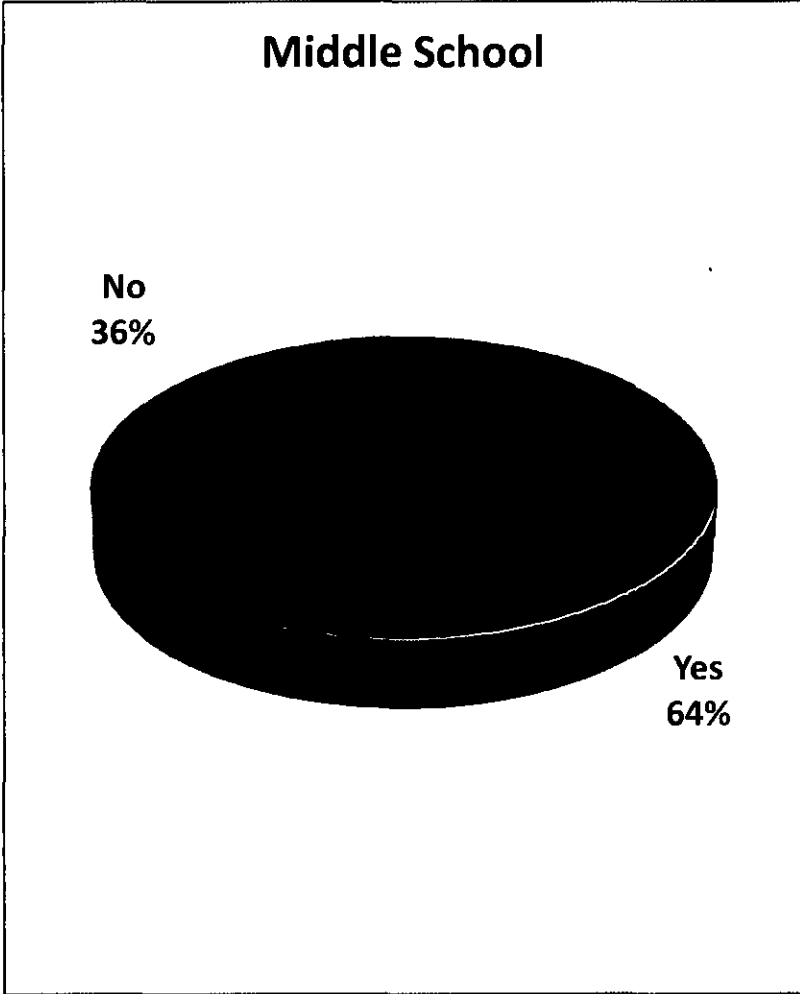
Grade	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
Middle School	49	44.5	6.4
High School	57.0	37.5	5.5

Recommendation #1

- **Increase meaningful adult and community involvement with youth**
 - Increase the protective factors
 - Resiliency (Alaska Healthy Kids Survey, Fall 2008)



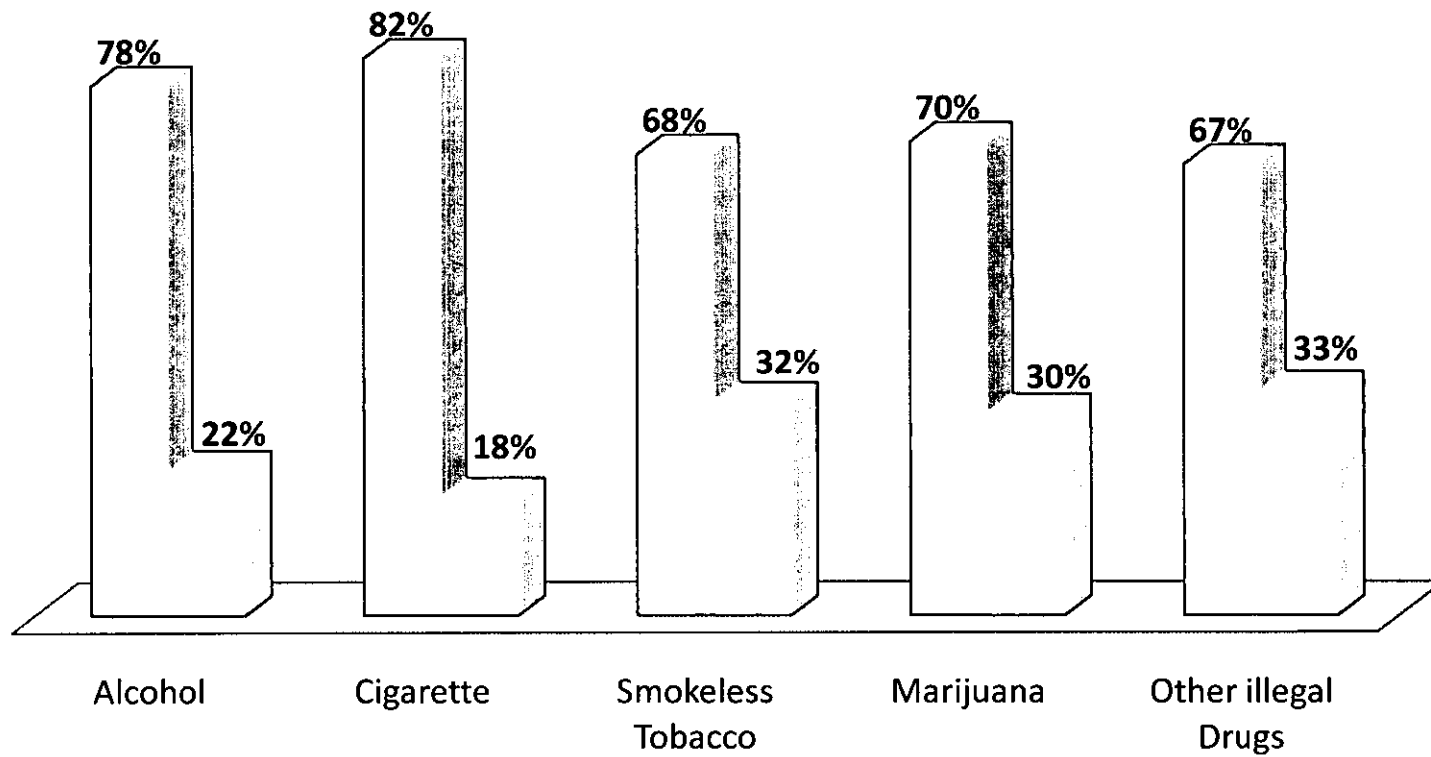
Are parents talking to their kids about substance use?



What age do our youth start using?

Age at First Use

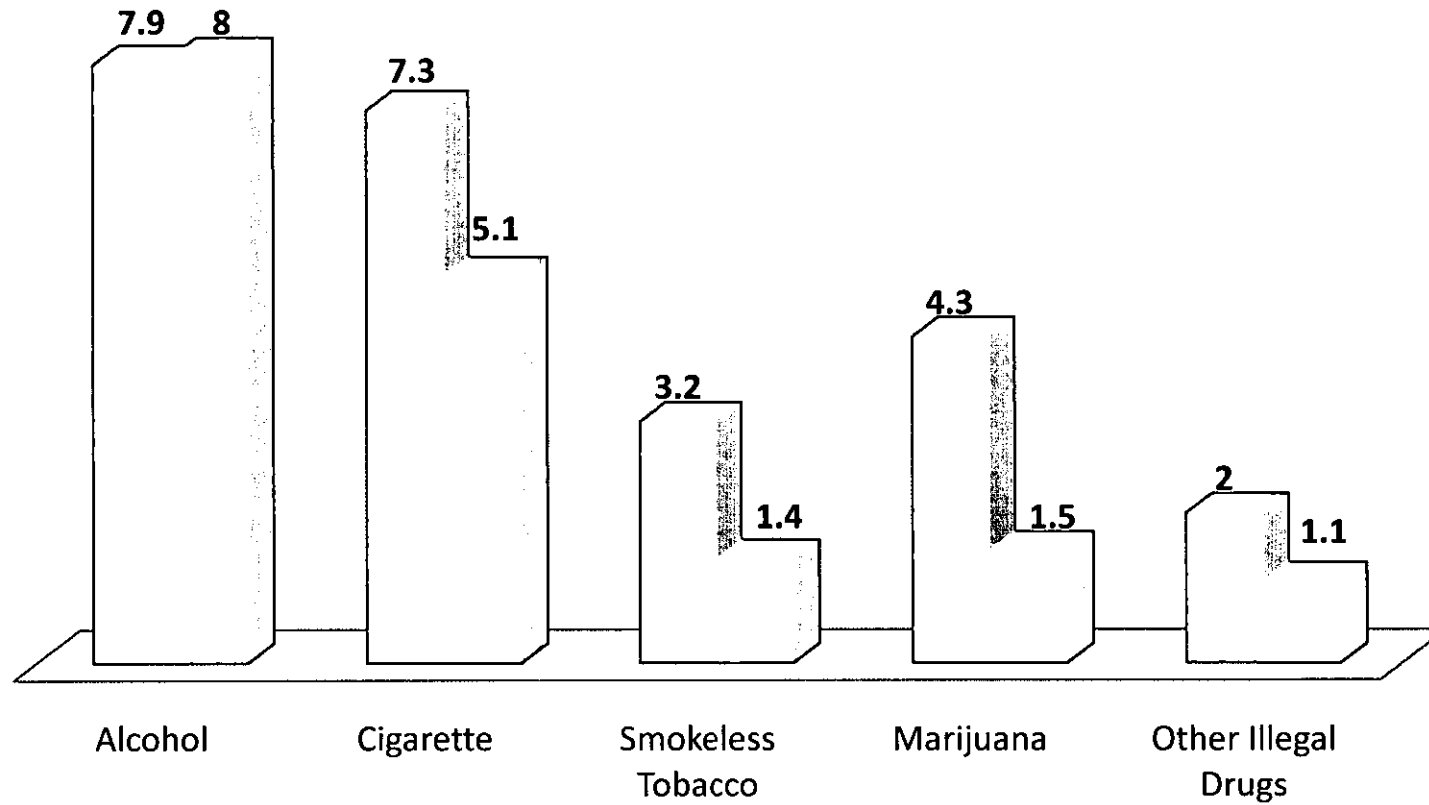
□ 14 and under □ 15-18



Age at first use

10 and Under

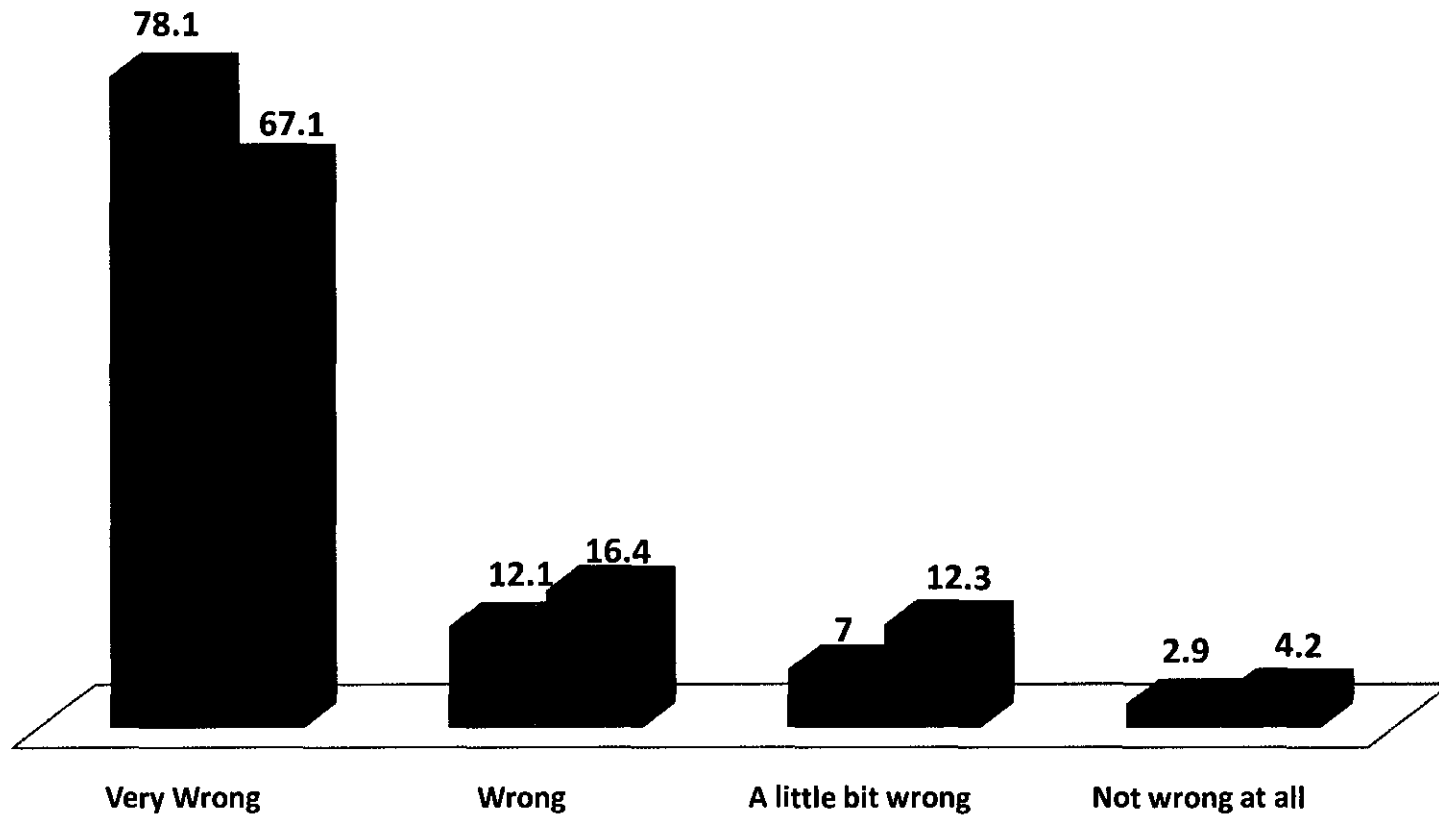
□ High School □ Middle School



Parent Perception of Use

How would your parents feel about you drinking regularly?

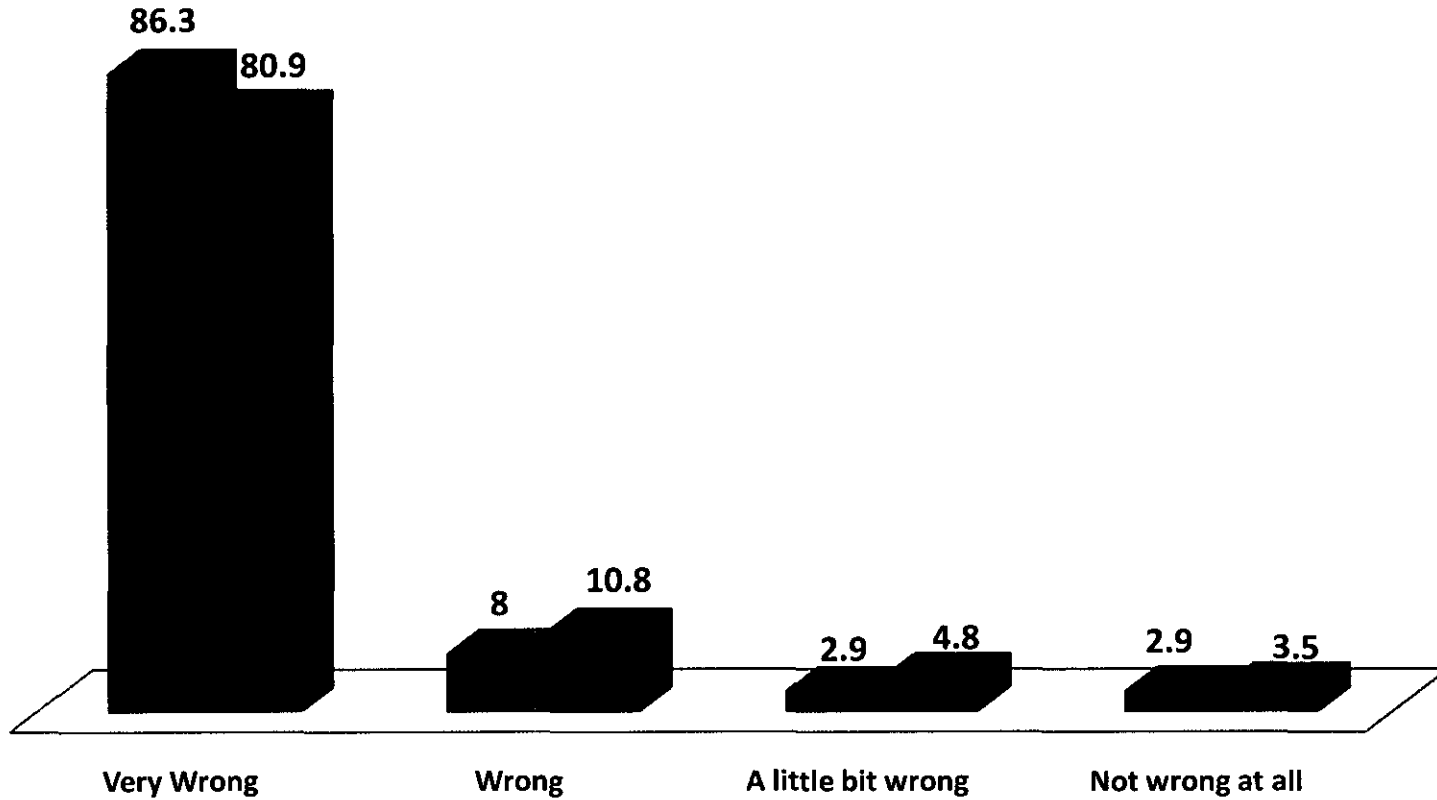
■ Middle School ■ High School



Parent Perception of Use

How would your parents feel about you smoking cigarettes?

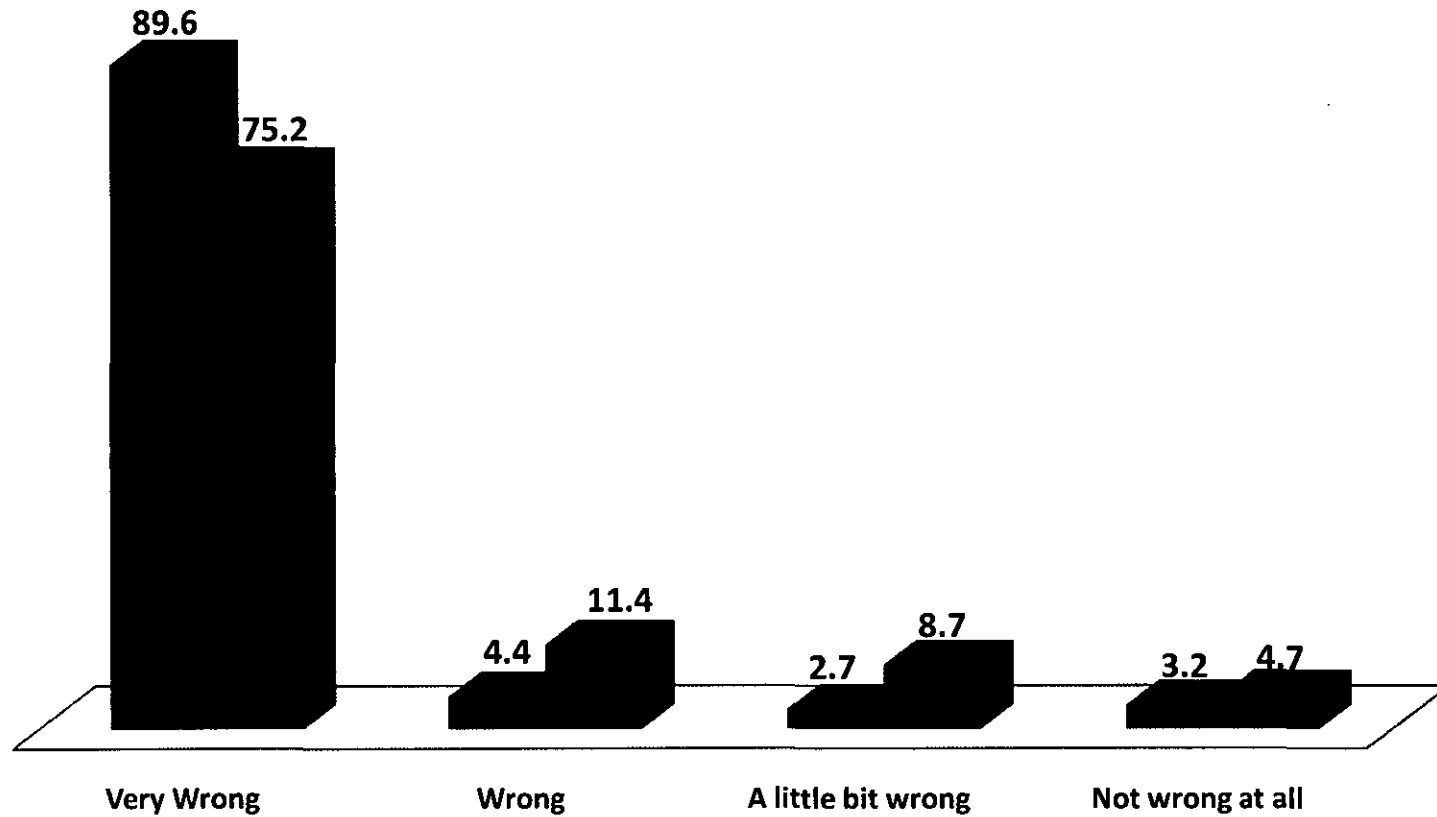
■ Middle School ■ High School



Parent Perception of Use

How would your parents feel about you smoking marijuana?

■ Middle School ■ High School



Recommendation #2



- **Increase parental involvement in prevention and early intervention measures in the Mat-Su Community**
 - Parents are an important source of information in youth decisions.
 - Having parents engaged in a more direct and meaningful way with prevention and early intervention may have a strong impact on the outcomes for our community's youth.

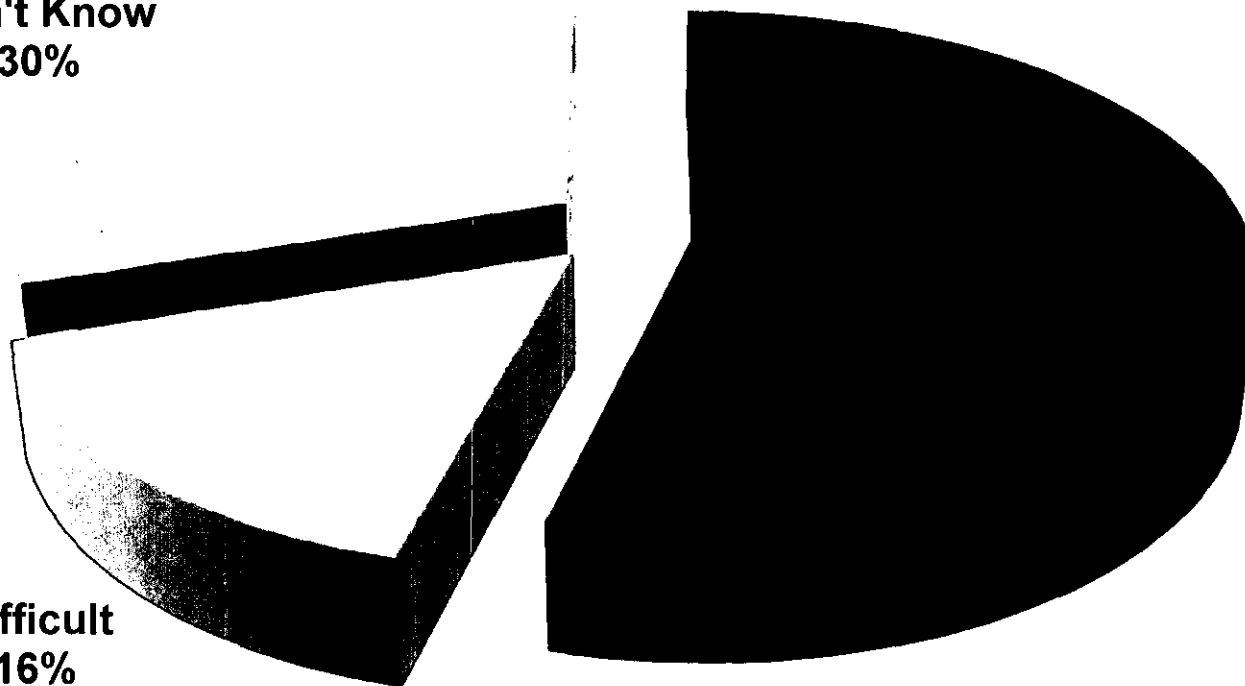
Are substances difficult to get?

Access to Tobacco

Don't Know
30%

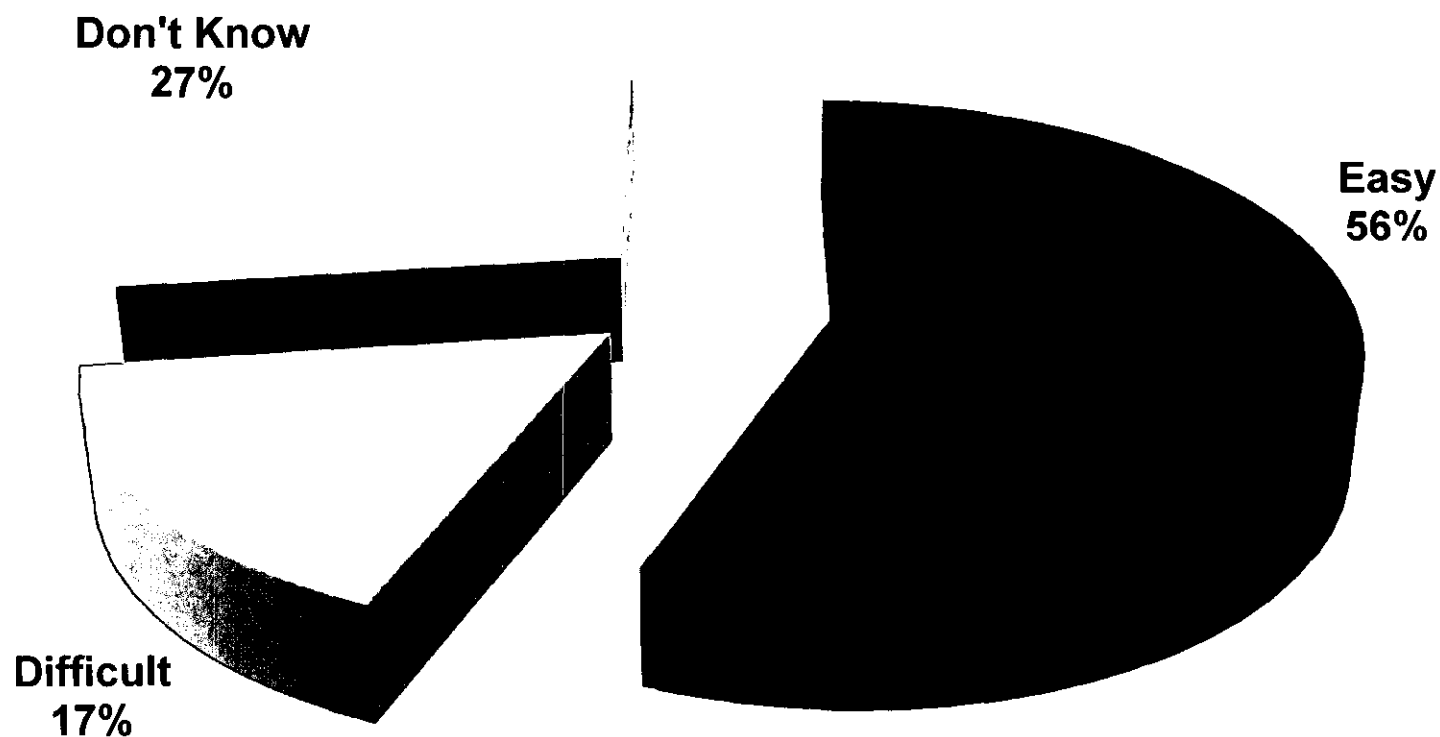
Difficult
16%

Easy
54%



Are substances difficult to get?

Access to Alcohol



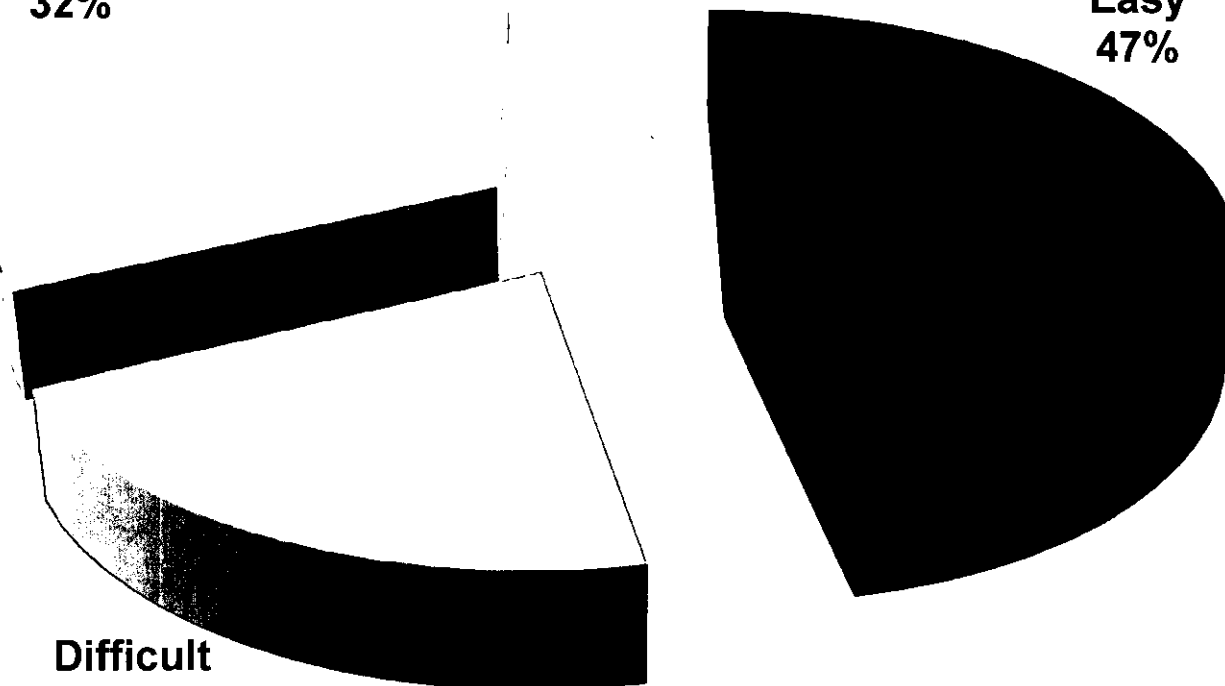
Are substances difficult to get?

Access to Marijuana

Don't Know
32%

Easy
47%

Difficult
21%



Recommendation #3

- **Reduce Access to substances**

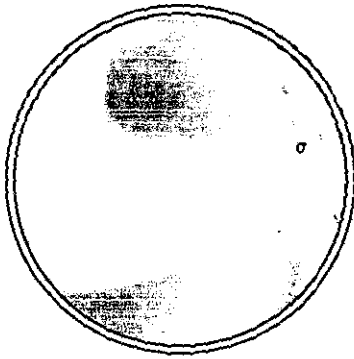
- Mat-Su youth are using a variety of substances and the reported usage is, in some cases, above state and national averages.
- The majority of students report that alcohol, tobacco and marijuana are easy to get.



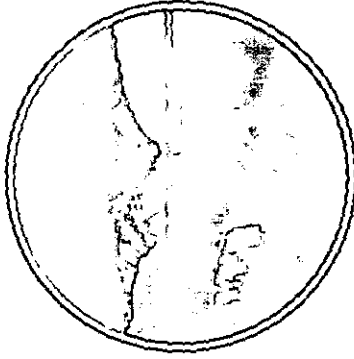
Data comparisons



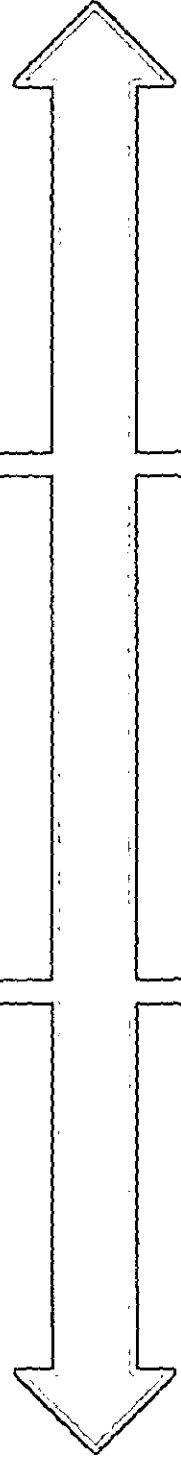
Alaska
Healthy
Kids Survey



Monitoring
the Future



Youth Risk
Behavior
Survey



Tobacco



Cancer



Cardiovascular Disease



Lung Disease



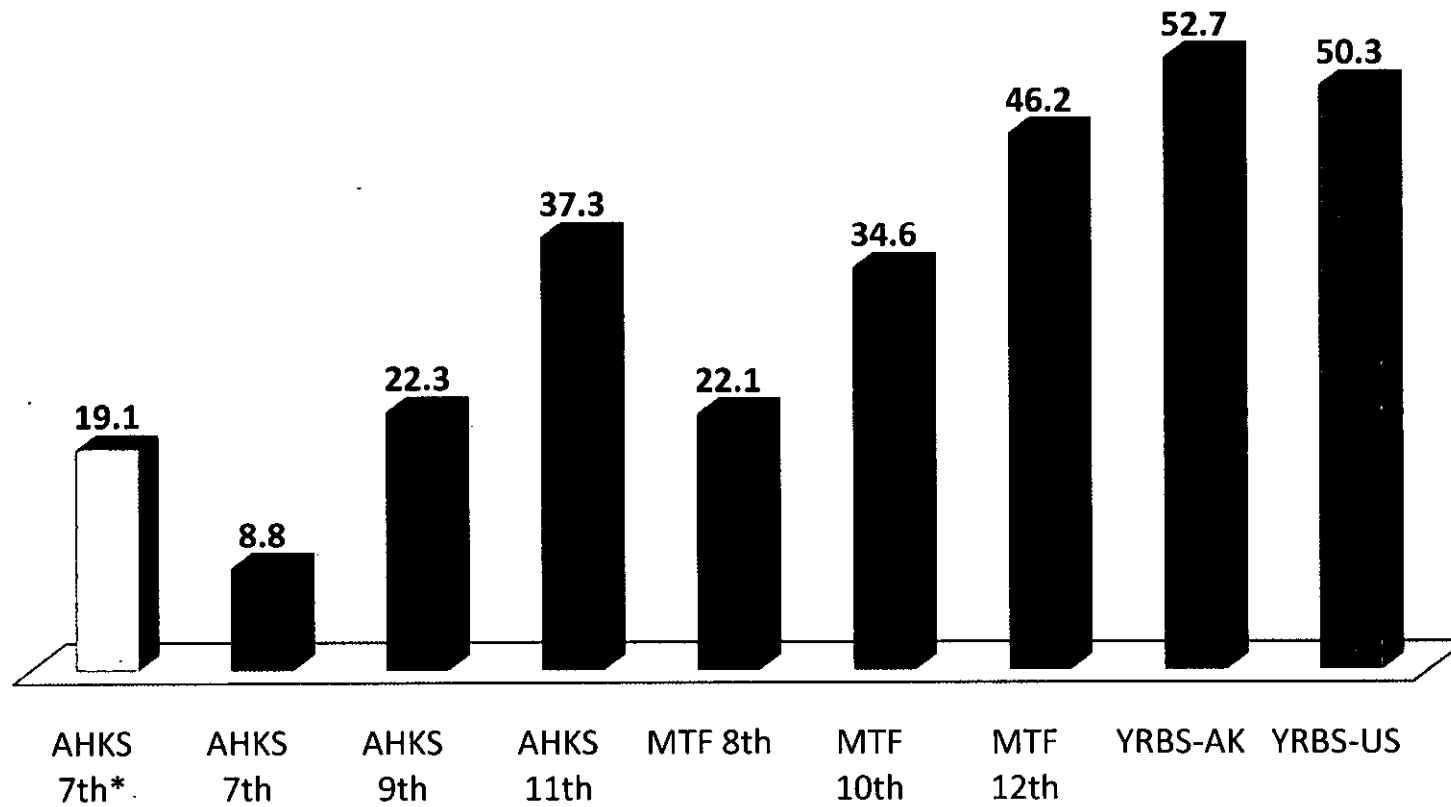
Impact on Reproductive Health



Economic Impact

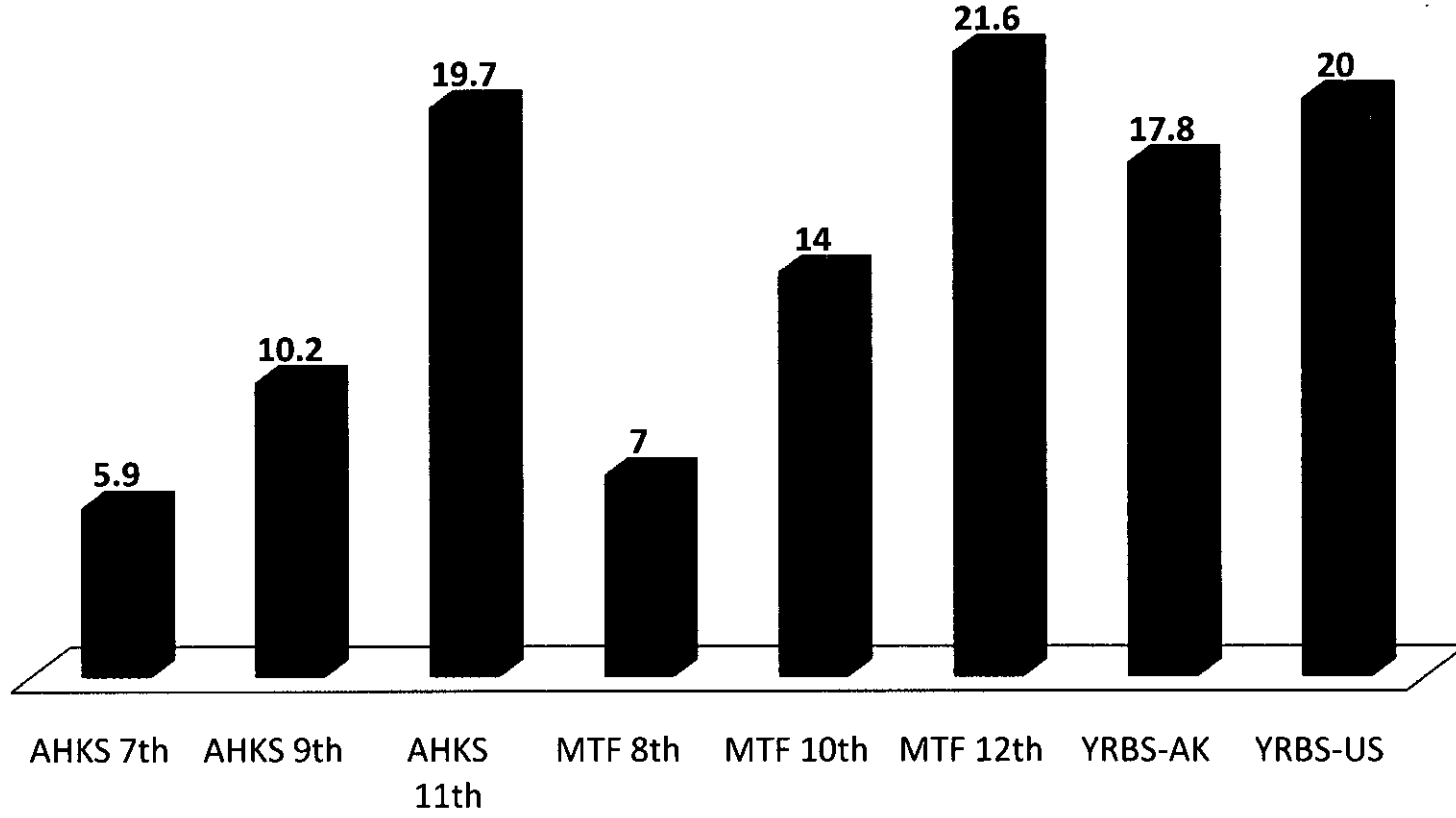
Tobacco

Lifetime Cigarette Use



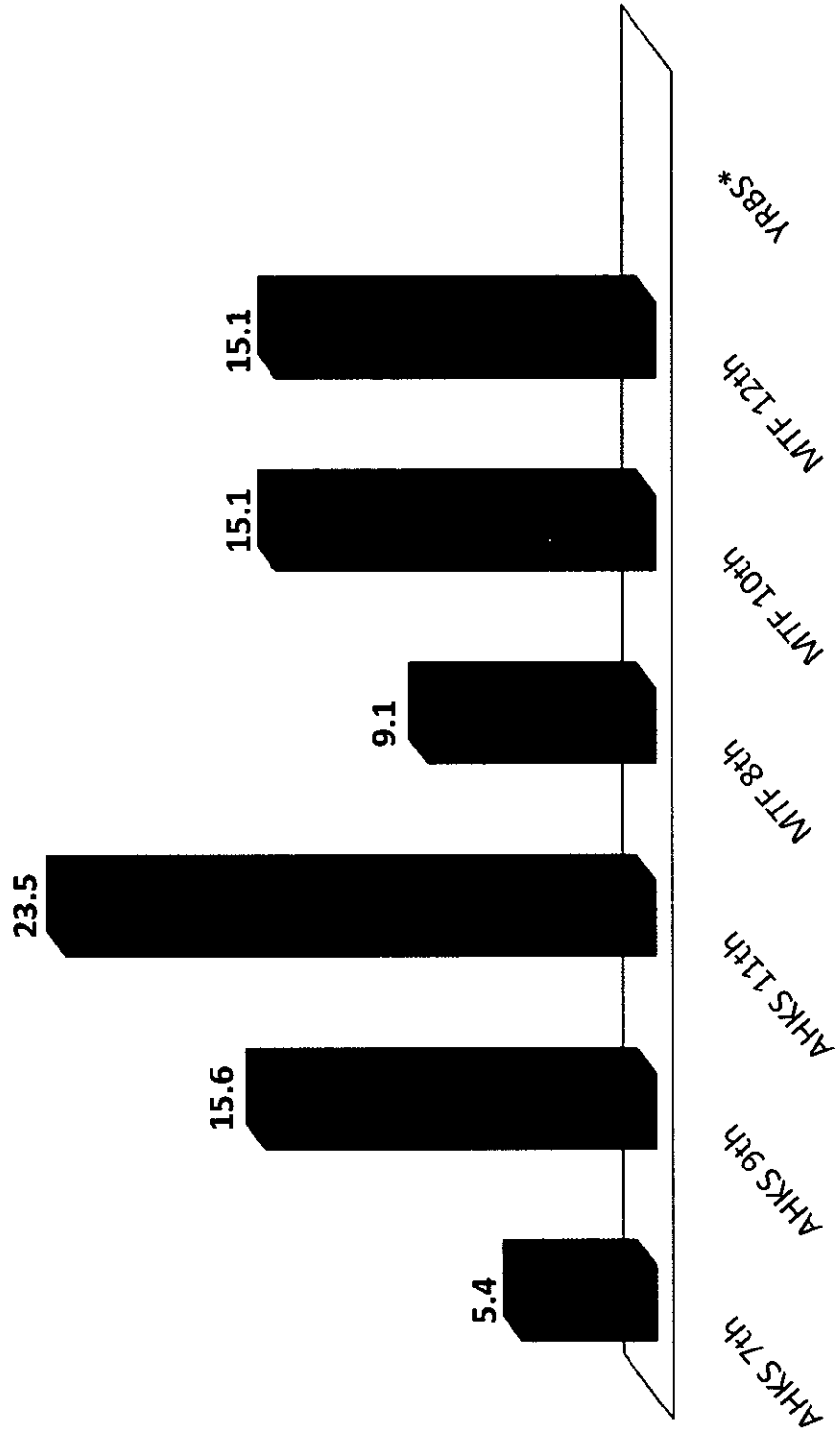
Tobacco

30 Day Cigarette Use



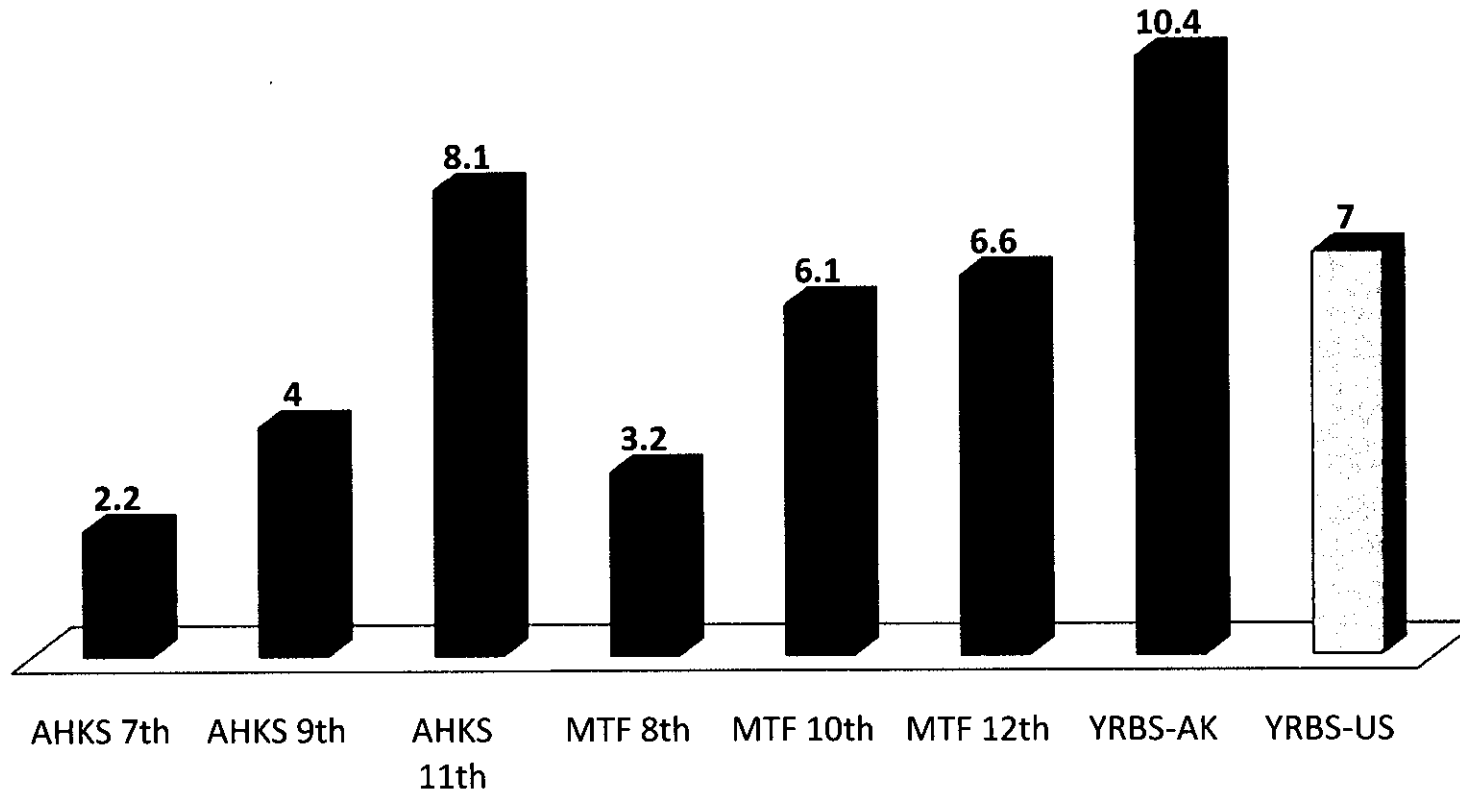
Tobacco

Lifetime Smokeless Tobacco Use

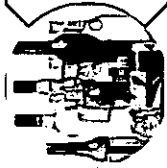


Tobacco

30 Day Smokeless Tobacco



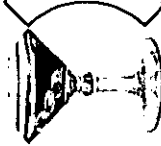
Alcohol



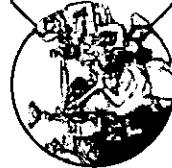
Impaired Judgment



Alcohol Induced Liver Disease



Cancer



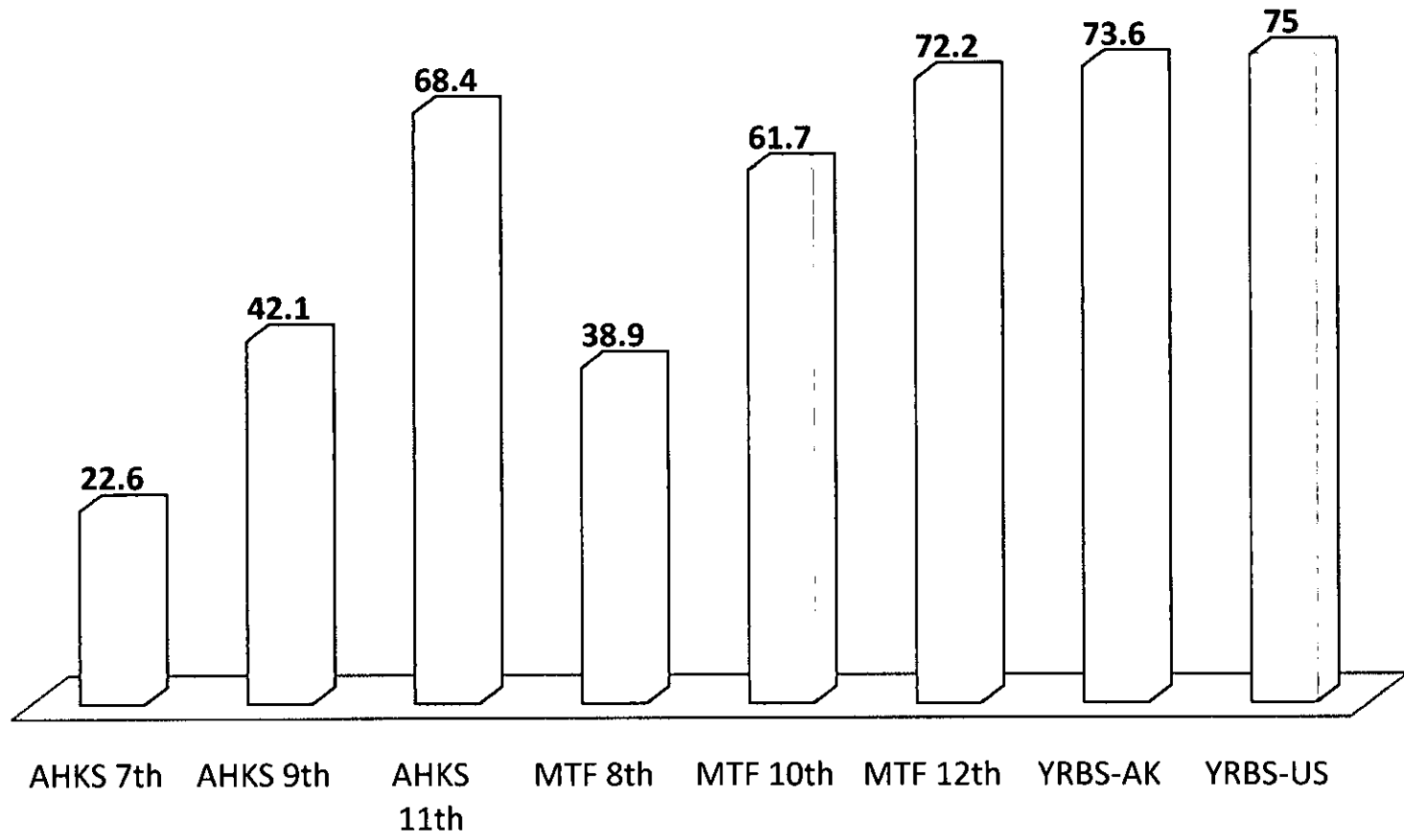
Cardiovascular Disease



Alcohol Dependence

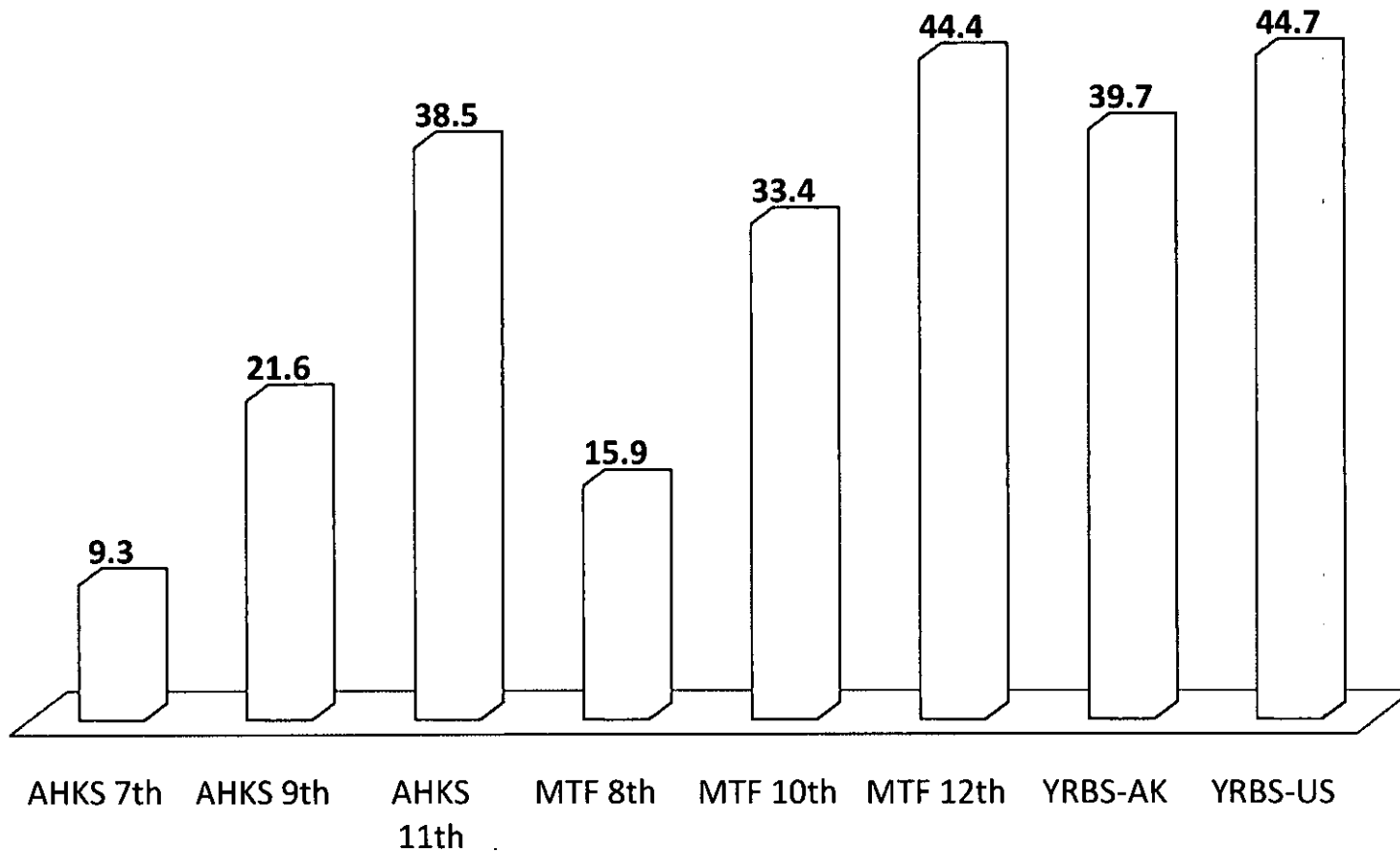
Alcohol

Lifetime Alcohol Use



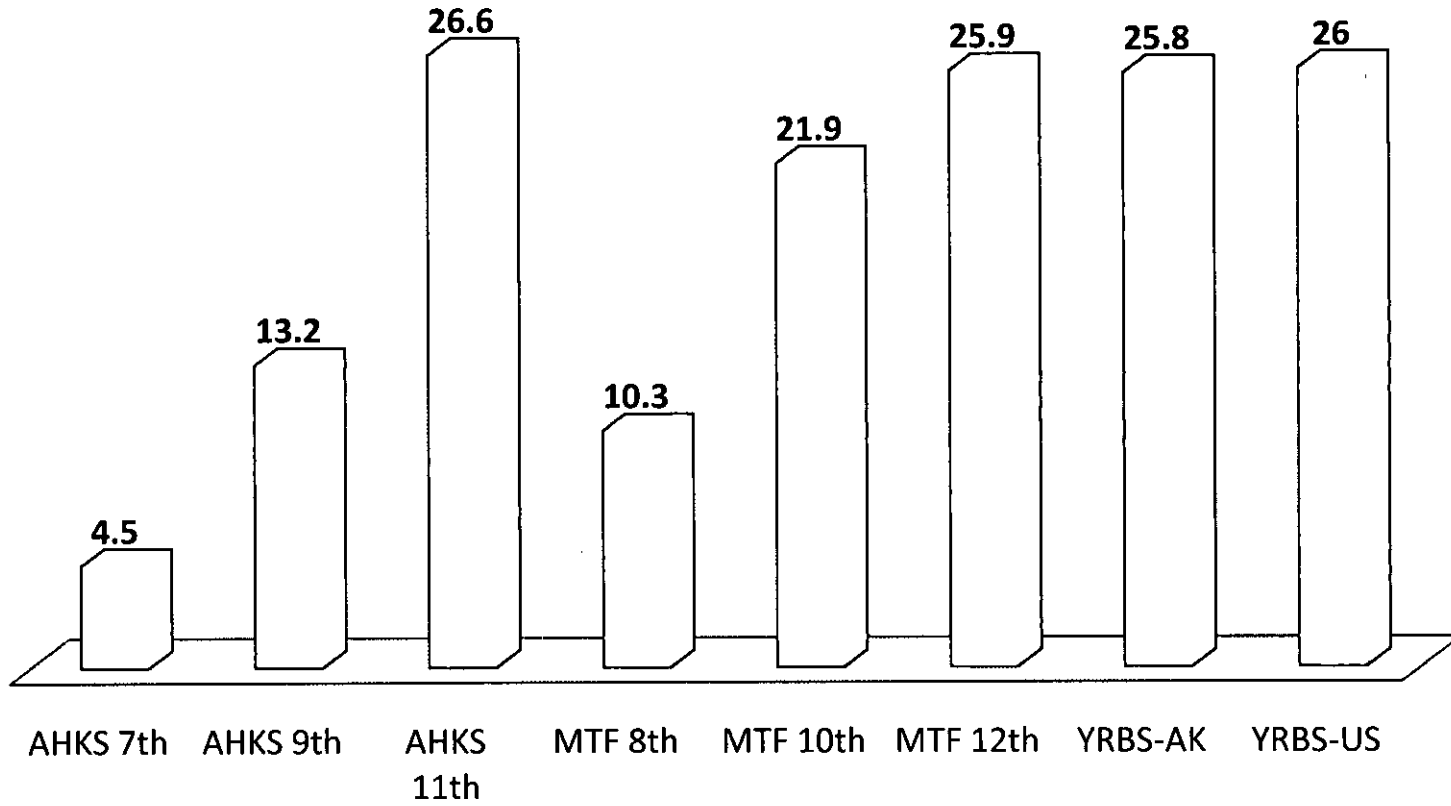
Alcohol

30 Day Alcohol Use



Alcohol

30 Day Binge Drinking



Marijuana



Impaired Judgment



Problems with Intellectual
Functioning



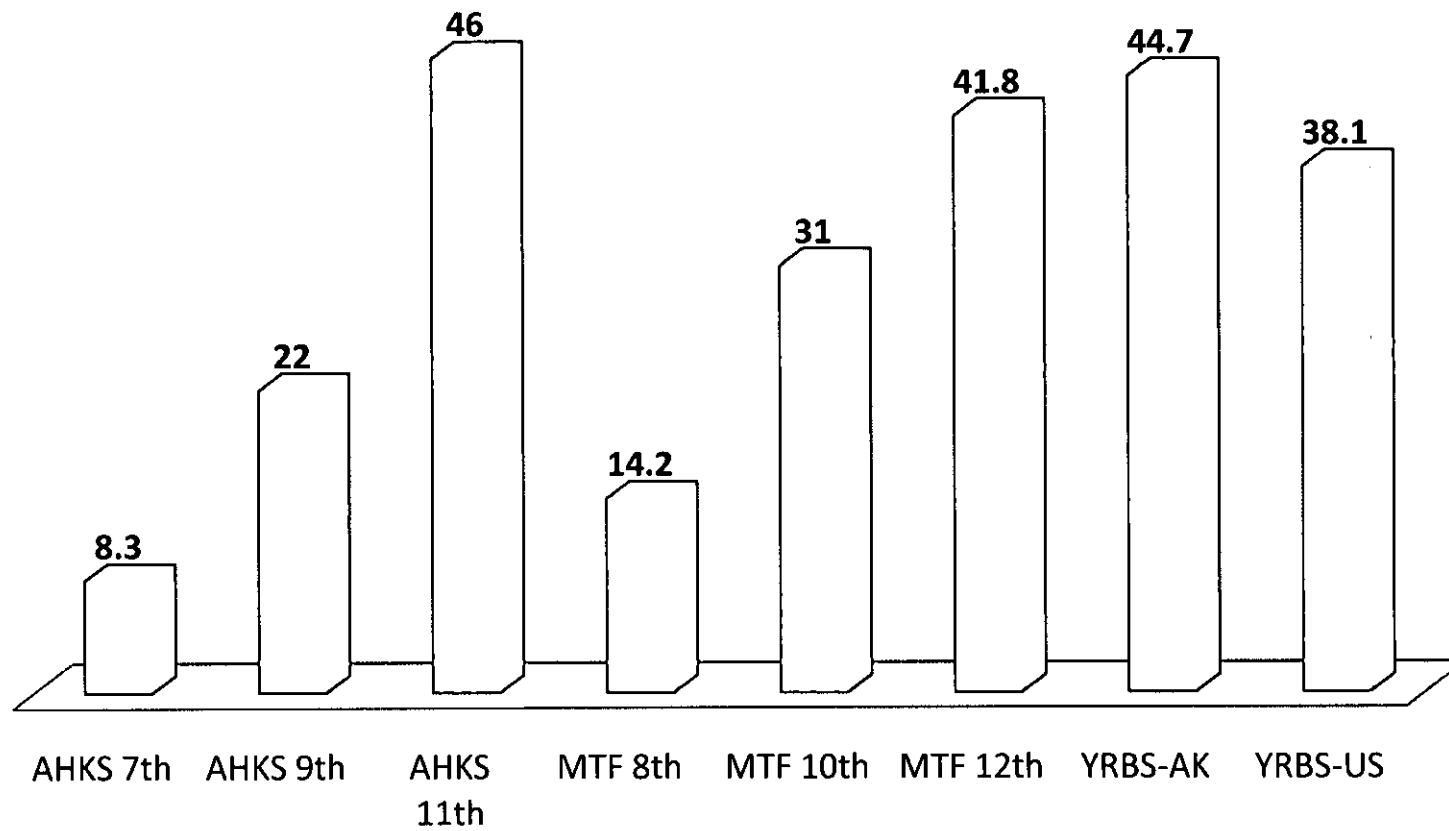
Greater Risk of Lung
Infections



Possible Cancer Link*

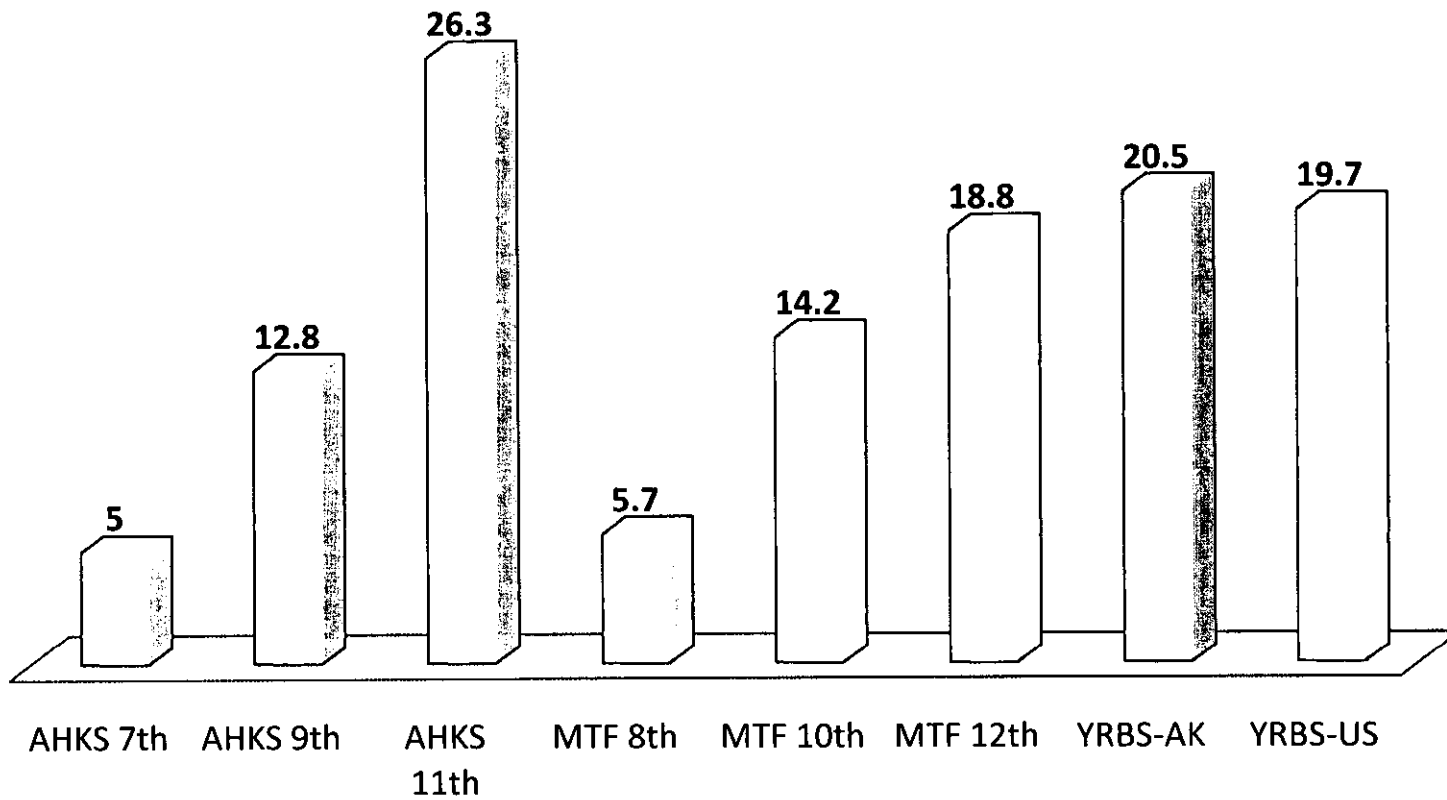
Marijuana

Lifetime Marijuana Use



Marijuana

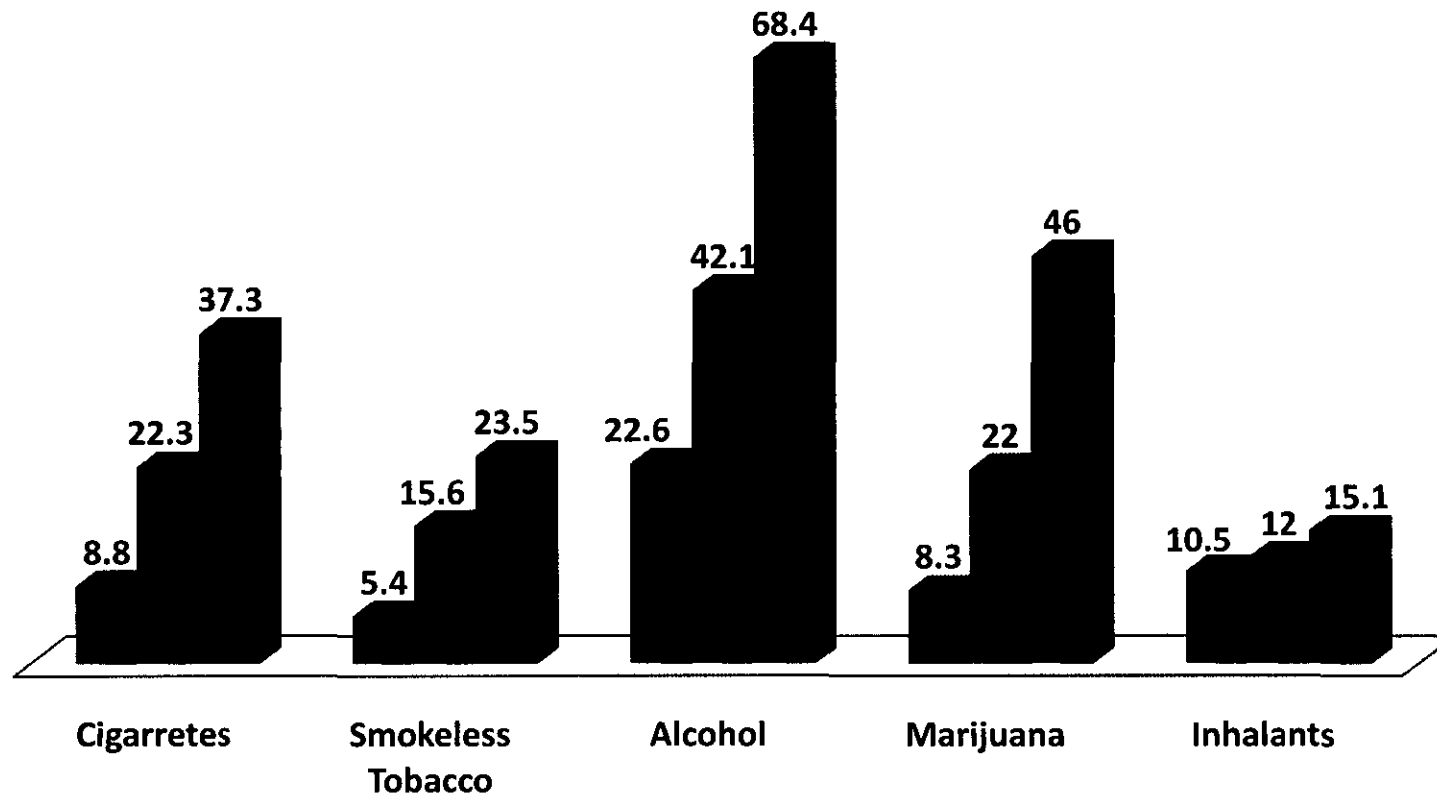
30 Day Marijuana Use



Substance Use Totals

AHKS Substance Use Summary

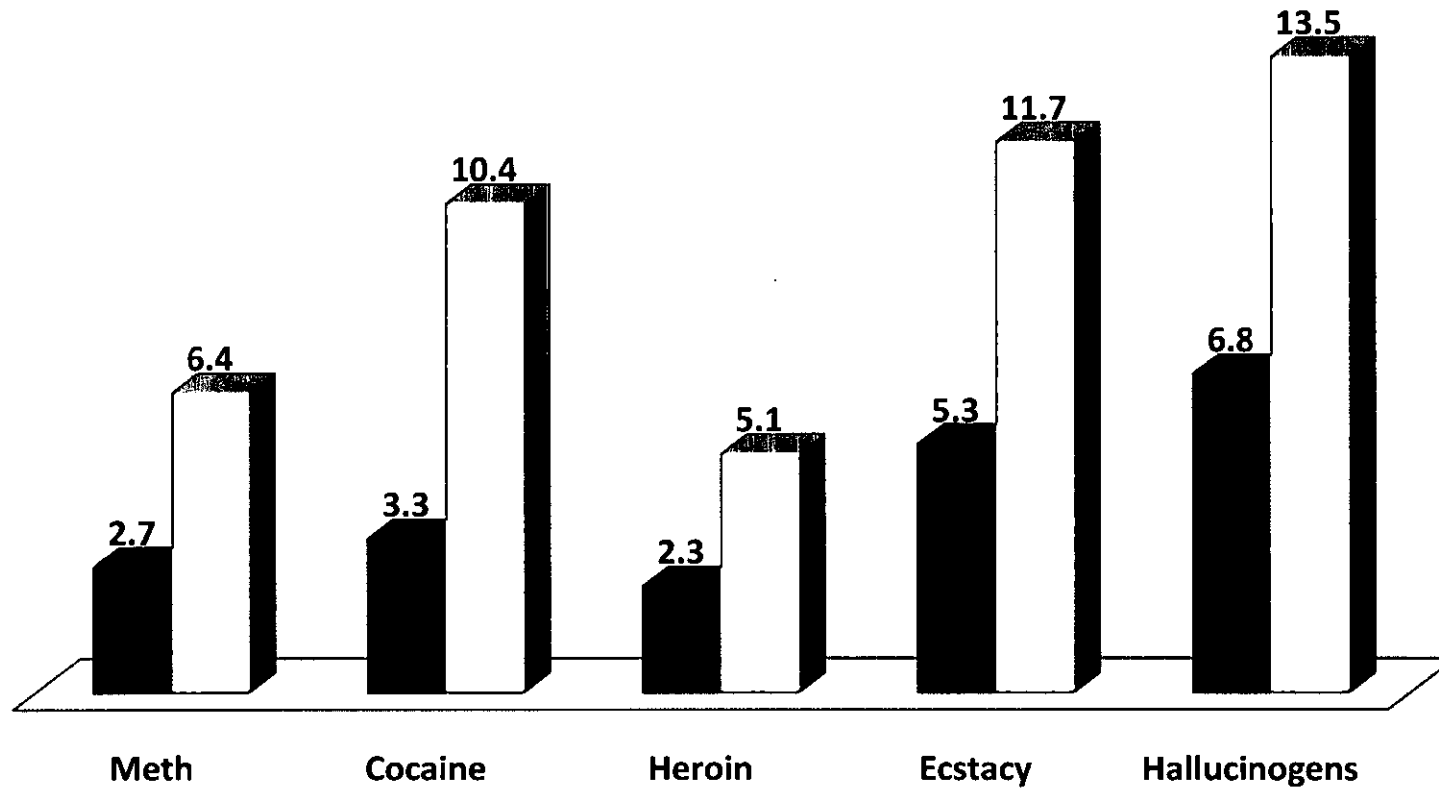
■ 7th Grade ■ 9th Grade ■ 11th Grade



Substance use Totals

AHKS Lifetime Substance Use Summary

■ 9th Grade □ 11th Grade



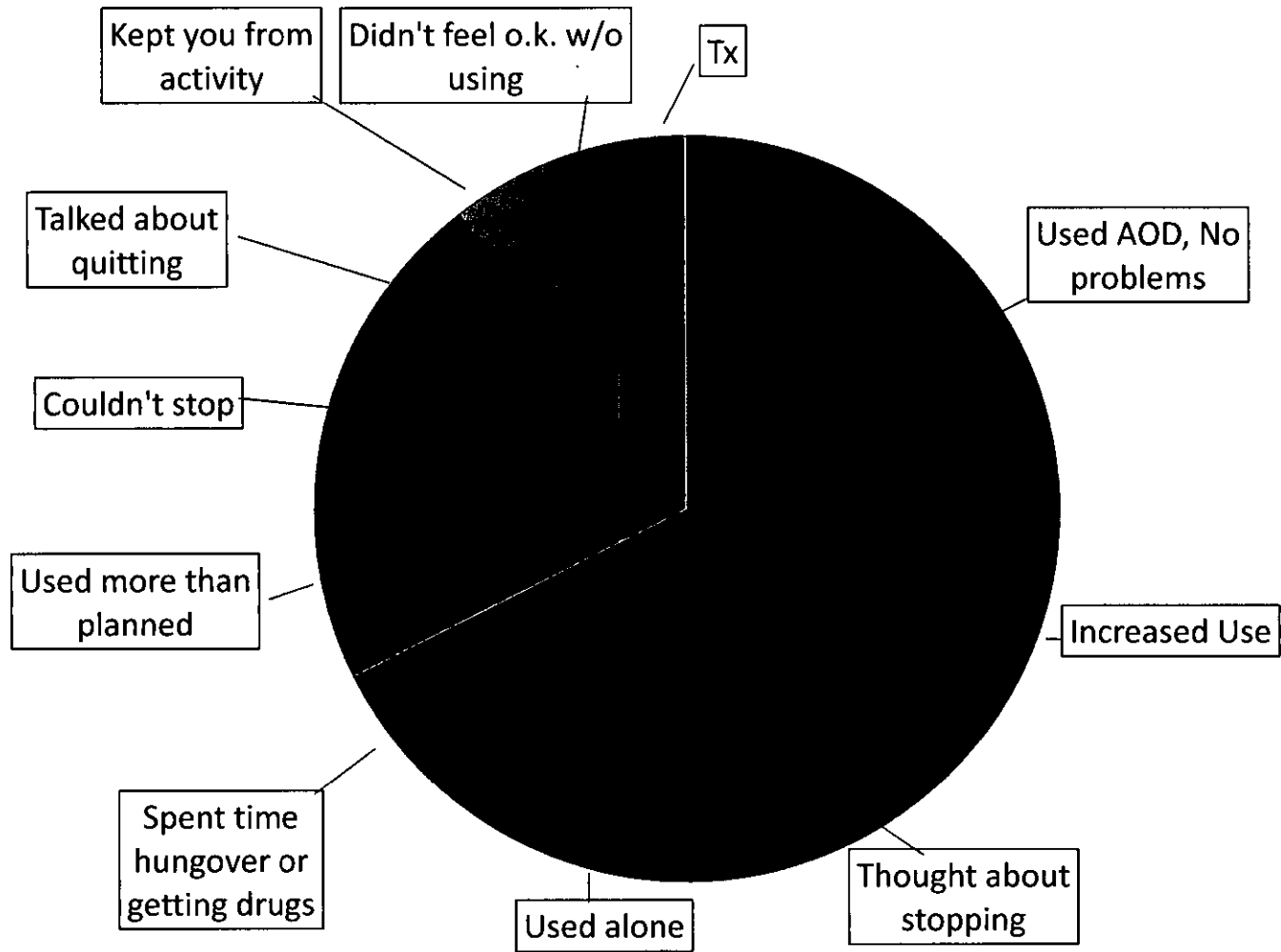
Recommendation #4

Increase community awareness of issues

- Alaska ranks in the United States:
 - #2 for illicit drug use (2007, National Survey on Drug Use and Health)
 - #6 for binge drinking among adults (2007, CDC, BFFSS).
- In many of the categories of use, the youth in the Valley reported above state and national averages.



Experiences from Alcohol and Drugs

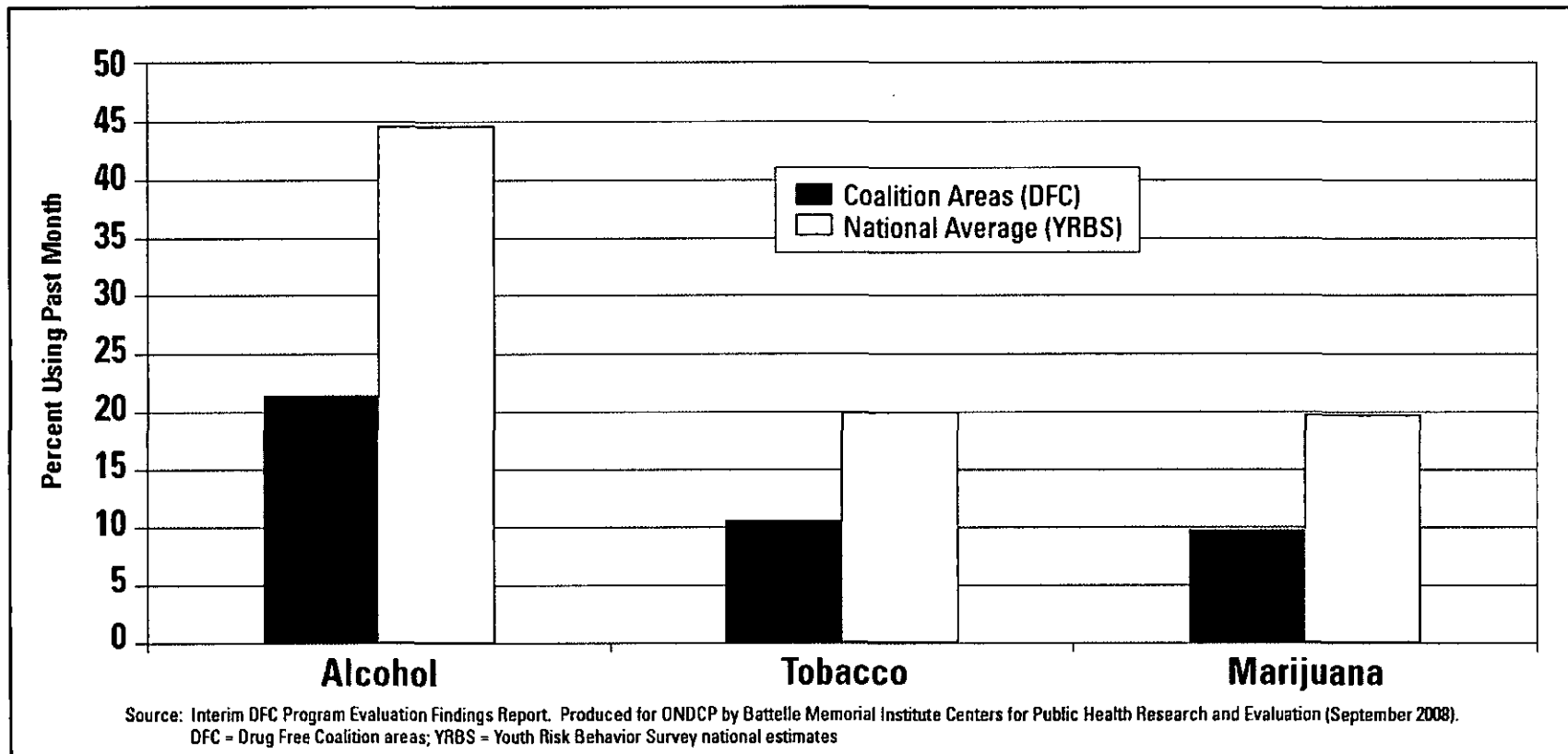


High school youth reported an average of 2 experiences

Coalitions are an effective solution

(Interim DFC Program Evaluation Findings Report, 2008)

Past Month Youth Substance Use Rates in Coalition Areas are Significantly Lower than the National Average in 2007



Our Coalition

- Includes leaders from our community
- Focuses on prevention
- Utilizes Environmental Strategies
 - Ex: advocating law and policy changes
- Coincides with the state plan to reduce underage drinking
 - Ex: youth leadership





Call to Action

- Review state statutes and regulations.
 - Laws are powerful messages that demonstrate social norms and expectations around drinking and using other substances.
- Get involved/understand your local coalition's goals and efforts.
- Support funding for further research, especially regional break-out data.
- Support funding for prevention—it works!

Thank you for your time...



20 Questions to Ask Your Legislator About Health Care Overhaul

1. Legislators in both the House of Representatives and in the Senate voted, in committee, to exempt Members of Congress from having to enroll in the public health plan they are drafting right now. This is outrageous! If this legislation is supposedly good enough for the American people – why exempt Congress from it? Will you vote to sign up you and your family for any public health care program that Congress passes for the American people?
2. There are claims that there's an unfunded liability of several trillion dollars up through 2075, and that the health bill actually reduces payments to Medicare by about several hundred billion over the next decade as a way to fund this bill. Wouldn't such a cut in Medicare then lead to rationing in the system?
3. When Congress and the President rushed to pass the \$1 trillion stimulus bill, we were told it needed to be passed fast. However, the legislation has had questionable results while paying for things like public bathrooms, sex shows in San Francisco and other examples of waste. Now we are told health care legislation must be passed right away for the same reasons. When restructuring 16 percent of our nation's economy, this rush appears more politically motivated than policy motivated. Isn't it more important to do it right?
4. Will you promise to read, understand and take full responsibility for everything that is in the final version of health care legislation?
5. Will you allow the American people sufficient time to review and publicly comment on the legislation before voting on it?
6. Many claim that abortion is covered in the health care bill, despite its not being mentioned specifically in the legislation itself. Furthermore, amendments offered in the Senate by Barbara Mikulski (D-Md.) and in the House by Lois Capps (D-Calif.) now guarantee that abortion will be a part of the health care legislation. Over seventy-one percent of Americans agree that taxpayer dollars should not fund nor subsidize abortion. When it comes to abortion exclusion, will you specify that none of the funds appropriated in the health reform bill, and no resources in any trust fund to which funds are appropriated in the bill, shall be expended for abortion? If not, why?
7. Can you guarantee me that my employer will not drop my health plan, and force me into the government run Health Information Exchange? Can you guarantee me and my family will not be one of the 100 million Americans predicted to lose their employer-provided health insurance and be forced into the Health Information Exchange?
8. I am self-employed. How can you vote for a law that says if I make a single change to my existing health plan, I will be forced into the Health Information Exchange, where my plan details are controlled by the Secretary of Health and Human Services? How can you stand there and say if you like your plan you can keep it, when I am going to be forced into the Health Information Exchange?
9. Do you know that the bill before Congress gives the Secretary of Health and Human Services uber-authority over everyone's health insurance and every single plan detail, and that the bill

grants her such authority and other authority over all aspects of health care more than 200 times in the bill?

10. Do you know that if a trillion dollars were a trillion seconds, counting backwards, a trillion seconds puts us at 30,000 years before the birth of Christ? How can a bill that costs \$1 trillion dollars and that cuts Medicare by \$400 billion be called "revenue-neutral?"
11. How can a bill that costs \$1 trillion dollars be passed without raising taxes as President Obama has promised?
12. Who decides what \$400 billion in benefits and services are cut from Medicare?
13. Congress has never cut Medicare by anywhere near \$400 billion; what makes you think Congress will make the cuts needed to pay for the uninsured's health care?
14. Why should we accept \$400 billion in Medicare cuts? Why aren't other programs being cut besides Medicare? Why is this health reform being funded on the backs of seniors?
15. Why does the bill change the definition of family by stretching it to become anything liberals want to call a family?
16. Will you agree to an iron-clad guarantee that this bill will not fund abortions, leave state abortion limits in place, and protect health care providers from being forced to perform abortions?
17. Medicaid, Medicare and Social Security are all government programs that are nearly broke. Why should the American people think the government can run an efficient or trustworthy health care program, especially when the Members of Congress vote to exempt themselves from the very program they tell the people will be so good?
18. In the House version of the health care legislation, H.R. 3200, Section 1233, titled "Advance Care Planning Consultation," the bill calls for "end-of-life" planning consultations once every five years. Who will be responsible for this "end-of-life" counseling, and why would anyone want the federal government to be involved at all in this very private matter?
19. The provision on "end-of-life" planning for seniors in the House bill comes from Rep. Earl Blumenauer, a Democratic congressman from Oregon who supports assisted suicide. The state of Oregon has sent seniors letters "consulting" them that, while the state-run plan would not pay for their cancer treatments, the state would be happy to pay for assisted suicide if they choose that option. Americans have always placed a high value on human life. Why would we be interested in such a utilitarian approach regarding these important issues?
20. President Obama himself has made several public statements indicating the federal government would be making decisions on what sort of treatments people get. In a town hall meeting on June 24, 2009 President Obama told a woman caring for her elderly mother: "(W)hat we (the federal government) can do is make sure that at least some of the waste that exists in the system that's not making anybody's mom better, that is loading up on additional tests or additional drugs that the evidence shows is (sic) not necessarily going to improve care, that at least we (the federal government) can let doctors know and your mom know that, you know what? Maybe this isn't going to help. Maybe you're better off not having the surgery, but taking the painkiller." Why would I want the federal government involved in a medical decision about surgery vs. a pain killer?

To House Bill 297

Proposed by: Representative Keller

House Education Committee

Amendment to Page 5, line 22 & 23

17 **Sec. 14.43.820. Eligibility for an academic scholarship.** (a) Subject to
18 appropriation, the commission shall award a merit-based academic scholarship to an
19 applicant who meets the eligibility criteria for the award under the program.

20 (b) The programmatic standards for eligibility for an award of a merit-based
21 academic scholarship under the program include the following:

22 (1) the four-year core academic curriculum **which may include a virtual**
23 **curriculum** that the student must have completed in high school; the core
[23] **24** academic curriculum must include

New Text Underlined [DELETED TEXT BRACKETED]

8/16-985

2/16/10
FOSTER
CARE
IN
ALASKA



Foster Care Fact Sheet

Independent Living

The Office of Children's Services Independent Living Program provides services to youth in foster care ages 16 ½ and older, and youth out of custody up to the age of 21. The number of youth being served by the OCS Independent Living Program by region as of February 1st is below.

236 Youth in care ages 16 ½ and older

- SERO-30
- NRO-35
- ANC-73
- SCRO-98

152 Youth out of custody up to age 21

- SERO-24
- NRO-32
- ANC-52
- SCRO-46

143 youth who received services from the Independent Living Program left custody in FY2009

Alaskan Foster Care Alumni Study Findings

Youth served by the Independent Living Program are more likely to, "age out," of custody at 18 or older. The Alaskan Foster Care Alumni Study conducted in 2005 measured outcomes for youth who age out of foster care in Alaska. Outcomes from the study are as follows:

Socio-emotional

- Rates of early parenthood-by age 19, 57% of females, and 41% of males were parents

Physical and Behavioral Health

- 80% reported lifetime use of behavioral or mental health services
- 35% reported overnight treatment stays
- 68% reported seeing a professional such as a psychologist, social worker, or minister

Education, Employment, and Housing

- Nearly 38% of alumni reported being homeless after leaving care. This number was higher than the 12-25% from other alumni studies.
- High school completion rates were below the statewide average. Alaskan Alumni took longer to complete their high school diploma (often finishing between the ages of 19-25). Few went on to complete post secondary education
- 4.5% graduated with a vocational or technical degree or certificate

Costs to Society

- Nearly 30% of alumni were incarcerated after leaving care.



Foster Care Fact Sheet

- Alumni reported high utilization of public assistance resources. 77% of alumni including those who lived alone or with others reported using some form of public assistance in the last 6 months.

Midwest Alumni Study

- Young adult who stayed in foster care beyond age 18 were more than twice as likely to be enrolled in a school or training program as those who had been discharged
- Young adults who extended custody beyond 18 were over 3 times more likely than those no longer in care to be enrolled in a 2-4 year college program
- Compared to the 19 year olds still in foster care those who left the system were more likely to become parents

Education

Educational stability is important for children and youth in foster care to obtain a GED or high school diploma. As children move between foster care placements, they often move between schools as well. With each school change a child falls behind 4-6 months in their education.

The Anchorage School Districts Child in Transition Program reported that only about 25% of high school freshman in foster care were on track to graduate with a diploma or GED on time in 2009.

The McKinney Vento Homeless Liaisons serve about 3/5 of school age children and youth in foster care by providing transportation, tutoring services, and the tracking of school information and credits.

Needed, Achievable Changes

Action To Allow School Stability: Allow youth to remain in their school when they are moved across town to a new foster home during the school term.

Cost-Efficient Action: Help Transition Youth To Success, Not Homelessness

- ❖ Grant Support To Recruit & Screen Volunteer Youth Mentors
- ❖ \$55,000 to expand UA Scholarships for foster youth from 10 to 15.
- ❖ Add Education and Mentorship into the OCS mission by statute
- ❖ OCS concedes that 4 statewide (ILP) staff is grossly inadequate to link youth aged 17-23 to job training, school, and success after care. OCS concedes this staffing is terribly inadequate.
- ❖ Allow Foster Care Until 21 Where There's An Available Family.
- ❖ Enhance Foster Parent Recruitment.

**2/18/10
CITIZEN
REVIEW
PANEL
OFFICE OF
CHILD. SER.**

SEAN PARNELL, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF CHILDREN'S SERVICES

P.O. BOX 110630
JUNEAU, ALASKA 99811-0630
PHONE: (907) 465-3170
FAX: (907) 465-3397

December 18, 2009

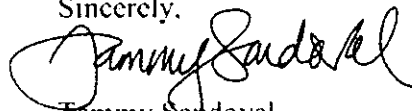
Susan Heuer, Chair
Citizen Review Panel
Office of Public Advocacy
900 W. 5th Ave., Suite 525
Anchorage, Alaska 99501

Dear Chair Heuer:

On behalf of the Department of Health and Social Services, Office of Children's Services, our other partners and our stakeholders in the child protection system, thanks to you and your panel for the 2009 Citizen's Review Panel annual report. Enclosed please find our response to your findings and recommendations.

I truly appreciate each panel member for the time and efforts freely contributed to the most important of visions – Safe Children and Strong Families. I look forward to another year of productive partnership.

Sincerely,



Tammy Sandoval
Director

Enclosure

The Office of Children's Services (OCS) is thankful to the Alaska Citizen Review Panel (CRP) for their diligence in examining policies, procedures and practices that then inform recommendations toward systems improvement of the OCS. We know that we cannot do the work necessary to prevent, reduce and remedy child maltreatment without the assistance of all of our community partners. In 2009, the CRP and OCS continued its collaborative work to ensure the safety, permanency and well being of the children of Alaska. We believe we have forged a very effective partnership.

2009 proved to be another active, but very productive year for the OCS. Again this year, there was a federal audit for which to prepare and host. In July of 2009, the Administration for Children and Families (ACF) conducted a secondary review of the Title IV-E Foster Care Program to determine the level of Alaska's compliance with federal mandates. Secondary reviews are mandated when a primary review determines a state not in substantial compliance with Title IV-E requirements as was the case for Alaska in September of 2006. Reviews ensure compliance with IV-E eligibility requirements and validate financial claims for federal reimbursement to ensure that payments were made on behalf of eligible children.

In November, the ACF determined the OCS to be in substantial compliance with federal eligibility requirements and with the allowable percentage case error and dollar error rate of 10 percent. The OCS was commended for its efforts to improve the program since the September 2006 review and provided with recommendations for continued improvement. The next review will be held within three years of July 2009.

Another federally mandated milestone that was reached this year is the Program Improvement Plan (PIP) was approved on December 1, 2009. The PIP is the corrective action plan to address areas needing improvement as identified in the Child and Family Services in September 2008. A copy of the PIP document can be viewed/downloaded at - http://hss.state.ak.us/ocs/Publications/2009_pip.pdf . The OCS will need support and assistance from every one of its stakeholders in completing the PIP in the required 2 year period. The foundation of the PIP and that of the entire OCS, is our Practice Model Overview. This document seeks to create a conceptual map and represent our organization's ideology to how staff, stakeholders and families served within the system will partner together to engage in child welfare services. See - http://hss.state.ak.us/ocs/Publications/2009_practicemodel.pdf.

As we did last year, we continued rolling out Family to Family (F2F) within OCS, this year to Wasilla. The F2F Initiative is now almost 5 years old and we have begun institutionalizing the core principles and practices statewide, therefore we are going to soon drop the phrase "Family to Family Initiative" and instead, refer to the particular associated practices, to demonstrate our commitment to the work being fully incorporated into OCS' repertoire.

The following are the responses to the specific recommendations made in the CRP 2009 Annual Report:

Recommendation 1 - That resources for state departments be standardized.

While the OCS can only request and encourage state government to allocate resources to increase support for the safety of our children, we are appreciative that the CRP has included this recommendation in the 2009 report. We also recognize the concerted efforts of the Administration and the Legislature to increase the resources available to OCS in the past several years. Since 2005, we have been given 70 new frontline positions and a net increase of close to \$12 million.

OCS completely agrees with your observations regarding the extremely slow Internet connection speeds in our rural offices. Unfortunately, the solution is far from simple and the problem is not exclusive to OCS. Many rural offices in Alaska have Internet connectivity issues.

Department and OCS information technology staff believe that the best and only effective solution to Internet connection speeds is for some entity; be it state, federal, or private, lay a fiber optic cable from Anchorage to Western Alaska. The cost of this enterprise is in the tens of millions if not hundreds of millions of dollars. Even if funding becomes available, a solution will not be realized for several years.

Knowing that the best and most permanent solution is out of immediate reach, we aggressively remind our state Enterprise Technologies staff of the problems in our rural offices and seize any and all alternate solutions. For example, OCS was able to dramatically increase Internet speeds in our Kodiak office by partnering with our federal peers. To quote Mary Gray, our Social Worker IV Supervisor in Kodiak: "It has utterly changed our productivity for the better."

Recognizing that our Bethel, St Mary's, and Aniak offices are some of the most adversely affected offices, we were able to work with the Governor's Office to secure funding for the purchase of 17 laptop computers that now allow the field workers from those offices to enter case notes and keep up on their email correspondence while in the field. Once the field worker returns to their respective office, the case notes can then be uploaded into ORCA.

OCS is also working with our Information Technology partners on new technologies for compressing the size of the Internet signal being transmitted through the satellite to and from our rural offices. This is a difficult and expensive solution, and there is a high risk that the technology will not work in Alaska. Because we believe that if there is a chance it will help our rural offices, we must at least try.

We also agree that the ability to provide rural housing would positively impact retention of staff in the rural areas. We have taken the issue to DHSS administration and learned that while there are some existing models in other departments; those models were grandfathered in, making the effort to provide housing a little more difficult for OCS. We have learned that we may be able to provide housing by leasing existing rental property, but must charge workers for rent. When vacant, the OCS would need to continue lease payments, dipping into already stretched operating funds. This option has not been discounted, and we will continue to determine where the most need is and explore options available to us.

CITIZEN REVIEW PANEL

2009 Annual Report



Alaska

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Mission and Mandate

MISSION

The Alaska Citizen Review Panel (CRP) is committed to reviewing and evaluating the practices and procedures of the Office of Children's Services (OCS) and in making recommendations relative to its findings to insure the safety and the well-being of the children of Alaska.

The CRP will achieve this commitment by examining the policies and procedures of the Office of Children's Services and collaborating agencies; examining, where appropriate, specific cases; evaluating the extent to which agencies are carrying out their child protection responsibilities; and preparing and making available to the public an annual report.

MANDATE FOR THE GROUP

The Citizens' Review Panel (CRP) is federally mandated through the Child Abuse Prevention and Treatment Act (CAPTA); Keeping Children and Families Safe Act of 2003. The CRP is also mandated through Alaska statute Sec. 47.14.205.

"By allowing the Panels to have complete access to child protection cases, by requiring Panels to publicize their findings, and by requiring states to respond to criticisms and recommendations of the Panels, the Committee intends to subject states to public criticism and political repercussion if they fail to protect children." (United States Congress, House Report 104-081, 1995, p.1)

DUTIES ASSIGNED TO THE GROUP

Summary of duties The CRP shall examine the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, to evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities.

CRP duties

- Evaluate OCS compliance with federal and state laws, examine policies and procedures for consistent statewide implementation, review cases with fatalities or near fatalities. The CRP shall evaluate the extent to which OCS is effectively discharging its child protection responsibilities under:
 1. the State Plan submitted to the U.S. Department of Health and Human Services under 42 U.S.C. 5106a(b);
 2. Child Protection Standards under federal and state laws; and
 3. any other criteria that the CRP considers important to ensuring the protection of children, including the level and efficiency of coordination of foster care and adoption programs in the state and a review of child fatalities and near fatalities.

In carrying out the responsibilities listed above, the CRP shall examine the policies, procedures, and practices of OCS, and, where appropriate, evaluate specific cases of child abuse or neglect.
- Maintain confidentiality. A person attending a CRP meeting or a CRP member or CRP staff may not make any disclosure related to information obtained during a review by the CRP. A violation is subject to a civil penalty of up to \$2,500 for each violation.
- Conduct public outreach. The CRP shall conduct public outreach and gather public comment on current OCS procedures and practices involving children and family services.
- Produce an annual report. The CRP shall prepare and make available to the governor, the legislature, and the public an annual report containing a summary of its activities and recommendations for the improvement of child protection services in the state.
- Meet at least every three months. The CRP is required by law to meet every three months. Additional meetings and/or teleconferences are scheduled as needed.

DUTIES ASSIGNED TO OCS RELATED TO THE CRP

HSS support. The Commissioner shall, by regulation, establish policies and procedures necessary to carrying out the duties of the CRP.

- Cooperation with state panel. OCS shall provide the panel access to information on child abuse or neglect cases that is necessary for the CRP to carry out its duties.
- Report response. Not later than six months after the date on which the report is released, OCS shall submit a written response that describes whether or how OCS will incorporate the recommendations of the CRP (where appropriate) to make *measurable* progress in improving the child protection system.

Membership and Staff Support

Required membership The panel shall be composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect.

Current membership

Fred Van Wallinga, Chair, Willow
Carol Olson, Vice Chair, Anchorage
Pamela Dupras, Kodiak
Dana W. Hallett, Soldotna
Arthur S. Hansen, Fairbanks
Susan Heuer, Anchorage
Kristin Hull, Wasilla
Ralph Taylor, Eagle River

Former members who left the group during this reporting period

Paul Burke, Nome
Esperanza Redelfs, Ketchikan

Desired membership The CRP would like to meet its requirement to be broadly representative of the state by widening the geographic and racial and ethnic diversity of the membership. The group is working to recruit new members from underrepresented areas of the state as well as a greater diversity of child-centered expertise and backgrounds.

OCS liaison Tammy Sandoval, Director, is the current liaison between OCS and the CRP.

Staff support Staff support is provided by Sylvan Robb and Nancy Lowe of Information Insights.

Meetings and Activities

Group meetings

July 10, 2008	In person — Anchorage
September 17, 2008	Teleconference
November 11, 2008	Teleconference
November 21, 2008	In person — Anchorage
February 4-6, 2009	In person — Juneau
March 26, 2009	Teleconference
May 1, 2009	In person — Anchorage
May 26, 2009	Teleconference
June 2, 2009	Teleconference
June 19, 2009	Teleconference
June 29, 2009	Teleconference

Other activities

August 28, 2008	Fairbanks: Art Hansen, Fred Van Wallinga, and Sylvan Robb met with Representative John Coghill and his Chief of Staff, Rynnieva Moss
September 10, 2008	Participated in teleconference for the Child and Family Services Review
November 18, 2008	Fairbanks: Art Hansen and Sylvan Robb met with Coleen Turner, Children's Services Manager for Northern Regional Office
November 20, 2008	Met with Alaska Department of Health and Social Services Commissioner, Bill Hogan
January 6, 2009	Safety training teleconference with Director Tammy Sandoval
January 7, 2009	Dillingham: Art Hansen and Susan Heuer met with local OCS staff and partnering agencies
January 8-9, 2009	King Salmon: Art Hansen and Susan Heuer met with local OCS staff and partnering agencies
January 12-13, 2009	St. Mary's: Dana Hallett and Kristin Hull met with local OCS staff and partnering agencies

January 18-21, 2009	Unalaska: Dana Hallett and Sylvan Robb met with local OCS staff and partnering agencies
January 28, 2009	Bethel: Pamela Dupras and Fred Van Wallinga met with local OCS staff and partnering agencies
January 29-30, 2009	Aniak: Pamela Dupras and Fred Van Wallinga met with local OCS staff and partnering agencies
April 27-30, 2009	Alaska Native Indian Child Welfare Agency, Second Annual Alaska Child Welfare Summit
May 14, 2009	Sylvan Robb presented to the Tribal State Consortium
May 20-22, 2009	Jackson Hole, Wyoming: Fred Van Wallinga attended the National Citizen Review Panel conference

Annual activities

Although the CRP was formed in May 2002, the core of its current membership has been in place for approximately five years. The group meets face-to-face quarterly, with monthly teleconferences in between. Panel membership has remained steady this year with eight members, although there were extended absences during the year. Two members missed a portion of the year; one for health reasons and the other due to military deployment. One member resigned when she moved out-of-state. A newly recruited member had to resign due to a family medical emergency before becoming very active. Another new member was recruited and has been an active participant for much of the year.

The CRP continued to focus this year on two areas for which we had previously advocated. The CRP visited the Copper River Basin area in November 2007. We had serious concerns about this area before and after our site visit. The local OCS field office in Glennallen was a one-person office and struggled to retain a staff person. We have continued to monitor the progress and keep a close eye on the office. We were extremely encouraged to see the community rally and organize to start a child advocacy center (CAC) for the area. OCS was responsive to the needs of the area and the acknowledged additional staff time required by the creation of the CAC. A second staff person has been assigned to the field office. The office suffered an unfortunate set back when the newly hired staffer was seriously injured in a car accident. OCS has been very responsive to the needs of the region and recently promptly filled that position with a new worker in the interim.

Our second area of focus has been, and continues to be, the creation of a fifth service region for OCS to be headquartered in the Bethel area. That was our most important

recommendation in our annual report last year and is a recommendation again this year. More information is included in the recommendations section of this report.

As more people become aware of our existence we receive more calls from dissatisfied citizens. As in the past, we inform people that we do not intervene in individual cases, but encourage people to avail themselves of either the OCS grievance process or to open a case with the Ombudsman's Office. When we are aware of cases, we do try to monitor complaints with an eye out for patterns of problems.

We collected a great deal of regional data personally through community site visits. We interviewed local OCS staff and staff from the following types of partnering agencies regarding what is working and what needs improvement in their relationship with OCS and how we can help facilitate those efforts.

- Counseling center staff
- District attorneys
- Foster parents
- Health aides & public health nurses
- Health clinic staff
- ICWA workers
- Local police departments
- Municipal representatives
- OCS staff
- School principals, nurses & counselors
- State troopers
- Tribal representatives
- WIC workers

We also learned a great deal from other people in these same job types during discussions at several conferences we attended. One conference we attended was the Second Annual Alaska Child Welfare Summit put on by the Alaska Native Indian Child Welfare Association (ANICWA). Attendance at these conferences provides extremely valuable networking opportunities, especially to hear from rural residents from many communities. Conference attendance is an excellent way to continue to make people aware of our existence. A 3' by 6' banner with our name and logo was purchased, and we were able to staff a table with information during the ANICWA conference. Unfortunately, attendance was down this year as travel budgets have been cut or frozen due to the poor economy.

We had additional training opportunities this year to include one member attending the National Citizen Review Panel Conference in Jackson Hole, Wyoming. Attendance at the national conference allows us to learn of any legislative changes that impact citizen review panels and to network with members from other states to exchange ideas. We are active participants in the national listserv for CRPs. We have responded to data requests

as well as submitting several questions to solicit information from the national community of CRPs.

In addition to collecting data, we also provided data this year. We attended a teleconference to provide input on the Child and Family Services Review conducted by the federal Children's Bureau. One of our members, Art Hansen, also participated in an in-person meeting and several teleconferences related to this process. We look forward to monitoring OCS' progress towards the goals laid out in the Performance Improvement Plan. We also provided feedback to OCS for the mandatory five-year plan they submitted to the federal government.

Director Tammy Sandoval has been our OCS liaison for the entire year. We have been pleased with the direct communication and access this affords us. The relationship and outcomes have improved between OCS and the CRP. In addition to her involvement in our quarterly meetings, Director Sandoval also provided us with a half-day tutorial on the Safety Assessment which is a new practice being implemented throughout the state.

As part of our public outreach we presented testimony to the Alaska House Health and Social Services Committee about our activities and recommendations. While in Juneau we also met with members of the Governor's staff, the Commissioner of Health and Social Services and numerous individual legislators. We also continue to maintain our website for public outreach at www.crpalaska.org.

At our May meeting, we held officer elections and Susan Heuer was elected as our new chair. Carol Olson was re-elected as vice chair.

Recommendations

Recommendation 1. That resources for state departments be standardized

Currently there are many resources that are available in numerous state departments that are not standardized. We acknowledge and agree that not all departments have the same needs nor do they require being treated the same in all circumstances. However, if Alaska values the safety of its children it will not prolong the time it allows the Office of Children's Services to continually be under-resourced.

In nearly every rural community we visited, we have heard of the problems plaguing OCS offices related to slow Internet connections. This is not a matter of convenience, as some may imagine it; the horrifically slow Internet connections endured by these offices has a tremendous impact on productivity. Workers in rural offices can spend 20 minutes doing something that takes two to three minutes in an office with a decent connection.

One result of these very slow connections is to impact the safety and outcomes for children as workers have less time to provide services to children and families. While that alone should be enough to motivate a remedy to the situation, directly jeopardizing the safety of children is not the only impact. Due to the overwhelming amount of time needed to enter data into OCS' ORCA database in offices with these tremendously slow connections, workers tend to get quite behind with their entries. This leads to a substantial lag between the data in ORCA and the reality on the ground. Since OCS is admirably trying to make decisions based on data, ORCA is frequently mined for data to inform decisions. However, those decisions are then made based on outdated data.

Another example of the impact this has on children could be witnessed during a recent termination trial. An OCS supervisor from Bethel was called as a witness and the Attorney General was asking her questions based on ORCA entries. Her testimony lasted four hours when it should have been 45 minutes. The long lapses allowed previously unprepared defense attorneys time to prepare and left the supervisor feeling frustrated and unprofessional. Even though it was not her fault, the delay left a bad impression of OCS's expertise on the court. Additionally, it wasted three hours of the supervisor's time.

The most frustrating part of this scenario is that in nearly all the communities we have visited where we heard of these exceedingly slow Internet connections, we have found other offices of state government to be connected at the highest speeds. OCS should not always be provided with the slowest connection. We understand that this problem requires remedy by those outside of OCS in other state agencies. We have faith that these agencies too will value Alaska's children's safety and work with OCS to find a solution to this issue. OCS workers have jobs with plenty of inherent challenges; they

don't need to endure this maddening one while knowing that the school, the Trooper's office, and the public health nurses all have faster connections.

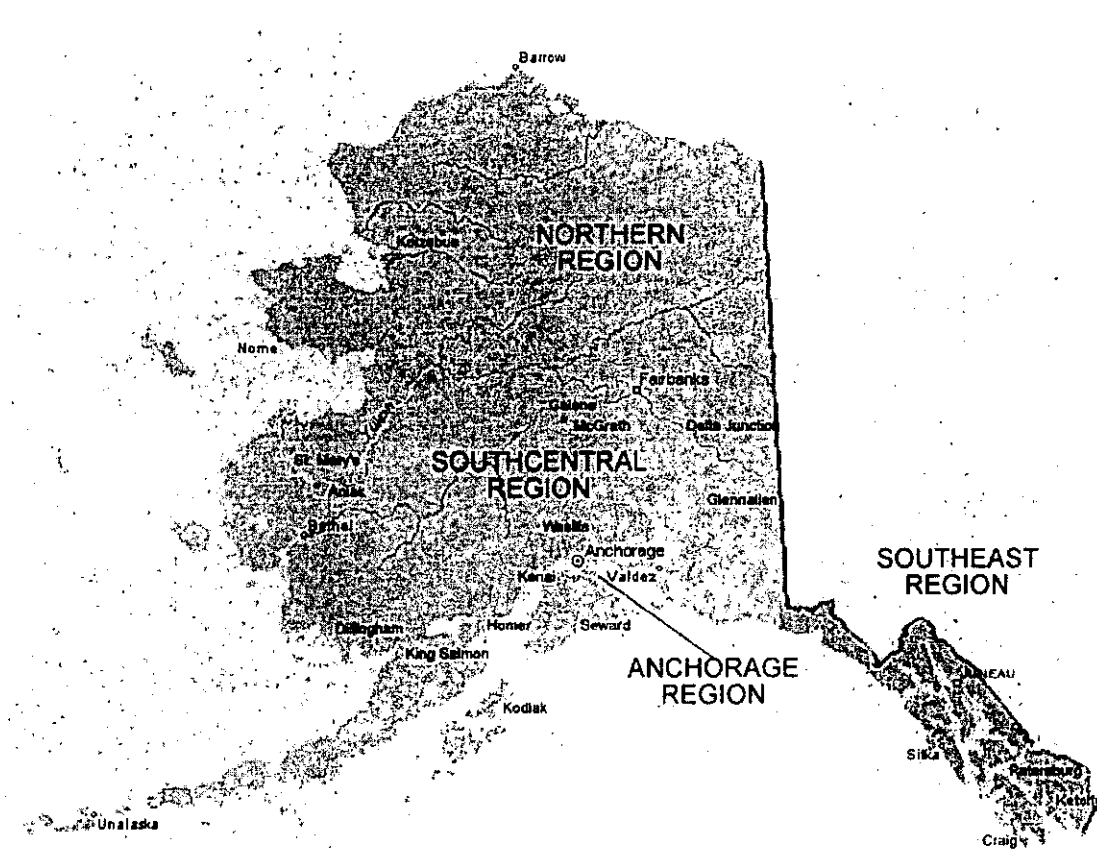
The other resource that is available to some state agencies as a recruitment tool for rural workers is housing. Schools and Troopers in some rural communities have recognized that being able to offer decent housing makes it much easier to recruit qualified workers to remote communities. OCS would like to be able to use this recruiting tool as well since attracting applicants to rural positions is difficult. We hope this issue can be explored. Since the model already exists in other departments, the issue seems one of funding rather than figuring logistics or having to pilot a project.

While our immediate desire is to see OCS receive the same quality Internet connection as other offices and the same recruiting tools, we think the state is missing an opportunity to save money by consolidating these services. In the same way that all state agencies must book travel through the state travel office, all state agencies in a community should share an Internet connection. Likewise, all agencies could share state housing in a community for recruiting purposes. We feel this has the potential to raise the caliber of everything being offered by various agencies. Better services would decrease frustration, improve employee retention, and improve the delivery of state services.

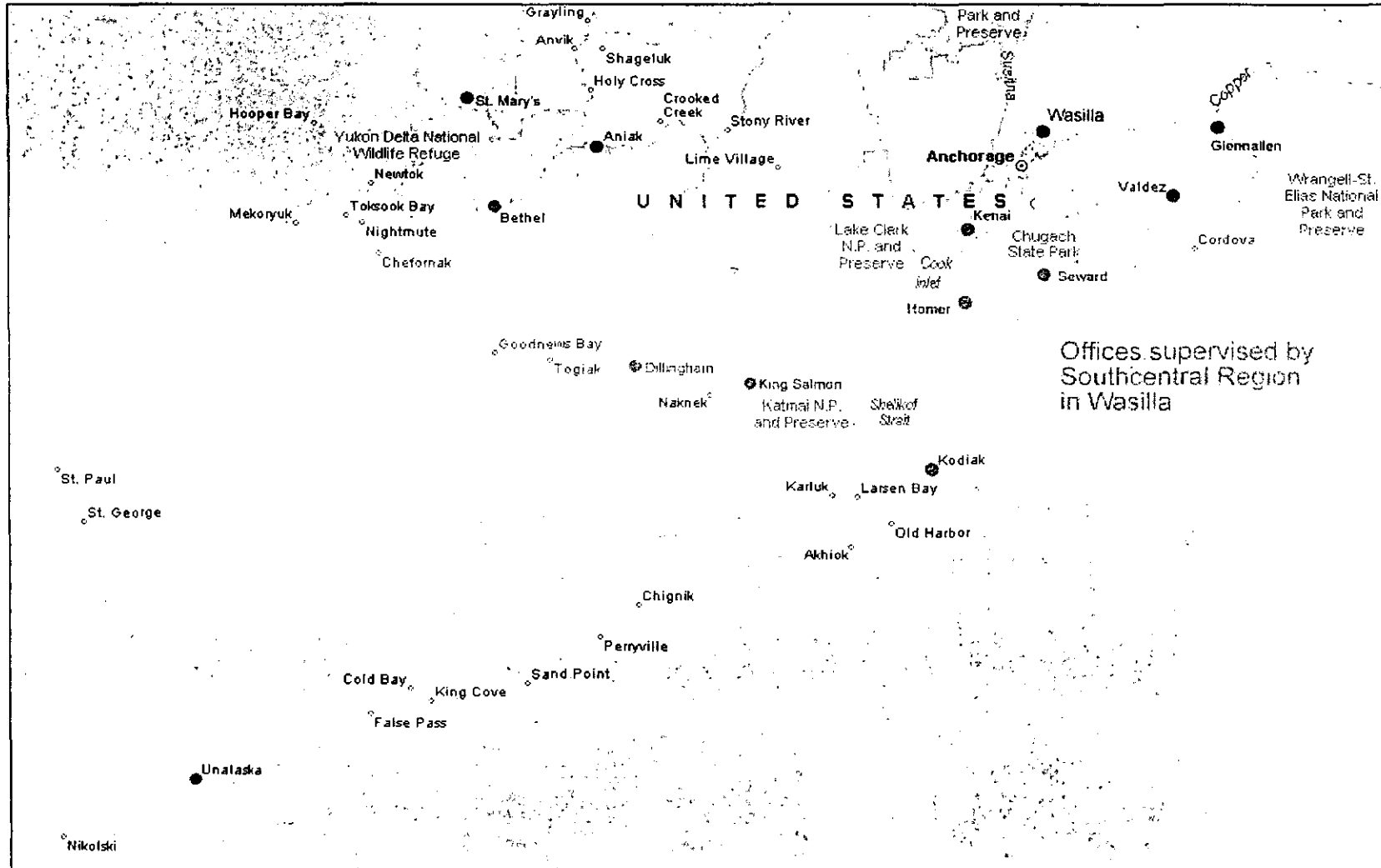
Recommendation 2. That OCS continue to work toward having a fifth service region headquartered in Bethel

Population and Land Area

Currently OCS serves the state through four regions: Southeast, Anchorage, the Northern region (which includes the area north of St. Mary's) and the Southcentral region (which is the remainder of the state). The map below shows the existing regions.



Currently there is one office in the Anchorage region, five offices in the Southeast region, seven offices in the Northern region and 13 offices in the Southcentral region. The existing Southcentral region has 12 field offices which is twice as many as the region with the next largest number of field offices—six in the Northern region--and three times as many field offices as Southeast (which has four field offices). The following map shows the dozen field offices in the Southcentral region and the regional headquarters in Wasilla.



We propose that in order to better serve the sizable and culturally distinct area of Southwest Alaska, OCS create a fifth region to be headquartered in Bethel. This region would be broken out from the existing Southcentral region (SCRO). The existing Southcentral region includes 37% of Alaska's land area and 30% of its population. SCRO as it exists is the size of California and Michigan combined.

In our annual report last year we also advocated strongly that OCS develop a fifth service region. Last year we advocated carving off six of the field offices from the existing SCRO—Aniak, Bethel, Dillingham, King Salmon, St. Mary's and Unalaska. We continue to feel passionately that creating a fifth service region will allow OCS to provide better services in both the new region and in SCRO--which would be much smaller after the creation of the new region. After making our recommendation in last year's annual report, we had the opportunity to travel to all six field offices that we proposed for inclusion in the new fifth region.

After meeting with OCS workers and community partners in all six communities, we are amending our recommendation this year. The fifth region we propose would be headquartered in Bethel and would include the Bethel, Aniak and St. Mary's field offices. While the inclusion of the six offices proposed last year makes sense geographically, the inclusion of all six communities does not make sense when travel routes are considered. As the crow flies, it is 850 miles from Wasilla to Unalaska and only 510 miles from Bethel to Unalaska. However, the only route between Unalaska and Bethel travels through Anchorage, so serving Unalaska and other communities on the Anchorage travel corridor from Bethel does not make sense. However, we continue to believe that the 56 Yup'ik villages in the Bethel area—a culturally cohesive area and an area with many challenges - deserves to be served from a region headquartered in the area.

The table below lists all the boroughs and census areas included in the existing Southcentral region. Those areas above the heavy line would remain in the Southcentral region after the proposed Southwest region is created. Those below the heavy line would be in the proposed Southwest region. The existing boundary between the Northern region and SCRO is a straight line east-west across the state, so it does not follow borough or census area boundaries. We have estimated the percentage of the census areas in the proposed Southwest region for those census areas bisected by the boundary.

Borough or Census Area	Population (2006 Census Bureau est.)	% Population Under 5 Years Old	% Population Under 18 Years Old	Land Area (sq. miles)
Aleutians East Borough	2,647	3.5	12.1	6,988
Aleutians West Census Area	5,239	3.2	12.8	4,397
Bristol Bay Borough	1,042	6.5	27.0	505
Dillingham Census Area	4,970	8.7	33.6	18,675
Lake and Peninsula Borough	1,548	8.1	31.2	23,782
Kenai Peninsula Borough	52,304	5.8	24.7	16,013
Kodiak Island Borough	13,072	7.7	30.0	6,560
Matanuska-Susitna Borough	80,480	6.4	26.2	24,682
Valdez-Cordova Census Area	9,872	6.2	24.7	34,319
Bethel Census Area	17,147	11.2	37.1	40,633
Wade Hampton Census Area	6,443*	13.7	42.4	14,614*
Yukon-Koyukuk Census Area	877**	6.5	27.9	21,885**
Total current SCRO	201,745	7.0	27.3	213,053
Total proposed Southwest region	24,467	11.7	38.2	77,132
Total remaining SCRO	177,278	6.2	25.6	135,921
Alaska	670,053	7.4	27.1	571,951

* Estimate 85% of Wade Hampton Census Area in proposed Southwest region, figure is 85% of total.

** Estimate 15% of Yukon-Koyukuk Census Area in proposed Southwest region, figure is 15% of total.

The proposed Southwest region would have 4% of Alaska's population, although it would contain 2% of Alaska's children under 18 years old. While the population in the proposed new region is not sizable, 38% of that population is children. The proposed Southwest region would also include 14% of Alaska's land area. This would leave the remaining SCRO with 26% of Alaska's population, 24% of Alaska's children under 18 years old and 24% of Alaska's land area.

The proposed Southwest region has a large number of communities. There are at least 56 villages in the Bethel region. All of those communities are substantially closer to Bethel than to Wasilla in many ways. The communities are geographically closer, culturally closer, and much closer in lifestyle being all off-road small, rural communities.

Great Need—Troubled Region

As reported in the Anchorage Daily News article, *Slowly, Western Alaska starts to break silence on sexual abuse, Children are often victims of relatives* by Alex DeMarban of the Tundra Drums, Bethel has more sexual assaults than Anchorage in absolute numbers (not per capita). This article was published on January 22, 2008. A portion of the article is excerpted below.

EPICENTER: BETHEL

New statistics from the Alaska State Troopers suggest that Western Alaska leads the state in cases of sexual abuse of a minor -- often when girls are raped or molested by intoxicated adult male relatives and acquaintances -- and cases of sexual assaults against women.

A soon-to-be released study of 989 such cases investigated statewide by troopers in 2003 and 2004 shows that the greatest number -- 476 cases, or 48 percent -- occurred in Western Alaska, said Katie TePas, a troopers program coordinator.

The region is immense -- containing more than one-third of the state's land mass -- and stretches from Kotzebue in the north to Kodiak in the south and out the Aleutian Chain past Unalaska. It's served by 13 trooper posts in what's known as the C Detachment.

But the population is small, represented by dozens of villages -- many with fewer than 500 people -- and a handful of hub communities, such as Kodiak, Bethel or Nome, each with fewer than 6,000 people.

In the vastly more populated regions along the road system -- including Anchorage, Fairbanks and the Matanuska-Susitna Borough -- troopers investigated fewer such cases during the two-year period. Combined, trooper posts in those areas investigated 299 of the studied cases, or 30.2 percent of the total during the two-year period.

Ground zero is the Bethel region, where troopers investigated 17 percent of the cases, more than any other post in the state, TePas said.

"We have an epidemic," she said. "It's a statewide epidemic, but the epicenter, our data shows, is the Bethel region."

CHILDREN MOST VULNERABLE

TePas presented the numbers at a summit on Alaska Native child sexual abuse in Anchorage earlier this month.

The results are highlights from an 102-page study done by the Justice Center at the University of Alaska Anchorage, she said.

Only trooper cases that entered the justice system during the two-year period and reached a conclusion -- cases that did and did not result in a conviction -- are included in the study, TePas said.

The early figures paint a disturbing picture of rapes and other sexual violence against adults and children in Western Alaska, where the population is largely Alaska Native and villages are often loose extensions of family.

In all the 989 cases, family members and friends sexually abuse or assault each other in more than 90 percent of the incidents, she said.

They're especially hurting children. The most common charge during the two years was second-degree sexual abuse of a minor, a class B felony that generally means the rape or other molestation of someone 16 years old or younger, often by an adult.

Almost one-fourth of the child victims were from ages 13 to 15, she said. Nearly the same number were from ages 6 to 12.

Strangers were the perpetrators in less than 1 percent of the cases involving children, TePas said.

Precedent in Other Agencies

There are other state agencies that have more than four regions. The best example is that the Alaska State Troopers divide the state into five detachments (A-E) headquartered in Anchorage, Fairbanks, Ketchikan, Palmer and Soldotna. They have posts in 36 communities. The Troopers are the best agency for OCS to compare itself to because both agencies share a need to be able to respond quickly in emergency situations. Safety requires proximity. Additionally, knowing the community can provide a great benefit in allowing workers to diffuse situations and find the most appropriate outcome. Workers in both agencies need to be culturally competent and familiar with the local services. While the Troopers' detachment C does not mirror exactly the proposed Southwest region, the areas are similar. This arrangement works well for the Troopers and would work well for OCS. With the Troopers being a primary partner for OCS, it makes good sense to have this region to strengthen the partnership between these agencies.

Community Support

Prior to our testimony before the House Health, Education, and Social Services we

received letters from residents and agencies in the Bethel area in support of keeping the Supervisor 5 position in Bethel and for the creation of a new region. We received 15 letters of support which may be viewed in their entirety on our website.

Conclusion

There are many strong reasons for creating this new region.

- The area is 14% of Alaska. If it were a state, it would be the eighteenth largest state just behind South Dakota, but ahead of Washington.
- The area is entirely off the road system, complicating travel and creating different circumstances than on-road communities face.
- The area has a higher percentage of population who are children than the state overall.
- The area has a great need having the highest rates of sexual assault.
- The area is culturally distinct due to the large, strong Yup'ik population.
- The Alaska State Troopers, who also provide public safety, serve the state through five regions.
- The community supports the effort.
- The OCS offices and staff are already in place. Only four new positions need to be added.

In addition to serving this culturally distinct area that comprises 14% of Alaska much better, removing responsibility for this area would allow the currently over-stretched SCRO to provide better services to all those children and families remaining in its area. SCRO has many challenges and would greatly benefit from having less on its plate. There are so many good reasons to do this.

Given what we have learned in the time since we first made this recommendation, we intend to continue to collect data regarding this idea. We also have a better grasp of the funding process and know that such an idea cannot be implemented immediately and will require much advocacy on our part and those from the communities in question who support the idea to make it a reality. Our conviction remains strong that this is needed to make headway at resolving a majority of the child protection issues in this region.

We request that OCS provide us with an action plan that includes a time line to make this a reality. We would like that plan to clearly specify what can be accomplished every year until the fifth region is created. The CRP pledges to continue to advocate for this region while collecting data via a survey to determine the exact boundaries of the proposed region.

Recommendation 3. Supporting and developing the relationship between OCS & ICWA (Indian Child Welfare Act) workers

A great deal of effort has been directed toward the problem of disproportionality in Alaska's child welfare system; the problem being that approximately 65% of the children in OCS custody are Alaska Native while only 15% of the population of the state is Alaska Native. There are many causes for this problem and many well-qualified, well-funded people have been and continue to work on this issue.

We have one recommendation that we feel can only help address this issue. An improved relationship between OCS workers and ICWA workers in all communities will improve communications, trust, and outcomes for children. If workers can see each other as resources, teammates, and trust that the other also has the best interest of the child as their motivation the system can only be improved.

We know that many efforts have been made at the highest levels to improve communication, collaboration and trust between OCS and the tribal agencies. However, we are really advocating for relationship building at the ground level. We recommend that OCS find models where these relationships exist, where there are new and different programs and try to replicate those successes. Some innovative programs include the Knowing Who You Are program supported by the Annie E. Casey Foundation, the program being implemented in Quinhok, and the Lakota program - Family Group Decision Making.

One way for OCS to demonstrate its trust in ICWA workers, and free its workers to make home visits and do other necessary tasks, is to allow ICWA workers to license foster homes. In many communities it takes nearly a year to become a licensed foster home, in part because of the infrequency of visits to many communities by OCS licensing workers. Allowing ICWA workers to make those visits would speed the process of becoming licensed. This will encourage more people to open their homes if the licensing process is not so drawn out and onerous.

We encourage OCS to implement any recommendations made by the Casey Foundation related to this issue.

Recommendation 4. OCS explore any and all means to relieve social workers of some of their paperwork burden

In too many of the communities we visit we hear social workers complaining that their title is a misnomer since they do not have time to practice social work due to paperwork burdens. Social workers are skilled practitioners and should be spending as much of their time as possible using those skills to provide services to children and families. Any ideas should be explored and encouraged to make this a reality, including a dictation service (being used by at least one office). Having more social services aids (SSA) on staff would enable these lower paid workers to handle some of the paperwork burden, freeing more highly paid social workers to use their valuable skills to help support Alaska's struggling families.

We urge OCS to develop and implement a staffing ratio for social workers-to-SSAs and to work to secure funding to enable this ratio to be implemented. Adequate ratio of SSAs to SW enables OCS to work smarter—using limited resources in a more efficient manner. Another way to improve social workers' productivity is to purchase more laptops for workers to use when traveling. Especially in rural Alaska where weather delays can last days, having a secure laptop is the difference between wasted time and productive time while waiting out a storm.

Enabling social workers to practice social works helps improve worker retention. This is the number one request we have heard from social workers when we are in the field. They need help with filing, making basic calls, and transporting children; all tasks that do not require a social work background to do a good job.

Commendations

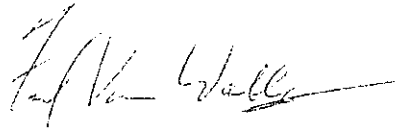
We would like to thank Governor Palin for granting a waiver to OCS during the hiring freeze.

We commend OCS for thinking outside the box to implement the Knowing Who You Are training sponsored by the Annie E. Casey Foundation to forge personal and working relationships between regional OCS and ICWA workers. Both groups report a high degree of satisfaction with the new collaborations that have resulted.

We commend OCS Director Tammy Sandoval for supporting the new child advocacy center in the Copper River Basin by finding a way to collocate the Glennallen OCS Field Office with the CAC.

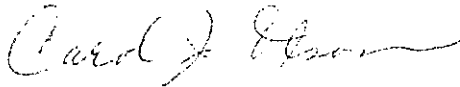
We commend OCS Director Tammy Sandoval for working to improve collaboration with several other state agencies, such as the Division of Juvenile Justice and the Division of Behavioral Health. This is an excellent idea and we hope she will continue in this vein, reaching out to as many other state agencies as possible. In this climate of reduced state funding, collaboration is one way to try and stretch state dollars to serve as many children and families as possible. Certainly, many state agencies can and frequently do have the same clients.

Respectfully submitted by the Citizen Review Panel:



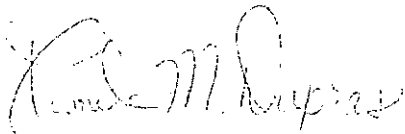
Electronically signed
June 30, 2009

Fred Van Wallinga, Chair



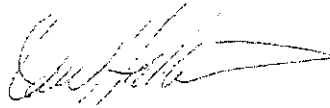
Electronically signed
June 30, 2009

Carol J. Olson, Vice Chair



Electronically signed
June 30, 2009

Pamela M. Dupras, Member



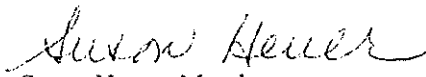
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Dana W. Hallett, Member



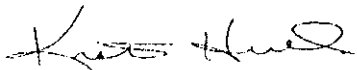
Electronically signed
June 30, 2009

Arthur S. Hansen, Member



Electronically signed
June 30, 2009

Susan Heuer, Member



Electronically signed
June 30, 2009

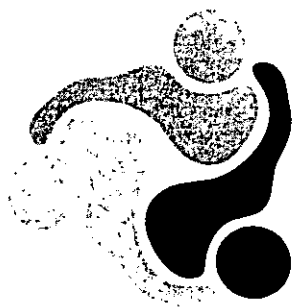
Kristin Hull, Member



Electronically signed
June 30, 2009

Ralph D. Taylor, Member

*Never doubt that a small, dedicated group of citizens can make a difference.
Indeed, it is the only thing that ever has...
~ Margaret Mead*



alaska office of
CHILDREN'S SERVICES
safe children | strong families



Practice Model

State of Alaska • Department of Health & Social Services
Office of Children's Services

Practice Model

Sean Parnell, Governor, State of Alaska
Bill Hogan, Commissioner, Department of Health & Social Services
Tammy Sandoval, Director, Office of Children's Services

State of Alaska • Department of Health & Social Services • Office of Children's Services
P.O. Box 110630 • Juneau, Alaska 99811-0630 • Telephone: (907) 465-3191 • FAX: (907) 465-3397
<http://www.hss.state.ak.us/ocs/>

Recommendation 2 - That OCS continue to work toward having a fifth service region headquartered in Bethel.

While the OCS believes there is merit to the CRP recommendation to establish a fifth, 'Southwest' service region for the Bethel area, again this year the Governor's Proposed FY2011 Budget does not include such a request for OCS. The CRP reports that the current South-central region's 12 field offices, Bethel included, are twice as many as the region with the next largest number of field offices (Northern region). The current South-central region includes 37% of Alaska's land area and 30% of Alaska's population. This newly proposed region includes an area of the state with the highest rates of sexual assault. It is culturally distinct due to its large Yup'ik population. Communities in this area are geographically and culturally closer to Bethel than Wasilla, the current region's headquarters. These communities represent off-road, small and rural communities and villages.

OCS believes having a fifth service region headquartered in Bethel could result in an increase in local knowledge of families; familiarity with the available service array; an increase in cultural competency of OCS staff; better support, retention, supervision and management of OCS staff; a savings in OCS travel expenses; and improved outcomes for children and families in the region.

While the CRP has created considerable public support for this area of the state standing as its own region, it is important to note that this recommendation is contingent upon other State of Alaska priorities.

Recommendation 3 - Supporting and developing the relationship between OCS & ICWA (Indian Child Welfare Act) workers.

The OCS agrees wholeheartedly with this recommendation. It is precisely our intent to continue to collaborate with tribal agencies to best serve Native Alaskan children and families. For several years OCS and tribes (Tribal State Collaboration Group) have come together three times a year to meet, discuss and plan our collaborative work to improve outcomes for Native Alaskan children in the state's custody. TSCG addresses all policies related to the Indian Child Welfare Act (ICWA) and state compliance with ICWA.

In the past several years, both OCS and tribes have agreed on the value of cross training and have begun to invite one another to training as a means of increasing collaboration, shared education experiences and improved cultural competency of state staff. One example of such training is "Knowing Who You Are" (KWYA) training. Please see <http://www.casey.org/Resources/Initiatives/KnowingWhoYouAre/> for more information about the specific 3 phase training that has been mandated for all OCS staff involved in child and family decision making.

Most evident of the commitment by OCS to collaborate with tribes is the work of the Federal Western and Pacific Child Welfare Implementation Center (IC). In April of 2009, Central Council of Tlingit and Haida Indian Tribes of Alaska, together with 15 other Alaska Tribal Organizations, applied for and received an award of assistance to further TSCG's efforts related to disproportionality within the state child welfare system. The IC will assist tribes, OCS and the Court System to develop a targeted strategy and action plan for addressing long term systematic change with a keen focus on several crucial issues impacting Native families who come to the attention of OCS.

Additionally, last year, state and tribal work expanded to include working together on child maltreatment prevention, in that an Alaskan Team was selected to attend a National PREVENT conference to develop culturally competent strategies related to reducing the rates of child maltreatment in the Native communities in Alaska.

The OCS continues to develop and support ways to empower tribes to intervene with families before an OCS intervention is warranted and to be involved in an Alaskan Native family's OCS intervention from the very beginning. Given the past history of state involvement with tribes, this work will be ongoing and critically reviewed to assure improvement in communication, trust and outcomes for families.

Recommendation 4 - OCS should explore any and all means to relieve social workers of some of their paperwork burden.

Like most of the challenges facing Alaska's Child Protective Services (CPS) caseworkers, the paperwork aspect of the job is an area of concern for CPS workers in many other states. CPS management across the nation strives to balance the necessity of meaningful family contact with the requirements of documentation and reporting a type of public service that is subject to legal review and strict federal funding rules. The OCS completely agrees with the recommendation that caseworkers should be spending as much of their time as possible with the children and families they serve. We will continue to explore and implement ideas that can decrease time spent on administrative duties and increase the time our staff spends doing work in the field with families.

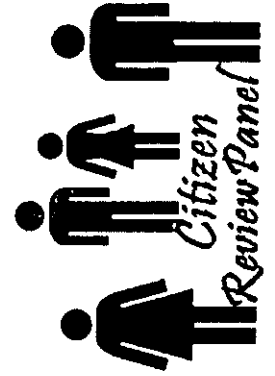
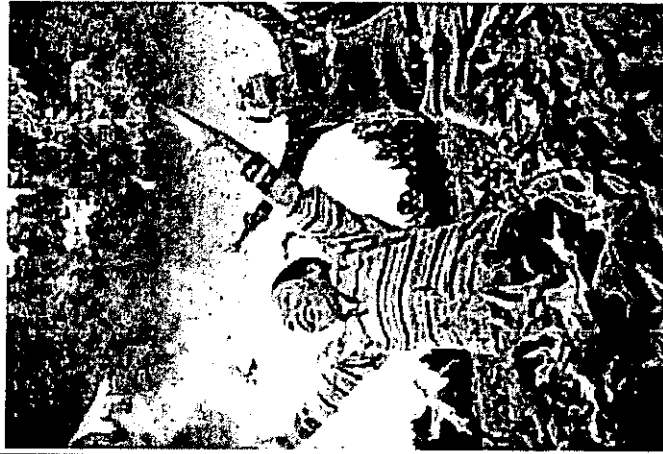
Transcription services or 'dictation services', as referenced in CRP report, was being utilized throughout the OCS Anchorage, Fairbanks, Ketchikan, Kenai, Wasilla, Homer and Unalaska offices during 2009. On average, approximately 32 caseworkers used the service each month. The availability of transcription services is explained to all new caseworkers when they attend the new employee orientation training provided by the UAA Family & Youth Services Training Academy. To increase transcription services usage in 2010, OCS management intends to focus on a promotional effort by identifying super-users of the service and asking them to deliver presentation and training opportunities to their peer groups. (As a side note to the dictation services issue, the Juneau OCS has also been using the transcription product Dragon Speak and the Fairbanks OCS recently started piloting this tool as well.)

In another effort to help caseworkers better manage the administrative requirements of their job, as noted above, the OCS distributed Netbooks to our Bethel, St. Mary's and King Salmon offices in October of 2009. These mini laptops will allow staff to access their State of Alaska e-mail accounts and word-processing applications while in travel status or otherwise away from their office computers. This tool is expected to help caseworkers maximize the hours in a work day, decreasing the amount of work waiting for them when they return to their desks and thereby increasing the amount of time available to them to make family contacts. The original distribution of Netbooks is being considered a pilot project. If implementation is deemed successful, the OCS intends to purchase more Netbooks and deploy this tool to all rural offices across the state.

The OCS agrees that having more Social Services Associates (SSA) would greatly assist the front line worker in completing their plethora of tasks; however, new appropriations are determined through the Governor's priorities and the will of the legislature. In lieu of no new proposed positions in the upcoming fiscal year, OCS will continue to review its staffing and workload levels around the state and propose current position relocations or reassignment of tasks between job positions if deemed necessary to manage workload.

In summary, OCS continues its efforts to change the culture and improve the practice of CPS work in Alaska. Systems reform will continue during 2010 and each year thereafter. Recruitment of quality staff, their development, and the support they're provided remains a top priority. We recognize that the safety of many children and the strength of many families are reliant upon our ability to retain the most competent of staff and provide the most effective of services Alaska has to offer.

Alaska's Citizen Review Panel



Our focus areas today will be:

- To provide a brief overview of the Citizen Review Panel & to highlight our activities since last year
- To share with you what we hear about the Office of Children's Services
- To ask you to help improve the situation



Mandate for the Group

The Citizen Review Panel is mandated by state and federal law. The CRP was created through the federal Child Abuse Prevention & Treatment Act (CAPTA); Keeping Children & Families Safe Act of 2003 and through Alaska statute Sec. 47.14.205.



CRP Vision

To enable the Office of Children's Services to implement its policies and procedures in a culturally sensitive and consistent manner across the state.



Who are we?

The CRP is composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect. The group chooses its own members.



Current members

- Fred VanWallinga,
Willow (Chair)
- Carol Olson,
Anchorage (Vice-
Chair)
- Pamela Dupras,
Kodiak
- Dana Hallett,
Soldotna
- Art Hansen,
Fairbanks
- Susan Heuer,
Anchorage
- Kristin Hull, Wasilla
- Ralph Taylor,
Anchorage (currently
deployed with the
Alaska National
Guard)



CRP Duties

Evaluate Office of Children's Services (OCS) compliance with federal and state laws, examine the policies, procedures and practices of OCS, and, where appropriate, evaluate specific cases of child abuse or neglect.



CRP Duties (continued)

The CRP must also:

- Maintain confidentiality
- Conduct public outreach
- Produce an annual report
- Meet at least quarterly



Our focus for the past year

- Potential for additional 5th service region
- Improving situation in Copper River Basin



What we've been doing

- Holding monthly teleconferences
- Produced an annual report
- Attended the Alaska Native Indian Child Welfare Summit
- Attended national Citizen Review Panel conference in Minnesota
- Meeting in-person quarterly



What else we've been doing

- Meeting with OCS partner agencies
- Meeting with OCS staff from Director Sandoval to line workers
- Participated in the federal Child and Family Services Review
- Met with UA staff responsible for OCS training
- Meeting with the Commissioner and Legislators



A couple more things we did

- Attended the Family to Family Conference
- Attended the Community Care Conference
- Heard from concerned citizens
- Received training on safety assessment



Where some of us have been

- Aniak
- Bethel
- Copper Center
- Dillingham
- Fairbanks
- Glennallen
- Juneau
- King Salmon
- Naknek
- St. Mary's
- Unalaska



We've met with...

- Counseling center staff
- District attorneys
- Foster parents
- Health aides & public health nurses
- ICWA workers
- Local police departments
- OCS staff
- School principals, nurses & counselors
- State troopers
- Tribal representatives
- WIC workers



OCS is improving due to...

- Key personnel changes
- System changes—safety assessment, expanded training, ORCA programming improvements
- Increased collaboration with partnering state agencies (DJJ, Dept. of Law, etc.)



OCS is improving due to...

- Continued and increased financial support from Legislature during past couple fiscal years
- Responsive to outside recommendations (ACTION for Children, CRP, federal audit)



Issues of concern

- Hiring freeze
- Region 5
- Many solutions to problems are beyond the control of OCS, Director lacks discretion
- Standardization



Issues of concern

- Hiring freeze

OCS is public safety like the Troopers in as much as they have a protective function

In rural areas, workers are already stretched, further unfillable vacancies with no end in sight will directly affect child safety

Increased risk of current workers leaving due to work overload



Issues of concern

- Region 5
 - Last year we strongly advocated for Region 5 based on Bethel community support
 - SCRO has 13 offices, next largest region has 7
 - OCS costed-out Region 5 for \$1.5 million, but the region was not in the Governor's budget



Issues of concern

- Region 5
 - Bethel OCS and community partners continue to support this idea, but other communities have concerns
 - Over the next year, the CRP will intensively survey all Southwestern Alaska field offices and community partners
 - We continue to think that a smaller more culturally focused region is in the best interest of children



Issues of concern

- Many solutions to problems are beyond the control of OCS, Director lacks discretionary powers



Issues of concern

- Standardization of supports for employees varies between state agencies
 - Housing
 - Internet



We'd like your help to address these concerns

- Support the exemption of OCS from hiring freeze and issuance of immediate variances
- Investigate and resolve the lack of standardization between state agencies



Benefits of CRP

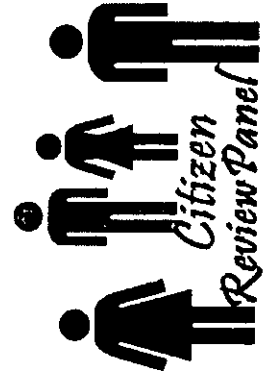
- Seven volunteer members all contributing a minimum of 250 active hours annually
- We're the eyes and ears of the public for the Legislature and OCS
- Unique function of identifying and advocating for ancillary services that OCS cannot request
- Jointly we can achieve a vastly improved child protection system for the children of Alaska



Alaska's Citizen Review Panel

For more
information,
please visit our
website

www.crpalaska.org



**OVERVIEW:
FEDERAL
HEALTH
CARE
REFORM
LEGIS.**

Overview of Federal Health Care Reform Legislation

Deborah Erickson
Department of Health & Social Services
March 30, 2010

03-30-10 DRAFT

1

Status

- P.L. 111-148: The Patient Protection & Affordable Health Care Act (H.R. 3590)
 - H.R. 3590 (health care reform legislation initially passed by the U.S. Senate last December)
 - Date of enactment: March 23, 2010

- H.R. 4872: The Health Care and Education Reconciliation Act
 - Contains the House changes to H.R. 3590
 - Passed Congress March 25, 2010
 - To be signed by the President today (March 30)

03-30-10 DRAFT

2

Status

- At the direction of the Governor, Alaska's AG is currently conducting a legal review of the new federal law
- A state executive branch interagency team is beginning work on policy review and impact analysis of the law
- The legislature will be involved in any decision regarding state implementation of any provision of the federal law that requires
 - A new state law
 - A state appropriation

03-30-10 DRAFT

3

Caveats & Disclaimers

- This presentation is a high-level overview of some key provisions and is not comprehensive
- Many of the details needed to support impact analyses and implementation planning are unknown:
 - Anticipate more than 100 pages of new federal regulations, program guidance, and grant guidance for each page of the new law

03-30-10 DRAFT

4

Overview of Legislation

- Health Care Coverage (Titles I & II)
- Health Care Delivery (Title III)
- Prevention and Public Health (Title IV)
- Health Care Workforce (Title V)
- Fraud, Waste, and Abuse (Title VI)
- Medical Technology (Title VII)
- Community Living Assistance (Title VIII)
- Taxes and Fees (Title IX)
- Amendments (Title X)

03-30-10 DRAFT

5

Health Care Coverage Overview

- Insurance Market Reforms
- Health Insurance Exchange
- Medicaid Expansion
- New Insurance Programs
- Individual Requirements & Subsidies
- Employer Requirements & Subsidies

03-30-10 DRAFT

6

Health Care Coverage

■ Insurance Market Reforms

- Exclusions for pre-existing conditions prohibited
 - For children in 2010
 - For adults in 2014
- Dependent coverage extended to 26 years of age (2010)
- Annual and lifetime limits prohibited (2010)
- Prohibition on rescissions (2010)
- Guaranteed issue and renewal rules (2014)
- Adjusted community rating rules limit variations in premiums to geographic area, tobacco use, age, and family composition (2014)
- Gender discrimination prohibited

03-30-10 DRAFT

7

Health Care Coverage

■ Health Insurance Exchange (2014)

- State-based; Multi-state option
- For individuals and small business (<100 employees)
 - Large businesses allowed to participate starting 2017
- Federal grants to states for planning and implementation (2010)
- Administered by gov't agency or non-profit
- Self-sustaining
- State opt-out provision
 - Federal government required to establish Exchanges for states that opt out

03-30-10 DRAFT

8

Health Care Coverage

- Medicaid Expansion (2014)
 - Eligibility expanded to all individuals under 65 (including childless adults) up to 133% FPL
 - Maintenance of effort requirement:
 - Effective as of March 23, 2010
 - States prohibited from reducing eligibility standards
 - For adults: Until Exchange is operational
 - For children: Until 09/30/2019
 - State option to implement expansion immediately without waiver (at state's FMAP rate until 2014, then enhanced)

03-30-10 DRAFT

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Health Care Coverage

- Medicaid Expansion *(continued)*
 - Enhanced FMAP for expansion population
 - 2014 – 2016: 100% Fed
 - 2017: 95% Fed
 - 2018: 94% Fed
 - 2019: 93% Fed
 - 2020 and beyond: 90% Fed

03-30-10 DRAFT

10

Health Care Coverage

■ Medicaid Expansion *(continued)*

- Alaska's Projected Cost for Newly Eligible and Enrolled with Projected # of New Enrollees

Federal Fiscal Year	# of "Expansion" Enrollees	FMAP	State GF Cost
2014	23,467	100% Fed	\$0
2015	23,584	100% Fed	\$0
2016	23,702	100% Fed	\$0
2017	23,821	95% Fed	\$5.5 million
2018	23,940	94% Fed	\$7.0 million
2019	24,059	93% Fed	\$8.7 million
2020	24,179	90% Fed	\$13.2 million

03-30-10 DRAFT

11

Health Care Coverage

■ New Insurance Programs

- High-risk health insurance pool (feds may contract with states) (2010)
- Multi-state health plans created (under contract with private insurers by OPM)
- Health Care Cooperatives: Non-profit member-operated health insurance companies created through loans and grants

03-30-10 DRAFT

12

Health Care Coverage

■ Individual Requirements & Subsidies

– Requirements (2014)

- Choice between having a qualified health plan or paying a tax penalty
 - Tax penalty \$695/year (Family capped at 3x individual penalty (\$2,085)) or 2.5% of household income, whichever is greater (phased in)
 - Exemptions include
 - Financial hardship
 - Religion
 - American Indians/Alaskan Natives
 - Lowest cost option exceeds 8% of income

03-30-10 DRAFT

13

Health Care Coverage

■ Individual Requirements & Subsidies

– Subsidies (eff. 2014)

- Premium Credits
 - Refundable/Advanceable credits for purchase of insurance through the Exchange
 - Individuals/families with incomes between 133%-400% FPL
 - Amounts tied to cost of plan and set on sliding scale based on income level
- Cost Sharing Subsidies
 - Individuals/families between 100% - 400% FPL

03-30-10 DRAFT

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Health Care Coverage

■ Employer Requirements & Subsidies

– Requirements (effective 2014)

- < 50 employees: Exempt
- > 50 employees - if 1 or more employee receives subsidy:
 - And employer does not offer coverage, employer required to pay fee of \$2,000/FTE (1st 30 FTEs excluded)
 - And employer provides coverage, employer required to pay fee of \$750/FTE or \$3,000 per subsidized employee (whichever is less)
- > 200 employees: Required to provide insurance
- Provide voucher to employees with incomes less than 400% FPL who chose to participate in Exchange
- Report value of health care benefits on employees' W-2 (2011)

03-30-10 DRAFT

15

Health Care Coverage

■ Employer Requirements & Subsidies

– Subsidies (phased in beginning 2010)

- < =25 employees: Tax credits (for businesses with average annual wages < \$50,000)
- Temporary Reinsurance Program (2010)
 - For employers (including state & local gov) offering health insurance to early retirees (aged 55-64)
 - Will reimburse employers 80% of retiree claims between \$15,000 and \$90,000 until 2014

03-30-10 DRAFT

16

Health Care Delivery

- Evidence-Based Practice (Comparative Effectiveness Research)
- Quality Improvement (National Strategy)
- Care Coordination and Service Integration
- Primary Care Enhancement
 - Medicare 10% bonus to primary care physicians (2011–2015)
 - Medicaid Medical Home State Plan Option (90% FMAP for two years) (2011)
 - Increase Medicaid payment to Medicare rate (n/a in AK)
- Payment Reform
 - Bundled payments (Medicare Pilot; Medicaid Demonstration)
 - Medicare Pay-for-Performance Program

03-30-10 DRAFT

17

Prevention & Public Health

- National Prevention Council and Fund
- Coverage of clinical preventive services
- Nutrition labeling on menus
- Community wellness grants
- Healthy lifestyles program incentives for Medicare and Medicaid enrollees

03-30-10 DRAFT

18

Health Care Workforce

- National HC Workforce Commission
- Health care workforce assessment
- Recruitment and retention programs
- National Health Service Corps increased
- Training and education programs
 - Redistribute GME (graduate medical ed) slots

03-30-10 DRAFT

19

Fraud, Waste & Abuse

- New provider enrollment processes for Medicare and Medicaid
- Data sharing across federal programs
- Financial disclosure of financial relationships between health entities
- Increased penalties
- Providers required to implement compliance program
- Demonstration grants to states for medical malpractice reform

03-30-10 DRAFT

20

Community Living Assistance

- New long-term care insurance program (2011)
 - Voluntary
 - 5-year vesting
 - Cash benefit to help aged/disabled stay in home or cover nursing home costs

03-30-10 DRAFT

21

Taxes & Fees

- 10% sales tax on indoor tanning (2010)
- \$2.8 billion annual fee on pharmaceutical industry (2012; increasing over time)
- 2.3% sales tax on medical devices (2013)
 - Glasses, contacts, hearing aids exempt
- Medicare payroll tax increased from 1.45% to 2.35% for individuals >\$200K and couples >\$250K (2013)
- New 3.8% tax on unearned income for individuals >\$200K and couples >\$250K (2013)
- Tax deduction for employers receiving Medicare Part D retiree subsidy eliminated (2013)
- \$8 billion annual fee on health insurance industry (2014; increasing over time)
- Tax on employer-sponsored high-value insurance plans (2018)

03-30-10 DRAFT

22

Other Provisions

- Enhanced funding for Community Health Centers
- Medicare Doughnut Hole Closure
- Medicare Funding Reductions
- Coordinated Health Care Office
- Indian Health Care Improvement Act
 - Adds long term care and behavioral health services

03-30-10 DRAFT

23

Timeline Highlights for States

- 2010
 - Medicaid Maintenance of Effort imposed (March)
 - Temporary high-risk insurance pool program established (June)
 - Temporary re-insurance program for early retirees established (June)
 - Feds establish website to facilitate insurance information (July)
 - Grants to states for
 - Exchange planning and implementation
 - Assistance with insurance premium review requirements
 - Establishing an office of health insurance consumer assistance
 - Smallest employers (<25) eligible for tax credits
 - Insurance Market Reforms Implemented
 - Pre-existing condition exclusion prohibited for children
 - Lifetime and annual limits prohibited
 - Prohibition on rescission of coverage
 - Preventive services coverage required
 - Dependent coverage to 26 years of age
 - Medical loss ratio reporting required

03-30-10 DRAFT

24

Timeline Highlights for States

■ 2011

- Medicaid
 - States eligible for 1% FMAP increase if certain preventive services covered with no cost-sharing
 - Required to cover tobacco cessation for pregnant women
 - New state option for home and community-based services for disabled
- Insurance Market Reforms
 - Required to spend 85% of premium revenue on medical claims (80% for insurers covering small business)

■ 2013

- States must notify U.S. DHHS regarding intent to establish Exchange
- Fed regs for health care choice compacts issued
- States eligible for 23% FMAP increase to regular CHIP match (up to 100%) until 2019

03-30-10 DRAFT

25

Timeline Highlights for States

■ 2014

- Insurance Exchanges implemented
- State Medicaid
 - Expansion to 133% FPL takes effect
 - Required to implement enrollment simplification and coordination with Exchanges
 - Required to offer premium assistance for employer-sponsored insurance
 - DSH funding reduced
 - Prohibition on exclusion of coverage for barbiturates, benzodiazepines, and tobacco cessation products
- States required to establish at least one reinsurance entity
- Insurance Market Reforms Implemented
 - Pre-existing condition exclusion prohibited for adults
 - Guaranteed issue and renewal required
 - Adjusted community rating rules take effect
- Individual and employer mandates and subsidies implemented

03-30-12 DRAFT

26

Timeline Highlights for States

- 2015
 - Insurance Exchanges must be self-sustaining
 - Medicaid programs required to begin annual enrollment reporting
- 2016
 - Health Care Choice Compacts may take effect
- 2017
 - States will begin funding share of Medicaid expansion
 - States may operate an alternative program in lieu of federal coverage reforms if waiver obtained in previous year
 - States may allow large companies (>100 employees) to participate in Exchange
- 2018
 - Excise tax on high-value health insurance plans imposed

03-30-10 DRAFT

27

CONFIRMA- TIONS 2009

WILLIAM H. HOGAN
P.O. Box 3896 Palmer, Alaska

William.Hogan@alaska.gov

EDUCATION

- 1991 Virginia Commonwealth University, Richmond, VA
Doctoral Work – Sociological Theory
- 1979 – 1980 West Virginia University, Morgantown, WV
Graduate – Master of Science in Social Work (MSW)
- 1976 – 1979 Syracuse University, Syracuse, NY
Graduate Course Work
- 1967- 1971 State University of New York at Buffalo, Buffalo, NY
Undergraduate – Bachelor of Arts in Sociology (B.A. Soc.)

PROFESSIONAL EXPERIENCE

2008-Current Alaska Department of Health and Social Services; Anchorage, Alaska – Commissioner –

Has authority and responsibility for all aspects of the department including policy development, planning, program and service delivery, finance and budgeting, information technology and statutory and regulatory compliance. The department is considered a “super agency” comprised of the Divisions of Public Health, Behavioral Health, Juvenile Justice, Public Assistance and Senior and Disabilities Services as well as the Office of Children’s Services and the Alaska Pioneer Homes. In addition the department provides oversight and financing (Medicaid and state grants and contracts) of all health facilities through its Division of Health Care Services.

The department currently employs over 3600 staff and has a budget of \$2.1 billion.

2005-2008 Alaska Department of Health and Social Services; Anchorage, Alaska – Deputy Commissioner, Family, Community and Integrated Services –

Had oversight responsibility for the Divisions of Public Assistance, Behavioral Health, Juvenile Justice, Senior and Disability Services, Office of Children’s Services (Child Welfare) and the Alaska Pioneer Homes (Long Term Care). In addition was the primary liaison with the Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, Governor’s Council on Special Education and Disabilities, Suicide Prevention Council and the Council on Domestic Violence and Sexual Assault. Also provided supervision to the Office of Faith Based and Community Initiatives.

In conjunction with directors, ensured each entity or agency met or exceeded performance goals while maintaining alignment with overall department vision, mission and values.

2003-2005 Alaska Department of Health & Social Services, Division of Behavioral Health; Juneau, Alaska - Director

Was responsible for directing, planning, organizing and managing statewide programs for mental health and substance abuse (behavioral health). Formulated policy for community mental health services, the state psychiatric center and community programs for those experiencing substance abuse problems. Monitored program performance, reviewed and evaluated existing policies, procedures, statutes, regulations and recommended changes as appropriate. Oversaw all Division program and policy functions, coordinated administrative and financial activities with other components of the Department and designed and implemented the Division's performance management program. Oversaw the integration of the mental health and substance abuse service delivery system (behavioral health) as well as the development and implementation of the "Bring the Kids Home" Initiative. This initiative, designed to bring Alaskan kids with a serious emotional disturbance back to the state from out of state Residential Psychiatric Treatment Centers – and to keep kids in Alaska - by building a comprehensive system of care and proactively managing care – is considered a model program. Developed the conceptual framework for the creation of Regional Behavioral Health Authorities designed to manage care for all behavioral health services provided to Seriously Emotionally Disturbed (SED) Children and Seriously and Persistently Mentally Ill (SPMI) adults. The Division of Behavioral Health has 320 staff with a budget of \$275 million.

1998-2003 Life Quest, Wasilla, Alaska – Chief Executive Officer – Was responsible for designing, developing, implementing and managing all prevention, treatment and rehabilitation services in a private not for profit community mental health center. The organization served over 1200 individuals annually in a geographic area comparable to the size of the state of West Virginia. The agency employed 150 staff with a budget of \$6.5 Million.

1997-1998 National Association of Social Workers, New York State Chapter, Albany, NY – Executive Director – Served as chief executive and was responsible for planning, organizing, directing, and implementing all chapter programs and activities. Had management responsibility for all administrative, financial, human resource, marketing, and educational functions. The New York Chapter was the largest of all NASW Chapters with approximately 12,500 members.

1993-1997 Southwest Mississippi Mental Health (SWMMH) Complex, McComb, MS – Executive Director – Responsible for directing, planning, coordinating, operating, and monitoring all mental health, developmental disabilities services and substance abuse programs within ten counties of Mississippi. Served as Chief Executive Officer of the SWMMH Commission and President of the SWMMH Foundation. Was administratively responsible for the supervision of 200 staff members and consultants, and a \$6.5 million annual budget. Was instrumental in preparing Mississippi mental health providers for Medicaid Managed Care through the creation of a community mental health provider network.

1986-1993 Colonial Community Services Board, Williamsburg, VA – Coordinator – Planned and coordinated mental health and substance abuse prevention, treatment, and rehabilitation services in York County and the City of Poquoson, Virginia. Supervised 12 staff members and consultants. Maintained a caseload of 50 clients.

1987-1993 Systemetrics – Medical Record Reviewer/Analyst – Responsible for reviewing both care coordination and mental health records in outpatient, residential and acute inpatient settings in the first mental health managed care program undertaken by the Dept. of Defense.

1990-1993 Catholic Charities of Hampton Roads, Virginia Beach, VA – Private Practitioner – Provided individual, couple, and family therapy in a managed care environment. Member of managed care provider panel. Experienced obtaining preauthorization for services and complying with all managed care requirements.

1990-1993 Virginia Commonwealth University, Richmond, VA – Adjunct Faculty Member – Supervised graduate-level students.

1984-1986 Essex County Community Services Board, Elizabethtown, NY – Director – Planned, coordinated, and served as chief executive of mental health and substance abuse prevention, treatment, and rehabilitation programming in Essex County, N.Y. Supervised 28 staff members.

1982-1984 Appalachian Mental Health Center, Developmental Disabilities Program, Elkins, WV – Director – Developed, directed, and coordinated services for developmentally disabled children and adults in four counties in West Virginia. Supervised a staff of 26.

1980-1981 Appalachian Mental Health Center, Barbour County, Philippi, WV – Director – Coordinated and ensured the delivery of mental health and substance abuse services to county residents. Maintained a caseload of 35 clients and supervised a staff of 12.

1979 West Virginia University Center for Extension and Continuing Education, Morgantown, WV – Graduate Social Work Intern – Facilitated the planning and implementation of the Cooperative Extension Leadership Development Program, which included program-evaluation mechanisms, project planning, and grant writing

1979 Summit Center for Human Development, Clarksburg, WV – Graduate Intern and Staff Member – Developed and implemented a primary prevention project in a small mining community. Involved grant writing, developing and conducting needs-assessment surveys, organizing community education programs, and revitalizing the Harrison County Mental Health Association.

1975-1978 Oswego County Community Mental Health Center, Oswego, NY – Social Work Assistant – Developed community support programs for long-term psychiatric

clients. Acted as the liaison to state hospitals and provided case-management services to 50 clients.

PUBLICATONS AND PRESENTATIONS

Mental Health in Rural Alaska-What's Different. Party Lines, a publication of the National Association for Rural Mental Health, Summer 1999 edition.

Collaborative Services and Professional Roles for Non-Psychiatrists. Presented at the 1997 Primary Care/Behavioral Healthcare Summit, The Leadership Forum on Integrating Behavioral Healthcare and the General Medical Sector in Chicago, Illinois.

Grief and Death Issues: Working with Families Having Medically Fragile and Terminally Ill Children. Presented at the 1995 Mississippi Department of Human Services Regional Conference in McComb, Mississippi.

Successful Mental Health Program Development for Children in a Small Community. Presented at the 1987 Virginia State Social Work Conference in Williamsburg, Virginia and the 1988 National Council of Community Mental Health Centers Annual Meeting in Boston Massachusetts.

Protecting and At-Risk Disabled Adult in the Community. Presented at the 1983 Behavioral Health Conference at West Virginia University in Morgantown, West Virginia.

The Development of a Good-Neighbor Program: Using Local Resources as Federal Funds Disappear. Presented at the 1982 Behavioral Health Conference at West Virginia University in Morgantown, West Virginia.

Rural Psychiatric Rehabilitation: Effective Techniques in Selecting, Monitoring, and Evaluation the Progress of State Mental Health Clients in the Community. Presented at the 1979 National Council of Community Mental Health Center Annual Meeting in Washington, D.C.

Development of a Rural Psychiatric Aftercare Group, in the Psychosocial Rehabilitation Journal, Volume 2, Number 1, 1978.

References

Mr. Jeff Jessee, Chief Executive Officer, Alaska Mental Health Trust Authority;
Anchorage, Alaska. 907-269-7963. jeff.jessee@alaska.gov

Mr. Joel Gilbertson, Vice President, Providence Health Systems; Anchorage, Alaska.
907-743-2784. Joel.Gilbertson@providence.org

Mr. Rod Betit, Chief Executive Officer, Alaska State Hospital and Nursing Home
Association; Juneau, Alaska. 907-586-3881. rodbetit@msn.com



Official Business

Alaska State Legislature

House of Representatives


Office of the Chief Clerk

State Capitol, Room 216
Juneau, AK 99801-1182
Phone: (907) 465-3725
Fax: (907) 465-5334

MEMORANDUM

Date: February 4, 2009

To: Representative Herron, Co-Chair
Representative Keller, Co-Chair ✓
Health and Social Services Committee

From: Suzi Lowell 
Chief Clerk

Subject: Governor's Appointment(s)

The Speaker referred the following Governor's appointment(s) to the Health and Social Services Committee:

Commissioner – Department of Health and Social Services

William H. Hogan
Appointed: 7/24/2008

State Medical Board

Edward A. Hall – Anchorage
Appointed: 5/19/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Casey M. Millar – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. David A. Miller -- Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2012

Dr. David J. Powers – Dillingham
Appointed: 12/2/2008 Term Expires: 3/1/2012

The Referral for Confirmation page(s), resume(s), and a signature page are attached for your use.

Attachments as noted

CURRICULUM VITAE

DAVID A. MILLER, MD, FACS

OFFICE ADDRESS: Alaska Minimally Invasive Surgery Center
3268 Hospital Drive, Suite C
Juneau, AK 99801 (907) 586-4126

PERSONAL:

EDUCATION: Leavenworth High School 1981
Leavenworth, Kansas

B.S. Chemistry 1985
University of Kansas
Lawrence, KS

M.D. Allopathic Medicine 1989
University of Kansas School of Medicine
Kansas City, KS

POST-GRADUATE Internship - General Surgery 1989-1990
Keesler Medical Center
Keesler AFB
Biloxi, MS

Residency - General Surgery 1990-1994
Keesler Medical Center
Keesler AFB
Biloxi, MS

BOARD QUALIFICATIONS: Board Certified and Diplomate of 1995-present
The American Board of Surgery

LICENSURE: State of Alaska #4283 Exp. 12/31/08

PROFESSIONAL AFFILIATIONS: American College of Surgeons 1996-present
Society of Laparoendoscopic Surgeons 2000-present
Society of Air Force Clinical Surgeons 1994-2001
38th Parallel Medical Society 1994-2001

PUBLICATIONS: H-Type Tracheoesophageal Fistula Repair,
41st Annual Symposium, Society of Air Force
Clinical Surgeons, San Antonio, TX 1994

TEACHING APPOINTMENTS:	Instructor, Advanced Laparoscopic Workshop 38 th Parallel Medical Society Seoul, Korea	1994
	Instructor, Advanced Laparoscopic Procedures National Hospital Columbo, Sri Lanka	1999
MILITARY SERVICE:	Air Force ROTC Scholarship University of Kansas, Lawrence, KS	1981
	Air Force Health Profession Scholarship University of Kansas, Kansas City, KS	1985
	Surgical Resident Keesler AFB, Biloxi, MS	1989-1994
	General Surgeon 51 st Medical Group, Osan, Korea	1994-1995
	General Surgeon 3 rd Medical Group, Elmendorf AFB Anchorage, AK	1995-2001
HONORS AND AWARDS:	Eagle Scout	1976
	National Honor Society	1980
	Kansas Honor Student	1981
	Vocal Scholarship, University of Kansas	1981
	Tuba Scholarship, University of Kansas	1981
	Air Force ROTC/Health Profession Scholarship	1981-1989
	Dean's Honor Roll	1981
	Sons of the American Revolution Award	1982
	Vice Commandant's Award	1983
	General Dynamics Award	1984
Honors Research in Chemistry	1985	
COMMUNITY SERVICE:	Assistant Scout Master, Boy Scouts of America	1981-1988
	Surgical Orderly, Cushing Memorial Hospital Leavenworth, KS	1980-1983
	Host Family Special Olympics World Winter Games	2001

PERFORMING ARTS:

<i>Bass Soloist with Symphony</i>	Leavenworth, KS	1981-1987
<i>Orchestra and Chorus:</i>	Lawrence, KS	1981-1985
	Biloxi, MS	1989-1994
	Anchorage, AK	1996-2000
	Juneau, AK	2008
<i>Operatic Roles:</i>	Figaro, <i>The Barber of Seville</i>	2005
	Leporello, <i>Don Giovanni</i>	2006
	Papageno, <i>The Magic Flute</i>	2007
	Gaston, <i>Beauty and the Beast</i>	2007
	Scarpia and Angelotti, <i>Tosca</i>	2007
	Morales, <i>Carmen</i>	2008
	Talpa, <i>Il Tabarro</i>	2008
	Simone, <i>Gianni Schicchi</i>	2008

147392

CURRICULUM VITAE

DAVID J. POWERS, M.D.
P.O. BOX 324
DILLINGHAM, AK 99576
(907) 842-5201 EXT. 6218 (HOSPITAL) --
(907) 842-1028 (HOME)

EDUCATION:

College: 1974-1978, Northwest Nazarene College, Nampa, Idaho
Degree: BA Biology, Minor in Chemistry
Honors: Freshman Chemistry Student Award
Senior Biology Student Award
Salutatorian of 1978 graduating class
Received academic scholarship Sophomore, Junior, Senior years

Medical School: 1979-1983, Oral Roberts University School of Medicine
Degree: M.D.
Honors: Graduated upper 1/3 of 1983 graduating class

PGY I: July 1983 – July 1984, Family Practice Internship at A.H. Gould, Family Practice Residency Program, University of Colorado Affiliated, Grand Junction, Colorado

PCY II & III: July 1987 – July 1989, Family Practice Residency of Idaho, Boise, Idaho

Certification: Board Certified, American Board of Family Practice
2003-2010

OCCUPATIONAL EXPERIENCE:

1994- Present Kanakanak Hospital, P.O. Box 130 Dillingham, AK 99576, Staff Physician. Currently Clinical Director

1992 – 1994 Emergency Room Physician, Boise, Idaho

1990 – 1992 Kanakanak Hospital, P.O. Box 130, Dillingham, AK 99576, Staff Physician.

1989 – 1990 Locum Tenens and Emergency Room work

1987 – 1989 Completed Residency Training, Family Practice Residency of Idaho, Inc., Boise, ID

1986 – 1987 Indian Health Service, Juneau, AK, General Practice

1984 – 1986 Alaska Native Medical Center, Anchorage, AK, General Medical Officer, Orthopaedics

Edward A. Hall
Physician Assistant-Certified
13601 Windward Circle
Anchorage, AK 99516
(907) 345-9365

Work History

August 2001-Present: Beacon Occupational Health and Safety Services, Anchorage, Alaska

-Provide family practice and occupational health care to private patients and contract clientele. These include all aspects of family practice healthcare, including travel medicine, pre-hire physicals, post offer/pre-hire assessments and work comp follow-ups. Also serve as Clinic Manager.

June 1994-August 2001: Primary Care & Associates, Anchorage, Alaska

-Provided family practice health care as well as occupational physical assessments and work comp follow ups. Care included all aspect of family practice medicine.

January 1990-June 1994: Kaiser Permanente, San Diego, California

-Health Appraisal Clinic-provided complete review of systems, physical assessments and appropriate referral for follow-up evaluations of health care members.

Education

-Emory University- Atlanta, Georgia- PA and Master of Medical Science Degree, 1990: 8 monthly required clinical rotations with 5 one month elective rotations, which included general surgery, orthopedics and trauma surgery rotations
-California State University Sacramento: BS-Biology-1979

Certifications/Licenses

- Alaska State PA License-AK 329
- National Commission Certification of Physician Assistants (NCCPA) since 1990
- Member Alaska Academy of Physician Assistants
- Breath Alcohol Technician Certified (BAT)
- Certified in Drug Collection
- DEA License MHO337964

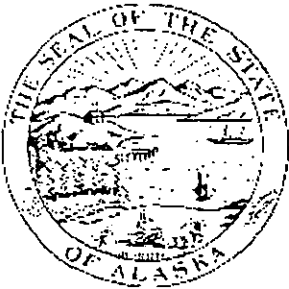
Affiliations

- PA Member Alaska State Medical Board since 3//05
- Work Comp Review Committee for State of Alaska

Social

Married, four children ages 17,19,21,23

References available upon request.



STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Medical Board, public seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Casey (Kathleen) M. Miller
Mailing Address: 15801 Windsong Dr.
Residence Address: " "
City, State and Zip Code: Anchorage, AK 99516
Home or Message Telephone: 907-522-2251 Business Telephone: _____
Fax Number: 2 Cell Phone: _____
Email address: millar@gci.net

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?

YES NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

See attached

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

1-1 1'

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

*Volunteer server @ the Anchorage Rescue Mission
Volunteer hosting weekly staff meetings for
YoungLife - Alaska*

D. Employment work history - paid, unpaid or voluntary: (Use additional paper of necessary).

See attached

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE MALE _____

ETHNICITY:
Alaska Native _____ American Indian _____ Asian or Pacific Islander _____ Black _____ Hispanic _____ White

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): *Casie (Kathleen) Mida* Date: *11-25-08*

Please attach a current resume with your application.



STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Cady (Kathleen) Miller

Date: 11-25-08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

Accounting Board
Aerospace Development Corporation
Aging Commission
Agriculture & Conservation
Alaska Juvenile Justice Advisory Committee
Alaska Retirement Management Board
Alaska Statehood Celebration Commission
Alaska-Alberta Bilateral Council
Alcohol/Drug Abuse
Alcoholic Beverage Control
Architects/Engineers/Land Surveyors
Arts Council
Assessment Review Board
Aviation Advisory Board
Bald Eagle Preserve
Bar Association
Barbers & Hairdressers
Bering Sea Fishery Advisory Board
Big Game Commercial Services
Boating Safety Council
Broadcasting Commission
Children's Trust Board
Chiropractic Examiners
Clemency Advisory Committee
Commemorative Coin Commission
Commercial Fisheries Entry
Commercial Fishing/Agriculture Bank
Community Service Commission
Denali Access System Advisory Committee
Dental Examiners
Disabilities/Special Education
Domestic Violence/Sexual Assault
Education & Early Development
Education Commission/States
Emergency Medical Services
Emergency Response Commission
Employment of People with Disabilities
Exxon Valdez Oil Spill Trustee
Faith-Based & Community Initiatives Council
Fire Standards Council
Fisheries

Fisherman's Fund Advisory & Appeals
Forestry
Game
Health Council
Historical Commission
Historical Records Advisory
Homeless Council
Housing Finance Corporation
Human Rights
Humanities Forum
Independent Living Council
Industrial Development/Export Authority
Interstate Oil & Gas Compact
Judicial Conduct
Judicial Council
Knik Arm Bridge
Labor Relations Agency
Libraries Advisory
Local Boundary Commission
Marine Pilots
Marine Transportation Advisory Board
Marital & Family Therapy
Medical Board #1
Mental Health Board
Mental Health Trust Authority
Midwives
Minerals Commission
Municipal Bond Bank
Natural Gas Authority
Natural Gas Pipeline Corporation
Natural Resources Conservation Dev
North Pacific Anadromous Fish
North Pacific Fisheries Management Council
North Pacific Research Board
Nursing
Occupational Safety
Oil & Gas Conservation Commission
Optometry
Pacific Marine Fisheries Commission
Pacific Salmon Commission-Commissioners
Pacific Salmon Commission- Northern Panel

Pacific Salmon Commission-Transboundary Panel
Parole Board
Permanent Fund
Pharmacy Board
Physical/Occupational Therapy
Pioneer's Home Advisory
Police Standards Council
Postsecondary Education
Professional Counselors
Professional Teaching Practices
Psychologist/ Psychological assoc.
Public Offices Commission
PWS Oil Spill Recovery Institute
Railroad Corporation
Real Estate Appraisers
Real Estate Commission
Regents
Regulatory Commission (RCA)
Royalty Oil & Gas Development
Safety Advisory Council
Seafood Marketing Institute
Seismic Hazards Safety Commission
Social Work Examiners
Student Loan Corporation
Subsistence Resource Commissions
Suicide Prevention Council
Telecommunications
Uniform State Laws
Veterans Advisory Council
Veterinary Examiners
Violent Crimes Compensation
Water and Wastewater Works
Western Interstate Comm/Higher Educ
Wood-Tikchik State Park
Worker's compensation
Worker's Compensation Appeals Commission
Workforce Investment Board
Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Casey Miller (Age): 51 of (Hometown): Anchorage
is (Job title/Place of employment): ASD / Student Nutrition.
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): _____

(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Lifelong Alaskan resident. Currently employed with the Anchorage School District, Student Nutrition. Previous small business owner. Married to Stuart Miller and mother of five grown children. Previously served nine years on a Private School Board. Interests include cooking, travel and catering small gatherings.

Kathleen (Casey) Millar

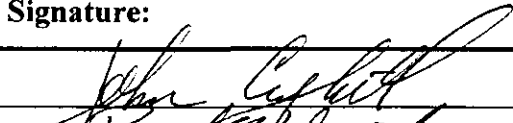
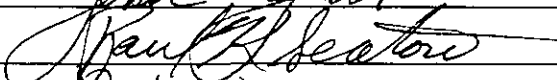
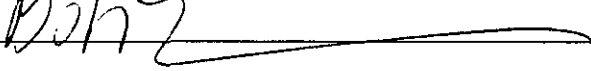

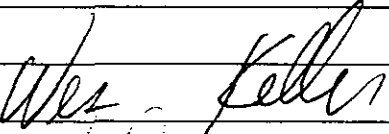

- Experience**
- August 2006 - Present Anchorage School District Anchorage, AK
Cafeteria Manager I
- Prepare and serve meals for 180 students a day; accounting of daily receipts; and prepare purchase orders for meals at Bowman Elementary and Huffinan Elementary;
- 1996 - 2007 Steamers Espresso Anchorage, AK
Owner/Operator
- Owned and operated a successful drive-thru coffee kiosk.
- 1996-2005 Heritage Christian School Anchorage, AK
School Board Member
- Worked on budget, policy, procedure manuals, accreditation, and overall governance and compliance issues for elementary and secondary private school.
- 1979 - 1982 Municipality of Anchorage Anchorage, AK
Purchasing Department/ Construction Bid Clerk
Administrative Secretary for the Division of Public Works Director
- Education**
- 1977-1978 Mesa Community College Mesa, AZ
- General Studies
- 1978-1981 University of Alaska, Anchorage
- General Studies
 - Certificate for Slingerland Studies
- Other Certificates:** Food Safety Certificate.

CONFIRMATION COMMITTEE REPORT

Action date: 3/26/09

The **Health and Social Services Committee** has reviewed the qualifications of the following Governor's appointee(s) as shown on the attached Referral for Confirmation forms(s) and recommends that the name(s) be forwarded to a joint session for consideration:

This does not reflect intent by any of the members to vote for or against this individual during any further sessions for the purposes of confirmation.

Signature:	Printed Last Name
	Coghill
	SEATON
	LYNN
	KISSNA
Co-Chair: 	Keller
Co-Chair: 	HERRON

Please attach appointee Referral for Confirmation form(s) and return to the Chief Clerk's office.



Official Business

Alaska State Legislature

House of Representatives

Office of the Chief Clerk

State Capitol, Room 216
Juneau, AK 99801-1182
Phone: (907) 465-3725
Fax: (907) 465-5334

REFERRAL FOR CONFIRMATION

Date Referred: February 4, 2009

Committee: **Health and Social Services**

State Medical Board

Edward A. Hall – Anchorage

Appointed: 5/19/2005

Reappointed: 3/1/2009 Term Expires: 3/1/2013

Action Date: 3/26/09
(Same date as on the accompanying signature page)

Note: Attach to a signature page and return to the Chief Clerk's office.



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Juneau, AK 99801-1182

Phone: (907) 465-3725

Fax: (907) 465-5334

REFERRAL FOR CONFIRMATION

Date Referred: February 4, 2009

Committee: **Health and Social Services**

State Medical Board

Casey M. Millar – Anchorage

Appointed: 3/1/2009 Term Expires: 3/1/2013

Action Date: 3/26/09
(Same date as on the accompanying signature page)

Note: Attach to a signature page and return to the Chief Clerk's office.



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REFERRAL FOR CONFIRMATION

Date Referred: February 4, 2009

Committee: **Health and Social Services**

State Medical Board

Dr. David A. Miller – Juneau

Appointed: 3/1/2009 Term Expires: 3/1/2012

Action Date: 3/26/09
(Same date as on the accompanying signature page)

Note: Attach to a signature page and return to the Chief Clerk's office.



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REFERRAL FOR CONFIRMATION

Date Referred: February 4, 2009

Committee: **Health and Social Services**

State Medical Board

Dr. David J. Powers – Dillingham

Appointed: 12/2/2008 Term Expires: 3/1/2012

Action Date: 3/26/09
(Same date as on the accompanying signature page)

Note: Attach to a signature page and return to the Chief Clerk's office.

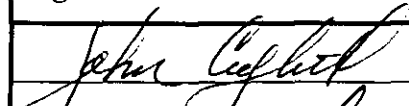
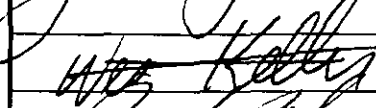
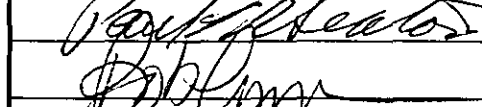
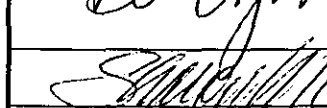
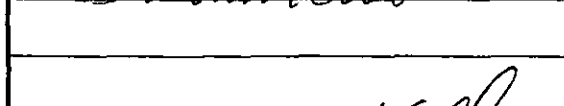
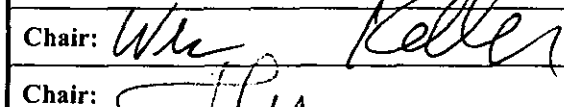
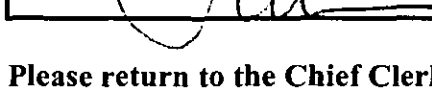
CONFIRMATION COMMITTEE REPORT

Action date: 3/26/04

The Health and Social Services Committee has reviewed the qualifications of the following Governor's appointee and recommends that this name be forwarded to a joint session for consideration:

Commissioner – Department of Health and Social Services
 William H. Hogan
 Appointed: 7/24/2008

This does not reflect intent by any of the members to vote for or against this individual during any further sessions for the purposes of confirmation.

Signature:	Printed Last Name
	Coghill
	Keller
	Seaton
	LYNN
	CISSNA
Chair: 	Keller
Chair: 	HERRON

Please return to the Chief Clerk's office.



Official Business

Alaska State Legislature

House of Representatives

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MEMORANDUM

Date: March 8, 2010

To: Representative Herron, Co-Chair
Representative Keller, Co-Chair ✓
Health and Social Services Committee

From: Suzi Lowell *SL*
Chief Clerk

Subject: Governor's Appointment(s)

The Speaker referred the following Governor's appointment(s) to the Health and Social Services Committee:

State Medical Board

Dr. William W. Resinger – Palmer
Appointed: 9/21/2007
Reappointed: 3/1/2010 Term Expires: 3/1/2014

The Referral for Confirmation page(s), resume(s), and a signature page are attached for your use. In addition, the resume(s) will also be sent electronically.

Attachments as noted



Official Business

Alaska State Legislature

House of Representatives

Office of the Chief Clerk

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Fax: (907) 465-5334

REFERRAL FOR CONFIRMATION

Date Referred: March 8, 2010

Committee: Health and Social Services

State Medical Board

Dr. William W. Resinger – Palmer

Appointed: 9/21/2007

Reappointed: 3/1/2010 Term Expires: 3/1/2014

Action Date: April 6, 2010
(Same date as on the accompanying signature page)

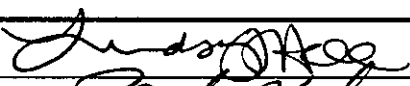
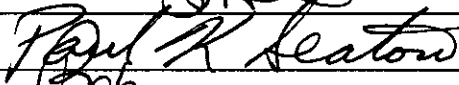
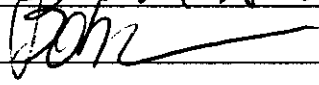
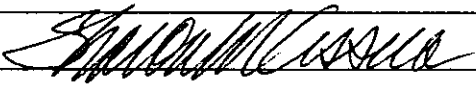
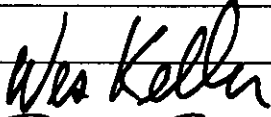

Note: Attach to a signature page and return to the Chief Clerk's office.

CONFIRMATION COMMITTEE REPORT

Action date: April 6, 2010

The **Health and Social Services Committee** has reviewed the qualifications of the following Governor's appointee(s) as shown on the attached Referral for Confirmation forms(s) and recommends that the name(s) be forwarded to a joint session for consideration:

This does not reflect intent by any of the members to vote for or against this individual during any further sessions for the purposes of confirmation.

Signature:	Printed Last Name
	Holmes
	SEATON
	LYNN
	CISSNA
Co-Chair: 	Keller
Co-Chair: 	HERRON

Please attach appointee Referral for Confirmation form(s) and return to the Chief Clerk's office.

CONFIRMA- TIONS 2010



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House of Representatives

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Juneau, AK 99801-1182
Phone: (907) 465-3725
Fax: (907) 465-5334

MEMORANDUM

Date: 2010

To: All Committees

From: Suzi Lowell
Chief Clerk

Subject: Confirmation Committee Report (Signature Page) for Governor's
Appointments

The attached Confirmation Committee Report (signature page) should be used in conjunction with the Referral for Confirmation form for the Governor's appointments to boards and commissions requiring legislative confirmation. After a committee has reviewed the qualifications of the appointee(s), the Referral for Confirmation form(s) should be dated and attached to a signature page. Have members sign the signature page and return the confirmation packet to the Chief Clerk's office.

Please use a single signature page for multiple appointees if the names of all members signing the report are the same for each attached referral. This change allows members to sign once for multiple appointments.

Attached are several signature pages for your use. We used colored paper to make them easier to identify. If you anticipate needing more forms or need assistance, please call Nancy McMullen at 6809.

Note: A separate report, including the signatures, will be used for department commissioners.

Attachments



Official Business

Alaska State Legislature

House of Representatives

Office of the Chief Clerk

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Juneau, AK 99801-1182

Phone: (907) 465-3725

Fax: (907) 465-5334

REFERRAL FOR CONFIRMATION

Date Referred: March 8, 2010

Committee: Health and Social Services

State Medical Board

Dr. William W. Resinger – Palmer

Appointed: 9/21/2007

Reappointed: 3/1/2010 Term Expires: 3/1/2014

Action Date: April 6, 2010
(Same date as on the accompanying signature page)

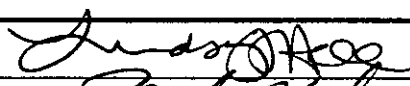
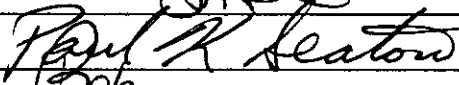
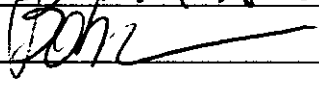
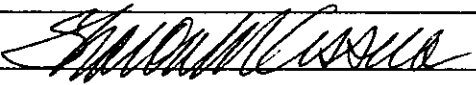
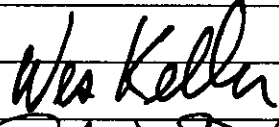

Note: Attach to a signature page and return to the Chief Clerk's office.

CONFIRMATION COMMITTEE REPORT

Action date: April 6, 2010

The **Health and Social Services Committee** has reviewed the qualifications of the following Governor's appointee(s) as shown on the attached Referral for Confirmation forms(s) and recommends that the name(s) be forwarded to a joint session for consideration:

This does not reflect intent by any of the members to vote for or against this individual during any further sessions for the purposes of confirmation.

Signature:	Printed Last Name
	Holmes
	SEATON
	LYNN
	CISSNA
Co-Chair: 	Keller
Co-Chair: 	HERRON

Please attach appointee Referral for Confirmation form(s) and return to the Chief Clerk's office.



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MEMORANDUM

Date: March 8, 2010

To: Representative Herron, Co-Chair
Representative Keller, Co-Chair ✓
Health and Social Services Committee

From: Suzi Lowell *sl*
Chief Clerk

Subject: Governor's Appointment(s)

The Speaker referred the following Governor's appointment(s) to the Health and Social Services Committee:

State Medical Board

Dr. William W. Resinger – Palmer
Appointed: 9/21/2007
Reappointed: 3/1/2010 Term Expires: 3/1/2014

The Referral for Confirmation page(s), resume(s), and a signature page are attached for your use. In addition, the resume(s) will also be sent electronically.

Attachments as noted

RESUME

William W. Resinger, M.D.
P.O. Box 839
Palmer, Alaska 99645

Phone: (907) 745-1763 (home, unlisted)

Married
Wife's name: Edrea
No children

---EDUCATION---

Titusville High School, Titusville, PA - 1961

Seibert Award for highest scholastic average (4.00)

Allegheny College, Meadville, PA - 1965

Phi Beta Kappa (junior year)
Alden Scholar (Dean's List) all four years,
Honors in Chemistry
Magna Cum Laude

University of Pennsylvania School of Medicine, Philadelphia, PA - 1969

Honors in Radiology

Harrisburg Polyclinic Hospital, Harrisburg, PA

Intern (rotating) 1969 - 1970
Resident Radiology 1970 - 1971

Postgraduate Course in Emergency Medicine, Hershey, PA

September 1974, April 1977

University Hospital, University of Michigan

Fellow in Nuclear Medicine 9-78 - 8-79

Oakwood Hospital, Dearborn, MI

Resident Radiology 9-79 - 2-81

Certified American Board of Radiology (ABR)

Diagnostic Radiology with special competence in Nuclear Medicine, 6-4-82

Continuing Medical Education

Average 50 hours or more CME (usually Cat. I) each year since 1981

Twenty Years Experience in Reading Mammograms

Mammography Accreditation by A.C.R. at Valley Hospital 1988-2001

Training in mammography

- 8 weeks during residency (in 1980)
- Stanford Breast Symposium 3-20 - 3-22-86 (13.5 hours)
- Tutorial with Dr. McClure Hall at Virginia Mason Hospital, Seattle, WA 6-5 - 6-6-86 (16 hours)
- (RAD SAT) (ME-SAT) (Videotape Series), Johns Hopkins (Breast Imaging Techniques, 1987) (4 hours)
- RSNA TODAY (Screening Mammography), Vol. I, No. 1, 1986 (one hour)
- At Least 15 hours Category I every three years to present

---WORK HISTORY---

Oil City Hospital, Oil City, PA

Emergency Physician 1971 - 1978

Mercy Memorial Hospital, Monroe, MI

Staff Radiologist 3-81 - 7-84

Valley Hospital, Palmer, Alaska

Staff Radiologist 8-84 - 12-01

Association Board Member 1992 - 2001

South Peninsula Hospital, Homer, Alaska

Locum Tenens Radiologist 2002,2003

Norton Sound Health Corp., Nome, Alaska

Locum Tenens Radiologist 2002-present

---ACTIVITIES AND ASSOCIATIONS---

ACEP (American College of Emergency Physicians)

Member 1971 - 1979

National Council Member 1973, 1974, 1975, 1977

Pennsylvania Chapter ACEP (American College of Emergency Physicians)

Board of Directors 1972 - 1978

Executive Committee 1973 - 1978
Treasurer 1974 - 1975
Editor of "EPIC" (newsletter) 1973 - 1977
President-elect 1976
President 1977

Community Ambulance Service

Board at large 1973
Board of Directors 1974

Comprehensive Health Planning Council of N.W. Pennsylvania

Member Venango County Task Force on Emergency Health Services
Executive Committee

Pennsylvania Emergency Health Services Council, 1974

Representative for N.W. Pennsylvania
Board of Directors
Subcommittee on Physician Training

Preceptor for Nurse Practitioner Program

Allegheny General Hospital and Oil City Hospital, 8-75 - 2-76

Medical Advisor EMS Council of N.W. Pennsylvania 1977-78

Glacier View Alliance Church, Palmer, Alaska

Elder and board member 1985-present

Pacific NW District of the Christian and Missionary Alliance

Liaison to the District Superintendent for Alaska 1995-present

Board of Trustees at Simpson University, Redding, CA

Member 1996-present, Chairman Student Affairs Committee

Board of Directors Heart Reach Pregnancy Center, Mat-Su Borough

Member 2001-9/2007

Board of Directors of Town and Country Manor, Santa Ana, CA

Member 2002-present, Chairman Benevolence and Health Services Committees

Society Memberships

American Institute of Ultrasound in Medicine -retired
Society of Nuclear Medicine -retired
RSNA (Radiological Society of North America) -active
ACR (American College of Radiology) -retired

---PUBLICATIONS AND ABSTRACTS---

Publications

Weigel, J.A., Resinger, W.W.: Are You in Good Hands? Pennsylvania Medicine 78:53-54, 1975.

Resinger, W.W., Thrall, J.H.: Diagnosis of Ruptured Bladder During a ^{99m}Tc -DTPA Renal Study: New Indications for Radionuclide Cystography? Clinical Nuclear Medicine 3:179-180, 1979.

E.A.: Scintigraphic Tomography of the Thyroid. Proceedings of the Eighth International Thyroid Congress Sydney, Australia, February, 1980.

Publications (continued)

Freites, J.E., Fink-Bennett, D.M., Thrall, J.H., Resinger, W.W.: Efficacy of Hepatobiliary Imaging in Acute Abdominal Pain: Concise Communication. Journal of Nuclear Medicine 21:919-924, 1980.

Resinger, W.W., Rose, E.A., Keyes, J.W., Jr., Koral, K.F., Rogers, W.L., Brady, T.J., Kline, R.C., Sisson, J.C., Thrall, J.H.: Tomographic Thyroid Scintigraphy: Comparison with Standard Pinhole Imaging. Journal of Nuclear Medicine 22:638-642, 1981.

Keyes, J.W., Jr., Kline, R.C., Resinger, W.W., Rose, E.A., Koral, K.F., Rogers, W.L.: Comparison of Observer Performance Reading from a Video CRT vs. Reading from Film Investig. Radiol. 18:298-300, 1983

Abstracts

Annual Meeting, June, 1980.

Scintigraphy: Comparison with Standard Pinhole Imaging. Society of Nuclear Medicine 27th Annual Meeting, June, 1980.



Official Business

Alaska State Legislature

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Phone: (907) 465-3725
Fax: (907) 465-5334

REFERRAL FOR CONFIRMATION

Date Referred: March 8, 2010

Committee: Health and Social Services

State Medical Board

Dr. William W. Resinger – Palmer

Appointed: 9/21/2007

Reappointed: 3/1/2010 Term Expires: 3/1/2014

Action Date: _____
(Same date as on the accompanying signature page)

Note: Attach to a signature page and return to the Chief Clerk's office.

RESUME

William W. Resinger, M.D.
P.O. Box 839
Palmer, Alaska 99645

Phone: (907) 745-1763 (home, unlisted)

Married
Wife's name: Edrea
No children

---EDUCATION---

Titusville High School, Titusville, PA - 1961

Seibert Award for highest scholastic average (4.00)

Allegheny College, Meadville, PA - 1965

Phi Beta Kappa (junior year)
Alden Scholar (Dean's List) all four years,
Honors in Chemistry
Magna Cum Laude

University of Pennsylvania School of Medicine, Philadelphia, PA - 1969

Honors in Radiology

Harrisburg Polyclinic Hospital, Harrisburg, PA

Intern (rotating) 1969 - 1970
Resident Radiology 1970 - 1971

Postgraduate Course in Emergency Medicine, Hershey, PA

September 1974, April 1977

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Fellow in Nuclear Medicine 9-78 - 8-79

Oakwood Hospital, Dearborn, MI

Resident Radiology 9-79 - 2-81

Certified American Board of Radiology (ABR)

Diagnostic Radiology with special competence in Nuclear Medicine, 6-4-82

Continuing Medical Education

Average 50 hours or more CME (usually Cat. I) each year since 1981

Twenty Years Experience in Reading Mammograms

Mammography Accreditation by A.C.R. at Valley Hospital 1988-2001

Training in mammography

- 8 weeks during residency (in 1980)
- Stanford Breast Symposium 3-20 - 3-22-86 (13.5 hours)
- Tutorial with Dr. McClure Hall at Virginia Mason Hospital, Seattle, WA 6-5 - 6-6-86 (16 hours)
- (RAD SAT) (ME-SAT) (Videotape Series), Johns Hopkins (Breast Imaging Techniques, 1987) (4 hours)
- RSNA TODAY (Screening Mammography), Vol. I, No. 1, 1986 (one hour)
- At Least 15 hours Category I every three years to present

---WORK HISTORY---

Oil City Hospital, Oil City, PA

Emergency Physician 1971 - 1978

Mercy Memorial Hospital, Monroe, MI

Staff Radiologist 3-81 - 7-84

Valley Hospital, Palmer, Alaska

Staff Radiologist 8-84 - 12-01

Association Board Member 1992 - 2001

South Peninsula Hospital, Homer, Alaska

Locum Tenens Radiologist 2002, 2003

Norton Sound Health Corp., Nome, Alaska

Locum Tenens Radiologist 2002-present

---ACTIVITIES AND ASSOCIATIONS---

ACEP (American College of Emergency Physicians)

Member 1971 - 1979

National Council Member 1973, 1974, 1975, 1977

Pennsylvania Chapter ACEP (American College of Emergency Physicians)

Board of Directors 1972 - 1978

Executive Committee 1973 - 1978
Treasurer 1974 - 1975
Editor of "EPIC" (newsletter) 1973 - 1977
President-elect 1976
President 1977

Community Ambulance Service

Board at large 1973
Board of Directors 1974

Comprehensive Health Planning Council of N.W. Pennsylvania

Member Venango County Task Force on Emergency Health Services
Executive Committee

Pennsylvania Emergency Health Services Council, 1974

Representative for N.W. Pennsylvania
Board of Directors
Subcommittee on Physician Training

Preceptor for Nurse Practitioner Program

Allegheny General Hospital and Oil City Hospital, 8-75 - 2-76

Medical Advisor EMS Council of N.W. Pennsylvania 1977-78

Glacier View Alliance Church, Palmer, Alaska

Elder and board member 1985-present

Pacific NW District of the Christian and Missionary Alliance

Liaison to the District Superintendent for Alaska 1995-present

Board of Trustees at Simpson University, Redding, CA

Member 1996-present, Chairman Student Affairs Committee

Board of Directors Heart Reach Pregnancy Center, Mat-Su Borough

Member 2001-9/2007

Board of Directors of Town and Country Manor, Santa Ana, CA

Member 2002-present, Chairman Benevolence and Health Services Committees

Society Memberships

American Institute of Ultrasound in Medicine -retired
Society of Nuclear Medicine -retired
RSNA (Radiological Society of North America) -active
ACR (American College of Radiology) -retired

---PUBLICATIONS AND ABSTRACTS---

Publications

Weigel, J.A., Resinger, W.W.: Are You in Good Hands? Pennsylvania Medicine 78:53-54, 1975.

Resinger, W.W., Thrall, J.H.: Diagnosis of Ruptured Bladder During a ^{99m}Tc-DTPA Renal Study: New Indications for Radionuclide Cystography? Clinical Nuclear Medicine 3:179-180, 1979.

E.A.: Scintigraphic Tomography of the Thyroid. Proceedings of the Eighth International Thyroid Congress Sydney, Australia, February, 1980.

Publications (continued)

Freites, J.E., Fink-Bennett, D.M., Thrall, J.H., Resinger, W.W.: Efficacy of Hepatobiliary Imaging in Acute Abdominal Pain: Concise Communication. Journal of Nuclear Medicine 21:919-924, 1980.

Resinger, W.W., Rose, E.A., Keyes, J.W., Jr., Koral, K.F., Rogers, W.L., Brady, T.J., Kline, R.C., Sisson, J.C., Thrall, J.H.: Tomographic Thyroid Scintigraphy: Comparison with Standard Pinhole Imaging. Journal of Nuclear Medicine 22:638-642, 1981.

Keyes, J.W., Jr., Kline, R.C., Resinger, W.W., Rose, E.A., Koral, K.F., Rogers, W.L.: Comparison of Observer Performance Reading from a Video CRT vs. Reading from Film Investig. Radiol. 18:298-300, 1983

Abstracts

Annual Meeting, June, 1980.

Scintigraphy: Comparison with Standard Pinhole Imaging. Society of Nuclear Medicine 27th Annual Meeting, June, 1980.

HB

2

ALASKA STATE LEGISLATURE
Rep. Carl Gatto



MEMORANDUM

TO: Representative Wes Keller Co-Chair Health and Social Services and
Representative Bob Herron Co-Chair Health and Social Services
FROM: Rep. Carl Gatto
DATE: January 22, 2009
RE: Request for Hearing

Enclosed is the committee packet for HB 2 "*An Act relating to the issuance of a certificate of birth resulting in stillbirth.*" I have included a sponsor statement, the most recent version of the bill, and other supplemental material.

Please schedule a committee hearing before the House Health and Social Services Committee at your earliest convenience. I appreciate your time and look forward to reviewing this bill.

Please contact my staff member Sandra Wilson at 465-3163 with any questions or comments regarding this request.

Thank you

Alaska State Legislature

Interim:

600 E. Railroad Ave
Wasilla, AK 99654

Phone: (907) 376-3725
Fax: (907) 376-4768

**Session:**

Alaska State Capitol, Rm 108
Juneau, AK 99801-1182

Phone: (907) 465-3743
Fax: (907) 465-2381
Toll Free: (800) 565-3743
Rep_Carl_Gatto@legis.state.ak.us

Representative Carl Gatto

Chair, House Military and Veteran Affairs Committee
District 13 - Palmer

SPONSOR STATEMENT

HB 2

"An Act relating to the issuance of a certificate of birth resulting in stillbirth."

HB 2 brings closure to parents who have suffered the loss of a stillborn child by giving them a Birth Certificate reflecting that they had a child who was stillborn. To paraphrase one parent of a stillborn child: being able to receive a Birth Certificate for my daughter would make me feel complete in that it would acknowledge that my daughter existed, even if it was only for a short while. This is true not only for her but also heard from other parents that have suffered this loss.

Under current law parents of stillborn children receive a fetal death certificate. HB 2 allows parents the option of requesting a certificate of birth for their stillborn child. This birth certificate is optional, and if the parents choose to receive a Birth Certificate they have the option of naming their child.

There are twenty-five states that now offer parents of stillborns the option of obtaining a Birth Certificate for their child. I urge your support for HB 2.

26-LS0003\R
Mischel
1/29/09

CS FOR HOUSE BILL NO. 2()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GATTO, Gruenberg, Dahlstrom, Lynn

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to the issuance of a certificate of birth resulting in a stillbirth."**

2 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 *** Section 1.** AS 18.50 is amended by adding a new section to read:

4 **Sec. 18.50.235. Certificate of birth resulting in stillbirth.** (a) The person
5 required to file a fetal death registration under AS 18.50.240(b) shall advise the
6 mother and, if the father is present, the father of a stillborn child

7 (1) that the parent may request the preparation of a certificate of birth
8 resulting in stillbirth;

9 (2) that the parent may obtain a certificate of birth resulting in stillbirth
10 by contacting the bureau; and

11 (3) of the contact information for the bureau.

12 (b) The parent of a stillborn child who requests a certificate of birth resulting
13 in stillbirth may provide a name of a stillborn child for placement on the certificate. If
14 a name is not provided, the bureau shall cause the certificate to show either "baby
15 boy" or "baby girl," as appropriate, and the last name of the parent who requested the

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certificate. The name of the stillborn child provided on the certificate of birth resulting in stillbirth must be the same name as the name on the fetal death certificate.

(c) A certificate of birth resulting in stillbirth must include the state file number of the corresponding fetal death certificate.

(d) The department shall prescribe the form and content of a certificate of birth resulting in stillbirth to record the birth of a stillborn child and specify the information required to prepare the certificate.

(e) A certificate issued under this section is not proof of a live birth, and the certificate must contain the phrase "not proof of live birth." The bureau may not use a certificate of birth resulting in stillbirth to calculate live birth statistics.

(f) A parent may request that the bureau issue a certificate of birth resulting in still birth regardless of the date on which the certificate of fetal death was issued.

(g) The department may adopt regulations needed to implement this section.

(h) In this section, "stillbirth" or "stillborn" refers to an unintended, intrauterine fetal death occurring in the state after a gestational age of 20 completed weeks.

AMENDMENT

TO: HB 2 (26-LS0003\R)

BY REPRESENTATIVE HOLMES

1 Page 2, line 14

2 After ""stillbirth" or "stillborn":

3 Insert "child"

26-LS0003\S
Mischel
3/5/09

CS FOR HOUSE BILL NO. 2()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES GATTO, Gruenberg, Dahlstrom, Lynn

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3 *** Section 1.** AS 18.50 is amended by adding a new section to read:

4 **Sec. 18.50.235. Certificate of birth resulting in stillbirth.** (a) After a
5 stillbirth occurs in the state, the person required to file a fetal death registration under
6 AS 18.50.240(b) shall advise the mother and, if the father is present, the father

7 (1) that the parent may request the preparation of a certificate of birth
8 resulting in stillbirth;

9 (2) that the parent may obtain a certificate of birth resulting in stillbirth
10 by contacting the bureau; and

11 (3) of the contact information for the bureau.

12 (b) A parent who requests a certificate of birth resulting in stillbirth may
13 provide a name for placement on the certificate. If a name is not provided, the bureau
14 shall cause the certificate to show either "baby boy" or "baby girl," as appropriate, and
15 the last name of the parent who requested the certificate. The name provided on the

1 certificate of birth resulting in stillbirth must be the same name as the name on the
2 fetal death certificate.

3 (c) A certificate of birth resulting in stillbirth must include the state file
4 number of the corresponding fetal death certificate.

5 (d) The department shall prescribe the form and content of a certificate of
6 birth resulting in stillbirth to record the birth and specify the information required to
7 prepare the certificate.

8 (e) A certificate issued under this section is not proof of a live birth, and the
9 certificate must contain the phrase "not proof of live birth." The bureau may not use a
10 certificate of birth resulting in stillbirth to calculate live birth statistics.

11 (f) A parent may request that the bureau issue a certificate of birth resulting in
12 stillbirth regardless of the date on which the certificate of fetal death was issued.

13 (g) The department may adopt regulations needed to implement this section.

14 (h) In this section,

15 (1) "stillbirth" means a fetal death that resulted in the issuance of a
16 fetal death certificate under AS 18.50.240;

17 (2) "fetal death" has the meaning given in AS 18.50.950.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 3, 2009

SUBJECT: Definition of "stillbirth" and "stillborn child"
(CS HB 2(); Work Order No. 26-LS0003/E)

TO: Representative Wes Keller
Attn: John Davies

FROM: Jean M. Mischel
Legislative Counsel 

A blank CS for the above referenced bill is provided, as requested, to add a definition of "stillborn child" and delete the word "stillborn" from the definition at page 2, line 18. In my opinion, these changes do not alter the meaning of the words defined.

If I may be of further assistance, please advise.

JMM:med
09-017.med

Enclosure

26-LS0003\E
Mischel
3/3/09

CS FOR HOUSE BILL NO. 2()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES GATTO, Gruenberg, Dahlstrom, Lynn

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the issuance of a certificate of birth resulting in a stillbirth."**

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3 *** Section 1.** AS 18.50 is amended by adding a new section to read:

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5 required to file a fetal death registration under AS 18.50.240(b) shall advise the
6 mother and, if the father is present, the father of a stillborn child

7 (1) that the parent may request the preparation of a certificate of birth
8 resulting in stillbirth;

9 (2) that the parent may obtain a certificate of birth resulting in stillbirth
10 by contacting the bureau; and

11 (3) of the contact information for the bureau.

12 (b) The parent of a stillborn child who requests a certificate of birth resulting
13 in stillbirth may provide a name of a stillborn child for placement on the certificate. If
14 a name is not provided, the bureau shall cause the certificate to show either "baby
15 boy" or "baby girl," as appropriate, and the last name of the parent who requested the

1 certificate. The name of the stillborn child provided on the certificate of birth resulting
2 in stillbirth must be the same name as the name on the fetal death certificate.

3 (c) A certificate of birth resulting in stillbirth must include the state file
4 number of the corresponding fetal death certificate.

5 (d) The department shall prescribe the form and content of a certificate of
6 birth resulting in stillbirth to record the birth of a stillborn child and specify the
7 information required to prepare the certificate.

8 (e) A certificate issued under this section is not proof of a live birth, and the
9 certificate must contain the phrase "not proof of live birth." The bureau may not use a
10 certificate of birth resulting in stillbirth to calculate live birth statistics.

11 (f) A certificate of birth resulting in stillbirth that is issued by the bureau shall
12 be filed with the local registrar of the registration district in which the delivery
13 occurred within five days after issuance. The local registrar shall file the certificate of
14 birth resulting in stillbirth with the fetal death certificate.

15 (g) A parent may request that the bureau issue a certificate of birth resulting in
16 still birth regardless of the date on which the certificate of fetal death was issued.

17 (h) The department may adopt regulations needed to implement this section.

18 (i) In this section,

19 (1) "stillbirth" means an unintended, intrauterine fetal death occurring
20 in the state after a gestational age of 20 completed weeks;

21 (2) "stillborn child" means a fetus that is the product of a stillbirth.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 002
 () Publish Date: _____

Identifier (file name): HB002-DHSS-BVS-02-18-09 Dept. Affected: Health & Social Services
 Title: Birth Certificate for Stillbirth RDU: Public Health
 Component: Bureau of Vital Statistics
 Sponsor: Gatto
 Requester: House HSS Component Number: 961

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB002 would require the Bureau of Vital Statistics (BVS) to issue, upon the request of a parent, a "certificate of birth resulting in a stillbirth" for an intrauterine fetal death occurring after 20 complete gestational weeks. These certificates would cost \$20 each. Approximately 50 stillbirths are recorded in Alaska annually. Based on response in other states passing similar legislation, it is expected most families would request such a certificate. The division has adequate budget authorization to receive these additional receipts, resulting in a zero fiscal note - even though there will be a cost to the requestor similar to other certificates. (Continued on P. 2)

Prepared by: Beverly Wooley, Director Phone 269-8126
 Division: Public Health Date/Time 1/23/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 2/18/2009
DHSS Finance & Management Services

FISCAL NOTE

**STATE OF ALASKA
2009 LEGISLATIVE SESSION**

BILL NO. HB002 _____

ANALYSIS CONTINUATION

Minimal programming and administrative time will be necessary to issue such certificates - amounting to an estimated \$1,000 annually. Assuming 50 certificates are issued each year at \$20 each, costs will be covered by the fee. The BVS budget is funded primarily by receipt supported services; all certificates issued - birth, death, fetal death - require a \$20 fee.

Alaska State Legislature

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600 E. Railroad Ave
Wasilla, AK 99654

Phone: (907) 376-3725

Fax: (907) 376-4768

**Session:**

Alaska State Capitol, Rm 108
Juneau, AK 99801-1182

Phone: (907) 465-3743

Fax: (907) 465-2381

Toll Free: (800) 565-3743

Rep_Carl_Gatto@legis.state.ak.us

Representative Carl Gatto

Chair, House Military and Veteran Affairs Committee
District 13 - Palmer

Witness list:

- Michelle Hoyt (Palmer)
- Rhonda Crawford (Soldotna)
- Joanne Cacciatore (Arizona) Will be calling in from off net.
- Mayme Ohnemus (Cooper Landing) Will be in the room to testify
- Deedra Hollowell (Palmer)
- Mitchell Phillips (Vital Statistics)

LEGAL SERVICES

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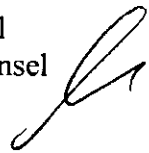
MEMORANDUM

January 22, 2009

SUBJECT: Sectional Summary (HB 2 (Work Order No. 26-LS0003\A))

TO: Representative Carl Gatto
Attn: Sandra Wilson

FROM: Jean M. Mischel
Legislative Counsel



You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Establishes a process for the bureau of vital statistics to issue a certificate of birth resulting in a stillbirth at the request of a parent of the stillborn child. Requires the bureau to transmit the certificate to the local registrar for filing with the fetal death certificate.

JMM:lmb
09-002.lmb

January 20, 2009

To the Alaska Legislature

In Support of HB 2

This is the Story of Daniel Gavin Sheppard,

My name is Chauna and in 2002, I became pregnant for the first time in my life at the age of 32. We were overjoyed and considered this a miracle baby after being diagnosed with Fertility problems.

I walked on air with happiness, eating healthier, drinking extra water and taking every breath with my precious baby in mind. That summer we purchased a larger car, a crib and swing, stocked up on diapers of various sizes, and dozens of outfits, We went to child birth classes and even did relaxation exercises at home to prepare for labor. I never missed a doctor appointment and even switched doctors so I could get higher quality care. We got ultrasound videos and pictures. I really enjoyed feeling his regular kicking, rolling and occasional hic ups.

Daniel was due on November 26th 2002. It was that morning that after a bit of poking and juice drinking that I couldn't seem to wake my son. My doctor sent me to the maternity ward where using a Doppler speaker they couldn't hear a heartbeat. At that point we had an ultrasound where we could not see any heart movement in those tiny, clearly visible, ribs on the tv screen. It was the most painful reality of my life to know my baby had died.

I was induced at apx 2:30pm that day. We went through 17 hours of labor that including an epidural, pain and nausea medication, IV's and 2 hours of pushing. Daniel Gavin was born weighing 7lb 14oz and 19 inches long at 7:30am on November 27, 2002. His warm, soft, beautiful body was placed on my chest where my husband and I cuddled and kissed and loved him even more than the day before. The nurse bathed him. We dressed him and friends and family came to hold him as well. I distinctly remember one dear friend rocking him just like he was any other baby. The hospital took foot prints and cut a lock of hair for us to keep. They also gave us two camera's to take pictures of our beautiful boy. We were so lucky to be able to keep him with us for 12 hours. We sang to him and prayed before we had to let him go and begin the long painful journey of grief.

The next day the hospital gave us a generic card with his name and birthday on it written in marker and told us that we won't get a birth certificate because he never took a breath. This was a harsh blow after all we had been through. After all, I had given birth to Daniel and he was certainly born.

We drove home from the hospital on Thanksgiving Day with an empty car seat, empty arms and broken hearts.

As sad as this was, we still love Daniel so much, he will always be a part of our family. We do things on his birthday and other times of the year to show him our love. Though we never saw his eyes or heard him cry, my son Daniel is such a gift and we are so thankful for him. There never has been a day when I thought I wasted 9 months carrying him or a time when I wish he never existed. Never, ever... I wish the State of Alaska would not treat him as such.

In 1892 American Author Mark Twin said, "Favored above Kings and Emperors is the stillborn child." I wish stillbirth and the experience of having to deliver a dead baby was respected in this manner today.

This tragedy strikes everywhere. According to the Center for Positive Outcomes in Pregnancy in Washington DC, there are more than 39,000 stillbirths in the U.S. every year.

Historically, we share this horrific experience with John Quincy Adams, Rutherford Hayes, Ernest and Pauline Hemingway, and John and Jackie Kennedy, whose stillborn daughter is buried with her parents and siblings.

Ask any woman why she would endure the pain and agony of giving birth and she will tell you because of the 'reward' at the end...it is 'all worth it' we frequently hear. But what about the silent births- the women who get no reward for all their hard work...

I am writing this today asking you for your support...Please pass HB 2.

Sincerely,

Chauna Sheppard
4032 Reka Drive #K-1
Anchorage, AK 99508
(907) 333-7650
chauna18@hotmail.com

Sandra Wilson

From: Hoyt Family [mehoyt@mtaonline.net]
Sent: Tuesday, January 20, 2009 7:30 PM
To: Sandra Wilson
Subject: RE: Hello

Sandra,

HB 2, to create a 'Birth Certificate resulting in a Still Birth' would make me and a lot of people feel complete. My daughter was still born at 36 weeks and we had a large funeral for her. The idea that the state will only accept the fact that she died is so heart breaking. How can a person die with out being born? Having that piece of paper in my hand would bring closure to the entire grieving process. This would validate that my little girl was once here and apart of our lives.

Thanks so much for bringing this bill forward.

*Michelle Hoyt
Project Linus - Alaska Chapter
Providing Security thru Blankets*

-----Original Message-----

From: Sandra Wilson [mailto:Sandra_Wilson@legis.state.ak.us]
Sent: Tuesday, January 20, 2009 4:44 PM
To: Carletta Gemmell; Chauna Sheppard; Colleen; Dayna Murphy; Dina Banez; Gretchen Mangrobang; Kaylene Johnson; Lynnette Haas; Michelle Hoyt; Rhonda Crawford; Sandy Thomas; WesCin Yuill
Subject: Hello

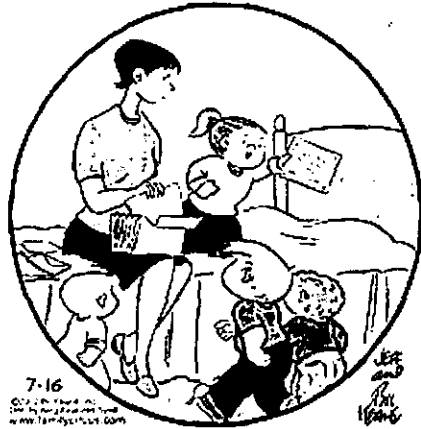
Hello everyone. Today was the first day of session and I am preparing the packet that will accompany our request for hearing. I need updated letters of support. You can either write new ones or use the same ones as last year but I need them to reflect the new bill number for this bill which is HB 2. The sooner you can get these to me the sooner I will get a request in. Again I thank everyone for being willing to take the time and send me these letters.

Sincerely,

Sandra Wilson
Staff to Rep. Carl Gatto
907-465-3163
Sandra_wilson@legis.state.ak.us

Why We Need a Certificate of Still Birth

Haven't we all at one time been in a movie theater when the film broke? One moment we're caught up in the action and suddenly, there is no story on the screen. Time out while the projectionist rethreads the rest of the reel. If only life were like that. If only sudden interruptions in life could pick up where they left off.



"Mommy has birth certificates for all of us. They prove that we were borned."

The birth of a dead baby is a break in the action. The story is over. We get to say hello and goodbye in the same breath. Instead of a bright future, all we're left with is the shattered dreams of what might have been. When a movie breaks we get our money back. In real life when the "film" breaks we're given a fetal death certificate. No baby to take home. No reward for the months of waiting. No acknowledgement for having given birth.

When we discover that what once lived within us is dead we want to run away. But we can't. First we must deliver our baby, just like mothers of live babies do. We must endure the pain. Just like mothers of live babies. And when it's over we hold our baby, just like mothers of live babies do. But then we have to give our baby back, and go home to an empty nursery.

Contrary to what the pundits say, it is possible to fool Mother Nature. She doesn't know our baby died, and so she dutifully produces milk to nourish and protect that, which is no longer. She knows we gave birth. We know we gave birth. But the state says not. Stillbirth mothers are not yet acknowledged as mothers by most states, but we're working to change that.

"We will recognize your baby's death, but not its birth" is the message.

But how can that die which has not been born? How did it come into being? Did it ride a space ship to earth? Or did it arrive the way every other baby arrived, from the womb of a mother who conceived and delivered it?

Birth is a process that all mothers endure; live or "still" is the outcome of that process. If we recognize a live birth, why would the state not recognize a stillbirth? Is it to punish the mother whose baby is born dead? Is she somehow not worthy? Did she fail? That's what she thinks. If we give a the mother of a live birth a "Certificate of Live Birth" why would we not give the mother of a stillborn baby a Certificate of Still Birth? That's the reality of what happened.

All mothers give birth; only the outcomes of those births differ.

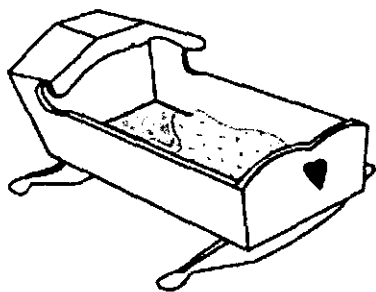
To deny a woman a "Certificate of Still Birth", when she fails to produce a living child, is to say that she did not give birth, which is not true. To deny a woman recognition for this seminal event in her life is to deny the event occurred. To deny a woman recognition is to tell her she is a failure. It is an open wound upon her soul that will never heal unless and until her sacrifice is recognized; just as live birth mothers are recognized.

On August 9, 2001 in Phoenix, Arizona, Sharon Arnold, wife of NSS Founder Richard K. Olsen, along with Joanne Cacciatore-Garard, NSS National Director and founder of the MISS Foundation, were given the first Certificates of Birth Resulting in Still Birth to be issued in the United States. Arizona has led the way by acknowledging that these brave women gave birth and that their daughters, Camille and Cheyenne, though born still, did for one brief and glorious moment pass through this world. Your state should recognize you and your babies too, because all our children matter.

The National Stillbirth Society

When Your Baby Is Stillborn

W I S S P



When your baby is stillborn, expectations, hopes and dreams are cruelly shattered and lives are changed. Many parents have initial feelings of shock and confusion when told that their baby has died. What happened? Why you? Babies are not supposed to die. When they do, it can be devastating, overwhelming, and painful. We are very sorry that your baby died. No one can take away the pain, but we hope the following information will answer some questions, provide reassurance, and help you.

What Is Stillbirth?

You may not have heard of stillbirth until you experienced it. When a baby dies before delivery, many people commonly think of miscarriage. Both stillbirth and miscarriage are types of pregnancy loss, but they differ by when the loss occurs. A *miscarriage* (sometimes called a spontaneous abortion) is when a baby dies *before* the 20th week of pregnancy. *Stillbirth* is the death of a baby *after* the 20th week of pregnancy but before delivery. Whenever parents deal with the death of their baby, whether it be early in pregnancy, late in pregnancy, or sometime after birth, there can be a great sense of disappointment, loss, and suffering. Stillbirth and miscarriage are separately defined not because one or the other is an easier or more difficult loss with which to deal, but because they differ in many ways. Stillbirth and miscarriage have different causes, need different evaluations, and differ medically and in the ways that parents and families can best be helped.

Stillbirth is common. It may affect anyone. There is no way to predict when stillbirth will happen or who will experience it. Stillbirth occurs in families of all races, religions, and income levels. Each year in the United States

about 25,000 babies, or 68 babies every day, are born still. This is about 1 stillbirth in every 115 births. Most often a stillbirth is detected while the baby is in the mother's uterus, sometimes not until labor is underway.

Why Was Your Baby Stillborn?

Following a stillbirth, parents frequently ask, "Why did this happen?" Sometimes a reason is found; other times a specific cause remains unknown. Extensive and careful evaluation of the baby and placenta following delivery may help identify a reason in about 40%-50% of stillbirths. When a specific cause is not identified, evaluation may still be helpful by at least ruling out potential high risks for recurrence.

Identifiable causes of stillbirth generally fall into one of three different categories: birth defects in the baby, problems with the placenta or umbilical cord, or maternal illnesses or conditions which may sometimes affect pregnancy.

- *Birth defects* are common but often overlooked causes for stillbirth. About one-fourth of babies who are stillborn have one or more birth defects that are responsible for their death.

- The *placenta and umbilical cord* are the baby's "lifeline" for oxygen and nutrients. Problems in either one may completely cut off or severely interfere with the needed flow of blood, oxygen, and nutrients to the baby. Although commonly pointed to as the likely cause for death of a baby, problems with the placenta or umbilical cord actually account for only a moderate number of stillbirths.

- Although uncommon, *maternal conditions* may be responsible for stillbirth. Certain illnesses in the mother, such as diabetes or hypertension, and their treatments, sometimes cause stillbirths. An increased risk for stillbirth is also associated with the use of certain recreational drugs, particularly cocaine.

In addition, there are many other rare causes of

stillbirth. Whether or not a specific cause for your baby's death is identified, it is most important to remember that *stillbirths most often are not caused by something you did or did not do.*

What Is Involved In An Extensive Evaluation Of The Baby?

Following delivery of a stillborn, parents may be asked to provide consent for extensive evaluation of their baby. This evaluation involves many different studies, including an internal post-mortem examination (autopsy), a physical examination, photographs of the baby's face, body, and any unusual features, X-rays, and genetic testing of some of the baby's tissues. If permission is given, evaluations are started soon after the baby's delivery. Detailed results are usually available and communicated to parents in a few weeks to a few months.

These studies can be helpful for many reasons. They may provide answers or insight to some of your questions including the frequently asked, "Why did it happen?" and "Will it happen again?", as well as those about management and care in future pregnancies. Even if some questions remain unanswered, there may be comfort in knowing that as much as possible was learned about the baby and that important information may be added to medical knowledge which could help other babies in the future. The baby is treated respectfully at all times. Agreeing to a comprehensive evaluation does not prevent a family from spending time with their baby or choosing to have a funeral, memorial service, cremation, or burial.

Such evaluation is valuable to most parents as they try to deal with the full impact of their loss. In fact, very few parents express regret for having the suggested evaluations done. Nevertheless, some may think that such assessment violates their baby and intrudes upon their grief. Parents must choose what is best for them. Whatever the decision, it is respected.

What About Future

Generally one stillbirth does not predict

*Pregnancies? Will
Stillbirth Happen
Again?*

another. On average, there is approximately a 3% chance for stillbirth to happen again in the next pregnancy—or approximately a 97% chance that a future pregnancy would *not* end in stillbirth. Extensive evaluation of the baby may provide information that allows a geneticist, genetics counselor, or your doctor to determine more accurately what the chances are that stillbirth could happen again. Finding a specific cause may imply a much higher or lower risk than this average one. Specific causes, when discovered, more often result in a decrease in the estimated risk that stillbirth may happen again and less often in an increase in that estimated risk. In almost all circumstances, subsequent healthy pregnancies *are* possible.

*Making Sense Of What
Happened*

In the natural course of life events, babies are least of all expected to die. The loss of a baby through stillbirth can be overwhelming and devastating. Although surprising to some, the stillbirth of a baby is a great loss, as great as that of an older child or any loved one.

When stillbirth occurs, parents who were anxiously awaiting a baby suddenly are not. It is natural for you to grieve deeply for your baby who has died and for the hopes, dreams, and wishes that will never be; hopes, dreams, and wishes that, for you, were real long before the anticipated birth of your baby. You may feel a strong sense of sadness, anger, or maybe bitterness at the unfairness of this tragedy. You may experience feelings of loneliness and longing, helplessness, or, because of the intensity of your emotions, confusion. Many parents also feel guilt. They often wonder if they did something to cause their baby's death; this is rarely true.

These intense emotions are real and a normal part of grieving. Grieving is a process of making meaning out of your loss and of life without your baby. Grieving is not easy. It is long, unpredictable, and requires a lot of energy. But you *need* time to grieve since grieving is necessary to work through pain toward healing.

Coping With Your Loss

Dealing with the death of your baby may be one of the most painful experiences in your life. Everyone copes and mourns differently. Perhaps a few of the following suggestions can help you survive some of the difficult times.

- *Take care of yourself.* Eat well. Get plenty of rest. Stay well physically so that you can continue to heal emotionally.

- *Express yourself.* Talk about your baby, your feelings, your fears, your grief. Or keep a diary, write a journal, create, start a flower garden. This may help you to see things more clearly.

- *Read written resources.* There are many books, articles, poems, and videos that can provide information, guidance, and support.

- *Find a support network.* Such a network may be your family, your friends, or your faith community. You may want to contact a support group for parents who have experienced the death of a baby, to share your story and feelings and to learn from others who have also "been there".

Above all, give yourself *time*. Be patient. You will never forget your baby, but you will heal. Healing is an ongoing process; it does not happen overnight. But it *will* happen.

For More Help:

Support:

Share. National Office, St. Joseph Health Center, 300 First Capitol Dr., St. Charles, MO 63301-2893; 800-821-6819.

Pen Parents, Inc. P.O. Box 8738, Reno, NV 89507-8738; 702-826-7332

Suggested Reading Material:

Empty Cradle, Broken Heart, by Deborah L. Davis, Ph.D., Fulcrum Press, 1996 (second edition).

*Department of Health and Social Services
Alaska Bureau of Vital Statistics*

Certificate of Birth Resulting in Stillbirth

According to Alaska State Records

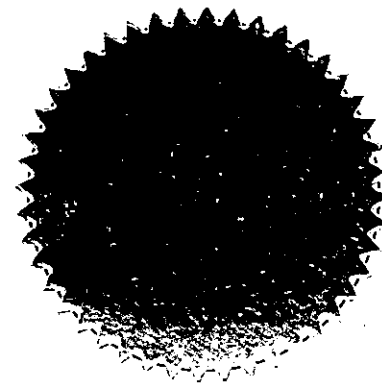
Bump Nevels Was Delivered on August 1, 2002

In Cicely, Alaska

To Carolyn Anne Puckett and John Earl Nevels

Date Issued: 11/29/2005

FD Number: 2002999999



This certificate is not proof of live birth

Fetal Deaths
Alaska 2000-2004

	deaths	rate*
2000	45	4.5
2001	41	4.1
2002	50	5.0
2003	59	5.8
2004	57	5.5

Note: Fetal deaths are calculated if gestation is at least 20 weeks
* rates are per 1,000 live births.

Source: Alaska Bureau of Vital Statistics, March 2007

Fetal deaths
From: Walden, Stephanie [Stephanie_Walden@health.state.ak.us]
Sent: Thursday, March 01, 2007 5:14 PM
To: Sandra Wilson
Subject: Fetal deaths

National Fetal Death rates:

2000	6.6
2001	6.5
2002	6.4
2003	6.2

Rates are per 1,000 live births in the U.S. for pregnancies lasting at least 20 weeks.

I couldn't find data for 2004.

Sorry about the delay in responding. I just received your email at 4:20, and it looks like you sent it this morning. Must be having problems with our system again.

Let me know if you need anything else.

Stephanie

Alaska State Legislature

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**Session:**

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Rep_Carl_Gatto@legis.state.ak.us

Representative Carl Gatto

Chair, House Military and Veteran Affairs Committee

District 13 - Palmer

Departments affected by HB 2:

Vital statistics is the only department affected by HB 2

Witness list:

I am unable to provide a witness list until the hearing date is schedule due to the schedules of those who may or may not be able to testify.

A **stillbirth** occurs when a fetus which has died in the uterus or during labor or delivery exits a woman's body. The term is often used in distinction to live birth or miscarriage. Most stillbirths occur in full term pregnancies.

Some sources reserve the term "stillbirth" for a fetus which has died after reaching mid-second trimester to full term gestational age. For example, in the United Kingdom, "stillbirth" is used to describe an infant delivered without life after 24 weeks gestation. The sources that use this definition tend to use the term "miscarriage" if the death occurs earlier in development. In contrast, other sources use the term "stillbirth" regardless of the stage of fetal development.

Sec. 18.50.950. Definitions.

In this chapter,

- (1) "adoptive parent" means a person who has adopted another person under AS 25.23;
- (2) "biological parent" means a parent named on the original certificate of birth of an adopted person;
- (3) "bureau" means the Bureau of Vital Statistics;
- (4) *[Repealed, 88 ch 56 SLA 2005.]*
- (5) "commissioner" means the commissioner of health and social services;
- (6) "dead body" means a lifeless human body or parts or bones of it from the state of which it reasonably may be concluded that death recently occurred;
- (7) "department" means the Department of Health and Social Services;
- (8) "fetal death" means death before the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, where
 - (A) the death is indicated by the fact that, after expulsion or extraction, the fetus does not breathe or show evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles; and
 - (B) the expulsion or extraction is not caused by an induced termination of pregnancy;
- (9) "filing" means the presentation of a certificate, report, or other record provided for in this chapter, of a birth, death, fetal death, adoption, marriage, or divorce for registration by the bureau;
- (10) "final disposition" means the burial, interment, cremation, or other disposition of a dead body or fetus;
- (11) "induced termination of pregnancy" means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and that does not result in a live birth, except that "induced termination of pregnancy" does not include management of prolonged retention of products of conception following fetal death;
- (12) "institution" means a public or private establishment that provides in-patient medical, surgical, or diagnostic care or treatment, or nursing, custodial, or domiciliary care to two or more unrelated individuals, or to which persons are committed by law;
- (13) "live birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that, after expulsion or extraction, breathes or shows evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;
- (14) "medical history" includes information relating to a person's medical conditions and treatment, immunization records, and other medical information about the person that could be important to the health care of the adopted person;
- (15) "physician" means a person authorized or licensed to practice medicine under the laws of the state;
- (16) "registration" means the acceptance by the bureau and the incorporation in its official records of certificates, reports, or other records provided for in this chapter, of births, deaths, fetal deaths, adoptions, marriages, or divorces;
- (17) "state registrar" means the state registrar of vital statistics;

(18) "system of vital statistics" includes the registration, collection, preservation, amendment, and certification of vital statistics records, and related activities including the tabulation, analysis, and publication of statistical data derived from them;

(19) "vital statistics" means records of birth, death, fetal death, induced termination of pregnancy, marriage, divorce, adoption, and related data.

What is the legal definition of a stillbirth?

A stillborn child is legally defined as a child born after the 24th week of pregnancy who did not show any signs of life after being born. UK

United Kingdom

In the **United Kingdom**, stillbirths must be **registered by law**. The Stillbirth Definition Act (**1992**) requires that any 'child' expelled or issued forth from its mother after the 24th week of pregnancy that did not breathe or show any other signs of life be registered as a stillbirth. This must be done within 42 days and a Stillbirth **Certificate** is issued to the parent(s).^[1]

United States

In the **United States**, there is no standard definition of the term 'stillbirth'.^[4] The **Centers for Disease Control and Prevention** collects statistical information on "live births, fetal deaths, and induced termination of pregnancy" from 57 reporting areas in the United States. Each reporting area has different guidelines and definitions for what is being reported; many do not use the term "stillbirth" at all. The federal guidelines suggests (at page 1) that fetal death and stillbirth can be interchangeable terms. The CDC definition of "fetal death" is based on the definition promulgated by the World Health Organization in 1950 (see **section above on Canada**).

The federal guidelines recommend reporting those fetal deaths whose birth weight is over 350g, or those over 19 weeks gestation. Forty-one areas use a definition very similar to the federal definition, thirteen areas use a shortened definition of fetal death, and three areas have no formal definition of fetal death. Only 11 areas specifically use the term 'stillbirth', oftentimes synonymously with fetal death, however they are split between whether stillbirths are "irrespective of the duration of pregnancy", or whether some age or weight constraint is applied.

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Representative Carl Gatto

Chair, House Military and Veteran Affairs Committee

District 13 - Palmer

Witness list:

- Michelle Hoyt (Palmer)
- Rhonda Crawford (Soldotna)
- Carletta Gemmell (Kenai)
- Joanne Cacciatore (Arizona)
- Mayme Ohnemus (Cooper Landing)
- Amber Ohnemus
- Chauna Sheppard (Anchorage)
- Daryl Logullo

John Davies

From: Mitchell, Phillip L (HSS) [phillip.mitchell@alaska.gov]
Sent: Friday, March 06, 2009 9:12 AM
To: John Davies
Subject: RE: Stillbirth definition

John,

I think your first alternative is fine, since if the bill is adopted the Bureau will be required to include the state file number from the corresponding fetal death certificate on the certificate of birth resulting in stillbirth under section (C). We can only do this if we have a fetal death record on record.

The only change I would suggest is to change "is issued" to "has been registered". We have many records (fetal death and otherwise) that have been registered but never issued. As (h) is currently written a stillbirth could meet the fetal death definition of 18.50.950 but not be considered a stillbirth since the fetal death certificate had never been issued. If I haven't explained this well let me know; it may be easier if we talked.

Phillip

From: John Davies [mailto:John_Davies@legis.state.ak.us]
Sent: Wednesday, March 04, 2009 9:13 AM
To: nss@cox.net
Cc: Mitchell, Phillip L (HSS); Wilson, Sandra (LAA)
Subject: RE: Stillbirth definition

Dear Richard Olsen,

Thank you for your prompt response. I have done significant research since my previous email to you. I have learned that a number of states have adopted laws providing birth certificates resulting in stillbirth, and that there is a split on the use of a specific gestation period.

Alaska Statutes presently defines "fetal death" at AS 18.50.950 (8), which definition is the same as the WHO definition. Alaska Dept. of Vital Statistics issues a fetal death certificate for stillborns at or beyond 20 weeks gestation, and it is optional to issue a fetal death certificate for a stillborn prior to 20 weeks.

So as to keep our stillbirth certificate law consistent with our fetal death and fetal abuse laws we are thinking that the definition in the propose law ought to be something such as follows:

- (h) In this section, "stillbirth" or "stillborn child" refers to a fetal death occurring in the state as defined in AS 18.50.950 (8) (A) and (B), and for which a fetal death certificate is issued.

Or alternatively:

- (h) In this section, "stillbirth" or "stillborn child" refers to a fetal death occurring in the state as defined in AS 18.50.950 (8) (A) and (B).
- (i) A certificate of birth resulting in stillbirth may only be issued if a certificate of fetal death has been issued.

I would appreciate your thoughts.

Thank you for your time and attention to this matter.

Regards,

John Davies

From: National Stillbirth [mailto:nss@cox.net]
Sent: Tuesday, March 03, 2009 6:17 PM
To: John Davies
Subject: RE: Stillbirth definition

TO: John Davies

Birth is an event. The majority of babies are delivered "live". In fact, what we commonly refer to as a "birth certificate" to memorialize the event is more properly described as a "Certificate of Live Birth". Have a look at http://www.cdc.gov/nchs/vital_certs_rev.htm for more information.

If there is a Certificate of Live Birth, does it not make a prima facie case for the issuance of a "Certificate of Stillbirth". As stated above, "birth" is an event. Live or still is an outcome.

A stillbirth is the delivery of a baby, that has completed 20 weeks or more of gestation, vaginally or by cesarean that is not live at time of birth. That means 1) there is no beating heart, 2) no pulsating umbilical cord, 3) no respiration and 4) no voluntary movement. If any of these signs are present and the baby subsequently dies it is deemed to be a fetal death.

Fetal deaths prior to 20 weeks gestation are deemed to be "miscarriages", not "stillbirths". The foregoing refers to involuntary fetal death that is not the product of an elective termination for medical or personal reasons.

See attached, "Why we Need a Certificate of Stillbirth" and Open Letter to Alaska Legislature sent last session.



National Stillbirth Society

Richard K. Olsen, Founder
 Post Office Box 10273
 Phoenix, AZ 85064
 TEL: 602-216-6600
 FAX: 602-861-8090
 nss@cox.net

From: John Davies [mailto:John_Davies@legis.state.ak.us]
Sent: Tuesday, March 03, 2009 4:27 PM
To: nss@cox.net
Cc: Rep. Wes Keller
Subject: Stillbirth definition

Dear National Stillborn Society,

I am working for the Alaska State Legislature, and we are in the process of drafting a law that would allow parents

of a stillborn child to obtain a birth certificate for the stillborn. We are struggling with a definition for "stillbirth" and "stillborn" and "stillborn child". Is there a model definition that we could use that would be acceptable to both the pro life and pro choice camps that would stand up to legal challenge? Any input would be greatly appreciated.

Thank You,

John Davies
Chief of Staff to
Rep. Wes Keller

John Davies

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 3:01 PM
To: John Davies
Subject: RE: HB 2

I am well aware of that fact. And yes I have seen that video and it is an excellent one. My concern has been that by holding up the bill drastically decreases the chances of it passing this year strictly due to time constraints. The bill was modeled off of another bill and the definition was taken directly from what other states had used.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 2:58 PM
To: Sandra Wilson
Subject: RE: HB 2

Thanks, I just came from that website before I wrote to you. I also went on the MISS website and viewed an excellent video. Will you carry the bill? Will you show the video? Yes, I read the definition in the Arizona materials. I don't mean to be reinventing the wheel, I was asked to weigh in on the definition and am doing my due diligence. You probably know all this already. In my view the more your bill looks like other existing legislation the better chance it has of passing without any "hitches". JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 2:52 PM
To: John Davies
Subject: RE: HB 2

Yes I am Familiar with the National stillbirth Society. The definition that is currently in the bill is one that is also in many versions around the country. I have spoken with the founder of this society and he actually testified on the bill last year. The lady whose name I mentioned is the founder of the M.I.S.S. Foundation. The national stillbirth society describes stillbirth as the intrauterine death and subsequent delivery of a developing infant that occurs beyond 20 completed weeks of gestation. (A loss prior to 20 weeks is termed a miscarriage or "pregnancy loss".) this is found on their website. <http://www.stillnomore.org/main.htm>

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 2:45 PM
To: Sandra Wilson
Subject: RE: HB 2

Sandra, Are you familiar with the National Stillbirth Society? I have been researching this issue and sent a request to them about a model definition. I see that the lady that you named is prominent in the Stillbirth educational community. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 1:16 PM
To: John Davies
Subject: RE: HB 2

Is there a specific committee member who has a problem with the bill that is holding it up? Or is it just details on the language?

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 1:14 PM
To: Sandra Wilson
Subject: RE: HB 2

Good thoughts Sandra. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 12:15 PM
To: John Davies
Subject: RE: HB 2

The suggestions would be as follows and this is based off of the CS that was heard in committee:

On page 1 line 6 following "of" delete "a stillborn child" and insert "the stillbirth"

On page 1 line 12 following "of" delete "a stillborn child" and insert "the stillbirth"

On page 1 line 13 following "name" delete "of a stillborn child"

On page 2 line 1 following "name" delete "of the stillborn child"

On page 2 line 6 following "birth" delete "of a stillborn child"

On page 2 line 14 remove everything following "stillbirth" and insert "is that as defined in AS 18.50.950(8).

If you were to make those changes there would be no reference to a child and take away any concerns that have been raised.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 11:58 AM
To: Sandra Wilson
Subject: RE: HB 2

Yes, I had the word fetus in my first draft, but changed it to follow the referred to statute. I am glad that you have been talking to others with experience. That's a great help. Based on your conversations do you have any new draft language? Thanks JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 10:27 AM
To: John Davies
Subject: RE: HB 2

I understand. I have been talking with those who have worked on this in other states. And in states where this issue has come up what they have done to quash any belief that this would in any way give rights to or somehow do what we did not want it to do was delete the word child and insert the word fetus. By doing this we take away any reference to a child.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 10:00 AM
To: Sandra Wilson
Subject: RE: HB 2

Let's talk to Jean about this tomorrow and look to get the bill out of committee next week. It would be better to get it right now to insure its passage later. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 9:52 AM
To: John Davies
Subject: RE: HB 2

You could make it simpler by saying that in this section "stillbirth" or "stillborn child" is that as defined in AS 18.56.950 (8)

I do not have a problem meeting with the two of you tomorrow. I was just hoping that we would be able to get this heard and passed out today because the hope that both myself and Rep. Gatto is that we could pass this bill through this year. This is more and more unlikely as it takes longer to get it out of committee. I guess I don't completely understand the issue at hand because it states very clearly in the bill that the issuance of the birth certificate is not proof of live birth.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 9:35 AM
To: Sandra Wilson
Subject: HB 2

Dear Sandra,

This email is a heads up for your to keep you apprised of the movement on your bill. Here is the proposed definition of "stillborn child" that we propose:

- (h) In this section, "stillbirth" or "stillborn child" refers to the unintended death of a product of human conception as defined in AS18.50.950 (8)(A) and (B).

Give this some thought. We have an appointment to meet with Jean Mischal, Leg Legal, tomorrow at 9am at her office in the TMOB. I would like you to attend with Matt and I so that you can have your input heard on this.

We are trying to make sure that the definition is tight enough so as not to cause the bill to fail or run into problems with legal challenges.

Jean was working on a drafting job today and couldn't see us until tomorrow.

Regards,
John Davies

John Davies

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Sandra Wilson
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465-3163

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You could make it simpler by saying that in this section "stillbirth" or "stillborn child" is that as defined in AS 18.56.950 (8)

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Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 9:35 AM
To: Sandra Wilson
Subject: HB 2

Dear Sandra,

This email is a heads up for your to keep you apprised of the movement on your bill. Here is the proposed definition of "stillborn child" that we propose:

- (h) In this section, "stillbirth" or "stillborn child" refers to the unintended death of a product of human conception as defined in AS18.50.950 (8)(A) and (B).

Give this some thought. We have an appointment to meet with Jean Mischal, Leg Legal, tomorrow at 9am at her office in the TMOB. I would like you to attend with Matt and I so that you can have your input heard on this.

We are trying to make sure that the definition is tight enough so as not to cause the bill to fail or run into problems with legal challenges.

Jean was working on a drafting job today and couldn't see us until tomorrow.

Regards,
John Davies

Matthew Johnson

From: Jim Pound
Sent: Thursday, March 05, 2009 1:58 PM
To: Matthew Johnson
Subject: 07 aac

7 AAC 05.450. Fetal deaths

Any product of gestation of less than 20 weeks duration of pregnancy, showing no evidence of life, may have a fetal death certificate prepared, filed, recorded, and registered as required above, at the option of the parents or others concerned; such certificate is not mandatory for fetal deaths with a duration of pregnancy of less than 20 weeks. However, this regulation does not release anyone from the duty of reporting any suspicion of foul play or illegal act; nor does it except such cases from any existing burial requirements or restrictions, or other health requirements, either state or local.

History: In effect before 7/28/59; am 7/25/60, Register 2

John Davies

From: John Davies
Sent: Wednesday, March 04, 2009 9:13 AM
To: 'nss@cox.net'
Cc: 'phillip.mitchell@alaska.gov'; Sandra Wilson
Subject: RE: Stillbirth definition

Dear Richard Olsen,

Thank you for your prompt response. I have done significant research since my previous email to you. I have learned that a number of states have adopted laws providing birth certificates resulting in stillbirth, and that there is a split on the use of a specific gestation period.

Alaska Statutes presently defines "fetal death" at AS 18.50.950 (8), which definition is the same as the WHO definition. Alaska Dept. of Vital Statistics issues a fetal death certificate for stillborns at or beyond 20 weeks gestation, and it is optional to issue a fetal death certificate for a stillborn prior to 20 weeks.

So as to keep our stillbirth certificate law consistent with our fetal death and fetal abuse laws we are thinking the definition in the propose law ought to be something such as follows:

- (h) In this section, "stillbirth" or "stillborn child" refers to a fetal death occurring in the state as defined in AS 18.50.950 (8) (A) and (B), ^{the death of a fetus} and for which a fetal death certificate ^{is issued}.

Or alternatively:

- (h) In this section, "stillbirth" or "stillborn child" refers to a fetal death occurring in the state as defined in AS 18.50.950 (8) (A) and (B).
 (i) A certificate of birth resulting in stillbirth may only be issued if a certificate of fetal death has been issued.

I would appreciate your thoughts.

Thank you for your time and attention to this matter.

Regards,
 John Davies

From: National Stillbirth [mailto:nss@cox.net]
Sent: Tuesday, March 03, 2009 6:17 PM
To: John Davies
Subject: RE: Stillbirth definition

TO: John Davies

Birth is an event. The majority of babies are delivered "live". In fact, what we commonly refer to as a "birth certificate" to memorialize the event is more properly described as a "Certificate of Live Birth". Have a look at http://www.cdc.gov/nchs/vital_certs_rev.htm for more information.

If there is a Certificate of Live Birth, does it not make a prima facie case for the issuance of a "Certificate of Stillbirth". As stated above, "birth" is an event. Live or still is an outcome.

A stillbirth is the delivery of a baby, that has completed 20 weeks or more of gestation, vaginally or by cesarean that is not live at time of birth. That means 1) there is no beating heart, 2) no pulsating umbilical cord, 3) no respiration and 4) no voluntary movement. If any of these signs are present and the baby subsequently dies it is

deemed to be a fetal death.

Fetal deaths prior to 20 weeks gestation are deemed to be "miscarriages", not "stillbirths". The foregoing refers to involuntary fetal death that is not the product of an elective termination for medical or personal reasons.

See attached, "Why we Need a Certificate of Stillbirth" and Open Letter to Alaska Legislature sent last session.



National Stillbirth Society

Richard K. Olsen, Founder
Post Office Box 10273
Phoenix, AZ 85064
TEL: 602-216-6600
FAX: 602-861-8090
nss@cox.net

From: John Davies [mailto:John_Davies@legis.state.ak.us]
Sent: Tuesday, March 03, 2009 4:27 PM
To: nss@cox.net
Cc: Rep. Wes Keller
Subject: Stillbirth definition

Dear National Stillborn Society,

I am working for the Alaska State Legislature, and we are in the process of drafting a law that would allow parents of a stillborn child to obtain a birth certificate for the stillborn. We are struggling with a definition for "stillbirth" and "stillborn" and "stillborn child". Is there a model definition that we could use that would be acceptable to both the pro life and pro choice camps that would stand up to legal challenge? Any input would be greatly appreciated.

Thank You,

John Davies
Chief of Staff to
Rep. Wes Keller

Subject: Stillbirth definition

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Thank You,

John Davies
Chief of Staff to
Rep. Wes Keller

John Davies

From: National Stillbirth [nss@cox.net]
Sent: Tuesday, March 03, 2009 6:17 PM
To: John Davies
Subject: RE: Stillbirth definition
Attachments: MAIL TO Legislators2.pdf; GENERIC.FOOTPRINTS.pdf; GENERIC.WHY WE NEED.pdf

TO: John Davies

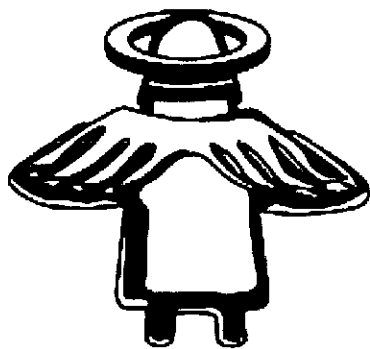
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Fetal deaths prior to 20 weeks gestation are deemed to be "miscarriages", not "stillbirths". The foregoing refers to involuntary fetal death that is not the product of an elective termination for medical or personal reasons.

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 Post Office Box 10273
 Phoenix, AZ 85064
 TEL: 602-216-6600
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From: John Davies [mailto:John_Davies@legis.state.ak.us]
Sent: Tuesday, March 03, 2009 4:27 PM
To: nss@cox.net
Cc: Rep. Wes Keller

John Davies

From: Sandra Wilson
Sent: Wednesday, March 04, 2009 8:47 AM
To: John Davies
Subject: RE: HB 2

I believe that a fetal death certificate is issued after the 20th week. All parents are required to fill out a fetal death certificate but they do not have to request a copy from VS. From the information I have been given by VS it indicates a fetal death is a death that occurs after 20 weeks gestation. The wording you have there is fine with me. The meeting today is at 9 at the terry miller building right?

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Wednesday, March 04, 2009 8:31 AM
To: Sandra Wilson
Subject: HB 2

Dear Sandra,

In your research for HB 2 have you had the opportunity to talk to Vital Statistics? Do you know the circumstances under which a fetal death certificate is issued? I did some research on the VS website and found a report called "Fetal and Infant Deaths" 1995 Annual Report. That report says a fetal death certificate is required if fetal death occurs at at least twenty weeks. It goes on to say the a fetal death certificate is optional for "fetal deaths which occur prior to the twentieth week of pregnancy. It also says that a "fetal death is defined as the death of a fetus after the eighth week of gestation and before delivery." That definition is different from the statute. Do you know if the statute was changed since 1995 regarding the definition?

I have a call in to Phillip Mitchell of VS to ask him about the mechanics of issuing the fetal death certificate.

Also I have taken a look at other jurisdictions and there is a split on whether a gestation period is used. The state of Maryland simple permits the issuance of the birth certificate if a fetal death certificate is issued which seems appropriate. Since in Alaska it appears that a fetal death certificate may be issued for a stillborn prior to 20 weeks I suggest that the definition of stillborn child be consistent with what the VS Dept is now doing with the fetal death certificates.

What do you think of this?

(h) In this section, "stillbirth" or "stillborn child" refers to an unintended fetal death occurring in the state as defined in AS 18.50.950 (8) (A) and (B) and for which a fetal death certificate is issued.

Good to be working with you on this.

Regards,
John Davies

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In your research for HB 2 have you had the opportunity to talk to Vital Statistics? Do you know the circumstances under which a fetal death certificate is issued? I did some research on the VS website and found a report called "Fetal and Infant Deaths" 1995 Annual Report. That report says a fetal death certificate is required if fetal death occurs at at least twenty weeks. It goes on to say the a fetal death certificate is optional for "fetal deaths which occur prior to the twentieth week of pregnancy. It also says that a "fetal death is defined as the death of a fetus after the eighth week of gestation and before delivery." That definition is different from the statute. Do you know if the statute was changed since 1995 regarding the definition?

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Good to be working with you on this.

Regards,
John Davies

John Davies

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 2:52 PM
To: John Davies
Subject: RE: HB 2

Yes I am Familiar with the National stillbirth Society. The definition that is currently in the bill is one that is also in many versions around the country. I have spoken with the founder of this society and he actually testified on the bill last year. The lady whose name I mentioned is the founder of the M.I.S.S. Foundation. The national stillbirth society describes stillbirth as the intrauterine death and subsequent delivery of a developing infant that occurs beyond 20 completed weeks of gestation. (A loss prior to 20 weeks is termed a miscarriage or "pregnancy loss".) this is found on their website. <http://www.stillnomore.org/main.htm>

Sandra Wilson
 Staff to Rep. Gatto
 465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 2:45 PM
To: Sandra Wilson
Subject: RE: HB 2

Sandra, Are you familiar with the National Stillbirth Society? I have been researching this issue and sent a request to them about a model definition. I see that the lady that you named is prominent in the Stillbirth educational community. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 1:16 PM
To: John Davies
Subject: RE: HB 2

Is there a specific committee member who has a problem with the bill that is holding it up? Or is it just details on the language?

Sandra Wilson
 Staff to Rep. Gatto
 465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 1:14 PM
To: Sandra Wilson
Subject: RE: HB 2

Good thoughts Sandra. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 12:15 PM
To: John Davies
Subject: RE: HB 2

Initial Statute
Philly Mitchell
465 8643

The suggestions would be as follows and this is based off of the CS that was heard in committee:

On page 1 line 6 following "of" delete "a stillborn child" and insert "the stillbirth"

On page 1 line 12 following "of" delete "a stillborn child" and insert "the stillbirth"

On page 1 line 13 following "name" delete "of a stillborn child"

On page 2 line 1 following "name" delete "of the stillborn child"

On page 2 line 6 following "birth" delete "of a stillborn child"

On page 2 line 14 remove everything following "stillbirth" and insert "is that as defined in AS 18.50.950(8).

If you were to make those changes there would be no reference to a child and take away any concerns that have been raised.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 11:58 AM
To: Sandra Wilson
Subject: RE: HB 2

Yes, I had the word fetus in my first draft, but changed it to follow the referred to statute. I am glad that you have been talking to others with experience. That's a great help. Based on your conversations do you have any new draft language? Thanks JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 10:27 AM
To: John Davies
Subject: RE: HB 2

I understand. I have been talking with those who have worked on this in other states. And in states where this issue has come up what they have done to quash any belief that this would in any way give rights to or somehow do what we did not want it to do was delete the word child and insert the word fetus. By doing this we take away any reference to a child.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 10:00 AM
To: Sandra Wilson
Subject: RE: HB 2

Let's talk to Jean about this tomorrow and look to get the bill out of committee next week. It would be better to get it right now to insure its passage later. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 9:52 AM
To: John Davies
Subject: RE: HB 2

You could make it simpler by saying that in this section "stillbirth" or "stillborn child" is that as defined in AS 18.56.950 (8)

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Regards,
John Davies

MISSING ANGELS FOUNDATION

MISSING ANGELS BILL FACT SHEET

- I. The bill establishes a "Certificate of Birth Resulting in Stillbirth" as an *optional* document for families requesting and paying for it in our state;
- II. There is already a *death certificate* issued and *legislated final disposition at families' expense* for all stillborn babies in our state;
- III. Stillbirth is the unintentional death of an unborn baby who has *passed 20 completed gestational weeks* as defined by the NICHD. These are not early losses or abortions. Rather these are the births of dead babies;
- IV. Between 25,000-30,000 babies are stillborn in the U.S. each year, one in 100 pregnancies. Most occur at or near full term to otherwise apparently healthy babies;
- V. Other countries including the United Kingdom, Australia, and Ireland already issue certificates of birth for stillborn babies;
- VI. The bill has been passed in 15 U.S. states, and legislation is pending in more than five states;
- VII. A baby born at 19 weeks gestation, pre-viability, but who takes one breath is issued a Certificate of Live Birth and is counted in infant mortality rates. Conversely, a baby born at 40 weeks gestation and past viability can die just one second prior to birth, will only receive a death certificate, and is not counted in infant mortality statistics;
- VIII. It is not only about dignity and validation, but also about maternal health and newborn well-being, epidemiology, and research. It is the right thing to do for women in our state and their families.

For more information visit www.missingangelsbill.org
Or contact your local representative of the MISS Foundation

Contact _____ SB/HB Number _____

"It is always the right time to do the right thing."
Martin Luther King, Jr.

Journal Entries:

- June 9, 2005
- May 13, 2005
- March 15, 2005
- March 14, 2005
- March 11, 2005
- March 10, 2005
- March 9, 2005
- March 7, 2005
- March 4, 2005
- February 26, 2005
- February 24, 2005
- February 16, 2005
- February 11, 2005
- February 10, 2005
- February 9, 2005
- January 25, 2005
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- January 3, 2005
- December, 2004
- November, 2004
- September, 2004
- March, 2004
- October, 2003
- September, 2003
- June, 2003
- May, 2003
- April, 2003
- March, 2003

National Institutes of Health
 Eunice Kennedy Shriver
 National Institute of Child
 Health and Human Development



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Last Update: 12/09/2008

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Research on Miscarriage and Stillbirth

Miscarriage

Miscarriage is the term health care providers use to describe the loss of pregnancy from natural causes before the 20th week of pregnancy. Most miscarriages occur very early in pregnancy, in some cases before a woman even knows she is pregnant. Researchers estimate that, among women who already know they are pregnant, nearly 15 percent will have a miscarriage.

There are many different causes for miscarriage, some of them known and others unknown. In most cases, there is nothing a woman can do to prevent a miscarriage. Having a miscarriage does not mean that a woman won't become pregnant again, or that she will not have normal pregnancies in the future. And, for most women, miscarriage is not a sign of a larger health problem.

Having a miscarriage can be devastating to a woman and her family. A woman or family who is having trouble coping with the loss of a miscarriage should ask a health care provider.

NICHD Research on Miscarriage

The NICHD supports and conducts research on the causes of miscarriage in hopes of finding ways to prevent women from having them. For instance, NICHD-supported researchers recently found that women with a disorder called Polycystic Ovary Syndrome (PCOS) are three times more likely to miscarry during the early months of pregnancy than women who don't have PCOS. Women with PCOS often have great difficulty getting pregnant naturally.

Research has found that women with PCOS also tend to have a condition called insulin resistance, which means their bodies have trouble using the insulin they make to get energy from their cells. Insulin resistance often occurs before someone develops diabetes. To treat this insulin resistance, researchers had been prescribing a drug called *metformin*. What they found was that metformin not only reduced insulin resistance, but it also brought about changes to the uterine lining that could help women with PCOS get pregnant and reduce the risk of miscarriage during their first trimester (the first three months) of pregnancy.

Studies are now underway to confirm the positive effects of the using metformin in women with PCOS, and to evaluate the safety of taking the drug throughout pregnancy. The NICHD's Reproductive Sciences Branch, through its Reproductive Medicine Network (RMN) is currently conducting a clinical trial for the treatment of infertility related to PCOS, using metformin. The RMN Web site provides more information on this trial and on the RNM itself.

Other NICHD-supported research is trying to learn more about repeated miscarriage. Researchers estimate that between 1 percent and 2 percent of women in the United States has more than one miscarriage without a known cause. Women who experience repeated miscarriages may undergo expensive and lengthy tests to try to identify a cause, but often get no answers. NICHD researchers, examining the vuva of these women, have found that many of them share a genetic mutation, or change. This mutation, on one of the X chromosomes, was found in nearly 15 percent of women who had a history of repeated, unexplained miscarriage. If this genetic mutation is confirmed as a cause of repeated miscarriages, researchers may be able to develop a simple blood test that could predict a

[Women's Health Home](#)

Research Areas

-Pregnancy and Birth

- [Prenatal Care](#)
- [Miscarriage and Stillbirth](#)
- [Preterm Labor and Premature Birth](#)
- [Disorders of Pregnancy](#)
- [Breastfeeding](#)
- [SIDS](#)
- [Birth Defects and Developmental Disabilities](#)
- [Other Topics](#)

-Disorders and Treatments

[Clinical Trials](#)

[News Releases and Publications](#)

[Information for Researchers and Health Care Providers](#)

[Additional Resources](#)

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woman's chances of having a miscarriage in future pregnancies.

For more information on NICHD-supported research on miscarriage, read the Institute's [news releases on miscarriage](#). The National Library of Medicine provides additional information on [pregnancy loss](#), which includes miscarriage. For more information, visit the [Medem™ Website](#) and do a search for "recurrent miscarriage" in the medical library.

Stillbirth

Stillbirth is the term health care providers use to describe the loss of a pregnancy after the 20th week of pregnancy, due to natural causes. According to national statistics, stillbirths occur in nearly one in 200 pregnancies in the United States every year.

Stillbirth can occur before delivery, or as a result of complications during labor and delivery. In at least half of all cases, researchers can find no cause for the pregnancy loss.

In some cases of stillbirth, the mother may notice a decrease in the movement or kicking of the fetus. In these cases, the health care provider uses an ultrasound, a machine that uses sound waves to create a picture of the fetus, to learn more about its health. If you are pregnant and have concerns about stillbirth, ask your health care provider if there are special ways he or she wants you to track movement.

Stillbirth can be devastating to a woman and her family. If you or your family are having trouble coping with the loss of a stillbirth, please talk to your health care provider.

In spite of how often stillbirth occurs, and how emotionally painful it can be, little research has been done on this type of pregnancy loss. To encourage more research on stillbirth, the NICHD is supporting a new research initiative, *Research on the Scope and Causes of Stillbirth in the United States*. Through this effort, the NICHD will create a network of research sites whose sole focus will be on understanding stillbirth, its features, its causes, and its effects on a woman's uterus. Patients in this network will include women from a variety of ethnic and economic backgrounds, to provide a clearer picture of this problem. Through this initiative, the NICHD hopes to support work that may some day be able to predict and prevent stillbirths.

The March of Dimes Birth Defects Foundation offers some patient information about stillbirth.

[NICHD Home](#) [Accessibility](#) [Contact](#) [Disclaimer](#) [FOIA](#)



[NIH Home](#)



[DHHS Home](#)



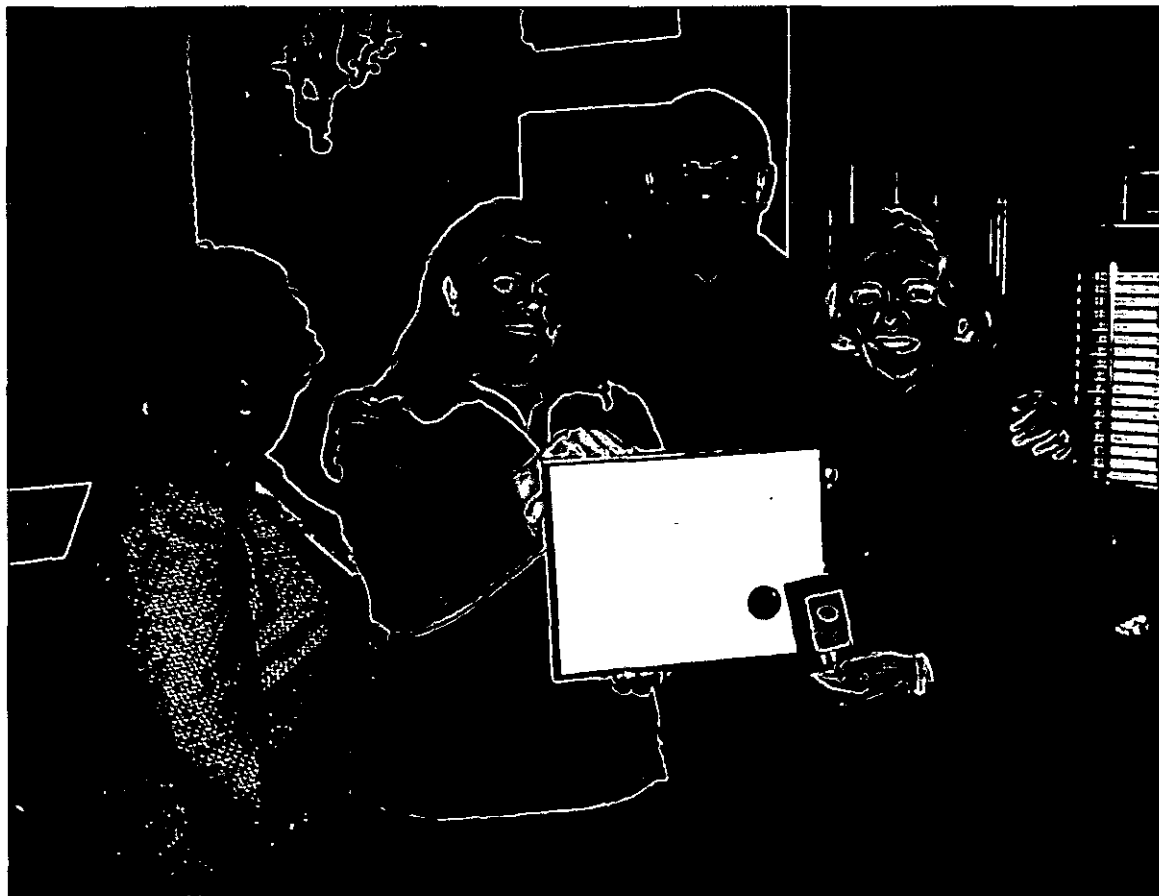
This journal has been organized in 'blog' fashion, with the most recent entry on top. These pages are maintained by John Nevels - please let me know if you have any questions.

Today is **December 15, 2005**.

On December 12, Carolyn and I were invited to Senator Zaffirini's office at the state capitol building in Austin.

We attended an informal ceremony there - and we were given Bump's Certificate of Birth Resulting in Stillbirth.

A picture (or two) is worth a thousand words:



Department of State of Health Services
Texas Vital Statistics

Certificate of Birth Resulting in Stillbirth

According to State Records Bump Nevels

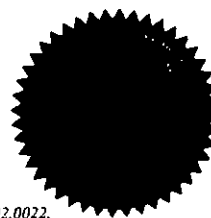
Was Delivered on August 1, 2002

In Weatherford, Parker County, Texas

To Carolyn Anne Puckett and John Earl Nevels II

Date Issued: 11/29/2005

FD Number: 001682-2002



This certificate is not proof of live birth.

This certificate has been issued in accordance to Texas Health and Safety Code Sec. §192.0022.

VS-300 9/2005

You can get a CBRS for your child by visiting: <http://www.dshs.state.tx.us/vs/field/stillbirth.shtm>

On **June 9, 2005**, Governor Rick Perry signed Senator Judith Zaffirini's Senate Bill 271 (The Texas MISSING Angels Bill) into law.

Starting on September 1, 2005, parents of stillborn children in the state of Texas will be able to request and receive a Certificate of Birth Resulting in Stillbirth for any stillborn child they have had, regardless of the date of stillbirth.

Words cannot convey how thankful we are to Senator Zaffirini and her Legislative Director, Mr. Larkin Tackett, for their tireless support and hard work.

If you have a moment - please take the time to thank them - for they are truly worthy of our praise.

You can send an e-mail to Senator Zaffirini **HERE**.

Representative Lon Burnam sponsored the bill on the House side.. you can send him an e-mail **HERE**.

The official History of Senate Bill 271 can be found here:
SB 271 - Legislative Session: 79(R)

At present time, we are waiting to hear from Austin on if (and when) a public bill-signing ceremony will take place. As soon as we hear - we'll get the word out!

On **May 13, 2005** - Senate Bill 271 was heard by the House Committee on Public Health.

Testimony in favor of the measure was given by Becky Ellis, John Nevels, and Brenda Nevels. Carolyn Nevels acted as a witness in support of the measure.

Of the committee members present (two were absent), a unanimous decision was made to favorably report the bill to the LOCAL & CONSENT CALENDERS committee. This is considered good news because passage from this committee will most likely mean that SB 271 will go to the House floor for a full vote within a few days.

If you'd like to see the public hearing, it's available on the internet. Make sure you have RealPlayer installed (it's free and easy to find on the internet if you don't already have it) and then click here: <http://www.house.state.tx.us/fx/av/committee79/50513p33.ram>.

NOTE: There were 3 bills heard before Senate Bill 271. This clip is only about 1 hour and 15 minutes in length.

On **March 15, 2005** - Senate Bill 271 was heard by the Senate Health and Human Services Committee. Upon stating the intent of the legislation, Senator Zaffirini also stated that a committee substitute was being offered that would only be technical in nature and would not impact the original intent of the bill.

Along with my oral testimony, the committee heard from stillbirth mother Amanda Turner, and two other stillbirth parents, Kristi & Howard Davis.

Also testifying on the bill was a young lady named Candice Lewis from the Austin branch of the ACLU. Her position was that she felt it was unfair that a woman who might have to give birth to a dead infant at 19 weeks and 5 days would not be able to receive a CBRS. She wanted 'viability language' written into the legislation.

In 1987, a Texas statute defined viability as follows: "Viable means the stage of fetal development when, in the medical judgment of the attending physician based on the particular fact of the case, an unborn child possesses the capacity of live outside its mother's womb after its premature birth resulting from any cause."

The 1987 bill and current statute also uses "good faith according to the physician's best medical judgment."

So, her suggestion was that the state consider offering a bill that replaces the 20 week gestational age with

"viability", as defined in the Medical Practice Act, determined by the attending physician acting in good faith and using his/her best medical judgement.

One of the Senators on the panel agreed with her and offered to submit an admendment that would redefine stillbirth as a doctor's decision of viability alone.

Senator Zaffirini came out against the admendment stating that the families who have had stillborn children have been waiting long enough, that she and her staff had made every effort to have the legislation be controversy-free, and that while she would accept language that made a compromise - such as "a doctor's determination of viability OR 20 weeks", she would not accept viability language alone.

The Senator with the viability language then withdrew his proposed amendment.

All of the Senators present then voted that the committee substitute for Senate Bill 271 be reported favorably to the Senate.

Afterwards, many of the Senators on the panel met with us, expressed their sympathy, and told us they would do whatever they could do to make the CBRS happen for us.

If you'd like to see the public hearing, it's available on the internet. Make sure you have RealPlayer installed (it's free and easy to find on the internet if you don't already have it) and then click here: <http://www.senate.state.tx.us/avarchive/ram.php?ram=00002175>.

NOTE: Once you get the clip up and running, the part regarding Senate Bill 271 starts at about 1:40:00 on the 2:14:13 length clip.

On **March 14, 2005** - Larkin sent me an email with one question:
Why does the bill define a stillbirth at twenty weeks?

I responded:

The bill specifies 20 weeks because that's the criteria that is used when a Certificate of Fetal Death is issued.....

Texas Administrative Code Title 25 Chapter 181.7

(a) A certificate of fetal death shall be filed for any fetus weighing 350 grams or more, or if the weight is unknown, a fetus aged 20 weeks or more as calculated from the start date of the last normal menstrual period to the date of delivery.

(b) A certificate of fetal death shall be considered properly filed:

(1) when all of the items thereon have been satisfactorily and definitely answered; and

(2) when the certificate has been presented for filing to the local registrar of the registration district in which the fetal death (stillbirth) occurred or the fetus was found. A certificate of fetal death (stillbirth) shall be filed with the local registrar within five days after the date of fetal death (stillbirth).

So.....the state should also offer the parents the opportunity to receive a CBRS based on the same '20 week' criteria.

Also on March 14, Larkin asked:

1. Why not replace the "20 weeks" definition with "after viability?"
2. Why not issue a seperate "Certificate of Birth Resulting in a Miscarriage?"

I responded:

1. Because we have a 'Certificate of Fetal Death' based on 20 weeks. We don't need to get doctors involved in making viability decisions when the state has already made it clear that our child has died and has issued us a 'Certificate of Fetal Death'. We want recognition of the birth event.
2. Stillbirth and Miscarriage are two different events entirely. There is no vital records registration required when a child is miscarried. Our issue is that whenever a 'Certificate of Fetal Death' is issued - a CBRS should be offered.

On **March 11, 2005** - Larkin sent an e-mail with 2 questions.

1. Why not have the fetal death certificate and CBRS be one certificate?
2. Will there be problems with fraud for a CBRS that is left blank?

I responded:

1. Why not have the fetal death certificate and CBRS be one certificate?
Currently, the specific cause of death data placed on Fetal Death Certificate is collected by the state in order to meet CDC/National Center for Health Statistics requirements. It wouldn't be a positive recognition of the birth of a child (whether 'live' or 'stillborn') if the parent had to look at the cause of death (or the contributing factors to that cause of death) on the combination certificate. It makes sense that if the state is mandated to issue a 'death certificate' that the state should issue a 'birth certificate' as well.
2. Will there be problems with fraud for a CBRS that is left blank?
There shouldn't be. The Certificate of Fetal Death is a document containing a serialized number. That number should also be used on the CBRS so that an effective match can be made. In the vast majority of cases.. the parent that does not wish to name a stillborn child will not order a CBRS. Since the CBRS is not proof of a live birth - there should be little if any chance that it would be used in a fraudulent manner.

On **March 10, 2005** - I heard from Larkin that Senator Van de Putte was interested in signing on to SB 271 as a co-author. Also, we heard on this date that the public hearing might be on March 15th (later in the day, it was confirmed, we were set for the 15th).

On **March 9, 2005** - Larkin asked if I could provide him with the full article from the Indianapolis Star that I had previously cited - so I did. A copy of it can be found here.

On **March 7, 2005** - In thinking more about the 'issue' that Planned Parenthood had created I did some research and emailed Larkin with an idea:

Larkin,
The Indianapolis Star ran an article titled "Bill allowing birth certificates for stillbirths advances" on January 22, 2002.

In that article, Dinah Farrington, vice president of public policy for Planned Parenthood of Great Indiana, said her group would not oppose Indiana's legislation because...

"The proposed certificate would not be proof of a live birth."

If we added the language similar to that into Senate Bill 271 - would it be enough to keep them happy?

Larkin then asked if I could provide him a copy of Indiana's law - so I did:

Indiana Code 16-37-1-8.5

Certificate of birth resulting in stillbirth; required contents of certificate

Sec. 8.5.

(a) Upon request by a parent of a stillborn child, a local health officer shall provide to the parent a certificate of birth resulting in stillbirth.

(b) A certificate of birth resulting in stillbirth provided under subsection (a) must contain the following:

(1) The caption "Certificate of Birth Resulting in Stillbirth".

(2) A space for the name of the stillborn child.

(c) A certificate provided under this section is in addition to a certificate of stillbirth registration provided under section 8 of this chapter.

(d) For purposes of federal, state, and local taxes, the certificate provided under this section is not proof of a live birth.

(e) A local health department may charge the same fee for a certificate provided under this section as the fee charged for a certificate of birth registration provided under section 8 of this chapter.

(f) A certificate of birth resulting in stillbirth must be issued on tamper resistant paper.

As added by P.L.13-2002, SEC.1.

On **March 4, 2005** - I received word from Larkin that Planned Parenthood had some issues with the language in Senate Bill 271 and they were proposing changes.

Here is the language proposal I received from Planned Parenthood folks.
Your thoughts?

Thanks,
Larkin

-----Original Message-----

In 1987, Texas passed a ban on third trimester abortions if the fetus was viable. The bill amended the Medical Practice Act of Vernon's Texas Civil Statutes. Sen. Zaffirini was already a member of the Texas Senate then.

You may want to look up the entire statute, but we generally concluded yesterday that it would be best to use some of the language from that existing statute to frame the stillborn birth certificate bill. Specifically, instead of using 20 weeks or any other number, we suggest that "after viability" be used. The 1987 statute defined viability as follows:

"Viable means the stage of fetal development when, in the medical judgment of the attending physician based on the particular fact of the case, an unborn child possesses the capacity of live outside its mother's womb after its premature birth resulting from any cause. However, the term does not apply to a fetus whose biparietal diameter is less than 60 millimeters."

The 1987 bill and current statute also uses "good faith according to the physician's best medical judgment."

Our suggestion is that you consider offering a bill with that replaces the 20 week gestational age with "viability", as defined in the Medical Practice Act, determined by the attending physician acting in good faith and using his/her best medical judgement.

Carolyn and I were both shocked. After a lot of thought (and after receiving some guidance from folks I really trusted) I responded to Larkin on Saturday, March 5, 2005:

Larkin,

I've given this a lot more thought - and I'm willing to provide you alternate definitions of "stillbirth" but I am not willing to muddy our legislation with definitions of "viability".

It is certainly not my desire to put you in the awkward position of placing Senator Zaffirini in the middle of a controversial firestorm.

I have to believe my son would have wanted me to stand up for him.

Let us not hinge the availability of this certificate - a certificate that can provide comfort and help heal grieving hearts - on a doctor's decision of viability.

In looking at the law Maryland passed (link:

<http://198.187.128.12/maryland/lpext.dll/Infobase/2b8ca/2bae3/2bb38/2bc4e?fn=document-frame.htm&f=templates#LPTOC1>) I found language that I would be willing to use as a substitute:

"The Department shall make available a certificate of birth resulting in stillbirth to the parent or parents of a stillborn child for whom a fetal death was registered."

Maryland (link:

<http://198.187.128.12/maryland/lpext.dll/Infobase/2b8ca/2bae3/2bb38/2bb39?fn=document-frame.htm&f=templates#LPTOC1>), defines "fetal death" as:

"Fetal death" means death of a product of human conception, before its complete expulsion or extraction from the mother, regardless of the duration of the pregnancy, as indicated by the fact that, after the expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as heart beat, pulsation of the umbilical cord, or definite movement of voluntary muscle."

Iowa (link: <http://www.legis.state.ia.us/IACODE/2003SUPPLEMENT/144/1.html>) defines "fetal death" as:

"Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy. Death is indicated by the fact that after expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. In determining a fetal death, heartbeats shall be distinguished from transient cardiac contractions, and respirations shall be distinguished from fleeting respiratory efforts or gasps."

Minnesota (link: <http://ww2.revisor.leg.state.mn.us/arule/4601/0100.html>) defines "fetal death" as:

"Fetal death. "Fetal death" means death of a product of human conception before the complete expulsion or extraction from its mother, irrespective of the duration of pregnancy, that is not an induced termination of pregnancy. The death is indicated by the fact that after expulsion or extraction, the fetus does not breathe or show any other evidence of life, including beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions. Respirations are to be distinguished from fleeting respiratory efforts

or gasps."

Could any of these definitions be used for "stillbirth" in our Senate Bill 271 - and therefore keep everyone happy? There's no mention of gestational age.

Larkin, even though my wife Carolyn spent 18 hours in pain to bring our son into this world, there was no acknowledgement of the birth of my son. The vast majority of the people I have told that to were absolutely shocked.

In working out how a parent would receive the CBRS if the stillbirth occurred before the law was enacted, we talked about the fact that having the Certificate of Fetal Death is the key - it would most likely be the 'qualifying criteria' that the state is going ask for when a parent requests a CBRS. What more would 'Planned Parenthood' ask a grieving parent to do? Track down a doctor and get his opinion on viability? What if the doctor is no longer in practice, no longer living, etc? How much more difficult must this be made to appease them? How much more grief would they have us endure?

We have come too far to have this thing turned upside-down on us now. Please - let's stay the course and try to make this happen the way we have worked so hard to have it happen. Let's leave viability out of it and make sure there's nothing 'commemorative' about it.

It's just too important to let it get screwed up.

On **February 26, 2005** - Adel, our precious daughter, died.

We learned that we were pregnant in January 2005.

We found out on February 18 that the HcG level in Carolyn's blood was rapidly falling.

We had already chosen names for this baby - and her name is Adel. It's short for Carolyn's hometown of Adelaide. Carolyn had had dreams about Adel - and she thought they were a positive sign because she had never dreamt about our other children before or after their deaths. In the last dream Carolyn had, Adel was about 8 or 9 years old, she had beautiful blonde hair, was dressed in denim overalls and she was playing outside. She looked so happy.

Adel left us at 12:15 in the morning on February 26.

We'll miss you always, Adel.

On **February 24, 2005**, Larkin sent me an email stating that Senator Zaffirini was going to request to hear SB271 (in committee) on March 8, 2005.

On **February 16, 2005**, I began reaching out to the membership of the MISS Foundation, my family, friends, and co-workers. I created a web page that included a sample letter (much like the one dated February 10 above) and the mailing address of all of the members of the Senate Committee on Health and Human Services. The money we spent on postage was well worth it. I wanted to make sure that the members of the committee were aware that there was, indeed, public support for the bill.

At this point in time - Senate Bill 271 had already been...
Received by the Secretary of the Senate (on 01/25/2005), Filed (on 01/25/2005), Read first time (on 02/03/2005), and Referred to Health & Human Services (on 02/03/2005).

It was rapidly approaching the time when a public hearing would take place - and Carolyn and I wanted to be there.

On **February 11, 2005** - Larkin responded to my February 10 email:

John,
Where does the reference in your letter to twenty weeks in other state regulations come from?

Thanks,
Larkin

I responded on the same day:

Larkin,
I'm glad you asked!
See: <http://www.cdc.gov/nchs/data/misc/itop97.pdf>

It's slightly different from state to state (and reporting area to reporting area), but the most widely accepted definition of 'Stillbirth' (a/k/a Fetal Death) is:

"Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Forty-one areas use a definition very similar to this definition, thirteen areas use a shortened definition of fetal death, and three areas have no formal definition of fetal death.

Current fetal death reporting requirements The 1992 Revision of the Model State Vital Statistics Act and Regulations (1) recommends the following reporting requirement for

fetal death:

"Each fetal death of 350 grams or more, or if weight is unknown, of 20 completed weeks gestation or more, calculated from the date last normal menstrual period began to the date of delivery, which occurs in this state shall be reported within 5 days after delivery to the (Office of Vital Statistics) or as otherwise directed by the State Registrar."

Eleven areas report all periods of gestation as a fetal death; 25 areas report gestation periods of 20 weeks or more; 13 areas specify birthweight of 350 grams or more or 20 weeks of gestation or more; 1 area specifies 20 weeks or more or birthweight of 400 grams or more; 1 area specifies 20 weeks or more or birthweight of 500 grams or more; 1 area specifies birthweight of 350 grams or more; 3 areas specify birthweight of 500 grams or more; 1 area specifies 16 weeks of gestation or more; and 1 area specifies 5 months of gestation or more.

Also on February 11, 2005 - I responded to Colin's February 9 email:

Colin,
Sorry not to have gotten back with you sooner.

If you'll give me about 2 weeks advance notice, I can pretty much be wherever you need me to be.

I'm very happy that Rep. Burnam has filed HB335, and that he has agreed to become the House sponsor for SB271 - but I'm a little concerned that the language is not quite the same.

SB271 will make it the state's responsibility to offer the Certificate of Birth Resulting in Stillbirth (instead of relying on the parent to know that it's available before the event occurs). SB271 also provides that a parent who has had a stillborn child prior to the enactment of the legislation will be able to request the certificate upon providing sufficient documentary evidence of the event.

Please let me know your thoughts.

Subsequently, I was told by Colin that any differences between House Bill 335 and Senate Bill 271 would be changed with what is known as a "Committee Substitute".

On **February 10, 2005** - I sent the following message to Larkin:

Larkin,
Per our recent telephone conversation, attached is the letter I intend to send to the Senate Committee Chairs and Members. Please review and let me know your thoughts. If something needs changing - please just let me know, okay? I just want your opinion on

how I can get this done the right way so we can be successful.
Thanks,
John

Here is the text from the letter that was attached to the e-mail:

A letter to the Senate Committee on Health and Human Services in support of SB-271, which requires the State of Texas to issue Certificates of Birth Resulting in Stillbirth (CBRS) to the parent of a stillborn child if the parent so requests.

February 10, 2005

The Honorable Jane Nelson
P.O. Box 12068
Capitol Station
Austin, Texas 78711

The Honorable Kyle Janek
P.O. Box 12068
Capitol Station
Austin, Texas 78711

Dear Committee Chair Nelson and Committee Vice Chair Janek,

We write today to urge your support for Senate Bill 271 (SB-271), introduced by Senator Judith Zaffirini (D-Laredo). Under this bill, parents whose children are stillborn would be given the option to receive a "Certificate of Birth Resulting in Stillbirth".

Your consideration of this legislation sends a message of hope and compassion for bereaved parents who suffer the devastating loss of a child by stillbirth. Current state policies mandate that when a woman loses a child after 20 weeks of gestation, even though in the vast majority of cases she will have to endure the physical and emotional pains of childbirth, the only certificate available to the parents is a "Certificate of Fetal Death".

By officially acknowledging our stillborn children in a positive manner, our state will provide a level of comfort and support that has been missing. However briefly, our state's stillborn children lived and died. Even in death, all of these children very much matter to all those who continue to love them, continue to grieve for their loss, and continue to wish to honor their memory.

We respectfully request your "YES" vote on SB-271.

Sincerely,

John & Carolyn Nevels

cc: Members, Senate Committee on Health and Human Services

On **February 9, 2005** - I received this message from Colin Leyden (Representative Burnam's aide):

As you are probably aware, Senator Zaffirini and Rep. Burnam have both filed the same legislation to establish a certificate of birth resulting in stillbirth. Our bill has been referred to the Public Health committee in the House of Representatives. We will request a hearing, and need to line up our witnesses to testify for the bill. What is your availability for testifying on behalf of the bill?

Senator Zaffirini will also be moving her bill through the Senate process. Rep. Burnam has agreed to defer to the Senator's bill, at which time he would become the House Sponsor for her bill, if and when it makes it over to the House. We feel it is important to keep the separate bills moving through both chambers, just to be sure. Please call when you get the chance so we can discuss further.

Thanks,
Colin Leyden

On **January 25, 2005** - I received this message from Larkin:

Today, Senator Zaffirini filed SB 271, which requires the State of Texas to issue Certificates of Birth Resulting in Stillbirth (CBRS) to the parents of a stillborn child if the parents so requests.

I'll be in touch.

Thanks,

Larkin Tackett
Legislative Director
Senator Judith Zaffirini

A copy of Senate Bill 271 - as it was first introduced - can be found **HERE**. (Adobe Acrobat Reader may be required).

Subsequently, I asked Larkin what I should be doing next. He suggested that I send a brief letter to each of the Senate Health & Human Services Committee members - asking them for their support on Senate Bill 271. It was also suggested that I have friends and colleagues do the same.

On **January 24, 2005** - after discussing some of the above issues with Joanne Cacciatore, I sent Larkin the following:

Here's something I just learned this from the founder of the MISS Foundation in Arizona (Joanne Cacciatore - who pioneered this legislation there) and wanted to pass it to you: "we've never experienced a circumstance in Arizona where a parent requested a CBRS and did NOT name their child at time of birth. **Never.** Never since 2001 and more than 2,000 CBRS issued."

On **January 21, 2005** - I sent the following comments to Larkin so that he could work with the DSHS and reach a consensus before filing:

Define it however it needs to be defined - but the certificate should remain titled "CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH". It is of paramount importance that the words "Certificate of Birth" are in the title of this certificate. Anything else (or anything less) is a Death Certificate - and that is **not** what I want.

If they give it the title "Certificate of Stillbirth" - that's a definite deal-breaker (as stated above). Moving on to the certificate 'name amending' thing... Make no mistake; the birth of my son - the event itself - was tremendously emotional and difficult. I can fully appreciate and understand why parents may not want to name their child at the time of the birth. My opinion is that if a parent did not have the desire (or emotional wherewithal) to name his or her child at the time of the birth, but now, months or years later they wish to do so, (regardless of whether or not they are trying to obtain a CBRS), the state should do **whatever it takes** to make it possible for a parent to name their heretofore un-named child. I'm relatively confident that the beneficial psychological aspects of naming a child are documented.

On **January 19, 2005** - Larkin sent me the following from the DSHS:

Here are the agency comments:

Sec. 192.0022 (b) (2) and (3) - References to Bureau of Vital Statistics - should be changed to reflect the new name under the Texas Department of State Health Services as "Texas Department of State Health Services Vital Statistics Unit."

Sec. 192.0022 (a) - Definitions on "stillbirth" - the definition in the draft bill may conflict with the National Center for Health Statistics (NCHS) definitions for "live birth" versus "fetal death or stillbirth." These NCHS definitions have been adopted by the World Health Assembly and are recommended for use in the United States. I have a copy of these definitions and will fax them to you separately. As Senator Zaffirini moves forward on this bill, DSHS staff will continue to research the definitions.

Sec. 192.0022 (c) - Name on Certificate of Stillbirth - because it would be necessary to corroborate prior stillborn deaths through existing fetal death certificates, any name placed on the "certificate of birth resulting in stillbirth" would need to be the same name

indicated on the fetal death record. According to the Vital Statistics staff, many of the past fetal death registrations do not have names listed. If the requesting parents want a name listed where no name currently exists, then The fetal death record would have to be amended. It is important that the "certificate" be linked to the fetal death record so there can not be different names on both documents. Parents should only be able to supply a name at the time of the fetal death or if no exists on a previously filed fetal death record.

On **January 7, 2005** - Representative Lon Burnam filed House Bill 335. I found this strange and interesting. It was an almost identical copy to the first draft that Larkin had sent to me back in November - but no other changes had been made to it. I was later told by Larkin that this would be okay - and we had little to worry about.

On **January 6, 2005** - I was sent yet another draft to review and comment on. The text is transcribed below - but you can also access it by clicking **HERE**. (Microsoft Word may be required).

A BILL TO BE ENTITLED
AN ACT

relating to the issuance of a certificate of birth resulting in stillbirth on request of a parent.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter A, Chapter 192, Health and Safety Code, is amended by adding Section 192.0022 to read as follows:

Sec. 192.0022. CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH.

(a) In this section:

- (1) "Stillbirth" means an unintended, intrauterine fetal death occurring in this state after a gestational age of not less than twenty completed weeks.
- (2) "Certificate of birth resulting in stillbirth" means a birth certificate issued to record the birth of a stillborn child.

(b) The person who is required to file a fetal death certificate under Section 193.002 shall advise the parent or parents of a stillborn child:

- (1) that a parent may, but is not required to, request the preparation of a certificate of birth resulting in stillbirth;
- (2) that a parent may obtain a certificate of birth resulting in stillbirth by contacting the bureau of vital statistics to request the certificate and paying the required fee; and
- (3) regarding the way or ways in which a parent may contact the bureau of vital statistics to request the certificate.

(c) A parent may provide a name for a stillborn child on the request for a certificate of birth resulting in stillbirth. The person who prepares the certificate shall leave blank any references to the stillborn child's name if the requesting parent does not wish to provide a name.

(d) The department shall prescribe the form and content of a certificate of birth resulting

in stillbirth and shall specify the information necessary to prepare the certificate.

(e) A parent may request the bureau of vital statistics to issue a certificate of birth resulting in stillbirth without regard to the date on which the fetal death certificate was issued.

(f) The executive commissioner of the Health and Human Services Commission may adopt rules necessary to administer this section.

SECTION 2. Not later than the 60th day following the effective date of this Act, the bureau of vital statistics of the Department of State Health Services shall prescribe the form and content of a certificate of birth resulting in stillbirth and specify the information necessary to prepare the certificate as required by Section 192.0022, Health and Safety Code, as added by this Act.

SECTION 3. A parent may request the bureau of vital statistics of the Department of State Health Services to prepare and issue a certificate of birth resulting in stillbirth without regard to whether the fetal death occurred on, before, or after the effective date of this Act.

SECTION 4. This Act takes effect September 1, 2005.

It was perfect. The only thing was - Larkin wanted to make sure that the DSHS completely agreed with the language in the bill before it would be filed in the Senate.

On **January 4, 2005** - Larkin wanted to make sure that I was okay with the renaming of the certificate from "Birth Certificates for Birth Resulting in Still Birth" (BCBRS) to "Certificates of Birth Resulting in Stillbirth" (CBRS). My response was affirmative - but I reminded him that anything less would not be acceptable.

On **January 3, 2005** - I was send a another draft to review and comment on. The text is transcribed below - but you can also access it by clicking **HERE**. (Microsoft Word may be required).

A BILL TO BE ENTITLED
AN ACT

relating to the issuance of a birth certificate for a birth resulting in stillbirth on request of a parent.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter A, Chapter 192, Health and Safety Code, is amended by adding Section 192.0022 to read as follows:

Sec. 192.0022. BIRTH CERTIFICATE FOR A BIRTH RESULTING IN STILLBIRTH.

(a) In this section, "stillbirth" means an unintended, intrauterine fetal death occurring in

this state after a gestational age of not less than twenty completed weeks.

(b) The party responsible for filing the fetal death certificate pursuant to Sec. XX shall advise the parent or parents of the stillbirth of all of the following:

(1) That they may request preparation of a birth certificate for a birth resulting in stillbirth.

(2) That preparation of the certificate is optional.

(3) How to obtain a certified copy of the certificate if one is requested and prepared.

~~) A parent may request the bureau of vital statistics to issue a birth certificate for a birth resulting in stillbirth.~~

(c) A parent may provide a name for a stillborn child on the request for a birth certificate for a birth resulting in stillbirth submitted under Subsection (b). The person who prepares the certificate shall leave blank any references to the stillborn child's name if the requesting parent does not wish to provide a name.

(d) The department shall prescribe the form and content of a birth certificate for a birth resulting in stillbirth and shall specify the information necessary to prepare the certificate.

(e) Any parent in possession of a fetal death certificate issued prior to the effective date of this Act may request a birth certificate for a birth resulting in stillbirth pursuant to this section.

(e) The executive commissioner of the Health and Human Services Commission may adopt rules necessary to administer this section.

SECTION 2. Not later than the 60th day following the effective date of this Act, the bureau of vital statistics of the Department of State Health Services shall prescribe the form and content of a birth certificate for a birth resulting in stillbirth as required by Section 192.0022, Health and Safety Code, as added by this Act.

SECTION 3. This Act takes effect September 1, 2005.

It met every expectation.

On **December 20, 2004** - I heard back from Larkin - he had feedback from DSHS and wanted to know if I had any questions:

Here are the initial thoughts from DSHS staff:

Basically, there is not any concern about giving parents information about the availability of a certificate at the time of stillbirth from the time of enactment of such legislation. This would be conducted by the hospital and/or funeral home staff as part of the other information the parents receive about the stillborn fetal death certificate. Information could be included in the training materials and process that are conducted by DSHS. Giving them information about the availability of a special certificate may, in fact, provide some measure of solace. However, there is concern that going back to parents whose stillbirth occurred five years ago is not the same situation at all.

As for the retroactive availability of the certificate or "grandfathering"...The grandfathering concept sounds good in principle, but program and legal staff view this as potentially problematic and recommend against inclusion in the bill language. How will parents of stillborn children know about this after the fact? If DSHS is mandated to contact them, there is concern that this would likely result in the reopening of old wounds and a lot of unintended heartache. This could create some unneeded ill will between the

State and these parents. Yet, we understand that there are some parents who would want this certificate regardless of the time that has passed.

And if DSHS is required to do a mass notification, it would obviously increase our short-term expenses and effort. Due to the nature of how records of fetal death certificates have been kept in Texas over time...if this bill is retroactive, it will be labor intensive and time consuming to produce a certificate of birth that resulted in a stillbirth if there was a large demand from years past. There is concern that requiring an affirmative notification of a parent of the availability of a certificate who experienced a stillborn birth prior to the enactment of the law could present some logistical and resources burdens, not to mention potential heartache for the parents. In addition, many of the fetal death registrations do not have names; and would also have to be amended for names to be added. If a fetal death certificate indicates a name, such as "Baby Smith," then program staff recommends that the name be the one used on a still birth certificate. It would be necessary to corroborate prior stillborn deaths through existing records. Please note the interesting facts regarding the registration of Texas fetal death certificates:

- * Fetal death registration begin in 1924 to the present
- * Years 1925, 1928 through 1931-no records located
- * From 1924 through 1988 (213,589 records)-no indices for retrieval (have to manually search each record) and no microfilm or electronic images
- * From 1989 to present (36,995 records as of December 2, 2004) These records also have not been imaged or microfilmed and there is only an limited abstracted database for these.

If Sen. Zaffirini wants to accommodate this request, we think the safest course of action is to simply create within the legislation the right of a parent to request a stillborn certificate for a stillborn event prior to the effective date of the bill, but not impose any obligation on the State or anyone else to affirmatively publicize this option beyond putting the information on our website. This is, of course, assuming we can corroborate a prior stillborn death.

On the same day - I sent the following response to Larkin:

Overall, I believe their feedback is positive. I'm pleased that the parents will be told of the availability of the certificate at the time of the stillbirth (this is still something that I want 'written' into the legislation, though, it's too important to leave out).

I fully understand their concerns with regards to 'grandfathering'. I absolutely agree with the last paragraph where they state that the best course of action is to "simply create within the legislation the right of a parent to request a stillborn certificate for a stillborn event prior to the effective date of the bill, but not impose any obligation on the State or anyone else to affirmatively publicize this option beyond putting the information on our website."

By the way - do we have any idea what the DSHS will require from the parents to corroborate the stillbirth of their child in order to receive the 'BIRTH CERTIFICATE FOR A BIRTH RESULTING IN STILLBIRTH'? All we have from the state is our son's Certificate of Fetal Death.. will that be enough?

Okay... what's next?

On **November 29, 2004** - I received by e-mail the first draft of the legislation for my personal review. It had not been made public - and it had not yet been filed. The text is transcribed below - but you can also access it by clicking **HERE**. (Microsoft Word may be required).

A BILL TO BE ENTITLED
AN ACT

relating to the issuance of a birth certificate for a birth resulting in stillbirth on request of a parent.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter A, Chapter 192, Health and Safety Code, is amended by adding Section 192.0022 to read as follows:

Sec. 192.0022. BIRTH CERTIFICATE FOR A BIRTH RESULTING IN STILLBIRTH.

(a) In this section, "stillbirth" means an unintended, intrauterine fetal death occurring in this state after a gestational age of not less than twenty completed weeks.

(b) A parent may request the bureau of vital statistics to issue a birth certificate for a birth resulting in stillbirth.

(c) A parent may provide a name for a stillborn child on the request for a birth certificate for a birth resulting in stillbirth submitted under Subsection (b). The person who prepares the certificate shall leave blank any references to the stillborn child's name if the requesting parent does not wish to provide a name.

(d) The department shall prescribe the form and content of a birth certificate for a birth resulting in stillbirth and shall specify the information necessary to prepare the certificate.

(e) The executive commissioner of the Health and Human Services Commission may adopt rules necessary to administer this section.

SECTION 2. Not later than the 60th day following the effective date of this Act, the bureau of vital statistics of the Department of State Health Services shall prescribe the form and content of a birth certificate for a birth resulting in stillbirth as required by Section 192.0022, Health and Safety Code, as added by this Act.

SECTION 3. This Act takes effect September 1, 2005.

Later that evening - after having had some time to review - I sent my concerns to Larkin Tackett:

Thanks for allowing me the opportunity to look this over. The language in this bill draft is a huge step in the right direction, but I think something is missing. Unless parents know that the certificate exists - they will not ask for it. Somewhere in the chain of events that occurs when a parent's baby dies to stillbirth - the parent needs to be told that this certificate has been made available for them. Somehow we need to mandate that hospitals (and/or funeral directors) educate their employees in order to ensure compliance with this new law. In some states where the education hasn't been mandated, the parents don't know that the state has made the certificate available to them until they find the information on a website somewhere.

Changes:

1. Let's strike the whole 'on request of a parent' thing. Lines 11 and 12 on Page 1 bug me. I would like it to be made MANDATORY that the parent be offered the opportunity to receive the Certificate of Birth Resulting in Stillbirth (BCBRS). The parent or parents should be offered the option to receive the BCBRS at the same time that the information for the Fetal Death Certificate is being gathered (presumably by the "person in charge of interment or in charge of removal of a body from a registration district for disposition" - because in the state of Texas, that's who is responsible for obtaining and filing a fetal death certificate).

Wisconsin's legislation includes this:

"...the party responsible for filing the fetal death report under s. 69.18(1)(e)1. shall advise the parent or parents of the stillbirth of all of the following:

- (a) That they may request preparation of a certificate of birth resulting in stillbirth.
- (b) That preparation of the certificate is optional.
- (c) How to obtain a certified copy of the certificate if one is requested and prepared."

Arizona's legislation includes the sentence:

"THIS CERTIFICATE SHALL BE OFFERED TO THE PARENT OR PARENTS OF A STILLBORN CHILD."

It's all about the word 'shall' - and I think it makes a huge difference.

2. I would like the Certificate of Birth Resulting in Stillbirth to be "grand-fathered" and made available to all the parents of stillborn children whose birth/death occurred BEFORE this legislation becomes law.

Wisconsin's legislation includes this:

"...if a birth that occurred in this state at any time resulted in a stillbirth for which a fetal death report was required under s. 69.18 (1)(e) 1. but a certificate of birth resulting in stillbirth was not prepared under sub. (2), a parent of the stillbirth may, on or after August 1, 2004, submit to the state registrar a written request for preparation of a certificate of birth resulting in stillbirth and evidence of the facts of the stillbirth that is satisfactory to the state registrar. The state registrar shall prepare and file the certificate of birth resulting in stillbirth within 30 days after receiving satisfactory evidence of the facts of the stillbirth."

3. With regards to lines 19 through 21 on Page 1 and lines 4 through 9 on Page 2, I know that there have been some issues in other states, most notably in South Carolina, where the form and content of the certificate was completely left to the discretion of the state (without input from parents, the true stakeholders) and in those cases, the parents were extremely disappointed when they received something that looked more akin to a fast-food receipt than a state-issued birth certificate. I'd like it very much if we could work together to provide parents what they would like.

Please let me know if you have any questions regarding the changes I'm asking for.

On **November 17, 2004** - I received official word that Senator Zaffirini had agreed to carry the bill.

Today is **November 3, 2004**. In the month of October, we made some significant progress. I've been in contact with hundreds of folks here in Texas - and I have asked them to tell their legislators that they fully support the 'MISSing Angels' legislation that Representative Burnam and Senator Zaffirini are considering.

By the way, if you live in Texas, and would like your legislators to know what's on your mind - regarding the MISSING Angels legislation or anything else - find out who represents you by clicking on the link below:

Who Represents Me? -- Districts By Address

Mr. Tackett and I have been in constant contact. I've also kept Mr. Colin Leyden (Representative Burnam's Legislative Aide) informed of the progress that is being made.

Yesterday, on a conference call with representatives from Department of State Health Services, Mr. Tackett gave me the opportunity to speak on why I was proposing the legislation. I can't say that all of the DSHS participants in the conference call really understood what it was I was asking for.

We are asking that Texas do something more - and that 'something more' is simply this: Under Texas Law, when a certificate of fetal death is required to be filed - and the child was stillborn - the parents will be offered the opportunity to receive (and subsequently pay for) a 'Certificate of Birth - Resulting in Stillbirth'. It really is that simple.

I'm confident that we're making steps in the right direction.

I'd like to say "THANKS!!" to everyone for hanging in there - and helping me to do this. I should have some more news to report in the days ahead.

On **September 24, 2004**, Mr. Tackett and I spoke on the phone. I was told that Senator Zaffairini was very interested in the legislation. Saturday evening, Carolyn and I spent a few hours putting together a packet of information for the Senator, and we'll be mailing it out to Austin on Monday morning, September the 27th.

On **September 23, 2004**, I received the following e-mail:

John & Carolyn,

My name is Larkin Tackett and I'm the Legislative Director for State Senator Judith Zaffirini. I've just recently joined Senator Zaffirini's staff and came across your work on the MISSING Angels bill. I would very much appreciate the opportunity to discuss this issue with you as we are currently compiling our legislative package for the 2005 Session.

Please give me a call or email at your earliest convenience.

Thanks,

Larkin Tackett
Legislative Director
Office of Senator Judith Zaffirini, 21st District
512.463.0121 (o)
512.475.3738 (f)
larkin.tackett@senate.state.tx.us

Today is **March 19, 2004**.

It's been a long time since my last update - sorry about that.

I've since met with the State Representative who represents the district I've worked in for the past 5 years. His name is Lon Burnam.

His Legislative Director in Austin, Colin Leyden, recently wrote:

"At this point it is on track to be part of our legislative package for the 79th session. All ideas for legislation will still be reviewed for final approval by our District 90 Legislative Committee."

"The legislature does not convene until January of 2005. Our final decisions for our legislative package will not happen until probably towards the end of this summer into early fall. You have been an effective advocate for the legislation. At this point, I don't see any reason why it won't end up as part of our final package. However, I will certainly let you know ASAP if it did not - to allow you time to "shop" the bill elsewhere. Please keep me updated with any developments of similar bills across the nation."

During our meeting, Representative Burnam seemed genuinely interested in introducing this legislation - and doing so in a manner that would make it clearly bipartisan.

As his Legislative Director requested, I've been keeping them updated on Missing Angels legislation across the country.

Today is **October 10, 2003**.

I've received an e-mail from my Representative's office - and the news isn't good.

The Representative's Chief of Staff wrote:

"In all truth, I can not offer you a lot of encouragement at this time as to her offering legislation in this regard. Her opinion seems to be that birth certificates are to be used for statistics and not memorials. She understands and certainly sympathizes with you and your wife."

The hope that Representative Anna Mowery had been giving us - was crushed.

So,... now I'm 'shopping' for a better, "kinder gentler" bill author - and I hope to know something soon. With Texas' continuing redistricting mess - and the next regular legislative session being so far away - I understand that this is going to be a slow, arduous process.

Keep checking back. This is Texas.. you never know what might happen.

Today is **October 2, 2003**.

So much has happened with our personal lives - and - in so short a time.

At the end of July (right around the time I last updated this site) Carolyn and I found out that we were pregnant. Cautiously optimistic, we began to prepare for the arrival of Bump's little brother or sister. On September 3rd, during a routine ultrasound examination, Carolyn and I learned that at just shy of 11 weeks gestational age, our baby's heart was no longer beating.

Although it was actually too early in the pregnancy to determine gender, we'd always thought of this baby as a girl and we decided to name her Skye. We're doing better day by day. Slowly, we're learning to deal with this new kind of grief. The messages of sympathy and support that we have received have been awesome. It means so much to us that so many kind people have kept us - and our children - in their thoughts.

From the bottom of our hearts - thank you all.

On **September 9, 2003**, the Governor issued yet another proclamation.

Yep, Congressional Redistricting is back on the agenda again (among other important topics). I haven't been in contact with Representative Mowery's aides in quite awhile. With all this "redistricting stuff" going on, it just seems a little pointless. Once this third special session is over (and it looks like Representative Mowery might be spending some amount of time in her district office) then I will be in contact.

Here we go again... today is **July 30, 2003**.

On July 28, Texas Governor Rick Perry issued yet another proclamation calling for a second special session to consider congressional redistricting.

The "very partisan environment" continues to unfold - and there is no end in sight.

I am still in regular contact with Representative Mowery's aides in Austin and Fort Worth. They have assured me that I will have a chance to speak with the Representative at the earliest possible moment.

I can only speculate that our meeting will take place sometime in later part of August.

Silently, our son came into this world on August 1, 2002. For me, it's hard to believe that nearly one year has passed... we'll always remember and miss you, Bump.

Today is **June 27th, 2003**.

On June 21, Texas Governor Rick Perry issued a proclamation calling the legislators back to Austin (starting June 30th) for a special session to "consider legislation relating to congressional redistricting."

I've since been in contact with Representative Mowery's office. Upon the completion of the special session (which has no set 'completion date') and prior to the Representative taking a leave of absence for a much-needed vacation, they have promised to set aside a block of time for us to visit her in the district office (in Fort Worth) and talk about a MISSING Angels Bill for Texas.

I think we're on the right track.

On **June 6, 2003**, I e-mailed (in part) the following to Representative Mowery's aide:

Once upon a time, you wrote: "If for some reason we are not able to get it passed this session, please contact us well before the next session starts and we can begin to work on it before the session starts."

I have a couple of questions. How soon can we begin working on this legislation, and, is Representative Mowery still interested in authoring and sponsoring it?

Thanks and Best Regards,

John Nevels, II
Proud Father to Bump Nevels
{Born Sleeping 8/1/2002}

Long story short, Representative Mowery is expecting to be called back to Austin for a special session.

I truly believe that her aide is NOT going to let her forget about the Texas MISSING Angels Bill.

This is due, in part, to that fact that I'm not going to let her aide forget about the Texas MISSING Angels Bill!

I'll keep you posted.

On **June 2, 2003**, the 78th Legislature 'Regular Session' ended. Not at all surprising to those familiar with the very partisan environment that unfolded during this session, the 'MISSing Angels Bill' was not formally introduced.

Indeed, we 'came to the table' too late.

Some may see this as a defeat, but this 'battle' has only just begun. With 'courageous patience', I assure you, this will be done.

On **May 22nd through the 24th 2003**, Carolyn and I attended The M.I.S.S. Foundation's annual "Passages" conference for 2003. "Fulfilling",... "thought-provoking",... "healing",... "refreshing". These are the words that come instantly to our minds when thinking of how much the conference meant to us. A special "THANK YOU!" goes out from us to all those who sponsored, attended, and publicized this event.

Kara L.C. Jones (writer, poet, publisher and friend) posted her account of the event, "A Bereaved Parent in Context: "Rising from the Ashes..." on The M.I.S.S. Foundation's Seattle Chapter's website.

On **May 1, 2003**, through e-mail correspondence, I learned from an aide in Representative Mowery's office that one of the Senators had expressed an interest and had planned to offer this as an amendment to one of the existing bills; however, when the bill came out, it did not have the amendment on it."

Subsequently, when I asked the aide if I had any "real" chance this session, I was told:

"As much as I'd like to say yes, there is not much of a chance this session. We got started too late and they are debating budget, ethics, etc. which is of primary interest to all of them now and they don't seem to be making much headway. I wish I could be more positive."

On **April 21, 2003**, I wrote a brief letter to each of the above asking for their support. The text of the letter follows:

Senator/Representative _____,

My name is John Nevels, II - I am the father of Bump Nevels, my only child, who was stillborn on August 1, 2002.

Recently, Representative Anna Mowery contacted your office with regards to adding a "Missing Angels" amendment to Senate/House Bill _____.

This amendment would allow for the issuance of a "Certificate of Birth Resulting in Stillbirth".

Please give the "Missing Angels" amendment proposal a close look - and then, please help to give our mothers in the State of Texas the recognition that they deserve.

Respectfully,

John Nevels, II
Proud Father of Bump Nevels
(Born Sleeping on August 1, 2002)

On **April 9, 2003**, Representative Mowery wrote me the following response:

Dear Mr. Nevels:

Thank you for your fax with bill numbers of possible germane legislation now pending. This was of tremendous help.

I have sent a copy of your original letter to each of the bill authors with a suggestion they offer an amendment to the bill which they have authored in the respective Houses.

I will let you hear from me as soon as I receive a reply from them.

Sincerely,
Anna Mowery

For the record:

House Bill No. 1353 was authored by State Representative Carlos Uresti,
House Bill No. 2990 was authored by State Representative Jaime Capelo,
Senate Bill No. 1553 was authored by Senator Kyle Janek, and,
Senate Bill No. 1744 was authored by Senator Judith Zaffirini.

On **March 31, 2003**, I received a phone call from Representative Mowery during which she informed me that in Texas, we were more than halfway through our current legislative session (which only meets once

every two years). We 'came to the table' too late to author and submit a "MISSing Angels Bill" all by itself. Representative Mowery assured me that she would look for existing legislation that might be germane (related to) the "MISSing Angels Bill". The idea is that the language contained in Arizona's "MISSing Angels Bill" could be written as an amendment and attached to the pre-existing and somewhat relative legislation.

After consulting with some well-respected colleagues, I did a little research on pending legislation and faxed Representative Mowery the following:

April 4, 2003

State Representative Anna Mowery
Texas House of Representatives
Capitol Office
Room CAP 1N.05
P.O. Box 2910
Austin, TX 78768

Representative Mowery,

Once again, thank you for your phone call last Monday afternoon.

I hope I'm not being too forward, but after doing some research, I believe that I may have found some bills that are germane to the "Missing Angels" legislation that I am requesting.

The bills that I've found are:

House Bill No. 1353
House Bill No. 2990
Senate Bill No. 1553
and
Senate Bill No. 1744

Please let me know what your thoughts are to amending one of these bills to include the "Missing Angels" language.

Respectfully,

John Nevels, II
Proud Father of Bump Nevels
(Born Sleeping on August 1, 2002)

On **March 24, 2003**, I sent a written letter to Texas State Representative Anna Mowery. The following is the text of that letter:

The Honorable Representative Anna Mowery
Texas House of Representatives

6421 Camp Bowie Blvd. #310
Fort Worth, Texas 76116

Dear Representative Mowery,

Texas' mothers, parents and families are in need of your help. As a registered voter and a constituent in your district, I ask that you please take a little time and consider what I am about to share with you.

Let me start by telling you about my wife Carolyn, and the birth of our son, Bump Nevels.

In mid-January 2002, Carolyn and I were overjoyed to learn that we were pregnant with our first child. Although having a child is meant to be one of the happiest things that can happen in one's life, our pregnancy ended abruptly in complete devastation. On July 30th, during a routine prenatal non-stress test, we discovered that our son's heart was no longer beating. He was no longer alive. It's important for me to convey to you that during our pregnancy Carolyn never drank alcohol, she didn't smoke, and she didn't endanger our son in any 'way, shape or form'. We followed our doctor's advice at every turn and regardless of our doing the 'right things', our son was dead. Our doctor prescribed medication that would induce labor on the 31st of July and after Carolyn endured natural childbirth for 18 long hours - she delivered our son on August 1, 2002.

'Stillbirth protocols' at hospitals, or the lack of them, dictate if the parents will be given mementos such as the 'crib-card' or the wrist and ankle bands associated with the birth of their baby. Parents of stillborn babies go home with empty arms and broken hearts. It's easy to understand how any 'tangible item' from these tragic events can be considered important in the bereavement process.

In those mind-numbing and surreal hours in the labor and delivery room after our son was born, we were asked what official name we'd like to give our son. We were then told that we would have to make a decision - our son would have to be buried or cremated. Within a few days of his delivery, we received an official 'Certificate of Fetal Death' along with our son's cremains (ashes) from the funeral home.

The most perfect and natural case of 'adding insult to injury' has to be this: Carolyn's body was still producing milk for our son nearly a full month after we had him cremated.

The second most perfect case of 'adding insult to injury' has to be this: Shortly after picking up Bump's ashes from the funeral home, we were shocked to learn that there would be no 'Birth Certificate' from the State of Texas - since there are no provisions for them 'by law', it's simply 'not done'.

Carolyn endured the physical pain of natural childbirth alone - as all mothers must do. I would have suffered that pain for her if it were scientifically possible - but it's not. Together, my wife and I have learned to live with the emotional trauma of our son's death. I think we've come a long way, but we still don't understand why the State of Texas, by omission, refuses to officially acknowledge the birth of our son.

I am asking you to support a 'Missing Angels Bill' for the State of Texas. Under this bill, parents who lose a child after 20 weeks of gestation would be given the option to receive a "Certificate of Birth Resulting in Stillbirth". As of this letter, Texas would be the 6th state to adopt such meaningful legislation as Arizona, Utah, Indiana, Massachusetts, and Michigan have already enacted 'Missing Angels Bills' into law.

According to The Texas Department of Health, Bureau of Vital Statistics 2001 Annual Report Summary, the number of fetal deaths (stillbirths) increased from 2,150 in 2000 to

2,315 in 2001. It is my hope that Texas will quickly rise to the occasion, follow Arizona's lead, and meet the expectations of bereaved parents who suffer such devastating losses. Perhaps one day the state will deem it appropriate to acknowledge my son Bump, and all of Texas' stillborn children. The fact is: they lived, they died, and that - even in death, all of these children very much matter.

I have enclosed four pages of information regarding Arizona's "Missing Angels Bill" for your review. I will contact your office for an appointment to meet with you regarding this, or if you have any further questions prior, you may contact me at either of the above phone numbers. Thanks for all that you do to help Texas families and we appreciate your attention to this important issue.

Respectfully,

John Nevels, II
Proud Father of Bump Nevels
(Born Sleeping on August 1, 2002)

P.S. A great number of people, at home and abroad, have shown their support in getting a Missing Angels Bill passed in Texas (and beyond). I encourage you to view two online petitions that I've created. They are located at:
www.PetitionOnline.com/bn812002 and www.PetitionOnline.com/4ourkids
I hope you will allow me some 'latitude' if you feel that the language on these petitions seems hostile towards legislators in general. Anger has often been identified as one of the many stages of grief; please be assured that I'm learning to better deal with it.
Thanks again.

Arizona House Bill 2416 – Certificate of Stillbirth Fact Sheet

What is the definition of “stillbirth?”

Stillbirth is the intrauterine death of an infant that occurs after the 20th week of pregnancy. (A miscarriage is an intrauterine death prior to 20 completed weeks.) Following its death the mother **must still deliver her baby**. Most stillbirths occur at or near full term.

How are stillbirths recorded in Arizona?

Prior to HB 2416 the Registrar of Vital Records issued only a “*Certificate of Fetal Death*”. This is the only record of the birth the family was able to receive. At the behest of The MISS Foundation the Arizona Legislature in 2001 enacted “The Missing Angels Bill”. It requires the Arizona Department of Health and Human Services to issue a “*Certificate of Birth, Resulting in Stillbirth*”.

How many stillbirths occur every year?

According to the ADHS website, in 1999 there were 682 stillbirths in Arizona. It is estimated 26,000 stillbirths occur nationwide every year, almost as many as there are highway fatalities! Accurate numbers are unknown due to the manner in which stillbirths are recorded. For one, **stillbirths are not included in infant mortality rates**, thereby substantially understating the extent of the problem. As a consequence of this lack of information neither couples nor the general public are aware of the true risks involved. If they were we believe there would be a hue and outcry for medical research to find the answers.

Why do stillbirths occur?

Only 40% of all stillbirths can be attributed to a specific cause such as a cord “accident”, placental problem, malformation, etc. The remainder are said to be due to “undetermined medical reasons”. Crack mothers can have normal babies and Norman Rockwell mothers can have stillborn babies. There is no identifiable socio-economic, ethnic, lifestyle or behavioral predictor that can be identified at this point. Stillbirth is truly an “Equal Opportunity” destroyer of dreams. Every woman who conceives is at risk when one considers that **1 in every 115 births is a stillbirth.**

House Bill 2416 benefits Arizona families in the following ways:

1. **Standardized statistical benefits:** Issuing Birth Certificates for stillbirths will allow clear definitions for accurate statistical analysis and enhanced understanding of stillbirth. It will also allow for better clarity in classification.
2. **Heightened sensitivity:** Feelings of inadequacy among women who experience the simultaneous death and birth of their stillborn infant can be devastating. Issuance of a Certificate of Stillbirth recognizes the reality that a physical birthing occurred and validates their “motherhood”.
3. **Consistency in the law:** The family of a stillborn infant is required by law to bury or cremate their child, despite the fact there was no acknowledgement by the state prior to HB 2416 that this infant they were obliged to dispose of had even been “born”.
4. **Common Sense:** Parents of a baby delivered prematurely at 21 weeks who takes just one breath before dying, are given a Certificate of Birth. Parents of a 10-pound baby whose heart stopped beating just minutes prior to delivery, do not receive a Certificate. This inequity has now been remedied by the passage of HB 2416. It is the first step toward solving the mystery of why babies unexpectedly die in their mother’s womb, by simply recognizing the event. “*Passing HB2416 was the right thing to do and long overdue*”, according to Governor Hull, who spoke those words at the Bill signing earlier

Arizona House Bill 2416 – Certificate of Stillbirth Fact Sheet

What is the definition of “stillbirth?”

Stillbirth is the intrauterine death of an infant that occurs after the 20th week of pregnancy. (A miscarriage is an intrauterine death prior to 20 completed weeks.) Following its death the mother **must still deliver her baby**. Most stillbirths occur at or near full term.

Medically speaking, stillbirth is the death of a baby in it's mother's womb, after 20 weeks gestational age up to the moment of delivery.

Stillbirth is unpredictable and random, and often strikes like lightning in a thunderstorm. There is no way to know if or when or where it will strike next. The reason it is unpredictable is because half to two-thirds of all stillbirths occur for indeterminable reasons, and cannot be attributed to a specific identifiable medical cause.

Because of it's randomness, and the lack of any warning, stillbirth is said to be "an equal opportunity destroyer of dreams". It cuts across socio-economic classes, races, religions, body types and maternal age groups. No woman is immune from this "last great mystery of obstetrics." Even women who have had several successful prior births can experience a subsequent stillbirth.

That so many stillbirths occur at or near late term- when the developing baby is well beyond the point of viability and could survive outside the womb- is especially devastating, leading mothers and their doctors to speculate what might have been had their baby been delivered earlier.

Autopsies, when performed, rarely uncover any cause of stillbirth not already apparent from physical examination of the baby and placenta. There is no uniform stillbirth post-mortem (autopsy) protocol in use today anywhere in America. Every autopsy is done according to local practice. Because of that there is no uniform data available for analysis. When a post-mortem procedure is performed, it is rare for the mother to be interviewed, in spite of the fact she may have vital clues to her baby's cause of death. A uniform protocol would address this shortcoming.

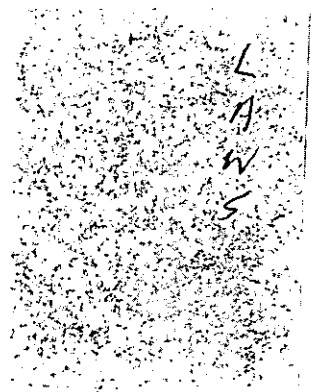
Mothers who suffer a stillbirth do not receive recognition in 44 of 50 states. Only Arizona, Utah, Indiana, Iowa, Kentucky and Massachusetts give these mothers a Certificate of Birth Resulting in Stillbirth. Birth is a process, live or dead is a result. Why would any state issue a "Certificate of Live Birth" to one mother, and not a "Certificate of Stillbirth" to the other? Both mothers did the same work, only the outcomes differed.

A mother of identical twins, who delivers one "still" is given a Certificate of Live Birth for the surviving twin, but nothing for the stillborn twin, rendering the birth of that child all but "invisible", and a non-event!

(From The National Stillbirth Society Website: <http://www.stillnomore.org>)

Stillborn info

<http://www.missingangelsbill.org/stchart.html>



HOUSE BILL 272

Unofficial Copy
J1

2003 Regular Session
(31r0237)

ENROLLED BILL

-- *Health and Government Operations/Education, Health, and
Environmental Affairs* --

Introduced by **Delegates Sophocleus, Boschert, Boteler, Cadden, Carter,
Costa, Dwyer, Impallaria, Menes, Murray, Parrott, and Rzepkowski
Rzepkowski, Boutin, McDonough, Elliott, Smigiel, Donoghue, and Kach**

Read and Examined by Proofreaders:

Proofreader.

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this
____ day of _____ at _____ o'clock, _____ M.

Speaker.

CHAPTER _____

1 AN ACT concerning

2 **Vital Statistics - Certificate of Birth Resulting in Stillbirth**

3 FOR the purpose of requiring the Secretary of Health and Mental Hygiene to
4 establish procedures for the issuance of a certificate of birth resulting in
5 stillbirth for each fetal death occurring after a certain gestation period;
6 requiring the Secretary to collect, index, and safeguard from certain damage
7 each certificate of birth resulting in stillbirth; requiring certain format and
8 filing requirements for each certificate of birth resulting in stillbirth; requiring
9 the Secretary to adopt certain regulations; requiring the Secretary to provide a
10 copy of a certificate of birth resulting in stillbirth upon request and to collect a
11 certain fee for a copy of a certificate of birth resulting in stillbirth; providing for
12 certain prohibited acts related to a certificate of birth resulting in stillbirth;
13 defining certain terms; requiring the Department of Health and Mental Hygiene
14 to offer make available a certificate of birth resulting in stillbirth to certain

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1 parents; requiring the Department to establish procedures for the issuance of a
 2 certificate of birth resulting in stillbirth upon the request of certain parents who
 3 had a stillborn child prior to the effective date of this Act; requiring the
 4 Department to implement certain procedures by a certain date; requiring the
 5 Department to make a certain report to certain committees of the General
 6 Assembly on or before a certain date; and generally relating to a certificate of
 7 birth resulting in stillbirth.

8 ~~BY repealing and reenacting, without amendments,~~

9 ~~Article - Health - General~~

10 ~~Section 4-201(a) and (e), 4-203, and 4-213(a) and (b)~~

11 ~~Annotated Code of Maryland~~

12 ~~(2000 Replacement Volume and 2002 Supplement)~~

13 ~~BY repealing and reenacting, with amendments,~~

14 ~~Article - Health - General~~

15 ~~Section 4-201(f), (m), (n), and (o), 4-204, 4-207, 4-217(a)(1) and (c)(1), and~~

16 ~~4-226~~

17 ~~Annotated Code of Maryland~~

18 ~~(2000 Replacement Volume and 2002 Supplement)~~

19 BY adding to

20 Article - Health - General

21 Section 4-213.1 and 4-213.2

22 Annotated Code of Maryland

23 (2000 Replacement Volume and 2002 Supplement)

24 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
 25 MARYLAND, That the Laws of Maryland read as follows:

26 **Article - Health - General**

27 ~~4-201.~~

28 ~~(a) In this subtitle the following words have the meanings indicated.~~

29 ~~(e) "Fetal death" means death of a product of human conception, before its~~
 30 ~~complete expulsion or extraction from the mother, regardless of the duration of the~~
 31 ~~pregnancy, as indicated by the fact that, after the expulsion or extraction, the fetus~~
 32 ~~does not breathe or show any other evidence of life, such as heart beat, pulsation of~~
 33 ~~the umbilical cord, or definite movement of voluntary muscle.~~

34 ~~(f) "File" means to present for registration any certificate, report, or other~~
 35 ~~record including records transmitted by approved electronic media, including~~
 36 ~~facsimile, of birth, BIRTH RESULTING IN STILLBIRTH, death, fetal death, adoption,~~
 37 ~~marriage, or divorce for which this subtitle provides and to have the Secretary accept~~
 38 ~~the record.~~

1 (m) "Registration" means acceptance by the Secretary and incorporation in the
2 records of the Department of any certificate, report, or other record of birth, BIRTH
3 RESULTING IN STILLBIRTH, death, fetal death, adoption, marriage, divorce, or
4 dissolution or annulment of marriage for which this subtitle provides.

5 (n) "Vital record" means a certificate or report of birth, BIRTH RESULTING IN
6 STILLBIRTH, death, fetal death, marriage, divorce, dissolution or annulment of
7 marriage, adoption, or adjudication of paternity that is required by law to be filed
8 with the Secretary.

9 (o) "Vital statistics" means the data derived from certificates and reports of
10 birth, BIRTH RESULTING IN STILLBIRTH, death, fetal death, marriage, divorce,
11 dissolution or annulment of marriage, and reports related to any of these certificates
12 and reports.

13 4-203.

14 (a) The Secretary is charged with administering efficiently and uniformly this
15 subtitle throughout this State.

16 (b) (1) The Secretary shall establish appropriate methods and the necessary
17 forms for accurate registration of vital records.

18 (2) The forms shall provide for the information that the Secretary needs
19 for proper registration and use of these vital records.

20 4-204.

21 (a) The Secretary shall collect, index, and safeguard from fire, loss, or damage
22 each certificate of birth, BIRTH RESULTING IN STILLBIRTH, death, and fetal death.

23 (b) After registration of a completed death or fetal death certificate, the
24 Secretary shall send a copy of the original certificate to the county registrar for the
25 county where the event occurred. The copy may be photographic or electronic or
26 produced by other means as prescribed by the Secretary.

27 4-207.

28 (a) (1) Each certificate of birth, BIRTH RESULTING IN STILLBIRTH, death, or
29 fetal death shall be typed or printed legibly in unfading black ink, or stored on
30 electronic media approved by the Secretary.

31 (2) The person who is required to complete the record shall attest to its
32 accuracy either by signature or by approved electronic process.

33 (b) A certificate is not complete or correct if it does not give each item of
34 required information to the extent the information is obtainable.

1 ~~4-213.~~

2 (a) ~~If a fetal death occurs after a gestation period of 20 weeks or more, then~~
3 ~~within 72 hours after delivery, a certificate of fetal death shall be filed by:~~

4 (1) ~~The mortician who first takes custody of a fetus;~~

5 (2) ~~The person in charge of the institution or the person's designated~~
6 ~~representative when a fetus is delivered in an institution;~~

7 (3) ~~The physician in attendance at or immediately after delivery when a~~
8 ~~fetus is delivered outside an institution; or~~

9 (4) ~~The medical examiner when a fetal death occurs without medical~~
10 ~~attendance at or immediately after the delivery when a medical examiner's inquiry is~~
11 ~~required.~~

12 (b) ~~The person who files the fetal death certificate shall obtain:~~

13 (1) ~~The personal information from the next of kin or the best qualified~~
14 ~~individual or source available; and~~

15 (2) ~~The medical certification of cause of death:~~

16 (i) ~~From the medical examiner, within 24 hours after the medical~~
17 ~~examiner takes charge of the fetus; or~~

18 (ii) ~~If the medical examiner does not take charge of the fetus, from~~
19 ~~the attending physician within 24 hours after delivery.~~

20 ~~4-213.1.~~

21 (A) ~~IN ADDITION TO THE REQUIREMENTS OF § 4-213 OF THIS SUBTITLE, THE~~
22 ~~SECRETARY SHALL ESTABLISH PROCEDURES FOR THE ISSUANCE OF A CERTIFICATE~~
23 ~~OF BIRTH RESULTING IN STILLBIRTH FOR EACH FETAL DEATH OCCURRING IN THE~~
24 ~~STATE AFTER A GESTATION PERIOD OF 20 WEEKS OR MORE.~~

25 (B) ~~THE CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH SHALL:~~

26 (1) ~~BE OFFERED TO THE PARENT OR PARENTS OF A STILLBORN CHILD;~~

27 (2) ~~BE FILED WITHIN 72 HOURS AFTER DELIVERY; AND~~

28 (3) ~~MEET ALL OF THE FORMAT AND FILING REQUIREMENTS OF § 4-208~~
29 ~~OF THIS SUBTITLE, RELATING TO A LIVE BIRTH.~~

30 (B) THE DEPARTMENT SHALL OFFER MAKE AVAILABLE A CERTIFICATE OF
31 BIRTH RESULTING IN STILLBIRTH TO THE PARENT OR PARENTS OF A STILLBORN
32 CHILD FOR WHOM A FETAL DEATH WAS REGISTERED.

1 (C) THE INDIVIDUAL PREPARING THE CERTIFICATE OF BIRTH RESULTING IN
 2 STILLBIRTH SHALL NOT INCLUDE ANY REFERENCES TO THE STILLBORN CHILD'S
 3 FIRST NAME IF THE STILLBORN CHILD'S PARENT OR PARENTS DO NOT WISH TO
 4 PROVIDE A FIRST NAME FOR THE STILLBORN CHILD.

5 ~~4-213.2.~~

6 (A) ~~THE SECRETARY SHALL ADOPT REGULATIONS TO GOVERN THE FILING OF~~
 7 ~~A RECORD OF BIRTH RESULTING IN STILLBIRTH IF A CERTIFICATE OF BIRTH~~
 8 ~~RESULTING IN STILLBIRTH IS NOT FILED WITHIN THE TIME REQUIRED BY § 4-213.1~~
 9 ~~OF THIS SUBTITLE.~~

10 (B) ~~THE REGULATIONS ADOPTED UNDER SUBSECTION (A) OF THIS SECTION~~
 11 ~~SHALL BE CONSISTENT WITH REGULATIONS ADOPTED UNDER § 4-210 OF THIS~~
 12 ~~SUBTITLE REGARDING DELAYED BIRTH REGISTRATION.~~

13 ~~4-217.~~

14 (a) (1) ~~Except as provided in subsection (b) of this section, the Secretary~~
 15 ~~shall provide, on request, any person authorized by regulations adopted under this~~
 16 ~~subtitle with a certified or abridged copy of a birth, BIRTH RESULTING IN~~
 17 ~~STILLBIRTH, death, or fetal death certificate registered under this subtitle or of the~~
 18 ~~certificate of a marriage performed after June 1, 1951.~~

19 (e) (1) ~~Except as otherwise provided by law, the Department shall collect a~~
 20 ~~\$6 fee for each certified or abridged copy of a birth, BIRTH RESULTING IN STILLBIRTH,~~
 21 ~~death, fetal death, or marriage certificate or for a report that a search of the files was~~
 22 ~~made and the requested record is not on file.~~

23 ~~4-226.~~

24 (a) ~~A person may not fail or refuse to execute and deliver a certificate of birth,~~
 25 ~~BIRTH RESULTING IN STILLBIRTH, death, or fetal death required by this subtitle.~~

26 (b) (1) ~~A person may not willfully provide false information for entry or~~
 27 ~~willfully enter false information on a certificate of birth, BIRTH RESULTING IN~~
 28 ~~STILLBIRTH, death, or fetal death.~~

29 (2) ~~A person may not fail to provide a Social Security number or willfully~~
 30 ~~provide a false Social Security number to the clerk of court under § 4-208(g) of this~~
 31 ~~subtitle.~~

32 (e) ~~Except as authorized by this subtitle, a person may not willfully alter any~~
 33 ~~certificate, certified copy of a certificate, or other certified statement that relates to a~~
 34 ~~birth, BIRTH RESULTING IN STILLBIRTH, death, fetal death, or marriage registered~~
 35 ~~under this subtitle.~~

36 (d) (1) ~~A person may not willfully use or attempt to use, with the intention to~~
 37 ~~deceive, any certificate of birth or certified copy of a record of birth knowing that the~~
 38 ~~certificate or certified copy:~~

1 (i) Was issued on a record that is wholly or partly false; or

2 (ii) Relates to the birth of another individual.

3 (2) A person may not willfully and knowingly provide a certificate of
4 birth or a certified copy of a record of birth to another person with the intention that
5 it be used by that person to deceive.

6 (e) Without authorization, a person may not produce, reproduce, or distribute
7 a blank certificate or other form that the Secretary uses to register or certify facts
8 that relate to a birth, BIRTH RESULTING IN STILLBIRTH, death, fetal death, or
9 marriage.

10 (f) A person may not willfully use or attempt to use a photocopy of a birth,
11 BIRTH RESULTING IN STILLBIRTH, death, fetal death, or marriage certificate for any
12 fraudulent or deceptive purpose.

13 (g) A person who has access to the birth, BIRTH RESULTING IN STILLBIRTH,
14 death, or fetal death records in the custody of the Secretary or an agent of the
15 Secretary may not willfully communicate to anyone known to the person to be
16 unauthorized any fact recorded on any birth, BIRTH RESULTING IN STILLBIRTH,
17 death, or fetal death certificate.

18 (h) A person may not willfully transport or accept for transportation,
19 dissection, or other disposition a body without a burial transit permit, as provided in
20 this subtitle.

21 (i) A person may not willfully:

22 (1) Violate any provision of this subtitle;

23 (2) Neglect to perform any duty imposed by this subtitle; or

24 (3) Violate any rule or regulation adopted under this subtitle.

25 ~~SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect~~
26 ~~October 1, 2003.~~

27 SECTION 2. AND BE IT FURTHER ENACTED, That the Department of
28 Health and Mental Hygiene shall establish procedures for the issuance of a certificate
29 of birth resulting in stillbirth upon the request of a parent or parents who have
30 received a certificate of fetal death prior to the effective date of this Act.

31 SECTION 3. AND BE IT FURTHER ENACTED, That:

32 (a) The Department of Health and Mental Hygiene shall adopt and implement
33 the procedures required by this Act on or before January 1, 2004; and

34 (b) On or before October 1, 2005, the Department of Health and Mental
35 Hygiene shall report to the Governor, and in accordance with § 2-1246 of the State
36 Government Article, to the Senate Education, Health, and Environmental Affairs

1 Committee and the House Health and Government Operations Committee, on the
2 implementation of this Act, including the number of certificates of births resulting in
3 stillbirth issued in the State and the procedures implemented by the Department.

4 SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take
5 effect ~~October 1, 2003~~ June 1, 2003.

this summer. HB 2416 took effect August 9th 2001 and is available for all stillbirths, prospective and past alike.

[Go To Actual Text of HB2416](#)

The National Stillbirth Society

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Stillbirth

From Wikipedia, the free encyclopedia


A **stillbirth** occurs when a fetus which has died in the uterus or during labor or delivery exits a woman's body. The term is often used in distinction to live birth or miscarriage. Most stillbirths occur in full term pregnancies.

Some sources reserve the term "stillbirth" for a fetus which has died after reaching mid-second trimester to full term gestational age. For example, in the United Kingdom, "stillbirth" is used to describe an infant delivered without life after 24 weeks gestation. The sources that use this definition tend to use the term "miscarriage" if the death occurs earlier in development. In contrast, other sources use the term "stillbirth" regardless of the stage of fetal development.

Contents

- 1 Human stillbirth
 - 1.1 Causes
 - 1.2 Prenatal diagnosis
 - 1.3 Prenatal maternal treatment
 - 1.4 Prevalence
- 2 Legal definitions of stillbirth
 - 2.1 Australia
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- 3 See also
- 4 References
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 - 5.2 Activism/Prevention
 - 5.3 Factual/Reference

Stillbirth
Classification and external resources



Ultrasonography is often used to diagnose stillbirth.

ICD-10	P95.
MedlinePlus	002304
eMedicine	topic list

Human stillbirth

Causes

The causes of a large percentage of human stillbirths remain unknown, even in cases where extensive testing and autopsy have been performed. A rarely used term to describe these is **sudden antenatal death syndrome** or SADS.^[1]

In cases where the cause is known, some possibilities of the cause of death are:

- bacterial infection

- birth defects
- chromosomal aberrations
- growth retardation
- Intrahepatic Cholestasis of Pregnancy
- maternal diabetes
- high blood pressure, including preeclampsia
- maternal consumption of nicotine, alcohol, recreational drugs (excluding cannabis^[2]), or pharmaceutical drugs contraindicated in pregnancy
- postdate pregnancy
- placental abruptions
- physical trauma
- radiation poisoning
- Rh disease
- umbilical cord accidents

Sometimes a pregnancy is terminated deliberately during a late phase, for example for congenital anomaly. UK law requires these procedures to be registered as "stillbirths".^[3] If a fetus is aborted late during pregnancy this is called feticide.

Prenatal diagnosis

A decrease or cessation of fetal activity may be an indication of fetal distress or death, though it is not entirely uncommon for a healthy fetus to exhibit such changes, particularly near the end of a pregnancy when there is considerably little space in the uterus for the fetus to move about. Still, medical examination, including a nonstress test, is recommended in the event of any change in the strength or frequency of fetal movement, especially a complete cease; most midwives and obstetricians recommend the use of a kick chart to assist in detecting any changes. Fetal distress or death can be confirmed or ruled out via fetoscopy/doptone, ultrasound, and/or electronic fetal monitoring. If the fetus is alive but inactive, extra attention will be given to the placenta and umbilical cord during ultrasound examination to ensure that there is no compromise of oxygen and nutrient delivery.

Prenatal maternal treatment

An in utero stillbirth does not usually present an immediate health risk to the woman and labour will usually begin spontaneously after two weeks, so the woman may choose to wait and deliver vaginally. After two weeks, the woman is at risk of developing blood clotting problems, and induction is recommended at this point. In many cases, the woman will find the idea of carrying the dead baby emotionally traumatizing and will elect to be induced. Cesarean birth is not recommended unless complications develop during vaginal birth.

Prevalence

Stillbirth is a relatively common, but often random, occurrence. The mean stillbirth rate in the United States is approximately 1 in 115 births, which is roughly 26,000 stillbirths each year, or on an average one every 20 minutes. In Australia,^[4] England, Wales, and Northern Ireland, the rate is approximately 1 in every 200 births, in Scotland 1 in 167. (From The National Statistical Office and other sources.) Many stillbirths occur at fullterm to apparently healthy mothers, and a postmortem evaluation reveals a cause of death in only about 40% of autopsied cases.^[5]

In developing countries, where medical care can be of low quality or unavailable, the stillbirth rate is much higher.

Legal definitions of stillbirth

Australia

In Australia any stillborn baby weighing more than 400 grams, or more than 20 weeks in gestation, must have its birth registered.^[6]

Canada

Beginning in 1959, "the definition of a stillbirth was revised to conform, in substance, to the definition of fetal death recommended by the World Health Organization." ^[7] The definition of "fetal death" promulgated by the World Health Organization in 1950 is as follows:

"Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.^[8]

United Kingdom

Throughout the United Kingdom, stillbirths must be registered by law. The Stillbirth Definition Act (1992) states: *"any 'child' expelled or issued forth from its mother after the 24th week of pregnancy that did not breathe or show any other signs of life should be registered as a stillbirth."*^[9] In England and Wales, this must be done within 42 days and a Stillbirth Certificate is issued to the parent(s).^[10] In Scotland, this must be done within 21 days.^[11]

United States

In the United States, there is no standard definition of the term 'stillbirth'.^[8] The Centers for Disease Control and Prevention collects statistical information on "live births, fetal deaths, and induced termination of pregnancy" from 57 reporting areas in the United States. Each reporting area has different guidelines and definitions for what is being reported; many do not use the term "stillbirth" at all. The federal guidelines suggests (at page 1) that fetal death and stillbirth can be interchangeable terms. The CDC definition of "fetal death" is based on the definition promulgated by the World Health Organization in 1950 (see section above on Canada).

The federal guidelines recommend reporting those fetal deaths whose birth weight is over 350g, or those more than 20 weeks gestation. Forty-one areas use a definition very similar to the federal definition, thirteen areas use a shortened definition of fetal death, and three areas have no formal definition of fetal death. Only 11 areas specifically use the term 'stillbirth', often synonymously with late fetal death, however they are split between whether stillbirths are "irrespective of the duration of pregnancy", or

whether some age or weight constraint is applied.

See also

Childbirth

- Live birth
- Perinatal death
 - Intrapartum death
 - Neonatal death
 - Sudden infant death syndrome
- Abortion
 - Elective abortion
 - Anomalous pregnancy
 - Ectopic pregnancy
 - Molar pregnancy
 - Spontaneous abortion
- Maternal death

References

1. ^ Collins JH (February 2002). "Umbilical cord accidents: human studies". *Semin. Perinatol.* **26** (1): 79–82. PMID 11876571.
2. ^ Fried, P.A. (2002). The consequences of marijuana use during pregnancy: a review of the human literature.
3. ^ Bythell M, et al. (2008) The contribution of late termination of pregnancy to stillbirth rates in Northern England, 1994-2005. *The British Journal of Obstetrics and Gynaecology*, 115(5):664-666
4. ^ Gordon, Adrienne (Dr). "Department of Neonatal Medicine Protocol Book: Royal Prince Alfred Hospital". <http://www.cs.nsw.gov.au/rpa/neonatal/html/newprot/stillbirths.htm>. Retrieved on 2006-09-13.
5. ^ Cacciatore, J. (2007). A phenomenological exploration of stillbirth and the effects of ritualization on maternal anxiety and depression, University of Nebraska-Lincoln Press, Digital Commons ; Froen, J.F. (2005).
6. ^ Lahra MM, Gordon A, Jeffery HE (2007). "Chorioamnionitis and fetal response in stillbirth". *Am. J. Obstet. Gynecol.* **196** (3): 229.e1–4. doi:10.1016/j.ajog.2006.10.900. PMID 17346531. "Stillbirth is defined within Australia as fetal death (no signs of life), whether antepartum or intrapartum, at ≥ 20 weeks of gestation or ≥ 400 g birthweight, if gestational age is unknown."
7. ^ Statistics Canada ("Canada's National Statistical Agency"), History, Vital Statistics - Stillbirth Database, in Vital Statistics – Stillbirth Database.
8. ^ ^a ^b Centers for Disease Control and Prevention. *State Definitions and Reporting Requirements* (1997 Revision ed.). National Center for Health Statistics. <http://www.cdc.gov/nchs/data/misc/itop97.pdf>.
9. ^ "Registration of Stillbirths and Certification for Pregnancy Loss before 24 Weeks Gestation" *Royal College of Midwives*. Retrieved September 27, 2007
10. ^ Guide to registering stillbirths in the UK
11. ^ Registering a stillbirth General Register Office for Scotland

External links

Grieving resources

- MISSing Angels Bill Legislation for Stillbirth Grassroots movement of bereaved stillbirth families, a program of the MISS Foundation
- The Forgotten Grief: Miscarriage, Stillbirth and Neo-natal Death

- MISS Foundation support site for those bereaved of a child and advice for professionals on their support.
- SANDS AUSTRALIA providing support, information & counselling for bereaved parents & families
- First Candle First Candle promotes safe pregnancies and the survival of babies through the first years of life. With programs of research, education and advocacy, they are working toward a future where all babies are provided the best possible chance to reach not only their first birthday, but many happy birthdays beyond. Until this goal is reached, they remain committed to providing compassionate grief support to all those affected by the death of a baby.
- Stillbirth Support Providing support, other's stories and ways to remember for families.

Activism/Prevention

- MISS Foundation an activist site of the MISS Foundation for parents of stillborn infants.
- National Stillbirth Society an activist group of parents for stillbirth education.
- Preferred Pregnancy Protocol for minimizing the risk of stillbirth due to cord accidents.
- Dr. Joanne Cacciatore Arizona State University researcher who specializes in stillbirth and traumatic loss.
- International Stillbirth Alliance is a non-profit coalition of organizations dedicated to understanding the causes and prevention of stillbirth.
- First Candle First Candle promotes safe pregnancies and the survival of babies through the first years of life. With programs of research, education and advocacy, they are working toward a future where all babies are provided the best possible chance to reach not only their first birthday, but many happy birthdays beyond. Until this goal is reached, they remain committed to providing compassionate grief support to all those affected by the death of a baby.

Factual/Reference

- The Wisconsin Stillbirth Service Program (WiSSP), a branch of the University of Wisconsin-Madison's Clinical Genetics Center. One of the foremost authorities on the causes of stillbirth and responsible for many stillbirth evaluation protocols, including the widespread use of the Kleihauer-Betke test in deciding whether Rh disease is to blame for a stillbirth.
- Pregnancy Institute founded by Dr. Jason H. Collins, OB/GYN specializes in umbilical cord research
- Investigating perinatal death: a review of the options when autopsy consent is refused.

Retrieved from "<http://en.wikipedia.org/wiki/Stillbirth>"

Categories: [Obstetrics](#) | [Fertility](#) | [Demography](#)

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The National Stillbirth Society

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**INFORMATION FOR
STATE DIRECTORS**

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Dear National Stillborn Society,

I am working for the Alaska State Legislature, and we are in the process of drafting a law that would allow parents of a stillborn child to obtain a birth certificate for the stillborn. We are struggling with a definition for "stillbirth" and "stillborn" and "stillborn child". Is there a model definition that we could use that would be acceptable to both the pro life and pro choice camps that would stand up to legal challenge? Any input would be greatly appreciated.

Thank You,

John Davies
Chief of Staff to
Rep. Wes Keller

House Engrossed

State of Arizona
House of Representatives
Forty-fifth Legislature
First Regular Session
2001

HOUSE BILL 2416

AN ACT

AMENDING TITLE 36, CHAPTER 3, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-329.01 AND 36-329.02; RELATING TO VITAL STATISTICS CERTIFICATES.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, chapter 3, article 2, Arizona Revised Statutes, is amended by adding sections 36-329.01 and 36-329.02, to read:

36-329.01. Certificate of birth resulting in stillbirth; requirements

A. IN ADDITION TO THE REQUIREMENTS OF SECTION 36-329, THE STATE REGISTRAR OF VITAL STATISTICS SHALL ESTABLISH A CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH ON A FORM APPROVED BY THE STATE REGISTRAR FOR EACH FETAL DEATH OCCURRING IN THIS STATE AFTER A GESTATIONAL PERIOD OF AT LEAST TWENTY COMPLETED WEEKS. THIS CERTIFICATE SHALL BE OFFERED TO THE PARENT OR PARENTS OF A STILLBORN CHILD.

B. THE CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH SHALL MEET ALL OF THE FORMAT AND FILING REQUIREMENTS OF SECTION 36-322, RELATING TO A LIVE BIRTH.

C. THE PERSON WHO PREPARES A CERTIFICATE PURSUANT TO THIS SECTION SHALL LEAVE BLANK ANY REFERENCES TO THE STILLBORN CHILD'S NAME IF THE STILLBORN CHILD'S PARENT OR PARENTS DO NOT WISH TO PROVIDE A NAME FOR THE STILLBORN CHILD.

D. NOTWITHSTANDING SUBSECTIONS A AND B OF THIS SECTION, THE CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH SHALL BE FILED WITH THE DESIGNATED REGISTRAR WITHIN THREE DAYS FOLLOWING THE DELIVERY AND PRIOR TO CREMATION OR REMOVAL OF THE FETUS FROM THE REGISTRATION DISTRICT.

36-329.02. Delayed registration of birth resulting in stillbirth

WHEN A BIRTH RESULTING IN STILLBIRTH OCCURRING IN THIS STATE HAS NOT BEEN REGISTERED WITHIN ONE YEAR AFTER THE DATE OF DELIVERY, A CERTIFICATE

MARKED "DELAYED" MAY BE FILED AND REGISTERED IN ACCORDANCE WITH REGULATIONS OF THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES RELATING TO EVIDENTIARY AND OTHER REQUIREMENTS SUFFICIENT TO SUBSTANTIATE THE ALLEGED FACTS OF BIRTH RESULTING IN STILLBIRTH.

Sec. 2. Short title

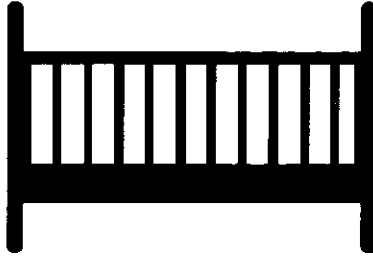
Section 36-329.01, Arizona Revised Statutes, as added by this act, may be cited as the "Missing Angels Act".

The National Stillbirth Society

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FETAL AND INFANT DEATHS

**FETAL AND
INFANT DEATHS**



Phillips Mitchell
465 8643

**42 FETAL DEATHS
80 INFANT DEATHS**

Al Jeter
Death Statute
no gestation period
18.50.950 8 113

20th week must
7 20th - no report
FETAL DEATHS

A fetal death is defined as the death of a fetus after the eighth week of gestation and before delivery. Alaska Statute 18.50.240 requires the filing of a certificate for each fetal death that occurs in the state when the pregnancy has lasted at least 20 weeks. The filing of certificates for fetal deaths which occur prior to the twentieth week of pregnancy is optional. This report includes information only for fetal deaths in which either the estimated gestation or the calculated gestation (last menstrual date subtracted from the date of delivery) is at least twenty weeks.

TABLE 2.1A FETAL DEATHS BY CENSUS AREA OF MOTHER'S RESIDENCE, ALASKA, 1995

CENSUS AREA OF MOTHER'S RESIDENCE	DEATHS
ANCHORAGE BOROUGH	19
BETHEL	2
FAIRBANKS NORTH STAR BOROUGH	3
JUNEAU BOROUGH	1
KENAI PENINSULA BOROUGH	3
KETCHIKAN GATEWAY BOROUGH	1
KODIAK ISLAND BOROUGH	3
MATANUSKA-SUSITNA BOROUGH	2
NOME	4
NORTH SLOPE BOROUGH	1
NORTHWEST ARCTIC BOROUGH	1
VALDEZ-CORDOVA	1
WADE HAMPTON	1
TOTAL	42

FETAL AND INFANT DEATHS (continued) Alaska Bureau of Vital Statistics

TABLE 2.1B FETAL DEATHS BY NATIVE REGIONAL CORPORATION OF MOTHER'S RESIDENCE, ALASKA, 1995

CENSUS AREA OF MOTHER'S RESIDENCE	DEATHS
ARCTIC SLOPE CORP.	1
BERING STRAITS CORP.	4
CALISTA CORP.	3
CHUGACH NATIVES INC.	2
COOK INLET REG. CORP.	23
DOYON LTD.	3
KONIAG INC.	3
NANA REGIONAL CORP.	1
SEALASKA CORP.	2
TOTAL	42

TABLE 2.1C FETAL DEATHS AND FETAL DEATH RATE BY MOTHER'S RACE, ALASKA, 1991-1995

MOTHER'S RACE	FETAL DEATHS						TOTAL BIRTHS	1991-1995 RATE
	1991	1992	1993	1994	1995	TOTAL		
WHITE	44	40	33	30	24	171	37,541	4.6
NATIVE	17	12	10	9	12	60	12,584	4.8
BLACK	3	3	2	4	5	17	2,577	6.6
ASIAN/PI	4	4	2	1		11	2,505	4.4
UNKNOWN	1				1	2	199	
TOTAL	69	59	47	44	42	261	55,406	4.7

TABLE 2.2 FETAL DEATHS BY AGE AND RACE OF MOTHER, ALASKA, 1995

MOTHER'S AGE	MOTHER'S RACE				
	WHITE	NATIVE	BLACK	UNKN	TOTAL
15-17	1	1			2
18-19		1			1
20-24	9	4	1	1	15
25-29	6		1		7
30-34	7	4	2		13
35-39	1	2	1		4
TOTAL	24	12	5	1	42

Alaska Bureau of Vital Statistics (continued) FETAL AND INFANT DEATHS

TABLE 2.3 FETAL DEATHS BY LENGTH OF GESTATION AND WEIGHT, ALASKA, 1995

GESTATION	WEIGHT IN GRAMS						UNK	TOTAL
	<500	500-999	1000-1499	1500-1999	2000-2499	2500-4000		
20-24 WEEKS	7	4						11
25-28 WEEKS		3	3					6
29-32 WEEKS	1		1	1				3
33-36 WEEKS			2	3	3	3	1	12
37-41 WEEKS					3	6	1	10
TOTAL	8	7	6	4	6	9	2	42

INFANT DEATHS

Infant deaths are defined as deaths which occur before an individual's first birthday. Infant mortality may be calculated by either of two methods: *birth cohort* or *death cohort*. The *birth cohort* method considers all babies born in one year and determines the number of those babies who die before reaching their first birthday, either in that year or the next. The *death cohort* method groups together infants who die in the same year.

The birth cohort method is more reliable for calculating infant mortality rates because it calculates a rate for a specific group of infants, whereas the death cohort method calculates a rate based on comparing deaths in one year against births in that same year. The flaw in using the death cohort is that some of the infants who died in that year were born in the previous year, and some of the infants born in that year will die in the next year. When using the birth cohort method in this report, all infants born in 1994 are considered, whether the death occurred in 1994 or 1995, if the infant died before its first birthday. Birth cohort calculations are not included for 1995 in this report because not all 1996 death records were complete at the time this report was compiled.

The death cohort method is used in this report for calendar year 1995. This method compares the number of deaths to infants who died during 1995 prior to their first birthday with the number of infants who were born in 1995.

Infant Mortality Rates

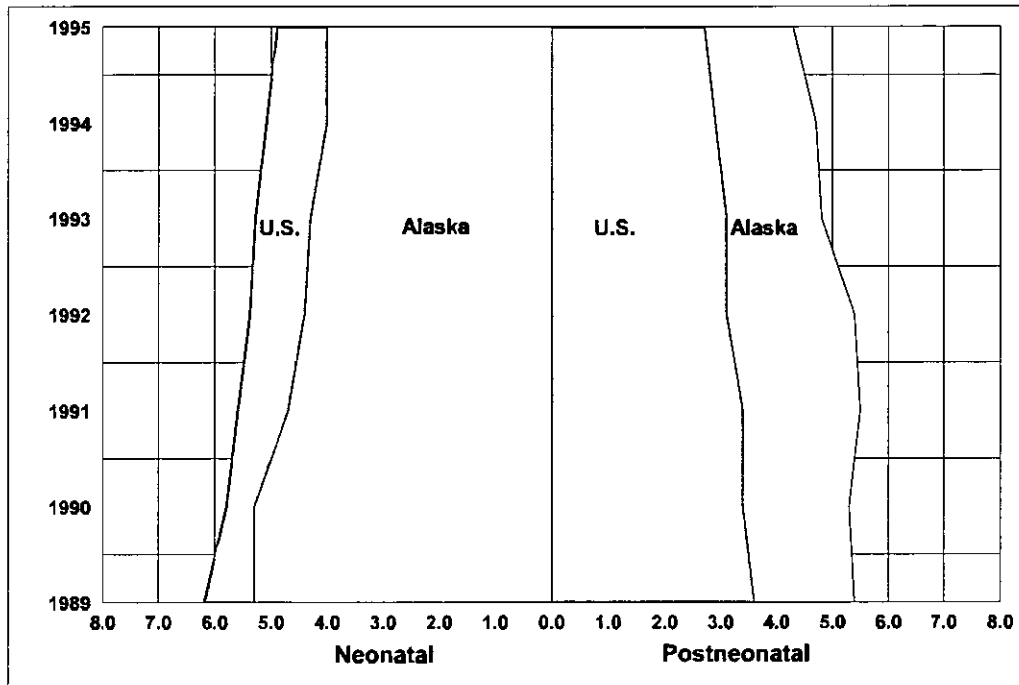
Using the death cohort, the total number of infant deaths during 1995 was 80. This is a 1.2 percent decrease from 82 infant deaths during 1994.¹ Since relatively small changes in infant deaths can cause large fluctuations in the infant mortality rate (IMR) from one year to the next, Alaska's annual IMR is calculated on a five-year moving average. The 1991-1995 five-year average infant mortality rate was 8.3 deaths per 1,000 live births, down from 8.8 deaths per 1,000 live births for 1990-1994. The U.S. infant mortality rate of 7.6 deaths per 1,000 live births in 1995 reflects a 5% decrease from 8.0 infant deaths per 1,000 live births in 1994.² Both the U.S. and Alaska infant mortality rates have been steadily decreasing in recent years, and both are now at the lowest rates ever recorded.

In discussing infant mortality, a distinction is made between neonatal mortality (deaths prior to the 28th day of life) and postneonatal mortality (deaths from the 28th day up to one year). Neonatal deaths are frequently associated with circumstances related to pregnancy and delivery while postneonatal deaths are associated with living conditions. Alaska's neonatal mortality rate has generally been lower than the neonatal mortality rate for the United States, while its postneonatal mortality rate has been higher. Chart 2.1 provides a graphic comparison of the neonatal and postneonatal rates for Alaska and the United States.

1 Crondahl, J., Mitchell, P., Zenk, A.E., Anderson, C., Walden, S. and Juan, I. Department of Health and Social Services, Division of Public Health, *Alaska Bureau of Vital Statistics 1994 Annual Report*, Juneau, Alaska, June 1996, p.47.
 2 National Center for Health Statistics, U.S. Department of Health and Human Services, "Report of Final Mortality Statistics, 1995," *Monthly Vital Statistics Report*, Vol. 45, No. 11(S2), June 12, 1997, p. 11.

FETAL AND INFANT DEATHS (continued) Alaska Bureau of Vital Statistics

CHART 2.1 NEONATAL AND POSTNEONATAL MORTALITY RATES PER 1,000 LIVE BIRTHS, ALASKA AND THE UNITED STATES, 1989-1995 (DEATH COHORT METHOD)



United States rates are single year rates and are provided by the National Center for Health Statistics.³ Alaska infant mortality rates are calculated using five-year moving averages per 1,000 live births, based on death-cohort.

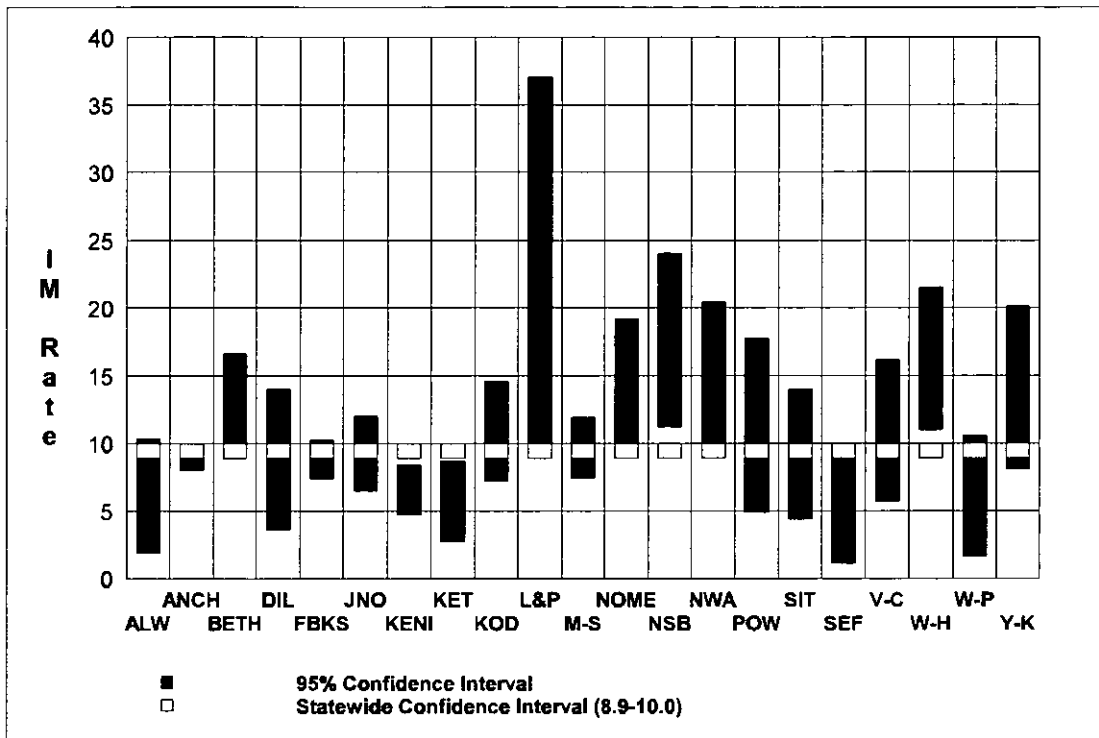
Chart 2.2 compares confidence intervals for infant mortality in individual census areas against the statewide average. When smaller populations, such as individual census areas, are analyzed, ten-year averages and 95 percent confidence intervals are used. The calculated infant mortality rate occurs at the midpoint of the confidence interval. The smaller the population, the larger the confidence interval. (For a detailed discussion of confidence intervals and statistical significance, refer to Appendix B.)

Several census areas (Aleutians East, Angoon-Hoonah-Skagway, Bristol Bay, Denali, Haines Borough, and Yakutat) have been omitted from Chart 2.2 because occurrences of infant mortality are too few for rates to be reliable. Those census areas which have infant mortality rates significantly above the statewide 95% confidence interval of 8.9-10.0 deaths per 1,000 live births are North Slope and Wade Hampton. Kenai Peninsula and Ketchikan are the only census areas with rates below the statewide 95% confidence interval. The confidence intervals for all other areas fell at least partly within the range of the statewide average.

³ Ibid., Table 25, pp. 66-67.

Alaska Bureau of Vital Statistics (continued) FETAL AND INFANT DEATHS

CHART 2.2 95% CONFIDENCE INTERVALS FOR INFANT MORTALITY BY CENSUS AREA, ALASKA, 1986-1995 (DEATH COHORT)



FETAL AND INFANT DEATHS (continued) Alaska Bureau of Vital Statistics

Infant Deaths by Age

TABLE 2.4A INFANT DEATHS BY CENSUS AREA OF DECEDENT'S RESIDENCE AND AGE, ALASKA, 1995 (DEATH COHORT METHOD)

CENSUS AREA OF DECEDENT'S RESIDENCE	DECEDENT'S AGE		TOTAL
	NEONATAL	POST-NEONATAL	
ANCHORAGE BOROUGH	25	13	38
BETHEL	4	1	5
DILLINGHAM	2		2
FAIRBANKS NORTH STAR BOROUGH	6	7	13
JUNEAU BOROUGH	2		2
KENAI PENINSULA BOROUGH	1		1
KETCHIKAN GATEWAY BOROUGH		1	1
KODIAK ISLAND BOROUGH	1		1
MATANUSKA-SUSITNA BOROUGH	3	2	5
NORTH SLOPE BOROUGH		3	3
NORTHWEST ARCTIC BOROUGH		1	1
PRINCE OF WALES-OUTER KETCHIKAN	1		1
VALDEZ-CORDOVA	2	1	3
WADE HAMPTON		1	1
WRANGELL-PETERSBURG		1	1
YUKON-KOYUKUK	1	1	2
TOTAL	48	32	80

TABLE 2.4B INFANT DEATHS BY NATIVE REGIONAL CORPORATION OF DECEDENT'S RESIDENCE AND AGE, ALASKA, 1995 (DEATH COHORT METHOD)

N R C OF DECEDENT'S RESIDENCE	DECEDENT'S AGE		TOTAL
	NEONATAL	POST-NEONATAL	
AHTNA INC.	1		1
ARCTIC SLOPE CORP.		3	3
BRISTOL BAY CORP.	2		2
CALISTA CORP.	4	2	6
CHUGACH NATIVES INC.	1	1	2
COOK INLET REG CORP.	29	15	44
DOYON LTD.	7	8	15
KONIAG INC.	1		1
NANA REGIONAL CORP.		1	1
SEALASKA CORP.	3	2	5
TOTAL	48	32	80

Alaska Bureau of Vital Statistics (continued) FETAL AND INFANT DEATHS

TABLE 2.4C INFANT DEATHS BY RACE, SEX, AND AGE OF DECEDENT, ALASKA, 1995 (DEATH COHORT METHOD)

DECEDENT'S RACE	DECEDENT'S AGE		TOTAL
	NEONATAL	POST-NEONATAL	
WHITE	25	17	42
NATIVE	14	10	24
BLACK	3	3	6
ASIAN/PI	6	2	8
TOTAL	48	32	80
SEX			
MALE	27	19	46
FEMALE	21	13	34
TOTAL	48	32	80

TABLE 2.5A INFANT DEATHS BY CENSUS AREA OF DECEDENT'S RESIDENCE AND AGE, ALASKA, BIRTH YEAR 1994 (BIRTH COHORT METHOD)

CENSUS AREA OF DECEDENT'S RESIDENCE	DECEDENT'S AGE		TOTAL
	NEONATAL	POST-NEONATAL	
ALEUTIANS WEST	1		1
ANCHORAGE BOROUGH	19	14	33
BETHEL	2	1	3
DILLINGHAM		1	1
FAIRBANKS NORTH STAR BOROUGH	1	4	5
JUNEAU BOROUGH	1	2	3
KENAI PENINSULA BOROUGH	2	2	4
KETCHIKAN GATEWAY BOROUGH		1	1
KODIAK ISLAND BOROUGH	2	1	3
LAKE AND PENINSULA	1		1
MATANUSKA-SUSITNA BOROUGH	1	2	3
NOME	1		1
NORTH SLOPE BOROUGH	2	2	4
NORTHWEST ARCTIC BOROUGH		2	2
PRINCE OF WALES-OUTER KETCHIKAN		2	2
SITKA BOROUGH		1	1
VALDEZ-CORDOVA		2	2
WADE HAMPTON		2	2
YUKON-KOYUKUK	1	1	2
TOTAL	34	40	74

FETAL AND INFANT DEATHS (continued) Alaska Bureau of Vital Statistics

TABLE 2.5B INFANT DEATHS BY NATIVE REGIONAL CORPORATION OF DECEDENT'S RESIDENCE AND AGE, ALASKA, BIRTH YEAR 1994 (BIRTH COHORT METHOD)

N R C OF DECEDENT'S RESIDENCE	DECEDENT'S AGE		TOTAL
	NEONATAL	POST-NEONATAL	
AHTNA INC.		1	1
ALEUT CORP.	1		1
ARCTIC SLOPE CORP.	2	2	4
BERING STRAITS CORP.	1		1
BRISTOL BAY CORP.	1	1	2
CALISTA CORP.	2	3	5
CHUGACH NATIVES INC.		1	1
COOK INLET REG CORP.	22	18	40
DOYON LTD.	2	5	7
KONIAG INC.	2	1	3
NANA REGIONAL CORP.		2	2
SEALASKA CORP.	1	6	7
TOTAL	34	40	74

TABLE 2.5C INFANT DEATHS BY RACE, SEX, AND AGE OF DECEDENT, ALASKA, BIRTH YEAR 1994 (BIRTH COHORT METHOD)

DECEDENT'S RACE	DECEDENT'S AGE		TOTAL
	NEONATAL	POST-NEONATAL	
WHITE	17	21	38
NATIVE	13	15	28
BLACK	1	3	4
ASIAN/PI	3	1	4
TOTAL	34	40	74
SEX			
MALE	16	18	34
FEMALE	18	22	40
TOTAL	34	40	74

Infant Mortality Rates by Race

Table 2.6 shows 5-year moving average infant mortality rates by race for the years 1991 through 1995. In the process of preparing this report, it was discovered that while the child's race at birth is reported to be the same as the mother's, the child's race on the death certificate may be reported differently. To ensure consistent reporting and calculation of rates, a new procedure was used in this report. All death certificates for decedents who were born in Alaska in 1989 or later are matched with the birth certificate and the child's race at birth is used for calculating deaths and death rates by race.

Alaska Bureau of Vital Statistics (continued) FETAL AND INFANT DEATHS

TABLE 2.6 BIRTHS AND INFANT DEATHS (DEATH COHORT METHOD) BY DEATH YEAR AND FIVE-YEAR MOVING AVERAGE INFANT MORTALITY RATES BY RACE, ALASKA, 1991-1995

RACE	BIRTHS, INFANT DEATHS, AND 5-YEAR MOVING RATES BY YEAR														
	1991			1992			1993			1994			1995		
	BTHS	DTHS	5-YR RATE	BTHS	DTHS	5-YR RATE	BTHS	DTHS	5-YR RATE	BTHS	DTHS	5-YR RATE	BTHS	DTHS	5-YR RATE
			1987-1991			1988-1992			1989-1993			1990-1995			1991-1995
WHITE	7,875	59	7.8	7,910	59	7.8	7,506	44	7.1	7,282	44	6.9	6,968	42	6.6
NATIVE	2,785	39	16.7	2,695	33	15.7	2,459	34	15.3	2,345	28	14.1	2,300	24	12.6
BLACK	518	5	13.9	537	5	13.0	584	7	10.4	491	5	10.5	447	6	10.9
ASIAN/PI	489	3	8.1	553	3	6.3	516	5	6.9	462	5	8.9	485	8	9.6
UNKNOWN	21		11.1	31			24			101			22		
TOTAL	11,688	106	10.2	11,726	100	9.8	11,089	90	9.1	10,681	82	8.8	10,222	80	8.3

Infant Deaths by Cause of Death

Although the same coding system (ICD9) is used in reporting causes of death for infants and the general population, the codes are grouped differently since causes of death for infants up to one year generally differ from those in the general population. For specific causes of death for infant mortality refer to Appendix C, Table C.2.

Certain causes of death are associated with factors such as age and birth weight. For instance, Sudden Infant Death Syndrome (SIDS) almost always occurs in the postneonatal period. Respiratory Distress Syndrome generally occurs only in low birth weight infants. The single greatest cause of infant death is Sudden Infant Death Syndrome. In the five-year period from 1991 through 1995, 120 infants were reported to have died of SIDS, a rate of 2.2 per thousand live births. This compares with a rate of 0.9 per thousand live births for the United States in 1995.⁴ The United States rate for SIDS deaths dropped 28% since 1994 when the rate was 1.1 deaths per thousand live births.

Because of its mysterious nature, Sudden Infant Death Syndrome can never be positively determined; rather, it is a diagnosis which occurs after other causes of death have been ruled out. What we can say about SIDS is that it affects normally healthy, sleeping infants under one year of age. One potential risk factor for SIDS is putting infants to sleep on their stomachs (the prone position).⁵

The Alaska Maternal and Infant Mortality Review Committee (MIMR) is composed of representatives from the medical professions including obstetricians and gynecologists, pediatricians, neonatologists, and representatives of the Indian Health Service. The work of the committee is coordinated by staff from the Section of Maternal, Child and Family Health in the Division of Public Health. This committee reviews medical records and, in some cases, police records for each infant death and either concurs with the cause of death as stated on the death certificate or determines a different cause of death. The committee reviewed 39 cases in 1993 and 1994 in which SIDS was the reported cause of death. In 33 of those cases they concurred that SIDS was the cause of death; in six cases they believed the cause of death to be other than SIDS.

In 1995, there were six SIDS deaths reported in the neonatal period (less than 28 days old). SIDS is extremely rare in this age group; there were only five SIDS deaths in this age group in the previous nine years.

4 National Center for Health Statistics, U.S. Department of Health and Human Services, "Report of Final Mortality Statistics, 1995," *Monthly Vital Statistics Report*, Vol. 45, No. 11(S2), June 12, 1997, Table 27, p.68.

5 Willinger, Marian, Ph.D., Hoffman, H., M.A., and Hartford, R., Ph.D., "Infant Sleep Position and Risk for Sudden Infant Death Syndrome: Report of Meeting Held January 13 and 14, 1994, National Institutes of Health, Bethesda, MD," *Pediatrics*, Vol. 93, No. 5, May 1994, p. 814.

FETAL AND INFANT DEATHS (continued) Alaska Bureau of Vital Statistics

TABLE 2.7 INFANT DEATHS BY SELECTED CAUSES OF DEATH AND AGE, ALASKA, 1995 (DEATH COHORT METHOD)

CAUSE OF DEATH	AGE AT DEATH		
	NEONATAL	POST-NEONATAL	TOTAL
PNEUMONIA & INFLUENZA		1	1
HERNIA OF ABDOMINAL CAVITY AND INTESTINAL OBSTRUCTIONS		1	1
CONGENITAL ANOMALIES	11		11
MATERNAL COMPLICATIONS OF PREGNANCY	2		2
PLACENTA, CORD, AND MEMBRANE COMPLICATIONS	6		6
LABOR & DELIVERY: OTHER COMPLICATIONS	2		2
SHORT GESTATION & LOW BIRTHWEIGHT RELATED DISORDERS	7	1	8
INTRAUTERINE HYPOXIA & BIRTH ASPHYXIA	1		1
RESPIRATORY DISTRESS SYNDROME	4		4
PERINATAL PERIOD INFECTIONS	2		2
SIDS	6	16	22
ACCIDENTS & ADVERSE EFFECTS	1	3	4
HOMICIDE		1	1
ALL OTHER CAUSES	6	9	15
TOTAL	48	32	80

TABLE 2.8 INFANT DEATHS BY SELECTED CAUSES OF DEATH AND RACE, ALASKA, 1995 (DEATH COHORT METHOD)

CAUSE OF DEATH	RACE				TOTAL
	WHITE	NATIVE	BLACK	AS/PI	
PNEUMONIA & INFLUENZA		1			1
HERNIA OF ABDOMINAL CAVITY AND INTESTINAL OBSTRUCTIONS		1			1
CONGENITAL ANOMALIES	7	4			11
MATERNAL COMPLICATIONS OF PREGNANCY	1			1	2
PLACENTA, CORD, AND MEMBRANE COMPLICATIONS	3	1		2	6
LABOR & DELIVERY: OTHER COMPLICATIONS	2				2
SHORT GESTATION & LOW BIRTHWEIGHT RELATED DISORDERS	3	3	2		8
INTRAUTERINE HYPOXIA & BIRTH ASPHYXIA		1			1
RESPIRATORY DISTRESS SYNDROME	2	1	1		4
PERINATAL PERIOD INFECTIONS	2				2
SIDS	9	8	3	2	22
ACCIDENTS & ADVERSE EFFECTS	2	2			4
HOMICIDE	1				1
ALL OTHER CAUSES	10	2		3	15
TOTAL	42	24	6	8	80

John Davies

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 12:15 PM
To: John Davies
Subject: RE: HB 2

The suggestions would be as follows and this is based off of the CS that was heard in committee:

On page 1 line 6 following "of" delete "a stillborn child" and insert "the stillbirth"

On page 1 line 12 following "of" delete "a stillborn child" and insert "the stillbirth"

On page 1 line 13 following "name" delete "of a stillborn child"

On page 2 line 1 following "name" delete "of the stillborn child"

On page 2 line 6 following "birth" delete "of a stillborn child"

On page 2 line 14 remove everything following "stillbirth" and insert "is that as defined in AS 18.50.950(8)."

If you were to make those changes there would be no reference to a child and take away any concerns that have been raised.

Sandra Wilson
 Staff to Rep. Gatto
 465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 11:58 AM
To: Sandra Wilson
Subject: RE: HB 2

Yes, I had the word fetus in my first draft, but changed it to follow the referred to statute. I am glad that you have been talking to others with experience. That's a great help. Based on your conversations do you have any new draft language? Thanks JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 10:27 AM
To: John Davies
Subject: RE: HB 2

I understand. I have been talking with those who have worked on this in other states. And in states where this issue has come up what they have done to quash any belief that this would in any way give rights to or somehow do what we did not want it to do was delete the word child and insert the word fetus. By doing this we take away any reference to a child.

Sandra Wilson
 Staff to Rep. Gatto
 465-3163

From: John Davies

Sent: Tuesday, March 03, 2009 10:00 AM
To: Sandra Wilson
Subject: RE: HB 2

Let's talk to Jean about this tomorrow and look to get the bill out of committee next week. It would be better to get it right now to insure its passage later. JD

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 9:52 AM
To: John Davies
Subject: RE: HB 2

You could make it simpler by saying that in this section "stillbirth" or "stillborn child" is that as defined in AS 18.56.950 (8)

I do not have a problem meeting with the two of you tomorrow. I was just hoping that we would be able to get this heard and passed out today because the hope that both myself and Rep. Gatto is that we could pass this bill through this year. This is more and more unlikely as it takes longer to get it out of committee. I guess I don't completely understand the issue at hand because it states very clearly in the bill that the issuance of the birth certificate is not proof of live birth.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 9:35 AM
To: Sandra Wilson
Subject: HB 2

Dear Sandra,

This email is a heads up for your to keep you apprised of the movement on your bill. Here is the proposed definition of "stillborn child" that we propose:

- (h) In this section, "stillbirth" or "stillborn child" refers to the unintended death of a product of human conception as defined in AS18.50.950 (8)(A) and (B).

Give this some thought. We have an appointment to meet with Jean Mischal, Leg Legal, tomorrow at 9am at her office in the TMOB. I would like you to attend with Matt and I so that you can have your input heard on this.

We are trying to make sure that the definition is tight enough so as not to cause the bill to fail or run into problems with legal challenges.

Jean was working on a drafting job today and couldn't see us until tomorrow.

Regards,
John Davies

John Davies

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Regards,
John Davies

John Davies

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 11:29 AM
To: John Davies
Subject: HB 2

Just a little more information, I talked with Joanne Cacciatore and she told me that no state has ever had anyone challenge their stillbirth laws. This includes states such as California which had strong opposition to the bill. Just wanted to make you aware of that.

Sandra Wilson
Staff to Rep. Carl Gatto
907-465-3163
Sandra_wilson@legis.state.ak.us

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*gestational period?
necessary?*

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Subject: HB 2

Dear Sandra,

This email is a heads up for you to keep you apprised of the movement on your bill. Here is the proposed definition of "stillborn child" that we propose:

- (h) In this section, "stillbirth" or "stillborn child" refers to the unintended death of a product of human conception as defined in AS18.50.950 (8)(A) and (B).

Give this some thought. We have an appointment to meet with Jean Mischal, Leg Legal, tomorrow at 9am at her office in the TMOB. I would like you to attend with Matt and I so that you can have your input heard on this.

We are trying to make sure that the definition is tight enough so as not to cause the bill to fail or run into problems with legal challenges.

Jean was working on a drafting job today and couldn't see us until tomorrow.

Regards,
John Davies

John Davies

From: Sandra Wilson
Sent: Tuesday, March 03, 2009 9:52 AM
To: John Davies
Subject: RE: HB 2

You could make it simpler by saying that in this section "stillbirth" or "stillborn child" is that as defined in AS 18.56.950 (8)

I do not have a problem meeting with the two of you tomorrow. I was just hoping that we would be able to get this heard and passed out today because the hope that both myself and Rep. Gatto is that we could pass this bill through this year. This is more and more unlikely as it takes longer to get it out of committee. I guess I don't completely understand the issue at hand because it states very clearly in the bill that the issuance of the birth certificate is not proof of live birth.

Sandra Wilson
Staff to Rep. Gatto
465-3163

From: John Davies
Sent: Tuesday, March 03, 2009 9:35 AM
To: Sandra Wilson
Subject: HB 2

Dear Sandra,

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Regards,
John Davies

To: KEVIN CLARKSON

WORK DRAFT

WORK DRAFT

WORK DRAFT

26-LS0003'R
Mischel
1/29/09

CS FOR HOUSE BILL NO. 2()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GATTO, Gruenberg, Dahlstrom, Lynn

A BILL
FOR AN ACT ENTITLED

"An Act relating to the issuance of a certificate of birth resulting in a stillbirth."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.50 is amended by adding a new section to read:

Sec. 18.50.235. Certificate of birth resulting in stillbirth. (a) The person required to file a fetal death registration under AS 18.50.240(b) shall advise the mother and, if the father is present, the father of a stillborn child

(1) that the parent may request the preparation of a certificate of birth resulting in stillbirth;

(2) that the parent may obtain a certificate of birth resulting in stillbirth by contacting the bureau; and

(3) of the contact information for the bureau.

(b) The parent of a stillborn child who requests a certificate of birth resulting in stillbirth may provide a name of a stillborn child for placement on the certificate. If a name is not provided, the bureau shall cause the certificate to show either "baby boy" or "baby girl," as appropriate, and the last name of the parent who requested the

1 certificate. The name of the stillborn child provided on the certificate of birth resulting
2 in stillbirth must be the same name as the name on the fetal death certificate.

3 (c) A certificate of birth resulting in stillbirth must include the state file
4 number of the corresponding fetal death certificate.

5 (d) The department shall prescribe the form and content of a certificate of
6 birth resulting in stillbirth to record the birth of a stillborn child and specify the
7 information required to prepare the certificate.

8 (e) A certificate issued under this section is not proof of a live birth, and the
9 certificate must contain the phrase "not proof of live birth." The bureau may not use a
10 certificate of birth resulting in stillbirth to calculate live birth statistics.

11 (f) A parent may request that the bureau issue a certificate of birth resulting in
12 still birth regardless of the date on which the certificate of fetal death was issued.

13 (g) The department may adopt regulations needed to implement this section.

14 (h) In this section, "stillbirth" or "stillborn" refers to an unintended,
15 intrauterine fetal death occurring in the state after a gestational age of 20 completed
16 weeks.

AMENDMENT

TO: HB 2 (26-LS0003\R)

BY REPRESENTATIVE HOLMES

1 Page 2, line 14

2 After ""stillbirth" or "stillborn":

3 Insert "child"

3/2/09
abortion driver's
definition -
no BL for abortion

Mischel
Jean Michelle - attorney ← rewrite definition
465-2450

Why definition on blocks not used - / old
here more restrictive definition
keep abortion

Violated Statute - ~~Jan~~ birth card
for live birth
not visible

no definition of stillborn child

National Right to Life -

- 258 2000 Kevin Clarkson

258 2001 Jay

Sec. 18.50.950. Definitions.

In this chapter,

- (1) "adoptive parent" means a person who has adopted another person under AS 25.23;
- (2) "biological parent" means a parent named on the original certificate of birth of an adopted person;
- (3) "bureau" means the Bureau of Vital Statistics;
- (4) *[Repealed, 88 ch 56 SLA 2005.]*
- (5) "commissioner" means the commissioner of health and social services;
- (6) "dead body" means a lifeless human body or parts or bones of it from the state of which it reasonably may be concluded that death recently occurred;
- (7) "department" means the Department of Health and Social Services;
- (8) "fetal death" means death before the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, where
 - (A) the death is indicated by the fact that, after expulsion or extraction, the fetus does not breathe or show evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles; and
 - (B) the expulsion or extraction is not caused by an induced termination of pregnancy;
- (9) "filing" means the presentation of a certificate, report, or other record provided for in this chapter, of a birth, death, fetal death, adoption, marriage, or divorce for registration by the bureau;
- (10) "final disposition" means the burial, interment, cremation, or other disposition of a dead body or fetus;
- (11) "induced termination of pregnancy" means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and that does not result in a live birth, except that "induced termination of pregnancy" does not include management of prolonged retention of products of conception following fetal death;
- (12) "institution" means a public or private establishment that provides in-patient medical, surgical, or diagnostic care or treatment, or nursing, custodial, or domiciliary care to two or more unrelated individuals, or to which persons are committed by law;
- (13) "**live birth**" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that, after expulsion or extraction, breathes or shows evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;
- (14) "medical history" includes information relating to a person's medical conditions and treatment, immunization records, and other medical information about the person that could be important to the health care of the adopted person;
- (15) "physician" means a person authorized or licensed to practice medicine under the laws of the state;
- (16) "registration" means the acceptance by the bureau and the incorporation in its official records of certificates, reports, or other records provided for in this chapter, of births, deaths, fetal deaths, adoptions, marriages, or divorces;
- (17) "state registrar" means the state registrar of vital statistics;

(18) "system of vital statistics" includes the registration, collection, preservation, amendment, and certification of vital statistics records, and related activities including the tabulation, analysis, and publication of statistical data derived from them;

(19) "vital statistics" means records of birth, death, fetal death, induced termination of pregnancy, marriage, divorce, adoption, and related data.

A **stillbirth** occurs when a fetus which has died in the uterus or during labor or delivery exits a woman's body. The term is often used in distinction to live birth or miscarriage. Most stillbirths occur in full term pregnancies.

Some sources reserve the term "stillbirth" for a fetus which has died after reaching mid-second trimester to full term gestational age. For example, in the United Kingdom, "stillbirth" is used to describe an infant delivered without life after 24 weeks gestation. The sources that use this definition tend to use the term "miscarriage" if the death occurs earlier in development. In contrast, other sources use the term "stillbirth" regardless of the stage of fetal development.

parent's second marriage and has not been adopted by that parent.

Step-down in basis. A reduction in the income tax basis of property. See also **Step-up in basis**.

Step-father. The husband of one's mother by virtue of a marriage subsequent to that of which the person spoken of is the offspring.

Step-in-the-dark rule. Such rule of contributory negligence is that one who enters a totally unfamiliar area in the darkness is not justified, in the absence of any special stress, in proceeding without first ascertaining whether there are any obstacles to his safe progress. *Yoder v. Greenwald*, Fla.App., 246 So.2d 148, 150.

Step-mother. The wife of one's father by virtue of a marriage subsequent to that of which the person spoken of is the offspring.

Step-parent. The mother or father of a child born during a previous marriage of the other parent and hence, not the natural parent of such child.

Step-son. The son of one's wife by a former husband, or of one's husband by a former wife.

Step-up in basis. An increase in the income tax basis of property.

Sterbreche, or strebrich. The breaking, obstructing, or straitening of a way.

Stère /stír/stéhr/. A French measure of solidity, used in measuring wood. It is a cubic meter.

Sterility /stérilēdi/. Barrenness; unfruitfulness; incapacity to germinate or reproduce.

Sterilization. The act or process by which one is rendered incapable of procreation as, for example, the act of tying the female Fallopian tubes or a vasectomy. Also, the act or process by which an article or instrument is rendered free of germs.

Sterling. In English law, current or standard coin, especially silver coin; a standard of coinage.

Stet processus /stét prasésás/. An entry on the roll in the nature of a judgment of a direction that all further proceedings shall be stayed (i.e., that the process may stand), and it is one of the ways by which a suit may be terminated by an act of the party, as distinguished from a termination of it by judgment, which is the act of the court. It was used by the plaintiff when he wished to suspend the action without suffering a nonsuit.

Stevadore. A person employed in loading and unloading vessels.

Steward. A man appointed in the place or stead of another. A union official who represents other union employees in grievances with management and who oversees the carrying out of the union contract.

Steward of all England. In old English law, an officer who was invested with various powers; among others, to preside on the trial of peers.

Steward of a Manor. In old English law, an important officer who had the general management of all

forensic matters connected with the manor of which he was steward. He stood in much the same relation to the lord of the manor as an under-sheriff did to the sheriff.

Stews. Certain brothels anciently permitted in England, suppressed by Henry VIII. Also, breeding places for tame pheasants.

Stickler. An arbitrator. An obstinate contender about anything.

Stick up. Rob at the point of a gun.

Stifling a prosecution. Agreeing, in consideration of receiving a pecuniary or other advantage, to abstain from prosecuting a person for an offense not giving rise to a civil remedy.

Still. Any device used for separating alcoholic spirits from fermented substances. The word is sometimes applied to the whole apparatus for evaporation and condensation used in the manufacture of ardent spirits, but in the description of the parts of the apparatus it is applied merely to the vessel or retort used for boiling and evaporation of the liquid.

Stillborn child. A child born dead or in such an early stage of pregnancy as to be incapable of living, though not actually dead at the time of birth.

Stillicidium /stilisid(i)yam/. Lat. In the civil law, the drip of water from the eaves of a house. The servitude stillicidii consists in the right to have the water drip from one's eaves upon the house or ground of another. The term "flumen" designated the rain-water collected from the roof, and carried off by the gutters, and there is a similar easement of having it discharged upon the adjoining estate.

Stint. In English law, limit; a limited number. Used as descriptive of a species of common. See *Common sans nombre*.

Stipend /stáypēnd/. A salary; settled pay; fixed or regular payment. Offering made to clergyman.

Stipendiary estates /stáypēnd(i)yēhri/. Estates granted in return for services, generally of a military kind.

Stipendiary magistrates. In English law, paid magistrates; appointed in London and some other cities and boroughs, and having in general the powers and jurisdiction of justices of the peace.

Stipendium /stáypēnd(i)yam/. Lat. In the civil law, the pay of a soldier; wages; stipend.

Stipes /stáypiyz/. Lat. In old English law, stock; a source of descent or title. *Communis stipes* the common stock.

Stipital /stípedal/. Relating to stirpes, roots, or stock. "Stipital distribution" of property, is distribution per stirpes; that is, by right of representation.

Stipulate. Arrange or settle definitely, as an agreement or covenant. See *Stipulation*.

Stipulated damage. Liquidated damage (q.v.).

Stipulatio /stípyaléysh(i)yow/. Lat. In the Roman law, stipulatio was the verbal contract (verbal contract).

tio), and was the most solemn contracts in that system entered into by question thereto, by the parties, at some time, and usually by *spondeo*, "promittis?" *pro*

Stipulatio aquillana /stípyaléy particular application of t used to collect together in the liabilities of every kind with a view to their being an *acceptilatio*, that mode ble only to the verbal contr

Stipulatio juris /stípyaléysh(iy or agreement beforehand or applicability, though a cour relation of erroneous law. F contract may stipulate as t law of a particular state or

Stipulation. A material condi cle in an agreement.

The name given to any attorneys engaged on opposi cially if in writing), regulat to the proceedings or trial jurisdiction. Voluntary agre counsel concerning dispositi so as to obviate need for pr litigable issues. *Arrington* 634, 636. An agreement, made in a judicial procedi or their attorneys. *Bourne* Co., 209 Kan. 511, 497 P.2d

Stipulations made during involve jury of less than tw master's findings (Rule 53(e) (Rule 41(a)), or discovery (s

A recognition of certain law "fide jussors") in the appearance of a defendant.

See also *Admission*; *Provi*

Discovery. Unless the cou parties may by written stip depositions may be taken b time or place, upon any no and when so taken may be tions; and (2) modify the these rules for other metho that stipulations extending th 33, 34; and 36 for respons made only with the approval UP, 29.

Stipulator. In the civil law, t question in the contract of party or he who answered, l for. But, in a more gene applied to both the parties.

Stipes /stárpíyz/. Lat. Desc stock of a tree. Figuratively person from whom a family the kindred or family. Tak representation is called "su opposition to taking in on

without the domin-
e king, it was called
to have been used
to a man of power
tion as a chief or

or advance of mon-

reement or composi-
between a creditor or
of usury, etc.; also

which is accessory

where futures con-
cultural products are

rewd cunning. The

lized Indian tribes.

st. Principal; lead-
importance; the best
several; paramount;

on for the principal

examination of a
s him.

in, *infra*.

g judge of the Eng-
g to the chief jus-
by Lord Chief Jus-

officer of a court,
rally charged, sub-
or officer, with the
ion of the business

e.

senior, or principal

erly given to the
ach division of the
bsence of the lord
urt, and also an ex
s. Now supersed-
England" who is
vision.

In England, the
ommon pleas, and
ivision of the high
fficio judges of the

old English law, a
gistrate, who pre-
orman kings, and

who was also the principal minister of state, the
second man in the kingdom, and, by virtue of his
office, guardian of the realm in the king's absence. 3
Bl.Comm. 38.

Chief lord. The immediate lord of the fee, to whom the
tenants were directly and personally responsible.

Chief magistrate. The head of the executive depart-
ment of government of a nation, state, or municipal
corporation. The President is the chief executive
of the United States.

Chief office. Office of paramount importance or the
leading office.

Chief pledge. In old English law, the borsholder, or
chief of the borough.

Chief rents. In old English law, the annual payments of
freeholders of manors; also called "quit-rents," be-
cause by paying them the tenant was freed from all
other rents or services. Abolished by Law of Proper-
ty Act of 1922.

Chiefrie. In feudal law, a small rent paid to the lord
paramount.

Chief, tenant in. In English feudal law, all the land in
the kingdom was supposed to be holden mediately or
immediately of the king, who was styled the "Lord
Paramount," or "Lord Above All;" and those that
held immediately under him, in right of his crown and
dignity, were called his tenants "*in capite*" or "in
chief," which was the most honorable species of
tenure, but at the same time subjected the tenant to
greater and more burdensome services than inferior
tenures did. One who held directly of the king.

Child. Progeny; offspring of parentage. Unborn or
recently born human being. *Wilson v. Weaver*, 358
F.Supp. 1147, 1154. At common law one who had
not attained the age of fourteen years, though the
meaning now varies in different statutes; e.g. child
labor, support, criminal, etc. statutes. The term
"child" or "children" may include or apply to: adopt-
ed, after-born, or illegitimate child; step-child;
child by second or former marriage; issue.

See also Delinquent child; Disobedient child; Fos-
ter child; Illegitimate child; Infancy; Juvenile; Minor;
Neglected child; Person; Posthumous child; Preter-
mitted heir; Viable child. For negligence of child, see
Parental liability.

Childs part. A "child's part," which a widow, by
statute in some states, is entitled to take in lieu of
dower or the provision made for her by will, is a full
share to which a child of the decedent would be
entitled, subject to the debts of the estate and the
cost of administration up to and including distribu-
tion.

Illegitimate child. Child born out of lawful wedlock.

Legitimate child. Child born in lawful wedlock.

Natural child. Child by natural relation or procrea-
tion. Child by birth, as distinguished from a child by
adoption. Illegitimate children who have been ac-
knowledged by the father.

Posthumous child. One born after the father's death.

Quasi-posthumous child. In the civil law, one who,
born during the life of his grandfather, or other male

ascendant, was not his heir at the time he made his
testament, but who by the death of his father became
his heir in his life-time.

Rights of unborn child. Medical authority has recog-
nized long since that a child is in existence (*i.e.* alive)
from the moment of conception, and for many pur-
poses its existence is recognized by the law. The
criminal law regards it as a separate entity, and the
law of property considers it in being for all purposes
which are to its benefit, such as taking by will or
descent. After its birth, it has been held that it may
maintain a statutory action for the wrongful death of
the parent. In addition, the child, if he is born alive,
is permitted to maintain an action for the conse-
quences of prenatal injuries, and if he dies of such
injuries after birth an action will lie for his wrongful
death. Many states have allowed recovery even
though the injury occurred during the early weeks of
pregnancy, when the child was neither viable nor
quick. *Sylvia v. Gobeille*, 1966, 101 R.I. 76, 220 A.2d
222; *Hornbuckle v. Plantation Pipe Line Co.*, 1956,
212 Ga. 504, 93 S.E.2d 727, conformed to 94 Ga.
App.2d 328, 94 S.E.2d 523; *Bennett v. Hymers*, 1958,
101 N.H. 483, 147 A.2d 108; *Sinkler v. Kneale*, 1960,
401 Pa. 267, 164 A.2d 93; *Smith v. Brennan*, 1960, 31
N.J. 353, 157 A.2d 497.

Child abuse. Any form of cruelty to a child's physical,
moral or mental well-being. Also used to describe
form of sexual attack which may or may not amount
to rape. Such acts are criminal offenses in most
states. See also *Abuse (Female child)*; *Abused and
neglected children.*

Child labor laws. Network of laws on both federal and
state levels prescribing working conditions for chil-
dren in terms of hours and nature of work which may
be performed, all designed to protect the child. See
also *Fair Labor Standards Act*; *Working papers.*

Children's court. See *Juvenile courts.*

Child support. The legal obligation of parents to con-
tribute to the economic maintenance, including edu-
cation, of their children; enforceable in both civil and
criminal contexts. In a dissolution or custody action,
money paid by one parent to another toward the
expenses of children of the marriage. See also *Non-
support.*

Child welfare. A generic term which embraces the
totality of measures necessary for a child's well be-
ing; physical, moral and mental.

Childwit. In Saxon law, the right which a lord had of
taking a fine of his bondwoman gotten with child
without his license.

The custom in Essex county, England, whereby
every reputed father of a bastard child was obliged to
pay a small fine to the lord.

Chilling a sale. The act of bidders or others who
combine or conspire to suppress fair competition at a
sale, for the purpose of acquiring the property at less
than its fair value.

Chilling effect doctrine. In constitutional law, any law
or practice which has the effect of seriously discour-
aging the exercise of a constitutional right, e.g. the
right of appeal. *North Carolina v. Pearce*, 395 U.S.
711, 89 S.Ct. 2072, 23 L.Ed.2d 656.

John Davies

From: Rep. Wes Keller
Sent: Friday, February 27, 2009 5:24 AM
To: John Davies
Cc: kclarkson@brenalaw.com; Jim Pound; Matthew Johnson
Subject: advice please

Good Morning John,

I think we need all the help and brains we can get focused on a pending amendment by Rep Holmes for HB 2. It is very possible that my concerns are exaggerated and unrealistic, but I need you, Kevin Clarkson, and Jim Pound and Matt to assure me that is so before we get to our next HSS meeting (March 3). Research to confirm that I am being over-cautious may be easy to come by, but frankly I don't have enough time or confidence in my legal abilities to make that assumption on my own.

Matt will help you with the bill (HB 2), the pending amendment language, and questions you may have of the Sponsor of HB 2.

The amendment simply adds the word "child" to 'stillborn'. My concern is the potential for a passionate, distracting, and maybe destructive debate about the definition of "child". AK statute establishing crimes against unborn children has a good definition of an "unborn child" but I do not remember what other definitions of 'child' there may be in statute. I am concerned that using the word 'child' in HB 2 will be the catalyst to enable someone to ask a legal question about whether a certificate would need to be issued for an aborted child... Maybe that is a good discussion to have, but I do not believe the sponsor of the bill is prepared for that ---and we need to ask ourselves if this is a battle we want right now. If my concern is appropriate the entire Committee needs to know the potential before we take on the amendment. It is possible that the maker of the amendment is being used (advised) by the pro-death lobby and would choose to withdraw her amendment if she gets a glimpse of the 'black hole'?--- It is possible that it is an innocent attempt to be helpful. It is also believable that she is fully aware and this is a first step to a 'full court press' ---- Either way, we need to proceed with both eyes open.

I recommend checking with National Right to Life to see what other states have done so we don't proceed without the advantage of any vetting that has already happened.

Clearly, the level of legal advice that we need at this point is probably not available from our own legal services. After we compare notes and either confirm or refute my concerns --- we can consider getting an official response from legal services on specific questions we want confirmed.

I am asking you to engage the group I am copying (if they are available and willing) --- divide the job up between you if appropriate, and take whatever action you feel is appropriate to get some consensus on the advice I am asking for. Maybe a teleconference and/or meeting @ our condo if my concerns are confirmed to have some validity.

Again --- I am asking for consideration regarding the wisdom or potential consequences of the amendment to HB 2 being proposed by Representative Lindsey Holmes. Your response will guide the 'next step/s'.

Thanks

Wes

2582001 *Jak*

When they pass through they often leave nothing behind but footprints.



Cheyenne Cacciatore July 27, 1994

Over 26,000 times a year in the United States a mother delivers a "still" baby. For many footprints on paper are the only memento they have to show they once had a baby who passed through this world. The lucky ones find out why their baby died. But for two-thirds of mothers no answer can be given them to explain why their "normal" baby was delivered dead. Not knowing a cause leaves them blaming themselves, and searching for answers.

Far from being a rare event, Sudden Antenatal Death Syndrome (SADS) – as it's referred to in medical circles - **was 12 times as prevalent as S.I.D.S. or crib death last year.** And yet one neither hears nor reads much about it. Until the National Stillbirth Society was founded last year by a bereaved stillbirth father, there was no organization fighting to defeat stillbirth.

One reason there's so little SADS awareness is because the birth of a "still" baby, rather than being acknowledged in official state records, has been swept under the carpet. The death of the baby is acknowledged, but not the birth. A woman who delivers a live baby receives a **Certificate of Live Birth.** But let the same mother give birth to a "still" baby and she doesn't get a certificate of birth for that baby.... as if that birth never happened!

Birth is a process; live or "still" is only a result. A mother of twins, who delivers one twin live and one "still", is now given a certificate for the live birth only in 38 states. We believe a mother should receive a **Certificate of Birth Resulting in Stillbirth** in recognition of having delivered her dead baby too, as should all stillbirth mothers. That's the reality of what happened. They all gave birth!

Arizona, the first state to pass legislation, named it "**The Missing Angel Act**". Since then states across the nation have introduced their own version of the Bill and as of February 1, 2004 there were 12 states that issue a Certificate of Birth Resulting in Stillbirth. It's a simple bill that seeks only to provide closure for mothers who suffered the pains and joys of pregnancy and childbirth, without getting to take home their reward.

The Missing Angel Act does not impact on or involve in any way "elective terminations of pregnancies". That is not our issue and never will be our issue! We are fighting solely for the rights of stillbirth mothers – and there are more than a million living in this country today – who carried a child, in some cases to full term, and having lost that child to stillbirth, were denied a certificate that says they tried. The right to receive a Certificate that acknowledges they went through a birthing process.

PLEASE SUPPORT OUR LEGISLATION IN YOUR STATE



The National Stillbirth Society
www.stillnomore.org

Richard K. Olsen, Executive Director E-mail: stillnomore@cox.net



Sudden Antenatal Death Syndrome

The National Stillbirth Society Inc.

"Because all our Children Matter"

TO: An Open Letter to Members of the Alaska Legislature

Please enact HB 159 to create Certificates of Birth Resulting in Stillbirth

The written record of life usually begins with a Certificate of Birth and ends with a Certificate of Death, but not for all babies. Last year 30,000 babies were "stillborn", victims of Sudden Antenatal Death Syndrome. These babies, past 20 weeks and for the most part viable, often died mysteriously in their mothers' wombs for no discernable reason. For them there is no Certificate of Birth. They are issued Certificates of Fetal Death that record their passing, but not Certificates of Birth that acknowledge their delivery. Why Not? Should not two certificates be issued, one to mark their death, the other to record their birth?

Birth is a process all mothers go through, regardless of the outcome. Mother's of stillborn babies "give birth", they just don't give life. The piece of paper we routinely refer to as a Certificate of Birth is actually titled, "Certificate of Live Birth". Doesn't this wording suggest there is another kind of birth? The answer is an obvious "Yes". There's "live birth" and then there's "stillbirth". Both qualify as "births".

Stillbirth mothers deserve to have their motherhood recognized and validated by the issuance of a Certificate of Birth Resulting in Stillbirth, just as live birth mothers have their birth event recognized. They are mothers; that their baby died before its birth does not take that reality away from them. And stillbirth fathers are no less fathers because of their loss.

I am a father. My daughter Camille died in utero on the eve of her delivery at 41 weeks!

Arizona recognized the inequality of how stillbirths were being treated and in 2001 passed HB2416, mandating that the Bureau of Vital Statistics offer parents of all stillborn babies a "Certificate of Birth Resulting in Stillbirth". This certificate is in addition to - and separate from - the Certificate of Fetal Death which is **not affected in any way by the legislation**. One document recognizes the brave act of the mother who bore a "still" baby, while the other recognizes the death of that child prior to birth. (For a recap of current legislative activity in all states and specimen bills see <http://www.missingangelsbill.org>.)

Both past and current stillbirths in Arizona are eligible to be issued such a Certificate.

The issuance of a Certificate of Birth Resulting in Stillbirth does not impact in any way a woman's right to choose to terminate her pregnancy. Such certificates are issued only for deliveries following naturally occurring fetal deaths. Women who choose an elective termination of their pregnancy would neither be required to obtain a Certificate of Birth Resulting in Stillbirth, nor would they even be eligible for the reason elective terminations don't fall within the definition of a "stillbirth".

Also important to note is that this measure is not about taxes or financial relief or gain of any type. Stillbirth parents are not seeking a dependent deduction, though one must ask whether it would not be appropriate to offer stillbirth parents the same tax benefit as live birth parents, since they bear the added cost of burial. But for the present, we want to focus solely on the societal issue of equal treatment for all birth mothers.

At present the mothers and fathers of stillborn babies suffer not only the loss of their baby but also the loss of societal acknowledgement that they are parents. Our country has historically been silent about stillbirth, preferring not to discuss this uncomfortable topic. Because of that silence there has been little done in the way of research or prevention. Stillbirth is a phenomenon that cuts across every strata of society; no one is immune. It strikes women as randomly as lightening bolts come to ground in a thunderstorm, making it all the more terrifying.

One in every 116 births is a stillbirth! Eighty eventy babies a day are born still every day in America; over five hundred every week.

The National Stillbirth Society, founded in 2001 by this stillbirth father, is sponsoring a nationwide drive to draw attention to the devastation caused to families worldwide by stillbirth. We will achieve this goal in part by getting state legislatures to enact legislation to acknowledge that mothers of stillborn babies are entitled to receive recognition for the child that they conceived and nurtured, but lost at birth..

When she signed the enabling legislation, Arizona's Governor Jane Dee Hull commented, "This is a step long overdue". She must have been right because legislators in every state where it has been enacted into law have done so on unanimous votes! That's because dead babies and bereaved parents are deemed to deserve more respect than they have been given up to now. It passed in Massachusetts – a liberal state – as easily as it did in Utah. This is truly a non-partisan issue, non-controversial issue. Thank you.



Richard K. Olsen, Founder & Executive Director

HB

26

Representative Mike Hawker

Alaska State Legislature



Session:

State Capitol
Juneau, AK 99801
907 465-4949 office
907 465-4979 fax

Interim:

716 W 4th Avenue
Anchorage, AK 99501
907 269-0244 office
907 269-0248 fax

House District 32:

Eagle River
Anchorage
Glen Alps
Rainbow
Indian
Bird
Girdwood
Portage
Whittier
Sunrise
Hope

TO: Representative Wes Keller, Co-Chairman
Representative Bob Herron, Co-Chairman
House Finance Committee

FROM: Representative Mike Hawker

A handwritten signature in black ink, appearing to be "MH".

DATE: January 29, 2009

RE: House Bill 26

I request that House Bill 26, which would extend the current Medicaid Adult Dental program, be scheduled for a hearing at your earliest convenience. The program is scheduled to sunset on June 30, 2009. Early passage of this legislation will ensure continuation of care for the patients who rely on these services.

I have attached a Sponsor Statement, copy of the bill, Sectional Analysis, and some background materials. I have requested additional materials from the Department of Health and Social Services, which is the only department affected by this program. As soon as these materials are finalized, I will forward them to you. I will not need any audio/visual equipment.

I expect testimony from the following organizations:

Department of Health & Social Services
The Alaska Mental Health Trust Authority
The Alaska Dental Society or Dental Providers

Please feel free to contact me, or my legislative aide, Juli Lucky at 465-6587, if you need any additional information.

Representative Mike Hawker

Alaska State Legislature



House Bill 26

Sponsor Statement

Session:

State Capitol
Juneau, AK 99801
907 465-4949 direct
800 478-4950 toll free
907 465-4979 fax

Interim:

716 W 4th Avenue
Anchorage, AK 99501
907 269-0244 office
907 269-0248 fax

House District 32:

Eagle River
Anchorage
Rainbow
Indian
Bird
Girdwood
Portage
Whittier
Sunrise
Hope

“An Act repealing the repeal of preventative and restorative adult dental services reimbursement under Medicaid; providing for an effective date by repealing the effective date of sec. 3, ch. 52, SLA 2006; and providing for an effective date.”

House Bill 26 would extend the current Medicaid Adult Dental program, which is scheduled to sunset this year. In 2006, the legislature passed House Bill 105, which restructured our approach to adult dental services allowed under Medicaid to provide a more complete level of services.

Prior to 2006, adults on Medicaid could only receive emergency care to relieve pain and fight infection. The passage of HB 105 authorized exams, cleaning, tooth restoration or extraction and dentures. In short, Alaska moved from a “Deferred Maintenance” to a “Preventative Maintenance” approach for adult dental care.

In order to have a chance to assess the viability of the program, the legislature added a sunset to the program of June 30, 2009. House Bill 26 would remove the sunset, allowing the program to become permanent.

HB 26

Sectional Analysis

Prepared by Representative Mike Hawker's Office

- Section 1:** Repeals Section 3 and 5 of ch. 52, SLA 2006 (HB 105). Section 3 reinserted the statute as it existed before passage of HB 105; Section 5 repealed the new section added by HB 105.
- Section 2:** Repeals Section 7 of ch. 52, SLA 2006 (HB 105), which provided an effective date for Section 3.
- Section 3:** Immediate effective date.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB026
() Publish Date: _____

Identifier (file name): HB026-DHSS-APDMS-02-23-09 Dept. Affected: Health & Social Services
Title: Medicaid for Adult Dental Services RDU: Health Care Services
Component: Adult Preventative Dental Medicaid
Sponsor: Hawker
Requester: House HSS Component Number: 2839

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	0.0	7,288.4	7,535.9	7,783.6	8,031.1	8,278.6	8,526.1
Miscellaneous							
TOTAL OPERATING	0.0	7,288.4	7,535.9	7,783.6	8,031.1	8,278.6	8,526.1

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	4,758.7	4,714.4	4,592.3	4,738.3	4,884.4	5,030.4
1003 GF Match	0.0	2,529.7	2,821.5	3,191.3	3,292.8	3,394.2	3,495.7
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	7,288.4	7,535.9	7,783.6	8,031.1	8,278.6	8,526.1

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This bill eliminates the sunset date of June 30, 2009 on enhanced dental services for adult Medicaid recipients. Services for adult Medicaid recipients would otherwise revert to emergent dental services (treatment for immediate relief of pain and acute infection), only. During FY2008 about 7,600 adults received treatment under this program. Forecasted expenditures are based on an analysis of paid claims reflecting the most recent trends. The estimated federal portion is based on projected federal financial participation rates for 2010 through 2015 using federal reimbursement rates from the American Recovery and Reinvestment Act 2009 economic stimulus bill. The amount for FY2010 is included in the Governor's amended budget request. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner Phone 279-7827
Division: Health Care Services Date/Time 2/20/09 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner Date 2/23/2009
DHSS Finance & Management Services

FISCAL NOTE

**STATE OF ALASKA
2009 LEGISLATIVE SESSION**

BILL NO. HB026

ANALYSIS CONTINUATION

In April 2007, Alaska began providing preventive and restorative dental care for adults age 21 and older enrolled in Medicaid. The Legislature established a three year trial period to evaluate the new program, which will end June 30, 2009, if not reauthorized. Services provided under the Adult Preventative Dental Medicaid program must be preauthorized and are subject to a \$1,150 annual cap per individual. Services include exams, cleanings, fillings, root canals and dentures. Total program costs are controlled by spending limits set by the legislature, ensuring that total program spending remains within the budgeted amount.

The Adult Preventative Dental Medicaid program helps protect and promote the health of Alaskans by improving affordable access to dental care services to the nearly 40,000 eligible adult Alaskans enrolled in Medicaid annually. During fiscal year 2008 about 7,600 adults received treatment under this program. In the past, Medicaid only treated emergency pain relief and acute infection for adult dental needs. This coverage expansion was added because infections in the mouth are no different than infections in other parts of the body. Dental infections cause pain and lost time at work, and affect overall health. Waiting until a dental emergency occurs can result in more expensive dental care. Missing teeth can affect employability.

The Alaska Mental Health Trust Authority contributed to state matching funds during the first three years of the program but will not do so after June 30, 2009. Fund source calculations for this fiscal note assume only GF match for the state portion. The federal portion is estimated for 2010 through 2015 based on the proportion of tribal and Title XIX reimbursable costs as forecast for 2010, and the estimates of federal matching percentages for 2010 through 2015. Approximately 18% of the claims are eligible for Indian Health Services which receives 100% federal reimbursement. The remaining 82% of claims are eligible for regular title XIX FMAP, which is projected to average 58.68% for state FY2010, 54.34% for FY2011 and 50% for FY2012 to FY2015.

HB 26

Adult Dental Program Facts

Prepared by Representative Mike Hawker's Office
Information Provided by DH&SS

1. How many recipients have taken advantage of the program?

The unduplicated count of adult Medicaid recipients receiving these services since implementation of the services on April 1, 2007 – September 30, 2008 is approximately 9,300 adults with 283 dental providers participating in the program.

2. How much has been expended so far?

The expenditure information on preventative and restorative dental services for adult Medicaid recipients (in thousands of dollars) is:

Fiscal Year 2007 (4th Quarter): \$418.5

Fiscal Year 2008: \$4,640.5

Providers have up to 12 months to submit Medicaid claims and the listed expenditures are based on the date of payment of the claims.

3. What services were the funds spent on?

The expenditures for categories of dental services for the period of April 1, 2007 – September 30, 2008 (as reflected on claims for this period that had been processed the 2nd week of November 2008) are:

- ◆ Fillings (1 and 2 surface amalgam and resin restorations): 9,313 procedures - \$1,015,196
- ◆ Root canal therapy on permanent teeth: 1,027 procedures (including 289 of those on front teeth) - \$435,412. *These are situations that would have often resulted in extracting teeth as Medicaid was not covering root canals under emergent dental.*
- ◆ Dentures (includes full & partial dentures): 2,343 procedures - \$2,227,288. *Please note that the Medicaid program restricts denture coverage to every five years for adults, however procedures to adjust the fit of the would be covered. The denture procedures and expenditures listed do not include repairs and/or adjustments to dentures.*



LAWS OF ALASKA

2006

Source
SCS CSHB 105(FIN)

Chapter No.
52

AN ACT

Relating to coverage for adult dental services under Medicaid; and providing for an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

THE ACT FOLLOWS ON PAGE 1

AN ACT

1 Relating to coverage for adult dental services under Medicaid; and providing for an effective
2 date.

3

4 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:

6 PURPOSE; INTENT. (a) The purpose of this Act is to increase adult dental care
7 services for an eligible recipient of Medicaid under AS 47.07 to ensure that services critical to
8 a recipient are implemented first, while controlling the overall growth of the costs of the
9 increase in services.

10 (b) It is the intent of the legislature that the Department of Health and Social Services
11 implement the increase in adult dental care services authorized by this Act through the
12 adoption of regulations consistent with the department's obligation to contain the costs of the
13 increased services in order to provide the services within appropriation limits. It is further the
14 intent of the legislature that the Department of Health and Social Services implement

1 mechanisms to contain costs, which may include establishing a maximum amount of benefits
2 for each eligible recipient in a fiscal year for the services and specifying the scope of the
3 services.

4 * **Sec. 2.** AS 47.07 is amended by adding a new section to read:

5 **Sec. 47.07.067. Payment for adult dental services.** (a) Subject to
6 appropriation, the department shall pay for minimum treatment and for preventative
7 and restorative adult dental services provided under AS 47.07.030(b) and under
8 regulations adopted by the commissioner in conformity with applicable federal
9 requirements and this chapter. Regulations adopted under this section must include the
10 following:

11 (1) a maximum amount of benefits for preventative and restorative
12 adult dental services of \$1,150 for each eligible recipient in a fiscal year; and

13 (2) specification of the scope of coverage for preventative and
14 restorative adult dental services.

15 (b) On or before June 30 of each year, the department shall review
16 appropriations available for the purposes of this section for the following fiscal year,
17 and estimate the scope of services to be used and the number of eligible recipients
18 anticipated to be served during the following fiscal year. Notwithstanding the
19 maximum amount of benefits specified in (a)(1) of this section, the department shall
20 reduce, by regulation, the specified maximum amount of benefits for the following
21 fiscal year if the department's estimates under this subsection would exceed
22 appropriations available for that fiscal year.

23 (c) Notwithstanding any contrary provision of AS 44.62, the department may
24 adopt emergency regulations to implement (b) of this section.

25 (d) As used in this section, "minimum treatment" means the application or
26 prescription of a medication or material deemed necessary by a licensed dentist for the
27 immediate relief of pain or to reduce the spread of infection.

28 * **Sec. 3.** AS 47.07.900 is amended by adding a new paragraph to read:

29 (20) "adult dental services" means minimum treatment for the
30 immediate relief of pain and acute infection provided by a licensed dentist.

31 * **Sec. 4.** AS 47.07.900(1) is repealed.

1 * **Sec. 5.** AS 47.07.067, as added in sec. 2 of this Act, is repealed June 30, 2009.

2 * **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 **TRANSITION: REGULATIONS.** The Department of Health and Social Services may
5 proceed to adopt regulations necessary to implement the changes made by this Act. The
6 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the
7 effective date of the statutory changes.

8 * **Sec. 7.** Section 3 of this Act takes effect July 1, 2009.

9 * **Sec. 8.** Section 6 of this Act takes effect immediately under AS 01.10.070(c).

10 * **Sec. 9.** Except as provided in secs. 7 and 8 of this Act, this Act takes effect July 1, 2006.



AARP Alaska
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Suite 1420
Anchorage, AK 99503

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F 907-341-2270
TTY 1-877-434-7598
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February 25, 2009

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 415
Juneau, AK 99801-1182

RE: HB 26 (Hawker)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support HB 26, authored by Representative Mike Hawker and co-sponsored by Representatives Munoz, Gara and Kerttula.

Previously, under Alaska's Medicaid program, the only dental coverage offered adult beneficiaries was for emergency care. HB 105 offered funding, albeit annually capped at \$1,150, which began to address preventive and restorative care. Now, for example, an older Alaskan on Medicaid who resides in a long term care facility and needs dentures can secure them under the program. Older persons who have dental problems, missing teeth, or are in need of dentures often have accompanying nutrition problems. These nutrition problems can exacerbate other health issues and create an overall deterioration in health status. We believe dental care is essential to quality health care. Funding for dental care should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not be need to be spent on more serious health care problems resulting from poor oral health status.

Understandably, the Legislature wanted to evaluate the initial results of the program and scheduled it to sunset in June, 2009. As Representative Hawker indicates in his sponsor's statement, the program has moved adult Alaska Medicaid beneficiaries from "deferred maintenance" to "preventive maintenance." Representative Hawker's HB 26 would eliminate the sunset provision.

Of the 7,600 adults who have benefited, about 1,800 are older Alaskans, including 900 who received dentures. The average cost for care provided to a senior Alaskan in the program was \$855.

The only concern we have about the program is the annual cap of \$1,150. Although the average cost of a senior Alaskan was \$855, we understand that the fee for an upper or lower set of dentures is now between \$1,700 and \$1,800. We also understand that some adult Medicaid beneficiaries have more significant oral health problems that may go considerably beyond the cap.

One of the goals of the program was to provide care that might take a Medicaid beneficiary from being among the unemployed because of missing teeth (and unable to pass an employment interview) to enabling them to secure employment and eventually getting off the Medicaid program. Some of these adults will need more oral care than can be provided under the cap.

We suggest exploring the possibility of raising the cap to enable more beneficiaries to get the total dental care they need.

AARP urges an "AYE" vote on HB 26.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Representative John Coghill
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes
Representative Mike Hawker

Adult Dental

New Adult Dental Services

On March 29, 2007, Alaska's Medicaid for adults began covering \$1,150 worth of preventive dental care, such as exams and cleanings, each year for Alaskans 21 and older who receive Medicaid services.

New services also include fillings, root canals and dentures.

In the past, adult dental Medicaid only treated emergency pain relief and acute infection.

For a full list of new services in the state regulations passed last year authorizing the changes, [click here](#).

The limited amount of preventive and restorative coverage, as well as limited access to dentists who accept Medicaid patients, means patients will need to

- ▶ plan carefully with their dentists what to do first, and when it can be scheduled;
- ▶ keep their appointments.

Missed appointments are a primary complaint among dentists. The state recently clarified that when dentists charge patients for missed appointments, that policy includes Medicaid patients. Medicaid will not cover the cost of missed appointments.

For help finding a dentist who takes new Medicaid patients, call the recipient helpline: 1-800-780-9972.

Funding

The state investment of \$1.3 million in general funds is being matched with federal funds and \$1.425 million a year from the Mental Health Trust Authority, for a total annual cost of \$10.2 million, an eight-fold return on state general fund dollars.

The coverage expansion was added because infections in the mouth are no different than infections in other parts of the body. Dental infections cause pain, lost time at work and missing teeth can affect employability. Waiting for dental emergencies often results in more expensive dental care and limits the dentist's ability to address dental problems that will result in future dental emergencies.

Recommended Reading:

- ▶ [press release](#)
- ▶ [fact sheet \(PDF\)](#)
- ▶ [letter to dentists explaining new regulations \(PDF\)](#)
- ▶ [state regulations authorizing the new services \(PDF\)](#)

Questions:

- ▶ Recipient helpline: 1 (800) 780-9972



Reauthorize preventative and restorative dental services for adult Medicaid recipients

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority, jointly support the reauthorization of preventive and restorative dental services for adult Medicaid recipients. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization. The provisions for this reauthorization are in HB 26.

- The Department of Health and Social Services reports that approximately 7,600 adult Medicaid recipients received these dental services in FY08 with 252 participating dental providers.
- The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs, and as former U.S. Surgeon General C. Everett Koop stated, "You're not healthy without good oral health."ⁱ
- Trust beneficiaries continue to list dental services as a priority unmet health needs.
- Dental pain, missing and decayed teeth and infection can affect employment and job advancement, contribute to missed work, dietary choices for seniors, and complicate management of other chronic diseases.ⁱⁱ
- Individuals on public assistance who receive rehabilitative dental treatment (including fillings, extractions, and dentures) were "... twice as likely to receive favorable or neutral employment outcomes as they were to receive unfavorable outcomes."ⁱⁱⁱ
- Dental infections due to periodontal disease have been associated with adverse pregnancy outcomes (e.g., pre-term births)^{iv}, management problems for individuals with diabetes, risks for pneumonia in nursing homes, and other chronic diseases including cardiovascular disease.^v
- The bacteria involved with the dental decay process are typically passed parent to child. Part of the efforts to reduce dental decay in young children relates to reducing the level of dental infection in the caregiver.^{vi} Additionally, parents with dental coverage are more likely to access dental services for their children.
- The coverage of preventive and restorative dental care for adult Medicaid recipients along with necessary behavioral changes, over the long term, offer the potential for

reduced utilization of emergent dental services (e.g., accessing the hospital emergency room for management of a dental infection).

Supporters: AARP-Alaska, Alaska Public Health Association, Alaska Dental Society All-Alaska Pediatric Partnership, ANTHC and Alaska Primary Care Association.

¹ Oral Health America, <http://www.oralhealthamerica.org/whoweare.html>, noting quote from C. Everett Koop, former U.S. Surgeon General.

² Association of State and Territorial Health Officials (ASTHO), "The oral health and chronic disease connection", available at: http://www.astho.org/templates/display_pub.php?pub_id=327, May 2002.

³ "Dental Treatment Highly Effective in Helping Welfare Recipients Gain Employment", University of California – San Francisco School of Dentistry", press release, March 10, 2004.

⁴ Lieff S, Hared H, McKaig R, et al., "Periodontitis and Preterm Low Birth Weight in Pregnant Women", *Journal of Dental Research*, 2000; 79(supplemental):608.

⁵ U.S. Department of Health and Human Services (USDHHS), *Oral Health in America: A Report of the U.S. Surgeon General*, USDHSS, National Institute of Dental and Craniofacial Research, National Institutes of Medicine, 2000.

⁶ Berkowitz, RJ, "Causes, treatment and prevention of early childhood caries: a microbiologic perspective", *Journal of the Canadian Dental Association*, 69(5):304-307b, 2003.

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

February 2, 2009

The Honorable Representative Mike Hawker, Co-Chair
House Finance Committee
Alaska State Capitol, Room 505
Juneau, AK 99801-1182

Subject: Support for Reauthorization of the Medicaid Adult Dental Program

Dear Co-Chair Hawker:

The Alaska Commission on Aging (ACoA) encourages support of HB 26, a bill to reauthorize preventive and restorative dental services for adult Medicaid recipients, sponsored by you and co-sponsored by Representative Muñoz. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain and missing or decayed teeth can affect dietary choices for seniors that may impact overall health and wellness. Without preventive and restorative dental services, which include exams, fillings, extractions, and dentures, vulnerable older Alaskans are at risk of developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease. Currently, Medicaid dental services are limited to expensive emergency care for immediate relief of pain and acute infection, with no coverage for preventative and restorative dental care. These limited services often lead to extraction of permanent teeth.

In addition to the health issues involved, decayed or missing teeth can be a significant factor in employability or job advancement, which is of concern to all persons seeking employment, regardless of age. Preventive and restorative dental services result in fewer tooth extractions for Medicaid clients and offer increased chance of employment, according to research findings (University of California, San Francisco School of Dentistry 2004).

Preventive and restorative dental services can help prevent the progression of serious dental disease and discomfort which can result in more costly emergency care. These services promote healthy lifestyles, assist in chronic disease prevention, and help to contain future Medicaid costs for emergency dental work and other related health care problems.

Since inception on April 1, 2007 through September 30, 2008, this program has served 9,267 unduplicated persons, which includes approximately 1,800 persons aged 60 years and older, of whom 900 received dentures.

Currently, the limit for services is \$1,150 per year per Medicaid beneficiary. This amount was originally used because it would pay for an exam and either an upper or lower set of dentures. We understand that the average cost for dentures has increased to \$1,700 or \$1,800 per set. The Commission suggests that the cap for services be reconsidered in light of the current costs for providing dental care.

ACoA supports HB 26 and believes this program to be a wise public investment that will help reduce expensive emergency dental needs and associated health care costs, and enhance health and wellness for elderly Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your support of this important legislation.

Sincerely,


Sharon Howerton-Clark
Chair Alaska Commission on Aging

Sincerely,


Denise Daniello
ACoA Executive Director

CC: House HSS Committee Members
Honorable Representative Herron, Co-Chair
Representative Cissna
Representative Lynn
Representative Coghill

Honorable Representative Keller, Co-Chair
Representative Holmes
Representative Seaton

**Alaska Commission on Aging
KEY POINTS TO KNOW ABOUT:**

**Continuation of the Medicaid Adult Dental Program
February 2009**

Issue:

The Alaska Commission on Aging was a strong proponent of the original 2006 legislation which added preventive and restorative dental care to the palette of services available to adult Medicaid recipients. At the time, we realized that many low-income seniors were living with a variety of painful, destructive dental problems because they could not afford to pay for routine dental exams or dentures.

Prior to implementation of this program in 2006, dental services for Medicaid recipients were limited to expensive emergency care for relief of pain and acute infection only – often leading to extraction of permanent teeth. Waiting for dental emergencies resulted in more expensive dental care and limited the dentist's ability to address problems that would result in future dental emergencies.

While much of the focus on tooth decay concentrates on children, adults remain at high risk for dental decay, especially elderly and other adults on certain medications or undergoing cancer treatments that decrease saliva output. Studies have also shown the link between oral health and chronic diseases such as diabetes and cardiovascular disease. For seniors, the inability to properly chew food due to poor dentition leads to chronic malnutrition and its many consequences for health. Furthermore, those with ill-fitting dentures, missing teeth, no dentures, and other disfiguring dental problems may avoid the social engagement that is so essential to maintaining mental and physical health for seniors.

Program statistics for the period April 1, 2007 through September 30, 2008 indicate the following:

- ◆ Approximately 1,800 seniors were served by this program, comprising 19.4 percent of all those served.
- ◆ Approximately 900 seniors received dentures under the program, 38.6 percent of the total persons who received dentures.
- ◆ Expenses for seniors totaled 24.6 percent of program expenses.
- ◆ The average cost for care provided to a senior on the program was \$855.

Recommendation:

Re-authorize the Medicaid Adult Dental Program. Continue this beneficial program, which supports the health of low-income seniors and others.

Matthew Johnson

From: Butch Carber
Sent: Tuesday, March 03, 2009 12:36 PM
To: Marianna Carpeneti; Matthew Johnson
Subject: HHSS committee today

Hi,

Last Thursday, Co-Chair Keller closed public testimony for HB 26. Do you know if there is a plan to open that again?

Do you know if there will be more public testimony on HB 2?

If so, I will prepare witness registers, though I do keep some blank ones with me, just in case.

Thanks,

Butch

Butch Carber

House Records

465-2258

26-LS0142\E
Mischel
2/20/09

CS FOR HOUSE BILL NO. 26()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES HAWKER, Muñoz, Gara, Kerttula

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to adult dental services; providing for an effective date by amending**
2 **the effective date of sec. 3, ch. 52, SLA 2006; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** Section 5, ch. 52, SLA 2006, is amended to read:

5 Sec. 5. AS 47.07.067, as added in sec. 2, ch. 52, SLA 2006 [OF THIS ACT], is
6 repealed June 30, 2014 [2009].

7 *** Sec. 2.** Section 7, ch. 52, SLA 2006, is amended to read:

8 Sec. 7. Section 3 of this Act takes effect July 1, 2014 [2009].

9 *** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

HB

50



Alaska State Legislature

Representative Peggy Wilson
House District 2

MEMORANDUM

HB 50 Version M Changes:

1. **Concern:** Rural hospitals may face more difficulty than urban facilities in complying with the HB 50 requirement

Mitigation 1: Added new exemption, "Temporary nurse staffing emergency"

- 30 day duration.
- Report describing efforts to staff the facility required.
- Report must be filed with DOL
 - i. Limit to 2 reports in 6 months or 3 in 1 year or the reports must be sent to the Legislature as well. (pg 4, line 19-31, pg 5, line1-3)

Mitigation 2: Unforeseen weather condition added. (pg 3, line 11-18)

Mitigation 3: Rural community is defined. (pg 8 line15-21)

2. **Concern:** Nurses would leave surgical units or other units while procedures or surgeries are ongoing.

Mitigation 1: An exemption for a nurse who is participating in an on-going surgery or medical procedure has been added. (pg 3, line 2-3)

3. **Concern:** Specialized work schedules for weekends used at North Star Behavioral Health would be a problem

Mitigation: This specific practice has been exempted. (pg 4, line 1-15)

4. **Concern:** On call hours could require a nurse to work beyond the maximum 14 consecutive hour limit.

Mitigation: An exemption allowing nurses the ability to refuse mandatory on-call if they believe they are too tired to perform their duties safely. (pg 3, line 21-24)



Alaska State Legislature

Representative Peggy Wilson
House District 2

5. **Concern:** The 80 limitation for 14 days was not flexible.

Mitigation: that limitation has been deleted

6. **Concern:** There are potential legal problems with jurisdiction.

Mitigation: The federal and Native facilities have been exempted. (pg. 7, line 13-17)

7. **Concern:** Reporting Requirements for facilities that do not use mandatory overtime are too arduous.

Mitigation: Allow a facility to submit a statement that there are no hours to report. (pg 7, line 9-10)

Two other changes were made to the bill: Facilities will be required to post a sign describing these statutes. (pg 7, line 18-23) The one hour exemption to find a replacement nurse has been extended to be more flexible (pg 4, line 16-18)

26-LS0274\M

Wayne

4/14/09

CS FOR HOUSE BILL NO. 50()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVES WILSON, GARA, TUCK, PETERSEN, LYNN, SEATON, GATTO, CISSNA, MUÑOZ, AND GARDNER, Ramras, Foster, Kerttula

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on mandatory overtime for registered nurses and**
2 **licensed practical nurses in health care facilities; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:

6 **LEGISLATIVE FINDINGS AND INTENT.** The legislature finds that

7 (1) it is essential that registered nurses and licensed practical nurses providing
8 direct patient care be available to meet the needs of patients;

9 (2) quality patient care is jeopardized by registered nurses and licensed
10 practical nurses who work unnecessarily long hours in health care facilities;

11 (3) registered nurses and licensed practical nurses are leaving their profession
12 because of workplace stresses, long work hours, and depreciation of their essential role in the
13 delivery of quality and direct patient care;

14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and licensed practical nurses, and the health and general well-being of the
2 persons receiving care from registered nurses and licensed practical nurses in health care
3 facilities;

4 (5) it is necessary that registered nurses and licensed practical nurses be made
5 aware of their rights, duties, and remedies concerning hours worked and patient safety; and

6 (6) health care facilities should provide adequate and safe nurse staffing
7 without the need for or use of mandatory overtime.

8 * **Sec. 2.** AS 18.20 is amended by adding new sections to read:

9 **Article 4. Overtime Limitations for Nurses.**

10 **Sec. 18.20.400. Limitations on nursing overtime.** (a) Except as provided in
11 (c) of this section, a nurse in a health care facility may not be required or coerced,
12 directly or indirectly,

13 (1) to work beyond a predetermined and regularly scheduled shift that
14 is agreed to by the nurse and the health care facility; or

15 (2) to accept an assignment of overtime if, in the judgment of the
16 nurse, the overtime would jeopardize patient or employee safety.

17 (b) Except as provided by (c) of this section, after working a predetermined
18 and regularly scheduled shift that is agreed to by the nurse and the health care facility
19 as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed
20 not less than 10 consecutive hours of off-duty time immediately following the end of
21 that work.

22 (c) Subsection (a) of this section does not apply to

23 (1) a nurse who is employed by a health care facility providing
24 services for a school, school district, or other educational institution, when the nurse is
25 on duty for more than 14 consecutive hours during an occasional special event, such as
26 a field trip, that is sponsored by the employer;

27 (2) a nurse voluntarily working overtime on an aircraft in use for
28 medical transport, so long as the shift worked is allowable under regulations adopted
29 by the Board of Nursing based on accreditation standards adopted by the Commission
30 on Accreditation of Medical Transport Systems;

31 (3) a nurse on duty in overtime status

1 (A) who is participating in the performance of a medical
2 procedure or surgery that has begun but has not been completed;

3 (B) because of an unforeseen emergency situation that could
4 jeopardize patient safety; in this subparagraph, "unforeseen emergency
5 situation" means an unusual, unpredictable, or unforeseen situation caused by
6 an act of terrorism, disease outbreak, natural disaster, major disaster as defined
7 in 42 U.S.C. 5122, or disaster emergency under AS 26.23.020 or 26.23.140,
8 but does not include a situation in which a health care facility has reasonable
9 knowledge of increased patient volume or inadequate staffing because of some
10 other cause, if that cause is foreseeable;

11 (C) because the health care facility has a scheduling problem
12 caused by unforeseen weather conditions that prevent a second nurse from
13 arriving at the facility to relieve the nurse on duty; in this subparagraph,
14 "unforeseen weather conditions" means unusual, unpredictable, or unforeseen
15 weather so extreme as to impair travel to the health care facility, but does not
16 include a situation in which the health care facility has knowledge of the
17 weather conditions far enough in advance to act so that a scheduling problem
18 under this subparagraph can reasonably be avoided; or

19 (D) at a health care facility located in a rural community that
20 declares a temporary nurse staffing emergency under AS 18.20.410;

21 (4) a nurse fulfilling on-call time that is agreed on by the nurse and a
22 health care facility before it is scheduled unless fulfilling the on-call time would, in the
23 nurse's judgment, create an unacceptable risk to the physical safety of the nurse, a
24 patient, or an employee of the facility;

25 (5) a nurse voluntarily working overtime so long as the work is
26 consistent with professional standards and safe patient care and does not exceed 14
27 consecutive hours;

28 (6) a nurse voluntarily working beyond 80 hours in a 14-day period so
29 long as the nurse does not work more than 14 consecutive hours without a 10-hour
30 break and the work is consistent with professional standards and safe patient care;

31 (7) a nurse who

1 (A) is employed

2 (i) at a psychiatric treatment hospital that treats only
3 adolescents and children;

4 (ii) at a residential psychiatric treatment center under
5 AS 18.07.111 or AS 47.12.990; or

6 (iii) at a secure residential psychiatric treatment center
7 under AS 47.32.900;

8 (B) voluntarily agrees to work a 16-hour shift for the period
9 between 5:00 p.m. on a Friday and 8:00 a.m. on the Monday that immediately
10 follows and receives pay and benefits for that work that are equal to or greater
11 than the pay and benefits the nurse would receive for working 20 regular hours
12 in the same position; and

13 (C) during the period described in (B) of this paragraph does
14 not work a 16-hour shift consecutive with another shift of eight hours or more
15 without an intervening break of at least eight hours;

16 (8) the first two hours on overtime status when the health care facility
17 is obtaining another nurse to work in place of the nurse in overtime status, so long as
18 the nurse in overtime status is not on duty for more than 14 consecutive hours.

19 **Sec. 18.20.410. Temporary nurse staffing emergency.** (a) If, after making a
20 substantial and reasonable effort to increase the number of available nurses on staff
21 and failing in that effort, a health care facility in a rural community determines it is not
22 able to meet the overtime limitations in AS 18.20.400 without putting the safety of its
23 patients at risk of serious harm, the health care facility may declare a temporary nurse
24 staffing emergency. A declaration of a temporary nurse staffing emergency under this
25 section

26 (1) must be made in a writing, signed by the administrator of the health
27 care facility or the administrator's designee, that describes the facility's reasonable
28 effort to avoid the temporary nurse staffing emergency; and

29 (2) may not exceed 30 days.

30 (b) Immediately after declaring a temporary nurse staffing emergency under
31 (a) of this section, a health care facility shall file with the division of labor standards

1 and safety, Department of Labor and Workforce Development, a report that includes a
2 copy of the signed writing required under (a) of this section. A report under this
3 subsection is a public document.

4 (c) In addition to the requirements of (a) and (b) of this section, a health care
5 facility shall notify the legislature immediately by delivery of a written report to the
6 Alaska Legislative Council each time the facility declares a temporary nurse staffing
7 emergency under AS 18.20.400(c) that exceeds two occurrences in a six-month period
8 that begins on January 1 or July 1 of the year in which the declaration occurs, or three
9 occurrences in the one-year period that begins on January 1 of that year. A report
10 under this subsection must include a copy of each report that is required of the health
11 care facility under (b) of this section for the one-year period that begins on January 1
12 of the year the excessive declaration under this subsection occurs.

13 **Sec. 18.20.420. Health care facility complaint process for overtime work**
14 **by nurses.** A health care facility shall provide for an anonymous process by which a
15 patient or a nurse may make a complaint about staffing levels and patient safety that
16 relate to overtime work by nurses and to limitations on overtime work by nurses under
17 AS 18.20.400.

18 **Sec. 18.20.430. Enforcement, offenses, and penalties.** (a) The commissioner
19 shall administer AS 18.20.400 - 18.20.499 and adopt regulations for implementing and
20 enforcing AS 18.20.400 - 18.20.499.

21 (b) A complaint alleging a violation of AS 18.20.400 - 18.20.499 must be filed
22 with the commissioner within 30 days after the date of the alleged violation. The
23 commissioner shall provide a copy of the complaint to the health care facility named
24 in the filing within three business days after receiving the complaint.

25 (c) If the commissioner finds that a health care facility has knowingly violated
26 an overtime provision of AS 18.20.400 - 18.20.499, the following civil penalties shall
27 apply:

28 (1) for a first violation of AS 18.20.400 - 18.20.499, the commissioner
29 shall reprimand the health care facility;

30 (2) for a second violation of AS 18.20.400 - 18.20.499 within 12
31 months, the commissioner shall reprimand the health care facility and assess a penalty

1 of \$500;

2 (3) for a third violation of AS 18.20.400 - 18.20.499 within 12 months,
3 the commissioner shall reprimand the health care facility and assess a penalty of not
4 less than \$2,500 but not more than \$5,000;

5 (4) for each violation of AS 18.20.400 - 18.20.499 after a third
6 violation of AS 18.20.400 - 18.20.499 within 12 months, the commissioner shall
7 reprimand the health care facility and assess a penalty of not less than \$5,000 but not
8 more than \$25,000.

9 (d) As an employer, a health care facility violates an overtime provision of
10 AS 18.20.400 - 18.20.499 "knowingly" when the facility is either aware that its
11 conduct is of a nature prohibited by the overtime provision or aware that the
12 circumstances described in the overtime prohibition exist; however, when knowledge
13 of the existence of a particular fact is required to establish that the violation was
14 knowing, that knowledge exists when the facility is aware of a substantial probability
15 of its existence, unless the facility reasonably believes it does not exist.

16 **Sec. 18.20.440. Prohibition of retaliation.** A health care facility may not
17 discharge, discipline, threaten, discriminate against, penalize, or file a report with the
18 Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.499
19 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.499.

20 **Sec. 18.20.450. Enforcement of prohibition against retaliation.** The
21 commissioner shall investigate every complaint alleging a violation of AS 18.20.440,
22 and, within 90 days after the date of filing of the complaint, provide to the
23 complainant, the Department of Law, and the health care facility named in the
24 complaint a written determination as to whether the health care facility violated
25 AS 18.20.440. If the commissioner finds a violation of AS 18.20.440, the
26 commissioner shall request that the Department of Law represent the department and
27 the complainant and obtain from the health care facility all appropriate relief,
28 including rehiring or reinstatement of the complainant to the complainant's former
29 position with back pay.

30 **Sec. 18.20.460. Report requirements.** (a) A health care facility shall file with
31 the division of labor standards and safety, Department of Labor and Workforce

1 Development, a semiannual report on a form provided by the department. The report
2 for the six-month period ending June 30 must be filed before the following August 1,
3 and the report for the six-month period ending December 31 must be filed before the
4 following February 1. The report must include, for each nurse employed by the health
5 care facility or under contract with the health care facility, the number of overtime
6 hours worked and the number of hours the nurse was on call. A health care facility that
7 does not employ a nurse who worked overtime hours or who was on call during the
8 reporting period is not required to describe hours worked as overtime and on-call
9 hours for individual nurses but may instead complete the report by stating on the form
10 that there are no reportable hours.

11 (b) A primary care outpatient facility is not subject to the reporting
12 requirements of (a) of this section.

13 **Sec. 18.20.470. Provisions not applicable to nurses employed in federal or**
14 **tribal facilities.** The provisions of AS 18.20.400 - 18.20.499 do not apply to a nurse
15 employed in a health care facility that is operated by

- 16 (1) the federal government; or
17 (2) a tribal organization as defined in 25 U.S.C. 450b.

18 **Sec. 18.20.480. Notice to employees.** A health care facility shall post and
19 maintain, in places readily accessible to individuals in the service of the health care
20 facility, printed statements that describe employee rights and employer obligations
21 under AS 18.20.400 - 18.20.499 and regulations adopted under AS 18.20.430. The
22 commissioner shall supply the printed statements to a health care facility without cost
23 to the facility.

24 **Sec. 18.20.499. Definitions.** In AS 18.20.400 - 18.20.499,

- 25 (1) "commissioner" means the commissioner of labor and workforce
26 development;
27 (2) "health care facility" means a private, municipal, or state hospital;
28 independent diagnostic testing facility; primary care outpatient facility; skilled nursing
29 facility; kidney disease treatment center, including freestanding hemodialysis units;
30 intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or
31 Alaska Veterans' Home administered by the Department of Health and Social Services

1 under AS 47.55; correctional facility owned or administered by the state; private,
2 municipal, or state facility employing one or more public health nurses; long-term care
3 facility; psychiatric hospital; residential psychiatric treatment center, as defined in
4 AS 18.07.111 or AS 47.32.900; secure residential psychiatric treatment center under
5 AS 47.32.990; juvenile detention facility; juvenile detention home, juvenile work
6 camp, or treatment facility as defined in AS 47.12.990;

7 (3) "nurse" means an individual licensed to practice registered nursing
8 or practical nursing under AS 08.68 who provides nursing services through direct
9 patient care or clinical services and includes a nurse manager when delivering in-
10 hospital patient care;

11 (4) "on-call" means a status in which a nurse must be ready to report to
12 the health care facility and may be called to work by the health care facility;

13 (5) "overtime" means the hours worked in excess of a predetermined
14 and regularly scheduled shift that is agreed to by a nurse and a health care facility;

15 (6) "rural community" means a village or city that has a population of
16 less than 10,000, as determined by the Department of Labor and Workforce
17 Development, and is in

18 (A) the unorganized borough; or

19 (B) an organized borough that has a population of less than
20 25,000, as determined by the Department of Labor and Workforce
21 Development.

22 * **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to
23 read:

24 **APPLICABILITY.** A health care facility that is required to file reports under
25 AS 18.20.460, enacted in sec. 2 of this Act, shall file its first report before February 1, 2010,
26 for the period July 1, 2009, through December 31, 2009.

27 * **Sec. 4.** AS 18.20.460, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect
28 July 1, 2009.

29 * **Sec. 5.** Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2010.



Alaska State Legislature

Representative Peggy Wilson
House District 2

MEMORANDUM

Date: March 30, 2009

To: Representative Bob Herron and Representative Wes Keller, Co-Chairs Health, and Social Services Committee

From: Representative Peggy Wilson *PW*

Re: HB 50 – Limit Overtime for Registered Nurses

I would like to request the House HSS Committee schedule another hearing on HB 50.

During the first hearing of this bill in the House Health and Social Services there was testimony that brought up several issues. The attached revision of the bill addresses those issues. This memo will outline the changes made to the bill and the issue it is designed to mitigate.

1. **Concern:** Rural hospitals may face more difficulty than urban facilities in complying with the requirement to not exceed the shift length maximum of 14 hours or to allow 10 hours of rest following such a shift. Witnesses in opposition testified that generally hospitals don't use mandatory overtime, but the concern was raised that in certain circumstances in remote rural facilities, mandatory overtime was occasionally necessary.

Mitigation 1: A new exemption has been added, called "Temporary nurse staffing emergency" for rural communities. Under this provision, facilities may declare a "temporary nurse staffing emergency" of up to 30 days after making all reasonable efforts to avoid this circumstance. These facilities shall file a report signed by the facility administrator with the Department of Labor & Workforce Development that describes the facilities' efforts to avoid the staffing emergency. The reports must also be filed with the Legislature if there are more than two such emergencies declared within 6 months or 3 emergencies within 1 year. (pg 4, Sec. 18.20.410)



Alaska State Legislature

Representative Peggy Wilson
House District 2

Mitigation 2: An exemption for "unforeseen weather condition" and a definition of that condition were added. (pg 3, line 12-19)

Mitigation 3: The temporary exemption described above is available to any village or city with a population of less than 10,000. This exemption also applies to communities in organized boroughs with a population of more than 25,000. (pg 7, line 30-31, pg 8 line 1-5)

2. **Concern:** Because of the 14 hour maximum for a shift there seemed to be a concern, from multiple witnesses testifying in opposition to the bill, that nurses would be forced to leave surgical units with ongoing surgeries or leaving neonatal units without the specially trained nurses in attendance. This was never the intent of the proponents of this bill.

Mitigation 1: An exemption for a nurse who is participating in an on-going surgery or medical procedure has been added. (pg 3, line 2-3)

Mitigation 2: The exemption for unforeseen emergency situation has been expanded to include "a life-threatening circumstance". (pg 3, line 7)

3. **Concern:** The committee heard testimony describing a situation where a modified Baylor program of staffing is used by North Star Behavioral Health. This staffing situation is used only at psychiatric hospitals and residential treatment centers that treat adolescents and children and only on the weekends.

Mitigation: This specific practice has been exempted. (pg 3, line 23-25)

4. **Concern:** During testimony by both those opposed and those in favor it was brought out that mandatory on-call was used more frequently as a staffing tool than mandatory overtime. This practice often requires nurses to work beyond the number of hours that are safe for both the patient and the nurse.

Mitigation: Language has been added to the general on-call exemption allowing nurses the ability to refuse mandatory on-call if they believe they are too tired to perform their duties safely. (pg 3, line 23-25)



Alaska State Legislature

Representative Peggy Wilson
House District 2

I have also made other changes described below.

Facilities will be required to post signs that describe the statutes created by this bill. The signs will be distributed by the Department of Labor and must be displayed in a conspicuous work area in all facilities. (pg 7, line 4-9)

The 1 hour exemption while the health care facility is obtaining another nurse to work in place of the nurse in overtime status has been extended to 2 hours so long as the nurse has not exceeded the 14 hour limit. In some cases nurses live some distance from the facility and I believe this extension of the provision gives the facility more flexibility. (pg 4, line 11)

Thank you for your consideration of my request.

26-LS0274-C
Wayne
3.28.09

CS FOR HOUSE BILL NO. 50()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

Offered:

Referred:

**Sponsor(s): REPRESENTATIVES WILSON, GARA, TUCK, PETERSEN, LYNN, SEATON, GATTO,
CISSNA, MUÑOZ, AND GARDNER, Ramras, Foster, Kerttula**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on mandatory overtime for registered nurses and**
2 **licensed practical nurses in health care facilities; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:

6 **LEGISLATIVE FINDINGS AND INTENT.** The legislature finds that

7 (1) it is essential that registered nurses and licensed practical nurses providing
8 direct patient care be available to meet the needs of patients;

9 (2) quality patient care is jeopardized by registered nurses and licensed
10 practical nurses who work unnecessarily long hours in health care facilities;

11 (3) registered nurses and licensed practical nurses are leaving their profession
12 because of workplace stresses, long work hours, and depreciation of their essential role in the
13 delivery of quality and direct patient care;

14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and licensed practical nurses, and the health and general well-being of the
2 persons receiving care from registered nurses and licensed practical nurses in health care
3 facilities;

4 (5) it is necessary that registered nurses and licensed practical nurses be made
5 aware of their rights, duties, and remedies concerning hours worked and patient safety; and

6 (6) health care facilities should provide adequate and safe nurse staffing
7 without the need for or use of mandatory overtime.

8 * **Sec. 2.** AS 18.20 is amended by adding new sections to read:

9 **Article 4. Overtime Limitations for Nurses.**

10 **Sec. 18.20.400. Limitations on nursing overtime.** (a) Except as provided in
11 (c) of this section, a nurse in a health care facility may not be required or coerced,
12 directly or indirectly,

13 (1) to work beyond a predetermined and regularly scheduled shift that
14 is agreed to by the nurse and the health care facility;

15 (2) to work beyond 80 hours in a 14-day period; or

16 (3) to accept an assignment of overtime if, in the judgment of the
17 nurse, the overtime would jeopardize patient or employee safety.

18 (b) Except as provided by (c) of this section, after working a predetermined
19 and regularly scheduled shift that is agreed to by the nurse and the health care facility
20 as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed
21 not less than 10 consecutive hours of off-duty time immediately following the end of
22 that work.

23 (c) Subsection (a) of this section does not apply to

24 (1) a nurse who is employed by a health care facility providing
25 services for a school, school district, or other educational institution, when the nurse is
26 on duty for more than 14 consecutive hours during an occasional special event, such as
27 a field trip, that is sponsored by the employer;

28 (2) a nurse voluntarily working overtime on an aircraft in use for
29 medical transport, so long as the shift worked is allowable under regulations adopted
30 by the Board of Nursing based on accreditation standards adopted by the Commission
31 on Accreditation of Medical Transport Systems;

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(3) a nurse on duty in overtime status

(A) who is participating in the performance of a medical procedure or surgery that has begun but has not been completed;

(B) because of an unforeseen emergency situation that could jeopardize patient safety; in this subparagraph, "unforeseen emergency situation" means an unusual, unpredictable, or unforeseen situation caused by an act of terrorism, disease outbreak, life-threatening circumstance, natural disaster, major disaster as defined in 42 U.S.C. 5122, or disaster emergency under AS 26.23.020 or 26.23.140, but does not include a situation in which a health care facility has reasonable knowledge of increased patient volume or inadequate staffing because of some other cause, if that cause is foreseeable;

(C) because the health care facility has a scheduling problem caused by unforeseen weather conditions that prevent a second nurse from arriving at the facility to relieve the nurse on duty; in this subparagraph, "unforeseen weather conditions" means unusual, unpredictable, or unforeseen weather so extreme as to impair travel to the health care facility, but does not include a situation in which the health care facility has knowledge of the weather conditions far enough in advance to act so that a scheduling problem under this subparagraph can reasonably be avoided; or

(D) at a health care facility located in a rural community that declares a temporary nurse staffing emergency under AS 18.20.410;

(4) a nurse fulfilling on-call time that is agreed on by the nurse and a health care facility before it is scheduled unless fulfilling the on-call time would, in the nurse's judgment, create an unacceptable risk to the physical safety of the nurse, a patient, or an employee of the facility;

(5) a nurse voluntarily working overtime so long as the work is consistent with professional standards and safe patient care and does not exceed 14 consecutive hours;

(6) a nurse voluntarily working beyond 80 hours in a 14-day period so long as the nurse does not work more than 14 consecutive hours without a 10-hour break and the work is consistent with professional standards and safe patient care;

1 (7) a nurse at a psychiatric treatment hospital that treats only
2 adolescents and children or a residential psychiatric treatment center under
3 AS 18.07.111 or AS 47.12.990, or a secure residential psychiatric treatment center
4 under AS 47.32.900 who voluntarily agrees to work a 16-hour shift on a weekend and
5 receives pay and benefits for that work that are equal to or greater than the pay and
6 benefits the nurse would receive for working 20 regular hours in the same position; a
7 nurse under this paragraph may not work a 16-hour shift consecutive with another
8 shift of eight hours or more without an intervening break of at least eight hours; in this
9 paragraph, "weekend" means the period between 5:00 p.m. on a Friday and 8:00 a.m.
10 on the Monday that immediately follows;

11 (8) the first two hours on overtime status when the health care facility
12 is obtaining another nurse to work in place of the nurse in overtime status, so long as
13 the nurse in overtime status is not on duty for more than 14 consecutive hours.

14 **Sec. 18.20.410. Temporary nurse staffing emergency.** (a) If, after making a
15 substantial and reasonable effort to increase the number of available nurses on staff
16 and failing in that effort, a health care facility in a rural community determines it is not
17 able to meet the overtime limitations in AS 18.20.400 without putting the safety of its
18 patients at risk of serious harm, the health care facility may declare a temporary nurse
19 staffing emergency. A declaration of a temporary nurse staffing emergency under this
20 section

21 (1) must be made in a writing, signed by the administrator of the health
22 care facility or the administrator's designee, that describes the facility's reasonable
23 effort to avoid the temporary nurse staffing emergency; and

24 (2) may not exceed 30 days.

25 (b) Immediately after declaring a temporary nurse staffing emergency under
26 (a) of this section, a health care facility shall file with the division of labor standards
27 and safety, Department of Labor and Workforce Development, a report that includes a
28 copy of the signed writing required under (a) of this section. A report under this
29 subsection is a public document.

30 (c) In addition to the requirements of (a) and (b) of this section, a health care
31 facility shall notify the legislature immediately by delivery of a written report to the

1 Alaska Legislative Council each time the facility declares a temporary nurse staffing
2 emergency under AS 18.20.400(c) that exceeds two occurrences in a six-month period
3 that begins on January 1 or July 1 of the year in which the declaration occurs, or three
4 occurrences in the one-year period that begins on January 1 of that year. A report
5 under this subsection must include a copy of each report that is required of the health
6 care facility under (b) of this section for the one-year period that begins on January 1
7 of the year the excessive declaration under this subsection occurs.

8 **Sec. 18.20.420. Health care facility complaint process for overtime work**
9 **by nurses.** A health care facility shall provide for an anonymous process by which a
10 patient or a nurse may make a complaint about staffing levels and patient safety that
11 relate to overtime work by nurses and to limitations on overtime work by nurses under
12 AS 18.20.400.

13 **Sec. 18.20.430. Enforcement, offenses, and penalties.** (a) The commissioner
14 shall administer AS 18.20.400 - 18.20.469 and adopt regulations for implementing and
15 enforcing AS 18.20.400 - 18.20.469.

16 (b) A complaint alleging a violation of AS 18.20.400 - 18.20.469 must be filed
17 with the commissioner within 30 days after the date of the alleged violation. The
18 commissioner shall provide a copy of the complaint to the health care facility named
19 in the filing within three business days after receiving the complaint.

20 (c) If the commissioner finds that a health care facility has knowingly violated
21 an overtime provision of AS 18.20.400 - 18.20.469, the following civil penalties shall
22 apply:

23 (1) for a first violation of AS 18.20.400 - 18.20.469, the commissioner
24 shall reprimand the health care facility;

25 (2) for a second violation of AS 18.20.400 - 18.20.469 within 12
26 months, the commissioner shall reprimand the health care facility and assess a penalty
27 of \$500;

28 (3) for a third violation of AS 18.20.400 - 18.20.469 within 12 months,
29 the commissioner shall reprimand the health care facility and assess a penalty of not
30 less than \$2,500 but not more than \$5,000;

31 (4) for each violation of AS 18.20.400 - 18.20.469 after a third

1 violation of AS 18.20.400 - 18.20.469 within 12 months, the commissioner shall
2 reprimand the health care facility and assess a penalty of not less than \$5,000 but not
3 more than \$25,000.

4 (d) As an employer, a health care facility violates an overtime provision of
5 AS 18.20.400 - 18.20.469 "knowingly" when the facility is either aware that its
6 conduct is of a nature prohibited by the overtime provision or aware that the
7 circumstances described in the overtime prohibition exist; however, when knowledge
8 of the existence of a particular fact is required to establish that the violation was
9 knowing, that knowledge exists when the facility is aware of a substantial probability
10 of its existence, unless the facility reasonably believes it does not exist.

11 **Sec. 18.20.440. Prohibition of retaliation.** A health care facility may not
12 discharge, discipline, threaten, discriminate against, penalize, or file a report with the
13 Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.469
14 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.469.

15 **Sec. 18.20.450. Enforcement of prohibition against retaliation.** The
16 commissioner shall investigate every complaint alleging a violation of AS 18.20.440,
17 and, within 90 days after the date of filing of the complaint, provide to the
18 complainant, the Department of Law, and the health care facility named in the
19 complaint a written determination as to whether the health care facility violated
20 AS 18.20.440. If the commissioner finds a violation of AS 18.20.440, the
21 commissioner shall request that the Department of Law represent the department and
22 the complainant and obtain from the health care facility all appropriate relief,
23 including rehiring or reinstatement of the complainant to the complainant's former
24 position with back pay.

25 **Sec. 18.20.460. Report requirements.** A health care facility shall file with the
26 division of labor standards and safety, Department of Labor and Workforce
27 Development, a semiannual report. The report for the six-month period ending June 30
28 must be filed before the following August 1, and the report for the six-month period
29 ending December 31 must be filed before the following February 1. The report must
30 include, for each nurse employed by the health care facility or under contract with the
31 health care facility, the number of overtime hours worked, the number of overtime

1 hours that were mandatory, the number of overtime hours that were voluntary, the
2 number of on-call hours, the number of on-call hours that were mandatory, and the
3 number of on-call hours that were voluntary.

4 **Sec. 18.20.465. Notice to employees.** A health care facility shall post and
5 maintain, in places readily accessible to individuals in the service of the health care
6 facility, printed statements that describe employee rights and employer obligations
7 under AS 18.20.400 - 18.20.469 and regulations adopted under AS 18.20.430. The
8 commissioner shall supply the printed statements to a health care facility without cost
9 to the facility.

10 **Sec. 18.20.469. Definitions.** In AS 18.20.400 - 18.20.469,

11 (1) "commissioner" means the commissioner of labor and workforce
12 development;

13 (2) "health care facility" means a private, municipal, state, or federal
14 hospital; psychiatric hospital; independent diagnostic testing facility; skilled nursing
15 facility; kidney disease treatment center, including freestanding hemodialysis units;
16 intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or
17 Alaska Veterans' Home administered by the Department of Health and Social Services
18 under AS 47.55; correctional facility owned or administered by the state; private,
19 municipal, state, or federal facility employing one or more public health nurses; long-
20 term care facility; juvenile detention facility; juvenile detention home, juvenile work
21 camp, or treatment facility, as defined in AS 47.12.990;

22 (3) "nurse" means an individual licensed to practice registered nursing
23 or practical nursing under AS 08.68 who provides nursing services through direct
24 patient care or clinical services and includes a nurse manager when delivering in-
25 hospital patient care;

26 (4) "on-call" means a status in which a nurse must be ready to report to
27 the health care facility and may be called to work by the health care facility;

28 (5) "overtime" means the hours worked in excess of a predetermined
29 and regularly scheduled shift that is agreed to by a nurse and a health care facility;

30 (6) "rural community" means a village or city that

31 (A) has a population of less than 10,000, as determined by the

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Department of Labor and Workforce Development;

(B) is in the unorganized borough; or

(C) is in an organized borough that has a population of less than 25,000, as determined by the Department of Labor and Workforce Development.

* Sec. 3. The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. A health care facility that is required to file reports under AS 18.20.460, enacted in sec. 2 of this Act, shall file its first report before February 1, 2010, for the period July 1, 2009, through December 31, 2009.

* Sec. 4. AS 18.20.460, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect July 1, 2009.

* Sec. 5. Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2010.

CS FOR HOUSE BILL NO. 50(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES WILSON, GARA, TUCK, PETERSEN, LYNN, SEATON, GATTO, CISSNA, MUÑOZ, AND GARDNER, Ramras, Foster, Kerttula

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on mandatory overtime for registered nurses and**
2 **licensed practical nurses in health care facilities; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:

6 **LEGISLATIVE FINDINGS AND INTENT.** The legislature finds that

7 (1) it is essential that registered nurses and licensed practical nurses providing
8 direct patient care be available to meet the needs of patients;

9 (2) quality patient care is jeopardized by registered nurses and licensed
10 practical nurses who work unnecessarily long hours in health care facilities;

11 (3) registered nurses and licensed practical nurses are leaving their profession
12 because of workplace stresses, long work hours, and depreciation of their essential role in the
13 delivery of quality and direct patient care;

14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and licensed practical nurses, and the health and general well-being of the
 2 persons receiving care from registered nurses and licensed practical nurses in health care
 3 facilities;

4 (5) it is necessary that registered nurses and licensed practical nurses be made
 5 aware of their rights, duties, and remedies concerning hours worked and patient safety; and

6 (6) health care facilities should provide adequate and safe nurse staffing
 7 without the need for or use of mandatory overtime.

8 * **Sec. 2.** AS 18.20 is amended by adding new sections to read:

9 **Article 4. Overtime Limitations for Nurses.**

10 **Sec. 18.20.400. Limitations on nursing overtime.** (a) Except as provided in
 11 (c) of this section, a nurse in a health care facility may not be required or coerced,
 12 directly or indirectly,

13 (1) to work beyond a predetermined and regularly scheduled shift that
 14 is agreed to by the nurse and the health care facility; or

15 (2) to accept an assignment of overtime if, in the judgment of the
 16 nurse, the overtime would jeopardize patient or employee safety.

17 (b) Except as provided by (c) of this section, after working a predetermined
 18 and regularly scheduled shift that is agreed to by the nurse and the health care facility
 19 as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed
 20 not less than 10 consecutive hours of off-duty time immediately following the end of
 21 that work.

22 (c) Subsection (a) of this section does not apply to

23 (1) a nurse who is employed by a health care facility providing
 24 services for a school, school district, or other educational institution, when the nurse is
 25 on duty for more than 14 consecutive hours during an occasional special event, such as
 26 a field trip, that is sponsored by the employer;

27 (2) a nurse voluntarily working overtime on an aircraft in use for
 28 medical transport, so long as the shift worked is allowable under regulations adopted
 29 by the Board of Nursing based on accreditation standards adopted by the Commission
 30 on Accreditation of Medical Transport Systems;

31 (3) a nurse on duty in overtime status

1 (A) who is participating in the performance of a medical
2 procedure or surgery that has begun but has not been completed;

3 (B) because of an unforeseen emergency situation that could
4 jeopardize patient safety; in this subparagraph, "unforeseen emergency
5 situation" means an unusual, unpredictable, or unforeseen situation caused by
6 an act of terrorism, disease outbreak, natural disaster, major disaster as defined
7 in 42 U.S.C. 5122, or disaster emergency under AS 26.23.020 or 26.23.140,
8 but does not include a situation in which a health care facility has reasonable
9 knowledge of increased patient volume or inadequate staffing because of some
10 other cause, if that cause is foreseeable;

11 (C) because the health care facility has a scheduling problem
12 caused by unforeseen weather conditions that prevent a second nurse from
13 arriving at the facility to relieve the nurse on duty; in this subparagraph,
14 "unforeseen weather conditions" means unusual, unpredictable, or unforeseen
15 weather so extreme as to impair travel to the health care facility, but does not
16 include a situation in which the health care facility has knowledge of the
17 weather conditions far enough in advance to act so that a scheduling problem
18 under this subparagraph can reasonably be avoided; or

19 (D) at a health care facility located in a rural community that
20 declares a temporary nurse staffing emergency under AS 18.20.410;

21 (4) a nurse fulfilling on-call time that is agreed on by the nurse and a
22 health care facility before it is scheduled unless fulfilling the on-call time would, in the
23 nurse's judgment, create an unacceptable risk to the physical safety of the nurse, a
24 patient, or an employee of the facility;

25 (5) a nurse voluntarily working overtime so long as the work is
26 consistent with professional standards and safe patient care and does not exceed 14
27 consecutive hours;

28 (6) a nurse voluntarily working beyond 80 hours in a 14-day period so
29 long as the nurse does not work more than 14 consecutive hours without a 10-hour
30 break and the work is consistent with professional standards and safe patient care;

31 (7) a nurse who

1 (A) is employed

2 (i) at a psychiatric treatment hospital that treats only
3 adolescents and children;

4 (ii) at a residential psychiatric treatment center under
5 AS 18.07.111 or AS 47.12.990; or

6 (iii) at a secure residential psychiatric treatment center
7 under AS 47.32.900;

8 (B) voluntarily agrees to work a 16-hour shift for the period
9 between 5:00 p.m. on a Friday and 8:00 a.m. on the Monday that immediately
10 follows and receives pay and benefits for that work that are equal to or greater
11 than the pay and benefits the nurse would receive for working 20 regular hours
12 in the same position; and

13 (C) during the period described in (B) of this paragraph does
14 not work a 16-hour shift consecutive with another shift of eight hours or more
15 without an intervening break of at least eight hours;

16 (8) the first two hours on overtime status when the health care facility
17 is obtaining another nurse to work in place of the nurse in overtime status, so long as
18 the nurse in overtime status is not on duty for more than 14 consecutive hours.

19 **Sec. 18.20.410. Temporary nurse staffing emergency.** (a) If, after making a
20 substantial and reasonable effort to increase the number of available nurses on staff
21 and failing in that effort, a health care facility in a rural community determines it is not
22 able to meet the overtime limitations in AS 18.20.400 without putting the safety of its
23 patients at risk of serious harm, the health care facility may declare a temporary nurse
24 staffing emergency. A declaration of a temporary nurse staffing emergency under this
25 section

26 (1) must be made in a writing, signed by the administrator of the health
27 care facility or the administrator's designee, that describes the facility's reasonable
28 effort to avoid the temporary nurse staffing emergency; and

29 (2) may not exceed 30 days.

30 (b) Immediately after declaring a temporary nurse staffing emergency under
31 (a) of this section, a health care facility shall file with the division of labor standards

1 and safety, Department of Labor and Workforce Development, a report that includes a
2 copy of the signed writing required under (a) of this section. A report under this
3 subsection is a public document.

4 (c) In addition to the requirements of (a) and (b) of this section, a health care
5 facility shall notify the legislature immediately by delivery of a written report to the
6 Alaska Legislative Council each time the facility declares a temporary nurse staffing
7 emergency under AS 18.20.400(c) that exceeds two occurrences in a six-month period
8 that begins on January 1 or July 1 of the year in which the declaration occurs, or three
9 occurrences in the one-year period that begins on January 1 of that year. A report
10 under this subsection must include a copy of each report that is required of the health
11 care facility under (b) of this section for the one-year period that begins on January 1
12 of the year the excessive declaration under this subsection occurs.

13 **Sec. 18.20.420. Health care facility complaint process for overtime work**
14 **by nurses.** A health care facility shall provide for an anonymous process by which a
15 patient or a nurse may make a complaint about staffing levels and patient safety that
16 relate to overtime work by nurses and to limitations on overtime work by nurses under
17 AS 18.20.400.

18 **Sec. 18.20.430. Enforcement, offenses, and penalties.** (a) The commissioner
19 shall administer AS 18.20.400 - 18.20.499 and adopt regulations for implementing and
20 enforcing AS 18.20.400 - 18.20.499.

21 (b) A complaint alleging a violation of AS 18.20.400 - 18.20.499 must be filed
22 with the commissioner within 30 days after the date of the alleged violation. The
23 commissioner shall provide a copy of the complaint to the health care facility named
24 in the filing within three business days after receiving the complaint.

25 (c) If the commissioner finds that a health care facility has knowingly violated
26 an overtime provision of AS 18.20.400 - 18.20.499, the following civil penalties shall
27 apply:

28 (1) for a first violation of AS 18.20.400 - 18.20.499, the commissioner
29 shall reprimand the health care facility;

30 (2) for a second violation of AS 18.20.400 - 18.20.499 within 12
31 months, the commissioner shall reprimand the health care facility and assess a penalty

1 of \$500;

2 (3) for a third violation of AS 18.20.400 - 18.20.499 within 12 months,
3 the commissioner shall reprimand the health care facility and assess a penalty of not
4 less than \$2,500 but not more than \$5,000;

5 (4) for each violation of AS 18.20.400 - 18.20.499 after a third
6 violation of AS 18.20.400 - 18.20.499 within 12 months, the commissioner shall
7 reprimand the health care facility and assess a penalty of not less than \$5,000 but not
8 more than \$25,000.

9 (d) As an employer, a health care facility violates an overtime provision of
10 AS 18.20.400 - 18.20.499 "knowingly" when the facility is either aware that its
11 conduct is of a nature prohibited by the overtime provision or aware that the
12 circumstances described in the overtime prohibition exist; however, when knowledge
13 of the existence of a particular fact is required to establish that the violation was
14 knowing, that knowledge exists when the facility is aware of a substantial probability
15 of its existence, unless the facility reasonably believes it does not exist.

16 **Sec. 18.20.440. Prohibition of retaliation.** A health care facility may not
17 discharge, discipline, threaten, discriminate against, penalize, or file a report with the
18 Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.499
19 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.499.

20 **Sec. 18.20.450. Enforcement of prohibition against retaliation.** The
21 commissioner shall investigate every complaint alleging a violation of AS 18.20.440,
22 and, within 90 days after the date of filing of the complaint, provide to the
23 complainant, the Department of Law, and the health care facility named in the
24 complaint a written determination as to whether the health care facility violated
25 AS 18.20.440. If the commissioner finds a violation of AS 18.20.440, the
26 commissioner shall request that the Department of Law represent the department and
27 the complainant and obtain from the health care facility all appropriate relief,
28 including rehiring or reinstatement of the complainant to the complainant's former
29 position with back pay.

30 **Sec. 18.20.460. Report requirements.** (a) A health care facility shall file with
31 the division of labor standards and safety, Department of Labor and Workforce

1 Development, a semiannual report on a form provided by the department. The report
 2 for the six-month period ending June 30 must be filed before the following August 1,
 3 and the report for the six-month period ending December 31 must be filed before the
 4 following February 1. The report must include, for each nurse employed by the health
 5 care facility or under contract with the health care facility, the number of overtime
 6 hours worked and the number of hours the nurse was on call. A health care facility that
 7 does not employ a nurse who worked overtime hours or who was on call during the
 8 reporting period is not required to describe hours worked as overtime and on-call
 9 hours for individual nurses but may instead complete the report by stating on the form
 10 that there are no reportable hours.

11 (b) A primary care outpatient facility is not subject to the reporting
 12 requirements of (a) of this section.

13 **Sec. 18.20.470. Provisions not applicable to nurses employed in federal or**
 14 **tribal facilities.** The provisions of AS 18.20.400 - 18.20.499 do not apply to a nurse
 15 employed in a health care facility that is operated by

16 (1) the federal government; or

17 (2) a tribal organization as defined in 25 U.S.C. 450b.

18 **Sec. 18.20.480. Notice to employees.** A health care facility shall post and
 19 maintain, in places readily accessible to individuals in the service of the health care
 20 facility, printed statements that describe employee rights and employer obligations
 21 under AS 18.20.400 - 18.20.499 and regulations adopted under AS 18.20.430. The
 22 commissioner shall supply the printed statements to a health care facility without cost
 23 to the facility.

24 **Sec. 18.20.499. Definitions.** In AS 18.20.400 - 18.20.499,

25 (1) "commissioner" means the commissioner of labor and workforce
 26 development;

27 (2) "health care facility" means a private, municipal, or state hospital;
 28 independent diagnostic testing facility; primary care outpatient facility; skilled nursing
 29 facility; kidney disease treatment center, including freestanding hemodialysis units;
 30 intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or
 31 Alaska Veterans' Home administered by the Department of Health and Social Services

1 under AS 47.55; correctional facility owned or administered by the state; private,
 2 municipal, or state facility employing one or more public health nurses; long-term care
 3 facility; psychiatric hospital; residential psychiatric treatment center, as defined in
 4 AS 18.07.111 or AS 47.32.900; secure residential psychiatric treatment center under
 5 AS 47.32.990; juvenile detention facility; juvenile detention home, juvenile work
 6 camp, or treatment facility as defined in AS 47.12.990;

7 (3) "nurse" means an individual licensed to practice registered nursing
 8 or practical nursing under AS 08.68 who provides nursing services through direct
 9 patient care or clinical services and includes a nurse manager when delivering in-
 10 hospital patient care;

11 (4) "on-call" means a status in which a nurse must be ready to report to
 12 the health care facility and may be called to work by the health care facility;

13 (5) "overtime" means the hours worked in excess of a predetermined
 14 and regularly scheduled shift that is agreed to by a nurse and a health care facility;

15 (6) "rural community" means a village or city that has a population of
 16 less than 10,000, as determined by the Department of Labor and Workforce
 17 Development, and is in

18 (A) the unorganized borough; or

19 (B) an organized borough that has a population of less than
 20 25,000, as determined by the Department of Labor and Workforce
 21 Development.

22 * Sec. 3. The uncodified law of the State of Alaska is amended by adding a new section to
 23 read:

24 **APPLICABILITY.** A health care facility that is required to file reports under
 25 AS 18.20.460, enacted in sec. 2 of this Act, shall file its first report before February 1, 2010,
 26 for the period July 1, 2009, through December 31, 2009.

27 * Sec. 4. AS 18.20.460, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect
 28 July 1, 2009.

29 * Sec. 5. Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2010.

CS FOR HOUSE BILL NO. 50()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

**Offered:
Referred:**

**Sponsor(s): REPRESENTATIVES WILSON, GARA, TUCK, PETERSEN, LYNN, SEATON, GATTO,
CISSNA, MUÑOZ, AND GARDNER, Ramras, Foster, Kerttula**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on mandatory overtime for registered nurses and**
2 **licensed practical nurses in health care facilities; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:

6 **LEGISLATIVE FINDINGS AND INTENT.** The legislature finds that

7 (1) it is essential that registered nurses and licensed practical nurses providing
8 direct patient care be available to meet the needs of patients;

9 (2) quality patient care is jeopardized by registered nurses and licensed
10 practical nurses who work unnecessarily long hours in health care facilities;

11 (3) registered nurses and licensed practical nurses are leaving their profession
12 because of workplace stresses, long work hours, and depreciation of their essential role in the
13 delivery of quality and direct patient care;

14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and licensed practical nurses, and the health and general well-being of the
2 persons receiving care from registered nurses and licensed practical nurses in health care
3 facilities;

4 (5) it is necessary that registered nurses and licensed practical nurses be made
5 aware of their rights, duties, and remedies concerning hours worked and patient safety; and

6 (6) health care facilities should provide adequate and safe nurse staffing
7 without the need for or use of mandatory overtime.

8 * Sec. 2. AS 18.20 is amended by adding new sections to read:

9 **Article 4. Overtime Limitations for Nurses.**

10 **Sec. 18.20.400. Limitations on nursing overtime.** (a) Except as provided in
11 (c) of this section, a nurse in a health care facility may not be required or coerced,
12 directly or indirectly,

13 (1) to work beyond a predetermined and regularly scheduled shift that
14 is agreed to by the nurse and the health care facility; or

15 (2) to accept an assignment of overtime if, in the judgment of the
16 nurse, the overtime would jeopardize patient or employee safety.

17 (b) Except as provided by (c) of this section, after working a predetermined
18 and regularly scheduled shift that is agreed to by the nurse and the health care facility
19 as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed
20 not less than 10 consecutive hours of off-duty time immediately following the end of
21 that work.

22 (c) Subsection (a) of this section does not apply to

23 (1) a nurse who is employed by a health care facility providing
24 services for a school, school district, or other educational institution, when the nurse is
25 on duty for more than 14 consecutive hours during an occasional special event, such as
26 a field trip, that is sponsored by the employer;

27 (2) a nurse voluntarily working overtime on an aircraft in use for
28 medical transport, so long as the shift worked is allowable under regulations adopted
29 by the Board of Nursing based on accreditation standards adopted by the Commission
30 on Accreditation of Medical Transport Systems;

31 (3) a nurse on duty in overtime status

1 (A) who is participating in the performance of a medical
2 procedure or surgery that has begun but has not been completed;

3 (B) because of an unforeseen emergency situation that could
4 jeopardize patient safety; in this subparagraph, "unforeseen emergency
5 situation" means an unusual, unpredictable, or unforeseen situation caused by
6 an act of terrorism, disease outbreak, natural disaster, major disaster as defined
7 in 42 U.S.C. 5122, or disaster emergency under AS 26.23.020 or 26.23.140,
8 but does not include a situation in which a health care facility has reasonable
9 knowledge of increased patient volume or inadequate staffing because of some
10 other cause, if that cause is foreseeable;

11 (C) because the health care facility has a scheduling problem
12 caused by unforeseen weather conditions that prevent a second nurse from
13 arriving at the facility to relieve the nurse on duty; in this subparagraph,
14 "unforeseen weather conditions" means unusual, unpredictable, or unforeseen
15 weather so extreme as to impair travel to the health care facility, but does not
16 include a situation in which the health care facility has knowledge of the
17 weather conditions far enough in advance to act so that a scheduling problem
18 under this subparagraph can reasonably be avoided; or

19 (D) at a health care facility located in a rural community that
20 declares a temporary nurse staffing emergency under AS 18.20.410;

21 (4) a nurse fulfilling on-call time that is agreed on by the nurse and a
22 health care facility before it is scheduled unless fulfilling the on-call time would, in the
23 nurse's judgment, create an unacceptable risk to the physical safety of the nurse, a
24 patient, or an employee of the facility;

25 (5) a nurse voluntarily working overtime so long as the work is
26 consistent with professional standards and safe patient care and does not exceed 14
27 consecutive hours;

28 (6) a nurse voluntarily working beyond 80 hours in a 14-day period so
29 long as the nurse does not work more than 14 consecutive hours without a 10-hour
30 break and the work is consistent with professional standards and safe patient care;

31 (7) a nurse who

1 (A) is employed

2 (i) at a psychiatric treatment hospital that treats only
3 adolescents and children;

4 (ii) at a residential psychiatric treatment center under
5 AS 18.07.111 or AS 47.12.990; or

6 (iii) at a secure residential psychiatric treatment center
7 under AS 47.32.900;

8 (B) voluntarily agrees to work a 16-hour shift for the period
9 between 5:00 p.m. on a Friday and 8:00 a.m. on the Monday that immediately
10 follows and receives pay and benefits for that work that are equal to or greater
11 than the pay and benefits the nurse would receive for working 20 regular hours
12 in the same position; and

13 (C) during the period described in (B) of this paragraph does
14 not work a 16-hour shift consecutive with another shift of eight hours or more
15 without an intervening break of at least eight hours;

16 (8) the first two hours on overtime status when the health care facility
17 is obtaining another nurse to work in place of the nurse in overtime status, so long as
18 the nurse in overtime status is not on duty for more than 14 consecutive hours.

19 **Sec. 18.20.410. Temporary nurse staffing emergency.** (a) If, after making a
20 substantial and reasonable effort to increase the number of available nurses on staff
21 and failing in that effort, a health care facility in a rural community determines it is not
22 able to meet the overtime limitations in AS 18.20.400 without putting the safety of its
23 patients at risk of serious harm, the health care facility may declare a temporary nurse
24 staffing emergency. A declaration of a temporary nurse staffing emergency under this
25 section

26 (1) must be made in a writing, signed by the administrator of the health
27 care facility or the administrator's designee, that describes the facility's reasonable
28 effort to avoid the temporary nurse staffing emergency; and

29 (2) may not exceed 30 days.

30 (b) Immediately after declaring a temporary nurse staffing emergency under
31 (a) of this section, a health care facility shall file with the division of labor standards

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and safety, Department of Labor and Workforce Development, a report that includes a copy of the signed writing required under (a) of this section. A report under this subsection is a public document.

(c) In addition to the requirements of (a) and (b) of this section, a health care facility shall notify the legislature immediately by delivery of a written report to the Alaska Legislative Council each time the facility declares a temporary nurse staffing emergency under AS 18.20.400(c) that exceeds two occurrences in a six-month period that begins on January 1 or July 1 of the year in which the declaration occurs, or three occurrences in the one-year period that begins on January 1 of that year. A report under this subsection must include a copy of each report that is required of the health care facility under (b) of this section for the one-year period that begins on January 1 of the year the excessive declaration under this subsection occurs.

Sec. 18.20.420. Health care facility complaint process for overtime work by nurses. A health care facility shall provide for an anonymous process by which a patient or a nurse may make a complaint about staffing levels and patient safety that relate to overtime work by nurses and to limitations on overtime work by nurses under AS 18.20.400.

Sec. 18.20.430. Enforcement, offenses, and penalties. (a) The commissioner shall administer AS 18.20.400 - 18.20.469 and adopt regulations for implementing and enforcing AS 18.20.400 - 18.20.469.

(b) A complaint alleging a violation of AS 18.20.400 - 18.20.469 must be filed with the commissioner within 30 days after the date of the alleged violation. The commissioner shall provide a copy of the complaint to the health care facility named in the filing within three business days after receiving the complaint.

(c) If the commissioner finds that a health care facility has knowingly violated an overtime provision of AS 18.20.400 - 18.20.469, the following civil penalties shall apply:

- (1) for a first violation of AS 18.20.400 - 18.20.469, the commissioner shall reprimand the health care facility;
- (2) for a second violation of AS 18.20.400 - 18.20.469 within 12 months, the commissioner shall reprimand the health care facility and assess a penalty

1 of \$500;

2 (3) for a third violation of AS 18.20.400 - 18.20.469 within 12 months,
3 the commissioner shall reprimand the health care facility and assess a penalty of not
4 less than \$2,500 but not more than \$5,000;

5 (4) for each violation of AS 18.20.400 - 18.20.469 after a third
6 violation of AS 18.20.400 - 18.20.469 within 12 months, the commissioner shall
7 reprimand the health care facility and assess a penalty of not less than \$5,000 but not
8 more than \$25,000.

9 (d) As an employer, a health care facility violates an overtime provision of
10 AS 18.20.400 - 18.20.469 "knowingly" when the facility is either aware that its
11 conduct is of a nature prohibited by the overtime provision or aware that the
12 circumstances described in the overtime prohibition exist; however, when knowledge
13 of the existence of a particular fact is required to establish that the violation was
14 knowing, that knowledge exists when the facility is aware of a substantial probability
15 of its existence, unless the facility reasonably believes it does not exist.

16 **Sec. 18.20.440. Prohibition of retaliation.** A health care facility may not
17 discharge, discipline, threaten, discriminate against, penalize, or file a report with the
18 Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.469
19 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.469.

20 **Sec. 18.20.450. Enforcement of prohibition against retaliation.** The
21 commissioner shall investigate every complaint alleging a violation of AS 18.20.440,
22 and, within 90 days after the date of filing of the complaint, provide to the
23 complainant, the Department of Law, and the health care facility named in the
24 complaint a written determination as to whether the health care facility violated
25 AS 18.20.440. If the commissioner finds a violation of AS 18.20.440, the
26 commissioner shall request that the Department of Law represent the department and
27 the complainant and obtain from the health care facility all appropriate relief,
28 including rehiring or reinstatement of the complainant to the complainant's former
29 position with back pay.

30 **Sec. 18.20.460. Report requirements.** (a) A health care facility shall file with
31 the division of labor standards and safety, Department of Labor and Workforce

1 Development, a semiannual report on a form provided by the department. The report
2 for the six-month period ending June 30 must be filed before the following August 1,
3 and the report for the six-month period ending December 31 must be filed before the
4 following February 1. The report must include, for each nurse employed by the health
5 care facility or under contract with the health care facility, the number of overtime
6 hours worked and the number of hours the nurse was on call. A health care facility that
7 does not employ a nurse who worked overtime hours or who was on call during the
8 reporting period is not required to provide overtime hours worked or ~~hours on call~~ for
9 individual nurses but may instead complete the report by stating on the form that there
10 are no reportable hours.

11 (b) A primary care outpatient facility is not subject to the reporting
12 requirements of (a) of this section.

13 **Sec. 18.20.465. Provisions not applicable to nurses employed in federal or**
14 **tribal facilities.** The provisions of AS 18.20.400 - 18.20.469 do not apply to a nurse
15 employed in a health care facility that is operated by

16 (1) the federal government; or

17 (2) a tribal organization as defined in 25 U.S.C. 450b.

18 **Sec. 18.20.467. Notice to employees.** A health care facility shall post and
19 maintain, in places readily accessible to individuals in the service of the health care
20 facility, printed statements that describe employee rights and employer obligations
21 under AS 18.20.400 - 18.20.469 and regulations adopted under AS 18.20.430. The
22 commissioner shall supply the printed statements to a health care facility without cost
23 to the facility.

24 **Sec. 18.20.469. Definitions.** In AS 18.20.400 - 18.20.469,

25 (1) "commissioner" means the commissioner of labor and workforce
26 development;

27 (2) "health care facility" means a private, municipal, state, or state
28 hospital; independent diagnostic testing facility; primary care outpatient facility;
29 skilled nursing facility; kidney disease treatment center, including freestanding
30 hemodialysis units; intermediate care facility; ambulatory surgical facility; Alaska
31 Pioneers' Home or Alaska Veterans' Home administered by the Department of Health

1 and Social Services under AS 47.55; correctional facility owned or administered by
 2 the state; private, municipal, or state facility employing one or more public health
 3 nurses; long-term care facility; psychiatric hospital; residential psychiatric treatment
 4 center, as defined in AS 18.07.111 or AS 47.32.900; secure residential psychiatric
 5 treatment center under AS 47.32.990; juvenile detention facility; juvenile detention
 6 home, juvenile work camp, or treatment facility as defined in AS 47.12.990;

7 (3) "nurse" means an individual licensed to practice registered nursing
 8 or practical nursing under AS 08.68 who provides nursing services through direct
 9 patient care or clinical services and includes a nurse manager when delivering in-
 10 hospital patient care;

11 (4) "on-call" means a status in which a nurse must be ready to report to
 12 the health care facility and may be called to work by the health care facility;

13 (5) "overtime" means the hours worked in excess of a predetermined
 14 and regularly scheduled shift that is agreed to by a nurse and a health care facility;

15 (6) "rural community" means a village or city that

16 (A) has a population of less than 10,000, as determined by the
 17 Department of Labor and Workforce Development;

18 (B) is in the unorganized borough; or

19 (C) is in an organized borough that has a population of less
 20 than 25,000, as determined by the Department of Labor and Workforce
 21 Development.

22 * Sec. 3. The uncoded law of the State of Alaska is amended by adding a new section to
 23 read:

24 APPLICABILITY. A health care facility that is required to file reports under
 25 AS 18.20.460, enacted in sec. 2 of this Act, shall file its first report before February 1, 2010,
 26 for the period July 1, 2009, through December 31, 2009.

27 * Sec. 4. AS 18.20.460, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect
 28 July 1, 2009.

29 * Sec. 5. Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2010.



Alaska State Legislature

Representative Peggy Wilson
House District 2

SPONSOR STATEMENT HB 50

“An Act relating to limitations on overtime for registered nurses and licensed practical nurses in health care facilities and providing for an effective date.”

Nurses are working excessive amounts of hours without adequate rest. This creates an unsafe work environment for patients and nurses. Mandatory overtime is one of the main reasons nurses leave nursing. Recent studies indicate that one in five nurses is considering leaving the profession. When polled on their reasons for leaving, mandatory overtime is always listed in the top ten. The purpose of HB 50 is to promote better patient and nurse safety and to create an environment that will keep nurses at the bedside.

HB 50 would prohibit mandatory overtime. Mandatory overtime hours are those hours above an agreed upon, predetermined, regularly scheduled shift, which the employer makes compulsory (as opposed to voluntary). The threat of reprisals includes but is not limited to discharge, discipline, demotion or assignment to unattractive tasks or work shifts or in some cases licensure removal, retaliatory reporting, and charges of “patient abandonment”.

The bill does not ban overtime. The bill allows nurses to work up to 14 consecutive hours, but then requires a rest period of at least 10 hours. Another provision provides a nurse cannot be forced to work more than 80 hours in a 14-day period. Nurses can voluntarily agree to exceed the 80-hour limit, so long as they don't work more than 14 consecutive hours without the 10-hour rest period.

HB 50 allows for a number of exceptions to these requirements, including school nurses on field trips, nurses working on medivac flights, and if needed, for an unforeseen emergency that could jeopardize patient safety such as natural disasters or disease outbreaks.

There are 15 other states that have adopted similar requirements, including Washington, Oregon and California. Most of these versions restrict nurses to only 12 consecutive hours, with a mandated rest period of 12 hours. HB 50 extended those requirements to a 14-hour limit with a 10-hour rest period to provide additional flexibility to our hospitals, particularly those operating in smaller communities.

HB 50 addresses these problems in a reasonable and balanced manner, while making a work environment safer. It will also help to retain nurses instead of giving them reason leave the state or retire early.

ALASKA STATE LEGISLATURE

Interim:
P.O. Box 109
Wrangell, AK 99929
Phone: (907) 874-3088
Fax: (907) 874-3055



Session:
State Capitol, Room 406
Juneau, AK 99801-1182
Phone: (907) 465-3824
1-800-686-3824
Fax: (907) 465-3175

REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

Sectional Analysis

House Bill 50

“An act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date.”

Section 1. Describes the intent and reasons for the Act.

Section 2. Defines the Act:

- the limitations on overtime for nurses,
- the process for complaints,
- the enforcement, offenses and penalties as they apply to mandatory overtime for nurses,
- prohibition of retaliation, and enforcement of the retaliation,
- the reporting requirements.
- the definitions of terms .

Section 3. Sets the reporting periods.

Section 4. Sets the effective date for sections 2 and 3 at July 1, 2009

Section 5. Sets effective date at Jan. 1, 2010.

ALASKA STATE LEGISLATURE

Interim:
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Session:
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Phone: (907) 465-3824
1-800-686-3824
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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

Sectional Analysis

House Bill 50

“An act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date.”

Section 1. Describes legislative findings and intent for the Act. The purpose of this Act is to ensure public safety and assist with the retention of nurses at health care facilities by minimizing long working hours for nurses without adequate rest.

Section 2. This section addresses the major elements of the proposed legislation.

- Sec. 18.20.400(a) prohibits a health care facility from forcing a nurse to work beyond certain prescribed periods of time, or to accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient safety or employee safety.
- Sec. 18.20.400(b) requires nurses to receive not less than 10 consecutive hours of rest after working a predetermined and regularly scheduled shift.
- Sec. 18.20.400(c) lists 7 exceptions to the requirements of (a) & (b), including for school nurses, medivac flights, unforeseen emergencies that could jeopardize patient safety, and certain on-call situations. Voluntary overtime is permitted so long as it does not exceed more than 14 consecutive hours.
- Sec. 18.20.410 requires a health care facility to provide an anonymous process for complaints by a patient or a nurse about staffing levels or patient safety related to overtime work by nurses.
- Sec. 18.20.420 lays out a process for formal complaints by individuals against a health care facility that violates the provision of this Act, a mechanism to adjudicate these complaints involving the Department of Labor and Workforce Development, and a graduated schedule of penalties if it is determined that a violation has occurred.
- Sec. 18.20.430 provides an explicit prohibition against retaliation by a health care facility against a nurse who attempts to exercise their rights under the Act, or for the good faith reporting of an alleged violation.

ALASKA STATE LEGISLATURE

Interim:
P.O. Box 109
Wrangell, AK 99929
Phone: (907) 874-3088
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Session:
State Capitol, Room 406
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REPRESENTATIVE PEGGY WILSON HOUSE DISTRICT 2

- Sec. 18.20.445 establishes a semiannual reporting requirement for a health care facility to provide certain data relating to overtime and on-call activity for nurses.
- Sec. 18.20.449 provides a number of definitions related to the Act.

Section 3. Sets the reporting period for this first report required under sec. 2 of this Act. The report for the last six months of 2009 will be due on February 1, 2010.

Section 4. Sets July 1, 2009 as the effective date for the provisions dealing with the reporting requirements under AS 18.20.445.

Section 5. Sets an effective date of January 1, 2010 for all other provisions of the Act.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB 50(HSS)
 () Publish Date: _____

Identifier (file name): HB050CS(HSS)-DOLWD-WH-04-15-09 Dept. Affected: Labor and Workforce Development
 Title: Limit Overtime for Registered Nurses RDU: Labor Standard & Safety
 Component: Wage and Hour
 Sponsor: Representatives Wilson, Gara, Tuck, Petersen, Lynn, et al
 Requester: House Health and Social Services Component Number: 345

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services	73.6		73.6	73.6	73.6	73.6	73.6	73.6
Travel	3.0		3.0	3.0	3.0	3.0	3.0	3.0
Contractual	18.9		18.9	18.9	18.9	18.9	18.9	18.9
Supplies	3.8		0.5	0.5	1.8	0.5	0.5	0.5
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	99.3	0.0	96.0	96.0	97.3	96.0	96.0	96.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF	99.3		96.0	96.0	97.3	96.0	96.0	96.0
1005 GF/Program Receipts								
1037 GF/Mental Health								
1157 Worker Safety Account								
TOTAL	99.3	0.0	96.0	96.0	97.3	96.0	96.0	96.0

Estimate of any current year (FY2009) cost: None

POSITIONS

Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The bill requires the Department of Labor and Workforce Development to investigate and take enforcement action to resolve complaints of unlawful mandatory overtime use and alleged retaliation. Due to the significant number of registered nurses and licensed practical nurses currently licensed in Alaska (approximately 9,000 RN's and 1,000 LPN's), the department anticipates the workload will require at least one full-time Wage and Hour Investigator I position funded with General Funds. Costs include \$73.6 for salary and benefits, \$3.0 for investigation travel, \$18.9 for contractual which includes normal per position costs such as office space, phone, data processing and administrative support and \$5.0 for Department of Law advice and representation, \$0.5 for office supplies and an additional \$3.3 for office furniture and equipment in the first year and an additional \$1.3 for computer equipment replacement in the fourth year.

Prepared by: Grey Mitchell, Director
 Division: Labor Standard & Safety
 Approved by: Click Bishop, Commissioner
 Agency: Department of Labor and Workforce Development

Phone 465-4855
 Date/Time 4/15/09 7:57 AM
 Date 4/15/09

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 50
 () Publish Date: _____

Identifier (file name): HB050-DOLWD-WH-03-06-09 Dept. Affected: Labor and Workforce Development
 Title: Limit Overtime for Registered Nurses RDU: Labor Standard & Safety
 Component: Wage and Hour
 Sponsor: Representatives Wilson, Gara, Tuck, Petersen, Lynn, et al
 Requester: House Health and Social Services Component Number: 345

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services	73.6		73.6	73.6	73.6	73.6	73.6	73.6
Travel	3.0		3.0	3.0	3.0	3.0	3.0	3.0
Contractual	18.9		18.9	18.9	18.9	18.9	18.9	18.9
Supplies	3.8		0.5	0.5	1.8	0.5	0.5	0.5
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	99.3	0.0	96.0	96.0	97.3	96.0	96.0	96.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF	99.3		96.0	96.0	97.3	96.0	96.0	96.0
1005 GF/Program Receipts								
1037 GF/Mental Health								
1157 Worker Safety Account								
TOTAL	99.3	0.0	96.0	96.0	97.3	96.0	96.0	96.0

Estimate of any current year (FY2009) cost: None

POSITIONS

Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The bill requires the Department of Labor and Workforce Development to investigate and take enforcement action to resolve complaints of unlawful mandatory overtime use and alleged retaliation. Due to the significant number of registered nurses and licensed practical nurses currently licensed in Alaska (approximately 10,000 RN's and 1,000 LPN's), the department anticipates the workload will require at least one full-time Wage and Hour Investigator I position funded with General Funds. Costs include \$73.6 for salary and benefits, \$3.0 for investigation travel, \$18.9 for contractual which includes normal per position costs such as office space, phone, data processing and administrative support and \$5.0 for Department of Law advice and representation, \$0.5 for office supplies and an additional \$3.3 for office furniture and equipment in the first year and an additional \$1.3 for computer equipment replacement in the fourth year.

Prepared by: Grey Mitchell, Director
 Division: Labor Standard & Safety
 Approved by: Click Bishop, Commissioner
 Agency: Department of Labor and Workforce Development

Phone 465-4855
 Date/Time 3/6/09 1:06 PM
 Date 3/6/09

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB050
() Publish Date: _____

Identifier (file name): HB050-DHSS-PH-03-09-09 Dept. Affected: Health & Social Services
Title Limit Overtime for Registered Nurses RDU Alaska Pioneer Homes
Component Pioneers Homes
Sponsor Wilson
Requester House HSS Component Number _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB 50 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities, provides penalties for violations, and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of HB 50 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

The division has determined that passage of this bill will have a zero fiscal impact. Situations requiring overtime are adequately addressed by utilizing on-call RNs and requesting voluntary overtime.

Prepared by: Dave Cote, Director Phone 465-5737
Division Alaska Pioneer Homes Date/Time 3/9/09 8:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 3/9/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB050
 () Publish Date: _____

Identifier (file name): HB050-DHSS-N-03-09-09 Dept. Affected: Health & Social Services
 Title Limit Overtime for Registered Nurses RDU Public Health
 Component Nursing
 Sponsor Wilson
 Requester House HSS Component Number _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill sets limitations for nurses working overtime hours beyond the scope of their regular duties. While the language in the bill makes it applicable to public health nurses, it would have a very limited effect on the Division of Public Health Section of Public Health Nursing. Most Public Health Nurses, as salaried employees, are not overtime eligible.

The mandated semi-annual report to the Department of Labor and Workforce Development would typically require no effort because public health nurses rarely work "in excess of a predetermined and regularly scheduled shift that is agreed upon by the nurse and a health care facility." Normal itinerant schedules, even though they often involve more than a 7.5-hour day, are always predetermined and agreed upon. In addition, the bill exempts reporting requirements for unforeseen emergencies requiring extra work. There is no projected fiscal impact on the Section of Public Health Nursing.

Prepared by: Jay Butler, Chief Medical Officer Phone 269-8126
 Division Public Health Date/Time 3/9/09 8:00 AM
 Approved by: Alison Elgee, Assistant Commissioner Date 3/9/2009
DHSS Finance & Management Services

Matthew Johnson

From: Rebecca Rooney
Sent: Thursday, February 12, 2009 10:30 AM
To: Matthew Johnson
Subject: hb 50 testifierst.doc
Attachments: hb 50 testifierst.doc

Hi Matt,

Here is a list of potential testifiers for a hearing in House HSS for the Nurses Mandatory Overtime bill, HB 50.

Let me know if there is anything else you need. One thing on your list is a Fiscal note. Since yours is the first committee you will be the one to request it. In the past the only fiscal note came from Labor.

Cheers,
Becky

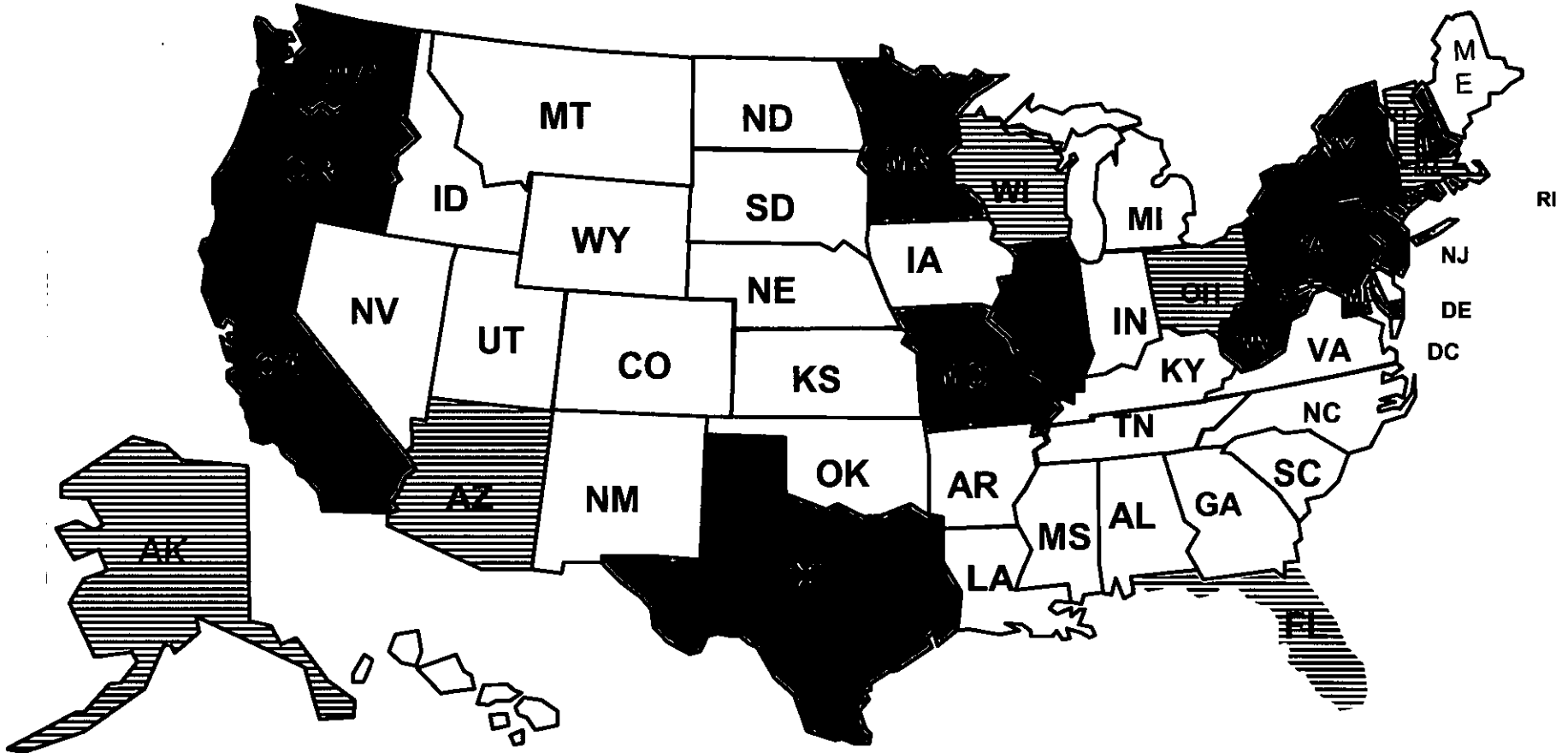

Only Department Affected



HB 50 Witnesses, House HSS

Debbie Thompson, BSN, RN, Executive Director AaNA - Anchorage
Nancy Davis, RN, MS - Board President - Juneau - might be out of town
Patricia Senner, MS, RN, ANP - AaNA - Legislative Chair Donna Phillips,
BSN, RN - Anchorage
Kathleen Gettys, RN, BSN, BA - Eagle River
Paul Mordini, RNC, BSN, MS - Eagle River
Lynn Hartz, MSN, FNP-BC - Anchorage
Mary Stackhouse, RN, BSN - Anchorage
Rebecca Bolling, RN - Ketchikan
Susan Walsh, RN - Ketchikan Tina Gonzales, Valdez
Ray Southwell, RN - Nikiski

The American Nurses Association's Nationwide State Legislative Agenda

PROHIBITION OF MANDATORY OVERTIME



-  Enacted legislation/adopted regulation to date 15 states; (12 states): CT, IL, MD, MN, NH, NJ, NY, OR, PA, RI, WA, and WV. (3 states) have provisions in regulations: CA, MO and TX
-  Introduced legislation in 2007-8; (18 states): AK, AZ, CA, DC, FL, IL, MA, MI, MN, MO, NE, NY, OH, PA, VT, WA, WI, WV

October 2008

Position Statements

Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings

Effective Date: December 8, 2006
Status: New Position Statement
Originated by: Congress on Nursing Practice and Economics
Adopted by: ANA Board of Directors

Purpose: This position statement articulates the American Nurses Association's position with regard to patient¹ safety and encourages employers of registered nurses² to establish policies and procedures that promote healthy nursing work hours and patterns that do not extend beyond the limits of safety for both nurses and patients.

ANA Position: Given the well-documented relationship between nurse fatigue and an increased risk of nurse error with the potential for compromising patient care and safety, it is the position of the American Nurses Association that all employers of registered nurses should ensure sufficient system resources to provide the individual registered nurse in all roles and settings with:

1. a work schedule that provides for adequate rest and recuperation between scheduled work; and
2. sufficient compensation and appropriate staffing systems that foster a safe and healthful environment in which the registered nurse does not feel compelled to seek supplemental income through overtime, extra shifts, and other practices that contribute to worker fatigue.

It is intended that this position statement be used in conjunction with ANA's position statement on the responsibility of the individual registered nurse to make decisions consistent with her or his ethical obligation to decline work assignments when fatigue may compromise her or his ability to deliver safe patient care, "*Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Fatigue*" (in press).

¹ ANA, in its *Nursing's Social Policy Statement*, "recognized the importance of clearly identifying the recipients of professional nursing care, be they individuals, groups, families, communities, or populations." The *Social Policy Statement* notes that "[t]o date, professional nursing has not yet selected ... the term best depicting the healthy or ill recipients of professional nursing care." Therefore the term "patient" was selected to be used "throughout the text to provide consistency and brevity" ... and readers are asked "to keep in mind that the breadth of nursing practice always includes the various recipients of care," be they the individual, the group, the family, the community, or the population. *Nursing's Social Policy Statement (2nd edition)*, 2003, American Nurses Association, p. v & 22.

² While ANA's membership is limited to registered nurses, it is ANA's belief that employers of health care personnel have a similar obligation to these employees to establish policies and procedures regarding employee fatigue and patient safety.

History/Previous Position Statements: In 2000, the American Nurses Association (ANA) House of Delegates adopted an action "Opposing the Use of Mandatory Overtime as a Staffing Solution" (CNPE-2). Embedded in this and other statements on related issues, ANA has consistently reiterated its position that registered nurses have a responsibility to reject any work assignment that puts patients or themselves in jeopardy (1995 ANA Position Statement, "*The Right to Accept or Reject an Assignment*"). Further, ANA's consistent position has been that such a principled rejection does not constitute "patient abandonment;" on the contrary, it is the only ethical option for the fatigued nurse.

Then, in 2004, the House of Delegates adopted a resolution entitled "Transforming the Work Environment for Nurses," based largely on the recommendations set out in the exhaustive Institute of Medicine (IOM) report of the same year, *Keeping Patients Safe: Transforming the Work Environment of Nurses*. The report described the central role of registered nurses in protecting patient safety and achieving better patient outcomes; and it discussed the frequent mismanagement of the nurse's work environment that often threatens these integral contributions. Among those issues highlighted in the report, the IOM focused on institutional support and structures for maintaining nurse staffing at levels sufficient to avoid patient safety issues cause by nurse fatigue.

The ANA 2005 House of Delegates overwhelmingly passed a resolution regarding the "Implications of Fatigue on Patient and Nurse Safety." That resolution built on the above described significant work that ANA has pursued for several years linking patient safety with a host of workplace environmental and staffing factors that affect the number of hours registered nurses work. It acknowledged the impact of nurse fatigue on patient safety, quality of care and nurse safety and urged individual nurses, nurse managers, nurse administrators, employers of nurses, trustees and other stakeholders to fulfill their legal and ethical obligations to assure that registered nurses' work hours and patterns do not extend beyond the limits of safety for both nurses and patients.

Supportive Material: The 2004 IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, recognized that creating a healthy work environment for registered nurses that is most conducive to patient safety will require fundamental change within a health care organization.

Strong evidence links prolonged work hours (more than 12 hours in a 24-hour span, or more than 60 hours in 7 days), rotating shifts and insufficient breaks to:

- slowed reaction time,
- lapses of attention to detail,
- errors of omission,
- compromised problem solving,
- reduced motivation, and
- decreased energy for successful completion of required tasks (IOM, 2004, p.12).

Further, Rogers, Hwang, Scott, Aiken, and Dinges (2004) found that the likelihood of making an error was three times higher when nurses worked shifts lasting 12.5 hours or more, and that

nurses, indeed, worked longer than scheduled on a daily basis, and generally worked more than 40 hours a week. Research examining consecutive hours worked by medical interns and residents also found that after extended work shifts there was an increased risk for both patient errors while at work and motor vehicle crashes leaving work (Landrigan, et al., 2004; Barger, et al., 2005).

Recent research with 2,273 RNs by Trinkoff, Geiger-Brown, Brady, Lipscomb and Muntaner (2006) documented that more than half of the hospital nurses in their study typically worked 12 hours or more per day and more than 50 hours per week. Further, nurses were likely to work many days consecutively, without sufficient rest between shifts and during scheduled time off.

Excessive total hours worked puts nurses and patients at risk; in addition, *rotating* shifts can also threaten patient safety. Research by Circadian Technologies Incorporated has found that the number of accidents for all shift workers is 1.2 times greater than that for traditional workers and the resulting incremental cost to business is \$8.5 billion (BNA, 2003).

Given this risk, the individual nurse's ethical responsibility to consider her or his level of fatigue when deciding whether to accept a patient assignment is addressed in the ANA's complementary position statement, "*Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued.*" In the present statement, "*Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings,*" ANA urges employers of registered nurses to acknowledge their responsibility to assure a safe workforce, and to initiate fundamental change in their staffing and salary policies so as to create incentives for a rested and safe nursing workforce.

At the institutional or organizational level, the risk that fatigue poses to both nurse and patient safety mandates that nurse managers and administrators actively promote changes in the work environment of nurses. Provision Six of *the Code of Ethics for Nurses with Interpretive Statements* clarifies:

The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action (p. 20).

Interpretive Statement 6.3 further delineates the ethical responsibilities of nurse managers and administrators to take action to curtail extended work hours and insufficient rest time between shifts:

Acquiescing and accepting unsafe or inappropriate practices, even if the individual does not participate in the specific practice, is equivalent to condoning unsafe practice (p. 21).

Nurse managers and administrators, bound by this ethical code of practice, may feel torn by conflicting professional obligations. Hospitals and other health care entities, not similarly bound, are clearly under pressure to reduce expenses; the managers of these institutions and organizations may not recognize the connections between their budget and nurse fatigue. Their

response to market pressures has often been an "adhocracy" of registered nurse understaffing, patched with excessive overtime, expensive agency nurses and rotating shifts that further deteriorates working conditions for already overworked nurses, thereby threatening patient safety.

Administrators need to be educated to the larger costs to their institutions of nurse fatigue as well as the costs of excessive overtime and agency nurses. The most obvious cause-and-effect may be seen in the reduction of adverse patient outcomes when an adequate, appropriate, and *rested* nursing staff is available. Study after study has concluded that nursing care, specifically, and appropriate staffing in general, is central to improved patient outcomes. This directly affects the institution's bottom line.

For example, ANA's 2000 study, *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting*, describes five adverse outcomes measures that respond favorably to adequate nurse staffing: hospital length of stay, nosocomial pneumonia, postoperative infections, pressure ulcers, and nosocomial urinary tract infections. Each of these might cost a hospital or health facility money that it would otherwise not spend. Appropriate nurse staffing that permits time for thorough patient assessment and timely interventions ultimately improves outcomes, and has the potential for significantly reducing these types of expensive risks.

Risks to nurses in the health care environment, only amplified by the fatigue factor, can similarly affect the cost of doing business for employers of nurses. Health care jobs are already among the most hazardous occupations. In a 2004 survey, the U.S. Bureau of Labor Statistics noted that, of the fourteen private industry sectors with the highest reported number of cases of injury or illness, three were in the health care and social assistance sector. In fact, "hospitals and nursing and residential care facilities have *led* [italics added] the list of industries reporting [the highest number of] cases for the past two years" (p. 8). The rate of illnesses experienced by workers in the hospital industry was almost three times that of workers in private industry as a whole.

Knowing all of this, and supported by the extensive research linking human fatigue with error, institutions that persist in policies supporting a culture where overwork, understaffing and underpay are the norm may ultimately find themselves facing extensive accountability for their short-sightedness. The consequence of institutional intractability is even more stark as the evidence accumulates specifically linking nurse fatigue with errors in clinical judgment that have the potential to harm patients or nurses themselves.

Employers may begin to experience the legal implications of the mounting research on fatigue, as well. For example, a registered nurse successfully claimed workers' compensation for injuries from a motor vehicle accident that occurred when she fell asleep while driving home after working back-to-back double shifts, at the behest of her manager and against her own judgment. The court ruled in her favor because it deemed the hospital's systematic abuse of overtime as a foreseeable and avoidable cause of the accident (*Deland v. Hutchings*, 1994). As hospitals and other health care institutions increasingly look to *institutional systems* to assure patient safety, as opposed to a model that only looks at individual responsibility, it is possible

that courts will follow the trend in finding institutional liability for those lapses in *institutional* policy that foreseeably result in harm to patients or staff.

Institutions also accrue the secondary costs of nurse fatigue that must be paid in time, and that ultimately affect the *entire* health care system. Clearly, nurse fatigue and the factors contributing to it are not isolated from the larger issues of health care workforce and access to care. In its 2001 report, "Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors," the US General Accountability Office cites "inadequate staffing, heavy workloads, the increased use of overtime, a lack of sufficient support staff, and the adequacy of wages" as key factors in the emerging registered nurse shortage (p. 2). When all the related factors are considered, fairer wages for registered nurses may be, at a minimum, cost-neutral for hospitals and other entities.

The drive for "organizational efficiency," when its proponents fail to balance it with other values, continues to backfire in industry after industry. Increasingly, businesses must balance the cost of assuring a rested workforce against the regrettable cost of *not* having rested workers. The shift and duty times of airline pilots and truck drivers are regulated for precisely these reasons. In health care, teaching hospitals can be denied their accreditation for graduate medical education if they routinely ignore resident work hour limits. Although the application of this logic has been slow to reach the rest of the health care community, employers need to make the connection between nurse fatigue and safety of both the patient and the nurse.

The management of hospitals and other healthcare entities must be accountable for making the changes necessary to align their rewards systems with their espoused value of high quality patient care and safety. Nursing can support this mission by generating specific recommendations as to what institutions can do differently to address the factors that contribute to nurse fatigue.

Several nursing specialty organizations have addressed how their members might best balance work and rest to optimize safety, and how their employers might support their doing so. The Association of periOperative Registered Nurses (AORN), an organizational affiliate of the American Nurses Association (ANA), offers several strategies in its 2005 Position Statement on Safe Work/On-Call Practices, to promote patient and perioperative personal safety. Those strategies that directly target action by institutions and organizational systems include:

- Perioperative Registered Nurses should not be required to provide direct patient care for more than 12 consecutive hours in 24 hours and not more than 60 hours in a seven-day period.
- Off-duty periods should be scheduled to provide for an uninterrupted eight-hour sleep cycle.
- Arrangements should be made to relieve a perioperative registered nurse who has worked on-call and is scheduled to work the following shift to allow for adequate off-duty recuperation time.
- The type of facility and possible number of sustained work hours should be taken into consideration when making on-call shift assignments.

- The individual's ability to be able to meet the potential work demands should be considered when making on call assignments.
- Employers should support perioperative registered nurses to change cultural attitudes so that fatigue is recognized as an unacceptable risk to patient and worker safety rather than a sign of their dedication to their job.

AORN's full position statement and guidance statement on Safe On-Call Practices in Perioperative Practices can be found on the AORN web site at the following link:
<http://www.aorn.org/about/positions/default.htm>.

The American Association of Critical Care Nurses has explored how "mental and physical fatigue can contribute to errors and 'near-misses' with medications and case-related procedures" in its position statement opposing mandatory overtime. Without the ability to resort to mandatory overtime, "hospitals and health care institutions will have to look at real remedies for understaffed facilities, such as: 1) hiring more RN's, and 2) utilizing strategies to recruit and retain more nurses" (<http://www.aacn.org/AACN/pubpolicy.nsf/vwdoc/pmp>, ¶ 7).

A 2006 study by Scott, Rogers, Hwang and Zhang targeted at this critical care nursing population generally affirms earlier studies, showing respondents "worked longer [hours] than scheduled and for extended periods," and that "longer work duration increased the risk of error and near error and decreased nurses' vigilance" (p. 1). It also supports the IOM's recommendations to minimize the use of 12-hour shifts and to limit nurses' working hours to 12 consecutive hours during any one 24-hour period. The authors were particularly persuaded by the potentially dire consequences of a fatigue-induced mistake in critical care, where "patients are not only exposed to more medications and treatments than are patients in general care areas but are also seriously ill, with little natural resilience or ability to defend themselves from the consequences of healthcare mishaps" (Scott, 2006, p. 1).

This evidence, highlighting the detrimental effects of nurse fatigue on patient and nurse safety, as well as on institutional and organizational accountability, leads ANA to recommend the following actions for registered nurses, employers, researchers and educators.

Recommendations: As a means of implementing this position statement, the ANA recommends the following eleven specific actions:

Practicing Registered Nurses:

1. Individual registered nurses should consistently exercise their ethical obligations as articulated in the ANA's position statement on *Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued* (ANA, in press).
2. Nurse managers and administrators have a responsibility to examine and institute scheduling practices that promote safe work hours, adequate break time, and minimal rotation of shifts.

Employers/Health Care Agencies:

3. All employers should provide fair compensation that encourages the elimination of the need for such strategies as excessive overtime or rotating shifts. The ANA recommends a thorough examination of overtime pay expenditures and a reassignment of those dollars toward both the additional staff necessary to eliminate overtime and subsequent increases in registered nurses' base compensation. These steps should be cooperatively pursued and negotiated in an open and equitable process that includes both registered nurses and healthcare administrators.
4. Registered nurses' salaries must be adjusted to appropriately reflect their education, training, experience and the value they add within the health care entity for which they work. In particular, "wage compression," or the stagnation of salary growth relatively early in a nurse's career, should be eliminated and experience rewarded so that the health care system retains its nursing workforce. Salaries should be such that registered nurses do not feel compelled to seek supplemental income through rotating shifts, overtime and other voluntary practices that contribute to worker fatigue.
5. All employers of health professionals should provide ongoing education to employees concerning the impact of consecutive and total hours worked and employee fatigue on patient safety, quality of care, and the personal safety of employees.
6. Employers should institute policies, including whistleblower protections, permitting the free exchange of ideas and information about staffing and quality of care issues among their staff without fear of reprisal or retribution.
7. Employers should adopt as official policy, the position that registered nurses have the right to accept or reject a work assignment based on fatigue; that such rejection does not constitute patient abandonment; and that registered nurses should not suffer adverse consequences in retaliation for rejecting in good faith a work assignment based on fatigue.
8. Employers should have a system in place for evaluating instances of registered nurses rejecting assignments in order to evaluate causes and effectiveness of staffing patterns.

Education:

9. Schools of Nursing should add to their curricula information on the impact of hours worked, rotating shifts, and neglecting to take meal and rest breaks on patient safety and harm to self and peers. In addition, the ethical obligation of the individual registered nurse to monitor fatigue and to decline assignments that put patients at risk should be

stressed, relying on Provisions and Interpretive Statements from the *Code of Ethics for Nurses* (ANA, 2001).

10. Academic education and training programs for health care administrators should include curricula content regarding the impact of nurse and health care worker fatigue on patient and staff safety, and the importance of supporting a healthy workplace for registered nurses and other employees.

Research:

11. ANA should partner with specialty nursing organizations and other stakeholders to assure that the following subjects are included on the research agendas of various funding entities:
 - Determinants of registered nurse fatigue
 - Impact of nurse fatigue on the health and well-being of nurses
 - Impact of registered nurse fatigue on patient safety
 - Patient classification/acuity systems
 - Staffing patterns and nursing-sensitive patient outcomes
 - Salaried registered nurse-staffing models
12. Schools of Nursing, as well as Schools of Public Health, Occupational Health, Health Services Research and Economics, should develop graduate research foci around the areas of patient acuity, nurse staffing patterns, nurse fatigue and quality of care.

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House Bill No.50: "Safe Nursing & Patient Care Act"

What Does *HB 50* Do?

- Protects patients and nurses in a health care facility by limiting forced overtime unless needed for an emergency.
- **Nurses cannot work more than 14 consecutive hours without 10 hours of rest**, or be forced to work more than 80 hours in a 14-day period. **Nurses can volunteer to work additional shifts beyond this limit, so long as the nurse does not work more than 14 consecutive hours without 10 hours of rest.**
- **Exceptions are allowed for unforeseen emergencies**, school nurses, medivac flights, and certain on-call situations.

Why is *HB 50* Needed?

- **Purpose of bill is to promote patient safety and better working conditions for nurses.**
- **Nurses in Alaska are working an excessive amount of overtime without adequate rest.** Nurses often work well beyond 12 consecutive hours, or come back within 2-4 hours of completing a 12-hour shift. In other cases, nurses are working several 12-day shifts over consecutive days.
- In most cases, **this is forced or mandated through a practice called "mandatory call", which the hospitals freely admit is used.** In some cases, this is accomplished by pressure tactics designed to get nurses to "volunteer" for overtime hours. Suggestions of patient abandonment or assertions that nurses will be letting down co-workers are not uncommon.
- ***HB 50* will help with nurse recruitment and retention by prohibiting excessive amounts of overtime.** The nurse workforce is aging – a ban on excessive overtime will keep these nurses working longer.
- A recent phone survey by AaNA documents that not all of the new UA nursing school graduates are being hired. **The bill will not exacerbate the so-called shortage – there are additional graduates available to fill positions.**
- **Data suggests many hospitals are using overtime as a staffing tool.** Hospitals are not hiring all available graduates and maintain vacancy rates of between 7% to 25%. It appears that many hospitals are trying to avoid hiring Full-Time Equivalent (FTE) employees.
- **83% of the Alaska RN workforce is over 40 years of age and 53% is over the age of 50. We need to conserve the workforce we have, and at the same time not scare away the 17% of the workforce that is under age 40.** People with young families are not going to stay in the profession if they are constantly being forced to work.

Patrick M. Nolan, D.O., F.A.C.E.

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Comments on SB 12 & HB 50: "An act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities." Patient Safety Act

To Whom It May Concern:


Thank you for listening to my comments. As a physician, specializing in endocrinology, I am distressed at the physical alterations that can occur in an aging nursing workforce while their hours and demands steadily rise. It is no secret that the population of America is aging. In Alaska the average age of a professional registered nurse is close to 49 years old.

According to John Howard, MD, former director of the National Institute for Occupational Safety and Health, "the average number of hours worked annually by workers in the United States has increased steadily over the past several decades and currently surpasses that of Japan and most of Western Europe." (2004) Dr. Howard continues noting, "the influence of overtime and extended work shifts on worker health and safety, as well as on worker errors, is gaining increased attention from the scientific community, labor representatives, and industry...the volume of legislative activity seen nationwide indicates a heightened level of societal concern and timeliness of the issue." Many states have passed safe patient legislation with its foundation based on research correlating much higher error rates with overtime. The Institute of Medicine identifies long hours for nurses as one of the critical problems in safety studies, and has been advocating for safeguards.

Nurses are critical thinking professionals employed to assess, treat, and evaluate patients, and need a non-mandated work environment to function well. Patients should not be subjected to those who are fatigued, stressed, and forced to work overtime. We all depend on the nurse to be alert and aware.

I encourage the Alaska Legislature to be judicious and rational in its thinking. Regardless of the workforce challenges for institutions, we have no alternative but to follow a strategy of safety for patients and communities. Please limit the overtime and extended hours worked by nurses in the State of Alaska.

I thank you for this opportunity,


Patrick M. Nolan, D.O., F.A.C.E.
3300 Providence Drive, Suite 206
Anchorage, AK 99508

February 12, 2009

Re: HB50/SB12

Dear Honorable Legislators

I would like to see mandatory overtime/on call addressed. I was in the hospital from 0645 till 0045 last night then had to return at 0645 today. I am on call again this pm 1900 to 0700 tomorrow.

I still have to come to work tomorrow and if I get called in tonight how mentally alert will I be?

Thanks,

JoAnne Zemlicka

To my Legislature regarding patient safety:

February 10, 2009

Ladies and Gentleman,

As a current Registered Nurse in Alaska of 31 years, I must say that patient safety is very important to me as a professional. I would not ever practice as a Nurse if patient safety was an issue for me. Making a Nurse work mandatory overtime puts not only the Nurse at risk of injury, it also puts her patients at risk as well. For 29 years I worked in an Intensive Care Unit full time 12 hour shifts leaving home at 6pm and getting home most mornings at 8:30am if my patients did not go bad on me in the last hour of work, otherwise it might be more like 10am.

Nurses work extremely hard with life and death situations and would not hesitate to help when needed. To make it mandatory for a Nurse to work overtime is not only wrong, it is dangerous.

I feel that Nursing is such a hard job, that it is truly a calling from God himself to accomplish this professional practice every single day.

Sincerely,

Helen Christine Wood, RN, B.S.N.
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February 11, 2009

RE: HB 50/SB12

Dear Legislators:

I am writing this letter in support of HB 50/SB 12, acts relating to limitations on mandatory overtime for RNs and LPNs. Having been a nurse for over 25 years I can attest to how physically and mentally draining it is to work a shift as a nurse. A nurse caring for adults lifts over 1.2 tons in an 8 hour shift. The patients are feeling poorly and can become critically ill at any point, medications must be given in correct amounts to avoid toxic effects, families are anxious and often a little short, and there are many other healthcare providers with whom care must be coordinated. Because the consequences of errors can be so serious, this is not the type of work environment where nurse fatigue should be allowed to happen.

Over 30% of the nursing workforce is over the age of 50 years, and many of these nurses plan to retire in the next five years. In Alaska we have worked hard to train new nurses. We do not want to drive these nurses out of the Alaskan workforce because they are being forced to work excessive hours. Remember, Oregon, Washington and California have banned mandatory overtime for nurses making them a very attractive destination for Alaska nurses. Everyone I have talked to has been amazed that there would be any opposition to limiting the hours a nurse can work to 14.

Thank you for considering my views. Hopefully this will be the year that we work to create a work environment in which RNs and LPNs can provide quality patient care without concern of being worked to exhaustion.

Sincerely,

Patricia Senner MS, RN, ANP

February 16, 2009

Re: SB12/HB50

Dear Legislators,

I am currently a nurse educator, but have 25+ years of clinical nursing experience, as well as having recently been a consumer of health care for close family members. I am also a Certified Professional in Healthcare Quality (CPHQ), and in that role in a hospital reviewed medical records and worked to drill down adverse patient outcomes. It has been my personal experience as a bedside nurse in hospital and long term care positions that mandated overtime to cover staffing shortfalls, that the quality of care delivered was adversely impacted.

Exhausted people make poor drug calculations, poor assessments, and are less apt to walk around and check in on their patients frequently. It puts patient care in jeopardy and it also puts nurses at risk for bad practice and subsequent litigation. It is also a major reason why some nurses quit practicing in direct care positions -- and we need those nurses with high standards and clear boundaries taking care of us and our families through critical illnesses.

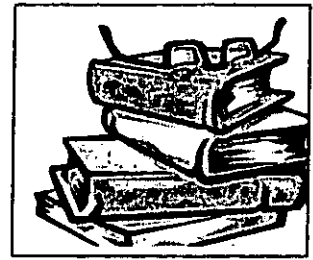
I ask you to support legislation that would ban mandatory overtime for nurses. Instead, support nursing education opportunities and we will continue to bring bright and motivated caregivers into the healthcare field.

Thank you for your consideration.

Anne Doerpinghaus, MS, RN, CPHQ
Assistant Professor, Allied Health
TVC, University of Alaska
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LAUREE MORTON

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February 16, 2009

Dear Representative Wilson:

Thank you for introducing HB 50, Limit Overtime for Nurses. Nurses perform tasks that require accuracy, quick thinking and sound judgment; each of which is diminished after long consecutive hours of work in stressful environments. Both as a patient myself and as a caretaker for my father and then my mother as they had extended stays in hospital settings, I have seen overworked nurses make mistakes. Fortunately, for us, they were not life-threatening, but it is easy to imagine how they might have been.

Although some nurses may want to work overtime in these tough economic times and hospitals may believe the practice saves money, neither reason should take precedence over patient safety. Nurses need to be alert and ready to handle emergency situations as they arise. We should do everything we can to help ensure the dedicated people who choose to work in the nursing profession can do their jobs safely and well. HB 50 is a good first step.

Sincerely,

Lauree Morton



ALASKA WOMEN'S LOBBY

AWL Mission: To defend and advance the rights and needs of Women, Children and Families in Alaska

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Letter of Support HB 50, Limit Overtime for Nurses

The Alaska Women's Lobby, a statewide group working to defend and advance the rights and needs of women, children and families, supports HB 50. Limiting overtime for nurses is a patient safety issue. When you are in their care you want someone available to you that is well rested and nourished, can think quickly on their feet, and can interact with patients in a friendly professional manner. You do not want someone responsible for your care that has been working for ten or twelve or more hours straight without a break to be the one in charge of the decisions that can mean the difference between your living or dying. Regardless of how hospitals or nurses posit this bill, patient safety should be paramount to any other concern.

Several studies have found patient safety is at risk when nurses work more than 12 hours in a 24 hour period. The 2004 study, Working Hours of Hospital Staff Nurses and Patient Safety, found that nurses working more than 12.5 consecutive hours were three times more likely to make an error than nurses working shorter hours. Working overtime at the end of a shift also increased the risk of making an error. Possible errors, which also applied to nurses who worked unplanned overtime at the end of a scheduled shift, included giving patients incorrect medications or dosages, according to the study.

According to a 2007 study sponsored by the US Agency for Healthcare Research and Quality (AHRQ), components of working conditions, including a hospital's organizational climate, staffing, and overtime, were found to influence outcomes in the elderly patients in hospital intensive care units (ICUs). Other recent AHRQ-funded studies on nurses' working conditions and patient outcomes have found a significantly greater risk to patient safety when nurses worked beyond their regularly scheduled number of hours.

The Institute of Medicine in its 2003 report, Keeping Patients Safe: Transforming the Work Environment of Nurses recommended that nurses provide direct patient care for no more than 12 hours in any given 24-hour period and less than 60 hours in a 7-day period. AHRQ called for the report in recognition of the key role of nurses in patient safety.

Alaska should do everything possible to ensure patient safety. Limiting overtime for nurses is a solid first step. Support passage of HB 50 this session. Take seriously the charge to keep Alaskans safe as they try and get their health care needs met.

2/11/09

Re: HB50/SB12

To the Honorable Senators and Representatives of the Alaska Legislature,

Please join with your counterparts in 12 other states that have passed legislation to prohibit mandatory overtime for nurses. Join our congressional delegation of Senator Murkowski and Congressman Young who co-sponsored the Safe Nursing and Patient Care Act of 2007 which prohibits mandatory overtime except in cases of states of emergency.

Most people would not choose to fly in a plane with a pilot forced to work beyond what they felt was their safety limit in competence for work hours. In fact, it is illegal. How then has it taken so long to pass this legislation that will contribute to patient safety? This is not a matter of employer rights in staffing. If a nurse tells the employer she or he has worked too many hours and is not safe to practice; why on earth would you not believe him/her? Would you risk your life or a loved one's on the nurse's word or their employers?

The rules for pilots solved this long ago. Similar restrictions in on-call and work hours are even now being addressed for medical residents due to safety reasons in an attempt to reduce medical errors. Alaska will not be the first state to address this problem with legislation but I certainly hope it will not be the last.

Although I no longer work in a hospital myself, I have been a patient in one and may be again. Speaking both as a nurse and a consumer, I urge you to support passage of HB 50 and SB 12.
Sincerely,

Lynn Hartz MSN, FNP-BC
3104 Brookside Drive
Anchorage, AK 99517
ph 907-248-4877
fax 907-222-1498

Re: HB50/SB12

2/11/09

Dear Legislators,

As a registered nurse (RN), I heartily support these two pieces of legislation. Patient safety will be jeopardized if health care facilities are given free reign to impose mandatory overtime.

Patient safety is Job 1 for nurses, to borrow a phrase from different industry. An RN who is required to work overtime beyond a twelve-hour day or even an eight-hour day is physically, mentally, and emotionally fatigued. Thus, her judgment is potentially compromised, her physical strength weakened, and her emotional capacity diminished.

In my institution, on my unit, I care for extremely sick individuals, with co-morbidities that include dementia, confusion, obesity (majority of patients), and often lower extremity amputation.

My unit is already suffering from budget issues that have resulted in less nurse's aide assistance. Hence I am responsible for safely assisting any combination of obese patients with altered mental status who are missing at least one leg to the toilet, with little or no staff assistance. At the end of a twelve-hour day, I am ready to go home. I have reached my daily limit of sharp, focused thought for decision-making, and accurate charting.

I may or may not have had a chance to take a quick break for a snack. Sometimes I am so busy caring for patients I forget to use the ladies room. Our institution's break and meal policy is catch as catch can. So, if mandatory overtime was added, I am not sure I would even get to eat dinner before my next "shift" started.

Mandatory overtime? That's too much to ask. It is not humane, IT IS NOT SAFE FOR THE PATIENT OR THE NURSE. An increase in back injuries in nurses, medication errors, and patient falls are examples of the consequences of mandatory overtime.

I care for renal patients who often have a minimum of a dozen or more scheduled medications in addition to "PRN" or as needed medications. These medications usually include insulin, blood pressure medications, and heparin or coumadin---all high risk medications. At the end of a twelve hour day, I can tell you that I become fatigued, and would be prone to making mistakes.

The health care industry is seriously compromising the public trust with mandatory overtime. The health care industry is exchanging the health and safety of their patients/clients for monetary gain.

Mandatory overtime results in nurses who themselves become patients due to fatigue, stress, and physical deterioration of their feet and legs.

The health care industry, in requiring mandatory overtime, falls in with a crowd that practices human exploitation.

Sincerely, Theresa E. Philbrick, RN

Gary C. Goins, MS,BSN, RN
3301 Eureka Street
Anchorage, AK 99503

February 10, 2009

To The Legislative Committee:

It is easy to see that the sacrifices a nurse makes to help the individuals in our communities is a significant one.

We do not take our responsibility lightly nor should we. Privileged to care for the injured and ill, for our neighbors and friends, sharing their moments of triumph and helping them cope with devastating losses.

I want to tell you that a nursing practice ratio makes a patient safer. In that bed that will be you, me, our child or our loved one. By focusing on each person we care for, we are able to see signs of problems early, catch them, alert the doctors and fix them. If we are exhausted from no breaks or seeing to many patients we can, like all good people, fail.

In practice for 20 years I have seen hundreds of these cases. I can tell you that patients in California are safer due to support to nurses for adequate breaks and established rules.

These laws most likely cost more but please believe me, if that was your child or your mom, you would sacrifice your life savings and more to secure their well being. I would too. No amount of tears can solve an error caused by lack of adequate and safe staffing. I have sat with people as those tears flow like mountain streams with family and clinicians devastated by the simple lack of prudence in health care planning.

I urge you, the noble men and women to adequately consider what effects are created by adequate staffing or the lack thereof.

Very truly yours:

Gary C. Goins MS, BSN, RN.

Staff Nurse

Adult Critical Care Unit Providence Alaska Medical Center

Emergency Department Alaska Regional Hospital

Recipient Congressional Certificate of Appreciation. United States Congress. 1987

February 11, 2009

Re: House Bill 50 Senate Bill 12

Dear Legislator,

My name is Debbie Thompson, I am a Registered Nurse certified in the Operating Room and Peri-Operative nursing and I am the Executive Director of the Alaska Nurses Association. In this role I act as a spokesperson for not only the public safety at large but just as importantly for the nurses of Alaska.

I would like to express my support in both House Bill 50 and Senate Bill 12. As a long time operating room nurse I can tell you that these bills address a serious public safety issue within the health care industry. Each citizen in the state of Alaska deserves to have a well rested nurse taking care of them. The government has stepped in made requirements for the airplane pilots, truck drivers and train conductors and engineers. Why would anyone put the lives of their loved ones or themselves at risk for potentially fatal medical errors.

Thank you for consideration to this matter.

Debbie Thompson, BSN, RN, CNOR

February 10, 2009

Dear Honorable Senators and Representatives:

I have been a Registered Nurse for the past 30 years. Twenty-nine of those have been spent in the Intensive Care Unit in various hospitals across the US. I have been contributing to the care of Alaskans for the past 15 years. I have shared in some very intense and uncertain times for many families. I know that nurses do not let patients or their families know when staffing is short, or when we are exhausted or hungry. We really try to make people feel secure when they are in our care.

The Institute of Medicine (IOM) report has identified how long hours and fatigue contributes to errors in healthcare. These errors can cost lives, or increase length of stay in the hospital which in turn adds to the already ballooning cost of healthcare.

I urge you to support HB 50 & SB 12. When patient are at their most vulnerable, is not the time they or their families should be concerned at the number of hours the nurse caring for them has worked. Long hours, fewer resources and higher patient acuity drive nurses from staying at the bedside in today's hospitals. Nurses will only last so long, when they go home after 12.5 hours concerned about what they might have missed because they are so exhausted and hungry. The University of Alaska is doing a great job educating tomorrow's nurses. I encourage you to do what you can by passing this legislation that will help to keep the nurses of the future working in hospitals.

Thank you,
Donna Phillips, RN
Girdwood, AK

February 13, 2009

Re: Support for HB50/SB12

Dear State Legislators,

I am a registered nurse of over 14 years now. I am in total favor of supporting HB50 and SB12. It is absolutely imperative that registered nurses and licensed practical nurses be able to provide safe patient care, this is why we became nurses, to care for patients. Patient care will without a doubt, be in jeopardy when nurses are forced against their better judgment to work excessive hours in health care facilities. Any overtime should be done out of personal choice and professional judgment. With mandatory overtime, we are placing the patients, whom have entrusted us to take care of them at one of the most vulnerable times in their life in danger.

Nurses are compassionate, caring individuals. It takes a special person to become a nurse, and then stay one for any length of time. Many nurses do not make it through the first year. That is not due to the fact that they suddenly do not care anymore. It is due to increased workload demands, workplace stresses, long working hours, and a complete lack of respect in general by administrative personnel who run hospitals.

Can you imagine what it is like to have to walk out of one patient's room who is dying of cancer and may be at the end of their life and then be able to go on to the next patient with a smile on our face and deal with a whole new set of circumstances. We are not only caring for that patient we are caring for their family members as well. This routine gets played out several times just in one shift.

Nurses are burning out at a high rate and there is not going to be another nurse just around the corner to replace them. By the year 2020 there will be a nursing shortage of estimated 500,000 nurses. We cannot continue to look the other way. We must make a positive step, not only to make nursing a honored profession to the newcomer, but also retain the experienced knowledgeable nurses we have.

A nurse's bottom line is patient care and safety. Please help support HB50 & SB12, the very life it may save may be your own.

Thank you,

Janet Hilleary RN

February 21, 2009

Re: Support for HB 50 & SB 12

Dear Legislators,

I know how important this bill is for the future of nursing experience. I do 12 hour nights and I know there's no way in the world I'd want to be responsible for patients beyond my shift time. I'm sure our malpractice insurance won't cover that kind of stupidity!

Thanks.

Ginny Weisman
242-9254

Feb. 22, 2009

Re: HB50/SB12

Dear Honorable Legislators,

My name is Barbara Quaid and I have been a registered nurse since 1970. Currently I am employed as a recovery room nurse at a local Anchorage hospital. Because I work in an O.R. setting we must take call. Recently I worked for 21 hrs, and that wasn't the first time. If it is your call night and things run late, or emergency cases are added, we must stay.

It is definitely a safety issue. A nurse at hour 3 of her shift is not the same nurse at hour 16, etc. With hospitals running at full capacity, be it due to a shortage of floor RNs or available beds, we must at times manage patients all night and all day in the recovery room. More times than not these are ICU/CCU patients.

We definitely need legislature governing the amount of hours a nurse is allowed to work, because it is not being safely managed the way it runs now. I testified via teleconference this past summer regarding this issue, and would be most willing to testify again. I hope this will be of assistance in your endeavor to keep nursing at a safe level.

Sincerely,

Barbara M. Quaid, R.N. CPAN.

February 13, 2009

Re: HB50/SB12

Dear Honorable Legislators,

My name is Ginger Spohr and I am an Emergency Room nurse. This is my first time getting involved in the legislative process and I am doing so because HB 50 and SB 12 are important bills for both myself and my co-workers. I strongly want to encourage support for both of these bills.

Right now there is a great opportunity for those in the House and Senate to help us continue the hard work that we do every day and help insure that we do so in a safe way.

My husband recently retired after working 20 years on the slope. He went back to school and earned a degree in nursing. After his first week of work, he told me, "I've never worked so hard in my entire life." Nursing is hard work at any age but with more and more people retiring and entering the field as a "second" profession, we must insure a safe and welcoming environment for them.

In closing, I would also like to ask anyone considering blocking these bills to imagine being a patient of a nurse who has just been told he/she must stay and work late. Imagine your boss telling you that you had to miss a birthday party of child or friend and that it would cost you your job if you didn't stay and work.

Please help keep nursing a respected profession. Most of the nurses I know are proud of what they do, please help us continue take pride in the work we do and help to ensure we are rested and willing to work.

Please support HB 50 and SB 12.

Sincerely,

Ginger Spohr, RN.

February 19, 2009

Re: SB12/HB50

I am a registered nurse at providence hospital. I want to tell you how important it is for nurses to be well rested & alert when caring for sick people. We make critical decisions, often at a moment's notice, that affect the lives of our patients. The giving of medications also is a critical event, considering the risk of making a mistake. Patients depend on us to make the right decisions for them. They have to trust us to do the job safely. That is dangerously hard to do when you are over tired & needing sleep.

Most of us work twelve hour shifts. The thought that employers can insist that we continue to work beyond that is scary. Likewise, working more than 3 days in a row, I feel, puts us at risk to make mistakes. When human lives are at stake, this could be a critical mistake. Only the individual knows how they feel, how tired, how sleepy, etc. nurses need to have the option to say no to mandatory overtime, to agree to that only if they feel fresh enough.

I'm hoping that we can get HB50SB12 passed this session.

Thank you for your help.

Sincerely,

Connie Lynch RN

2/19/09

Re: HB50/SB12

Dear Legislators,

Please support HB50 and SB 12. I believe RN's will provide overtime when we can. For our 36 week, we do what we can, as the population gets sicker. Management is getting more illogical.

Scott Young, RN

258-1861

2/14/09

Re: HB50/SB12

Dear State Legislator,

I am against mandatory overtime in any form. When we are subjected to mandatory overtime it leads too more mistakes in medication administration because we are tired. At one of my jobs; I work a 12 hour shift at a local hospital and find that the longer I am required to stay to finish required paperwork or patient care the more I have problems focusing on the task at hand and thus the more potential for a mistake. At another job that I work 8 hours; if I am mandated to work an extra shift The more I feel unsafe as I work in a psychaitric facility where patient safety and staff safety are imperative. Being tired I have problems with determining when patient's are feeling unsafe or threatened and thus there is more potential for violent and threatening outcomes.

Again I am very against manditory overtime. I just hope with the nursing shortage coming it is not made worse by mandating overtime in unsafe jobs as it will lead to more nurses rethinking this line of career choice thus increasing the nursing shortage.

Thank you for allowing me to air my opinions,

Barbara Popken RN

February 14, 2009

Re: HB50/SB12

Dear Legislatures,

I am an active member of the AaNA organization. I send this message in support of HB 50 and SB 12. Upon review of the last years (2008) activity around these two Bills, I stand behind all of the nurses in support of the passing of these two Bills.

As a nurse, I am in support of protecting the nursing professional at the bedside (and elsewhere as it applies) in being able to conduct a full day's work without the intimidation of mandatory overtime on their shoulders.

Thank you for all the work you do.

Sincerely,

Shirley LaForge, RN, MSN

2/11/09

Re: HB50 and SB12

Dear Honorable Senators and Representatives,

I am not in favor of mandatory overtime for nurses. Any overtime should be the nurse's choice. In addition I am not in favor of a nurse working more than 14 hours in a row. That allows for a 12 hour shift and any follow-up charting, etc. I know too many nurses who cannot recall how they even got home after working too long. Also, though 15 minute breaks are great, what concerns me is someone who doesn't even have time for lunch.

Thank you,

Mary Ann Wilson, RNC

2/12/09

Re: HB50/SB12

Dear Honorable Senators and Representatives,

I support the passage of HB 50 and SB 12. Please work on my behalf as well as my colleagues and patients to see that these bills are passed. Mandatory overtime for nurses has the potential for creating a more severe shortage of nurses in areas already in desperate need of licensed staff. Mandatory overtime and inflexible scheduling has the potential for deterring students from selecting nursing as a career option.

Please seek options that enhance the appeal of nursing as a career option, increase the nurse's ability to provide safe and effective care at the bedside, and decrease the attrition of nursing staff related to excessive work hours and work load. Please vote yes on HB50/SB12.

Thank you,

Janice McGraw, MS, RN, CNRN

February 10, 2009

Re: HB50/SB12

Dear Legislators,

As a Registered Nurse in the State of Alaska, I find it critically important that we have a say in our work scheduling and who dictates our professional practice. As a Registered Nurse, I make it my prime responsibility to be the advocate of patients. Because of this and the importance of our profession, I am supportive of House Bill 50 and Senate Bill 12.

Sincerely,

Joshua Meals, RN, BSN.

2/11/09

Re: HB5/SB 12

To the Honorable Senators and Representatives:

This is a letter of support for HB 50 and SB 12. As a working nurse in the Operating Room at Providence Hospital, I feel it is important for me to share my support for legislation that ends the practice of mandatory overtime for nurses in Alaska. Such practices are unfair to nurses, and unfair to the patients who deserve top-notch care from nurses who are properly rested and satisfied in their work environment. Currently, I am obligated to be available for over 24 hours of mandatory overtime each month.

Sincerely,

Paul Bryner

2/11/09

Re: HB50/SB12

Dear Honorable Legislators,

I am asking for your support on House Bill 50 & Senate Bill 12. I have been a registered nurse for 16 years and have been personally affected by both mandatory overtime and insufficient rest between shifts. We have tried to address these safety concerns with our employer; however, there is no incentive for hospital administrations to change current practice. It becomes financial, and the bottom line is it is cheaper to work a nurse extended hours than it is to provide safe working conditions. I have worked in other states with this type of legislature and it does have a positive impact. Therefore, I ask for your support from a state level. If the employer won't self regulate, then someone needs to for the sake of quality patient care and safe working conditions for the nurses. .

Thanks you for your time.

Wendy Conradi, RN, CNOR

2/11/09

Subject: Support for HB 50 and SB12

I urge house and senate members to support HB 50 and SB 12 to protect the rights of our patients and the welfare of our nurses.

Patricia Peacock, RN, BSN, CURN, CHPN.

RE: HB50/SB12

2/11/09

Dear Legislator,

As an RN of 30+ years, I am writing to support HB 50 and SB 12. I recently returned to bedside nursing after working outside of the hospital for the past 14 years. I find it astounding that the legislature wants to continue to require mandatory overtime for nurses.

After working 3, 12 hr. shifts in one week, I find I need a day to recovery and then have 3 days "off" to enjoy things other than my job, which allow me to have the energy to return to the bedside for 3 more days the next week. While I have worked overtime in the past year, it was done by choice. If overtime is to be required, it will decrease morale in nursing staff, thereby compromising patient care. Perhaps a meat packing plant or other assembly line type job sees the benefits of mandatory overtime. When one is caring for the human spirit and body, it is definitely not in the best interests of the patient to be cared for by a nurse who is working mandatory overtime.

Thank you for your work on our behalf.

Sincerely Yours,
Jeanne Kemp RN, BSN

Date: 2/11/09
Re: HB50/SB12

Dear Legislators,

I have just been informed of the ASHNA's position regarding legislation to block any regulations regarding employer rights to address such issues as nurse and patient safety. It seems to me that this is not in the best interest of any of the parties that participate in direct patient care, much less the person who is being cared for. I seriously doubt that the public knows anything regarding this and would that be known, there would be an abundance of objections from both parties. The only persons who this would benefit would be the people managing the books of these employers and their board of directors. That is, unless it was their family or themselves who was receiving this care. This issue has been going on for too long and as one of those people who work long shifts for the sickest of these patients, it would be akin to whipping a horse who has plowed the fields too long in the day. It just can't be done without consequences. These consequences would have implications for public health and in the long run risk increasing hospital days for the patients who got marginal care from the employees forced to do this work. It is also comparable to asking for volunteers, then picking them anyway, should no one raise their hand. It is one thing for someone to use their judgement in working overtime, but another to cut costs and recruiting people to do this extra work, such as travelers who have no intention to stay in this area. The answer to the higher paid travelers would be make the lower paid employees do this work. It is also like bringing in employees from out of the country, give them lower wages, and make them do a job, whatever that job is. Thankfully, we have the union here to prevent such nonsense, but then the ASHNA position is just as ridiculous. The term "Magnet Hospital" has been tossed around as a buzz word for quite some time now, and it is laughable that forcing employees to do something that not only would affect their life outside of work, but to risk their license as well, would somehow make a difference in obtaining that status. It is words on paper and a status that looks good but really means nothing if employees are not happy. Please know that even though you may not have hundreds of comments regarding this, that it is due to not many people knowing the position of this board. I have been in critical care for close to 30 years and have seen my job get harder, despite the experience I have. This risks everything that health care has to offer, despite breakthroughs in disease prevention and treatment.

Sincerely Yours,

Debbie O'Brien, RN, CCRN
Anchorage, Alaska

2/11/09

Re: HB50/SB12

To the Honorable Senators and Representatives of the Alaska Legislature,

Please join with your counterparts in 12 other states that have passed legislation to prohibit mandatory overtime for nurses. Join our congressional delegation of Senator Murkowski and Congressman Young who co-sponsored the Safe Nursing and Patient Care Act of 2007 which prohibits mandatory overtime except in cases of states of emergency.

Most people would not choose to fly in a plane with a pilot forced to work beyond what they felt was their safety limit in competence for work hours. In fact, it is illegal. How then has it taken so long to pass this legislation that will contribute to patient safety? This is not a matter of employer rights in staffing. If a nurse tells the employer she or he has worked too many hours and is not safe to practice; why on earth would you not believe him/her? Would you risk your life or a loved one's on the nurse's word or their employers?

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Although I no longer work in a hospital myself, I have been a patient in one and may be again. Speaking both as a nurse and a consumer, I urge you to support passage of HB 50 and SB 12. Sincerely,

Lynn Hartz MSN, FNP-BC
3104 Brookside Drive
Anchorage, AK 99517
ph 907-248-4877
fax 907-222-1498

Re: HB50/SB12

2/11/09

Dear Legislators,

As a registered nurse (RN), I heartily support these two pieces of legislation. Patient safety will be jeopardized if health care facilities are given free reign to impose mandatory overtime.

Patient safety is Job 1 for nurses, to borrow a phrase from different industry. An RN who is required to work overtime beyond a twelve-hour day or even an eight-hour day is physically, mentally, and emotionally fatigued. Thus, her judgment is potentially compromised, her physical strength weakened, and her emotional capacity diminished.

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The health care industry, in requiring mandatory overtime, falls in with a crowd that practices human exploitation.

Sincerely, Theresa E. Philbrick, RN



POSITION PAPER

SB 12/HB 50 – "An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

**CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org**

DATE: March 9, 2009

POSITION: Oppose

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. We employ 500 nurses. In January of this year ANMC was recognized for a second time as a Magnet Hospital, a highly prized award given by the American Nursing Association. Only five percent of all U.S. hospitals achieve Magnet Status, and even fewer are designated a second time. ANMC is the first and only Alaska hospital to receive Magnet Status. Magnet hospitals have demonstrated that they meet a set of criteria designed to measure the strength and quality of their nursing, including the ability of its nurses to contribute to patient outcomes, and where nurse job satisfaction, low turnover rates and appropriate grievance resolution are part of the standard.

We value our nurses, but we do not support SB 12 or HB 50, bills that seek to legislate work schedules and tie the hands of managers who are constantly juggling the demands of patient care against workforce availability and rising costs/chronic underfunding in the tribal health care system. We have three primary concerns about the bill as currently written:

- 1) *It would have a disproportionate and detrimental impact on patients in rural Alaska*
- 2) *It conflicts with Alaska's longstanding policy of supporting access to health care through allowing health care facilities an appropriate degree of flexibility in scheduling direct health care providers.*
- 3) *It creates the inaccurate impression that it applies to federal and tribal facilities and programs that comprise the Alaska Tribal Health System*

1) Disproportionate and Detrimental Impact on Patients in Rural Alaska

The bill provides no new resources and no new options. In rural Alaska recruiting and retaining qualified nurses is not merely a challenge, as it is for all of Alaska and much of the United States; it is a constant struggle. Vacancy rates, recruitment costs and staff turn-over continually plague these providers, especially tribal health providers.

This bill restricts the ability of hospital managers to work with their nursing staff to craft options in a health system that is already stretched to its limits in both staffing and financial resources. There is a real risk that the bill would lower nurse/patient ratios and decrease the quality of care patients receive by tying the hands of providers to balance patient needs with available workforce, including nurses. In rural Alaska, when nurses are not available, then patients must be diverted to another facility. Since there are no other options in rural Alaska, patients typically get diverted to the Alaska Native Medical Center. Because ANMC, as a statewide facility, serves all regions, then we experience a compounding effect at ANMC, a facility that is already too small to meet patient care needs. When ANMC is at capacity, we too are forced to divert patients to other facilities in Anchorage. This is an every day challenge, but is especially problematic during public health outbreaks. Diverting patients disrupts the continuity of care for our patients and imposes an additional financial burden on our already under-funded health system.

The bill also sets forth a reporting requirement to the State Department of Labor. Because tribal health facilities are not licensed by the state, as explained below, we believe we would not be subject to the reporting requirements. To the extent a tribal provider did comply, it would create a new, costly system of collecting data and preparing reports. ANMC employs nurses who are licensed by the state and nurses who are part of the Commissioned Corp under the federal Public Health Service, further complicating any perception of what would be required under a state law.

2) Conflict with Longstanding State Policy of Supporting Access to Health Care

The Alaska Legislature has recognized the necessity of promoting access to health care through appropriate limitations to wage and hour requirements since at least 1962 when it enacted the "hospital employee" exemption.¹ From 1962 to 1983, all employees of *non-profit hospitals* were exempt from that law. While the exemption was narrowed slightly in 1983 to cover only those employees who provide "medical services," the Legislature also expanded the exemption to the employees of *all hospitals*, not just those employed by non-profits.² This change addresses the "interest in keeping medical facilities open and providing more flexible schedules for employees whose extended hours of labor were needed to maintain the hospital in operation at all time" and more generally the need to "enhanc[e] access to health care" in Alaska.³

¹ AS 12.10.060 (1962); *Hutka v. Sisters of Providence*, 102 P.3d 947, 952 (Alaska 2004).

² *Hutka*, 102 P.3d at 952-53.

³ *Hutka*, 102 P.3d at 953.

3) Applicability to Federal and Tribal Health Providers

Providing health care services to Alaska Natives and American Indians is a federal function that contributes to the fulfillment of the federal government's trust responsibility to Alaska Natives and their Tribes.⁴ A federal facility performing a federal function is not subject to state regulation, even if the function is carried out by another entity, unless Congress clearly authorizes such regulation.⁵ Congress has not authorized state regulation of federal health facilities serving Indian tribes and their members or of tribal facilities that fulfill this federal function pursuant to the Indian Self-Determination and Education Assistance Act.

Rather, Congress has taken pains to promote self-determination and self-governance by ensuring that Tribes and tribal organizations have sufficient flexibility to address the unique needs of Native Americans and the extraordinary challenges of providing quality, culturally appropriate health care with very limited resources, often in extremely remote locations. This is because one of the purposes of the ISDEAA is to provide

a meaningful Indian self-determination policy which will permit the orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.⁶

For similar reasons, Congress has provided an explicit exemption for Tribes and tribal organizations from the operation of most federal employment law, including Title VII of the Civil Rights Act of 1964, the American with Disabilities Act, and the Davis-Bacon prevailing wage rate requirements.⁷ Courts have also recognized tribal exemptions with respect to other federal laws, like the Age Discrimination in Employment Act (ADEA), that do not specifically address their applicability to Tribes and tribal organizations.⁸ One federal appellate court ruled that other federal laws and interests must give way to ISDEAA's overriding objectives when it

⁴See, e.g., 25 USC § 1616f; S. Rep. No. 102-392 at 2 (1992), as reprinted in 1992 USCCAN 3943, 3944. See, also, note 2, *supra*.

⁵*Goodyear Atomic Corporation v. Miller*, 486 U.S. 174, 181 (1988).

⁶25 USC § 450a(b).

⁷42 USC § 2000e(b)(1); 42 USC § 12111(5)(B)(i); 25 USC § 450e(a). See also, *Pink v. Modoc Indian Health Project*, 157 F.3d 1185, 1188-89 (9th Cir. 1998) (non-profit corporation created by two tribes qualified as an "Indian tribe" under Title VII where corporation was formed to deliver health care services under an ISDEAA agreement, even though services were provided outside the boundaries of a reservation), *Setchell v. Little Six, Inc.*, No. C4-95-2208, 1996 WL 162560, at *2 (Minn.App. April 9, 1996), *cert. den.* 521 U.S. 1124 (1997).

⁸29 USC § 626(d). E.g., *EEOC v. Karuk Tribe Housing Authority*, 260 F.3d 1071, 1081 (9th Cir. 2001) (ADEA inapplicable to tribal housing authority that "occupies a role quintessentially related to self-governance"); *Taylor v. Alabama Intertribal Council*, 261 F.3d 1032 (11th Cir. 2001) (employee's race discrimination claim concerned tribal self-governance and intramural Indian matters). See also *Penobscot Nation v. Fellencer*, 164 F.3d 706 (1st Cir. 1999) (employment of a non-Native in federally funded public health nurse position is an "internal tribal matter" and not subject to state regulation).

addressed the potential applicability of the National Labor Relations Act to the Yukon-Kuskokwim Health Corporation.⁹

Congress and the federal courts have thus essentially deemed the Fair Labor Standards Act (FLSA) to be sufficient protection for tribal employees.¹⁰ Because of the unique nature of nursing care, however, some nurses are exempt from FLSA's wage and hour requirements while others are protected through special provisions that specifically accommodate the need for scheduling flexibility. The Act's implementing regulations were recently revised with the benefit of comprehensive comments from nursing associations, patient advocacy groups, and health care facilities and they continue to recognize the need and appropriateness of allowing for this degree of flexibility. Alaska's own wage and hour laws and regulations are quite similar to the federal scheme in this respect.

At the same time, the Indian Health Care Improvement Act (IHCIA) and the Indian Self-Determination and Education Assistance Act (ISDEAA) provide a comprehensive framework for regulating tribal health care. Their broad language, together with the exemption from most federal employment law, provide a clear indication that Congress did not intend to allow federal agencies to impose their own rules on Tribes and tribal organizations, much less subject them to potentially overlapping and less flexible requirements enacted by individual states. Otherwise state law would "obstruct[] the execution of the purpose of the federal [law]."¹¹ The Supremacy Clause and the federal preemption doctrine prohibit this, especially in areas like Indian health care that has been a federal responsibility for centuries.¹²

"The Alaska courts have noted that the provision of Indian health care services is an area that is "comprehensively and pervasively regulated by the federal government which is manifested in both the ISDEAA and the IHCIA."¹³ Once the federal government has thus occupied the field, there is no allowance for state regulations, even if it is consistent with statutory purposes.¹⁴

⁹*YKHC v. NLRB*, 234 F.3d 714, 718 (D.C. Cir. 2000) ("NLRA must make in order to accommodate federal Indian law, as reflected in [ISDEAA]"). The Board concluded that it was inappropriate to exercise jurisdiction over YKHC in light of its role in fulfilling federal government's trust responsibility to provide free health care to Alaska Natives. See also 29 USC § 151, *et seq.*; *YKHC and International Brotherhood of Teamsters, Local 959, AFL-CIO, CLC*, 341 NLRB No. 139, May 28, 2004 (declining to exert jurisdiction over off-reservation tribal health organization fulfilling federal trust responsibility to provide free health care to Alaska Natives, even though organization employs many non-Natives and provides health care services to a small number of non-Natives).

¹⁰ 29 USC § 201, *et seq.*

¹¹*The Alaska Dental Society, et. al. v. State of Alaska, et. al.*, 3AN-0604797 CI, 12 (June 27, 2006), quoting *Catalina Yachts v. Pierce*, 105 P.3d 125, 128 (Alaska 2005).

¹² *Alaska Dental Society* at 15, citing *Wachovia Bank, N.A. v. Burke*, 414 F.3d 305, 313 (2d Cir. 2005) (no presumption against federal preemption in fields substantially occupied by federal authority for extended time); *United States v. Locke*, 529 US 89, 108 (2000) (no presumption against preemption is triggered when significant history of a federal presence.).

¹³ *Alaska Dental Society* at 15, citing *Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, 75 P.3d 1043, 1049 (Alaska 2003). See also, *id.* at 1048 (majority setting aside issues of whether tribal health clinic is "subject to comprehensive and pervasive federal oversight.")

¹⁴E.g., *National Audubon Society v. Davis*, 307 F.2d 835, 851 (9th Cir. 2002).

In addition to this existing federal law, CMS quality standards and Joint Commission standards impose high quality standards on federal and tribal facilities that participate in the Medicare and Medicaid programs. In Alaska, this includes all of the major IHS and tribal health facilities.

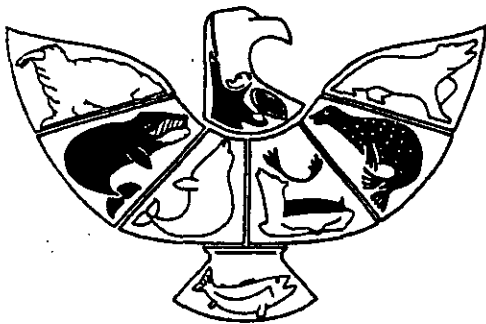
Together, these federal laws address the same concerns intended to be addressed by SB12/HB50. However, they do so in a way that allows facilities more flexibility. While they impose certain performance and quality standards, they do not dictate the means for accomplishing them by imposing rigid requirements that may or may not lead to the same level of performance or quality (or, in the case of rural Alaska, undermine the very goals that the bill sponsor is trying to promote).

Conclusion

We understand that the bill sponsors and supporters are trying to protect nurses from being overworked and patients from accidental errors that may occur as a result. However, we don't believe legislating hours is the right solution. ANTHC and our partner tribal health facilities work very hard to recruit and retain quality nurses. We place high value on the nurses who work for us, and are actively involved in programs like the University of Alaska's Rural Nursing Program. We have been innovative in crafting solutions where physician and nursing services have been non-existent—principal among them, the Community Health Aide Program.

We also value the partnerships we have with many of our non-tribal hospitals/health system partners. We understand the value of flexibility in workforce negotiations. Legislation, of course, takes discussion regarding choices off the table. We in the tribal health system have our own history of suffering unintended consequences from legislation that started with the best of intentions. Today, through our compact with the Indian Health Service, we engage each year in a very formal negotiation, where challenges for everyone involved are brought to the table and worked through to the point of consensus. We support the request of our partners that this legislation be held and to let the process of labor negotiations to proceed.

Thank you for your careful consideration of these issues. We would be happy to provide any further information upon request.



Alaska Native Health Board

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Phone: (907) 562-6006
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March 6, 2009

Representative Peggy Wilson
State Capital Building, Room 406
Juneau, Alaska 99801-1182

Dear Representative Wilson,

We write to express our deep reservations over HB 50, limiting mandatory nurse overtime.

The Alaska Native Health Board appreciates and values the services nurses provide to patients in Alaska, especially our Alaska Native patients, whom we consider to be our customer-owners.

It is the experience of Tribal health providers that nurses are highly dedicated, caring providers who will give their last ounce of skill to care for their patients. Tribal health providers expend a great deal of effort and expense to recruit and retain good nurses to provide care and cover all necessary shifts. Providing adequate and safe nurse staffing is an important part of Tribal health providers' overall responsibility to provide high-quality care to our patients. It is out of this responsibility to care for our patients that we express our concerns over HB 50, as follows:

HB 50 will hurt patient care, especially in rural Alaska

In healthcare, the guiding principle is "do no harm." However, with HB 50, in many remote Tribal health locations, all it would take to leave a shift uncovered would be for one or two nurses to decide, for any reason or no reason at all, that they don't want to work overtime.

The rural Tribal health provider would in many cases have no choice but to simply not cover the shift and put patients at risk, because rural Tribal health providers do not have the urban luxuries of (1) calling in other off-duty nurses, (2) getting temporary "agency" nurses to cover shifts on short notice or (3) re-directing patients to other nearby facilities.

In practice, HB 50 would make it impossible for Tribal health providers to make sure all shifts were covered, particularly in the remote rural parts of the State. Perhaps this is why almost no rural States have adopted legislation similar to HB 50.

HB 50 is an unfunded mandate that will unnecessarily drive up costs

Many Alaska Tribal health providers are having a tough time financially due to sky-high fuel and other costs commonly associated with running a facility in rural Alaska. They have had no choice in some cases but to lay off healthcare workers and reduce services.

Under HB 50, even in a situation where a Tribal health provider might be able to cover a shift when one or more nurses were to choose not to work overtime, the Tribal health provider would likely only be able to do so at GREAT COST, e.g., (1) over-hiring extra regular-shift nurses ahead of time (assuming a sufficient labor pool) and hoping one of the new hires is willing to pull non-scheduled shifts; (2) flying in temporary "agency" nurses from an urban area at the last minute (expensive), or (3) transferring / referring patients to an urban provider (adding an additional expensive travel cost to providers and to the Medicaid program).

Laws such as HB 50 are intended to solve urban problems not applicable in Alaska

Legislation such as HB 50 has been adopted in only 15 States, nearly all urban, out of concern that hospitals might be (1) under-hiring and then abusing mandatory overtime in order to control payroll/benefits costs, or (2) abusing mandatory overtime rules as a collective bargaining tactic.

There is no evidence that these conditions exist in Alaska. While there are well-documented chronic challenges in nurse staffing, particularly among Tribal health providers, these staffing challenges are no different than the staffing challenges we experience with all the healthcare professional categories. And while we cannot speak for others, we can say unequivocally that Alaska Tribal health providers are not purposely understaffing as an abusive labor practice. The reality is that to the degree we have nurse staffing challenges, it is because of the tight national nurse labor market, compounded by the never-ending challenge of figuring out how to get good nurses, doctors, technicians, administrators, etc. to live and work in remote locations in Alaska.

HB 50's proponents agree that *"there are few official overtime complaints by nurses..."*, and that there are *"low numbers of complaints and benign exit interviews..."*

We acknowledge that nursing is a tough profession. The work itself is challenging enough, in addition to the difficult shift scheduling that of necessity must put patients' needs first. But those challenges come with the territory in healthcare: Physicians, administrators, technicians, clerks, etc. also must adjust the scheduling of their work to meet the needs of the patients.

HB 50 is unnecessary: mandatory nurse overtime issues can be addressed by other means

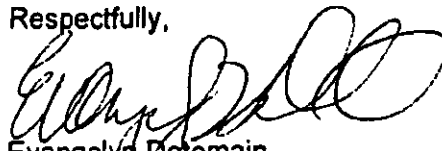
Because of the well-documented nurse shortage in Alaska, there is a very tight labor market for nurses. Nurses have significant leverage in negotiating the terms and conditions of their employment. Hours and shifts to be worked, shift-swapping flexibility, on-call requirements and how to handle anticipated overtime are all commonly agreed to in employment agreements.

In reality, the tight labor market for nurses in Alaska, combined with well-established avenues and procedures for nurses to negotiate the terms and conditions of employment, give nurses more than sufficient leverage to address any concerns they might have with regard to mandatory overtime, or for that matter, any other terms or conditions of employment.

The result, acknowledged by HB 50's proponents, is that *"there are few official overtime complaints by nurses..."*, and *"low numbers of complaints and benign exit interviews..."*

Representative Wilson, we thank you for efforts on behalf of Alaska Tribal health providers. We appreciate this opportunity to express our concerns with HB 50, and we look forward to working with you in a cooperative manner on the many important healthcare issues pending this session.

Respectfully,



Evangelyn Dotomain
President/CEO



Alaska State Hospital and Nursing Home Association

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TESTIMONY ON HOUSE BILL 50

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

ASHNHA's membership does not believe the limitations proposed in House Bill 50 are needed to assure continued delivery of excellent patient care throughout the State.

ASHNHA's members have a long-standing commitment to respect the individual importance of each nurse in our health care delivery mission, and to treat each nurse fairly in the work place. This obligation to our nursing staff must be balanced with providing the best possible care to each patient.

ASHNHA believes our members are responsibly negotiating work scheduling policies with their nursing staff through local work agreements that meet the unique needs in each community. Solutions in Anchorage to work scheduling challenges for Petersburg will be different than what will meet the needs of management and nursing staff in Anchorage. A standard statewide mandate on how work scheduling must be done as proposed in House Bill 50 is not a realistic approach to solving these work scheduling challenges around the state.

From the consumers' perspective there are tools for determining objectively how well Alaska hospitals and nursing homes are meeting their patient care goals while not overburdening the nursing staff. Two of these resources include:

1. *Hospital Compare* data collected by the U.S. Department of Health & Human Services. This data captures critical information on care provided as well as patient feedback on their experience in the hospital setting. Specifically with respect to the patient's satisfaction with their hospital experience, Alaska's hospitals compare quite favorably against national statistics in this area. Some examples from the U.S. DHSS data include:
 - How often did patients feel they received help quickly?
 - a. U.S. average was 88% reporting 'always' or 'usually'
 - b. Alaska average was 90% reporting 'always' or 'usually'
 - How often did nurses communicate well to the patients?
 - a. U.S. average was 94% reporting 'always' or 'usually'
 - b. Alaska average was 95% reporting 'always' or 'usually'
 - How did patients rate their hospital experience overall?
 - a. U.S. average was 89% reporting 7 or higher on scale of 10
 - b. Alaska average was 89% reporting 7 or higher on scale of 10

2. **Numerous federal, state and private resources** are available that examine medical care delivery processes, policies, outcomes, patient complaints, and adequacy of staffing among others. None of these organizations have pointed to any patient care issues related to requiring nurses to work beyond agreed upon shifts.

In addition to these consumer resources, *ASHNHA* has tracked mandatory overtime usage for four years in Alaska through our own survey. The latest data is shown in the attached table. This survey has allowed *ASHNHA* to gain a better understanding of the frequency with which 'mandatory' overtime is used by our member facilities. 'Mandatory' in this context is overtime that is not willingly worked by a nurse and does not include 'on-call' overtime hours.

While there certainly are times when a nurse is required to stay beyond their shift because of an unexpected staffing problem, this happens very seldom and management's policy is to find nursing staff quickly to fill these unanticipated staffing gaps. *ASHNHA's* latest nurse overtime survey comparing 2007 and 2008 mandatory overtime usage demonstrates our members continuing commitment to minimize use of mandatory overtime. In fact only 4 facilities reported mandatory overtime usage in 2008 and the majority of the overtime hours reported were by the state operated Alaska Psychiatric Institute.

How do Alaska facilities keep use of mandatory overtime to a minimum? Alaska facilities have developed strategies to avoid situations that would require the use of mandatory overtime. These strategies begin with a comprehensive analysis of patient activity, types of procedures and other information to determine the number of nursing staff required by time of year, time of day and area of hospital care. Management uses this information to insure adequate staff is available to meet patient care needs 24/7, 365 days a year.

Based on this analysis, management and nursing staff agree to on-call policies to meet the needs of patients during low demand periods for very specialized procedures. These on-call expectations are known by nursing staff when they choose these specialized areas to work in. In small, rural facilities there may be general on-call expectations in order to be sure nursing staff is available 24/7 given the low volume of patient admissions that these facilities experience and the greater difficulty these facilities have hiring experience nursing staff.

In addition, hospitals and nursing homes have pre-established arrangements with temporary nurse staffing agencies to bring in temporary nursing staff to fill unexpected gaps in staffing. As you will note on the attached table displaying temporary nursing hours purchased by Alaska facilities, nearly ¼ million hours of temporary nursing time was used by Alaska facilities to avoid imposing mandatory overtime on their nursing staff.

A key contributor to Alaska's facilities' need to use temporary staffing hours is the ongoing challenge in hiring adequate nursing staff for the many different care settings that a facility must provide. *ASHNHA* members have been very proactive to address this issue over the last five years including:

1. Financially contributing to the University of Alaska expansion of their nursing program from 100 nurses each year to over 200 nurses each year.
2. Creating clinical experiences for student nurses and recently graduated nurses to gain hands-on nursing experience required to complete their education, or to achieve the patient care experiences necessary to become employed in a hospital setting.
3. Providing distance learning opportunities so local residents can take nursing courses in their own community with minimal need to spend large amounts of time out of town to achieve their clinical experiences.
4. Purchasing tens of thousands of hours of temporary nursing hours to fill staffing gaps to minimize use of mandatory overtime.

Even with these initiatives approximately 1/3rd of the facilities reporting on this year's survey believe the nursing shortage situation has worsened. The good news is that with all the additional attention provided by the University of Alaska to graduate more nurses combined with Alaska facilities expanded programs to provide hands-on training experiences for them, 2/3rd of the facilities reported that the nursing shortage was at least the same if not better. This is a slight improvement over years past.

RECAP OF ASHNHA's CONCERNS with HB 50:

- *ASHNHA's* data shows Alaska's hospitals and nursing homes are not routinely relying on mandatory overtime to fill staffing gaps. On the contrary *ASHNHA's* data shows that use of mandatory overtime is a rare occurrence with all but 4 facilities reporting **ZERO** use of mandatory overtime in 2008 (see attached chart).
- *ASHNHA's* data continues to show that no employee grievances on inappropriate use of mandatory overtime were reported for 2007 or 2008 by facilities.
- *ASHNHA* believes that establishing work hours and scheduling are appropriately a local employer responsibility to negotiate with its employees. This is being done in every community in a responsible manner with equal concern to employee and patient concerns. Work force challenges vary significantly from one community to the next making a single approach to addressing this challenge unworkable. A number of facilities are either in negotiations with nursing staff or will begin those negotiations shortly. These negotiations should be given an opportunity to address any concerns from nursing staff.
- The ongoing monitoring systems operated by federal, state or independent private agencies that review patient care show Alaska health care quality is excellent. None of these organizations has identified use of mandatory overtime as a problem related to delivery of excellent patient care in Alaska.
- *ASHNHA's* members have worked diligently to reduce the nursing shortage problem in Alaska by contributing substantial funding over the last four years to help support an expanded nursing program at the University of Alaska. This program is now graduating 200 nurses annually compared to 100 nurses before the program's expansion.

- House Bill 50 would impose a new reporting burden for Alaska facilities. These reports would have to be filed semi-annually and must contain detailed work hour information for each staff nurse employed by the facility as well as each contract nurse.

Contact for more information: Rod Betit, President/CEO ASHNHA rbetit@ashnha.com

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.

ASHNHA 2007 and 2008 NURSE OVERTIME SURVEY RESULTS -
(March 11, 2009)

Facility	Nurses in Union?	Shortage Better, Worse, Same	Length of Shift (Hrs)	Nurse Vacancy Rates as %		Mandatory OT Usage- Total Hrs		On-call Policy		Temp Nursing Hours Needed to Fill Vacancy		# of OT grievances filed 2008
				2007	2008	2007	2008	Require	# times /month	2007	2008	
Alaska Regional Hospital	Yes	Same	12	19%	15%	0	0	OR only	3x	44,349	30,542	0
Alaska Native Medical Center	No	Data Not Available at This Time										
Alaska Pioneer Homes (All Six Facilities)	Yes	Same	7.5,10,15	n/a	n/a	0	0	n/a	n/a	0	0	0
Alaska Psychiatric Institute	Yes	Same	8,10,12	19%	14%	468.5	285.5	No	n/a	n/a	n/a	0
Bartlett Regional Hospital	Yes	Worse	12	14%	5%	108	104	OR only	56hr/mo	19625	18518	0
Central Peninsula General Hospital	Yes	Same	8,12	10%	2%	37	36	Surgery	7x	1230	0	0
Cordova Community Medical Center ✓	No	Same	12	10%	11%	0	0	Certain Units	3x	2673	2452	0
Denali Center Nursing Home	No	Better	8,10,12	6%	5%	0	0	No	n/a	1860	1760	0
Fairbanks Memorial Hospital	No	Same	8,10,12	10%	10%	0	0	Certain Units	Varies by Unit	n/a	47000	0
Heritage Place Nursing Home	No	Same	8,10,12	10%	10%	0	0	No	n/a	0	0	0
Kanakanak General Hospital ✓	No	Data Not Available at This Time										
Ketchikan General Hospital ✓	Yes	Better	8,9,10,12	7%	8%	0	0	Certain Units	1 to 10x	11,700	15,000	0
Manilaq Health Center ✓	No	Data Not Available at This Time										
Mt. Edgecumbe SEARHC Hospital	No	Better	8,9,10,12	25%	12%	0	100+	Certain Units	1 to 10x	27,960	15,421	0
North Star Behavioral Health System	No	Same	8,16	10%	10%	0	0	No	n/a	0	0	0
Norton Sound Regional Hospital ✓	No	Data Not Available at This Time										
Petersburg Medical Center ✓	No	Same	12	13%	12%	0	0	Yes	8	3000	2650	0
Providence Alaska Medical Center	Yes	Worse	8,10,12	8%	12%	0	0	Certain Units	n/a	102,438	85,103	0
Providence Extended Care Center	No	Worse	8,10,12	9%	13%	0	0	No	n/a	188	0	0
Providence Kodiak Island Medical Center ✓	Yes	Worse	8,10,12	8%	16%	0	0	Certain Units	n/a	2192	0	0
Providence Seward Medical & Care Center ✓	No	Worse	8,10,12	11%	4%	0	0	No	n/a	2318	905	0
Providence Valdez Medical Center ✓	No	Worse	8,10,12	36%	22%	0	0	No	n/a	2193	4853	0
Sitka Community Hospital ✓	No	Better	8,12	21%	6%	0	0	No	n/a	5100	2748	0
South Peninsula Hospital ✓	Yes	Same	8,10,12	3%	8%	0	0	Certain Units	4-13x	840	4920	0
Wildflower Court Nursing Home	No	Same	8,10,12	0%	0%	0	0	Yes	1	0	1000	0
Wrangell Medical Center ✓	No	Worse	8,12	0%	10%	0	0	Yes	4hr - 14X	0	500	0
Yukon Kuskokwim Regional Hospital	No	Same	10,12	n/a	n/a	0	0	Certain Units	n/a	n/a	12,600	0
TOTAL	9Y 18N	12S7W4B		12.0%	9.0%	613.5	425.5			227,666	245,972	0



House Bill No. 50: "Safe Nursing & Patient Care Act"

What Does *HB 50* Do?

- **Protects patients and nurses in a health care facility by limiting forced overtime unless needed for an emergency.** A health care facility cannot force a nurse to work beyond certain prescribed periods of time, or to accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient safety or employee safety.
- **Nurses cannot work more than 14 consecutive hours without 10 hours of rest, or be forced to work more than 80 hours in a 14-day period. Nurses can volunteer to work additional shifts beyond this limit, so long as the nurse does not work more than 14 consecutive hours without 10 hours of rest.**
- **Exceptions are allowed for unforeseen emergencies, school nurses, medivac flights, and certain on-call situations.**

Why is *HB 50* Needed?

- **Purpose of bill is to promote patient safety and better working conditions for nurses.**
- **Nurses in Alaska are working an excessive amount of overtime without adequate rest.** Nurses often work well beyond 12 consecutive hours, or come back within 2-4 hours of completing a 12-hour shift. In other cases, nurses are working several 12-hour shifts over consecutive days.
- **In most cases, this is forced or mandated through a practice called "mandatory call", which the hospitals freely admit is used.** In some cases, this is accomplished by pressure tactics designed to get nurses to "volunteer" for overtime hours. Suggestions of patient abandonment or assertions that nurses will be letting down co-workers are not uncommon.
- ***HB 50* will help with nurse recruitment and retention by prohibiting excessive amounts of overtime.** The nurse workforce is aging – a ban on excessive overtime will keep these nurses working longer.
- **A recent phone survey by AANA documents that not all of the new UA nursing school graduates are being hired. The bill will not exacerbate the so-called shortage – there are additional graduates available to fill positions.**
- **Data suggests many hospitals are using overtime as a staffing tool.** Hospitals are not hiring all available graduates and maintain vacancy rates of between 7% to 25%. It appears that many hospitals are trying to avoid hiring Full-Time Equivalent (FTE) employees.
- **83% of the Alaska RN workforce is over 40 years of age and 53% is over the age of 50. We need to conserve the workforce we have, and at the same time not scare away the 17% of the workforce that is under age 40.** People with young families are not going to stay in the profession if they are constantly being forced to work.



House Bill No. 50: "Safe Nursing & Patient Care Act"

Facility October 1st - March 31, 2008	Facility Visited	Nurses Interviewed	Staff Nurses Reporting mandatory Overtime	Mandatory On-Call Required	Number of Nurses Interviewed	Practice Issues if Abandoning Patients
Alaska Regional Hospital	Yes	Yes	100%	Yes	25	Yes
Alaska Psychiatric Institute	No	Yes	50%	Yes	10	Yes
Bartlett Regional Hospital	Yes	Yes	100%	Yes	30	Yes
Central Peninsula Hospital	Yes	Yes	75%	Yes	60	Yes
Fairbanks Memorial Hospital	Yes	Yes	100%	Yes	10	Yes
Heritage Place Nursing Home	Yes	Yes	100%	Yes	14	Yes
Providence Alaska Medical Center	Yes	Yes	100%	Yes	150	Yes
Providence Kodiak Island Medical Center						
Providence Seward Medical Center	Yes	Yes	100%	Yes	2	Yes
Providence Valdez Medical Center	Yes	Yes	100%	Yes	5	Yes
Sitka Community Hospital						
South Peninsula Hospital	Yes	Yes	50%	Yes	30	Yes
Wrangell Medical Center	No	Yes	100%	Yes	2	Yes

This data is based on face to face meetings conducted by Tom Renkes prior Executive Director of AaNA, and confirmed over the past months by current Executive Director Debbie Thompson.



Dangers of Mandatory Overtime: **FATIGUE and ERRORS**

Support House Bill 50

Referred to as the Alaska Safe Nursing and Patient
Care Act



Danger: Might As Well Of Had a Drink!

The long hours worked by some nurses pose some of the most serious threats to patient safety. Prolonged periods of wakefulness can produce effects that are similar to the effects produced by alcohol intoxication. This may include decreases in reaction time and the speed of mental processing.



Danger – Close to Intoxication

Periods of wakefulness in excess of 16 hours can produce performance decrements equivalent to a blood alcohol concentration (BAC) level of .05 percent. Alcohol intoxication is defined as .08 to .10 varying among the individual states. Do you want an exhausted nurse taking care of you or your family members?



Danger – Patient Safety at Risk

The impact of hours worked, duration of work, and overtime in this study were shown to have a statistically significant impact on patient safety as well as nurse satisfaction and retention in the profession.



Danger –
likely to make at least one error

“The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more....” and “working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.”



Link Found

The authors of this study conclude that these findings imply a link between poor working conditions (long hours and overtime, mandatory or otherwise) and patient safety. In response to this and other admonitions concerning the elimination of mandatory overtime for nurses, almost half of the states in the nation have either enacted or introduced legislation concerning this issue.



- The sources for the previous slides are a 2002 Report from the Michigan Nurses Association and from an article by the Institute of Medicine written in 2004, with updates from other sources.



Danger — PATIENT SAFETY AT RISK!

Threats to patient safety that are likely to result from extensive nursing overtime include the following:

- **Nurses being less alert to changes in patients' condition**
- **Nurses having slower reactions**
- **Medication errors – adverse drug events**
- **Increase in nosocomial infections**
- **Increase in decubiti**



Institute of Medicine Report

The Institute of Medicine estimates that approximately 100,000 hospital deaths can be attributed to medical errors each year. Mandatory overtime is a serious contributing factor to medical errors. The final recommendation of the IOM is that all overtime, voluntary and mandatory/involuntary done by nurses should be curtailed.



Not A “Bargaining Issue”!

This is a Public Safety Issue

The Alaska public has a right to expect when they walk into a healthcare facility, that the nurse taking care of them is properly rested and alert.

(And that their RN hasn't been working 16 hours that day already.)



Not A “Bargaining Issue”! This is a Public Safety Issue

- At registration, a member of the public should not have to request a copy of the most recent Collective Bargaining Agreement to see how successful their nursing staff has been in negotiating reasonable working conditions.
- Not all nurses are represented by a union. What do we do for these nurses and their patients?



Washington State Passes Law in 2002

Anne Piazza, lobbyist for WSNA testified before Representative Peggy Wilson's special House HESS committee in January 2006:

“The State of Washington passed a law to prohibit mandatory overtime for nurses with the cooperation of the WSNA, other nursing unions, and the Washington Hospital Association.”



Washington State

Mandatory overtime puts patients, nurses and the profession at risk. Many health care facilities have turned to the use of mandatory overtime as a common practice to fill longstanding staffing and scheduling problems.

Shifting the entire burden to employees when there is a labor shortage is not the answer to attracting qualified persons to the profession.



Washington State

One of the reasons that the nursing shortage as it exists today is because qualified nurses are not working in the field or leaving the profession because they can no longer work the long hours or safely take care of their patients. Forced overtime is adding to this shortage.



Massachusetts Study

Research from the University of Massachusetts shows a strong link between working overtime and sustaining a work-related injury. This was found to be true for all occupations... working longer hours (12 hours a day or more) was associated with a 37 percent increase in risk.

(Chantal Britt, Bloomberg, "Overtime, Long Hours Increase Illness, Injury Risk, Study Shows," August 22, 2005.)



States Which Ban or Limit Forced Overtime

California

Connecticut

Illinois

Maine

Maryland

Minnesota

Missouri

New Hampshire

New Jersey

New York

Pennsylvania

Oregon

Texas

Washington

West Virginia



Additional States Lining Up

There is legislation banning the use of mandatory overtime pending in the following states:

Alaska

Florida

Georgia

Hawaii

Iowa

Michigan

Nevada

Ohio

Rhode Island

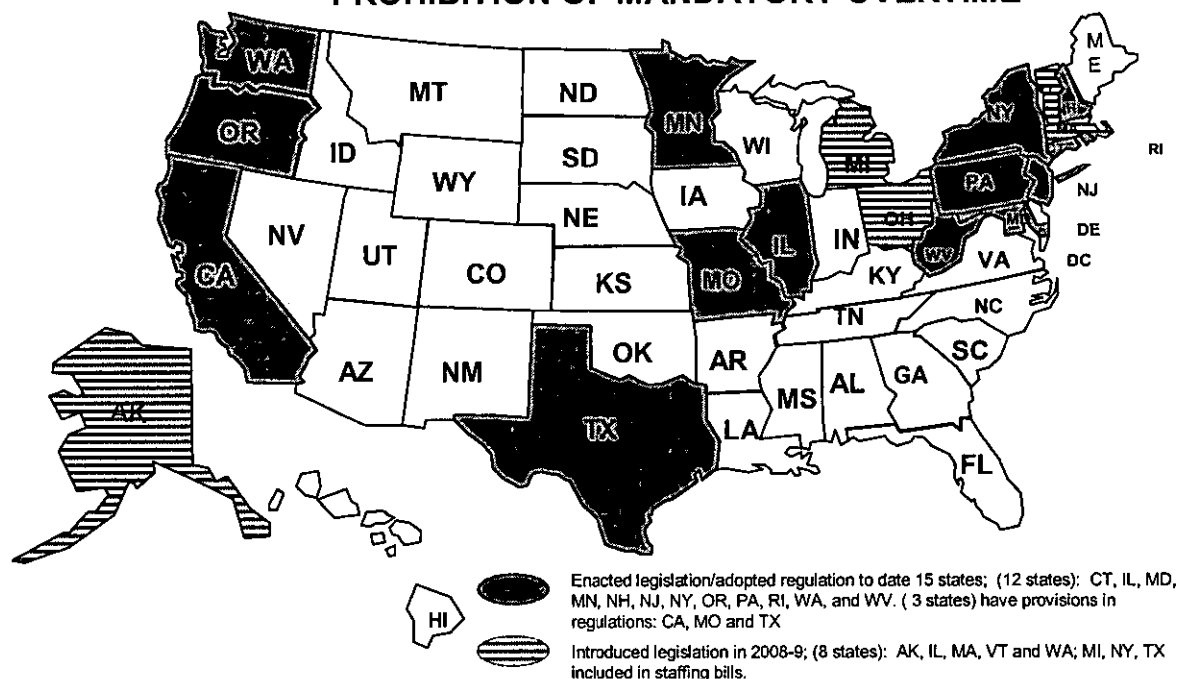
Tennessee

Vermont

States that have passed a Mandatory Overtime Bill & States with Legislation Pending.

The American Nurses Association's Nationwide State Legislative Agenda

PROHIBITION OF MANDATORY OVERTIME





Support Alaska House Bill 50

Your nurse will always be there for you in time of an unforeseen emergency situation, disease outbreak, natural or man-made disaster.

Your nurse will be able to voluntarily work overtime so long as the work is consistent with professional standards of safe patient care and does not exceed 14 consecutive hours.



Questions for you as Law Makers

- The Federal Government has passed laws to limit the number of hours that pilots can safely fly, truckers can safely drive, construction workers and engineers can drive a train and a ship. IOM has recommended the number of consecutive hours that medical residents and interns can safely work - all for public safety. Why would anyone not want to do the same for nurses when they care people who are at their most vulnerable?
- Where is the law that says as a nurse you lose your right to basic human rights? Time off, time to rest, to eat and to have time off for family?



Support Alaska House Bill 50

But with HB 50, a nurse will be able to say, “I am tired and do not think that I can practice quality, safe patient care at this time.”

Knowing his or her own limits, the nurse can refuse to be assigned the forced overtime in the first place. Our nurse would now be able to do this without fear of reprisal, retribution, or loss of job.



Questions for you as Law Makers

•Do you think that nurses should have the right to refuse
 over a basic _____ use
 safety _____ in emergency?

•When you answer these questions, we hope that you will
 not only support HB50, but also support the nurses that have
 come forward putting safe patient care above their job, their
 license and concern for retaliation to protect the public when,
 _____ care at a time when patients are their most
 vulnerable and need a strong committed advocate. Now it is
 your turn to become a nurse advocate.



We Urge Your Support for HB 50

It will protect the individual patient.

It will protect the Registered Nurse.

It will protect the healthcare facility.

It will enhance the nursing profession.

It will help recruit nurses.

It will help retain nurses.

It's good public policy.

It's common sense.

Thank you.

Testimony on House Bill 50
House Health and Social Services Committee
presented by Roger Lewerenz, RN at the Heart Center
Providence Alaska Medical Center
March 12, 2009

Good afternoon Mr. Chairman and Committee members. My name is Roger Lewerenz and I am a registered nurse and work as a clinical nurse education for the Heart Center at Providence which includes cardio vascular observation, cardio vascular intervention unit and the Cath Lab.

The cath lab is a highly specialized area where patients having heart attacks, strokes and other life-threatening problems receive care. The staff consists of RN's, cardio vascular technologists, and radiology technologists. All of these staff have extensive specialized training making them competent to work in the Cath Lab. We care for patients from neonatal infants, who are hours old, to those who are just over one hundred years old.

I cannot have just any RN come into the Lab to assist because of the specialized nature of the work. I would estimate it would take approximately one year to fully train an experienced critical care nurse before he or she could be deemed qualified to provide care in the Cath Lab.

We staff the Cath Lab, Monday to Friday from 7:30 a.m. to 4:00 p.m. to handle regularly scheduled procedures. From 4:00 p.m. until 7:30 a.m. the next morning and on weekends we utilize a call team. This call team consists of an RN, a radiology technologist, and cardio vascular technologist. Each individual takes one night a week and one weekend every five weeks.

It is not unusual for this team to be called in, in the middle of the night, to provide care for a patient experiencing a heart attack or other life threatening emergency.

Without the availability of this call team, many patients may not receive the timely care they require.

Recently the team was called in to care for a patient experiencing a heart attack. Because of the availability of this call team, the patient survived.

There are nights when the call team does not get called in. There are other nights when they are there for several hours.

The restrictions that would be imposed if this bill passes would negatively impact our ability to care for this patient population due to the unavailability of trained staff.

Thank you very much for the opportunity to testify today.

Testimony on House Bill 50
House Health and Social Services Committee
presented by Cindy Alkire, Assistant Chief Nurse Executive
Providence Alaska Medical Center
Marcy 12, 2009

Good afternoon Mr. Chairman and members of the Committee. My name is Cindy Alkire and I am here today to testify on behalf of Providence Health and Services Alaska. I am the Assistant Chief Nurse Executive at Providence Alaska Medical Center. I have been a nurse for over 26 years and have provided direct patient care during my nursing career. In my current role as a nurse executive I am responsible for managing and directing the activities of nurses employed within The Children's Hospital at Providence.

Providence opposes House Bill 50 for many reasons. First, most Alaskan hospitals have been successful in avoiding the use of mandatory scheduled overtime, recognizing that nurses need rest between their shifts. Providence does not use mandatory overtime.

Secondly, this bill does not appropriately address the "on call" issue currently present in our operating rooms, post anesthesia care unit, cath lab, and dialysis unit. "On call" is defined as being available within 30 minutes to come in to work and care for patients. This is only used to provide rapid response to care for patients in life-threatening situations.

I have read through the history of this legislation and the "on call" issue appears to be the most critical issue that is unresolved.

The issue of "on call" is not easily solved since hospitals must provide emergency services 24 hours per day. Nurses working in the OR, Cath lab (Acute stroke, acute MI, infant cardiac defects), and Dialysis must have specialized training and experience to work in those areas. It is such specialized training that it makes its impossible to have just any RN step in and help. This specialized training can take up to 2 years to complete. Even within the Operating room there are specialties such as "the heart team". While routine procedures in these areas are scheduled during normal operating hours healthcare institutions must have a mechanism to deal with emergencies outside of normal business hours, that is the reason an "on-call" system was developed. Why is this important?

Our interpretation of the bill uses "on call" to mean the same as "work" thus limiting staff in these critical areas to be on call in combination with time actually worked. For example, if a nurse is on call in any of these areas during the week he/she could easily exceeds the 80 hours in a 14 day period or more than 14 hours in one day mandate.

Furthermore nurses many times choose to take their call time on the days they are scheduled to work so that it does not interfere with their regularly scheduled day off – this legislation would impact the nurse's ability to manage their own schedule and their own time off.

While Providence has done much to limit the amount of "on-call" it is still necessary because these areas must staff available for emergencies that occur on evenings, nights, holidays, and weekends. If requiring an "on call" staff person to fulfill their on call obligation is considered mandatory overtime, this bill would adversely impact the ability of hospitals to provide emergency surgery, heart cath, and emergency dialysis.

The way this bill is written and the implications of the "on call" piece could result in unsafe conditions for patients because there would not be enough volunteers of staff with the experience needed to provide 24 hours 7 day a week access to emergency care. There is even the risk that Alaskan hospitals would have to close some of their beds causing patients to seek healthcare outside of Alaska.

I ask you to consider for a moment how such an unsafe patient situation could occur. In our Neonatal Intensive Care unit we care for the most vulnerable of babies. One of the complications that can occur as they are growing and developing is an infection in their intestines. This infection can lead to an intestinal rupture and it occurs quite suddenly. The only way to survive this complication is immediate surgical intervention. This legislation could prevent this surgery from happening. Put yourself in the place of the family of this baby when they are told their baby died because we did not have the staff to perform the needed surgery. This type of situation could occur with many different patients and families if our "on-call" system is compromised. Therefore, we must have the flexibility to effectively staff, manage, and deliver healthcare that our patients expect and demand of our health care system.

Quality and safe patient care is Providence's first priority. Hospitals and health systems have many safeguards in place to ensure that patients receive quality care, including detailed inspections by the federal government, the state Department of Public Health, and private accrediting agencies such as the Joint Commission. Quality, performance improvement, staffing, competencies, and patient satisfaction are monitored continuously. In order to maintain accreditation, hospitals are required to measure patient acuity and care requirements and provide adequate hours of nursing care to meet those requirements. In addition our hospital's ability to maintain the confidence of their communities in providing top quality care determines, in large measure, the success of their futures.

Finally, Providence believes the use of mandatory nurse overtime which according to the this bill could include "on-call" is a labor relations issue and needs to be handled at the negotiating table. Collective bargaining affords

management and nursing representatives to work out local issues with solutions that work for that community. Flexibility in developing solutions and adjusting those along the way is far preferable to a one-size solution prescribed in state law. Providence is scheduled to begin negotiations with the union representing our nurses, the Alaska Nurses Association, in mid-March and the use of mandatory nurse overtime will be a part of those negotiations. Providence respectfully requests that the Alaska Legislation allow us the opportunity to address these critical issues during our upcoming negotiations.

Thank you for allowing me the opportunity to appear before you today to present testimony on House Bill 50.

Testimony on House Bill 50
House Health and Social Services Committee
presented by Marilyn Edwards, Operating Room Clinical Manager
Providence Alaska Medical Center
Marcy 12, 2009

Mr. Chairman and members of the Committee – my name is Marilyn Edwards and I am the Operating Room Clinical Manager at Providence Alaska Medical Center. I have been a nurse for 31 years, 30 of those in the operating room – the last five years at Providence.

My immediate concerns revolve around safe quality patient outcomes and a safe work environment for my operating room staff.

It would be devastating to patient outcomes to enact a "one-size solution" prescribed in state law to resolve/control a mandatory nurse overtime concern that does not exist at the Providence Alaska Medical Center Operating Room.

We pride ourselves in the OR at Providence in being able to provide quality care to our patients needing surgical intervention while providing optimal work/life balance for our staff.

We have staff RN's scheduled to work from Sunday at 6:45 a.m. through Saturday at 7:00 p.m.

We are fully staffed with RN's. I have zero vacancies currently. To clarify optimum work/life balance: less than half of my RN's work full time. The full breakdown is as follows:

48 OR registered nurses total. This includes:

- 2 educators
- 1 RN traveler
- 6 Team leads
- 1 registered dialysis nurse

8 of the 48 nurses work 12 hour shifts

Four of these 12 hour shifts were added in the past year at the request of four of these 48 RN's

7 nurses work 10 hour shifts, and
33 nurses work 8 hour shifts

22 of the 48 RN's work a 1.0 full time equivalent position

9 RN's work a .09 full time equivalent

4 RN's work a .08 full time equivalent, and

2 RN's work a .06 full time equivalent

We have 10 "registry" RN's – a registry RN is only required to work 3 shifts per month, with minimal call.

A 1.0 full time employee working 6:45 a.m. to 3:15 p.m., has an average of one evening call, one night call, and two weekend shifts, either scheduled shifts or "call" per four week period.

A 12 hour RN, .09 FTE, usually has night or weekend "call." Much of this call is assigned around the individual RN's request because they may want the call scheduled when they are also scheduled to work to allow for consecutive days/nights of time off.

2 RN team leads volunteer to take second night call more often. One team lead averages 7 to 9 orthopedic call shifts per month. The one heart team leader averages 14 to 17 calls/shifts per month that she volunteers for.

During the interview process for a new position, all OR staff candidates are notified of the call requirements for the OR. The assigned call coverage is necessary to provide rapid (30 minutes from when notified) response for emergent patient care above what we are routinely staffed for based on volume trends of operation.

I have read and heard anecdotal stories of nurses being "tired" and unable to provide quality, safe care to our patients. One such story I saw in the February 2009 edition of the Alaska Nurses Association publication reports "an acuity system that was failing the nurses at a facility. There was sadness expressed regarding the load these nurses carried home with them." I'm unsure if the over-worked and under-staffed nurses that this article mentions were in a Montana facility where the author's relative received care. I'm not sure because it does not mention the location of the facility.

Why I bring this up is that we provided for time off for the employee to be with their sick and dying relative out of state. During this period, OR RN's volunteered and covered the mentioned employee's shifts and call while we interviewed and contracted to bring a traveling RN in to fill the staffing gap so as not to overburden our nurses with more call for a longer duration.

If the fellow PAMC OR nurses had not been "allowed" to cover the call shifts due to already meeting their call and work requirements, as set out by this bill, we would not have been able to accept heart patients during this short time period. That would be devastating to these critically ill patients -- to have to turn them away – divert them from the care they desperately need.

Tanana Chiefs Conference

Chief Peter John Tribal Building

122 First Avenue, Suite 600

Fairbanks, Alaska 99701-4897

(907) 452-8251 Fax: (907) 459-3850

SUBREGIONS

UPPER

KUSKOKWIM

McGrath
Medfra
Nikolai
Takatna
Telida

April 10, 2009

The Honorable Bob Herron
The Honorable Wes Keller
Co-Chairs
House Health and Social Services Committee
Alaska State Legislature
State Capitol, Room 106
Juneau, Alaska 99801

LOWER YUKON

Anvik
Grayling
Holy Cross
Shageluk

UPPER TANANA

Dot Lake
Eagle
Healy Lake
Northway
Tanacross
Tetlin
Tok

Re: Nurse Overtime
HB 50 and 51

Dear Representatives Herron and Keller:

Current proposals to limit Mandatory Nurse Overtime (HB 50, 51 and SB 12) seek to address a very real and serious problem: i.e. the national and state shortage of nurses. The national nursing shortage is expected to continue to worsen through 2016. In response, hospitals outside of Alaska have increased mandatory nurse overtime, and in response, national nursing associations have initiated a national state-by-state effort to obtain limits on mandatory nursing overtime. To date, fifteen (15) other states have enacted legislation to limit mandatory nursing overtime in some form.

The bills before the legislature seek to implement a generic national response to the nursing shortage problem with regulation similar to that recently enacted in other states. This approach may be appropriate to large urbanized metropolitan states, and may reflect an appropriate national response to a national problem. However, the approach may not necessarily reflect Alaska's unique health care system circumstances and needs. Specifically, Alaska presents unique circumstances, including

- labor market forces in which nurses are in high demand, requiring employer accommodation to individual nurse demands
- collective bargaining agreements, with strong nurse unions
- heavy reliance on *locum tenens* (traveling) nurses sourced out-of-state
- the challenges presented in providing rural health services in Alaska's bush, and
- an extensive federal health care system (tribal/Indian Health Service, Veterans, military)

A number of concerns have arisen in response to this proposed legislation, which should be addressed in the legislative process. These concerns include:

YUKON FLATS

Arctic Village
Beaver
Birch Creek
Canyon Village
Chalkyitsik
Circle
Fort Yukon
Venetie

YUKON

KOYUKUK

Galena
Huslia
Kallag
Koyukuk
Nulato
Ruby

YUKON TANANA

Alatna
Akiakaket
Evansville
Fairbanks
Hughes
Lake
Minchumina
Monley Hot
Springs
Minto
Nenana
Rampart
Stevens Village
Tanana

1) Federal Facilities. The legislation purports to apply these regulations to "federal" facilities, which is likely beyond the state's regulatory authority. These federal facilities include Veterans, and military facilities which are clearly beyond the states' regulatory authority. Equally, the Indian Health Facilities, which are federal, raise serious questions, particularly with nurses who are federal employees working with tribal organizations under Intergovernmental Personal Act (IPA) assignments. The legislation would be clearly pre-empted as to the IPA nurses, and is highly questionable as to direct hire nurses (non-IPA) working in a federal facility.

2) IPA/non-IPA Parity. If the legislation does apply to non-IPA staff working in federal facilities, the legislation has the un-intended consequences of shifting the entire burden of possible mandatory overtime to federal IPA nurses, which concentrates and exacerbates the problem as to certain nurses.

3) Travel. Nurses travel from urban centers to rural areas. The legislation does not address how travel time is treated, which would normally be dealt with in light of federal regulations which are incorporated by reference into the AWHHA; however, the legislation is inconsistent with several provisions of federal laws and regulations and the treatment of travel time under inconsistent regulations will cause serious problems. Moreover, some proposed substitutes attempt to make distinctions between rural/urban nurses. Urban based nurses traveling to rural areas to work will create confusion as to which rules apply if the substitutes are adopted.

4) Nurse Specialties. The bill assumes that nurses are fungible; i.e. any single nurse may be substituted for another nurse. This does not reflect various nursing specialties, so that nurses practicing in specialty areas cannot be easily replaced by general nurses or nurses with specialties in other areas.

5) Collective Bargaining Agreements. The bill would conflict with some existing collective bargaining agreements, which would raise constitutional issues associated with state statutes that impair the right of contract. Moreover, the bill would prohibit certain scheduling systems (e.g. 3 x12 hours shifts a week). Scheduling issues are mandatory bargaining subjects under the National Labor Relations Act, and are the state statute may impair the rights of employer and nurse unions to negotiate a mandatory bargaining subject.

6) Application to Non-Hospital Facilities. In almost all cases, the concerns relate to nurse staffing patterns in hospitals. However, the statute applies to many non-hospital facilities. It is not clear that problems arising in hospital work environments relate to non-hospital work environments. The legislation is overly broad relative to the problem being addressed, and if adopted, should apply to hospital environments only.

7) Unnecessary Reporting. The bill would impose regulatory reporting and related burdens on all nurse employers, even if the nurse employers do not utilize

mandatory overtime practices. The majority of nurse employers in Alaska do not require mandatory overtime, but would be required to report on non-activity. This is highly unusual in labor law, which normally only requires reporting where the activity in question is occurring. The reporting requirements respecting non-activity, is unnecessary.

Finally, we do not believe that that increased regulation in Alaska will effectively address a national nursing shortage. We believe that a better approach is to provide support for increased training of nurses in Alaska, particularly for Alaska residents that are likely to remain in Alaska or likely to seek employment in underserved areas such as rural Alaska. We would encourage the Legislature to explore options to expand UAF nurse training as a more effective approach to deal with the nurse shortage.

Sincerely,
TANANA CHIEFS CONFERENCE


Michael J. Waller
General Counsel



MEMORANDUM

Date: April 8, 2009

To: Rod Betit, President/CEO ASHNHA
Evangelyn Dotomain, President/CEO Alaska Native Health Board

From: Starla Fox, Deputy Director of Nursing

Cc: Robert Clark, CEO
Lorraine Jewett, COO
Sue Mulkeit, Director of Nursing

Re: Response to Nurse Overtime Bill

This memo is testimony regarding HB 50 and SB 12 – Nurse Overtime Bill.

As the direct supervisor of the current Inpatient and Emergency Nursing workforce at BBAHC, I've heard the concerns voiced by nurses on the unit. Many are upset that the possibility of working extra hours and extra shifts may not be available for them or will be limited by the legislation. As you probably know there are some nurses who are not interested in working extra and they are never forced to do so; however we do have a group of nurses who are very interested in working extra to gain added income. These staff members know their limitations and are never forced to cover shifts if they do not want to. My concern for this bill is that it puts the facilities in a difficult situation, yet may not help with solving the issue of nurses working long tedious hours if that is what the nurses choose to do. For example, if I'm a nurse in the Anchorage area, I can work as many hours as I choose and no one would know the difference. I could be employed at one facility and also moonlight at another facility down the street. It seems that the language of this Overtime Bill does not limit the individual nurse but instead the facilities. If the purpose of limiting hours worked is to protect the patient population from fatigued and overworked nurses, then the responsibility should also be placed on the individual nurse as well as the facility.

Rural hospitals in Alaska are very isolated and have a small limited workforce. There is not a major competitor down the street that we can pull nurses from to moonlight for us

when there is a shift that needs to be covered. This Overtime Bill will limit the small hospitals and increase our cost without truly getting to the problem in the larger urban settings defined in SECTION 1 #2 that reads "*quality of patient care is jeopardized by registered nurses and licensed practical nurses who work unnecessarily long hours in health care facilities;*". Nurses who want the additional income that live in the city will still be able to work as many hours as they want if they work part-time at several facilities in addition to their permanent employer. I don't see this as helping with patient safety in these urban areas and it puts undue stress on the rural facilities that have a smaller pool of licensed nurses to draw from. It will be difficult to sell 8 hour shifts to nurses who love working 12 hour shifts and the housing availability in the remote settings is limited and will only worsen if we are forced to increase our workforce to accommodate 8 hour shifts. The reporting requirements in HB 50 and SB 12 are onerous for the small hospitals. I believe that this bill will create additional barriers to affordable healthcare for those patients who reside in remote parts of the state. The April-June 2007 issue of Nursing Administration Quarterly was entitled "The Perfect Storm: Ratios, Retirement and Entry Into Practice". We are already experiencing a nationwide nursing shortage, why would our legislators want to tie the hands of the rural healthcare facilities by passing a bill that does not solve the real issue of nurses working long hours in the urban settings.

Please consider this testimony as you prepare your statement to our state legislature.

Sincerely,

Starla Fox, RN, MNS
Deputy Director of Nursing

HB

71

CS FOR HOUSE BILL NO. 71()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVES HOLMES, DAHLSTROM, MILLETT, AND KAWASAKI

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to a registry for advance health care directives."**

2 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 *** Section 1.** AS 13.52.080 is amended by adding a new subsection to read:

4 (d) A health care facility or hospital is not subject to civil or criminal liability
5 for

6 (1) acting in reliance on an advance health care directive obtained from
7 the directive registry established under AS 13.52.310; or

8 (2) not checking the directive registry established under AS 13.52.310
9 to determine if a patient of the health care facility has filed an advance health care
10 directive in the registry.

11 *** Sec. 2.** AS 13.52 is amended by adding a new section to read:

12 **Sec. 13.52.310. Advance health care directive registry.** (a) The department
13 shall establish and maintain a registry for advance health care directives. The registry
14 must consist of

15 (1) a list of the names of individuals who have made written directives

1 for themselves and who have filed them with the department under (b) of this section;
2 and

3 (2) scanned copies of the directives identified in (1) of this subsection.

4 (b) An individual who has made a written directive for the individual may file
5 the directive with the department for placement in the registry.

6 (c) Except as provided in this subsection and by (d) of this section, the registry
7 is confidential, and the department may not use the information in the registry for
8 another purpose. The department may release by mail or fax

9 (1) the name of an individual who filed a directive with the department
10 under (b) of this section and a copy of a directive in the registry to

11 (A) the individual who made the directive;

12 (B) the agent, guardian, or surrogate of the individual who
13 made the directive; or

14 (C) a health care facility in this state or hospital in this state if
15 the individual who made the directive is a patient of the health care facility or
16 hospital;

17 (2) a copy of a directive in the registry to a hospital in another state if
18 requested by the

19 (A) individual who made the directive; or

20 (B) agent, guardian, or surrogate of the individual who made
21 the directive.

22 (d) The department shall make the registry accessible for viewing on the
23 Internet 24 hours a day to a hospital in this state to determine if an individual who is a
24 patient at the health care facility has a directive or to obtain a copy of a directive for an
25 individual who is a patient at the health care facility.

26 (e) The department is not required to review a directive for validity or
27 compliance with this chapter or another law before placing the directive in the
28 registry.

29 (f) The department shall remove a directive from the registry and return it to
30 the individual who made the directive if the individual requests in writing that the
31 directive be removed.

1 (g) Not filing a directive with the department for placement in the registry
2 does not affect the validity of the directive. Failure to notify the department that a
3 directive in the registry has been revoked does not affect the validity of the revocation.

4 (h) The department may charge a fee to file, return, or provide a copy of a
5 directive filed in the registry under this section, except that the department may not
6 charge a fee for removing a directive from the registry or for answering an inquiry by
7 a health care facility or hospital in this state regarding whether an individual has a
8 directive in the registry. The fee may not exceed the department's administrative costs
9 of fulfilling the request.

10 (i) To protect the security of the directives and names on the registry, the
11 department shall establish by regulation identification procedures and requirements for
12 an individual, agent, surrogate, guardian, hospital, or health care facility to access the
13 registry.

14 (j) The department shall establish by regulation criteria and a schedule for
15 removing directives from the registry.

16 (k) The department and its employees are not liable for civil damages as a
17 result of an act or omission in the establishment or maintenance of the registry or other
18 implementation of this section.

19 (l) In this section,

20 (1) "directive" means a written advance health care directive;

21 (2) "registry" means the registry established under this section.

AMENDMENT B

TO: HB 71 (26-LS0289\P)

BY REPRESENTATIVE HOLMES

1 Page 3, line 14

2 After "criteria":

3 Insert "and procedures for the collection, storage, access, distribution,

4 removal and disposal of directives from the registry"

AMENDMENT A

TO: HB 71 (26-LS0289P)

BY REPRESENTATIVE HOLMES

1 Page 2, line 29 & 30

2 After "registry":

3 Delete "and return it to the individual who made the directive"

4 Page 3, line 4

5 After "file"

6 Delete ", return,"



REPRESENTATIVE LINDSEY HOLMES

HOUSE DISTRICT 26

House Bill 71 Sponsor Statement

An Act relating to a registry for advance health care directives.

An advance health care directive is a document that allows a person to designate what health care they wish to receive and who can make medical decisions for them in the case that they are incapacitated. Alaska Statute 13.52.010 provides that anyone may fill out an advance health care directive, but it does not provide a system to store and access these important documents.

Medical emergencies can occur at any place at any time. A person may be on vacation and not have a copy of their advance health care directive with them, or family members may simply be too distraught to remember or find a copy of the directive. In cases like these, medical professionals and family members need an effective tool to locate and access information on a patient's health care wishes.

House Bill 71 would establish a voluntary registry of advance health care directives for the State of Alaska. The registry would be strictly voluntary—no person would ever be required to submit his or her advance health care directive to the registry, and directives not filed with the registry would remain every bit as valid. Other features of the registry include:

- Hospitals and similar health care facilities would have 24-hour online access to their patients' records in case of emergencies.
- A person or his or her agent, guardian or surrogate would be able to request copies of their directive.
- The Department of Health and Social Services would be able to charge modest fees to pay for administrative costs of the registry.
- All advance health care directives in the registry would be confidential.
- An individual could update or remove his or her advance health care directive from the registry at any time.

A number of other states already use an advance health care directive registry to ensure that patients' wishes are available to guide the decisions of doctors and loved ones during medical emergencies.

Please join me in helping to ensure that Alaskans' medical decisions are respected by supporting this legislation.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

January 23, 2009

SUBJECT: Sectional summary of HB 71, a bill relating to a registry for advance health care directives (Work Order No. 26-LS0289\E)

TO: Representative Lindsey Holmes
Attn: James Waldo

FROM: *JB*
Theresa Bannister
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Protects a health care facility from civil or criminal liability for two listed types of actions related to the directive registry.

Section 2. Allows a hospital to make a reasonable search of the directive registry when the hospital refers an individual at or near death to a procurement organization.

Section 3. Makes a procurement organization's access to the department's records subject to the new directive registry provisions.

Section 4. This is the main authorizing section for the directive registry. Directs the department to maintain a registry for advance health care directives. Allows individuals to place their directives in the registry. Makes the registry confidential and indicates when the department may release information from the registry. Directs the department to make the registry accessible for viewing on the Internet 24 hours a day to a health care facility for the facility's patients. States that the department is not required to review a directive for validity or compliance with law before placing it in the registry. Directs the department to remove a directive from the registry and return it to the maker when requested by the maker or an agent, guardian, or surrogate of the maker. Requires the department to review the registry every five years and to remove directives of individuals deceased for six months or more. Provides that not filing a directive does not affect the directive's validity. Provides that failing to tell the department about a revocation does not affect the revocation. Allows the department to charge certain fees to implement the section. Directs the department to adopt regulations about identification procedures and requirements to protect the security of the registry.

If I may be of further assistance, please advise.

TLB:ljw
09-040.ljw

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

April 15, 2009

SUBJECT: CSHB 71(HSS) relating to a registry for advance health care directives (Work Order No. 26-LS0289\C)

TO: Representative Wes Keller
Co-Chair of the House Health and Social Services Committee
Attn: Matthew Johnson

FROM:  Theresa Bannister
Legislative Counsel

This memo accompanies the bill described above. This bill incorporates amendments made by the committee. I recommend that certain adjustments be made to the amendments to carry out the intent of the amendments and that two corrections be made to the language that was in the version that the committee considered. Since this bill has passed out of your committee, would you please pass these comments along to the next committee of referral?

1. Corrections. On page 2, "health care facility" should be replaced with "hospital" on both lines 24 and 25 because sec. 13.52.310(d) is limited to hospitals.
2. First adjustment. In sec. 13.52.310(f), on page 2 of the bill, the phrase "who made the directive" needs to be added after "individual" to indicate which individual can request the removal.
3. Second adjustment. In sec. 13.52.310(j), on page 3, the added language needs to be changed to avoid using "from the registry" for all of the listed preceding items. The language could read "and procedures for the collection of, storage of, access to, and distribution of directives in the registry and the removal and disposal of directives from the registry." Right now each item hinges on "from the registry," which doesn't completely work. For example, you would not say "storage from the registry."

If I may be of further assistance, please advise.

TLB:ljw
09-255.ljw

Enclosure

**Representative
Lindsey Holmes**

Capitol Room 405
465-4919
465-2137 fax



MEMORANDUM

Date: 26 January 2009

To: Representative Wes Keller and Representative Bob Herron,
Co-Chairs for House Health and Social Services Committee

From: James R. Waldo, staff to Representative Holmes

RE: State agencies affected by HB 71: Advance Health Care Directives Registry

The state Department of Health and Social Services is the only state department that would be affected by the passage of HB 71.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB071
 () Publish Date: _____

Identifier (file name): HB071-DHSS-02-22-09 Dept. Affected: Health & Social Services
 Title Advance Health Care Directives Registry RDU Public Health
 Sponsor Holmes Component Injury Prevention and Emergency Medical Services
 Requester House HSS Component Number 2876

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services	156.1		156.1	156.1	156.1	156.1	156.1	156.1
Travel	5.0		20.0	5.0	5.0	5.0	5.0	5.0
Contractual	50.0		50.0	50.0	50.0	50.0	50.0	50.0
Supplies	1.5		1.5	1.5	1.5	1.5	1.5	1.5
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	212.6	0.0	227.6	212.6	212.6	212.6	212.6	212.6

CAPITAL EXPENDITURES	300.0							
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF	512.6		227.6	212.6	212.6	212.6	212.6	212.6
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	512.6	0.0	227.6	212.6	212.6	212.6	212.6	212.6

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time	2.0		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The bill is intended to more effectively honor and implement an individual's advance health care directive by creating a central registry for access by health care providers and procurement organizations. Information Technology Business Applications staff estimate that development of the registry, either by the state or a third party vendor, will require an estimated capital expenditure of \$250K with an additional \$50K to develop an interface with the Bureau of Vital Statistics. Two FTE personnel will be required to enter the documents into the registry and provide access to the information: Public Health Specialist II (R20, step C) at \$100K and an Administrative Clerk III (R10, step C) at \$56.1K. Work stations, lease, phone service, etc. is estimated to be \$19K for the 2 employees. An additional contractual expenditure is system maintenance (10%), or \$25K per year. Training expenditures for hospital and other personnel to access the registry is estimated at \$6K per year, with a one-time travel increase in FY2011 to train hospital personnel. Supplies are estimated at \$1.5K per year. The fund source amount includes the total anticipated operating and capital expenditures.

Prepared by: Beverly Wooley, Director Phone 465-4079
 Division Public Health Date/Time 2/2/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 2/22/2009
DHSS Finance Management Services

DRAFT

26G-1
(1/22/2009)
(1:46 pm)

AMENDMENT

OFFERED IN THE HOUSE HEALTH AND
SOCIAL SERVICES COMMITTEE
TO: HB 71

BY _____

1 Page 3, following line 14:

2 Insert:

3 "(k) The department and its employces are not liable for civil damages as a result
4 of an act or omission in the establishment or maintenance of the registry."

5

6 Page 3, line 15:

7 Delete "(k)"

8 Insert "(l)"



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March 31, 2009

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 415
Juneau, AK 99801-1182

RE: HB 71 (Holmes, Dahlstrom, Millett, Kawasaki)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support HB 71, authored by your Committee colleague Representative Lindsey Holmes and Representatives Nancy Dahlstrom, Charisse Millett, and Scott Kawasaki.

AARP encourages our 97,000 members in Alaska to prepare advance health care directives and to discuss their wishes with their family.

Unfortunately, all too often a serious illness or accident may strike when an individual does not have their directives on their person. It is also not uncommon for someone to arrive at a hospital and be unable to speak and express their wishes. This often results in a health care provider being unable to discern or to follow the preferences of a patient.

HB 71 would help alleviate this situation. HB 71 would establish a voluntary registry for health care directives which could be accessed by health care providers in time of need.

HB 71 offers everything we could ask for:

- Voluntary
- Confidential
- Available on a 24 hour basis
- Inexpensive
- Available for updating if the individual so chooses

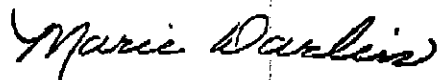
If passed, AARP Alaska will encourage every one of our members to participate in the registry and to encourage their younger family members to do likewise.

AARP urges an "AYE" vote on HB 71.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Representative John Coghill
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes
Representative Nancy Dahlstrom
Representative Charisse Millett
Representative Scott Kawasaki

HB

89

STATE OF ALASKA

Department of Labor and Workforce Development

OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 111149
JUNEAU, ALASKA 99811-1149

PHONE: (907) 465-2700
FAX: (907) 465-2784

February 1, 2010

The Honorable Bob Herron
The Honorable Wes Keller
Co-Chairs House Health and Social Services Committee
State Capital Building
Juneau, AK 99801-1182

Dear Representatives Herron and Keller,

Thank you for scheduling House Bill 89 which establishes a State Vocational Rehabilitation Committee (SVRC) in the House Health and Social Services Committee. The primary purpose of this legislation is to bring current state statute into compliance with federal law. The SVRC will function as the State Rehabilitation Council and the Assistive Technology Advisory Committee, both of which are required by federal law to accept funding from the U.S. Department of Education, Rehabilitation Services Administration to operate the Vocational Rehabilitation Client Services program and Assistive Technology grant. The SVRC will replace the Governor's Committee on Employment and Rehabilitation of People with Disabilities (GCERPD).

It is important that this legislation pass during this session. The Division of Vocational Rehabilitation is currently undergoing a federal review and monitoring of programs authorized under Title I of the Rehabilitation Act of 1973, as amended. Management and organization of the State Rehabilitation Council is included in this compliance review to determine whether the agency is fully constituted in accordance with federal law and regulations, including membership composition. Current state statutes are not in compliance with the federal laws related to the State Rehabilitation Council or the Assistive Technology Advisory Committee. Current statute was written for a committee that no longer exists, the President's Committee on Employment of People with Disabilities.

The GCERPD will continue to perform the duties of the State Rehabilitation Council and the Assistive Technology Advisory Committee until this matter is resolved. The Division of Vocational Rehabilitation could be sanctioned during the federal review. Similar legislation regarding SVRC was introduced during the 25th Legislative Session.

Federal compliance is critical to assist Alaskans with disabilities to become employed and have access to appropriate assistive technology services and devices. Thank you for your consideration of this important matter. Please contact me or my Legislative Liaison, Paula Scavera at 465-2700 if you would like to discuss this further.

Sincerely,



Clark Bishop
Commissioner

CS HB 89 (L& C)

An Act relating to the State Vocational Rehabilitation Committee

Sectional Analysis

Section 1 repeals the Governor's Committee on Employment of People with Disabilities (GCEPD). Creates the State Vocational Rehabilitation Committee and describes its purpose.

Section 2 describes the appointment, number, composition of committee members. It states that the number and composition of the committee must consistent with the requirements of 29 U.S.C. 725 and 29 U.S.C. 3003, as amended.

Section 3 addresses the selection and term of the Committee Chair. It eliminates the need for the Governor to appoint the Chair, allowing the voting members of the Committee to make a selection, subject to disapproval by the Governor. Term of Chair is one year.

Section 4 provides for four (4) meetings per year. Meeting may be conducted telephonically.

Section 5 addresses the transition of current members of the GCEPD. Current members, who on the day before the effective date of this Act meet the requirements for membership on the new committee, will continue to serve their original GCEPD term on the new committee until that term would have expired. They may apply to the Governor for reappointment after their term expires.

Section 6 is a new section that changes the heading of art. 2 of AS 23.15 from the "Governor's Committee on Employment of People with Disabilities" to "State Vocational Rehabilitation Committee."

Section 7 provides for an effective date.

Prepared by the Alaska Department of Labor and Workforce Development

February 1, 2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB 89(L&C)
 () Publish Date: _____

Identifier (file name): HB089CS(L&C)-DOLWD-CS-01-21-10 Dept. Affected: Labor and Workforce Development
 Title: Vocational Rehabilitation Committee RDU: Vocational Rehabilitation
 Sponsor: Rules Committee Component: Client Services
 Requester: Governor Component Number: 1828

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES							
Personal Services							
Travel		7.5	7.5	7.5	7.5	7.5	7.5
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	7.5	7.5	7.5	7.5	7.5	7.5

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES ()							
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		7.5	7.5	7.5	7.5	7.5	7.5
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	7.5	7.5	7.5	7.5	7.5	7.5

Estimate of any current year (FY2010) cost: None

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This bill will increase the number of individuals on the State Vocational Rehabilitation Committee to align with federal regulations by adding three additional seats. Additional costs estimated at \$7.5 will result from travel, per-diem, and lodging for the three additional members. The Client Services component will absorb the additional costs within currently budgeted funding.

Prepared by: Cheryl Walsh, Director
 Division: Division of Vocational Rehabilitation
 Approved by: Click Bishop, Commissioner
 Agency: Department of Labor and Workforce Development

Phone 465-6926
 Date/Time 1/22/10 12:15 PM
 Date 1/22/10

CITE-

29 USC Sec. 725

-EXPCITE-

TITLE 29 - LABOR

CHAPTER 16 - VOCATIONAL REHABILITATION AND OTHER REHABILITATION
SERVICES

SUBCHAPTER I - VOCATIONAL REHABILITATION SERVICES

Part A - General Provisions

-HEAD-

Sec. 725. State Rehabilitation Council

-STATUTE-

(a) Establishment

(1) In general

Except as provided in section 721(a)(21)(A)(i) of this title, to be eligible to receive financial assistance under this subchapter a State shall establish a State Rehabilitation Council (referred to in this section as the "Council") in accordance with this section.

(2) Separate agency for individuals who are blind

A State that designates a State agency to administer the part of the State plan under which vocational rehabilitation services are provided for individuals who are blind under section 721(a)(2)(A)(i) of this title may establish a separate Council in accordance with this section to perform the duties of such a Council with respect to such State agency.

(b) Composition and appointment

(1) Composition

(A) In general

Except in the case of a separate Council established under subsection (a)(2) of this section, the Council shall be composed of -

(i) at least one representative of the Statewide Independent Living Council established under section 796d of this title, which representative may be the chairperson or other designee of the Council;

(ii) at least one representative of a parent training and information center established pursuant to section 671 of the Individuals with Disabilities Education Act [20 U.S.C. 1471];

(iii) at least one representative of the client assistance program established under section 732 of this title;

(iv) at least one qualified vocational rehabilitation counselor, with knowledge of and experience with vocational rehabilitation programs, who shall serve as an ex officio, nonvoting member of the Council if the counselor is an employee of the designated State agency;

(v) at least one representative of community rehabilitation program service providers;

(vi) four representatives of business, industry, and labor;

(vii) representatives of disability advocacy groups representing a cross section of -

(I) individuals with physical, cognitive, sensory, and mental disabilities; and

(II) individuals' representatives of individuals with disabilities who have difficulty in representing themselves

or are unable due to their disabilities to represent themselves;

(viii) current or former applicants for, or recipients of, vocational rehabilitation services;

(ix) in a State in which one or more projects are carried out under section 741 of this title, at least one representative of the directors of the projects;

(x) at least one representative of the State educational agency responsible for the public education of students with disabilities who are eligible to receive services under this subchapter and part B of the Individuals with Disabilities Education Act [20 U.S.C. 1411 et seq.]; and

(xi) at least one representative of the State workforce investment board.

(B) Separate Council

In the case of a separate Council established under subsection (a) (2) of this section, the Council shall be composed of -

(i) at least one representative described in subparagraph

(A) (i);

(ii) at least one representative described in subparagraph

(A) (ii);

(iii) at least one representative described in subparagraph

(A) (iii);

(iv) at least one vocational rehabilitation counselor described in subparagraph (A) (iv), who shall serve as described in such subparagraph;

(v) at least one representative described in subparagraph

(A) (v);

(vi) four representatives described in subparagraph

(A) (vi);

(vii) at least one representative of a disability advocacy group representing individuals who are blind;

(viii) at least one individual's representative, of an individual who -

(I) is an individual who is blind and has multiple disabilities; and

(II) has difficulty in representing himself or herself or is unable due to disabilities to represent himself or herself;

(ix) applicants or recipients described in subparagraph (A) (viii);

(x) in a State described in subparagraph (A) (ix), at least one representative described in such subparagraph;

(xi) at least one representative described in subparagraph (A) (x); and

(xii) at least one representative described in subparagraph (A) (xi).

(C) Exception

In the case of a separate Council established under subsection (a) (2) of this section, any Council that is required by State law, as in effect on October 29, 1992, to have fewer than 15 members shall be deemed to be in compliance with subparagraph (B) if the Council -

(i) meets the requirements of subparagraph (B), other than

the requirements of clauses (vi) and (ix) of such subparagraph; and

(ii) includes at least -

(I) one representative described in subparagraph (B) (vi); and

(II) one applicant or recipient described in subparagraph (B) (ix).

(2) Ex officio member

The Director of the designated State unit shall be an ex officio, nonvoting member of the Council.

(3) Appointment

Members of the Council shall be appointed by the Governor or, in the case of a State that, under State law, vests authority for the administration of the activities carried out under this chapter in an entity other than the Governor (such as one or more houses of the State legislature or an independent board), the chief officer of that entity. The appointing authority shall select members after soliciting recommendations from representatives of organizations representing a broad range of individuals with disabilities and organizations interested in individuals with disabilities. In selecting members, the appointing authority shall consider, to the greatest extent practicable, the extent to which minority populations are represented on the Council.

(4) Qualifications

(A) In general

A majority of Council members shall be persons who are -

(i) individuals with disabilities described in section 705(20)(B) of this title; and

(ii) not employed by the designated State unit.

(B) Separate Council

In the case of a separate Council established under subsection (a) (2) of this section, a majority of Council members shall be persons who are -

(i) blind; and

(ii) not employed by the designated State unit.

(5) Chairperson

(A) In general

Except as provided in subparagraph (B), the Council shall select a chairperson from among the membership of the Council.

(B) Designation by chief executive officer

In States in which the chief executive officer does not have veto power pursuant to State law, the appointing authority described in paragraph (3) shall designate a member of the Council to serve as the chairperson of the Council or shall require the Council to so designate such a member.

(6) Terms of appointment

(A) Length of term

Each member of the Council shall serve for a term of not more than 3 years, except that -

(i) a member appointed to fill a vacancy occurring prior to the expiration of the term for which a predecessor was appointed, shall be appointed for the remainder of such term; and

(ii) the terms of service of the members initially appointed shall be (as specified by the appointing authority described in paragraph (3)) for such fewer number of years as

will provide for the expiration of terms on a staggered basis.

(B) Number of terms

No member of the Council, other than a representative described in clause (iii) or (ix) of paragraph (1)(A), or clause (iii) or (x) of paragraph (1)(B), may serve more than two consecutive full terms.

(7) Vacancies

(A) In general

Except as provided in subparagraph (B), any vacancy occurring in the membership of the Council shall be filled in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(B) Delegation

The appointing authority described in paragraph (3) may delegate the authority to fill such a vacancy to the remaining members of the Council after making the original appointment.

(c) Functions of Council

The Council shall, after consulting with the State workforce investment board -

(1) review, analyze, and advise the designated State unit regarding the performance of the responsibilities of the unit under this subchapter, particularly responsibilities relating to -

(A) eligibility (including order of selection);

(B) the extent, scope, and effectiveness of services provided; and

(C) functions performed by State agencies that affect or that potentially affect the ability of individuals with disabilities in achieving employment outcomes under this subchapter;

(2) in partnership with the designated State unit -

(A) develop, agree to, and review State goals and priorities in accordance with section 721(a)(15)(C) of this title; and

(B) evaluate the effectiveness of the vocational rehabilitation program and submit reports of progress to the Commissioner in accordance with section 721(a)(15)(E) of this title;

(3) advise the designated State agency and the designated State unit regarding activities authorized to be carried out under this subchapter, and assist in the preparation of the State plan and amendments to the plan, applications, reports, needs assessments, and evaluations required by this subchapter;

(4) to the extent feasible, conduct a review and analysis of the effectiveness of, and consumer satisfaction with -

(A) the functions performed by the designated State agency;

(B) vocational rehabilitation services provided by State agencies and other public and private entities responsible for providing vocational rehabilitation services to individuals with disabilities under this chapter; and

(C) employment outcomes achieved by eligible individuals receiving services under this subchapter, including the availability of health and other employment benefits in connection with such employment outcomes;

(5) prepare and submit an annual report to the Governor and the Commissioner on the status of vocational rehabilitation programs operated within the State, and make the report available to the public;

(6) to avoid duplication of efforts and enhance the number of individuals served, coordinate activities with the activities of other councils within the State, including the Statewide Independent Living Council established under section 796d of this title, the advisory panel established under section 612(a)(20) of the Individuals with Disabilities Education Act [20 U.S.C. 1412(a)(20)], the State Council on Developmental Disabilities established under section 15025 of title 42, the State mental health planning council established under section 300x-3(a) of title 42, and the State workforce investment board;

(7) provide for coordination and the establishment of working relationships between the designated State agency and the Statewide Independent Living Council and centers for independent living within the State; and

(8) perform such other functions, consistent with the purpose of this subchapter, as the State Rehabilitation Council determines to be appropriate, that are comparable to the other functions performed by the Council.

(d) Resources

(1) Plan

The Council shall prepare, in conjunction with the designated State unit, a plan for the provision of such resources, including such staff and other personnel, as may be necessary and sufficient to carry out the functions of the Council under this section. The resource plan shall, to the maximum extent possible, rely on the use of resources in existence during the period of implementation of the plan.

(2) Resolution of disagreements

To the extent that there is a disagreement between the Council and the designated State unit in regard to the resources necessary to carry out the functions of the Council as set forth in this section, the disagreement shall be resolved by the Governor consistent with paragraph (1).

(3) Supervision and evaluation

Each Council shall, consistent with State law, supervise and evaluate such staff and other personnel as may be necessary to carry out its functions under this section.

(4) Personnel conflict of interest

While assisting the Council in carrying out its duties, staff and other personnel shall not be assigned duties by the designated State unit or any other agency or office of the State, that would create a conflict of interest.

(e) Conflict of interest

No member of the Council shall cast a vote on any matter that would provide direct financial benefit to the member or otherwise give the appearance of a conflict of interest under State law.

(f) Meetings

The Council shall convene at least four meetings a year in such places as it determines to be necessary to conduct Council business and conduct such forums or hearings as the Council considers appropriate. The meetings, hearings, and forums shall be publicly announced. The meetings shall be open and accessible to the general public unless there is a valid reason for an executive session.

(g) Compensation and expenses

The Council may use funds allocated to the Council by the designated State unit under this subchapter (except for funds appropriated to carry out the client assistance program under section 732 of this title and funds reserved pursuant to section 730(c) of this title to carry out part C of this subchapter) to reimburse members of the Council for reasonable and necessary expenses of attending Council meetings and performing Council duties (including child care and personal assistance services), and to pay compensation to a member of the Council, if such member is not employed or must forfeit wages from other employment, for each day the member is engaged in performing the duties of the Council.

(h) Hearings and forums

The Council is authorized to hold such hearings and forums as the Council may determine to be necessary to carry out the duties of the Council.

-SOURCE-

(Pub. L. 93-112, title I, Sec. 105, as added Pub. L. 105-220, title IV, Sec. 404, Aug. 7, 1998, 112 Stat. 1151; amended Pub. L. 105-277, div. A, Sec. 101(f) [title VIII, Sec. 402(c)(6)], Oct. 21, 1998, 112 Stat. 2681-337, 2681-415; Pub. L. 106-402, title IV, Sec. 401(b)(3)(A), Oct. 30, 2000, 114 Stat. 1737; Pub. L. 108-446, title III, Sec. 305(h)(2), (3), Dec. 3, 2004, 118 Stat. 2805.)

-REFTEXT-

REFERENCES IN TEXT

The Individuals with Disabilities Education Act, referred to in subsec. (b)(1)(A)(x), is title VI of Pub. L. 91-230, Apr. 13, 1970, 84 Stat. 175, as amended. Part B of the Act is classified generally to subchapter II (Sec. 1411 et seq.) of chapter 33 of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

-MISC1-

PRIOR PROVISIONS

A prior section 725, Pub. L. 93-112, title I, Sec. 105, as added Pub. L. 102-569, title I, Sec. 126(a), Oct. 29, 1992, 106 Stat. 4381; amended Pub. L. 103-73, title I, Sec. 107(d)(1), Aug. 11, 1993, 107 Stat. 721, related to State Rehabilitation Advisory Council, prior to the general amendment of this subchapter by Pub. L. 105-220.

AMENDMENTS

2004 - Subsec. (b)(1)(A)(ii). Pub. L. 108-446, Sec. 305(h)(2), substituted "671 of the Individuals with Disabilities Education Act" for "682(a) of the Individuals with Disabilities Education Act (as added by section 101 of the Individuals with Disabilities Education Act Amendments of 1997; Public Law 105-17)".

Subsec. (c)(6). Pub. L. 108-446, Sec. 305(h)(3), substituted "section 612(a)(20)" for "section 612(a)(21)" and "Individuals with" for "Individual with" and struck out "(as amended by section 101 of the Individuals with Disabilities Education Act Amendments of 1997; Public Law 105-17)" before ", the State Council".

2000 - Subsec. (c)(6). Pub. L. 106-402 substituted "the State Council on Developmental Disabilities established under section

15025 of title 42" for "the State Developmental Disabilities Council described in section 6024 of title 42".

1998 - Subsec. (b)(3). Pub. L. 105-277, Sec. 101(f) [title VIII, Sec. 402(c)(6)(A)], substituted "Governor or, in the case of a State that, under State law, vests authority for the administration of the activities carried out under this chapter in an entity other than the Governor (such as one or more houses of the State legislature or an independent board), the chief officer of that entity" for "Governor" in first sentence and "appointing authority" for "Governor" in second and third sentences.

Subsec. (b)(4)(A)(i). Pub. L. 105-277, Sec. 101(f) [title VIII, Sec. 402(c)(6)(B)], substituted "section 705(20)(B)" for "section 705(20)(A)".

Subsec. (b)(5)(B). Pub. L. 105-277, Sec. 101(f) [title VIII, Sec. 402(c)(6)(C)], substituted "chief executive officer" for "Governor" in heading and "appointing authority described in paragraph (3) shall" for "Governor shall" in text.

Subsec. (b)(6)(A)(ii), (7)(B). Pub. L. 105-277, Sec. 101(f) [title VIII, Sec. 402(c)(6)(D)], substituted "appointing authority described in paragraph (3)" for "Governor".

-End-

29 USC SEC. 3003

-EXCISE-

TITLE 29 TABLE

CHAPTER 31 - ASSISTIVE TECHNOLOGY FOR INDIVIDUALS WITH DISABILITIES
CHAPTER 311

-FED-

Sec. 3003. State grants for assistive technology

SEC. 3003 - STATE GRANTS FOR ASSISTIVE TECHNOLOGY

-STATUTE-

(a) Grants to States

The Secretary shall award grants under subsection (b) to States to maintain comprehensive statewide programs of technology-related assistance to support programs that are designed to maximize the ability of individuals with disabilities across the human lifespan and across the wide array of disabilities, and their family members, guardians, advocates, and authorized representatives, to obtain assistive technology, and that are designed to increase access to assistive technology.

(b) Amount of financial assistance

(1) In general

From funds made available to carry out this section, the Secretary shall award a grant to each eligible State and eligible outlying area from an allotment determined in accordance with paragraph (c).

(2) Calculation of State grants

(A) Base year

Except as provided in subparagraphs (E) and (C), the Secretary shall allot to each State and outlying area for a fiscal year an amount that is not less than the amount the State or outlying area received under the grants provided under section 3011 of this title (as in effect on the day before October 25, 2004) for fiscal year 2004.

(B) Ratable reduction

(i) In general

If funds made available to carry out this section for any fiscal year are insufficient to make the allotments required for each State and outlying area under subparagraph (A) for such fiscal year, the Secretary shall ratably reduce the allotments for such fiscal year.

(ii) Additional funds

If, after the Secretary makes the reductions described in clause (i), additional funds become available to carry out this section for the fiscal year, the Secretary shall ratably increase the allotments, until the Secretary has allotted the entire base year amount.

(C) Higher appropriation years

Except as provided in subparagraph (D), for a fiscal year for which the amount of funds made available to carry out this section is greater than the base year amount, the Secretary shall -

(i) make the allotments described in subparagraph (A);

(ii) from a portion of the remainder of the funds after the Secretary makes the allotments described in clause (i), the Secretary shall -

(I) from 50 percent of the portion, allot to each State

or outlying area an equal amount; and

(II) from 50 percent of the portion, allot to each State or outlying area an amount that bears the same relationship to such 50 percent as the population of the State or outlying area bears to the population of all States and outlying areas,

until each State has received an allotment of not less than \$410,000 and each outlying area has received an allotment of \$125,000 under clause (i) and this clause;

(iii) from the remainder of the funds after the Secretary makes the allotments described in clause (ii), the Secretary shall -

(I) from 80 percent of the remainder allot to each State an amount that bears the same relationship to such 80 percent as the population of the State bears to the population of all States; and

(II) from 20 percent of the remainder, allot to each State an equal amount.

(D) Special rule for fiscal year 2005

Notwithstanding subparagraph (C), if the amount of funds made available to carry out this section for fiscal year 2005 is greater than the base year amount, the Secretary may award grants on a competitive basis for periods of 1 year to States or outlying areas in accordance with the requirements of subchapter III of this chapter (!) (as in effect on the day before October 25, 2004) to develop, support, expand, or administer an alternative financing program.

(E) Base year amount

In this paragraph, the term "base year amount" means the total amount received by all States and outlying areas under the grants described in subparagraph (A) for fiscal year 2004.

(c) Lead agency, implementing entity, and advisory council

(1) Lead agency and implementing entity

(A) Lead agency

(i) In general

The Governor of a State shall designate a public agency as a lead agency -

(I) to control and administer the funds made available through the grant awarded to the State under this section; and

(II) to submit the application described in subsection (d) on behalf of the State, to ensure conformance with Federal and State accounting requirements.

(ii) Duties

The duties of the lead agency shall include -

(I) preparing the application described in subsection (d) and carrying out State activities described in that application, including making programmatic and resource allocation decisions necessary to implement the comprehensive statewide program of technology-related assistance;

(II) coordinating the activities of the comprehensive statewide program of technology-related assistance among public and private entities, including coordinating efforts related to entering into interagency agreements, and

maintaining and evaluating the program; and

(III) coordinating efforts related to the active, timely, and meaningful participation by individuals with disabilities and their family members, guardians, advocates, or authorized representatives, and other appropriate individuals, with respect to activities carried out through the grant.

(B) Implementing entity

The Governor may designate an agency, office, or other entity to carry out State activities under this section (referred to in this section as the "implementing entity"), if such implementing entity is different from the lead agency. The implementing agency shall carry out responsibilities under this chapter through a subcontract or another administrative agreement with the lead agency.

(C) Change in agency or entity

(i) In general

On obtaining the approval of the Secretary, the Governor may redesignate the lead agency, or the implementing entity, if the Governor shows to the Secretary good cause why the entity designated as the lead agency, or the implementing entity, respectively, should not serve as that agency or entity, respectively. The Governor shall make the showing in the application described in subsection (d).

(ii) Construction

Nothing in this paragraph shall be construed to require the Governor of a State to change the lead agency or implementing entity of the State to an agency other than the lead agency or implementing entity of such State as of October 25, 2004.

(2) Advisory council

(A) In general

There shall be established an advisory council to provide consumer-responsive, consumer-driven advice to the State for, planning of, implementation of, and evaluation of the activities carried out through the grant, including setting the measurable goals described in subsection (d)(3).

(B) Composition and representation

(i) Composition

The advisory council shall be composed of -

(I) individuals with disabilities that use assistive technology or the family members or guardians of the individuals;

(II) a representative of the designated State agency, as defined in section 7 of the Rehabilitation Act of 1973 (29 U.S.C. 705) and the State agency for individuals who are blind (within the meaning of section 101 of that Act (29 U.S.C. 721)), if such agency is separate;

(III) a representative of a State center for independent living described in part C of title VII of the Rehabilitation Act of 1973 (29 U.S.C. 796f et seq.);

(IV) a representative of the State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821);

(V) a representative of the State educational agency, as defined in section 7801 of title 20; and

(VI) representatives of other State agencies, public agencies, or private organizations, as determined by the

State.

(ii) Majority

(I) In general

A majority, not less than 51 percent, of the members of the advisory council, shall be members appointed under clause (i)(I).

(II) Representatives of agencies

Members appointed under subclauses (II) through (VI) of clause (i) shall not count toward the majority membership requirement established in subclause (I).

(iii) Representation

The advisory council shall be geographically representative of the State and reflect the diversity of the State with respect to race, ethnicity, types of disabilities across the age span, and users of types of services that an individual with a disability may receive.

(C) Expenses

The members of the advisory council shall receive no compensation for their service on the advisory council, but shall be reimbursed for reasonable and necessary expenses actually incurred in the performance of official duties for the advisory council.

(D) Period

The members of the State advisory council shall be appointed not later than 120 days after October 25, 2004.

(E) Impact on existing statutes, rules, or policies

Nothing in this paragraph shall be construed to affect State statutes, rules, or official policies relating to advisory bodies for State assistive technology programs or require changes to governing bodies of incorporated agencies who carry out State assistive technology programs.

(d) Application

(1) In general

Any State that desires to receive a grant under this section shall submit an application to the Secretary, at such time, in such manner, and containing such information as the Secretary may require.

(2) Lead agency and implementing entity

The application shall contain information identifying and describing the lead agency referred to in subsection (c)(1)(A). The application shall contain information identifying and describing the implementing entity referred to in subsection (c)(1)(B), if the Governor of the State designates such an entity.

(3) Measurable goals

The application shall include -

(A) measurable goals, and a timeline for meeting the goals, that the State has set for addressing the assistive technology needs of individuals with disabilities in the State related to -

(i) education, including goals involving the provision of assistive technology to individuals with disabilities who receive services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.);

(ii) employment, including goals involving the State vocational rehabilitation program carried out under title I

of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.);
(iii) telecommunication and information technology; and
(iv) community living; and

(B) information describing how the State will quantifiably measure the goals to determine whether the goals have been achieved.

(4) Involvement of public and private entities

The application shall describe how various public and private entities were involved in the development of the application and will be involved in the implementation of the activities to be carried out through the grant, including -

(A) in cases determined to be appropriate by the State, a description of the nature and extent of resources that will be committed by public and private collaborators to assist in accomplishing identified goals; and

(B) a description of the mechanisms established to ensure coordination of activities and collaboration between the implementing entity, if any, and the State.

(5) Implementation

The application shall include a description of -

(A) how the State will implement each of the required activities described in subsection (e), except as provided in subsection (e) (6) (A); and

(B) how the State will allocate and utilize grant funds to implement the activities, including describing proposed budget allocations and planned procedures for tracking expenditures for activities described in paragraphs (2) and (3) of subsection (e).

(6) Assurances

The application shall include assurances that -

(A) the State will annually collect data related to the required activities implemented by the State under this section in order to prepare the progress reports required under subsection (f);

(B) funds received through the grant -

(i) will be expended in accordance with this section; and
(ii) will be used to supplement, and not supplant, funds available from other sources for technology-related assistance, including the provision of assistive technology devices and assistive technology services;

(C) the lead agency will control and administer the funds received through the grant;

(D) the State will adopt such fiscal control and accounting procedures as may be necessary to ensure proper disbursement of and accounting for the funds received through the grant;

(E) the physical facility of the lead agency and implementing entity, if any, meets the requirements of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) regarding accessibility for individuals with disabilities;

(F) a public agency or an individual with a disability holds title to any property purchased with funds received under the grant and administers that property;

(G) activities carried out in the State that are authorized under this chapter, and supported by Federal funds received under this chapter, will comply with the standards established

by the Architectural and Transportation Barriers Compliance Board under section 508 of the Rehabilitation Act of 1973 (20 (12) U.S.C. 794d); and

(H) the State will -

- (i) prepare reports to the Secretary in such form and containing such information as the Secretary may require to carry out the Secretary's functions under this chapter; and
- (ii) keep such records and allow access to such records as the Secretary may require to ensure the correctness and verification of information provided to the Secretary under this subparagraph.

(7) State support

The application shall include a description of the activities described in paragraphs (2) and (3) of subsection (e) that the State will support with State funds.

(e) Use of funds

(1) In general

(A) Required activities

Except as provided in subparagraph (B) and paragraph (6), any State that receives a grant under this section shall use a portion of the funds made available through the grant to carry out activities described in paragraphs (2) and (3).

(B) State or non-Federal financial support

A State shall not be required to use a portion of the funds made available through the grant to carry out the category of activities described in subparagraph (A), (B), (C), or (D) of paragraph (2) if, in that State -

- (i) financial support is provided from State or other non-Federal resources or entities for that category of activities; and
- (ii) the amount of the financial support is comparable to, or greater than, the amount of the portion of the funds made available through the grant that the State would have expended for that category of activities, in the absence of this subparagraph.

(2) State-level activities

(A) State financing activities

The State shall support State financing activities to increase access to, and funding for, assistive technology devices and assistive technology services (which shall not include direct payment for such a device or service for an individual with a disability but may include support and administration of a program to provide such payment), including development of systems to provide and pay for such devices and services, for targeted individuals and entities described in section 3002(16) (A) of this title, including -

- (i) support for the development of systems for the purchase, lease, or other acquisition of, or payment for, assistive technology devices and assistive technology services; or
- (ii) support for the development of State-financed or privately financed alternative financing systems of subsidies (which may include conducting an initial 1-year feasibility study of, improving, administering, operating, providing capital for, or collaborating with an entity with respect to, such a system) for the provision of assistive technology

devices, such as -

- (I) a low-interest loan fund;
- (II) an interest buy-down program;
- (III) a revolving loan fund;
- (IV) a loan guarantee or insurance program;
- (V) a program providing for the purchase, lease, or other acquisition of assistive technology devices or assistive technology services; or
- (VI) another mechanism that is approved by the Secretary.

(E) Device reutilization programs

The State shall directly, or in collaboration with public or private entities, carry out assistive technology device reutilization programs that provide for the exchange, repair, recycling, or other reutilization of assistive technology devices, which may include redistribution through device sales, loans, rentals, or donations.

(C) Device loan programs

The State shall directly, or in collaboration with public or private entities, carry out device loan programs that provide short-term loans of assistive technology devices to individuals, employers, public agencies, or others seeking to meet the needs of targeted individuals and entities, including others seeking to comply with the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

(D) Device demonstrations

(i) In general

The State shall directly, or in collaboration with public and private entities, such as one-stop partners, as defined in section 101 of the Workforce Investment Act of 1998 (29 U.S.C. 2801), demonstrate a variety of assistive technology devices and assistive technology services (including assisting individuals in making informed choices regarding, and providing experiences with, the devices and services), using personnel who are familiar with such devices and services and their applications.

(ii) Comprehensive information

The State shall directly, or through referrals, provide to individuals, to the extent practicable, comprehensive information about State and local assistive technology vendors, providers, and repair services.

(3) State leadership activities

(A) In general

A State that receives a grant under this section shall use a portion of not more than 40 percent of the funds made available through the grant to carry out the activities described in subparagraph (B). From that portion, the State shall use at least 5 percent of the portion for activities described in subparagraph (B) (i) (III).

(B) Required activities

(i) Training and technical assistance

(I) In general

The State shall directly, or provide support to public or private entities with demonstrated expertise in collaborating with public or private agencies that serve individuals with disabilities, to develop and disseminate

training materials, conduct training, and provide technical assistance, for individuals from local settings statewide, including representatives of State and local educational agencies, other State and local agencies, early intervention programs, adult service programs, hospitals and other health care facilities, institutions of higher education, and businesses.

(II) Authorized activities

In carrying out activities under subclause (I), the State shall carry out activities that enhance the knowledge, skills, and competencies of individuals from local settings described in subclause (I), which may include -

(aa) general awareness training on the benefits of assistive technology and the Federal, State, and private funding sources available to assist targeted individuals and entities in acquiring assistive technology;

(bb) skills-development training in assessing the need for assistive technology devices and assistive technology services;

(cc) training to ensure the appropriate application and use of assistive technology devices, assistive technology services, and accessible technology for e-government functions;

(dd) training in the importance of multiple approaches to assessment and implementation necessary to meet the individualized needs of individuals with disabilities; and

(ee) technical training on integrating assistive technology into the development and implementation of service plans, including any education, health, discharge, Olmstead, employment, or other plan required under Federal or State law.

(III) Transition assistance to individuals with disabilities

The State shall directly, or provide support to public or private entities to, develop and disseminate training materials, conduct training, facilitate access to assistive technology, and provide technical assistance, to assist -

(aa) students with disabilities, within the meaning of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), that receive transition services; and

(bb) adults who are individuals with disabilities maintaining or transitioning to community living.

(ii) Public-awareness activities

(I) In general

The State shall conduct public-awareness activities designed to provide information to targeted individuals and entities relating to the availability, benefits, appropriateness, and costs of assistive technology devices and assistive technology services, including -

(aa) the development of procedures for providing direct communication between providers of assistive technology and targeted individuals and entities, which may include partnerships with entities in the statewide and local workforce investment systems established under the Workforce Investment Act of 1998 (29 U.S.C. 2801 et

seq.), State vocational rehabilitation centers, public and private employers, or elementary and secondary public schools;

(bb) the development and dissemination, to targeted individuals and entities, of information about State efforts related to assistive technology; and

(cc) the distribution of materials to appropriate public and private agencies that provide social, medical, educational, employment, and transportation services to individuals with disabilities.

(II) Collaboration

The State shall collaborate with entities that receive awards under paragraphs (1) and (3) of section 3005(b) of this title to carry out public-awareness activities focusing on infants, toddlers, children, transition-age youth, employment-age adults, seniors, and employers.

(III) Statewide information and referral system

(aa) In general

The State shall directly, or in collaboration with public or private (such as nonprofit) entities, provide for the continuation and enhancement of a statewide information and referral system designed to meet the needs of targeted individuals and entities.

(bb) Content

The system shall deliver information on assistive technology devices, assistive technology services (with specific data regarding provider availability within the State), and the availability of resources, including funding through public and private sources, to obtain assistive technology devices and assistive technology services. The system shall also deliver information on the benefits of assistive technology devices and assistive technology services with respect to enhancing the capacity of individuals with disabilities of all ages to perform activities of daily living.

(iii) Coordination and collaboration

The State shall coordinate activities described in paragraph (2) and this paragraph, among public and private entities that are responsible for policies, procedures, or funding for the provision of assistive technology devices and assistive technology services to individuals with disabilities, service providers, and others to improve access to assistive technology devices and assistive technology services for individuals with disabilities of all ages in the State.

(4) Indirect costs

Not more than 10 percent of the funds made available through a grant to a State under this section may be used for indirect costs.

(5) Prohibition

Funds made available through a grant to a State under this section shall not be used for direct payment for an assistive technology device for an individual with a disability.

(6) State flexibility

(A) In general

Notwithstanding paragraph (1)(A) and subject to subparagraph (B), a State may use funds that the State receives under a

grant awarded under this section to carry out any 2 or more of the activities described in paragraph (2).

(B) Special rule

Notwithstanding paragraph (3)(A), any State that exercises its authority under subparagraph (A) -

(i) shall carry out each of the required activities described in paragraph (3)(B); and

(ii) shall use not more than 30 percent of the funds made available through the grant to carry out the activities described in paragraph (3)(B).

(F) Annual progress reports

(1) Data collection

States shall participate in data collection as required by law, including data collection required for preparation of the reports described in paragraph (2).

(2) Reports

(A) In general

Each State shall prepare and submit to the Secretary an annual progress report on the activities funded under this chapter, at such time, and in such manner, as the Secretary may require.

(B) Contents

The report shall include data collected pursuant to this section. The report shall document, with respect to activities carried out under this section in the State -

(i) the type of State financing activities described in subsection (e)(2)(A) used by the State;

(ii) the amount and type of assistance given to consumers of the State financing activities described in subsection (e)(2)(A) (who shall be classified by type of assistive technology device or assistive technology service financed through the State financing activities, and geographic distribution within the State), including -

(I) the number of applications for assistance received;

(II) the number of applications approved and rejected;

(III) the default rate for the financing activities;

(IV) the range and average interest rate for the financing activities;

(V) the range and average income of approved applicants for the financing activities; and

(VI) the types and dollar amounts of assistive technology financed;

(iii) the number, type, and length of time of loans of assistive technology devices provided to individuals with disabilities, employers, public agencies, or public accommodations through the device loan program described in subsection (e)(2)(C), and an analysis of the individuals with disabilities who have benefited from the device loan program;

(iv) the number, type, estimated value, and scope of assistive technology devices exchanged, repaired, recycled, or reutilized (including redistributed through device sales, loans, rentals, or donations) through the device reutilization program described in subsection (e)(2)(B), and an analysis of the individuals with disabilities that have benefited from the device reutilization program;

(v) the number and type of device demonstrations and

referrals provided under subsection (e) (2) (D), and an analysis of individuals with disabilities who have benefited from the demonstrations and referrals;

(vi) (I) the number and general characteristics of individuals who participated in training under subsection (e) (3) (B) (i) (such as individuals with disabilities, parents, educators, employers, providers of employment services, health care workers, counselors, other service providers, or vendors) and the topics of such training; and

(II) to the extent practicable, the geographic distribution of individuals who participated in the training;

(vii) the frequency of provision and nature of technical assistance provided to State and local agencies and other entities;

(viii) the number of individuals assisted through the public-awareness activities and statewide information and referral system described in subsection (e) (3) (B) (ii);

(ix) the outcomes of any improvement initiatives carried out by the State as a result of activities funded under this section, including a description of any written policies, practices, and procedures that the State has developed and implemented regarding access to, provision of, and funding for, assistive technology devices, and assistive technology services, in the contexts of education, health care, employment, community living, and information technology and telecommunications, including e-government;

(x) the source of leveraged funding or other contributed resources, including resources provided through subcontracts or other collaborative resource-sharing agreements, from and with public and private entities to carry out State activities described in subsection (e) (3) (B) (iii), the number of individuals served with the contributed resources for which information is not reported under clauses (i) through (ix) or clause (xi) or (xii), and other outcomes accomplished as a result of such activities carried out with the contributed resources; and

(xi) the level of customer satisfaction with the services provided.

-SOURCE-

(Pub. L. 105-394, Sec. 4, as added Pub. L. 108-364, Sec. 2, Oct. 25, 2004, 118 Stat. 1714.)

-REFTEXT-

REFERENCES IN TEXT

Section 3011 of this title, referred to in subsec. (b) (2) (A), was omitted in the general amendment of this chapter by Pub. L. 108-364, Sec. 2, Oct. 25, 2004, 118 Stat. 1707.

Subchapter III of this chapter, referred to in subsec. (b) (2) (D), which consisted of sections 3051 to 3058 of this title, was omitted in the general amendment of this chapter by Pub. L. 108-364, Sec. 2, Oct. 25, 2004, 118 Stat. 1707.

The Rehabilitation Act of 1973, referred to in subsecs. (c) (2) (B) (i) (III) and (d) (3) (A) (ii), is Pub. L. 93-112, Sept. 26, 1973, 87 Stat. 355, as amended. Title I of the Act is classified generally to subchapter I (Sec. 720 et seq.) of chapter 16 of this title. Part C of title VII of the Act is classified generally to

subpart 3 (Sec. 796f et seq.) of part A of subchapter VII of chapter 16 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 701 of this title and Tables.

The Individuals with Disabilities Education Act, referred to in subsecs. (d) (3) (A) (i) and (e) (2) (C), (3) (B) (i) (III) (aa), is title VI of Pub. L. 91-230, Apr. 13, 1970, 84 Stat. 175, as amended, which is classified generally to chapter 33 (Sec. 1400 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Americans with Disabilities Act of 1990, referred to in subsecs. (d) (6) (E) and (e) (2) (C), is Pub. L. 101-336, July 26, 1990, 104 Stat. 327, as amended, which is classified principally to chapter 126 (Sec. 12101 et seq.) of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 12101 of Title 42 and Tables.

The Workforce Investment Act of 1998, referred to in subsec. (e) (3) (B) (ii) (I) (aa), is Pub. L. 105-220, Aug. 7, 1998, 112 Stat. 936, as amended. For complete classification of this Act to the Code, see Short Title note set out under section 9201 of Title 20, Education, and Tables.

-FOOTNOTE-

(!1) See References in Text note below.

(!2) So in original. Probably should be "(29)".

-End-

STATE OF ALASKA

Department of Labor and Workforce Development

DIVISION OF VOCATIONAL REHABILITATION

Governor's Committee on Employment & Rehabilitation
Of People with Disabilities

Sean Parnell, Governor

801 West 10th Street, Suite A
Juneau, AK 99801

V/TTY: (907) 465-2814

Fax: (907) 465-2856

January 26, 2010

Dear Representative:

The Governor's Committee on Employment & Rehabilitation of People with Disabilities strongly supports CS House Bill 89(L&C). This legislation will bring state statute into compliance with federal law. It will also eliminate the need to change state statute every time federal law changes. This committee will also function as the assistive technology advisory council which is also required under federal law and has similar membership requirements.

The Governor's Committee on Employment and Rehabilitation of People with Disabilities, which operates as Alaska's State Rehabilitation Council, is mandated by 29 U.S.C. 725 as amended, to have a very specific composition that is comprised of employers, service providers and individuals with disabilities. This varied composition provides an avenue for the Division of Vocational Rehabilitation to receive direct public feedback from a variety of stakeholders throughout Alaska. The Division utilizes this valuable feedback to continuously improve and refine its program.

We support the name change of the Governor's Committee on Employment of People with Disabilities to the State Vocational Rehabilitation Committee. Since this committee provides oversight to the Vocational Rehabilitation program, the name will clearly align it with the State of Alaska, Department of Labor and Workforce Development, Division Vocational Rehabilitation. The name change will also reduce the on-going confusion between this committee and the Governor's Council on Disability and Special Education.

Thank you for considering the CS HB 89(L&C). It is important that this committee is compliant with federal law to ensure continued funding which is critical to assist Alaskans with disabilities to become employed and have access to appropriate assistive technology services and devices. Please contact us if we can be of any assistance or provide any additional information.

Sincerely,



Ron Boynton
Committee Chair



3903 Taft Drive
Anchorage, AK 99517-3069
(907)248-7770
1(800)770-7517
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info@AlaskaBVI.org www.AlaskaBVI.org

Equipping Alaskans who are blind and visually impaired with skills for success in life and work

February 3, 2009

To Whom It May Concern:

This letter is to express strong support for HB 89, changing the name of the Governor's Committee on Employment of People with Disabilities to the State Vocational Rehabilitation Committee. Since this committee provides oversight of Vocational Rehabilitation, the name will clearly align it with the State of Alaska, Department of Labor and Workforce Development, Division of Vocational Rehabilitation. The name change will also reduce the ongoing confusion between this committee and the Governor's Council on Disabilities and Special Education.

This legislation will bring state statute into compliance with federal law. It will eliminate the need to change statutes every time federal law changes. This committee will also function as the assistive technology advisory council as required under federal law.

Thank you for considering HB 89. It is important that this committee is compliant with federal law to ensure continued funding which is critical to assisting Alaskans with visual and other disabilities to be employed and have access to assistive technology services. Please contact me if I can be of any assistance or provide additional information.

Sincerely,

Karla Jutzi
Executive Director





SARAH PALIN, GOVERNOR
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

P.O. Box 240249 • Anchorage, Alaska 99524-0249 • Phone: 907-269-8990 • Fax: 907-269-8995 • Toll Free 888-269-8990

February 3, 2009

To Whom It May Concern:

The Governor's Council on Disabilities and Special Education strongly supports HB 89 and SB 83 to change the name of the Governor's Committee on Employment of People with Disabilities to the State Vocational Rehabilitation Committee. Since this committee provides oversight to the Vocational Rehabilitation program, the name change will clearly align it with the State of Alaska, Department of Labor and Workforce Development, Division Vocational Rehabilitation. The name change will also reduce the on-going confusion between this committee and our Council.

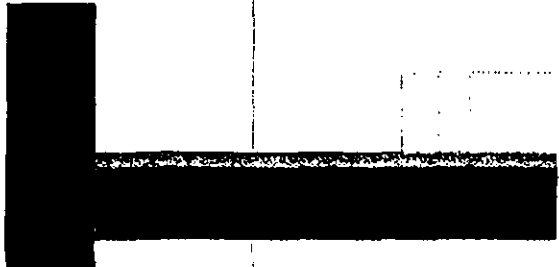
This legislation will bring state statute into compliance with federal law and ensure continued funding, which is critical to assist Alaskans with disabilities to become employed and have access to appropriate assistive technology services and devices. It will also eliminate the need to change state statute every time federal law changes.

Thank you for considering HB 89 and SB 83. Please contact me if I can be of any assistance or provide any additional information.

Sincerely,

Millie Ryan
Executive Director

ALASKA STATEWIDE INDEPENDENT LIVING COUNCIL, INC.



1057 W. Fireweed Lane, Ste. 206
Anchorage, AK 99503

Toll Free 1 888 284 7452
Phone 907 263-2092, 2011
Fax 907 263-2012

February 2, 2009

To Whom It May Concern:

The Statewide Independent Living Council strongly supports HB 89. This legislation will bring state statute into compliance with federal law. It will also eliminate the need to change state statute every time federal law changes. This committee will also function as the assistive technology advisory council as required under federal law.

We support the name change of the Governor's Committee on Employment of People with Disabilities to the State Vocational Rehabilitation Committee. Since this committee provides oversight to the Vocational Rehabilitation program, the name will clearly align it with the State of Alaska, Department of Labor and Workforce Development, Division Vocational Rehabilitation. The name change will also reduce the on-going confusion between this committee and the Governor's Council on Disability and Special Education.

Thank you for considering HB 89. It is important that this committee is compliant with federal law to ensure continued funding which is critical to assist Alaskans with disabilities to become employed and have access to appropriate assistive technology services and devices. Please contact us if we can be of any assistance or provide any additional information.

Sincerely,

Jim Beck
Chair

Sarah Palin, Governor

801 West 10th Street, Suite A
Juneau, AK 99801
V/TTY: (907) 465-2814
Fax: (907) 465-2856

Department of Labor and Workforce Development

DIVISION OF VOCATIONAL REHABILITATION

Governor's Committee on Employment
of People with Disabilities

January 26, 2009

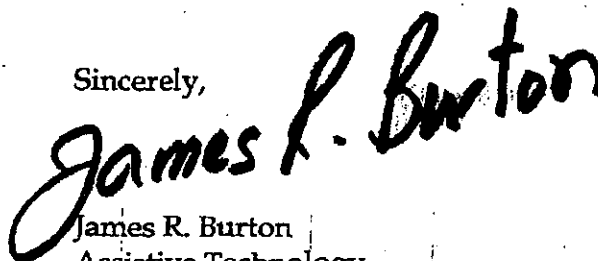
To Whom It May Concern:

The Governor's Committee on Employment of People with Disabilities strongly supports HB 89. This legislation will bring state statute into compliance with federal law. It will also eliminate the need to change state statute every time federal law changes. This committee will also function as the assistive technology advisory council as required under federal law.

We support the name change of the Governor's Committee on Employment of People with Disabilities to the State Vocational Rehabilitation Committee. Since this committee provides oversight to the Vocational Rehabilitation program, the name will clearly align it with the State of Alaska, Department of Labor and Workforce Development, Division Vocational Rehabilitation. The name change will also reduce the on-going confusion between this committee and the Governor's Council on Disability and Special Education.

Thank you for considering HB 89. It is important that this committee is compliant with federal law to ensure continued funding which is critical to assist Alaskans with disabilities to become employed and have access to appropriate assistive technology services and devices. Please contact us if we can be of any assistance or provide any additional information.

Sincerely,



James R. Burton
Assistive Technology
Sub-Committee Chairperson
GCEPD

HB

110

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182

Phone: (907) 465-4942 • Fax: (907) 465-4589



House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

Akiachak
Akiak
Atmaultluk
Bethel
Chefnorak
Eek
Goodnews Bay
Kasigluk
Kipnuk
Kongiganak
Kwethluk
Kwigillingak
Lower Kalskag
Mekoryuk
Mertarvik
Napakiak
Napaskiak
Newtok
Nightmute
Nunapitchuk
Oscarville
Platinum
Quinhagak
Taksook Bay
Tuluksak
Tununak
Tuntutuliak
Upper Kalskag

House Bill 110 - "Psychologists' Licensing and Practice"

Sponsor Statement

HB 110, "Psychologists' Licensing and Practice", hopes to clarify current statute regarding the licensing and regulation of psychologists in Alaska.

When current statute was written outlining the licensure of psychologists, the State Board of Psychologist and Psychological Associate Examiners offered the qualifying exam once every six months. Now the exam is offered more frequently, but AS 08.86.162 still specifically requires that an applicant who takes but does not pass the exam must wait six months before trying again. HB 110 deletes this requirement, allowing applicants to re-take the exam the next time it is offered. This change creates a more efficient licensure system, without sacrificing professional standards or quality.

HB 110 also clarifies to whom Alaska's laws regarding licensure do, and do not, apply. Passage will not limit the work of any other mental health service providers in Alaska – secular, spiritual, professional, or within volunteer-driven programs.

HB 110 is supported by the State Board of Psychologist and Psychological Associate Examiners, the Alaska Psychological Association, the Alaska Mental Health Board, and the Advisory Board on Alcohol and Drug Abuse.

Thank you for your interest. Please freely contact myself, or aide Liz Clement, with any questions.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

November 3, 2009

SUBJECT: Sectional summary (CSHB 110(HSS);
Work Order No. 26-LS0474\A)

TO: Representative Bob Herron
Co-chair of the House Health and Social Services Committee
Attn: Liz Clement

FROM: Alpheus Bullard *AB*
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Removes language that prevented a person from taking a psychological associate examination if the person had failed an examination administered by the Board of Psychologist and Psychological Associate Examiners in the preceding six months.

Section 2. Clarifies that the state's laws regulating psychologists and psychological associates (AS 08.86) do not apply to (1) school psychologists performing duties within school district facilities for a school district employer and (2) officers or employees of the United States Government practicing psychology while in the discharge of their official duties.

TLAB:ljw
09-363.ljw

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB110
 () Publish Date: _____

Identifier (file name): HB110-DHSS-BHA-01-14-10 Dept. Affected: Health & Social Services
 Title: Psychologists' Licensing & Practice RDU: Behavioral Health
 Component: Behavioral Health Administration
 Sponsor: Herron
 Requester: House HSS Component Number: 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill will have no significant fiscal impact on Behavioral Health. The bill relates to the practice and licensing of psychologists including a change in the qualifications of who is eligible to take a psychological associate examination and a clarification of Sec. 08.86.180 indicating who can practice psychology and who is exempt from those requirements (Section (b)).

Prepared by: Melissa W. Stone Phone 269-3410
 Division: Behavioral Health Date/Time 12/28/09 5:00 PM
 Approved by: Alison Elgee, Assistant Commissioner Date 1/14/2010
Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB110
() Publish Date: _____

Identifier (file name): HB110-DHSS-BHA-03-13-09 Dept. Affected: Health & Social Services
Title: Psychologists' Licensing & Practice RDU: Behavioral Health
Component: Behavioral Health Administration
Sponsor: Herron
Requester: House HSS Component Number: 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill will have no significant fiscal impact on Behavioral Health. The bill relates to the practice and licensing of psychologists including a change in the qualifications of who is eligible to take a psychological associate examination and a clarification of Sec. 08.86.180 indicating who can practice psychology and who is exempt from those requirements (Section (b)).

Prepared by: Melissa Stone Phone 269-3410
Division: Behavioral Health Date/Time 3/12/09 5:00 PM

Approved by: Alison Elgee, Assistant Commissioner Date 3/13/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB 110
 () Publish Date: _____

Identifier (file name): HB110CS(HSS)-CED-CBPL-02-16-10 Dept. Affected: DCCED
 Title: Psychologists' Licensing and Practice RDU: Corp, Bus, & Prof Licensing (117)
 Component: Corp., Bus., & Prof. Licensing
 Sponsor: Representative Herron
 Requester: House Labor and Commerce Committee Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB 110 amends AS 08.86, the statutes governing psychologists and psychological associates allowing psychological associates to take or re-take the licensure examination when ready; and exempts school psychologists and federal employees from State licensing requirements while performing their duties as employees. New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Chief
 Division: Corporations, Business & Professional Licensing
 Approved by: Emil Notti, Commissioner
Commerce, Community and Economic Development

Phone (907) 465-2144
 Date/Time 2/16/10 9:44 AM
 Date 2/16/2010

Alaska Psychological Association

advancing psychology as a science, profession, and means of promoting human welfare

P.O. Box 241292
Anchorage, Alaska 99524
ak-pa.org
(907) 344-8878

2/26/08

Lorin Bradbury Ph.D.
Chairperson
Board of Psychologists and Psychological
Associate Examiners

Dear Dr. Bradbury;

The Executive Board of the Alaska Psychological Association voted unanimously at its February 11th meeting to support the efforts of the Psychological Licensing Board to modify the language of the Psychology Licensing Law that describes who can call themselves Psychologists or advertise themselves as Psychologists. Currently in the Scope of practice section of our license, any mental health professional working in a government agency, private mental health clinic or other mental health organization could potentially practice as a licensed psychologist and advertise themselves as such in providing psychological evaluations, psychological testing and related psychological reports to the public or other agencies. The Alaska Psychological Association Executive Board appointed Phillip Baker Ed.D. And Robert Lane Ph.D. to work with the Psychological Licensing Board to help prepare and testify in new legislation to close this loop hole. We feel that anyone working in any setting that is holding themselves out as a psychologist, **MUST HAVE A PSYCHOLOGIST LICENSE.**

This letter was written to display the support of our professional organization for this proposed legislation. If there are further questions about this letter, please direct them to Dr. Phillip Baker Ed.D., Legislative Chair Person for the Alaska Psychological Association. Dr. Baker's telephone number is: (907) 562-2392. His email address is:

Sincerely,
Phillip Baker Ed.D.
Phillip Baker Ed.D.
Licensed Clinical Psychologist
AK-PA Legislative Chairperson

Bradbury Psychological Services
P.O. Box 1748
Bethel, AK 99559
Ph. (907) 543-3266
FAX (907) 543-4767
E-mail: lorin192@unicom-alaska.com

February 11, 2009

Representative Bob Herron
State Capitol
Juneau, AK 99801-1182

Re: HB 110

Dear Mr. Herron:

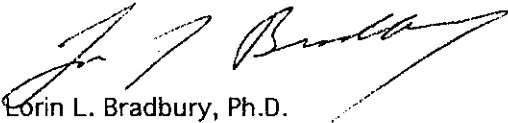
This letter is in support of HB 110, which has the support of both the Board of Psychologist and Psychological Associate Examiners, and the Alaska Psychological Association. The most substantial change by passage of this bill will be to AS 08.86.180(b). Passage of this bill is clearly in the best interest of the public because it provides the level of protection to the public that was originally intended by the passage of a licensing law for psychologists.

As the law currently stands, it has led some to believe that AS 08.86.180(b)(1) exempts a variety of individuals who might be eligible for licensure from the requirement of licensure. Passage of HB 110 will more clearly define who needs to obtain licensure.

Passage of this bill will not discriminate against school psychologists who are credentialed by the Department of Education, nor against those already exempted from licensure by federal law. Also, it will not negatively impact other mental health professionals because they are already protected under AS 08.86.180(b)(5) and (d).

Thank you for your support of this very worthy piece of legislation.

Sincerely,



Lorin L. Bradbury, Ph.D.

Chairman

Board of Psychologist and Psychological Associate Examiners

Board of Psychologist and Psychological Associate Examiners

State of Alaska >Commerce >Professional Licensing >Psychologists Examiners

Applications

The Board of Psychologist and Psychological Associate Examiners is staffed by the Division of Corporations, Business and Professional Licensing. The Board consists of three psychologists, one psychological associate, and one public member. Board members are appointed by the governor and confirmed by the legislature.

Examinations

Meeting Dates

Meeting Minutes

Psychologist & Psychological Associate Statutes & Regulations

The Board adopts regulations to carry out laws governing the practice of psychology in Alaska. It makes final licensing decisions and takes disciplinary actions against people who violate licensing laws. The Board meets three times a year and offers a public comment period at each meeting. Meeting agendas are available from the licensing examiner.

Central Licensing Statutes & Regulations

Professions Regulated by the Board

National Organizations

- a. Psychological Associate
- b. Psychologist

Contact Information

Licensing Examiner: Jan Mays
 Phone: (907) 465-5470
 Fax: (907) 465-2974
 E-mail: janalete.mays@alaska.gov
 Address: PO Box 110806
 Juneau, AK 99811-0806

Investigations/Complaints

To file a complaint or to bring a matter pertaining to the actions of a licensed, or unlicensed, professional to the attention of our investigative staff, please send an email to: investigations@alaska.gov

- Acupuncturists ▲
- Architects, Engineers, and Land Surveyors ▲
- Audiologists and Speech-Language Pathologists ▲
- Barbers and Hairdressers ▲
- Big Game Commercial Services Board ▲
- Chiropractic Examiners ▼

Webmaster Contact the Division

Quick Links...

- ▶ Buy a Business License
- ▶ Business License Search
- ▶ Professional License Search
- ▶ Download List of License Holders

Of Interest...

- ▶ Business Licensing
- ▶ Small Business Development
- ▶ Other Occupations Licensed in Alaska
- ▶ Notices of Proposed Regulations



Applications may be viewed and printed with Adobe Acrobat Reader 6.0 or higher. If you do not have Adobe Acrobat Reader 6.0 or higher, please click on the Adobe logo and download the free software now. If you are unable to view or download an application, please contact us by telephone or e-mail. Providing your complete mailing address will enable us to mail you the application.

Other application forms may be mailed to you or picked up at a division office. Completed applications must be signed and submitted to the division with the appropriate fees.

ALASKA STATE LEGISLATURE

State Representative Bob Herron

Official Business



State Capitol
Juneau, Alaska
99801-1182

HOUSE BILL 110

"Psychologists' Licensing and Practice"

Questions and Answers

What does HB 110 do?

Two things. Section 1 is a simple efficiency measure, to ease the licensing process. When current statute was written, the Board of Psychologists and Psychological Associates Examiners offered the qualifying exam only once every six months. It is now offered every three months. This change to AS 08.86.162 will allow applicants who need to re-take the exam to do so in a more timely manner.

Section 2 clarifies who is subject to regulation by the Board, and who is not. It takes away very vague language (a person employed "by a governmental unit, educational institution or private agency who may be required to engage in some phase of work of a psychological nature in the course of the person's employment"), and replaces it with more specific groups:

- 1) School psychologists under the supervision of their employing districts. These professionals do not fall under the purview of the Board of Psychologists and Psychological Associate Examiners. School psychology is a unique field of study, separate from general psychology. In Alaska, school psychologists are licensed and regulated by the state's Department of Education and Early Development.
- 2) Federal officers and employees, *while performing official job duties*. The State does not have the authority to regulate the official work of the Federal government. It is important to note this exemption applies only while the individual in question is performing official duties.

Other exemptions to Board regulation currently in statute will remain untouched for:

- Properly supervised psychology students, interns, and residents in a board-approved course of study.
- Other mental health professionals whose work is also of a psychological nature, as long as they do not publicly claim to be a psychologist. – Examples: Licensed Professional Counselors (regulated by the Board of Professional Counselors), Marital and Family Therapists (regulated by the Board of Marital and Family Therapy), and Licensed Clinical Social Workers (regulated by the Board of Social Work Examiners). For further information on the qualifications these professions require in Alaska, please see the attached Mental Health Provider Comparison chart.

Who does HB 110 affect?

HB 110 affects only individuals seeking licensure by the Board of Psychologist and Psychological Associate Examiners, and people who may publicly claim to be psychologists but do not have the required board-issued license.

Other licensed mental health professionals doing work within their scope of practice and in accordance with their own profession's ethics code (including various State of Alaska employees) are *not* impacted by the HB 110. Volunteers serving in either secular or faith-based peer support programs are *not* impacted by HB 110.

What differentiates a psychologist's work from the work of other types of licensed professionals whose work may also be of a "psychological nature"?

Psychologists are the only professionals who can purchase, perform, evaluate, and interpret psychological tests. Counseling (or "psychotherapy") is a specialty area for psychologists, but it is not necessarily an area of expertise for all psychologists in the way it is for Licensed Professional Counselors or Marital and Family Therapists.

Is there a difference between a "psychologist" and a "school psychologist"?

Yes. School psychology is its own unique field of study. Educational programs in school psychology are accredited by different organizations than are educational programs in "psychology". In Alaska, as in many other states, school psychologists are also licensed and regulated by the state's Department of Education and Early Development. They are not licensed to practice independently, but rather to perform work under supervision of the employing school districts, within district facilities. School psychologists are not subject to the authority of AS 08.86 or the Board of Psychologist and Psychological Associate Examiners, and therefore will not be impacted by passage of HB110.

Alaska Mental Health Providers: Pre-Licensure Requirements

Psychologists

Regulated by the Board of Psychologist and Psychological Associate Examiners

Per AS 08.86.130:

1. Doctorate degree in psychology from a program that meets the Board's criteria in clinical psychology, counseling psychology, or a specialty deemed equivalent by the Board,
2. Has not engaged in dishonorable conduct related to the practice of counseling or psychometry, and
3. Has one year of post doctoral supervised experience approved by the Board.

Psychological Associates

Regulated by the Board of Psychologist and Psychological Associate Examiners

Per AS 08.86.160 and AS 08.86.162:

1. Masters degree in psychology from a program that meets the Board's criteria in clinical psychology, counseling psychology, or a specialty deemed equivalent by the Board,
2. Has not engaged in dishonorable conduct related to the practice of counseling or psychometry,
3. Has two years of post master's supervised experience approved by the Board, and
4. Passes the Board-approved objective examination for psychological associates.

Qualifications to sit for the Psychologist Associate Examination:

- a) Number 1, above.
- b) Number 2, above, including the equivalent of at least 48 semester credit hours of graduate course work directly related to a specialized area of psychology,
- c) Recommendation by an immediate supervisor, and
- d) Has not failed the exam within the previous six months.*

**HB 110 also seeks to remove the six month requirement.*

School Psychologists

Regulated by the Alaska Department of Education and Early Development, not subject to changes made by HB 110.

1. Masters or Doctoral degree in school psychology, and
2. Recommendation for endorsement by an institution whose program has been approved by:
 - a) The National Council for Accreditation of Teacher Education,
 - b) The National Association of State Directors of Teacher Education and Certification,
 - c) The National Association of School Psychologists, or
 - d) The American Psychological Association, and
3. Completes a 1,200 hour internship in school psychology;

OR

Be a nationally certified school psychologist under the National School Psychologist Certification System established by the National Association of School Psychologists.

Courtesy of Representative Herron
State Capitol, Room 411, (907) 465.4942

Alaska Mental Health Providers: Pre-Licensure Requirements

<u>Licensed Professional Counselors</u>	<u>Marital and Family Therapists</u>	<u>Licensed Clinical Social Workers</u>
<p style="text-align: center;"><i>Regulated by the Board of Professional Counselors, <u>not subject to changes made by HB 110.</u></i></p> <p style="text-align: center;">Per AS 08.29.010:</p> <ol style="list-style-type: none"> 1. Age 18 or older, 2. Is not under investigation related to the practice of counseling, 3. Does not have a license related to the practice of counseling, psychology, marital and family therapy, or social work suspended, revoked, or surrendered, 4. Has passed a written exam approved by the Board, 5. Has completed either: <ol style="list-style-type: none"> a) A Doctoral degree in counseling or a related field, or b) A Masters degree in counseling or a related field, and at least 60 graduate semester hours in counseling during or after earning the Master's degree, and 6. Has at least 3,000 hours of post-degree supervised counseling experience, performed over a period of at least two years. 	<p style="text-align: center;"><i>Regulated by the Board of Marital and Family Therapy, <u>not subject to changes made by HB 110.</u></i></p> <p style="text-align: center;">Per AS 08.63.100:</p> <ol style="list-style-type: none"> 1. Has not engaged in dishonorable conduct, 2. Master's or Doctorate degree in marital and family therapy or an allied mental health field from a Board-approved institution, 3. Has completed 1,500 hours of direct clinical contact with couple, individuals, and families. At least 200 of these hours must be supervised, 4. Has training related to domestic violence, and 5. Has passed a written or oral exam given by the Board. 	<p style="text-align: center;"><i>Regulated by the Board of Social Work Examiners, <u>not subject to changes made by HB 110.</u></i></p> <p style="text-align: center;">Per AS 08.95.110:</p> <ol style="list-style-type: none"> 1. Has a Master's or Doctoral degree in Social Work, 2. Has completed, within 10 years of application, supervised by a licensed social worker, licensed psychologist, or licensed psychiatrist: <ol style="list-style-type: none"> a) At least two years of continuous full time employment in postgraduate clinical social work, or b) At least 3,000 hours of less than full-time employment in a period of not less than two years in postgraduate social work, 3. Shows good moral character, 4. Maintains good professional standing, 5. Provides three professional references, and 6. Completes the Board-issued examination.

Courtesy of Representative Herron
State Capitol, Room 411, (907) 465.4942

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182

Phone: (907) 465-4942 • Fax: (907) 465-4589



House District 38
Kuskokwim & Johnson Rivers
Kuskokwin Bay & Nelson Island

Sponsor Statement

Akiachak

Akiak

Atmoutluak

Bethel

Chefornak

Eek

Goodnews Bay

Kasigluk

Kipnuk

Kongiganak

Kwethluk

Kwigillingok

Lower Kalskag

Mekoryuk

Mertarvik

Napakiak

Napaskiak

Newtok

Nightmute

Nunapitchuk

Oscarville

Platinum

Quinhagak

Toksook Bay

Tuluksak

Tununak

Tuntutuliak

Upper Kalskag

HB110 has the support of the Psychological Licensing Board as well as the Executive Board of the Alaska Psychological Association. Its main purpose is to clarify statutory language regarding the licensing of psychologists. Under current law, any mental health professional working in a government agency, private mental health clinic, or other mental health organization could potentially practice as a licensed psychologist. The Psychological Licensing Board believes that anyone working in any setting that is holding themselves out as a psychologist must have a psychological license. The bill, therefore, replaces the broader language with language to allow only school psychologists to be exempt. It also requires that the school district maintain appropriate supervision of the activities of the school psychologist. The bill also adds a section exempting an officer or employee of the US Gov't while executing official duties.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 17, 2009

SUBJECT: Sectional summary (HB 110; Work Order No. 26-LS0474\A)

TO: Representative Bob Herron
Attn: Marianna Carpeneti

FROM: Alpheus Bullard *TLAB*
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Removes language that prevented a person from taking a psychological associate examination if the person had failed an examination administered by the Board of Psychologist and Psychological Associate Examiners in the preceding six months.

Section 2. Clarifies that the state's laws regulating psychologists and psychological associates (AS 08.86) do not apply to (1) school psychologists performing duties within school district facilities for a school district employer and (2) officers or employees of the United States Government practicing psychology while in the discharge of their official duties.

Section 3. Changes the statutory definition of "to practice psychology," by providing that certain activities constitute the "practice of psychology" whether or not they are rendered or offered for a fee.

TLAB:plm
09-180.plm

Psychometrics

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For the parapsychology phenomenon of distance knowledge, see [psychometry](#).

For the measurement of the heat and water vapor properties of air, see [psychrometrics](#).

Psychometrics is the field of study concerned with the theory and technique of [educational](#) and [psychological measurement](#), which includes the measurement of knowledge, abilities, attitudes, and [personality](#) traits. The field is primarily concerned with the study of measurement instruments such as [questionnaires](#) and [tests](#). It involves two major research tasks, namely: (i) the construction of instruments and procedures for measurement; and (ii) the development and refinement of theoretical approaches to measurement.

person's out-of-state license or certificate were essentially similar to or higher than the examination and qualification requirements for licensure under this chapter;

(2) is a diplomate in good standing of the American Board of Professional Psychology; or

(3) is certified or registered with a credentialing organization in psychology approved by the board in regulation and with requirements essentially similar to or higher than the requirements for licensure under this chapter. (§ 1 ch 136 SLA 1967; am § 10 ch 58 SLA 1980; am § 3 ch 29 SLA 1983; am § 4 ch 63 SLA 1986; am § 7 ch 36 SLA 2005)

Effect of amendments. — The 2005 amendment, effective June 3, 2005, added paragraph (3) and made a related stylistic change.

Article 4. Licensing of Psychological Associates.

Section	Section
160. Licensing requirements	164. Scope of practice by associate
162. Qualifications for associates' examination	166. Temporary license

Administrative Code. — For experience and education, see 12 AAC 60, art. 2.
For examinations, see 12 AAC 60, art. 3.

Sec. 08.86.160. Licensing requirements. (a) The board shall issue a psychological associate license to a person who

(1) holds an earned master's degree from an academic institution whose program of graduate study for a master's degree in psychology meets the criteria established by the board by regulation in

- (A) clinical psychology;
- (B) counseling psychology; or
- (C) education in a field of specialization considered equivalent by the board;

(2) has not engaged in dishonorable conduct related to the practice of counseling or psychometry;

(3) has two years of post master's supervised experience approved by the board; and

(4) takes and passes the objective examination developed or approved by the board for psychological associates.

(b) The board may not deny recognition as an accredited or approved academic institution to an educational institution solely because its program has not been accredited by a professional organization of psychologists. (§ 5 ch 65 SLA 1973; am § 4 ch 51 SLA 1996)

Effect of amendments. — The 1996 amendment, effective September 4, 1996, rewrote this section.

NOTES TO DECISIONS

Applied in *Allred v. State*, 554 P.2d 411 (Alaska 1976).

Sec. 08.86.162. Qualifications for associates' examination. A person is entitled to take a psychological associate examination if the board finds that the person:

- (1) has not engaged in dishonorable conduct related to the practice of counseling or psychometry;

shall issue a psychologist institution whose program of criteria established by the

nt by the board; practice of counseling or

proved by the board; and approved by the board.

d or approved academic program has not been

ch 136 SLA 1967; am § 8 996)

rbeck, 126 P.3d 1057 (Alaska

a temporary license to a (2). A temporary license

ified in the person's plan the requirements of AS

am § 3 ch 51 SLA 1996)

S 08.86.130(a)(3)" for "until the ation following the issuance of are published."

der AS 08.01.065 for the

am § 2 ch 38 SLA 1970; 94 SLA 1987)

licensed or certified as entitled to be licensed in the application form, submit board, pays the credential

hology that satisfies the tion requirements for the

(2) holds a master's degree with primary emphasis on psychology from an academic institution whose program of graduate study for a master's degree in psychology meets the criteria established by the board by regulation, with the equivalent of at least 48 semester credit hours of graduate course work directly related to a specialized area of psychology in which licensure is requested, including a practicum;

(3) *[Repealed, § 11 ch 51 SLA 1996.]*

(4) has the recommendation of an immediate supervisor if a licensed psychologist, or two licensed psychologists who hold doctoral degrees; and

(5) has not within the preceding six months failed an examination given by the board. (§ 5 ch 65 SLA 1973; am §§ 11, 12, 21 ch 58 SLA 1980; am § 5 ch 63 SLA 1986; am § 2 ch 21 SLA 1992; am § 11 ch 51 SLA 1996)

Revisor's notes. — The definition of "supervised experience" in former (3) of this section was enacted as an amendment to AS 08.86.230(11). Renumbered in 1980.

Effect of amendments. — The 1996 amendment, effective September 4, 1996, repealed paragraph (3).

NOTES TO DECISIONS

Applied in *Allred v. State*, 554 P.2d 411 (Alaska 1976).

Sec. 08.86.164. Scope of practice by associate. (a) A psychological associate shall be licensed to provide psychological services within the nature and extent of the psychological associate's training and experience as defined in regulation.

(b) *[Repealed, § 11 ch 51 SLA 1996.]*

(c) *[Repealed, § 11 ch 51 SLA 1996.]*

(d) *[Repealed, § 11 ch 51 SLA 1996.]*

(e) *[Repealed, § 11 ch 51 SLA 1996.]* (§ 13 ch 58 SLA 1980; am § 6 ch 63 SLA 1986; am §§ 5, 11 ch 51 SLA 1996)

Effect of amendments. — The 1996 amendment, effective September 4, 1996, in subsection (a), substituted "to provide psychological services within" for "for specific activities or areas of competence as deter-

mined by" and "as defined in regulation" for "and those areas shall be specified on the license" and repealed subsections (b)-(e).

Sec. 08.86.166. Temporary license. The board may issue a temporary license to a person who meets the requirements of AS 08.86.160(a)(1), (2), and (4). A temporary license issued under this section is valid only for the time period identified in the person's plan for the purpose of obtaining supervised experience to meet the requirement of AS 08.86.160(a)(3). (§ 6 ch 51 SLA 1996)

Article 5. Prohibitions and Penalties.

Section

- 170. Use of title
- 180. Practice of psychology
- 190. Name under which person practices
- 200. Confidentiality of communication

Section

- 204. Grounds for imposition of disciplinary sanctions
- 210. Penalty
- 220. Limits or conditions on license; discipline

Administrative Code. — For rules of professional conduct, see 12 AAC 60, art. 4.

Sec. 08.86.170. Use of title. (a) Unless licensed under this chapter, a person may not use the title "psychologist" or a title, designation, or device indicating or tending to indicate that the person is a psychologist or practices psychology.

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a licensed psychologist, or

nation given by the board. 5 ch 63 SLA 1986; am § 2

ments. — The 1996 amendment, 4, 1996, repealed paragraph (3).

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a temporary license to a 2), and (4). A temporary identified in the person's at the requirement of AS

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hapter, a person may no ndicating or tending y.

(b) Unless licensed under this chapter, a person may not use the title "psychological associate" or a title, designation, or device indicating or tending to indicate that the person is a psychological associate or practices counseling or psychometrics. (§ 1 ch 136 SLA 1967; am § 6 ch 65 SLA 1973)

Cross references. — For professional designation requirements for psychologists, see AS 08.02.010.

NOTES TO DECISIONS

Applied in Allred v. State, 554 P.2d 411 (Alaska 1976).

Sec. 08.86.180. Practice of psychology. (a) Unless licensed under this chapter, a person may not practice psychology or hold out publicly as a psychologist or as practicing psychology. A person holds out as a psychologist by using a title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychometry," "psychotherapy," "psychotherapeutic," "psychotherapist," "psychoanalysis," or "psychoanalyst" or when holding out publicly to be trained, experienced, or qualified to render services in the field of psychology.

(b) This section does not apply to

(1) a person employed by a governmental unit, educational institution or private agency who may be required to engage in some phase of work of a psychological nature in the course of the person's employment, if the employer maintains appropriate supervision of psychological activities and professional conduct, and if the person is performing the psychological activities as part of the duties for which the person was employed, is performing the activities solely within the facilities of the organization in which the person is employed or under the supervision of the organization in which the person is employed, and does not render or offer to render psychological services to the public for compensation in addition to the salary the person receives from the organization;

(2) a student, intern, or resident in psychology pursuing a course of study approved by the board as qualifying training and experience for a psychologist, if that person's activities constitute a part of that person's supervised course of study and that person is designated by titles such as "psychology intern" or "psychology trainee";

(3) a qualified member of another profession, in doing work of a psychological nature consistent with that person's training and consistent with the code of ethics of that person's profession, if the person does not hold out to the public by a title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychometry," "psychotherapy," "psychotherapeutic," "psychotherapist," "psychoanalysis," or "psychoanalyst" or represent to be trained, experienced, or qualified to render services in the field of psychology.

(4) [Repealed, § 15 ch 65 SLA 1973.] — psychiatrists

(5) a physician engaged in the normal practice of medicine for which the physician is licensed under AS 08.64.

(c) Nothing in this chapter authorizes a person licensed as a psychologist to engage in the practice of medicine, as defined by the laws of the state.

(d) Nothing in this section prohibits a licensed clinical social worker, a licensed marital and family therapist, or a licensed professional counselor from holding out to the public by a title or description of services incorporating the words "psychoanalysis," "psychoanalyst," "psychotherapy," "psychotherapist," or "psychotherapeutic." (§ 1 ch 136 SLA 1967; am § 10 ch 69 SLA 1970; am §§ 7, 15 ch 65 SLA 1973; am §§ 14, 15 ch 58 SLA 1980; am §§ 4, 5 ch 29 SLA 1983; am § 1 ch 77 SLA 2006)

Effect of amendments. — The 2006 amendment, effective September 17, 2006, substituted "licensed clinical social worker, a licensed marital and family therapist, or a licensed professional counselor" for "clinical social worker," and inserted "psychoanalysis," "psychoanalyst," in subsection (d).

Collateral references. — Psychologist, 81 ALR2d 791.

Sec. 08.86.185. Practice of counseling and psychometrics. [Repealed, § 24 ch 58 SLA 1980. For current law, see AS 08.86.180.]

Sec. 08.86.190. Name under which person practices. (a) A licensed psychologist may practice psychology only under that person's own name.

(b) A licensed psychological associate may practice counseling or psychometry only under that person's own name. (§ 1 ch 136 SLA 1967; am § 9 ch 64 SLA 1973)

NOTES TO DECISIONS

Applied in *Allred v. State*, 554 P.2d 411 (Alaska 1976).

Sec. 08.86.200. Confidentiality of communication. (a) A psychologist or psychological associate may not reveal to another person a communication made to the psychologist or psychological associate by a client about a matter concerning which the client has employed the psychologist or psychological associate in a professional capacity. This section does not apply to

(1) a case conference with other mental health professionals or with physicians and surgeons;

(2) a case in which the client in writing authorized the psychologist or psychological associate to reveal a communication;

(3) a case where an immediate threat of serious physical harm to an identifiable victim is communicated to a psychologist or psychological associate by a client;

(4) disclosures of confidential communications required under Rule 504, Alaska Rules of Evidence; or

(5) proceedings conducted by the board or the department where the disclosure of confidential communications is necessary to defend against charges that the psychologist or psychological associate has violated provisions of this chapter; information obtained by the board or department under this paragraph is confidential and is not a public record for purposes of AS 40.25.110 — 40.25.140.

(b) Notwithstanding (a) of this section, a psychologist or psychological associate shall report to the appropriate authority incidents of child abuse or neglect as required by AS 47.17.020, incidents of abuse of a vulnerable adult as required by AS 47.24.010, and incidents of abuse of disabled persons disclosed to the psychologist or psychological associate by a client. In this subsection "disabled person" means a person who has a physical or mental disability or a physical or mental impairment, as defined in AS 18.80.300. (§ 1 ch 136 SLA 1967; am § 10 ch 65 SLA 1973; am § 7 ch 63 SLA 1986; am §§ 1, 2 ch 102 SLA 1988; am § 1 ch 129 SLA 1994; am § 7 ch 51 SLA 1996)

Revisor's notes. — In 2000, "AS 40.25.110 — 40.25.140" was substituted for "AS 09.25.110 — 09.25.140" to reflect the 2000 renumbering of AS 09.25.110 — 09.25.140.

Effect of amendments. — The 1994 amendment, effective July 9, 1994, substituted "abuse of a vulnerable adult" for "elder abuse" in the first sentence in subsection (b).

The 1996 amendment, effective September 4, 1996, in subsection (a), substituted "mental health professionals" for "psychologists, psychological associates" in paragraph (1) and added the semicolon and the language following it at the end of paragraph (5).

NOTES TO DECISIONS

Enactment as "anti-gossip" measure. — For case discussing enactment of this section as an "anti-gossip" measure rather than as creation of a statutory privilege in criminal cases, see *Allred v. State*, 554 P.2d 411 (Alaska 1976).

Assertion of insanity defense waives privilege. — The psychotherapist-patient privilege is waived by the assertion of a defense of insanity as to communications which are relevant to that defense. *Post v. State*, 580 P.2d 304 (Alaska 1978).

Marianna Carpeneti

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Tuesday, March 17, 2009 12:32 PM
To: Marianna Carpeneti
Cc: Casto, L Diane (HSS)
Subject: HB 110

Mari,

In response to your question regarding department comments on HB 110, the Department of Health and Social Services has reviewed these recommended changes and does not believe they will impact our department or our community-based provider system in their ability to provide quality work of a psychological nature.

Wilda Laughlin, DHSS Legislative Liaison
Juneau: 907-465-1613
Cell: 907-723-3802

Bradbury Psychological Services
P.O. Box 1748
Bethel, AK 99559
Ph. (907) 543-3266
FAX (907) 543-4767
E-mail: lorin192@unicom-alaska.com

February 11, 2009

Representative Bob Herron
State Capitol
Juneau, AK 99801-1182

Re: HB 110

Dear Mr. Herron:

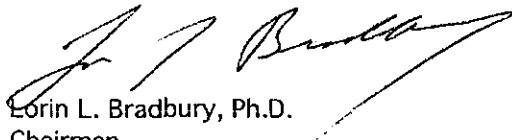
This letter is in support of HB 110, which has the support of both the Board of Psychologist and Psychological Associate Examiners, and the Alaska Psychological Association. The most substantial change by passage of this bill will be to AS 08.86.180(b). Passage of this bill is clearly in the best interest of the public because it provides the level of protection to the public that was originally intended by the passage of a licensing law for psychologists.

As the law currently stands, it has led some to believe that AS 08.86.180(b)(1) exempts a variety of individuals who might be eligible for licensure from the requirement of licensure. Passage of HB 110 will more clearly define who needs to obtain licensure.

Passage of this bill will not discriminate against school psychologists who are credentialed by the Department of Education, nor against those already exempted from licensure by federal law. Also, it will not negatively impact other mental health professionals because they are already protected under AS 08.86.180(b)(5) and (d).

Thank you for your support of this very worthy piece of legislation.

Sincerely,



Lorin L. Bradbury, Ph.D.
Chairman
Board of Psychologist and Psychological Associate Examiners

Alaska Psychological Association

Advancing psychology as a science, profession, and means of promoting human welfare

P.O. Box 241292
Anchorage, Alaska 99524
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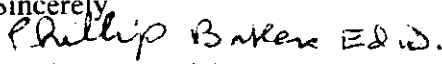
2/26/08

Lorin Bradbury Ph.D.
Chairperson
Board of Psychologists and Psychological
Associate Examiners

Dear Dr. Bradbury;

The Executive Board of the Alaska Psychological Association voted unanimously at its February 11th meeting to support the efforts of the Psychological Licensing Board to modify the language of the Psychology Licensing Law that describes who can call themselves Psychologists or advertise themselves as Psychologists. Currently in the Scope of practice section of our license, any mental health professional working in a government agency, private mental health clinic or other mental health organization could potentially practice as a licensed psychologist and advertise themselves as such in providing psychological evaluations, psychological testing and related psychological reports to the public or other agencies. The Alaska Psychological Association Executive Board appointed Phillip Baker Ed.D. And Robert Lane Ph.D. to work with the Psychological Licensing Board to help prepare and testify in new legislation to close this loop hole. We feel that anyone working in any setting that is holding themselves out as a psychologist, MUST HAVE A PSYCHOLOGIST LICENSE.

This letter was written to display the support of our professional organization for this proposed legislation. If there are further questions about this letter, please direct them to Dr. Phillip Baker Ed.D., Legislative Chair Person for the Alaska Psychological Association. Dr. Baker's telephone number is: (907) 562-2392. His email address is:

Sincerely,

Phillip Baker Ed.D.
Licensed Clinical Psychologist
AK-PA Legislative Chairperson

Model Act for State Licensure of Psychologists

As APA policy, the Model Act serves as a prototype for drafting state legislation regulating the practice of psychology. State legislatures are encouraged to use the language of this document and the policies that it espouses as the model for their own state licensure law. Inevitably each state law will reflect compromises and changes particular to that state, but the APA Model Act is meant to serve as a guide for those involved in the drafting process. State licensing boards must develop their own rules and regulations to supplement the legislation proposed here.

This is the fourth set of guidelines for state legislation regulating the practice of psychology that has been developed by the American Psychological Association (APA). The first model for such regulation was developed and adopted as APA policy in 1955 (APA, 1955).

The 1955 guidelines stood for 12 years, during which the number of states enacting licensure legislation grew from 9 to 32. In 1967 the APA Committee on State Legislation (COSL) prepared the first revision of the guidelines. That revision was more comprehensive, provided more detailed guidance, and covered more issues relating to regulation of the practice of psychology, while reaffirming the basic concept found in the 1955 model (APA, 1967).

By 1977 all states and the District of Columbia had enacted licensure legislation. APA's Council of Representatives then determined that the model approved in 1967 was outdated and directed COSL to undertake a revision. However, in January 1979 the Council of Representatives failed to approve the revised model guidelines, leaving the 1967 guidelines to remain as APA policy.

In 1984 the Council of Representatives directed the Board of Professional Affairs (BPA) to develop another revision of the existing 1967 model for the Council's consideration. BPA, in turn, directed its Committee on Professional Practice (COPP) to prepare it.

A COPP subcommittee undertook this effort. Its early drafts were based on a review of the comments provided by APA governance units and divisions regarding the 1979 COSL proposal. Specific recommendations were received from the Board of Directors (B/D) Subcommittee on the Future of Professional Psychology in April 1985. Numerous drafts were subsequently developed and revised based on comments provided by members of COPP and BPA, the American Association of State Psychology Boards, individual psychologists from around the country and Canada, relevant APA divisions and governance groups, unaffiliated psychology interest groups, and APA legal counsel. This document, Draft 14, is the result of three years of continual discussion, review, and compromise by many concerned and dedicated APA members. It was passed unanimously by the Council of Representatives on February 7, 1987.

Each section of the proposed Model Act is introduced by commentary, the purpose of which is to explain the rationale for the proposed section that follows. To differentiate between the commentary and the proposed statutory language, the latter is set in smaller type.

A. Declaration of Policy

This section declares that the intent of legislation for state licensure of psychologists is to ensure the practice of psychology in the public interest. The consumer should be assured that psychological services will be provided by qualified professionals. The public must also be protected from the consequences of unprofessional conduct by persons licensed to practice psychology.

The practice of psychology in (name of state) is hereby declared to affect the public health, safety, and welfare, and to be subject to regulation to protect the public from the practice of psychology by unqualified persons and from unprofessional conduct by persons licensed to practice psychology.

B. Definitions

Definitions provide consistent interpretation throughout the Act without unnecessary repetition of terms. Thus *Board* once defined in this section can subsequently be cited with the same meaning as presented in the definition.

In defining *institution of higher education*, professional schools are included as a result of a number of suggestions to recognize these institutions' growing contributions to the education and training of professional psychologists. It is further recognized that many foreign institutions prepare psychologists for professional practice, and provision should be made to accommodate them in Board regulations.

In 1979, the definition of the *practice of psychology* appeared to be the major obstacle that prevented passage of the Committee on State Legislation's (COSL) guidelines. A predominant concern in defining the practice of psychology for the purpose of licensure is to describe psychological services adequately. These services must be specified in order to identify clearly the areas of psychological services, provided to individuals or groups of individuals, that require qualified and sound professional psychological practice. The final definition in this section deals with the term *psychologist* as it applies to the Act in the provision of psychological services. The title "psychologist" is also used by psychologists who are exempt from licensure as specified in Section J of this Act in their roles as teachers, researchers, and consultants to or employees of organizations.

1. *Board* means the (name of state) State Board of Examiners of Psychologists.

2. *Institution of higher education* means any regionally accredited institution of higher education in the United States, including a professional school, that offers a full-time doctoral course of study in psychology that is acceptable to the Board. For Canadian universities, it means an institution of higher education that holds recognized membership in the Association of Universities and Colleges of Canada.
3. *Practice of psychology* is defined as the observation, description, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, accident, injury, or disability; and psychoeducational evaluation, therapy, remediation, and consultation. Psychological services may be rendered to individuals, families, groups, and the public. The practice of psychology shall be construed within the meaning of this definition without regard to whether payment is received for services rendered. (See Section J for exemptions.)
4. *Psychologist*: A person represents himself or herself to be a psychologist if that person uses any title or description of services incorporating the words *psychology*, *psychological*, or *psychologist*, or if he or she possesses expert qualification in any area of psychology, or if that person offers to the public or renders to individuals or to groups of individuals services defined as the practice of psychology in this Act.

C. State Board of Examiners of Psychologists

Legislation concerning the membership of the Board of Examiners should designate a sufficient number of members to accomplish the work of the Board, as well as make provisions for the appointment of public members. The appointing authority shall ensure that specialties in psychology are represented, as well as trainers and practitio-

The Model Act was developed over a period of three years, and was largely the work of Jarold R. Niven and Norma P. Simon, both members of the Board of Professional Affairs' Committee on Professional Practice (COPP). In the last year major revisions were accomplished by a COPP subcommittee chaired by Norma P. Simon and consisting of Jarold R. Niven, R. Mark Mays, David H. Reilly, and Tommy T. Stigall. As a member of the Board of Directors Subcommittee on the Future of Professional Psychology, Carl N. Zimet played a major role in the coordination process. Other COPP members who worked on the project over the three years include Jean L. Balinky, Jacob Chwast, Herbert Dorken, G. Rita Dudley, Thomas J. Hefele, Hannah R. Hirsh, Robert J. Resnick, and Castellano B. Turner. Bev Hitchins served as staff liaison to the project with the support of Patricia J. Aletky, Paul D. Nelson, and Russ Newman.

Correspondence concerning this document should be addressed to Office of Professional Affairs, American Psychological Association, 1200 17th St., NW, Washington, DC 20036.

ners. A minimum of five psychologists plus one public member is recommended.

The addition of public (consumer) members on boards is a recognition of the impact of consumerism on the current functioning of boards. The involvement of the public in Board affairs can be of great value to both psychology and the public and should be viewed as an opportunity to enhance the stature of psychology with the public.

Obviously, members should be appointed at staggered times so that the entire group of members is not replaced at any one time.

There is hereby created the (*name of state*) State Board of Examiners of Psychologists. The Board shall consist of minimally five licensed psychologists and one public member. At least two members shall be engaged full-time in the doctoral teaching and training of psychologists, and at least two members shall be engaged full-time in the professional practice of psychology. Psychologist Board members shall be licensed to practice in this state.

Each psychologist serving on the Board shall have a minimum of five years of postlicensure experience. Board members shall reflect a diversity of practice specialties.

Board members shall be appointed who are free from conflicts of interest in performing the duties of the Board. A public member shall not be a psychologist, an applicant or former applicant for licensure as a psychologist, a member of another health profession, or a member of a household that includes a psychologist, or otherwise have conflicts of interest or the appearance of such conflicts with duties as Board members. Appointments to the Board shall be made by the duly constituted appointing authority in this state. The appointing authority in this state shall solicit nominations from psychological organizations and licensed psychologists in this state. The term of office shall be five years, with provision for reappointment for one additional term. Lengths of terms of Board members shall be staggered. The Board as first constituted shall have two members, including the public member, appointed for five years; one member appointed for four years; two members appointed for three years; and one member appointed for two years.

It is clear that the Board will need, from time to time, to adopt or delete rules and regulations to carry out the provisions of the Act that establish and enable the Board to operate. It is wise to have this authority clearly established within the Act.

In addition to the powers set forth elsewhere in this Act, the Board may adopt rules and regulations to carry out the provisions of this Act.

It is desirable for the Board to be self-supporting. Self-generated fees should be sufficient to cover all costs. This avoids the necessity of the Board's returning to the budgetary authority for approval each time fees must be increased in order for the Board to remain self-supporting. Boards should consider carefully the various elements of expense in establishing fees. Items such as overhead, examination costs, travel and per diem, disciplinary proceedings, and other expenses should be considered.

The Board shall, from time to time, establish reasonable fees for the issuance and renewal of licenses and its other services. Fees shall be set so as to defray the cost of administering the provisions of this Act, including applications, examinations, enforcement, and the cost of maintaining the Board.

It is important to have within the Act a statement that a member of the Board shall not be civilly liable for any act performed in good faith and within the scope of duties of the Board. It should be noted that such a statement does not pertain to any criminal charges brought against a member of the Board.

A member of the Board or any employee or agent of the Board shall not be held civilly liable for any act performed in good faith and within the scope of the duties of the Board.

D. Requirements for Licensure

This recommendation includes significant changes from the 1967 guidelines. It should be noted that terms such as *department of psychology* and *PhD* are explicitly excluded from the recommended wording.

There is a core of basic theory, principles, and accumulated knowledge that all professional psychologists should possess. Each practitioner must also master the specific skills and knowledge appropriate for the competent performance of psychological practice. The language of the model requires the Board to specify its criteria for acceptable professional education in psychology. In this regard, the Board will be guided by national standards.

This revision states that by 1995 all applicants for licensure must minimally be graduates of a regionally accredited institution of higher education and must have completed a training program accredited by the American Psychological Association. Where no accreditation exists, the applicant will be required to meet standards developed by the Board. These standards will be based on recognized standards for the area of competence. The law recognizes that new doctoral programs may be developed in newly or already recognized specialties of professional psychology. In such instances, the law affords those programs an eight-year period in which to achieve accreditation, during which the graduates of those programs may sit for licensure.

1. Educational Requirements

The Act recognizes the doctorate as the minimum educational requirement for entry into professional practice as a psychologist.

Applicants for licensure shall possess a doctoral degree in psychology from an institution of higher education. The degree shall be obtained from a recognized program of graduate study in psychology as defined by the rules and regulations of the Board.

By 1995 applicants for licensure shall have completed a doctoral program in psychology that is accredited by the American Psychological Association (APA). In areas where no accreditation exists, applicants for licensure shall have completed a doctoral

program in psychology that meets recognized acceptable professional standards as determined by the Board. When a new specialty of professional psychology is recognized as being within the accreditation scope of the APA, doctoral programs within that specialty will be afforded a transition period of eight years from their first class of students to the time of their accreditation. During that transition period, graduates of such programs may sit for licensure examination whether or not the program has been accredited. The same principle applies as well to new doctoral programs of specialties previously recognized within the scope of APA accreditation.

Applicants trained in institutions outside the United States shall meet requirements established by the Board.

2. Experience Requirements

APA recommends that legislation requires one year of supervised experience subsequent to the granting of the doctorate. In rules and regulations, the Board must define acceptable supervised experience at the predoctoral and postdoctoral levels as well as mechanisms for evaluation of this experience. Psychologists are required to limit their practice to their demonstrated areas of professional competence. Experience should be compatible with training.

For admission to the licensure examination, applicants shall demonstrate that they have completed two years of supervised professional experience, one year of which shall be postdoctoral. The criteria for appropriate supervision shall be in accordance with regulations to be promulgated by the Board. Postdoctoral experience shall be compatible with the knowledge and skills acquired during formal doctoral or postdoctoral education in accordance with professional requirements and relevant to the intended area of practice. Applicants shall be required to show evidence of good character, that is, that they have not been convicted of a criminal offense that bears directly on the fitness of the individual to be licensed.

3. Examinations

APA recommends that the Act specify the requirements for examination and the conditions under which the Board is authorized to waive examination. All examinations serve the purpose of verifying that a candidate for licensure has acquired a basic core of knowledge in the discipline of psychology and can apply that knowledge to the problems confronted in the practice of psychology. Boards should clearly specify the conditions under which the endorsement of another license will be granted. The Board shall administer examinations to qualified applicants on at least an annual basis. The Board shall determine the subject matter and scope of the examination and shall require a written, and may require an oral examination of each candidate for licensure. The Board at its discretion, according to rules and regulations promulgated by the Board, may waive said examination of candidates for licensure.

4. Prior Credentials

APA recommends that the Act provide for continued licensure of persons already licensed as a psychologist at the time of enactment of a new law.

A person who is licensed as a psychologist under the provisions of (cite relevant section(s) of previous licensing law) as of the effective date of this Act shall be deemed to have met all requirements for licensure under this Act and shall be eligible for renewal of licensure in accordance with the provisions of this Act.

E. Interstate Practice of Psychology

Psychologists may have legitimate interests in practicing in another jurisdiction for a limited amount of time. This section provides for limited practice in a jurisdiction other than the state in which the psychologist is licensed. The psychologist must have an earned doctoral degree in another jurisdiction.

Nothing in this Act shall be construed to prohibit the practice of psychology in this state by a person holding an earned doctoral degree in psychology from an institution of higher education who is licensed or certified as a psychologist under the laws of another jurisdiction, provided that the aggregate of sixty (60) days of professional services as a psychologist per year under the provision of this subsection is not exceeded.

F. Temporary Authorization to Practice

This portion of the Act provides for the conditions under which a licensed psychologist may practice until obtaining licensure in another jurisdiction. Provision is also made for the Board to waive examination if the requirements met by the psychologist in the original jurisdiction are judged to be equivalent to those in this state.

A psychologist licensed or certified under the laws of another jurisdiction may be authorized by the Board to practice psychology as defined in this Act for a maximum of one year, provided that the psychologist has made application to the Board for licensure and has met the educational and experience requirements for licensure in this state. Denial of licensure terminates this authorization. The Board may choose to waive examination if a psychologist has been licensed in another jurisdiction on the basis of qualifications that are not less than those required for licensure in this state.

G. Limitation of Practice

This provision of the Act is intended to ensure that licensed psychologists will not practice outside the limits of their competence. The burden of proof is on the applicant to provide evidence, acceptable to the Board, that the applicant has obtained the training necessary to engage in the practice of psychology in the specified area of competence. The Board may wish to develop forms that provide for the specification of the intended area of practice and the evidence necessary to document competence. This provision recognizes the broad areas of specialization (e.g., clinical, counseling, school, industrial/organizational) and emerging specialties (e.g., neuropsychology, environmental) and the variety of academic training as separate from proficiencies. It is expected that if the psychologist is trained in a broad specialty area, there are many proficiencies within that training that are possible areas of competence. This limitation is intended to ensure

that a psychologist trained in one area (e.g., experimental, developmental) will not practice in another area (e.g., counseling, industrial/organizational) without completing a retraining program.

The Board shall ensure through regulations and enforcement that licensees limit their practice to demonstrated areas of competence as documented by relevant professional education, training, and experience.

H. Inactive Status

A psychologist who is on military assignment outside the state, suffering from health problems, on sabbatical, or who moves to another state may wish to be on inactive status. Relieving the psychologist from paying the fee will make it possible for that person to remain in good standing without being an active practitioner.

A psychologist in good standing who will not be practicing in the state for at least one year may petition the Board to have his or her license placed on inactive status without penalty. When such psychologist wishes to return to practice, an application shall be made to the Board, which shall reinstate him or her upon payment of the registration fee for the current year.

I. Practice Without a License

The Act must clearly specify what constitutes a violation of law and what penalties may be imposed for practice without a license or for misrepresentation of oneself as a psychologist. State legislatures have the latitude to determine penalties for such illegal activities. Boards are provided with the authority to suspend or revoke licenses and to prescribe conditions for reinstatement.

It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to represent himself or herself as a psychologist. It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to engage in the practice of psychology as defined in this Act, whether practicing as an individual, firm, partnership, corporation, agency, or other entity.

Any person who shall represent himself or herself as a psychologist in violation of this Act, or who shall engage in the practice of psychology in violation of this Act, shall be guilty of a misdemeanor and shall be fined not less than ___ dollars and not more than ___ dollars and, in addition thereto, may be imprisoned for not more than ___ months. Each day such person shall practice psychology without meeting all the requirements of all laws now in force and of this Act shall constitute a separate offense. Any person filing or attempting to file, as his or her own, a diploma or license of another or a forged affidavit of identification shall be guilty of a felony and shall be subject to the punishment prescribed for forgery in the second degree.

Whenever a license to practice as a psychologist in the state has been suspended or revoked, it shall be unlawful for the person whose license has been so suspended or revoked to practice psychology in this state. The Board may issue, with or without reexamination, a new license whenever it deems such course safe and just.

The Board on its own motion may investigate any evidence or

allegation that appears to show that any person is or may be in violation of any provision of this Act.

J. Exemptions

1. There should be an exemption from licensure for persons engaged solely in teaching, research, or provision of psychological services to organizations, because such activities are unlikely to pose a risk of immediate harm to the public health or welfare. For example, an organizational psychologist providing consultation to business in order to improve efficiency, a teacher of child development courses at a university, a researcher in the field of sleep disorders, and a social psychologist researching group behavior in stressful situations would all be exempt. The exemption should not be determined on the basis of work setting or place of primary employment, but on the basis of the purpose of the activity as defined in Section B3 (Practice of psychology). The exemption should not be allowed if the individual engages in the direct delivery or supervision of psychological services to individuals or groups of individuals in any setting. Persons engaged in teaching, research, or the provision of psychological services to organizations should not be excluded from licensure if they meet the statutory requirements for licensure.

Nothing in this Act shall be construed to prevent the teaching of psychology, the conduct of psychological research, or the provision of psychological services or consultation to organizations or institutions, provided that such teaching, research, or service does not involve the delivery or supervision of direct psychological services to individuals or groups of individuals who are themselves, rather than a third party, the intended beneficiaries of such services, without regard to the source or extent of payment for services rendered. Nothing in this Act shall prevent the provision of expert testimony by psychologists who are otherwise exempted by this Act. Persons holding an earned doctoral degree in psychology from an institution of higher education may use the title "psychologist" in conjunction with the activities permitted by this subsection.

2. Members of other established professions, such as physicians, attorneys, and clergy, may provide services that are similar or related to the scope of practice of psychology. They should be exempted from licensure on the condition that they not represent themselves to be psychologists.

Nothing in this Act shall be construed to prevent members of other recognized professions that are licensed, certified, or regulated under the laws of this state from rendering services consistent with their professional training and code of ethics, provided that they do not represent themselves to be psychologists. Duly recognized members of the clergy shall not be restricted from functioning in their ministerial capacity, provided that they do not represent themselves to be psychologists.

3. It is recognized that school psychologists who are certified by the state education agency are permitted to use the term *school psychologist* or *certified school psychologist* as long as they are practicing in the public schools.

Individuals who have been certified as school psychologists by the (*cite relevant state education authority or statutory provisions*) shall be permitted to use the term "school psychologist" or "certified school psychologist." Such persons shall be restricted in their practice to employment within those settings under the purview of the state board of education. By 1995 such exempted persons should be certificated by the state board of education on the basis of having completed a program for the preparation of school psychologists that is accredited by a specialized professional accrediting body recognized by the Council on Postsecondary Accreditation.

4. Graduate students, interns, postdoctoral trainees, and applicants for licensure are permitted to function under the supervision of a licensed psychologist, as are assistants not eligible for licensure in some states. None may use the title psychologist, but titles such as *psychological trainee*, *psychological intern*, *psychological resident*, and *psychological assistant* would be permissible under this exemption. The supervising psychologist is responsible for the actions of the student, trainee, or assistant. The Board is required to adopt regulations defining the nature and extent of training for qualified assistants and supervision for each category.

Nothing in this Act shall be construed to prevent persons from engaging in activities defined as the practice of psychology, provided that such persons shall not represent themselves by the title "psychologist." Such persons may use the terms "psychological trainee," "psychological intern," "psychological resident," and "psychological assistant" and provided further that such persons perform their activities under the supervision and responsibility of a licensed psychologist in accordance with regulations promulgated by the Board. Nothing in this section shall be construed to apply to any person other than:

- (a) a matriculated graduate student in psychology whose activities constitute a part of the course of study for a graduate degree in psychology at an institution of higher education;
- (b) an individual pursuing postdoctoral training or experience in psychology, including persons seeking to fulfill the requirements for licensure under the provisions of this Act; or
- (c) a qualified assistant employed by, or otherwise directly accountable to, a licensed psychologist. The Board in regulations shall determine the number of assistants that a psychologist may employ and the conditions under which they will be supervised.

K. Grounds for Suspension or Revocation of Licenses

In order to have an effective law, the Board must have the power to suspend and revoke a license. In the previous guidelines, the offenses requiring suspension or revocation were not specified. Many state laws specify these offenses. Actions that are a violation of the standards subscribed to by the Board should be clearly stated in the licensing law. Two considerations are specified below that refer to specific points in the text that follows:

1. Concerning Numbers 6 and 7

The Board shall specify, in rules and regulations, criteria for determining how long or under what conditions an individual or group of individuals remains a patient or a client.

2. Concerning Number 17

In this section, physical condition shall be differentiated from physical disability. There is no intent to obstruct physically disabled candidates' entry into the profession of psychology nor from practicing their profession after licensure as long as they practice with reasonable skill and safety to patients or clients.

A psychologist and anyone under his or her supervision shall conduct his or her professional activities in conformity with ethical and professional standards promulgated by the Board under its rules and regulations.

The Board shall have the power and duty to suspend, place on probation, or require remediation for any psychologist for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology or to take any other action specified in the rules and regulations whenever the Board shall find by a preponderance of the evidence that the psychologist has engaged in any of the following acts or offenses:

1. fraud in applying for or procuring a license to practice psychology;
2. immoral, unprofessional, or dishonorable conduct as defined in the rules and regulations promulgated by the Board;
3. practicing psychology in such a manner as to endanger the welfare of clients or patients;
4. conviction of a felony (a copy of the record of conviction, certified to by the clerk of the court entering the conviction shall be conclusive evidence);
5. conviction of any crime or offense that reflects the inability of the practitioner to practice psychology with due regard for the health and safety of clients or patients;
6. harassment, intimidation, or abuse, sexual or otherwise, of a client or patient;
7. engaging in sexual intercourse or other sexual contact with a client or patient;
8. use of repeated untruthful or deceptive or improbable statements concerning the licensee's qualifications or the effects or results of proposed treatment, including functioning outside of one's professional competence established by education, training, and experience;
9. gross malpractice or repeated malpractice or gross negligence in the practice of psychology;
10. aiding or abetting the practice of psychology by any person not licensed by the Board;
11. conviction of fraud in filing Medicare or Medicaid claims or in filing claims to any third party payor (a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence);
12. exercising undue influence in such a manner as to exploit the client, patient, student, or supervisee for financial or other personal advantage to the practitioner or a third party;
13. the suspension or revocation by another state of a license to practice psychology (a certified copy of the record of suspension or revocation of the state making such a suspension or revocation shall be conclusive evidence thereof);

14. refusal to appear before the Board after having been ordered to do so in writing by the executive officer or chair of the Board;

15. making any fraudulent or untrue statement to the Board;

16. violation of the code of ethics adopted in the rules and regulations of the Board; and

17. inability to practice psychology with reasonable skill and safety to patients or clients by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance, or as a result of any mental or physical condition.

When the issue is whether or not a psychologist is physically or mentally capable of practicing psychology with reasonable skill and safety to patients or clients, then, upon a showing of probable cause to the Board that the psychologist is not capable of practicing psychology with reasonable skill and safety to patients, the Board may petition a court of competent jurisdiction to order the psychologist in question to submit to a psychological examination by a psychologist to determine psychological status and/or a physical examination by a physician to determine physical condition. Such psychologist and/or physician is to be designated by the court. The expense of such examination shall be borne by the Board. Where the psychologist raises the issue of mental or physical competence or appeals a decision regarding his or her mental or physical competence, the psychologist shall be permitted to obtain his or her own evaluation at the psychologist's expense. If the objectivity or adequacy of the examination is suspect, the Board may complete an examination by its designated practitioners at its own expense. When mental or physical capacity to practice is at issue, every psychologist licensed to practice psychology in the state shall be deemed to have given consent to submit to a mental or physical examination or to any combination of such examinations and to waive all objections to the admissibility of the examination, or to previously adjudicated evidence of mental incompetence.

L. Board Hearings and Investigations

In the interest of protecting the public, the Board must have authority to regulate the practice of psychology. This section specifies the powers and duties of the Board to conduct investigations, hold hearings, consider evidence or allegations brought against a psychologist, and to discipline a licensee for violation of law or regulation. Both the Board and licensee are required to follow due process standards in any disciplinary proceeding.

The Board on its own motion may investigate or cause to be investigated any allegation or evidence that appears to show that a psychologist licensed to practice in this state is, or may be, in violation of this Act or of any of the acts, offenses, or conditions set forth by the Board in rules and regulations.

The Board shall have the power and duty to suspend, place on probation, or require remediation for a licensee for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology, whenever the licensee shall be found by the Board, by a preponderance of the evidence, to have engaged in conduct prohibited by this Act or rules and regulations duly promulgated pursuant thereto.

Any psychologist holding a license to practice in this state is required to report to the Board any information such psychologist in good faith may have that appears to show that any psychologist holding a license to practice in this state may be in violation of this Act or guilty of any of the acts, offenses, or

conditions set forth by the Board. Any psychologist who in good faith makes such a report to the Board shall be absolutely immune from civil liability to any person for any statement or opinion made in such report.

If, in the opinion of the majority of the Board, there is probable cause that the information provided to it under the provisions of this section may be valid, the Board shall request by registered mail a formal interview with the psychologist. If the psychologist who is ordered to a formal interview before the Board refuses to appear for such interview, such refusal shall be considered grounds for the Board, at its discretion, to suspend or revoke the license of such psychologist. Any proceeding for suspension or revocation of a license to practice as a psychologist in this state shall be conducted in accordance with procedures established by the Board. The psychologist shall be informed of his or her rights concerning Board hearings and investigations:

1. the right to notice and hearing;
2. the right to self-representation or representation by counsel;
3. the right to produce witnesses and to confront and cross-examine opposing witnesses;
4. the right to a written decision setting forth the violation, findings of fact, sanctions, and reasons for the sanctions;
5. a determination of the size of the vote necessary to find a violation;
6. a determination whether the hearing will be closed or open to the public; and
7. the right to an appeal to an administrative board of review and/or to a court of competent jurisdiction.

The licensee may knowingly and voluntarily waive his or her right to the formal adversary proceeding described in this section.

The Board shall have the right to conduct an *ex parte* hearing if, after due notice, the individual fails or refuses to appear. The Board shall have the right to issue subpoenas for production of documents and witnesses and to administer oaths. The Board shall have the right to apply to a court of competent jurisdiction to take appropriate action should a subpoena not be obeyed.

The Board shall temporarily suspend the license of a psychologist without a hearing simultaneously with the institution of proceedings for a hearing provided under this section if the Board finds that evidence in its possession indicates that the psychologist's continuation in practice may constitute an immediate danger to the public. Appropriate officials may petition the court for an injunction barring further practice unless or until the person is properly licensed. The injunction may be issued in addition to, or in lieu of, the criminal sanctions provided for in this section.

A psychologist may surrender his or her license when such person is charged with unethical conduct and upon receipt of that charge, that person decides to surrender the license, such surrender and acceptance by the Board shall constitute acknowledgment by the psychologist of guilt as charged.

A psychologist may request in writing to the Board that a restriction be placed upon his or her license to practice as a psychologist. The Board, in its discretion, may accept a surrender or grant such a request for restriction and shall have the authority to attach such restrictions to the license of the psychologist to practice psychology within this state or otherwise to discipline the licensee.

Subsequent to the holding of a hearing and the taking of evidence by the Board as provided for in this section, if a majority of the

Board finds that a psychologist is in violation of this Act or guilty of any of the acts, offenses, or conditions as enumerated by the Board, the following actions may be taken:

1. The Board may revoke or suspend the license and impose a monetary penalty.
2. The Board may suspend imposition of a revocation or suspension of a license and/or a monetary penalty.
3. The Board may impose revocation or suspension of a license and/or a monetary penalty, but suspend enforcement thereof by placing the psychologist on probation, which probation shall be revocable if the Board finds the conditions of the probation order are not being followed by the psychologist.
4. As a condition of probation the Board may require the psychologist to submit to care, counseling, or treatment by a professional designated by the Board. The expense of such action shall be borne by the psychologist.
5. The Board may, at any time, modify the conditions of the probation and may include among them any reasonable condition for the purpose of the protection of the public, or for the purpose of the rehabilitation of the probationer, or both.
6. The Board shall have the power to require restitution when necessary.
7. The Board shall have the power to assess the costs of the disciplinary proceeding.

M. Privileged Communication

This section regulates and limits the powers of the judicial system. The courts or other administrative agencies with subpoena power have the right to make use of all relevant information in the judicial fact-finding process unless this right of access to information is specifically limited. Historically, courts and legislatures have been charged with fact-finding in order to seek truth and administer justice. At the same time they have attempted to maintain the integrity of the confidential and private relationship between psychologist and patient or client. However, some societal issues have emerged, such as child abuse and sexual abuse, that have changed the absolute nature of privileged communication. Though the privilege is not absolute, it is designed to be sufficiently broad to cover all situations except those specifically enumerated. It is a privilege "owned" by the patient or client, who may assert it or waive it, although the psychologist may assert it for a patient or client who wishes to maintain such privilege of communication. It is understood that the privilege encompasses only communications between the patient or client and the psychologist in a professional relationship.

In judicial proceedings, whether civil, criminal, or juvenile; in legislative and administrative proceedings; and in proceedings preliminary and ancillary thereto, a patient or client, or his or her guardian or personal representative, may refuse to disclose or prevent the disclosure of confidential information, including information contained in administrative records, communicated to a psychologist licensed or otherwise authorized to practice psychology under the laws of this jurisdiction, or to persons reasonably believed by the patient or client to be so licensed, and their agents, for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or disorder. In the absence of evidence to the contrary, the psychologist is presumed authorized to claim the privilege on the patient's or client's behalf.

This privilege may not be claimed by the patient or client, or on his or her behalf by authorized persons, in the following circumstances:

1. where abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals is known or reasonably suspected;
2. where the validity of a will of a former patient or client is contested;
3. where such information is necessary for the psychologist to defend against a malpractice action brought by the patient or client;
4. where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist;
5. in the context of civil commitment proceedings, where an immediate threat of self-inflicted damage is disclosed to the psychologist;
6. where the patient or client, by alleging mental or emotional damages in litigation, puts his or her mental state at issue;
7. where the patient or client is examined pursuant to court order; or
8. in the context of investigations and hearings brought by the patient or client and conducted by the Board, where violations of this Act are at issue.

N. Severability

As with any law, one provision may be subject to court challenge and ruled invalid or unconstitutional. For example, it is not legally clear whether state licensing boards can regulate persons working for federal agencies. Thus, if any provision is ruled invalid or unconstitutional, it is

important that the entire Act not be affected. This can only be achieved by inserting a clause at the end of the Act stating that each provision of the Act is severable from all other provisions and that the declaration that one section is invalid or unconstitutional will not affect the constitutionality or enforceability of any other section.

If any section in this Act or any part of any section thereof shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder of any section or part thereof.

O. Effective Date

In any law regulating a profession there needs to be a specific date establishing when the law shall become effective. Thus, the final paragraph states:

This Act shall become effective upon the date it is signed by the Governor or on the date it otherwise becomes effective by operation of law.

REFERENCES

- APA Committee on Legislation. (1955). Joint report of the APA and CSPA (Conference of State Psychological Associations). *American Psychologist*, 10, 727-756.
- APA Committee on Legislation. (1967). A model for state legislation affecting the practice of psychology 1967: Report of the APA Committee on Legislation. *American Psychologist*, 22, 1095-1103.

American Psychological Association

Model Act for State Licensure

Public Comment

Model Act for State Licensure (1987)	Revision of Model Act for State Licensure (Revised 03/06/2009)
<p><i>Preamble</i></p> <p>As APA policy, the Model Act serves as a prototype for drafting state legislation regulating the practice of psychology. State legislatures are encouraged to use the language of this document and the policies that it espouses as the model for their own state licensure law. Inevitably each state law will reflect compromises and changes particular to that state, but the APA Model Act is meant to serve as a guide for those involved in the drafting process. State licensing boards must develop their own rules and regulations to supplement the legislation proposed here.</p> <p>This is the fourth set of guidelines for state legislation regulating the practice of psychology that has been developed by the American Psychological Association (APA). The first model for such regulation was developed and adopted as APA policy in 1955 (APA, 1955).</p> <p>The 1955 guidelines stood for 12 years, during which the number of states enacting licensure legislation grew from 9 to 32. In 1967 the APA Committee on State Legislation (COSL) prepared the first revision of the guidelines. That revision was more comprehensive, provided more detailed guidance, and covered more issues relating to regulation of the practice of psychology, while reaffirming the basic concept found in the 1955 model (APA, 1967).</p> <p>By 1977 all states and the District of Columbia had enacted licensure legislation. APA's Council of Representatives then determined that the model approved in 1967 was outdated and directed COSL to undertake a revision. However, in January 1979 the Council of Representatives failed to approve the revised model guidelines, leaving the 1967 guidelines to remain as APA policy.</p> <p>In 1984 the Council of Representatives directed the Board of Professional Affairs (BPA) to develop another revision of the existing 1967 model for the Council's consideration. BPA, in turn, directed its Committee on Professional Practice (COPP) to prepare it.</p> <p>A COPP subcommittee undertook this effort. Its early drafts were based on a review of the comments provided by APA governance units and divisions regarding the 1979 COSL proposal. Specific recommendations were received from the Board of Directors (B/D) Subcommittee on the Future of Professional Psychology in April 1985. Numerous drafts were</p>	<p><i>Preamble</i></p> <p>As APA policy, the Model Act serves as a prototype for drafting state legislation regulating the practice of psychology. State legislatures are encouraged to use the language of this document and the policies that it espouses as the model for their own state licensure law. Inevitably each state law will reflect compromises and changes particular to that state, but the APA Model Act is meant to serve as a guide for those involved in the drafting process. State licensing boards must develop their own rules and regulations to supplement the legislation proposed here.</p> <p>This is the fifth set of guidelines for state legislation regulating the practice of psychology that has been developed by the American Psychological Association (APA). The first model for such regulation was developed and adopted as APA policy in 1955 (APA, 1955).</p> <p>The 1955 guidelines stood for 12 years, during which the number of states enacting licensure legislation grew from 9 to 32. In 1967 the APA Committee on State Legislation (COSL) prepared the first revision of the guidelines. That revision was more comprehensive, provided more detailed guidance, and covered more issues relating to regulation of the practice of psychology, while reaffirming the basic concept found in the 1955 model (APA, 1967).</p> <p>By 1977 all states and the District of Columbia had enacted licensure legislation. APA's Council of Representatives then determined that the model approved in 1967 was outdated and directed COSL to undertake a revision. However, in January 1979 the Council of Representatives failed to approve the revised model guidelines, leaving the 1967 guidelines to remain as APA policy. In 1984 the Council of Representatives directed the Board of Professional Affairs (BPA) to develop another revision of the existing 1967 model for the Council's consideration. BPA, in turn, directed its Committee on Professional Practice (COPP) to prepare it.</p> <p>This document was approved by the Council of Representatives in February, 1987.</p> <p>In 2006, at the recommendation of the Board of Professional Affairs and the Committee for the Advancement of Professional Practice, the APA Board of Directors and Council of Representatives funded a Task Force to undertake the revision of the 1987 model act. The existing model act did not reflect the</p>

subsequently developed and revised based on comments provided by members of COPP and BPA, the American Association of State Psychology Boards, individual psychologists from around the country and Canada, relevant APA divisions and governance groups, unaffiliated psychology interest groups, and APA legal counsel. This document, Draft 14, is the result of three years of continual discussion, review, and compromise by many concerned and dedicated APA members. It was passed unanimously by the Council of Representatives on February 7, 1987.

Each section of the proposed Model Act is introduced by commentary, the purpose of which is to explain the rationale for the proposed section that follows. To differentiate between the commentary and the proposed statutory language, the latter is set in smaller type.

developments in professional practice that had occurred over the preceding 20 years. Specific developments included some psychologists obtaining prescriptive authority, changes in the provision of industrial/organizational and consulting psychology that could make it desirable for those psychologists to be licensed, and changes in the recommended sequence of education and training for psychologists. The Task Force undertook this effort beginning with a comprehensive review of the 1987 document as well as relevant APA policies and other documents. Draft revisions were circulated for review and a 90-day public comment period ensued. Changes were made to the document based on commentary received. A second public comment period ensued and another review by governance groups occurred prior to the document being approved by Council.

Each section of the proposed Model Act is introduced by commentary, the purpose of which is to explain the rationale for the proposed section that follows. To differentiate between the commentary and the proposed statutory language, the latter is *italicized*.

A. Declaration of Policy

This section declares that the intent of legislation for state licensure of psychologists is to ensure the practice of psychology in the public interest. The consumer should be assured that psychological services will be provided by qualified professionals. The public must also be protected from the consequences of unprofessional conduct by persons licensed to practice psychology.

The practice of psychology in (name of state) is hereby declared to affect the public health, safety, and welfare, and to be subject to regulation to protect the public from the practice of psychology by unqualified persons and from unprofessional conduct by persons licensed to practice psychology.

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The practice of psychology in (name of state) is hereby declared to affect the public health, safety, and welfare, and to be subject to regulation to protect the public from the practice of psychology by unqualified persons and from unprofessional conduct by persons licensed to practice psychology.

B. Definitions

Definitions provide consistent interpretation throughout the Act without unnecessary repetition of terms. Thus *Board* once defined in this section can subsequently be cited with the same meaning as presented in the definition.

In defining *institution of higher education*, professional schools are included as a result of a number of suggestions to recognize these institutions' growing contributions to the education and training of professional psychologists. It is further recognized that many foreign institutions prepare psychologists for professional practice, and provision should be made to accommodate them in Board regulations.

In 1979, the definition of the *practice of psychology* appeared to be the major obstacle that prevented passage of the Committee on State Legislation's (COSL) guidelines. A

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In defining institution of higher education, it is further recognized that many foreign institutions prepare psychologists for professional practice, and provision should be made to accommodate them in Board regulations.

Psychological services should be described adequately and specified in order to identify clearly the areas of psychological services, provided to individuals, groups of individuals, or organizations, that require qualified and sound professional psychology practice. There can be a legitimate use for

predominant concern in defining the practice of psychology for the purpose of licensure is to describe psychological services adequately. These services must be specified in order to identify clearly the areas of psychological services, provided to individuals or groups of individuals that require qualified and sound professional psychological practice. The final definition in this section deals with the term *psychologist* as it applies to the Act in the provision of psychological services. The title "psychologist" is also used by psychologists who are exempt from licensure as specified in Section J of this Act in their roles as teachers, researchers, and consultants to or employees of organizations.

1. *Board* means the (name of state) State Board of Examiners of Psychologists.
2. *Institution of higher education* means any regionally accredited institution of higher education in the United States, including a professional school that offers a full-time doctoral course of study in psychology that is acceptable to the Board. For Canadian universities, it means an institution of higher education that holds recognized membership in the Association of Universities and Colleges of Canada.
3. *Practice of psychology* is defined as the observation, description, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, accident, injury, or disability; and psychoeducational evaluation, therapy, remediation, and consultation. Psychological services may be rendered to individuals, families, groups, and the public. The practice of psychology shall be construed within the meaning of this definition without regard to whether payment is received for services rendered. (See Section J for exemptions.)
4. *Psychologist*: A person represents himself or herself to be a psychologist if that person uses any title or description of services incorporating the words *psychology*, *psychological*, or *psychologist*, or if he or she possesses expert qualification in any area of psychology, or if that person offers to the public or renders to individuals or to groups of individuals services defined as the practice of psychology in this Act.

technology-supported services, such as electronic or telephonic means. All such activities must operate within appropriate APA Ethical guidelines.

1. *Board* means the (name of state) State Psychology Board.
2. *Institution of higher education* means any regionally accredited institution of higher education in the United States, including a professional school, that offers a full-time doctoral course of study in psychology that is acceptable to the Board. For Canadian universities, it means an institution of higher education that is provincially or territorially chartered.
3. *Practice of psychology* is defined as the observation, description, evaluation, interpretation, prediction, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purposes of (a) preventing, eliminating, evaluating, assessing, or predicting symptomatic, maladaptive, or undesired behavior; (b) evaluating, assessing and/or facilitating the enhancement of individual, group and/or organizational effectiveness – including personal effectiveness, adaptive behavior, interpersonal relationships, work and life adjustment, health, and individual, group and/or organizational performance, or (c) assisting in legal decision-making.

The practice of psychology includes, but is not limited to, (a) psychological testing and the evaluation or assessment of personal characteristics, such as intelligence; personality; cognitive, physical, and/or emotional abilities; skills; interests; aptitudes; and neuropsychological functioning; (b) counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; (c) diagnosis, treatment, and management of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, accident, injury, or disability; (d) psychoeducational evaluation, therapy, and remediation; (e) consultation with physicians, other health care professionals and patients regarding all available treatment options, including medication; (f) provision of direct services to individuals and/or groups for the purpose of enhancing individual and thereby organizational effectiveness, using psychological principles, methods and/or procedures to assess and evaluate individuals on personal characteristics for individual development and/or behavior change or for making decisions about the individual, such as selection; and (g) the supervision of any of the above. Psychological services may be rendered to individuals, families, groups, systems, and/or organizations. The practice of psychology shall be construed within the meaning of this definition without regard to whether payment is received for services rendered. (See Section G for Limitation of Practice and Maintaining and Expanding Competence and Section J for Exemptions.)

4. *Psychologist*: Means (a) any person licensed as a psychologist under this act and (b) any General applied psychologist (see 5b

below) whose practice areas are specifically exempted under this act, and includes a person representing himself or herself to be a psychologist if that person uses any title or description of services incorporating the words psychology, psychological, or psychologist, or if he or she uses any term that implies that he or she possesses expert qualification in any area of psychology, or if that person offers to the public or renders to individuals or groups of individuals services defined as the practice of psychology in this Act. The title "psychologist" is also used by psychologists who are exempt from licensure as specified in Section J of this Act in their roles as teachers and/or researchers.

5. Applied psychologist

An applied psychologist is one who provides services to individuals, groups and/or organizations outside of an academic setting. Within this broad category there are two major groupings – those who are Health Service Providers and those who are not. Although licensure is generic, some of the Board's Rules and Regulations need to account for variations in relevant training, supervision and practice.

a. Health service provider (HSP)

Psychologists are certified as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic, therapeutic intervention and management services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level.

b. General applied psychologists

General applied psychologists provide psychology services that are defined as services outside of the health and mental health field and shall include: 1) the provision of direct services to individuals and groups, using psychological principles, methods and/or procedures to assess and evaluate individuals on personal abilities and characteristics for individual development, behavior change, and/or for making decisions (e.g., selection, individual development, promotion, reassignment) about the individual, all for the purpose of enhancing individual and/or organizational effectiveness; and 2) the provision of services to organizations that are provided for the benefit of the organization and do not involve direct services to individuals, such as job analysis, attitude/opinion surveys, selection testing (group administration of standardized tests in which responses are mechanically scored and interpreted), selection validation studies, designing performance appraisal systems, training, organization design, advising management on human behavior in organizations, organizational assessment, diagnosis and intervention, and related services.

6. Specialty

A specialty is a defined area of psychological practice which requires advanced knowledge and skills acquired through an

organized sequence of education and training. The advanced knowledge and skills specific to a specialty are obtained subsequent to the acquisition of core scientific and professional foundations in psychology.

7. Developed area of practice

Developed practice areas of psychology have all of the following characteristics:

- National recognition of the practice area by a national organization(s) whose purpose includes recognizing or representing and developing the practice area, by relevant divisions of the APA, or by involvement in similar umbrella organizations;
- An accumulated body of knowledge in the professional literature that provides a scientific basis for the practice area including empirical support for the effectiveness of the services provided;
- Representation by or in a national training council that is recognized, functional, and broadly accepted;
- Development and wide dissemination by the training council of doctoral educational and training guidelines consistent with the Accreditation Guidelines & Principles;
- Existence of the practice area in current education and training programs;
- Geographically dispersed psychology practitioners who identify with the practice area and provide such services

8. Emerging area of practice

An emerging area of practice is one that meets some but not all of the six requirements for a Developed Area of Practice, or does not meet some of the requirements completely (e.g., there is some professional literature providing a scientific basis, but not an "accumulated body of knowledge" in that literature).

9. Client

The term client is used to refer to the child, adolescent, adult, older adult, couple, family, group, organization, community, or other populations receiving psychological services. In many situations there are important and valid reasons for using such terms as patient, consumer or person in place of client to describe the recipients of services.

C. State Board of Examiners of Psychologists

Legislation concerning the membership of the Board of Examiners should designate a sufficient number of members to accomplish the work of the Board, as well as make provisions for the appointment of public members. The appointing authority shall ensure that specialties in psychology are represented, as well as trainers and practitioners. A minimum of five psychologists plus one public member is recommended.

The addition of public (consumer) members on

C. State Psychology Board

Legislation concerning the membership of the State Psychology Board should designate a sufficient number of members to accomplish the work of the Board, as well as make provisions for the appointment of public members. The appointing authority shall ensure that specialties in psychology are represented, as well as trainers and practitioners, both in health care and general applied psychology. A minimum of six psychologists plus one public member is recommended.

boards is a recognition of the impact of consumerism on the current functioning of boards. The involvement of the public in Board affairs can be of great value to both psychology and the public and should be viewed as an opportunity to enhance the stature of psychology with the public.

Obviously, members should be appointed at staggered times so that the entire group of members is not replaced at any one time.

There is hereby created the (name of state) State Board of Examiners of Psychologists. The Board shall consist of minimally five licensed psychologists and one public member. At least two members shall be engaged full-time in the doctoral teaching and training of psychologists, and at least two members shall be engaged full-time in the professional practice of psychology. Psychologist Board members shall be licensed to practice in this state.

Each psychologist serving on the Board shall have a minimum of five years of postlicensure experience. Board members shall reflect a diversity of practice specialties.

Board members shall be appointed who are free from conflicts of interest in performing the duties of the Board. A public member shall not be a psychologist, an applicant or former applicant for licensure as a psychologist, a member of another health profession, or a member of a household that includes a psychologist, or otherwise have conflicts of interest or the appearance of such conflicts with duties as Board members. Appointments to the Board shall be made by the duly constituted appointing authority in this state. The appointing authority in this state shall solicit nominations from psychological organizations and licensed psychologists in this state. The term of office shall be five years, with provision for reappointment for one additional term. Lengths of terms of Board members shall be staggered. The Board as first constituted shall have two members, including the public member, appointed for five years; one member appointed for four years; two members appointed for three years; and one member appointed for two years.

It is clear that the Board will need, from time to time, to adopt or delete rules and regulations to carry out the provisions of the Act that establish and enable the Board to operate. It is wise to have this authority clearly established within the Act.

In addition to the powers set forth elsewhere in this Act, the Board may adopt rules and regulations to carry out the provisions of this Act.

It is desirable for the Board to be self-supporting. Self-generated fees should be sufficient to cover all costs. This avoids the necessity of the Board's returning to the budgetary authority for approval each time fees must be increased in order for the Board to remain self-supporting. Boards should consider carefully the various elements of expense in establishing fees. Items such as overhead, examination costs, travel and per diem, disciplinary proceedings, and other expenses should be considered.

The Board shall, from time to time, establish reasonable fees for the

Public (consumer) members on boards is a recognition of the impact of consumerism on the current functioning of boards. A public member is recommended in order to insure the representation of the public; that is, the recipient of psychological services. Members should be appointed at staggered times so that the entire group of members is not replaced at any one time.

There is hereby created the (name of state) State Psychology Board. The Board shall consist of minimally six licensed psychologists and one public member. Members should be representative of teaching, training and the professional practice of psychology. Psychologist Board members shall be licensed to practice in this state. Each psychologist serving on the Board shall have a minimum of five years of post-licensure experience. Board members shall reflect a diversity of practice specialties, both in health care and other applications.

Board members shall be appointed who are free from conflicts of interest in performing the duties of the Board. A public member shall not be a psychologist, an applicant or former applicant for licensure as a psychologist, a member of another health profession, or a member of a household that includes a psychologist, or otherwise have conflicts of interest or the appearance of such conflicts with duties as Board members. Appointments to the Board shall be made by the duly constituted appointing authority in this state. The appointing authority in this state shall solicit nominations from psychological organizations and licensed psychologists in this state. The term of office shall be five years, with provision for reappointment for one additional term. Lengths of terms of Board members shall be staggered.

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The Board shall, from time to time, establish reasonable fees for the issuance and renewal of licenses and its other services. Fees shall be set so as to defray the cost of administering the provisions of this Act, including applications, examinations, enforcement, and the cost of maintaining the Board.

issuance and renewal of licenses and its other services. Fees shall be set so as to defray the cost of administering the provisions of this Act, including applications, examinations, enforcement, and the cost of maintaining the Board.

It is important to have within the Act a statement that a member of the Board shall not be civilly liable for any act performed in good faith and within the scope of duties of the Board. It should be noted that such a statement does not pertain to any criminal charges brought against a member of the Board.

A member of the Board or any employee or agent of the Board shall not be held civilly liable for any act performed in good faith and within the scope of the duties of the Board.

It is important to have within the Act a statement that a member of the Board shall not be civilly liable for any act performed in good faith and within the scope of duties of the Board. It should be noted that such a statement does not pertain to any criminal charges brought against a member of the Board. Though individual members of the Board will not be held civilly liable, individuals may pursue legal action against the Board under any applicable state laws, such as, for example, under any administrative procedure act.

A member of the Board or any employee or agent of the Board shall not be held civilly liable for any act performed in good faith and within the scope of the duties of the Board.

D. Requirements for Licensure

This recommendation includes significant changes from the 1967 guidelines. It should be noted that terms such as *department of psychology* and *PhD* are explicitly excluded from the recommended wording.

There is a core of basic theory, principles, and accumulated knowledge that all professional psychologists should possess. Each practitioner must also master the specific skills and knowledge appropriate for the competent performance of psychological practice. The language of the model requires the Board to specify its criteria for acceptable professional education in psychology. In this regard, the Board will be guided by national standards.

This revision states that by 1995 all applicants for licensure must minimally be graduates of a regionally accredited institution of higher education and must have completed a training program accredited by the American Psychological Association. Where no accreditation exists, the applicant will be required to meet standards developed by the Board. These standards will be based on recognized standards for the area of competence. The law recognizes that new doctoral programs may be developed in newly or already recognized specialties of professional psychology. In such instances, the law affords those programs an eight-year period in which to achieve accreditation, during which the graduates of those programs may sit for licensure.

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All applicants for licensure must minimally be graduates of a regionally accredited institution of higher education, or a Canadian university that is provincially or territorially chartered, and must have completed a planned program of study which reflects an integration of the science and practice of psychology. A formal training program accredited by the American Psychological Association or Canadian Psychological Association is required. For areas of psychology where APA or CPA program accreditation does not exist, psychology programs must meet all the requirements listed below (D1).

The law recognizes that new doctoral programs may be developed in newly or already recognized specialties of professional psychology. In such instances, the law affords those programs an eight-year period in which to achieve accreditation or to meet the standards described in D1, during which the graduates of those programs may sit for licensure.

D-1. Educational Requirements

The Act recognizes the doctorate as the minimum educational requirement for entry into professional practice as a psychologist.

Applicants for licensure shall possess a doctoral degree in psychology from an institution of higher education. The degree shall be obtained from a recognized program of graduate study in psychology as defined by the rules and regulations of the Board. By 1995 applicants

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Applicants for licensure shall possess a doctoral degree in psychology from a regionally accredited institution of higher education or from a Canadian university that is provincially or territorially chartered. The degree shall be obtained from a

for licensure shall have completed a doctoral program in psychology that is accredited by the American Psychological Association (APA). In areas where no accreditation exists, applicants for licensure shall have completed a doctoral program in psychology that meets recognized acceptable professional standards as determined by the Board. When a new specialty of professional psychology is recognized as being within the accreditation scope of the APA, doctoral programs within that specialty will be afforded a transition period of eight years from their first class of students to the time of their accreditation. During that transition period, graduates of such programs may sit for licensure examination whether or not the program has been accredited. The same principle applies as well to new doctoral programs of specialties previously recognized within the scope of APA accreditation. Applicants trained in institutions outside the United States shall meet requirements established by the Board.

recognized program of graduate study in psychology as defined by the rules and regulations of the Board.

Applicants for licensure shall have completed a doctoral program in psychology that is accredited by the American Psychological Association (APA) or Canadian Psychological Association (CPA) or where APA or CPA program accreditation does not exist that meets all of the following requirements:

- 1. Training in professional psychology is doctoral training offered in a regionally accredited institution of higher education. A regionally accredited institution is an institution with regional accreditation in the United States or an university that is provincially or territorially chartered in Canada.*
- 2. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists.*
- 3. The psychology program must stand as a recognizable, coherent organizational entity within the institution.*
- 4. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines.*
- 5. The program must be an integrated, organized sequence of study.*
- 6. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities and a psychologist responsible for the program.*
- 7. The program must have an identifiable body of students who are matriculated in that program for a degree.*
- 8. The program must include supervised practicum, internship, field or laboratory training appropriate to the individual's chosen area of practice of psychology.*
- 9. The curriculum shall encompass a minimum of three academic years of full time graduate study and a minimum of one year's residency or the equivalent thereof at the educational institution granting the doctoral degree. The core program shall require every student to demonstrate competence in each of the following substantive areas. Some content areas may appropriately be taught by integrating content across the curriculum, or this requirement may be met through substantial instruction in each of these foundational areas, as demonstrated by evidence of an integrated curriculum or a minimum of three graduate semester hours, 4.5 or more graduate quarter hours (when an academic term is other than a semester, credit hours will be evaluated on*

the basis of fifteen hours of classroom instruction per semester hour), or the equivalent:

- a. scientific and professional ethics and standards;
- b. research design and methodology;
- c. statistics;
- d. psychometric theory;
- e. biological bases of behavior: such as physiological psychology, comparative psychology, neuropsychology, sensation and perception, physical ergonomics or psychopharmacology;
- f. cognitive-affective bases of behavior: such as learning, thinking, motivation, emotion, memory, cognitive information processing, or social cognition;
- g. social bases of behavior: such as social psychology, group processes, organizational and systems theory; and
- h. individual differences: such as personality theory, human development, personnel psychology, or abnormal psychology.

10. All professional education programs in psychology shall include course requirements in developed practice areas/specialties.

11. The program must demonstrate that it provides training relevant to the development of competence to practice in a diverse and multicultural society.

When a new area of professional psychology is recognized as being a developed practice area and within the accreditation scope of the APA, doctoral programs within that area will be afforded a transition period of eight years from their first class of students to the time of their accreditation – or, where there is no accreditation, applicants for licensure must show that they have successfully obtained substantial instruction in the foundational areas listed above. During that transition period, graduates of such programs may sit for licensure examination whether or not the program has been accredited. The same principle applies as well to new doctoral programs in traditional practice areas previously recognized within the scope of APA accreditation.

Applicants trained in institutions outside the United States shall meet requirements established by the Board.

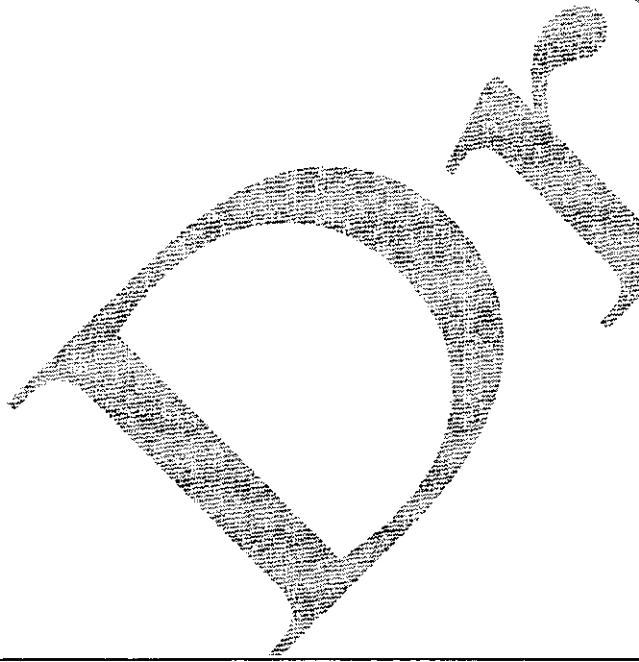
Psychologists trained in an area that falls outside the scope of APA accreditation (e.g., experimental, developmental, social) and who intend to practice in a traditional or developed practice area must complete a retraining program and/or appropriate supervised experience (e.g., internship in the developed practice area). Similarly, psychologists trained in HSP programs who intend to practice in General Applied Psychology non-exempt areas and psychologists trained in General Applied Psychology areas who intend to provide health services must first acquire the appropriate training and supervision.

D-2. Experience Requirements

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APA recommends that legislation requires one year of supervised experience subsequent to the granting of the doctorate. In rules and regulations, the Board must define acceptable supervised experience at the predoctoral and postdoctoral levels as well as mechanisms for evaluation of this experience. Psychologists are required to limit their practice to their demonstrated areas of professional competence. Experience should be compatible with training.

For admission to the licensure examination, applicants shall demonstrate that they have completed two years of supervised professional experience, one year of which shall be postdoctoral. The criteria for appropriate supervision shall be in accordance with regulations to be promulgated by the Board. Postdoctoral experience shall be compatible with the knowledge and skills acquired during formal doctoral or postdoctoral education in accordance with professional requirements and relevant to the intended area of practice. Applicants shall be required to show evidence of good character, that is, that they have not been convicted of a criminal offense that bears directly on the fitness of the individual to be licensed.



APA recommends that legislation requires the equivalent of two full-time years of sequential, organized, supervised, professional experience prior to obtaining the license. This training may be completed prior or subsequent to the granting of the doctoral degree. For applicants prepared for practice in the health services domain of psychology, one of those two years of supervised professional experience shall be a predoctoral internship which may be completed as a part-time intern over a two year period provided that the total experience is the equivalent of one year of full time experience. For applicants prepared for practice in the General Applied (non-HSP) domain of psychology, whose graduate programs may not have formal internships, the option to obtain all supervision post doctorally should be available. In rules and regulations, the Board must define acceptable supervised experience at the predoctoral and postdoctoral levels as well as mechanisms for evaluation of this experience. Boards are encouraged to create definitions that are flexible and capture the variety of training and supervisory models that are appropriate for both HSP and General Applied practice. Psychologists are required to limit their practice to their demonstrated areas of professional competence. Experience should be compatible with training.

To obtain licensure, applicants shall demonstrate that they have completed the equivalent of two full-time years of sequential, organized, supervised professional experience. For applicants prepared for practice in the health services domain of psychology, one of those two years of supervised professional experience shall be a predoctoral internship. For applicants prepared for practice in the General Applied domain of psychology, whose graduate programs may not have formal internships, the option to obtain all supervision post doctorally should be available. The criteria for appropriate supervision shall be in accordance with regulations to be promulgated by the Board. Experience shall be compatible with the knowledge and skills acquired during formal doctoral and/or postdoctoral education in accordance with professional requirements and relevant to the intended area of practice. General Applied (non-HSP) Psychologist trainees may be supervised by an appropriate licensed psychologist outside the supervisee's place of employment so long as (a) the supervisee's employer engages the licensed supervisor to provide the required supervision; and (b) the supervisor assumes responsibility for the training of the supervisee. Applicants shall be required to show evidence of good character, e.g., that they have not been convicted of a criminal offense that bears directly on the fitness of the individual to be licensed.

D-3. Examinations

APA recommends that the Act specify the requirements for examination and the conditions under which the Board is authorized to waive examination. All examinations serve the purpose of verifying that a candidate for licensure has acquired a basic core of knowledge in the discipline of psychology and can apply that knowledge to the problems

D-3. Examinations

APA recommends that the Act specify the requirements for examination and the conditions under which the Board is authorized to waive examination. All examinations serve the purpose of verifying that a candidate for licensure has acquired a basic core of knowledge in the discipline of psychology and can apply that knowledge to the problems confronted in the practice

confronted in the practice of psychology. Boards should clearly specify the conditions under which the endorsement of another license will be granted. The Board shall administer examinations to qualified applicants on at least an annual basis. The Board shall determine the subject matter and scope of the examination and shall require a written, and may require an oral examination of each candidate for licensure. The Board at its discretion, according to rules and regulations promulgated by the Board, may waive said examination of candidates for licensure.

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D-4. Prior Credentials

APA recommends that the Act provide for continued licensure of persons already licensed as a psychologist at the time of enactment of a new law.

A person who is licensed as a psychologist under the provisions of *(cite relevant section(s) of previous licensing law)* as of the effective date of this Act shall be deemed to have met all requirements for licensure under this Act and shall be eligible for renewal of licensure in accordance with the provisions of this Act.

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D-5. Applications from individuals licensed in other jurisdictions.

Jurisdictions are strongly encouraged to adopt regulations to facilitate the mobility and portability of licensure. Jurisdictions may set criteria to determine conditions under which verification of education, experience and examination requirements will be waived. These criteria may include holding a credential that verifies education and experiences of individuals (e.g. American Board of Professional Psychology (ABPP), National Register of Health Service Providers in Psychology, Association of State and Provincial Psychology Boards' Certificate of Professional Qualification in Psychology (ASPPB's CPQ)), Board determination that the criteria of the other jurisdiction are comparable to the Board's criteria or other specified mechanism.

An individual applying for licensure with the Board who holds an active psychology license in another jurisdiction and shows evidence of good character is considered an eligible candidate for licensure in the jurisdiction. The Board may waive verifying the education, experience and examination requirements for individuals who meet these criteria and for whom the Board's mechanism for verifying comparability of education, experience and examination requirements is met. The Board retains the right to administer any required jurisdiction-specific examinations (written, oral, jurisprudence) prior to awarding the license.

E. Interstate Practice of Psychology

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Psychologists may have legitimate interests in practicing in another jurisdiction for a limited amount of time. This section provides for limited practice in a jurisdiction other than the state in which the psychologist is licensed. The psychologist must have an earned doctoral degree in another jurisdiction.

Nothing in this Act shall be construed to prohibit the practice of psychology in this state by a person holding an earned doctoral degree in psychology from an institution of higher education who is licensed or certified as a psychologist under the laws of another jurisdiction, provided that the aggregate of sixty (60) days of professional services as a psychologist per year under the provision of this subsection is not exceeded.

Psychologists may have legitimate interests in practicing in another jurisdiction for a limited amount of time. This section provides for limited practice in a jurisdiction other than the state in which the psychologist is licensed. This is not intended to eliminate the necessity for licensure for those who are setting up a regular professional practice in that jurisdiction. The psychologist must have an earned doctoral degree and be licensed in another jurisdiction.

Nothing in this Act shall be construed to prohibit the practice of psychology in this state by a person holding an earned doctoral degree in psychology from an institution of higher education who is licensed or certified as a psychologist under the laws of another jurisdiction, provided that the aggregate of sixty (60) days per year of professional services as a psychologist per year under the provision of this subsection is not exceeded. Prior to providing services in this state, a doctoral level licensed psychologist from another jurisdiction should provide written notice to the Board of the type of services to be provided, approximate duration of such services along with documentation of licensure and consent to operating under the jurisdiction, law and regulations of this state. Because the state recognizes the occasional need for rapid provision of certain services, notice does not require approval of the Board prior to delivery of service if the aggregate of 60 days of services is maintained and the individual does not establish an ongoing, regular, professional practice in the jurisdiction.

In disaster situations the time frame and conditions under which psychologists will provide disaster services in the jurisdiction will be defined by the Board.

To the extent that the jurisdiction has adopted the Uniform Emergency Volunteer Health Practitioners Act, it will apply in times of disaster.

F. Temporary Authorization to Practice

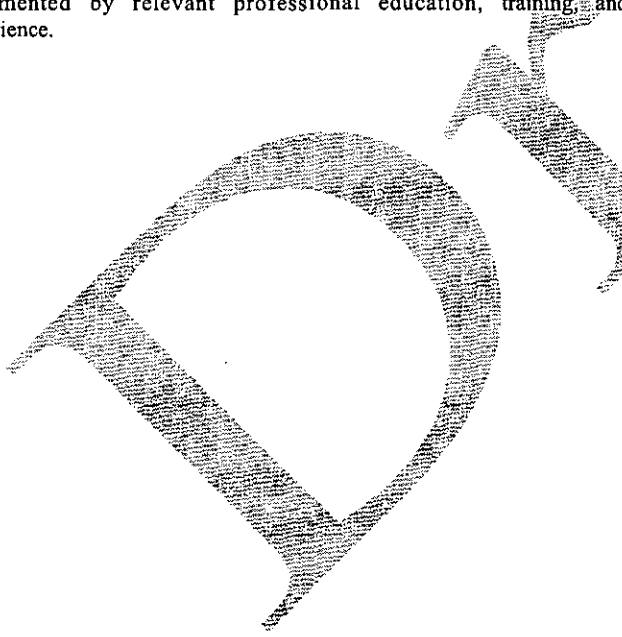
This portion of the Act provides for the conditions under which a licensed psychologist may practice until obtaining licensure in another jurisdiction. Provision is also made for the Board to waive examination if the requirements met by the psychologist in the original jurisdiction are judged to be equivalent to those in this state.

A psychologist licensed or certified under the laws of another jurisdiction may be authorized by the Board to practice psychology as defined in this Act for a maximum of one year, provided that the psychologist has made application to the Board for licensure and has met the educational and experience requirements for licensure in this state. Denial of licensure terminates this authorization. The Board may choose to waive examination if a psychologist has been licensed in another jurisdiction on the basis of qualifications that are not less than those required for licensure in this state.

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A psychologist holding a current, active license or certification under the laws of another jurisdiction may be authorized by the Board to practice psychology as defined in this Act for a maximum of one year, provided that the psychologist has made application to the Board for licensure and has met the educational and experience requirements for licensure in this state. Denial of licensure terminates this authorization. The Board may choose to waive examination if a psychologist is licensed in another jurisdiction on the basis of qualifications that

	<i>are not less than those required for licensure in this state.</i>
<p>G. Limitation of Practice</p> <p>This provision of the Act is intended to ensure that licensed psychologists will not practice outside the limits of their competence. The burden of proof is on the applicant to provide evidence, acceptable to the Board, that the applicant has obtained the training necessary to engage in the practice of psychology in the specified area of competence. The Board may wish to develop forms that provide for the specification of the intended area of practice and the evidence necessary to document competence. This provision recognizes the broad areas of specialization (e.g., clinical, counseling, school, industrial/organizational) and emerging specialties (e.g., neuropsychology, environmental) and the variety of academic training as separate from proficiencies. It is expected that if the psychologist is trained in a broad specialty area, there are many proficiencies within that training that are possible areas of competence. This limitation is intended to ensure that a psychologist trained in one area (e.g., experimental, developmental) will not practice in another area (e.g., counseling, industrial/organizational) without completing a retraining program.</p> <p>The Board shall ensure through regulations and enforcement that licensees limit their practice to demonstrated areas of competence as documented by relevant professional education, training, and experience.</p> 	<p>G. Limitation of Practice; Maintaining and Expanding Competence</p> <p>This provision of the Act is intended to ensure licensed psychologists who provide services will not practice outside the limits of their competence. The burden of proof is on the applicant to provide evidence, acceptable to the Board, that the applicant has obtained the training necessary to engage in the practice of psychology in the specified area of competence. The Board may wish to develop forms that provide for the specification of the intended area of practice and the evidence necessary to document competence. The Board should recognize that training in psychology includes broad and general training in scientific psychology and in the foundations of practice. Practice areas include: clinical psychology, counseling psychology, school psychology, industrial-organizational psychology and other developed practice areas.</p> <p>Psychologists provide services to populations and in areas within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience and do not practice beyond their areas of competence. The Board develops requirements or structures (e.g., continuing education in general areas of practice as well as in specific areas such as ethics, domestic violence and multicultural competence; declaration and documentation of competence) to ensure that psychologists undertake ongoing efforts to identify, develop, and maintain competence and ethical practice. Boards may choose to require applicants for licensure and renewal of licensure to self-declare their areas of practice competence. Should a psychologist's area of practice change, then the psychologist shall be required to provide documentation of the training, supervision and/or mentoring undertaken to achieve competence in the new area at the time of license renewal. Psychologists practicing in emerging areas take reasonable steps to ensure the competence of their work by using relevant research, training, consultation, or study.</p> <p><i>The Board shall ensure through regulations and enforcement that licensees limit their practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. The Board shall develop structures to ensure that psychologists undertake ongoing efforts to maintain competence and ethical practice. The Board adopts as its standard of conduct the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association.</i></p>
<p>H. Inactive Status</p> <p>A psychologist who is on military assignment outside the state, suffering from health problems, on sabbatical, or who moves to another state may wish to be on inactive status. Relieving the psychologist from paying the fee will make it possible for that person to remain in good standing without being an active</p>	<p>H. Inactive Status</p> <p>A psychologist who is on military assignment outside the state, suffering from health problems, on sabbatical, retired, or who moves to another state may wish to be on inactive status. Relieving the psychologist from paying the fee will make it possible for that person to remain in good standing without being</p>

<p>practitioner.</p> <p>A psychologist in good standing who will not be practicing in the state for at least one year may petition the Board to have his or her license placed on inactive status without penalty. When such psychologist wishes to return to practice, an application shall be made to the Board, which shall reinstate him or her upon payment of the registration fee for the current year.</p>	<p>an active practitioner.</p> <p><i>A psychologist in good standing who will not be practicing in the state for at least one year may petition the Board to have his or her license placed on inactive status without penalty. When such psychologist wishes to return to practice, an application shall be made to the Board, which shall reinstate him or her upon payment of the registration fee for the current year.</i></p>
<p>I. Practice Without a License</p> <p>The Act must clearly specify what constitutes a violation of law and what penalties may be imposed for practice without a license or for misrepresentation of oneself as a psychologist. State legislatures have the latitude to determine penalties for such illegal activities. Boards are provided with the authority to suspend or revoke licenses and to prescribe conditions for reinstatement.</p> <p>It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to represent himself or herself as a psychologist. It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to engage in the practice of psychology as defined in this Act, whether practicing as an individual, firm, partnership, corporation, agency, or other entity.</p> <p>Any person who shall represent himself or herself as a psychologist in violation of this Act, or who shall engage in the practice of psychology in violation of this Act, shall be guilty of a misdemeanor and shall be fined not less than _____ dollars and not more than _____ dollars and, in addition thereto, may be imprisoned for not more than _____ months. Each day such person shall practice psychology without meeting all the requirements of all laws now in force and of this Act shall constitute a separate offense. Any person filing or attempting to file, as his or her own, a diploma or license of another or a forged affidavit of identification shall be guilty of a felony and shall be subject to the punishment prescribed for forgery in the second degree.</p> <p>Whenever a license to practice as a psychologist in the state has been suspended or revoked, it shall be unlawful for the person whose license has been so suspended or revoked to practice psychology in this state. The Board may issue, with or without reexamination, a new license whenever it deems such course safe and just.</p> <p>The Board on its own motion may investigate any evidence or allegation that appears to show that any person is or may be in violation of any provision of this Act.</p>	<p>I. Practice Without a License</p> <p>The Act must clearly specify what constitutes a violation of law and what penalties may be imposed for practice without a license or for misrepresentation of oneself as a psychologist. State legislatures have the latitude to determine penalties for such illegal activities. Boards are provided with the authority to suspend or revoke licenses and to prescribe conditions for reinstatement.</p> <p><i>It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to represent himself or herself as a psychologist. It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to engage in the practice of psychology as defined in this Act, whether practicing as an individual, firm, partnership, corporation, agency, or other entity.</i></p> <p><i>Any person who shall represent himself or herself as a psychologist in violation of this Act, or who shall engage in the practice of psychology in violation of this Act, shall be guilty of a misdemeanor and shall be fined not less than _____ dollars and not more than _____ dollars and, in addition thereto, maybe imprisoned for not more than _____ months. Each day such person shall practice psychology without meeting all the requirements of all laws now in force and of this Act shall constitute a separate offense. Any person filing or attempting to file, as his or her own, a diploma or license of another or a forged affidavit of identification shall be guilty of a felony and shall be subject to the punishment prescribed for forgery in the second degree.</i></p> <p><i>Whenever a license to practice as a psychologist in the state has been suspended or revoked, it shall be unlawful for the person whose license has been so suspended or revoked to practice psychology in this state. The Board may issue, with or without reexamination, a new license whenever it deems such course safe and just.</i></p> <p><i>The Board on its own motion may investigate any evidence or allegation that appears to show that any person is or may be in violation of any provision of this Act.</i></p>
<p>J. Exemptions</p> <p>1. There should be an exemption from licensure for persons</p>	<p>J. Exemptions</p> <p>1. There should be an exemption from licensure for persons</p>

engaged solely in teaching, research, or provision of psychological services to organizations, because such activities are unlikely to pose a risk of immediate harm to the public health or welfare. For example, an organizational psychologist providing consultation to business in order to improve efficiency, a teacher of child development courses at a university, a researcher in the field of sleep disorders, and a social psychologist researching group behavior in stressful situations would all be exempt. The exemption should not be determined on the basis of work setting or place of primary employment, but on the basis of the purpose of the activity as defined in Section B3 (Practice of psychology). The exemption should not be allowed if the individual engages in the direct delivery or supervision of psychological services to individuals or groups of individuals in any setting. Persons engaged in teaching, research, or the provision of psychological services to organizations should not be excluded from licensure if they meet the statutory requirements for licensure.

Nothing in this Act shall be construed to prevent the teaching of psychology, the conduct of psychological research, or the provision of psychological services or consultation to organizations or institutions, provided that such teaching, research, or service does not involve the delivery or supervision of direct psychological services to individuals or groups of individuals who are themselves, rather than a third party, the intended beneficiaries of such services, without regard to the source or extent of payment for services rendered. Nothing in this Act shall prevent the provision of expert testimony by psychologists who are otherwise exempted by this Act. Persons holding an earned doctoral degree in psychology from an institution of higher education may use the title "psychologist" in conjunction with the activities permitted by this subsection.

2. Members of other established professions, such as physicians, attorneys, and clergy, may provide services that are similar or related to the scope of practice of psychology. They should be exempted from licensure on the condition that they not represent themselves to be psychologists.

Nothing in this Act shall be construed to prevent members of other recognized professions that are licensed, certified, or regulated under the laws of this state from rendering services consistent with their professional training and code of ethics, provided that they do not represent themselves to be psychologists. Duly recognized members of the clergy shall not be restricted from functioning in their ministerial capacity, provided that they do not represent themselves to be psychologists.

3. It is recognized that school psychologists who are certified by the state education agency are permitted to use the term *school psychologist* or *certified school psychologist* as long as they are practicing in the public schools.

Individuals who have been certified as school psychologists by the (*cite relevant state education authority or statutory provisions*) shall be permitted to use the term "school psychologist" or "certified school psychologist." Such persons shall be restricted in their practice to employment within those settings under the purview of the state board of education. By 1995 such exempted persons should be certificated by the state board of

engaged solely in teaching in academic institutions, or research in academic and/or research institutions. In addition, those General Applied (non-HSP) Psychologists who provide services for the benefit of the organization and not involving direct services to individuals should be exempt from licensure and be allowed to refer to themselves as psychologists. The exemption should not be determined on the basis of work setting or place of primary employment, but on the basis of the purpose of the activity as defined in Section B3 (Practice of psychology). The exemption should not be allowed if the individual engages in the direct delivery or supervision of psychological services to individuals or groups of individuals in any setting. Persons engaged in teaching or research, should not be excluded from licensure if they meet the statutory requirements for licensure.

Nothing in this Act shall be construed to prevent the teaching of psychology or the conduct of psychological research, provided that such teaching or research does not involve the delivery or supervision of direct psychological services. Nothing in this Act shall prevent the provision of General Applied Psychology services to organizations so long as those services are for the benefit of the organization, and does not involve direct service to individuals. Nothing in this Act shall prevent the provision of expert testimony by psychologists who are otherwise exempted by this Act. Persons holding a doctoral degree in psychology from an institution of higher education may use the title "psychologist" in conjunction with the activities permitted by this subsection.

2. Members of other established professions, such as physicians, attorneys, and clergy, may provide services that are similar or related to the scope of practice of psychology. They should be exempted from licensure on the condition that they not represent themselves to be psychologists.

Nothing in this Act shall be construed to prevent members of other recognized professions that are licensed, certified, or regulated under the laws of this state from rendering services consistent with their professional training and code of ethics, provided that they do not represent themselves to be psychologists. Duly recognized members of the clergy shall not be restricted from functioning in their ministerial capacity, provided that they do not represent themselves to be psychologists.

3. The prior version of this Model Act included an exemption for the use of the terms *school psychologist* or *certified school psychologist* for all individuals credentialed by the state agency regulating practice in public schools. This version restricts the use of the term *school psychologist* or *certified school psychologist* to individuals who: 1) have a doctoral degree in psychology; 2) are certified by the state education agency; and (3) are using the terms only during their practice in the public schools.

Only those persons who are credentialed by state education agencies to provide psychoeducational services and who possess a doctoral degree in

education on the basis of having completed a program for the preparation of school psychologists that is accredited by a specialized professional accrediting body recognized by the Council on Postsecondary Accreditation.

4. Graduate students, interns, postdoctoral trainees, and applicants for licensure are permitted to function under the supervision of a licensed psychologist, as are assistants not eligible for licensure in some states. None may use the title psychologist, but titles such as *psychological trainee*, *psychological intern*, *psychological resident*, and *psychological assistant* would be permissible under this exemption. The supervising psychologist is responsible for the actions of the student, trainee, or assistant. The Board is required to adopt regulations defining the nature and extent of training for qualified assistants and supervision for each category.

Nothing in this Act shall be construed to prevent persons from engaging in activities defined as the practice of psychology, provided that such persons shall not represent themselves by the title "psychologist." Such persons may use the terms "psychological trainee," "psychological intern," "psychological resident" and "psychological assistant" and provided further that such persons perform their activities under the supervision and responsibility of a licensed psychologist in accordance with regulations promulgated by the Board. Nothing in this section shall be construed to apply to any person other than:

- (a) a matriculated graduate student in psychology whose activities constitute a part of the course of study for a graduate degree in psychology at an institution of higher education;
- (b) an individual pursuing postdoctoral training or experience in psychology, including persons seeking to fulfill the requirements for licensure under the provisions of this Act; or
- (c) a qualified assistant employed by, or otherwise directly accountable to, a licensed psychologist. The Board in regulations shall determine the number of assistants that a psychologist may employ and the conditions under which they will be supervised.

psychology from a regionally accredited institution may use the title "school psychologist" or "certified school psychologist." Such persons shall be restricted in their practice and in the use of such title to those settings under the purview of the state education agency. This provision is not intended to apply to licensed psychologists.

4. Graduate students, interns, unlicensed postdoctoral trainees, and applicants for licensure are permitted to function under the supervision of a licensed psychologist, as are assistants not eligible for licensure in some states. None may use the title psychologist, but titles such as *psychological trainee*, *psychological intern*, *psychological resident*, and *psychological assistant* or *psychological associate* would be permissible under this exemption. The supervising psychologist is responsible for the professional actions of the student, trainee, or assistant. The Board is required to adopt regulations defining the nature and extent of training for qualified assistants and supervision for each category.

Nothing in this Act shall be construed to prevent graduate students, interns, unlicensed postdoctoral trainees and applicants for licensure under the supervision of a licensed psychologist from engaging in activities defined as the practice of psychology, provided that such persons shall not represent themselves by the title "psychologist" in accordance with regulations promulgated by the Board. Such persons may use the terms such as "psychological trainee," "psychological intern," "psychological resident," and "psychological assistant" and provided further that such persons perform their activities under the supervision and responsibility of a licensed psychologist in accordance with regulations promulgated by the Board.

Nothing in this section shall be construed to apply to any person other than:

- (a) a matriculated graduate student in psychology whose activities constitute a part of the course of study for a graduate degree in psychology at an institution of higher education;*
- (b) an unlicensed individual pursuing postdoctoral training or experience in psychology, including persons seeking to fulfill the requirements for licensure under the provisions of this Act; or*
- (c) a qualified assistant employed by, or otherwise directly accountable to, a licensed psychologist. The Board in regulations shall determine the number of assistants that a psychologist may employ and the conditions under which they will be supervised.*

5. This provision clarifies that the focus of licensure is the individual providing the services. Where the individual providing the services is duly licensed and qualified to provide the services, the goal of assuring the public that the services will be provided by licensed and qualified professionals is served.

Nothing in this Act shall be construed to require a license under this Act in order for a firm, partnership, corporation, limited liability company or other entity to provide General Applied

Psychology services where such services are performed by an individual: (a) duly licensed in this State or otherwise authorized to provide General Applied Psychology services under this Act; or (b) supervised by a licensed psychologist in this State and permitted to provide General Applied Psychology services with such supervision under this Act.

6. Individuals who were previously unable to obtain licensure because of exemptions or exclusions in the previous version of this Act or where fulfilling requirements for licensure has been prohibitive (in some instances this has included I-O, Human factors and consulting psychologists) but are now expected to become licensed under the new regulations, a provision for extending licensure to those psychologists should be enacted.

All who have been practicing for 5 years or more exclusively outside of the healthcare psychology area and who were previously unable to obtain licensure because of exemptions or exclusions in the previous version of this Act or where fulfilling requirements has been prohibitive shall be grandparented, with the following requirements:

(a) Candidates should have graduated from a regionally accredited institution with a doctoral degree in I-O, consulting, or other recognized program in general applied psychology.

(b) Attestation from the candidate that documents at least 5 years of relevant work history in I-O, consulting, or other general applied psychology practice. This should include written support from at least two licensed psychologists in good standing within that jurisdiction or APA Fellows in the same or similar area of practice that attests to the candidate's work history, quality of work, ethical practice and lack of any disciplinary action.

(c) Completion of the jurisprudence examination of that jurisdiction with a passing grade.

Individuals must have applied for this Grandparenting option within two years from the enactment of this act. After that date, the individual must comply with the regular licensing laws.

K. Grounds for Suspension or Revocation of Licenses

In order to have an effective law, the Board must have the power to suspend and revoke a license. In the previous guidelines, the offenses requiring suspension or revocation were not specified. Many state laws specify these offenses. Actions that are a violation of the standards subscribed to by the Board **should be** clearly stated in the licensing law. Two considerations are specified below that refer to specific points in the text that follows:

1. Concerning Numbers 6 and 7

The Board shall specify, in rules and regulations, criteria for determining how long or under what conditions an individual or group of individuals remains a patient or a client.

K. Grounds for Suspension or Revocation of Licenses

In order to have an effective law, the Board must have the power to suspend and revoke a license. Actions that are a violation of the enforceable standards of the APA Ethical Principles of Psychologists and Code of Conduct and other standards subscribed to by the Board should be clearly stated in the licensing law. One consideration is specified below that refers to a specific point in the text that follows:

Concerning Number 14

In this section, physical condition shall be differentiated from physical disability. There is no intent to obstruct physically disabled candidates' entry into the profession of psychology nor from practicing their profession after licensure as long as they practice with reasonable skill and safety to patients or clients.

2. Concerning Number 17

In this section, physical condition shall be differentiated from physical disability. There is no intent to obstruct physically disabled candidates' entry into the profession of psychology nor from practicing their profession after licensure as long as they practice with reasonable skill and safety to patients or clients.

A psychologist and anyone under his or her supervision shall conduct his or her professional activities in conformity with ethical and professional standards promulgated by the Board under its rules and regulations.

The Board shall have the power and duty to suspend, place on probation, or require remediation for any psychologist for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology or to take any other action specified in the rules and regulations whenever the Board shall find by a preponderance of the evidence that the psychologist has engaged in any of the following acts or offenses:

1. fraud in applying for or procuring a license to practice psychology;
2. immoral, unprofessional, or dishonorable conduct as defined in the rules and regulations promulgated by the Board;
3. practicing psychology in such a manner as to endanger the welfare of clients or patients;
4. conviction of a felony (a copy of the record of conviction, certified to by the clerk of the court entering the conviction shall be conclusive evidence);
5. conviction of any crime or offense that reflects the inability of the practitioner to practice psychology with due regard for the health and safety of clients or patients;
6. harassment, intimidation, or abuse, sexual or otherwise, of a client or patient;
7. engaging in sexual intercourse or other sexual contact with a client or patient;
8. use of repeated untruthful or deceptive or improbable statements concerning the licensee's qualifications or the effects or results of proposed treatment, including functioning outside of one's professional competence established by education, training, and experience;
9. gross malpractice or repeated malpractice or gross negligence in the practice of psychology;
10. aiding or abetting the practice of psychology by any person not licensed by the Board;
11. conviction of fraud in filing Medicare or Medicaid claims or in filing claims to any third party payor (a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence);
12. exercising undue influence in such a manner as to exploit the client, patient, student, or supervisee for financial or other personal advantage to the practitioner or a third party;
13. the suspension or revocation by another state of a license to practice psychology (a certified copy of the record of suspension or revocation of the state making such a suspension or revocation shall be conclusive evidence thereof);
14. refusal to appear before the Board after having been ordered to do so in writing by the executive officer or chair of the Board;
15. making any fraudulent or untrue statement to the Board;
16. violation of the code of ethics adopted in the rules and regulations of the Board; and
17. inability to practice psychology with reasonable skill and

A psychologist and anyone under his or her supervision shall conduct his or her professional activities in conformity with the ethical and professional standards of the APA Ethical Principles of Psychologists and Code of Conduct and those standards promulgated by the Board under its rules and regulations.

The Board shall have the power and duty to suspend, place on probation, or require remediation for any psychologist for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology or to take any other action specified in the rules and regulations whenever the Board shall find by a preponderance of the evidence that the psychologist has engaged in any of the following acts or offenses:

1. *fraud in applying for or procuring a license to practice psychology;*
2. *immoral, unprofessional, or dishonorable conduct as defined in the rules and regulations promulgated by the Board;*
3. *practicing psychology in such a manner as to endanger the welfare of clients or patients;*
4. *conviction of a felony (a copy of the record of conviction, certified to by the clerk of the court entering the conviction shall be conclusive evidence);*
5. *conviction of any crime or offense that reflects the inability of the practitioner to practice psychology with due regard for the health and safety of clients or patients;*
6. *use of repeated untruthful or deceptive or improbable statements concerning the licensee's qualifications or the effects or results of proposed treatment, including functioning outside of one's professional competence established by education, training, and experience;*
7. *gross malpractice or repeated malpractice or gross negligence in the practice of psychology;*
8. *aiding or abetting the practice of psychology by any person not licensed by the Board;*
9. *conviction of fraud in filing Medicare or Medicaid claims or in filing claims to any third party payor (a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence);*
10. *the suspension or revocation by another state of a license to practice psychology (a certified copy of the record of suspension or revocation of the state making such a suspension or revocation shall be conclusive evidence thereof);*
11. *refusal to appear before the Board after having been ordered to do so in writing by the executive officer or chair of the Board;*
12. *making any fraudulent or untrue statement to the Board;*
13. *violation of the APA Ethical Principles of Psychologists and Code of Conduct and other standards adopted in the rules and regulations of the Board; and*
14. *inability to practice psychology with reasonable skill and safety to patients or clients by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance, or as a result of any mental or physical condition.*

When the issue is whether or not a psychologist is physically or mentally capable of practicing psychology with reasonable skill

safety to patients or clients by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance, or as a result of any mental or physical condition.

When the issue is whether or not a psychologist is physically or mentally capable of practicing psychology with reasonable skill and safety to patients or clients, then, upon a showing of probable cause to the Board that the psychologist is not capable of practicing psychology with reasonable skill and safety to patients, the Board may petition a court of competent jurisdiction to order the psychologist in question to submit to a psychological examination by a psychologist to determine psychological status and/or a physical examination by a physician to determine physical condition. Such psychologist and/or physician is to be designated by the court. The expense of such examination shall be borne by the Board. Where the psychologist raises the issue of mental or physical competence or appeals a decision regarding his or her mental or physical competence, the psychologist shall be permitted to obtain his or her own evaluation at the psychologist's expense. If the objectivity or adequacy of the examination is suspect, the Board may complete an examination by its designated practitioners at its own expense. When mental or physical capacity to practice is at issue, every psychologist licensed to practice psychology in the state shall be deemed to have given consent to submit to a mental or physical examination or to any combination of such examinations and to waive all objections to the admissibility of the examination, or to previously adjudicated evidence of mental incompetence.

and safety to patients or clients, then, upon a showing of probable cause to the Board that the psychologist is not capable of practicing psychology with reasonable skill and safety to patients or clients, the Board may petition a court of competent jurisdiction to order the psychologist in question to submit to a psychological examination by a psychologist to determine psychological status and/or a physical examination by a physician to determine physical condition. Such psychologist and/or physician is to be designated by the Board. The expense of such examination shall be borne by the Board. Where the psychologist raises the issue of mental or physical competence or appeals a decision regarding his or her mental or physical competence, the psychologist shall be permitted to obtain his or her own evaluation at the psychologist's expense. If the objectivity or adequacy of the examination is suspect, the Board may complete an examination by its designated practitioners at its own expense. When mental or physical capacity to practice is at issue, every psychologist licensed to practice psychology in the state shall be deemed to have given consent to submit to a mental or physical examination or to any combination of such examinations and to waive all objections to the admissibility of the examination, or to previously adjudicated evidence of mental incompetence.

L. Board Hearings and Investigations

In the interest of protecting the public, the Board must have authority to regulate the practice of psychology. This section specifies the powers and duties of the Board to conduct investigations, hold hearings, consider evidence or allegations brought against a psychologist, and to discipline a licensee for violation of law or regulation. Both the Board and licensee are required to follow due process standards in any disciplinary proceeding.

The Board on its own motion may investigate or cause to be investigated any allegation or evidence that appears to show that a psychologist licensed to practice in this state is, or may be, in violation of this Act or of any of the acts, offenses, or conditions set forth by the Board in rules and regulations.

The Board shall have the power and duty to suspend, place on probation, or require remediation for a licensee for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology, whenever the licensee shall be found by the Board, by a preponderance of the evidence, to have engaged in conduct prohibited by this Act or rules and regulations duly promulgated pursuant thereto.

Any psychologist holding a license to practice in this state is required to report to the Board any information such psychologist in good faith may have that appears to show that any psychologist holding a license to practice in this state may be in violation of this Act or guilty of any of the acts, offenses, or conditions set forth by the Board. Any psychologist who in good faith makes such a report to the Board shall be absolutely immune from civil liability to any person for any statement or opinion made in such report.

L. Board Hearings and Investigations

In the interest of protecting the public, the Board must have authority to regulate the practice of psychology. This section specifies the powers and duties of the Board to conduct investigations, hold hearings, consider evidence or allegations brought against a psychologist, and to discipline a licensee for violation of law or regulation. Both the Board and licensee are required to follow due process standards in any disciplinary proceeding.

The Board on its own motion may investigate or cause to be investigated any allegation or evidence that appears to show that a psychologist licensed to practice in this state is, or may be, in violation of this Act or of any of the acts, offenses, or conditions set forth by the Board in rules and regulations.

1) Any accusation filed against a psychologist licensed to practice in this state shall be filed within three years from the date the Board discovers the alleged act or omission that is the basis for disciplinary action, or within seven years from the date the alleged act or omission that is the basis for disciplinary action occurred, whichever occurs first. If an alleged act or omission involves a minor, the seven-year limitations period provided for shall be tolled until the minor reaches the age of majority.

2) The following are exceptions to the limitations period in paragraph (1):

a. acts or offences involving a violation of Sections K(1)

If, in the opinion of the majority of the Board, there is probable cause that the information provided to it under the provisions of this section may be valid, the Board shall request by registered mail a formal interview with the psychologist. If the psychologist who is ordered to a formal interview before the Board refuses to appear for such interview, such refusal shall be considered grounds for the Board, at its discretion, to suspend or revoke the license of such psychologist. Any proceeding for suspension or revocation of a license to practice as a psychologist in this state shall be conducted in accordance with procedures established by the Board. The psychologist shall be informed of his or her rights concerning Board hearings and investigations:

1. the right to notice and hearing;
2. the right to self-representation or representation by counsel;
3. the right to produce witnesses and to confront and cross-examine opposing witnesses;
4. the right to a written decision setting forth the violation, findings of fact, sanctions, and reasons for the sanctions;
5. a determination of the size of the vote necessary to find a violation;
6. a determination whether the hearing will be closed or open to the public; and
7. the right to an appeal to an administrative board of review and/or to a court of competent jurisdiction.

The licensee may knowingly and voluntarily waive his or her right to the formal adversary proceeding described in this section. The Board shall have the right to conduct an *ex parte* hearing if, after due notice, the individual fails or refuses to appear. The Board shall have the right to issue subpoenas for production of documents and witnesses and to administer oaths. The Board shall have the right to apply to a court of competent jurisdiction to take appropriate action should a subpoena not be obeyed.

The Board shall temporarily suspend the license of a psychologist without a hearing simultaneously with the institution of proceedings for a hearing provided under this section if the Board finds that evidence in its possession indicates that the psychologist's continuation in practice may constitute an immediate danger to the public. Appropriate officials may petition the court for an injunction barring further practice unless or until the person is properly licensed. The injunction may be issued in addition to, or in lieu of, the criminal sanctions provided for in this section.

A psychologist may surrender his or her license when such person is charged with unethical conduct and upon receipt of that charge, that person decides to surrender the license, such surrender and acceptance by the Board shall constitute acknowledgment by the psychologist of guilt as charged.

A psychologist may request in writing to the Board that a restriction be placed upon his or her license to practice as a psychologist. The Board, in its discretion, may accept a surrender or grant such a request for restriction and shall have the authority to attach such restrictions to the license of the psychologist to practice psychology within this state or otherwise to discipline the licensee.

Subsequent to the holding of a hearing and the taking of evidence by the Board as provided for in this section, if a majority of the Board finds that a psychologist is in violation of this Act or guilty of any of the

K(13), or K(15) ;

- b. acts or offences involving a violation of Sections K4, where there is an element of dishonesty or fraud, and Section K5.
- c. acts or offences involving fraudulent, deceptive or dishonest conduct that adversely affects the persons' ability or fitness to practice psychology.
- d. acts or offences involving allegations of sexual misconduct with a client, or with a former client for a period of two years following the date of the last professional contact with the former client.

The Board shall have the power and duty to suspend, place on probation, or require remediation for a licensee for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology, whenever the licensee shall be found by the Board, by a preponderance of the evidence, to have engaged in conduct prohibited by this Act or rules and regulations duly promulgated pursuant thereto.

Any psychologist holding a license to practice in this state is required to report to the Board ethical violations by a licensed psychologist who has substantially harmed or is likely to substantially harm a person or organization, if that violation is not appropriate for informal resolution (APA Ethical Standard 1.04, Informal Resolution of Ethical Violations and 1.05, Reporting Ethical Violations.) Any psychologist who in good faith makes such a report to the Board shall be absolutely immune from civil liability to any person for any statement or opinion made in such report.

If, in the opinion of the majority of the Board, there is probable cause that the information provided to it under the provisions of this section may be valid, the Board shall request by registered mail a formal interview with the psychologist. If the psychologist who is ordered to a formal interview before the Board refuses to appear for such interview, such refusal shall be considered grounds for the Board, at its discretion, to suspend or revoke the license of such psychologist. Any proceeding for suspension or revocation of a license to practice as a psychologist in this state shall be conducted in accordance with procedures established by the Board. In the event that these provisions conflict with the state's general administrative procedures, these specific provisions will take precedence. The psychologist shall be informed of his or her rights concerning Board hearings and investigations:

1. the right to a hearing and 30-days notice of the hearing;
2. the right to see a signed complaint (non anonymous);
3. the right to have access to the Board's rules and procedures;
4. the right to self-representation or representation by counsel;
5. the right to discovery: each side can request from the other side relevant documents, a list of witnesses, and for any expert witnesses, the name, C.V. and a detailed

acts, offenses, or conditions as enumerated by the Board, the following actions may be taken:

1. The Board may revoke or suspend the license and impose a monetary penalty.
2. The Board may suspend imposition of a revocation or suspension of a license and/or a monetary penalty.
3. The Board may impose revocation or suspension of a license and/or a monetary penalty, but suspend enforcement thereof by placing the psychologist on probation, which probation shall be revocable if the Board finds the conditions of the probation order are not being followed by the psychologist.
4. As a condition of probation the Board may require the psychologist to submit to care, counseling, or treatment by a professional designated by the Board. The expense of such action shall be borne by the psychologist.
5. The Board may, at any time, modify the conditions of the probation and may include among them any reasonable condition for the purpose of the protection of the public, or for the purpose of the rehabilitation of the probationer, or both.
6. The Board shall have the power to require restitution when necessary.
7. The Board shall have the power to assess the costs of the disciplinary proceeding.

- report of the expert's expected testimony;*
6. *the right to compel the attendance of, and produce, witnesses and to confront and cross examine opposing witnesses, and to have witnesses testify under oath;*
7. *the right to a written decision setting forth the violation, findings of fact, sanctions, and reasons for the sanctions;*
8. *a determination of the size of the vote necessary to find a violation;*
9. *a determination whether the hearing will be closed or open to the public;*
10. *the right not to have Board members who were on the investigative committee also appear on the formal hearing panel.*
11. *the right to an appeal to an administrative board of review and/or to a court of competent jurisdiction.*

The licensee may knowingly and voluntarily waive his or her right to the formal adversary proceeding described in this section.

The Board shall have the right to conduct an ex parte hearing if, after due notice, the individual fails or refuses to appear. The Board shall have the right to issue subpoenas for production of documents and witnesses and to administer oaths. The Board shall have the right to apply to a court of competent jurisdiction to take appropriate action should a subpoena not be obeyed.

The Board shall temporarily suspend the license of a psychologist without a hearing simultaneously with the institution of proceedings for a hearing provided under this section if the Board finds that evidence in its possession indicates that the psychologist's continuation in practice may constitute an immediate danger to the public. Appropriate officials may petition the court for an injunction barring further practice unless or until the person is properly licensed. The injunction may be issued in addition to, or in lieu of, the criminal sanctions provided for in this section.

A psychologist may surrender his or her license when such person is charged with unethical conduct and upon receipt of that charge, that person decides to surrender the license, such surrender and acceptance by the Board shall constitute acknowledgment by the psychologist of guilt as charged.

A psychologist may request in writing to the Board that a restriction be placed upon his or her license to practice as a psychologist. The Board, in its discretion, may accept a surrender or grant such a request for restriction and shall have the authority to attach such restrictions to the license of the psychologist to practice psychology within this state or otherwise to discipline the licensee.

Subsequent to the holding of a hearing and the taking of evidence by the Board as provided for in this section, if a majority of the Board finds that a psychologist is in violation of this Act or guilty

of any of the acts, offenses, or conditions as enumerated by the Board, the following actions may be taken:

1. The Board may revoke or suspend the license and impose a monetary penalty.
2. The Board may suspend imposition of a revocation or suspension of a license and/or a monetary penalty.
3. The Board may impose revocation or suspension of a license and/or a monetary penalty, but suspend enforcement thereof by placing the psychologist on probation, which probation shall be revocable if the Board finds the conditions of the probation order are not being followed by the psychologist.
4. As a condition of probation the Board may require the psychologist to submit to care, counseling, or treatment by a professional designated by the Board. The expense of such action shall be borne by the psychologist.
5. The Board may, at any time, modify the conditions of the probation and may include among them any reasonable condition for the purpose of the protection of the public, or for the purpose of the rehabilitation of the probationer, or both.
6. The Board shall have the power to require restitution when necessary.
7. The Board shall have the power to assess the costs of the disciplinary proceeding.

M. Privileged Communication

This section regulates and limits the powers of the judicial system. The courts or other administrative agencies with subpoena power have the right to make use of all relevant information in the judicial fact-finding process unless this right of access to information is specifically limited. Historically, courts and legislatures have been charged with fact-finding in order to seek truth and administer justice. At the same time they have attempted to maintain the integrity of the confidential and private relationship between psychologist and patient or client. However, some societal issues have emerged, such as child abuse and sexual abuse that have changed the absolute nature of privileged communication. Though the privilege is not absolute, it is designed to be sufficiently broad to cover all situations except those specifically enumerated. It is a privilege "owned" by the patient or client, who may assert it or waive it, although the psychologist may assert it for a patient or client who wishes to maintain such privilege of communication. It is understood that the privilege encompasses only communications between the patient or client and the psychologist in a professional relationship.

In judicial proceedings, whether civil, criminal, or juvenile; in legislative and administrative proceedings; and in proceedings preliminary and ancillary thereto, a patient or client, or his or her guardian or personal representative, may refuse to disclose or prevent the disclosure of confidential information, including information contained in administrative records, communicated to a psychologist licensed or otherwise authorized to practice psychology under the laws of this jurisdiction, or to persons reasonably believed by the patient or client to be so licensed, and their agents, for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or

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disorder. In the absence of evidence to the contrary, the psychologist is presumed authorized to claim the privilege on the patient's or client's behalf.

This privilege may not be claimed by the patient or client, or on his or her behalf by authorized persons, in the following circumstances:

1. where abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals is known or reasonably suspected;
2. where the validity of a will of a former patient or client is contested;
3. where such information is necessary for the psychologist to defend against a malpractice action brought by the patient or client;
4. where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist;
5. in the context of civil commitment proceedings, where an immediate threat of self-inflicted damage is disclosed to the psychologist;
6. where the patient or client, by alleging mental or emotional damages in litigation, puts his or her mental state at issue;
7. where the patient or client is examined pursuant to court order; or
8. in the context of investigations and hearings brought by the patient or client and conducted by the Board, where violations of this Act are at issue.

to students, interns, and trainees under the supervision of a licensed psychologist, and their agents, for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or disorder. In the absence of evidence to the contrary, the psychologist is presumed authorized to claim the privilege on the patient's or client's behalf.

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2. where the validity of a will of a former patient or client is contested;
3. where such information is necessary for the psychologist to defend against a malpractice action brought by the patient or client;
4. where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist;
5. in the context of civil commitment proceedings, where an immediate threat of self-inflicted damage is disclosed to the psychologist;
6. in any proceeding in which the party relies upon his or her mental or emotional condition as an element of the party's claim or defense;
7. where the patient or client is examined pursuant to court order; or
8. in the context of investigations and hearings brought by the patient or client and conducted by the Board, where violations of this Act are at issue.

N. Severability

As with any law, one provision may be subject to court challenge and ruled invalid or unconstitutional. For example, it is not legally clear whether state licensing boards can regulate persons working for federal agencies. Thus, if any provision is ruled invalid or unconstitutional, it is important that the entire Act not be affected. This can only be achieved by inserting a clause at the end of the Act stating that each provision of the Act is severable from all other provisions and that the declaration that one section is invalid or unconstitutional will not affect the constitutionality or enforceability of any other section.

If any section in this Act or any part of any section thereof shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder of any section or part thereof.

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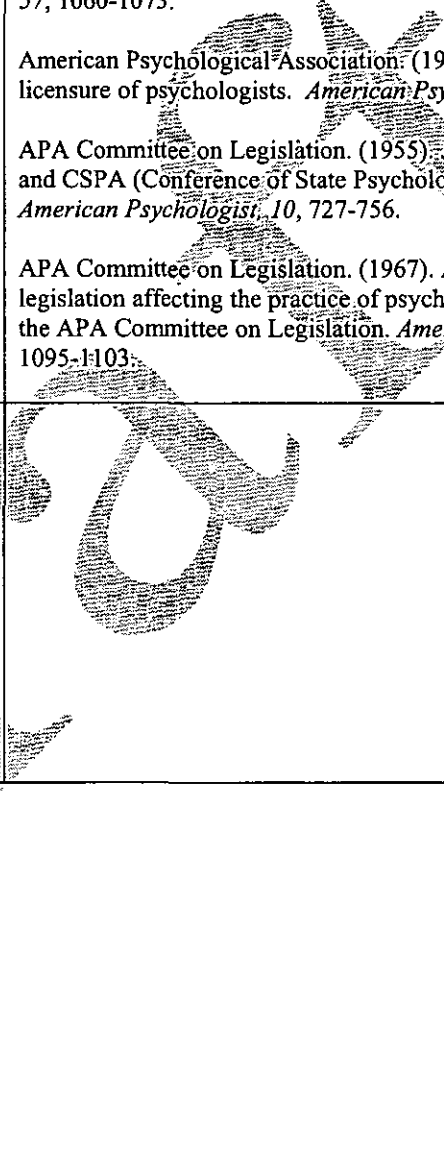
If any section in this Act or any part of any section thereof shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder of any section or part thereof.

O. Effective Date

In any law regulating a profession there needs to be a specific date establishing when the law shall become effective. Thus, the final paragraph states:

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In any law regulating a profession there needs to be a specific date establishing when the law shall become effective. Thus, the final paragraph states:

<p>This Act shall become effective upon the date it is signed by the Governor or on the date it otherwise becomes effective by operation of law.</p>	<p><i>This Act shall become effective upon the date it is signed by the Governor or on the date it otherwise becomes effective by operation of law.</i></p>
<p>References:</p> <p>APA Committee on Legislation. (1955). Joint report of the APA and CSPA (Conference of State Psychological Associations). <i>American Psychologist</i>, 10, 727-756.</p> <p>APA Committee on Legislation. (1967). A model for state legislation affecting the practice of psychology 1967: Report of the APA Committee on Legislation. <i>American Psychologist</i>, 22, 1095-1103.</p>	<p>References:</p> <p>American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. <i>American Psychologist</i>, 57, 1060-1073.</p> <p>American Psychological Association. (1987). Model act for state licensure of psychologists. <i>American Psychologist</i>, 42, 696-703.</p> <p>APA Committee on Legislation. (1955). Joint report of the APA and CSPA (Conference of State Psychological Associations). <i>American Psychologist</i>, 10, 727-756.</p> <p>APA Committee on Legislation. (1967). A model for state legislation affecting the practice of psychology 1967: Report of the APA Committee on Legislation. <i>American Psychologist</i>, 22, 1095-1103.</p>
<p>The Model Act was developed over a period of three years, and was largely the work of Jarold R. Niven and Norma P. Simon, both members of the Board of Professional Affairs' Committee on Professional Practice (COPP). In the last year major revisions were accomplished by a COPP subcommittee chaired by Norma P. Simon and consisting of Jarold R. Niven, R. Mark Mays, David H. Reilly, and Tommy T. Stigall. As a member of the Board of Directors Subcommittee on the Future of Professional Psychology, Carl N. Zimet played a major role in the coordination process. Other COPP members who worked on the project over the three years include Jean L. Balinky, Jacob Chwast, Herbert Dorken, G. Rita Dudley, Thomas J. Hefele, Hannah R. Hirsh, Robert J. Resnick, and Castellano B. Turner. Bev Hitchins served as staff liaison to the project with the support of Patricia J. Aletky, Paul D. Nelson, and Russ Newman.</p> <p>Correspondence concerning this document should be addressed to Office of Professional Affairs, American Psychological Association, 1200 17th St., NW, Washington, DC 20036.</p>	

Matthew Johnson

From: Rep. Wes Keller
Sent: Monday, March 23, 2009 8:01 PM
To: Matthew Johnson
Subject: FW: Request for Information
Attachments: RateChanges_20090320.xls; BHserviceratesFiledNov26Partone (2) (3).pdf

Please print this email plus the attachments and put them in our file on HB110.
 thanks much
 w

From: Casto, L Diane (HSS) [l.casto@alaska.gov]
Sent: Monday, March 23, 2009 6:40 PM
To: Rep. Wes Keller
Cc: Laughlin, Wilda J (HSS)
Subject: FW: Request for Information

Dear Representative Keller –

Last week at the hearing for HB 110, you asked a question related to the reimbursement rate for services and if the level of certification or type of provider (psychologist, social worker, etc.) influenced the rate of pay received. Since we have just made changes to our reimbursement rate, I wanted to check and be sure I gave you the correct response. Teri Keklak from our Anchorage office provides the following comments and attachments. As Teri states, the rate of reimbursement is based on the service, not the provider.

After you have a chance to review the attached information, please do not hesitate to contact me if you have additional questions. I hope this information answers your question.

L. Diane Casto, MPA
 Manager
 DBH, Prevention & Early Intervention Services
 907-465-1188

Partners Promoting Healthy Communities

From: Keklak, Teri (HSS)
Sent: Monday, March 23, 2009 2:48 PM
To: Casto, L Diane (HSS)
Subject: RE: Request for Information

Diane, the BH Medicaid rates for services provided at Community Mental Health Clinics and Substance Abuse Agencies are based on the service provided. While there are no differentials based solely on the credentials of the servicing provider, many of the services require a certain level of professional licensure. The cost of the individual practitioners was considered in our rate review and therefore the services that must be provided by licensed psychologists or physicians typically have the highest reimbursement rates. I have attached a copy of the revised regulations that indicate the rate changes that went into effect on December 26.

The Medicaid rates for services provided by Independent Psychologists are based on the Medicaid physician (RBRVS) fee schedule. As a result of the emergency regulations that were effective March 1, rates to these providers changed. I have attached a spreadsheet which indicates these changes.

From: Casto, L Diane (HSS)
Sent: Friday, March 20, 2009 1:08 PM
To: Keklak, Teri (HSS)
Cc: Knapp, Brenda L (HSS); Toner, Stacy B (HSS); Haines-Simeon, Mark C (HSS)
Subject: Request for Information

Hello Teri – Yesterday I received a request for information from Rep. Keller asking if our payment rates vary for different professional groups – such as someone with a BSW, MSW, LCSW, Psychological Associate, Psychologist, etc.). I told him I would get the specific information to him—I know we just went through a rate review project, so I want to make sure I give him the most recent information. If I could have a response from you by COB Monday that would be great. Thanks so much. Please let me know if you have any questions.

L. Diane Casto, MPA
Manager
DBH, Prevention & Early Intervention Services
907-465-1188

Partners Promoting Healthy Communities

Code	Description	Max thru 12/31/08	As of 1/1/09	As of 3/1/09
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these tests results and preparing the report.	\$123.82	\$164.22	\$151.06
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report.	\$57.36	\$79.61	\$73.23
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.	\$101.01	\$106.97	\$98.39
96110	Developmental testing: limited (e.g. Developmental Screening test II, Early Language Milestone Screen) with interpretation and report	\$17.25	\$15.59	\$14.34
96111	Developmental testing: extended (includes assessment of motor, language, social adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.	\$186.97	\$245.56	\$225.87
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spacial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.	\$139.02	\$178.20	\$163.92
96118	Neurobehavioral testing (e.g. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	\$243.83	\$295.86	\$272.15

Questions and Answers

Q: Why do we need this legislation? Have there been specific complaints submitted regarding people who are not licensed doing the work of a licensed psychologist?

A: The reason is protection of the public. Right now it is possible for someone who has lost their license for misconduct in another state, province, or territory to come to Alaska and obtain employment in an agency as a clinician, or potentially as a psychologist. The person would have the skills and the individual might even be given the title of Clinical Psychologist by an agency, but without being licensed the misconduct would go undiscovered and others could be hurt. By that person being required to obtain a license, their background would be thoroughly checked.

Q: Why should we remove the language "for a fee", which in essence defines the practice of psychology as only that work done in exchange for payment?

A: The reason the statute revision is necessary is the same as above, protection of the public. If you are not allowed to harm people for a fee, you shouldn't be allowed to harm them for free. This part of the bill will not impact other types of professionals – *only* licensed psychologists. This statute only applies to those who would qualify as psychologists educationally. (See comparison of psychologists to other licensed professionals in the counseling fields). These other types of counselors are exempt under AS 08.86.180(d). The language has nothing to do with pastors, pastoral counselors, licensed clinical social workers, marital and family counselors, licensed professional counselors, etc.

Q: What differentiates a psychologist's work from that of another type of licensed professional who engages in counseling work?

A: Psychologists are the only group who can purchase, perform and evaluate/interpret psychological tests – in fact, counseling is not necessarily an area of expertise for psychologists (as opposed to licensed professional counselors or marital and family counselors).

Q: Is the point of tightening the language to exclude faith based groups (which under current statute would fall under "private organizations")?

A: Faith-based has nothing to do with licensing. Faith-based is the concept that government funds can be used to fund ministries by faith-based groups to help people in a multitude of ways, such as treatment for substance abuse, sex-offenders, etc. As long as the workers are not presenting themselves to the

public as psychologists or psychological associates, this legislation would not apply.

Q: What are some examples of tests that only licensed psychologists can give? Why is it important that only licensed psychologists give these tests? Also - can school psychologists give any types of psychological tests, such as an IQ test?

A: I have attached a Test Qualification Form. Some of the tests cannot be purchased even by Psychological Associates because they must be licensed to a Psychologist or an agency that takes responsibility for the security and use of the test. To find the names of tests all you have to do is get a testing catalog or go on line to a test publisher. They require that you send in your credentials before you can buy the test. **IQ tests, Personality Tests, Neuropsychological Tests,** are examples of some that require licensure at the doctoral level.

Compare Psychologists to other counselors

Psychologists

1. Doctorate degree in psychology in:
 - o Clinical psychology
 - o Counseling psychology
 - o Education in equivalent field
2. Hasn't engaged in dishonorable conduct
3. Has **one** year post doctoral supervised experience approved by the board

NB: The board may not deny recognition as an accredited or approved academic institution to an educational institution solely because its program has not been accredited by a professional organization of psychologists.

Psychological Associates

1. Masters Degree in psychology in:
 - o Clinical psychology
 - o Counseling psychology
 - o Education in an equivalent field
2. Hasn't engaged in dishonorable conduct
3. Has **two** years of post masters supervised experience approved by the board
4. Takes and passes the objective examination approved by the board for psychological associates

NB: The board may not deny recognition as an accredited or approved academic institution to an educational institution solely because its program has not been accredited by a professional organization of psychologists.

Qualifications to take the Exam:

1. Hasn't engaged in dishonorable conduct
2. Holds a masters w/primary emphasis on psychology [...] with the equivalent of at least 48 semester credit hours of grad course work related to a specialized area of psychology
3. Has the recommendation of an immediate supervisor
4. *has not failed the exam w/in the proceeding 6 months*

School Psychologists

1. Has a Masters or Doctoral degree in school psychology and
2. Has been recommended for endorsement by an institution whose psychology program has been approved by:
 - a. The National Council for Accreditation of Teacher Education,
 - b. The National Association of State Directors of Teacher Education and Certification,
 - c. The National Association of School Psychologists, or
 - d. The American Psychological Association

AND has completed a 1200 hour internship in school psychology;

OR

Be a nationally certified school psychologist under the National School Psychologist Certification System established by the National Association of School Psychologists

Compare Psychologists to other counselors

Licensed Professional Counselors

4. 18 or older
5. Is not under investigation
6. Has not had a license related to the practice of counseling, psychology, marital and family therapy or social work suspended, revoked or surrendered
7. Has passed a written exam
8. Has completed either:
 - o A Doctoral degree in counseling or a related field
 - o A Masters degree in counseling or a related field AND at least 60 graduate semester hours in counseling during or after earning the Masters degree
9. Has at least 3000 hours of supervised experience practicing professional counseling

Marital and Family Therapists

5. Applies on a form
6. pays the fee
7. Furnishes evidence that:
 - o They haven't engaged in dishonorable conduct
 - o They hold a master's degree or doctorate in marital and family therapy or allied mental health field
 - o After receiving the degree mentioned above, has:
 - i. 1500 hours of clinical contact
 - ii. Supervised for at least 200 hours
 - o Has training related to domestic violence
 - o Has passed the written or oral examination

Licensed Clinical Social Worker

3. Has a Masters or Doctoral degree in social worked
4. Has completed, within 10 years of application, and under the supervision of a licensed social worker:
 - a. At least two years of continuous full time employment in post-grad clinical social work, or
 - b. At least 3000 hours of less than full time employment in a period of not less than two years
5. Is of good moral character
6. Is in good professional standing
7. Has provided three professional references
8. Has completed the examination
9. Has paid the required fees
- 10.

HB

126

26-LS0309\O
Mischel
3/30/10

CS FOR HOUSE BILL NO. 126()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

**Sponsor(s): REPRESENTATIVES GARA, Crawford, Kerttula, Gardner, Harris, Richard Foster, Edgmon,
Muñoz, Lynn**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to residential shelters for runaway minors; and relating to extensions**
2 **of state custody of children."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.10.080(c) is amended to read:

5 (c) If the court finds that the child is a child in need of aid, the court shall

6 (1) order the child committed to the department for placement in an
7 appropriate setting for a period of time not to exceed two years or in any event not to
8 extend past the date the child becomes 19 years of age, except that the department, the
9 child, or the child's guardian ad litem may petition for and the court may grant in a
10 hearing

11 (A) two-year extensions of commitment that do not extend
12 beyond the person's 21st birthday if the continued custody is in the best
13 interests of the person and the person consents to it [ONE-YEAR
14 EXTENSIONS OF COMMITMENT THAT DO NOT EXTEND BEYOND

1 THE CHILD'S 19TH BIRTHDAY IF THE EXTENSION IS IN THE BEST
2 INTERESTS OF THE CHILD]; and

3 (B) an additional [ONE-YEAR] period of state custody past 19
4 years of age or, if the person is emancipated, past the date of emancipation,
5 that does not extend beyond the person's 21st birthday, if the resumption
6 of [CONTINUED] state custody is in the best interests of the person and the
7 person

8 (i) consents to it;

9 (ii) was placed in out-of-home care by the
10 department immediately before being released from state custody,
11 if the person was released for a reason other than court-ordered
12 reunification with the person's parent; and

13 (iii) is in need of out-of-home care to avoid personal
14 harm, homelessness, or economic hardship, or to enhance the
15 person's ability to continue the person's education or training or
16 otherwise improve the person's successful transition to
17 independent living;

18 (2) order the child released to a parent, adult family member, or
19 guardian of the child or to another suitable person, and, in appropriate cases, order the
20 parent, adult family member, guardian, or other person to provide medical or other
21 care and treatment; if the court releases the child, it shall direct the department to
22 supervise the care and treatment given to the child, but the court may dispense with
23 the department's supervision if the court finds that the adult to whom the child is
24 released will adequately care for the child without supervision; the department's
25 supervision may not exceed two years or in any event extend past the date the child
26 reaches 19 years of age, except that the department or the child's guardian ad litem
27 may petition for and the court may grant in a hearing

28 (A) one-year extensions of supervision that do not extend
29 beyond the child's 19th birthday if the extensions are in the best interests of the
30 child; and

31 (B) an additional one-year period of supervision past 19 years

1 of age if the continued supervision is in the best interests of the person and the
2 person consents to it; or

3 (3) order, under the grounds specified in (o) of this section or
4 AS 47.10.088, the termination of parental rights and responsibilities of one or both
5 parents and commit the child to the custody of the department, and the department
6 shall report quarterly to the court on efforts being made to find a permanent placement
7 for the child.

8 * Sec. 2. AS 47.10.310 is amended by adding a new subsection to read:

9 (e) A program for runaway minors that operates a licensed residential shelter
10 in the state shall provide a shelter with a capacity designated in the license issued
11 under AS 47.10.300 - 47.10.390.

12 * Sec. 3. AS 47.10.990(3) is amended to read:

13 (3) "child" means a person who is

14 (A) under 18 years of age;

15 (B) [AND A PERSON] 19 years of age if that person was
16 under 18 years of age at the time that a proceeding under this chapter was
17 commenced; and

18 (C) under 21 years of age if that person is living in out-of-
19 home care as defined in AS 47.14.900;

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: CSHB 126(), Draft Version "O"

1 Page 2, line 12:

2 Delete "and"

3 Insert "in this sub-subparagraph, "parent" means a biological or adoptive parent
4 or a legal guardian of the person;"

5

6 Page 2, line 14:

7 Delete "harm, homelessness, or economic hardship,"

8 Insert "harm or homelessness"

9

10 Page 2, line 17, following "living;":

11 Insert "and

12 (iv) if requested by the department, agrees to
13 reasonable terms for resuming state custody that may include
14 matters relating to the person's education, attainment of a job or
15 life skills, or other terms found by the court to be reasonable and in
16 the person's best interest;"

17

18 Page 3, line 19:

19 Delete "AS 47.14.900"

20 Insert "AS 47.14.400"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: CSHB 126(), Draft Version "O"

1 Page 1, line 1:

2 Delete "**and**"

3

4 Page 1, line 2, following "**children**":

5 Insert "**; and providing for an effective date**"

6

7 Page 3, following line 19:

8 Insert a new bill section to read:

9 **** Sec. 4. This Act takes effect January 1, 2011.**"

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSHB126(HSS)
() Publish Date: _____

Identifier (file name): HB126CS(HSS)-DHSS-FCSN-04-01-10 Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless RDU: Children's Services
Component: Foster Care Special Needs
Sponsor: Gara
Requester: House HSS Component Number: 2238

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims		93.6	93.6	93.6	93.6	93.6	93.6	93.6
Miscellaneous								
TOTAL OPERATING		93.6	0.0	93.6	93.6	93.6	93.6	93.6

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1002 Federal Receipts	5.5		5.5	5.5	5.5	5.5	5.5
1003 GF Match	88.1		88.1	88.1	88.1	88.1	88.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	93.6	0.0	93.6	93.6	93.6	93.6	93.6

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The intent of CSHB126(HSS) is to improve outcomes for youth that are preparing to transition out of state custody and their foster care settings into independent living situations by extending the time they may remain in state custody and allowing for opportunities to re-enter state custody after they have exited foster care.

This fiscal note addresses increased foster care special needs costs for youth who remain in foster care beyond age 18. Special needs costs include items such as extraordinary clothing, family vacations, biological family visitation, medical costs that fall outside of Medicaid.

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services

Phone 465-3191
Date/Time 4/1/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 4/1/2010

ANALYSIS CONTINUATION

The following assumptions have been applied:

1. OCS successfully implements all federal program requirements to extend foster care to age 21.
2. The number of youth who return to foster care after emancipation will be minimal. An estimate provided by the Facing Foster Care in Alaska group equaled 3. These youth are included in the calculations provided below.
3. The number of youth who turn age 18 will remain somewhat consistent from year to year. No consideration has been included in this note for a possible influx of youth into the program extension during the first year of implementation.
4. Calculations are based on full time equivalents (FTEs) to account for youth who move in and out of the program for varying reasons.
5. FTEs are a simple estimate based on the unsupported assumptions that 10% of the number of FTE youth currently in care ages 18, 19, and 20, will remain in foster care (34 FTE youth).
6. Excluding youth already in extended care because of special needs, 6 FTE special needs children ages 18, 19, and 20 will remain in care longer, bringing the annual FTE count to 40.
7. Calculations use the average cost per child for special needs items.
8. The foster care penetration rate and the Federal Medical Assistance Percentage will remain somewhat stable.
9. 66% percent of the youth who remain in care will pursue secondary education and thus remain within the requirements of the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 and eligible for IV-E federal reimbursement.

Estimated cost per FTE = \$2,340.00 annually x 40 FTEs = \$93,600. Federal reimbursement for these costs is estimated at 5.4% or \$5,540.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB126(HSS)
 () Publish Date: _____

Identifier (file name): HB126CS(HSS)-DHSS-CSM-04-01-10 Dept. Affected: Health & Social Services
 Title Foster Care/CINA/Education of Homeless RDU Children's Services
 Component Children's Services Management
 Sponsor Gara
 Requester House HSS Component Number 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual	204.2		0.0	0.0	0.0	0.0	0.0	0.0
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	204.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	73.5							
1003 GF Match	130.7							
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	204.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

The intent of CS HB126 (HSS) is to improve outcomes for youth that are preparing to transition out of state custody and their foster care settings into independent living situations by extending the time they may remain in state custody and allowing for opportunities to re-enter state custody after they have exited foster care.

The Office of Children's Services Online Resource for the Children of Alaska (ORCA) data base is mandated by the federal government and must be continuously updated to reflect changes in both state and federal law and policy. The following provides the estimated cost of ORCA updates that will be required to implement this bill.

Prepared by: Tammy Sandoval, Director
 Division Office of Children's Services

Phone 465-3191
 Date/Time 4/1/10 1:00 PM

Approved by: Alison Elgee, Assistant Director
DHSS Finance & Management Services

Date 4/1/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. CSHB126(HSS)

ANALYSIS CONTINUATION

Requirement	Functional LOE (hours)	Development LOE (hours)	Total LOE (hours)	Cost
Update Services page for new services.	120	80	200	\$22,000.00
Update Education page with post-secondary educational institutions.	80	60	140	\$15,400.00
Update OHP for unlicensed independent living service categories and service types.	120	80	200	\$22,000.00
Update OHP for licensed service categories and service types over 18.	120	100	220	\$24,200.00
Update Ref Value for age change from 18 to 21	80	60	140	\$15,400.00
Update Eligibility page calculations for new age requirement.	180	160	340	\$37,400.00
Update Medicaid Eligibility page calculations for new page	180	160	340	\$37,400.00
Visitation Report	40	36	76	\$8,360.000
Batch updates for OHP and Eligibility	40	160	200	\$22,000.00
Days:	960/8 = 120 days	896/8 = 112 days	1856/8 = 232 total days	Total Estimate \$204,160.00

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSHB126(HSS)
() Publish Date: _____

Identifier (file name): HB126CS(HSS)-DHSS-04-01-10 Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless RDU: Children's Services
Component: Foster Care Base Rate
Sponsor: Gara
Requester: House HSS Component Number: 2236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURE	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	508.0		508.0	508.0	508.0	508.0	508.0	508.0
Miscellaneous								
TOTAL OPERATING	508.0	0.0	508.0	508.0	508.0	508.0	508.0	508.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1002 Federal Receipts	84.3		84.3	84.3	84.3	84.3	84.3
1003 GF Match	423.7		423.7	423.7	423.7	423.7	423.7
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	508.0	0.0	508.0	508.0	508.0	508.0	508.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The intent of CSHB126(HSS) is to improve outcomes for youth that are preparing to transition out of state custody and their foster care settings into independent living situations by extending the time they may remain in state custody and allowing for opportunities to re-enter state custody after they have exited foster care.

This fiscal note addresses increased foster care base rate reimbursements to providers for youth who remain in foster care beyond age 18.

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services

Phone 465-3191
Date/Time 4/1/2010 10:00 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 4/1/2010

ANALYSIS CONTINUATION

The following assumptions have been applied:

- 1) OCS successfully implements all federal program requirements to extend foster care to age 21.
- 2) The number of youth who return to foster care after emancipation will be minimal. An estimate provided by the Facing Foster Care in Alaska group equaled 3. These youth are included in the calculations provided below.
- 3) The number of youth who turn age 18 will remain somewhat consistent from year to year. No consideration has been included in this note for a possible influx of youth into the program extension during the first year of implementation.
- 4) Calculations are based on full time equivalents (FTEs) to account for youth who move in and out of the program for varying reasons.
- 5) FTEs are a simple estimate based on the unsupported assumptions that 10% of the number of FTE youth currently in care ages 18, 19, and 20, will remain in foster care (34 FTE youth).
- 6) Excluding youth already in extended care because of special needs, 6 FTE special needs children ages 18, 19, and 20 will remain in care longer, bringing the annual FTE count to 40.
- 7) Calculations use 360 days at an average daily rate of \$35.33 per day.
- 8) The foster care penetration rate and the Federal Medical Assistance Percentage will remain somewhat stable.
- 9) 66% percent of the youth who remain in care will pursue secondary education and thus remain within the requirements of the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 and eligible for IV-E federal reimbursement.

Fiscal Year	FTEs	Annual Cost per/FTE	Est. FFP	Total Annual Est. Cost	Federal Funds	General Funds
2011	40	\$12.7	16.59%	\$508.0	\$84.3	\$423.7
2012	40	\$12.7	16.59%	\$508.0	\$84.3	\$423.7
2013	40	\$12.7	16.59%	\$508.0	\$84.3	\$423.7
2014	40	\$12.7	16.59%	\$508.0	\$84.3	\$423.7
2015	40	\$12.7	16.59%	\$508.0	\$84.3	\$423.7
2016	40	\$12.7	16.59%	\$508.0	\$84.3	\$423.7

A M E N D M E N T

OFFERED IN THE HOUSE

TO: CSHB 126(EDC), Draft Version "P"

1 Page 1, line 9, through page 2, line 2:

2 Delete all material and insert:

3 "Except as provided in (b) and (d) of this section and notwithstanding the availability
4 of federal funding, the governing body of a school district shall comply with the requirements
5 for continuing the education of a homeless student under 42 U.S.C. 11432(g)(3)(A) and (B)
6 and 11432(g)(5)(A) (McKinney-Vento Homeless Education Assistance Improvement Act of
7 2001), as those provisions existed on February 1, 2009, for the remainder of the school year,
8 or, if the student is attending school for a summer term, for the remainder of the summer
9 term."

10

11 Page 2, following line 13:

12 Insert a new subsection to read:

13 "(e) Nothing in this section is intended to limit a school district's compliance
14 with 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education Assistance
15 Improvement Act of 2001) or to require the hiring of additional personnel if the school
16 district is receiving federal funding under that Act."

17

18 Reletter the following subsection accordingly.

AMENDMENT

OFFERED IN THE HOUSE
TO: CSHB 126(EDC)

1 Page 11, following line 10:

2 Insert a new bill section to read:

3 **"* Sec. 18.** AS 47.32.160 is amended by adding a new subsection to read:

4 (c) A nonprofit organization that, and a person acting on behalf of the
5 organization who, engages in recruitment activities for foster homes that become
6 licensed under this chapter may not be held liable for the consequences of the
7 recruitment."

AMENDMENT

OFFERED IN THE HOUSE
TO: CSHB 126(EDC)

BY REPRESENTATIVE GARA

1 Page 1, line 8, through page 2, line 5:

2 Delete all material and insert:

3 "Sec. 14.03.096. Continuing the public education of a homeless student. (a)
4 Except as provided in (b) and (d) of this section, the governing body of a school
5 district shall, consistent with the student's best interest, provide transportation services
6 and coordinate with the Department of Health and Social Services the continuation of
7 the public education of a homeless student in the student's school of origin for the
8 remainder of the current school year or, if the student is attending school for a summer
9 term, for the remainder of the summer term.

10 (b) The requirements in (a) of this section do not apply if the student
11 moves to a school district other than the school district in which the student's school of
12 origin is located."

13

14 Page 2, following line 13:

15 Insert new subsections to read:

16 "(e) A school district shall promote a homeless student's best interest by

17 (1) except when requested by the student or the student's legal
18 guardian, maintaining the enrollment of the homeless student in the student's school of
19 origin;

20 (2) providing a written explanation that includes an appeal procedure
21 for a decision that removes a homeless student from the student's school of origin; and

22 (3) considering the views of the homeless student and the student's
23 legal guardian.

1 (f) A school district shall designate a liaison between the school district and
 2 the homeless student and the student's legal guardian to coordinate compliance with
 3 this section.

4 (g) Nothing in this section is intended to supersede the applicable
 5 requirements of 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education
 6 Assistance Improvement Act of 2001) or to require the hiring of additional personnel."
 7

8 Reletter the following subsection accordingly.

9
 10 Page 2, lines 15 - 20:

11 Delete all material and insert:

12 "(1) "homeless student" means a person under 19 years of age who is
 13 in a state of homelessness for lack of a fixed, regular, and adequate nighttime
 14 residence that is intended to serve as a permanent home; "homelessness" includes

15 (A) placement in an emergency shelter;

16 (B) placement in out-of-home care as defined under
 17 AS 47.14.400;

18 (C) placement in transient housing; and

19 (D) the period in which a student is awaiting placement in out-
 20 of-home care as defined under AS 47.14.400."
 21

22 Page 9, following line 10:

23 Insert a new bill section to read:

24 **** Sec. 9.** AS 47.10.080(c) is amended to read:

25 (c) If the court finds that the child is a child in need of aid, the court shall

26 (1) order the child committed to the department for placement in an
 27 appropriate setting for a period of time not to exceed two years or in any event not to
 28 extend past the date the child becomes 19 years of age, except that the department or
 29 the child's guardian ad litem may petition for and the court may grant in a hearing

30 (A) one-year extensions of commitment that do not extend
 31 beyond the child's 19th birthday if the extension is in the best interests of the

1 child; and

2 (B) one-year extensions of commitment that do not extend
 3 beyond the child's 21st birthday [AN ADDITIONAL ONE-YEAR PERIOD
 4 OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state
 5 custody is in the best interests of the person and the person consents to it;

6 (2) order the child released to a parent, adult family member, or
 7 guardian of the child or to another suitable person, and, in appropriate cases, order the
 8 parent, adult family member, guardian, or other person to provide medical or other
 9 care and treatment; if the court releases the child, it shall direct the department to
 10 supervise the care and treatment given to the child, but the court may dispense with
 11 the department's supervision if the court finds that the adult to whom the child is
 12 released will adequately care for the child without supervision; the department's
 13 supervision may not exceed two years or in any event extend past the date the child
 14 reaches 19 years of age, except that the department or the child's guardian ad litem
 15 may petition for and the court may grant in a hearing

16 (A) one-year extensions of supervision that do not extend
 17 beyond the child's 19th birthday if the extensions are in the best interests of the
 18 child; and

19 (B) an additional one-year period of supervision past 19 years
 20 of age if the continued supervision is in the best interests of the person and the
 21 person consents to it; or

22 (3) order, under the grounds specified in (o) of this section or
 23 AS 47.10.088, the termination of parental rights and responsibilities of one or both
 24 parents and commit the child to the custody of the department, and the department
 25 shall report quarterly to the court on efforts being made to find a permanent placement
 26 for the child."

27
 28 Renumber the following bill sections accordingly.

29
 30 Page 9, line 11:

31 Delete "a new subsection"

1 Insert "new subsections"

2

3 Page 9, lines 18 - 19:

4 Delete "the department or the department's contractors"

5 Insert "the department's employees or contractors"

6

7 Page 9, following line 20:

8 Insert a new subsection to read:

9 "(w) The department shall

10 (1) notify the governing body of a school district and the principal of the
11 school in which a student who is in the custody of the department is enrolled of a
12 change in the placement of the student if the placement is outside of the attendance
13 boundaries of the school; and

14 (2) assist the district in complying with the requirements of AS 14.03.096."

15

16 Page 11, line 1:

17 Delete "receiving services under the program"

18 Insert "eligible for services under the program who has left out-of-home care"

19

20 Page 11, line 2:

21 Delete "less"

22 Insert "more"

23

24 Page 11, line 4:

25 Delete "after the individual leaves out-of-home care"

26 Insert "and shall end before the individual is 23 years of age"

AMENDMENT

OFFERED IN THE HOUSE

TO: CSHB 126(), Draft Version "C"

1 Page 12, line 26, through page 13, line 1:

2 Delete all material and insert:

3 **"Sec. 47.18.335. Monetary living expense stipend.** (a) The department shall
4 provide a monthly monetary living expense stipend for a period not to exceed nine
5 months in an amount described in (b) of this section to an individual who

6 (1) has left out-of-home care at age 18 or older;

7 (2) is participating in services in the program; and

8 (3) has monthly contact with a social worker involved in the program.

9 (b) A stipend provided under this section shall be in an amount necessary to
10 meet an eligible individual's living expense as determined by the department. The
11 amount may not exceed

12 (1) for the first six months of eligibility, the daily rate provided to a
13 licensed foster parent; or

14 (2) for a period not to exceed three additional months during the period
15 that follows the first six months of eligibility, half of the daily rate provided to a
16 licensed foster parent.

17 (c) The department shall pay the stipend provided under this section until the
18 later of the date that the individual

19 (1) reaches 21 years of age; or

20 (2) has left out-of-home care for six months.

21 (d) The department may adopt regulations to implement this section."

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE GARA

TO: CSHB 126(), Draft Version "C"

1 Page 13, following line 6:

2 Insert a new bill section to read:

3 **"* Sec. 19. AS 47.32.160 is amended by adding a new subsection to read:**

4 (c) A nonprofit organization that, and a person acting on behalf of the
5 organization who, engages in recruitment activities for foster homes that become
6 licensed under this chapter may not be held liable for the consequences of the
7 recruitment."

AMENDMENT

OFFERED IN THE HOUSE

TO: CSHB 126(), Draft Version "C"

1 Page 1, line 10, following "shall,":

2 Insert "to the extent feasible and"

3

4 Page 1, line 13, through page 2, line 1:

5 Delete "or, if the student is attending school for a summer term, for the remainder of
6 the summer term"

7

8 Page 3, line 19, following "available":

9 Insert "subsidized"

10

11 Page 3, line 23:

12 Delete "commission"

13 Insert "institution"

AMENDMENT

OFFERED IN THE HOUSE HSS
COMMITTEE

BY _____

TO: WORK DRAFT CSHB 126() \ 26-LS0309C

- 1 Page 11, line 5, following "placement.", through line 7:
- 2 Delete "Nothing in this paragraph creates a private right of action against the
- 3 department's employees or contractors."

CS FOR HOUSE BILL NO. 126()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GARA, Crawford, Kerttula, Gardner, Harris, Foster, Edgmon, Muñoz

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to continuing the secondary public education of a homeless student;**
2 **relating to the purpose of certain laws as they relate to children; relating to tuition**
3 **waivers, loans, and medical assistance for a child placed in out-of-home care by the**
4 **state; relating to foster care; relating to children in need of aid; and relating to out-of-**
5 **home care transition to independent living."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1. AS 14.03 is amended by adding a new section to read:**

8 **Sec. 14.03.096. Continuing the public education of a homeless student. (a)**
9 **Except as provided in (b) and (d) of this section, the governing body of a school**
10 **district shall, consistent with the student's best interest, provide transportation services**
11 **and coordinate with the Department of Health and Social Services the continuation of**
12 **the public education of a homeless student in the student's school of origin for the**
13 **remainder of the current school year or, if the student is attending school for a summer**

1 term, for the remainder of the summer term.

2 (b) The requirements in (a) of this section do not apply if the student moves to
3 a school district other than the school district in which the student's school of origin is
4 located.

5 (c) If a homeless student is transferred to a school other than the student's
6 school of origin, the school of origin shall provide a copy of the student's records to
7 the student's new school within seven school days after notification of the transfer.
8 The student's new school shall allow the student to attend school while awaiting the
9 transfer of records under this subsection.

10 (d) A school district is required to comply with this section only

11 (1) if the legislature appropriates funds for the purpose; and

12 (2) to the extent possible using funds appropriated for the purpose.

13 (e) A school district shall promote a homeless student's best interest by

14 (1) except when requested by the student or the student's legal
15 guardian, maintaining the enrollment of the homeless student in the student's school of
16 origin;

17 (2) providing a written explanation that includes an appeal procedure
18 for a decision that removes a homeless student from the student's school of origin; and

19 (3) considering the views of the homeless student and the student's
20 legal guardian.

21 (f) A school district shall designate a liaison between the school district and
22 the homeless student and the student's legal guardian to coordinate compliance with
23 this section.

24 (g) Nothing in this section is intended to supersede the applicable
25 requirements of 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education
26 Assistance Improvement Act of 2001) or to require the hiring of additional personnel.

27 (h) In this section,

28 (1) "homeless student" means a person under 19 years of age who is in
29 a state of homelessness for lack of a fixed, regular, and adequate nighttime residence
30 that is intended to serve as a permanent home; "homelessness" includes

31 (A) placement in an emergency shelter;

1 (B) placement in out-of-home care as defined under
2 AS 47.14.400;

3 (C) placement in transient housing; and

4 (D) the period in which a student is awaiting placement in out-
5 of-home care as defined under AS 47.14.400;

6 (2) "school of origin" means the school in which the student was last
7 enrolled.

8 * Sec. 2. AS 14.43 is amended by adding a new section to read:

9 **Article 3A. Free Tuition for a Person Who Was in Out-of-Home Care.**

10 **Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home**
11 **care.** (a) A person who enrolls as a student in good standing in a state-supported
12 educational institution in the state is entitled to a waiver of tuition, fees, and room and
13 board expenses if the person provides adequate proof that the person

14 (1) was in the custody of the state under AS 47.10 or AS 47.14;

15 (2) was placed in out-of-home care for a period of not less than six
16 consecutive months on or after the person became 16 years of age;

17 (3) has applied for educational grants or scholarships that the person is
18 otherwise eligible for as recommended by the educational institution;

19 (4) has applied for an available federal education loan; and

20 (5) is under 29 years of age.

21 (b) The amount of the waiver to which a person is entitled under this section is
22 the amount of unmet need for tuition, room, and board expenses, as determined by the
23 commission, after deducting funding for the school year from education loans, grants,
24 or scholarships received by a person eligible for a waiver.

25 (c) The proceeds of an education loan, grant, or scholarship received by a
26 person eligible for a waiver under this section must be paid to the educational
27 institution to offset the person's tuition, fees, and room and board expenses.

28 (d) A state-supported educational institution in the state is required to provide
29 a waiver under (a) of this section only if the legislature appropriates funds for the
30 purpose of offsetting waivers under this section. If an appropriation is not sufficient to
31 fully offset waivers for each person entitled to a waiver under (a) of this section, the

1 institution may offer full or partial waivers to eligible applicants as funding permits
2 and at the discretion of the institution.

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4 (7) "out-of-home care" has the meaning given in AS 47.14.400.

5 * **Sec. 4.** AS 36.30.850(b)(42) is amended to read:

6 (42) grants and contracts with qualified entities for services under
7 AS 47.18.330 for the out-of-home [FOSTER] care transition program;

8 * **Sec. 5.** AS 47.05.060 is amended to read:

9 **Sec. 47.05.060. Purpose and policy relating to children.** The purpose of this
10 title as it relates to children is to secure for each child the care and guidance,
11 preferably in the child's own home, as well as an education, that will serve the moral,
12 emotional, mental, intellectual, and physical welfare of the child and the best interests
13 of the community; to preserve and strengthen the child's family ties unless efforts to
14 preserve and strengthen the ties are likely to result in physical or emotional damage to
15 the child, removing the child from the custody of the parents only as a last resort when
16 the child's welfare or safety or the protection of the public cannot be adequately
17 safeguarded without removal; and, when the child is removed from the family, to
18 secure for the child adequate custody, education, and care and adequate planning for
19 permanent placement of the child.

20 * **Sec. 6.** AS 47.05.065 is amended to read:

21 **Sec. 47.05.065. Legislative findings related to children.** The legislature finds
22 that

23 (1) parents have the following rights and responsibilities relating to the
24 care and control of their child while the child is a minor:

25 (A) the responsibility to provide the child with food, clothing,
26 shelter, education, and medical care;

27 (B) the right and responsibility to protect, nurture, train, and
28 discipline the child, including the right to direct the child's medical care and
29 the right to exercise reasonable corporal discipline;

30 (C) the right to determine where and with whom the child shall
31 live;

1 (D) the right and responsibility to make decisions of legal or
2 financial significance concerning the child;

3 (E) the right to obtain representation for the child in legal
4 actions; and

5 (F) the responsibility to provide special safeguards and care,
6 including appropriate prenatal and postnatal protection for the child;

7 (2) it is the policy of the state to strengthen families and to protect
8 children from child abuse and neglect; the state recognizes that, in some cases,
9 protection of a child may require removal of the child from the child's home; however,

10 (A) except in those cases involving serious risk to a child's
11 health or safety, the Department of Health and Social Services should provide
12 time-limited family support services to the child and the child's family in order
13 to offer parents the opportunity to remedy parental conduct or conditions in the
14 home that placed the child at risk of harm so that a child may return home
15 safely and permanently; and

16 (B) the state also recognizes that when a child is removed from
17 the home, visitation between the child and the child's parents or guardian and
18 family members reduces the trauma for the child and enhances the likelihood
19 that the child will be able to return home; therefore, whenever a child is
20 removed from the parental home, the Department of Health and Social
21 Services should encourage frequent, regular, and reasonable visitation of the
22 child with the child's parent or guardian and family members;

23 (3) it is the policy of the state to recognize that, when a child is a ward
24 of the state, the child is entitled to reasonable safety, adequate care, and adequate
25 treatment and that the Department of Health and Social Services as legal custodian and
26 the child's guardian ad litem as guardian of the child's best interests and their agents
27 and assignees, each should make reasonable efforts to ensure that the child is provided
28 with reasonable safety, adequate care, and adequate treatment for the duration of time
29 that the child is a ward of the state;

30 (4) it is in the best interests of a child who has been removed from the
31 child's own home for the state to apply the following principles in resolving the

1 situation:

2 (A) the child should be placed in a safe, secure, and stable
3 environment;

4 (B) the child should not be moved unnecessarily;

5 (C) a planning process should be followed to lead to permanent
6 placement of the child;

7 (D) every effort should be made to encourage psychological
8 attachment between the adult caregiver and the child;

9 (E) frequent, regular, and reasonable visitation with the parent
10 or guardian and family members should be encouraged; [AND]

11 (F) parents and guardians must actively participate in family
12 support services so as to facilitate the child's being able to remain in the home;
13 when children are removed from the home, the parents and guardians must
14 actively participate in family support services to make return of their children
15 to the home possible; **and**

16 **(G) the child should continue to attend the child's school of**
17 **origin as provided under AS 14.03.096;**

18 (5) numerous studies establish that

19 (A) children undergo a critical attachment process before the
20 time they reach six years of age;

21 (B) a child who has not attached with an adult caregiver during
22 this critical stage will suffer significant emotional damage that frequently leads
23 to chronic psychological problems and antisocial behavior when the child
24 reaches adolescence and adulthood; and

25 (C) it is important to provide for an expedited placement
26 procedure to ensure that all children, especially those under the age of six
27 years, who have been removed from their homes are placed in permanent
28 homes expeditiously.

29 * Sec. 7. AS 47.07.020(b) is amended to read:

30 (b) In addition to the persons specified in (a) of this section, the following
31 optional groups of persons for whom the state may claim federal financial

1 participation are eligible for medical assistance:

2 (1) persons eligible for but not receiving assistance under any plan of
3 the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act,
4 Supplemental Security Income) or a federal program designated as the successor to the
5 aid to families with dependent children program;

6 (2) persons in a general hospital, skilled nursing facility, or
7 intermediate care facility, who, if they left the facility, would be eligible for assistance
8 under one of the federal programs specified in (1) of this subsection;

9 (3) persons under 21 years of age who are under supervision of the
10 department, for whom maintenance is being paid in whole or in part from public
11 funds, and who are in out-of-home care [FOSTER HOMES] or private child-care
12 institutions;

13 (4) aged, blind, or disabled persons, who, because they do not meet
14 income and resources requirements, do not receive supplemental security income
15 under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not
16 receive a mandatory state supplement, but who are eligible, or would be eligible if
17 they were not in a skilled nursing facility or intermediate care facility to receive an
18 optional state supplementary payment;

19 (5) persons under 21 years of age who are in an institution designated
20 as an intermediate care facility for the mentally retarded and who are financially
21 eligible as determined by the standards of the federal program designated as the
22 successor to the aid to families with dependent children program;

23 (6) persons in a medical or intermediate care facility whose income
24 while in the facility does not exceed \$1,656 a month but who would not be eligible for
25 an optional state supplementary payment if they left the hospital or other facility;

26 (7) persons under 21 years of age who are receiving active treatment in
27 a psychiatric hospital and who are financially eligible as determined by the standards
28 of the federal program designated as the successor to the aid to families with
29 dependent children program;

30 (8) persons under 21 years of age and not covered under (a) of this
31 section [,] who would be eligible for benefits under the federal program designated as

1 the successor to the aid to families with dependent children program, except that they
2 have the care and support of both their natural and adoptive parents;

3 (9) pregnant women not covered under (a) of this section and who
4 meet the income and resource requirements of the federal program designated as the
5 successor to the aid to families with dependent children program;

6 (10) persons under 21 years of age not covered under (a) of this section
7 who the department has determined cannot be placed for adoption without medical
8 assistance because of a special need for medical or rehabilitative care and who the
9 department has determined are hard-to-place children eligible for subsidy under
10 AS 25.23.190 - 25.23.210;

11 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title
12 XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom
13 a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title
14 XVI, Social Security Act) because they meet all of the following criteria:

15 (A) they are 18 years of age or younger and qualify as disabled
16 individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

17 (B) the department has determined that

18 (i) they require a level of care provided in a hospital,
19 nursing facility, or intermediate care facility for the mentally retarded;

20 (ii) it is appropriate to provide their care outside of an
21 institution; and

22 (iii) the estimated amount that would be spent for
23 medical assistance for their individual care outside an institution is not
24 greater than the estimated amount that would otherwise be expended
25 individually for medical assistance within an appropriate institution;

26 (C) if they were in a medical institution, they would be eligible
27 for medical assistance under other provisions of this chapter; and

28 (D) home and community-based services under a waiver
29 approved by the federal government are either not available to them under this
30 chapter or would be inappropriate for them;

31 (12) disabled persons, as described in 42 U.S.C.

1 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under
 2 applicable federal regulations or guidelines, is less than 250 percent of the official
 3 poverty line applicable to a family of that size according to the United States
 4 Department of Health and Human Services, and who, but for earnings in excess of the
 5 limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be
 6 individuals with respect to whom a supplemental security income is being paid under
 7 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is
 8 not eligible under another provision of this section shall pay a premium or other cost-
 9 sharing charges according to a sliding fee scale that is based on income as established
 10 by the department in regulations;

11 (13) persons under 19 years of age who are not covered under (a) of
 12 this section and whose household income does not exceed 175 percent of the federal
 13 poverty line as defined by the United States Department of Health and Human
 14 Services and revised under 42 U.S.C. 9902(2);

15 (14) pregnant women who are not covered under (a) of this section and
 16 whose household income does not exceed 175 percent of the federal poverty line as
 17 defined by the United States Department of Health and Human Services and revised
 18 under 42 U.S.C. 9902(2);

19 (15) persons who have been diagnosed with breast or cervical cancer
 20 and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII);

21 (16) persons under 21 years of age who were in the custody of the
 22 department under AS 47.10 or AS 47.14 and who were placed in out-of-home
 23 care for a period of not less than six consecutive months on or after reaching 16
 24 years of age.

25 * Sec. 8. AS 47.07.020 is amended by adding a new subsection to read:

26 (o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

27 * Sec. 9. AS 47.10.080(c) is amended to read:

28 (c) If the court finds that the child is a child in need of aid, the court shall

29 (1) order the child committed to the department for placement in an
 30 appropriate setting for a period of time not to exceed two years or in any event not to
 31 extend past the date the child becomes 19 years of age, except that the department or

1 the child's guardian ad litem may petition for and the court may grant in a hearing

2 (A) one-year extensions of commitment that do not extend
3 beyond the child's 19th birthday if the extension is in the best interests of the
4 child; and

5 (B) one-year extensions of commitment that do not extend
6 beyond the child's 21st birthday [AN ADDITIONAL ONE-YEAR PERIOD
7 OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state
8 custody is in the best interests of the person and the person consents to it;

9 (2) order the child released to a parent, adult family member, or
10 guardian of the child or to another suitable person, and, in appropriate cases, order the
11 parent, adult family member, guardian, or other person to provide medical or other
12 care and treatment; if the court releases the child, it shall direct the department to
13 supervise the care and treatment given to the child, but the court may dispense with
14 the department's supervision if the court finds that the adult to whom the child is
15 released will adequately care for the child without supervision; the department's
16 supervision may not exceed two years or in any event extend past the date the child
17 reaches 19 years of age, except that the department or the child's guardian ad litem
18 may petition for and the court may grant in a hearing

19 (A) one-year extensions of supervision that do not extend
20 beyond the child's 19th birthday if the extensions are in the best interests of the
21 child; and

22 (B) an additional one-year period of supervision past 19 years
23 of age if the continued supervision is in the best interests of the person and the
24 person consents to it; or

25 (3) order, under the grounds specified in (o) of this section or
26 AS 47.10.088, the termination of parental rights and responsibilities of one or both
27 parents and commit the child to the custody of the department, and the department
28 shall report quarterly to the court on efforts being made to find a permanent placement
29 for the child.

30 * Sec. 10. AS 47.10.080 is amended by adding new subsections to read:

31 (v) A social worker employed by or under contract with the department shall,

1 not less than monthly, conduct visits with a child committed to the custody of the
 2 department under (c) of this section. The visits must be of sufficient substance and
 3 duration to address issues pertinent to case planning and service delivery to ensure the
 4 child's safety, permanency, and well-being. The majority of the visits conducted under
 5 this subsection must be at the location of the child's current placement. Nothing in this
 6 paragraph creates a private right of action against the department's employees or
 7 contractors. In this subsection, "visit" means face-to-face contact between social
 8 worker and child.

9 (w) The department shall

10 (1) notify the governing body of a school district and the principal of
 11 the school in which a student who is in the custody of the department is enrolled of a
 12 change in the placement of the student if the placement is outside of the attendance
 13 boundaries of the school; and

14 (2) assist the district in complying with the requirements of
 15 AS 14.03.096.

16 * Sec. 11. AS 47.10.990(3) is amended to read:

17 (3) "child" means a person who is

18 (A) under 18 years of age;

19 (B) [AND A PERSON] 19 years of age if that person was
 20 under 18 years of age at the time that a proceeding under this chapter was
 21 commenced; and

22 (C) under 21 years of age if that person is living in out-of-
 23 home care;

24 * Sec. 12. AS 47.10.990 is amended by adding a new paragraph to read:

25 (33) "out-of-home care" has the meaning given in AS 47.14.400.

26 * Sec. 13. AS 47.18.300(a) is amended to read:

27 (a) The department, in coordination with local public and private agencies,
 28 shall design, develop, and implement an out-of-home care [A FOSTER CARE]
 29 transition program to provide support and services to individuals who

30 (1) reach or have reached the age of 16 or older while in state custody
 31 and placed in out-of-home [FOSTER] care and have not yet reached 23 years of age;

1 and

2 (2) meet other eligibility criteria established by the department under
3 (b) of this section.

4 * Sec. 14. AS 47.18.310 is amended to read:

5 **Sec. 47.18.310. Program design.** The department, in coordination with local
6 public and private agencies, shall design the program as a continuation of the training
7 efforts related to independent living skills that were initiated for a child in state
8 custody who was placed in out-of-home care and [WHEN THE STATE FOSTER
9 CARE RECIPIENTS WERE] identified as being likely to remain in out-of-home
10 [STATE FOSTER] care until reaching not less than the age of 18. The program
11 design must require that program participants are directly involved in identifying the
12 program activities that will prepare them for independent living.

13 * Sec. 15. AS 47.18.320(a) is amended to read:

14 (a) Subject to the availability of an appropriation made for the purposes of
15 AS 47.18.300 - 47.18.390, the program may provide

- 16 (1) education and vocational training;
17 (2) assistance in obtaining basic education and training;
18 (3) career and employment services;
19 (4) training in basic life skills;
20 (5) housing and utility assistance;
21 (6) mentoring and counseling; and
22 (7) other appropriate services to complement the efforts of former state
23 foster care recipients or a child who was in state custody and placed in out-of-
24 home care to achieve self-sufficiency.

25 * Sec. 16. AS 47.18 is amended by adding a new section to read:

26 **Sec. 47.18.335. Monetary living expense stipend.** The department shall
27 provide to an individual eligible for services under the program who has left out-of-
28 home care a monthly stipend in an amount that is necessary to meet an individual's
29 living expenses as determined by the department and that is not more than the daily
30 rate provided to a licensed foster parent. The stipend shall continue for a period of not
31 more than one year and shall end before the individual is 23 years of age. The

1 department may adopt regulations to implement this section.

2 * Sec. 17. AS 47.18.390(1) is amended to read:

3 (1) "program" means the out-of-home [FOSTER] care transition
4 program authorized under AS 47.18.300 - 47.18.390;

5 * Sec. 18. AS 47.18.390(3) is repealed and reenacted to read:

6 (3) "out-of-home care" has the meaning given in AS 47.14.400.

26-LS0309\T
Mischel
4/15/09

CS FOR HOUSE BILL NO. 126(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES GARA, Crawford, Kerttula, Gardner, Harris, Foster, Edgmon, Muñoz, Lynn

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to continuing the secondary public education of a homeless student;**
2 **relating to the purpose of certain laws as they relate to children; relating to tuition**
3 **waivers, loans, and medical assistance for a child placed in out-of-home care by the**
4 **state; relating to foster care; relating to children in need of aid; and relating to out-of-**
5 **home care transition to independent living."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1.** AS 14.03 is amended by adding a new section to read:

8 **Sec. 14.03.096. Continuing the public education of a homeless student. (a)**
9 Except as provided in (b) and (d) of this section, the governing body of a school
10 district shall, to the extent feasible and consistent with the student's best interest,
11 provide transportation services and coordinate with the Department of Health and
12 Social Services the continuation of the public education of a homeless student in the
13 student's school of origin for the remainder of the current school year.

1 (b) The requirements in (a) of this section do not apply if the student moves to
2 a school district other than the school district in which the student's school of origin is
3 located.

4 (c) If a homeless student is transferred to a school other than the student's
5 school of origin, the school of origin shall provide a copy of the student's records to
6 the student's new school within seven school days after notification of the transfer.
7 The student's new school shall allow the student to attend school while awaiting the
8 transfer of records under this subsection.

9 (d) A school district is required to comply with this section only

10 (1) if the legislature appropriates funds for the purpose; and

11 (2) to the extent possible using funds appropriated for the purpose.

12 (e) A school district shall promote a homeless student's best interest by

13 (1) except when requested by the student or the student's legal
14 guardian, maintaining the enrollment of the homeless student in the student's school of
15 origin;

16 (2) providing a written explanation that includes an appeal procedure
17 for a decision that removes a homeless student from the student's school of origin; and

18 (3) considering the views of the homeless student and the student's
19 legal guardian.

20 (f) A school district shall designate a liaison between the school district and
21 the homeless student and the student's legal guardian to coordinate compliance with
22 this section.

23 (g) Nothing in this section is intended to supersede the applicable
24 requirements of 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education
25 Assistance Improvement Act of 2001) or to require the hiring of additional personnel
26 or more than one liaison in each school district.

27 (h) In this section,

28 (1) "homeless student" means a person under 19 years of age who is in
29 a state of homelessness for lack of a fixed, regular, and adequate nighttime residence
30 that is intended to serve as a permanent home; "homelessness" includes

31 (A) placement in an emergency shelter;

1 (B) placement in out-of-home care as defined under
2 AS 47.14.400;

3 (C) placement in transient housing; and

4 (D) the period in which a student is awaiting placement in out-
5 of-home care as defined under AS 47.14.400;

6 (2) "school of origin" means the school in which the student was last
7 enrolled.

8 * **Sec. 2.** AS 14.43 is amended by adding a new section to read:

9 **Article 3A. Free Tuition for a Person Who Was in Out-of-Home Care.**

10 **Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home**
11 **care.** (a) A person who enrolls as a student in good standing in a state-supported
12 educational institution in the state is entitled to a waiver of tuition, fees, and room and
13 board expenses if the person provides adequate proof that the person

14 (1) was in the custody of the state under AS 47.10 or AS 47.14;

15 (2) was placed in out-of-home care for a period of not less than six
16 consecutive months on or after the person became 16 years of age;

17 (3) has applied for educational grants or scholarships that the person is
18 otherwise eligible for as recommended by the educational institution;

19 (4) has applied for an available subsidized federal education loan; and

20 (5) is under 29 years of age.

21 (b) The amount of the waiver to which a person is entitled under this section is
22 the amount of unmet need for tuition, room, and board expenses, as determined by the
23 institution, after deducting funding for the school year from education loans, grants, or
24 scholarships received by a person eligible for a waiver.

25 (c) The proceeds of an education loan, grant, or scholarship received by a
26 person eligible for a waiver under this section must be paid to the educational
27 institution to offset the person's tuition, fees, and room and board expenses.

28 (d) A state-supported educational institution in the state is required to provide
29 a waiver under (a) of this section only if the legislature appropriates funds for the
30 purpose of offsetting waivers under this section. If an appropriation is not sufficient to
31 fully offset waivers for each person entitled to a waiver under (a) of this section, the

1 institution may offer full or partial waivers to eligible applicants as funding permits
2 and at the discretion of the institution.

3 * **Sec. 3.** AS 14.43.160 is amended by adding a new paragraph to read:

4 (7) "out-of-home care" has the meaning given in AS 47.14.400.

5 * **Sec. 4.** AS 36.30.850(b)(42) is amended to read:

6 (42) grants and contracts with qualified entities for services under
7 AS 47.18.330 for the out-of-home [FOSTER] care transition program;

8 * **Sec. 5.** AS 47.05.060 is amended to read:

9 **Sec. 47.05.060. Purpose and policy relating to children.** The purpose of this
10 title as it relates to children is to secure for each child the care and guidance,
11 preferably in the child's own home, as well as an education, that will serve the moral,
12 emotional, mental, intellectual, and physical welfare of the child and the best interests
13 of the community; to preserve and strengthen the child's family ties unless efforts to
14 preserve and strengthen the ties are likely to result in physical or emotional damage to
15 the child, removing the child from the custody of the parents only as a last resort when
16 the child's welfare or safety or the protection of the public cannot be adequately
17 safeguarded without removal; and, when the child is removed from the family, to
18 secure for the child adequate custody, education, and care and adequate planning for
19 permanent placement of the child.

20 * **Sec. 6.** AS 47.05.065 is amended to read:

21 **Sec. 47.05.065. Legislative findings related to children.** The legislature finds
22 that

23 (1) parents have the following rights and responsibilities relating to the
24 care and control of their child while the child is a minor:

25 (A) the responsibility to provide the child with food, clothing,
26 shelter, education, and medical care;

27 (B) the right and responsibility to protect, nurture, train, and
28 discipline the child, including the right to direct the child's medical care and
29 the right to exercise reasonable corporal discipline;

30 (C) the right to determine where and with whom the child shall
31 live;

1 (D) the right and responsibility to make decisions of legal or
2 financial significance concerning the child;

3 (E) the right to obtain representation for the child in legal
4 actions; and

5 (F) the responsibility to provide special safeguards and care,
6 including appropriate prenatal and postnatal protection for the child;

7 (2) it is the policy of the state to strengthen families and to protect
8 children from child abuse and neglect; the state recognizes that, in some cases,
9 protection of a child may require removal of the child from the child's home; however,

10 (A) except in those cases involving serious risk to a child's
11 health or safety, the Department of Health and Social Services should provide
12 time-limited family support services to the child and the child's family in order
13 to offer parents the opportunity to remedy parental conduct or conditions in the
14 home that placed the child at risk of harm so that a child may return home
15 safely and permanently; and

16 (B) the state also recognizes that when a child is removed from
17 the home, visitation between the child and the child's parents or guardian and
18 family members reduces the trauma for the child and enhances the likelihood
19 that the child will be able to return home; therefore, whenever a child is
20 removed from the parental home, the Department of Health and Social
21 Services should encourage frequent, regular, and reasonable visitation of the
22 child with the child's parent or guardian and family members;

23 (3) it is the policy of the state to recognize that, when a child is a ward
24 of the state, the child is entitled to reasonable safety, adequate care, and adequate
25 treatment and that the Department of Health and Social Services as legal custodian and
26 the child's guardian ad litem as guardian of the child's best interests and their agents
27 and assignees, each should make reasonable efforts to ensure that the child is provided
28 with reasonable safety, adequate care, and adequate treatment for the duration of time
29 that the child is a ward of the state;

30 (4) it is in the best interests of a child who has been removed from the
31 child's own home for the state to apply the following principles in resolving the

1 situation:

2 (A) the child should be placed in a safe, secure, and stable
3 environment;

4 (B) the child should not be moved unnecessarily;

5 (C) a planning process should be followed to lead to permanent
6 placement of the child;

7 (D) every effort should be made to encourage psychological
8 attachment between the adult caregiver and the child;

9 (E) frequent, regular, and reasonable visitation with the parent
10 or guardian and family members should be encouraged; [AND]

11 (F) parents and guardians must actively participate in family
12 support services so as to facilitate the child's being able to remain in the home;
13 when children are removed from the home, the parents and guardians must
14 actively participate in family support services to make return of their children
15 to the home possible; and

16 (G) the child should continue to attend the child's school of
17 origin as provided under AS 14.03.096;

18 (5) numerous studies establish that

19 (A) children undergo a critical attachment process before the
20 time they reach six years of age;

21 (B) a child who has not attached with an adult caregiver during
22 this critical stage will suffer significant emotional damage that frequently leads
23 to chronic psychological problems and antisocial behavior when the child
24 reaches adolescence and adulthood; and

25 (C) it is important to provide for an expedited placement
26 procedure to ensure that all children, especially those under the age of six
27 years, who have been removed from their homes are placed in permanent
28 homes expeditiously.

29 * Sec. 7. AS 47.07.020(b) is amended to read:

30 (b) In addition to the persons specified in (a) of this section, the following
31 optional groups of persons for whom the state may claim federal financial

1 participation are eligible for medical assistance:

2 (1) persons eligible for but not receiving assistance under any plan of
3 the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act,
4 Supplemental Security Income) or a federal program designated as the successor to the
5 aid to families with dependent children program;

6 (2) persons in a general hospital, skilled nursing facility, or
7 intermediate care facility, who, if they left the facility, would be eligible for assistance
8 under one of the federal programs specified in (1) of this subsection;

9 (3) persons under 21 years of age who are under supervision of the
10 department, for whom maintenance is being paid in whole or in part from public
11 funds, and who are in out-of-home care [FOSTER HOMES] or private child-care
12 institutions;

13 (4) aged, blind, or disabled persons, who, because they do not meet
14 income and resources requirements, do not receive supplemental security income
15 under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not
16 receive a mandatory state supplement, but who are eligible, or would be eligible if
17 they were not in a skilled nursing facility or intermediate care facility to receive an
18 optional state supplementary payment;

19 (5) persons under 21 years of age who are in an institution designated
20 as an intermediate care facility for the mentally retarded and who are financially
21 eligible as determined by the standards of the federal program designated as the
22 successor to the aid to families with dependent children program;

23 (6) persons in a medical or intermediate care facility whose income
24 while in the facility does not exceed \$1,656 a month but who would not be eligible for
25 an optional state supplementary payment if they left the hospital or other facility;

26 (7) persons under 21 years of age who are receiving active treatment in
27 a psychiatric hospital and who are financially eligible as determined by the standards
28 of the federal program designated as the successor to the aid to families with
29 dependent children program;

30 (8) persons under 21 years of age and not covered under (a) of this
31 section [,] who would be eligible for benefits under the federal program designated as

1 the successor to the aid to families with dependent children program, except that they
2 have the care and support of both their natural and adoptive parents;

3 (9) pregnant women not covered under (a) of this section and who
4 meet the income and resource requirements of the federal program designated as the
5 successor to the aid to families with dependent children program;

6 (10) persons under 21 years of age not covered under (a) of this section
7 who the department has determined cannot be placed for adoption without medical
8 assistance because of a special need for medical or rehabilitative care and who the
9 department has determined are hard-to-place children eligible for subsidy under
10 AS 25.23.190 - 25.23.210;

11 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title
12 XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom
13 a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title
14 XVI, Social Security Act) because they meet all of the following criteria:

15 (A) they are 18 years of age or younger and qualify as disabled
16 individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

17 (B) the department has determined that

18 (i) they require a level of care provided in a hospital,
19 nursing facility, or intermediate care facility for the mentally retarded;

20 (ii) it is appropriate to provide their care outside of an
21 institution; and

22 (iii) the estimated amount that would be spent for
23 medical assistance for their individual care outside an institution is not
24 greater than the estimated amount that would otherwise be expended
25 individually for medical assistance within an appropriate institution;

26 (C) if they were in a medical institution, they would be eligible
27 for medical assistance under other provisions of this chapter; and

28 (D) home and community-based services under a waiver
29 approved by the federal government are either not available to them under this
30 chapter or would be inappropriate for them;

31 (12) disabled persons, as described in 42 U.S.C.

1 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under
2 applicable federal regulations or guidelines, is less than 250 percent of the official
3 poverty line applicable to a family of that size according to the United States
4 Department of Health and Human Services, and who, but for earnings in excess of the
5 limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be
6 individuals with respect to whom a supplemental security income is being paid under
7 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is
8 not eligible under another provision of this section shall pay a premium or other cost-
9 sharing charges according to a sliding fee scale that is based on income as established
10 by the department in regulations;

11 (13) persons under 19 years of age who are not covered under (a) of
12 this section and whose household income does not exceed 175 percent of the federal
13 poverty line as defined by the United States Department of Health and Human
14 Services and revised under 42 U.S.C. 9902(2);

15 (14) pregnant women who are not covered under (a) of this section and
16 whose household income does not exceed 175 percent of the federal poverty line as
17 defined by the United States Department of Health and Human Services and revised
18 under 42 U.S.C. 9902(2);

19 (15) persons who have been diagnosed with breast or cervical cancer
20 and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII);

21 (16) persons under 21 years of age who were in the custody of the
22 department under AS 47.10 or AS 47.14 and who were placed in out-of-home
23 care for a period of not less than six consecutive months on or after reaching 16
24 years of age.

25 * Sec. 8. AS 47.07.020 is amended by adding a new subsection to read:

26 (o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

27 * Sec. 9. AS 47.10.080(c) is amended to read:

28 (c) If the court finds that the child is a child in need of aid, the court shall

29 (1) order the child committed to the department for placement in an
30 appropriate setting for a period of time not to exceed two years or in any event not to
31 extend past the date the child becomes 19 years of age, except that the department or

1 the child's guardian ad litem may petition for and the court may grant in a hearing

2 (A) one-year extensions of commitment that do not extend
3 beyond the child's 19th birthday if the extension is in the best interests of the
4 child; and

5 (B) one-year extensions of commitment that do not extend
6 beyond the child's 21st birthday [AN ADDITIONAL ONE-YEAR PERIOD
7 OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state
8 custody is in the best interests of the person and the person consents to it;

9 (2) order the child released to a parent, adult family member, or
10 guardian of the child or to another suitable person, and, in appropriate cases, order the
11 parent, adult family member, guardian, or other person to provide medical or other
12 care and treatment; if the court releases the child, it shall direct the department to
13 supervise the care and treatment given to the child, but the court may dispense with
14 the department's supervision if the court finds that the adult to whom the child is
15 released will adequately care for the child without supervision; the department's
16 supervision may not exceed two years or in any event extend past the date the child
17 reaches 19 years of age, except that the department or the child's guardian ad litem
18 may petition for and the court may grant in a hearing

19 (A) one-year extensions of supervision that do not extend
20 beyond the child's 19th birthday if the extensions are in the best interests of the
21 child; and

22 (B) an additional one-year period of supervision past 19 years
23 of age if the continued supervision is in the best interests of the person and the
24 person consents to it; or

25 (3) order, under the grounds specified in (o) of this section or
26 AS 47.10.088, the termination of parental rights and responsibilities of one or both
27 parents and commit the child to the custody of the department, and the department
28 shall report quarterly to the court on efforts being made to find a permanent placement
29 for the child.

30 * Sec. 10. AS 47.10.080 is amended by adding new subsections to read:

31 (v) A social worker employed by or under contract with the department shall,

1 not less than monthly, conduct visits with a child committed to the custody of the
2 department under (c) of this section. The visits must be of sufficient substance and
3 duration to address issues pertinent to case planning and service delivery to ensure the
4 child's safety, permanency, and well-being. The majority of the visits conducted under
5 this subsection must be at the location of the child's current placement. In this
6 subsection, "visit" means face-to-face contact between social worker and child.

7 (w) The department shall

8 (1) notify the governing body of a school district and the principal of
9 the school in which a student who is in the custody of the department is enrolled of a
10 change in the placement of the student if the placement is outside of the attendance
11 boundaries of the school; and

12 (2) assist the district in complying with the requirements of
13 AS 14.03.096.

14 * Sec. 11. AS 47.10.990(3) is amended to read:

15 (3) "child" means a person who is

16 (A) under 18 years of age;

17 (B) [AND A PERSON] 19 years of age if that person was
18 under 18 years of age at the time that a proceeding under this chapter was
19 commenced; and

20 (C) under 21 years of age if that person is living in out-of-
21 home care;

22 * Sec. 12. AS 47.10.990 is amended by adding a new paragraph to read:

23 (33) "out-of-home care" has the meaning given in AS 47.14.400.

24 * Sec. 13. AS 47.18.300(a) is amended to read:

25 (a) The department, in coordination with local public and private agencies,
26 shall design, develop, and implement an out-of-home care [A FOSTER CARE]
27 transition program to provide support and services to individuals who

28 (1) reach or have reached the age of 16 or older while in state custody
29 and placed in out-of-home [FOSTER] care and have not yet reached 23 years of age;
30 and

31 (2) meet other eligibility criteria established by the department under

1 (b) of this section.

2 * **Sec. 14.** AS 47.18.310 is amended to read:

3 **Sec. 47.18.310. Program design.** The department, in coordination with local
4 public and private agencies, shall design the program as a continuation of the training
5 efforts related to independent living skills that were initiated for a child in state
6 custody who was placed in out-of-home care and [WHEN THE STATE FOSTER
7 CARE RECIPIENTS WERE] identified as being likely to remain in out-of-home
8 [STATE FOSTER] care until reaching not less than the age of 18. The program
9 design must require that program participants are directly involved in identifying the
10 program activities that will prepare them for independent living.

11 * **Sec. 15.** AS 47.18.320(a) is amended to read:

12 (a) Subject to the availability of an appropriation made for the purposes of
13 AS 47.18.300 - 47.18.390, the program may provide

- 14 (1) education and vocational training;
- 15 (2) assistance in obtaining basic education and training;
- 16 (3) career and employment services;
- 17 (4) training in basic life skills;
- 18 (5) housing and utility assistance;
- 19 (6) mentoring and counseling; and
- 20 (7) other appropriate services to complement the efforts of former state
21 foster care recipients or a child who was in state custody and placed in out-of-
22 home care to achieve self-sufficiency.

23 * **Sec. 16.** AS 47.18 is amended by adding a new section to read:

24 **Sec. 47.18.335. Monetary living expense stipend.** (a) The department shall
25 provide a monthly monetary living expense stipend for a period not to exceed nine
26 months in an amount described in (b) of this section to an individual who

- 27 (1) has left out-of-home care at age 18 or older;
- 28 (2) is participating in services in the program; and
- 29 (3) has monthly contact with a social worker involved in the program.

30 (b) A stipend provided under this section shall be in an amount necessary to
31 meet an eligible individual's living expense as determined by the department. The

1 amount may not exceed

2 (1) for the first six months of eligibility, the daily rate provided to a
3 licensed foster parent; or

4 (2) for a period not to exceed three additional months during the period
5 that follows the first six months of eligibility, half of the daily rate provided to a
6 licensed foster parent.

7 (c) The department shall pay the stipend provided under this section until the
8 later of the date that the individual

9 (1) reaches 21 years of age; or

10 (2) has left out-of-home care for six months.

11 (d) The department may adopt regulations to implement this section.

12 * **Sec. 17.** AS 47.18.390(1) is amended to read:

13 (1) "program" means the out-of-home [FOSTER] care transition
14 program authorized under AS 47.18.300 - 47.18.390;

15 * **Sec. 18.** AS 47.18.390(3) is repealed and reenacted to read:

16 (3) "out-of-home care" has the meaning given in AS 47.14.400.

17 * **Sec. 19.** AS 47.32.160 is amended by adding a new subsection to read:

18 (c) A nonprofit organization that, and a person acting on behalf of the
19 organization who, engages in recruitment activities for foster homes that become
20 licensed under this chapter may not be held liable for the consequences of the
21 recruitment.

ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA

April 5, 2010

Dear Health and Social Services Committee members:

During a committee hearing on April 1, 2010 a committee member asked how the cost of foster care compared to other costs to society. In response to that question, I have prepared the attached comparison.

The figures are from the 2005 Alaska Foster Care Alumni Study prepared by the University of Alaska Anchorage, School of Social Work and the 2009 Cost of Crime Research Summary prepared by the Institute of Social and Economic Research. Both reports are attached.

Please let me know if you have any questions or would like any additional information.

Thank you,

A handwritten signature in cursive script that reads "Rose Foley".

Rose Foley
Aide to Representative Les Gara
465-2647

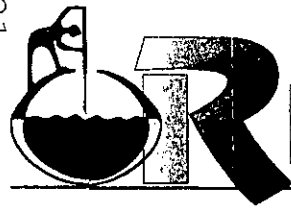
Incarceration

Cost of Extending Foster Care to age 21:	\$508,000 for 40 youth
Cost per youth per year:	\$12,700
Percentage of foster youth incarcerated after leaving care:	29%
Average number of incarcerations:	2.1
Average longest incarceration:	53.5 days
Cost of incarceration per year:	\$44,000
Cost of incarceration per day:	\$120
Average cost of foster youth incarceration:	\$12,840

Incarceration costs approximately \$140 per year more than foster care.

Public Assistance

Percentage of former foster youth receiving public assistance:	73.3%
Percentage of former foster youth living with someone who receives public assistance:	78.4%



RESEARCH SUMMARY

Institute of Social and Economic Research
University of Alaska Anchorage • January 2009
R.S. No. 71

THE COST OF CRIME: COULD THE STATE REDUCE FUTURE CRIME AND SAVE MONEY BY EXPANDING EDUCATION AND TREATMENT PROGRAMS?

By Stephanie Martin and Steve Colt

Alaska's prison population is among the fastest-growing in the U.S., with five times more inmates in 2007 than in 1981. Spending for the state justice system has nearly doubled since 1981—but the crime rate has dropped only about 30%.

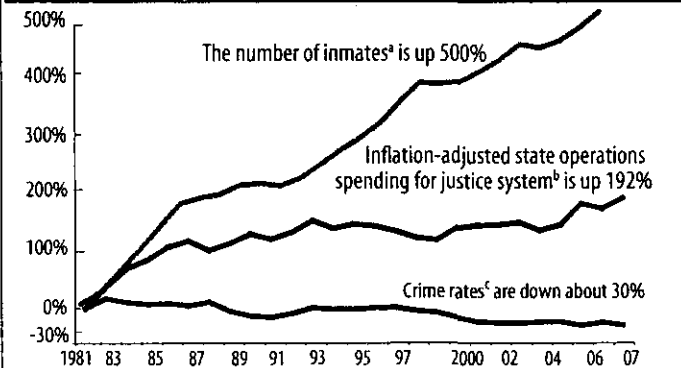
Here's the dilemma for the state, given the pattern shown in Figure 1: what can it do to hold down the number of inmates and stem the rising costs—while at the same time keeping the public safe and using tax dollars effectively?

Senator Hollis French asked ISER to project growth in the number of Alaska inmates and the associated costs—and then evaluate whether the state could reduce that growth by expanding intervention and prevention programs for people already in prison or at risk of ending up there. Alaska currently spends about \$17 million a year for such programs, but they aren't available to many of those who might benefit from them.

There are a wide range of such programs. But it is programs for adults who are already in prison or jail that have the most potential to save money and reduce crime in the next 20 years. That's because they can reach the most people.

We know that without any intervention, about two-thirds of those who serve their sentences and are released commit new crimes. Stopping at least some of them from committing more crimes would not only help improve public safety but also reduce growth in both the number of inmates and in spending.

Figure 1. Percentage Changes in Alaska Crime Rate, Spending for Justice System, and Number of Inmates, 1981-2007



^aInmates in prisons, jails, and halfway houses

^bSpending for Departments of Corrections, Public Safety, and Law; court system; Division of Juvenile Justice; Public Defender Agency; and Office of Public Advocacy. Does not include capital spending or payment on debt.

^cRates per 100,000 for murder, rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft.

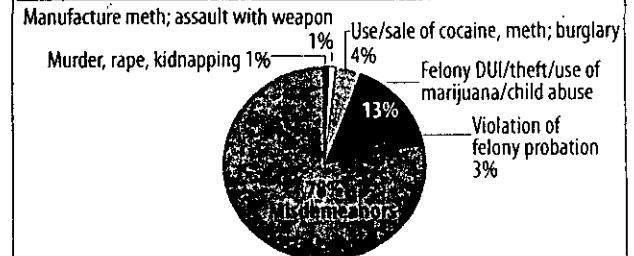
Sources: U.S. Department of Justice; state budget documents; Alaska Department of Corrections

Also, most of those released committed misdemeanors (Figure 2). Those who commit the most serious crimes serve long sentences and make up a small share of those released in any given year.

To analyze which programs have the most potential to reduce crime *and* save the state money, we worked with the Alaska Criminal Justice Working Group and the Washington State Institute of Public Policy. That institute did a similar analysis for Washington state and provided us with data it collected from program evaluations nationwide (see back page). What did our study show?

Figure 2. Who Gets out of Jail or Prison in Alaska?

(Total Releases, 2002-2007: 82,339)



Source: Alaska Department of Corrections

• With no change in policies, the number of Alaska inmates is likely to double by 2030, from 5,300 to 10,500.

• If the state spent an additional \$4 million a year to expand programs it already has, the prison population in 2030 might be 10% smaller than projected—about 1,050 fewer inmates.

• The state would spend about \$124 million for expanded programs through 2030 but would avoid \$445 million in costs—a savings of \$321 million. It would save money by incarcerating fewer people and by delaying prison construction costs. (Figures 3 and 8).

• Education and substance-abuse treatment programs—in prison, after prison, and instead of prison—save the state two to five times what they cost and reach the most people. Programs for teenagers are also very effective at reducing crime and saving money, but they reach fewer people.

Figure 3. Potential Effects, Costs of, and Savings from Expanded Prevention or Intervention Programs

Immediate Costs

- \$17 million: Current annual state spending on programs
- \$4 million: Additional spending every year to expand programs

Long-Term Effects on Prison Population



By 2030, expanded programs could keep 1 in 10 people out of prison who would otherwise be there

Long-Term Savings (2009-2030)

Cost of expanded programs* **\$124 million** — Savings: **\$321 million**
 Avoided inmate costs and delayed prison construction costs* **\$445 million**

*Assumes 2% annual inflation through 2030

WHY CONSIDER EXPANDING PROGRAMS?

In 1980, 2 in 1,000 Alaskans were behind bars; today that share is approaching 10 in 1,000. The sharp increase started in the 1980s, when the state government began collecting large oil revenues. The state used some of that money to expand police agencies, courts, and other parts of the criminal justice system statewide. Also in the 1980s, it made sentencing for the most serious felonies more uniform and stiffened sentences.

The crime rate in Alaska has declined since the 1980s. But the number of Alaskans in prisons, jails, and halfway houses has increased much faster, as have costs for the state justice system. Alaska's prisons are full, and the 1,500-bed prison scheduled to open in 2012 is projected to be full soon after it opens.

Locking people up is expensive, whether their crimes are major or less serious. Alaska spends on average \$44,000 a year per inmate in prisons, jails, and halfway houses. Adjusted for inflation, that's actually less than in the 1980s—but it's still a lot (Figure 4).

Studies in other states have shown that some intervention and prevention programs can help cut both costs and crime, either by keeping people who have served their sentences from committing new crimes after they're released, or preventing some people from going to prison in the first place.

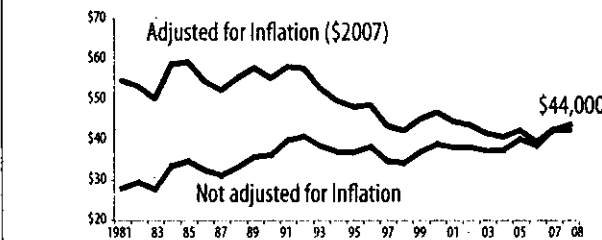
WHAT PROGRAMS DID WE ANALYZE?

The Alaska Criminal Justice Working Group gave us a list of programs to analyze. We looked for programs with the biggest potential payoff for the state—those that could reduce growth in both numbers of inmates and in spending for corrections, at a reasonable cost for the state.

Alaska already has a number of programs in place, and we found that expanding some of those would be most cost-effective. Table 1 lists the programs in our final analysis. As a guideline for what was a "reasonable" expansion, we used 10% to 20% of the eligible people not already served—except for very small programs that can't easily be expanded that much.

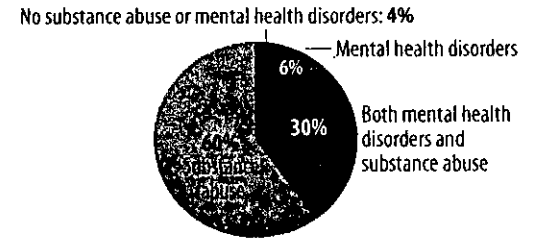
These programs would serve inmates, at-risk juveniles, and young children. They are all intended to reduce future crime in some way. Programs that treat substance-abuse or mental health disorders have been shown to reduce recidivism—and as Figure 5 shows, almost all current inmates have those disorders.

Figure 4. Annual State Costs Per Inmate,* 1981-2008
(In Thousands of Dollars)



*Average cost of incarcerating people in prisons, jails, and halfway houses.
Source: Alaska Department of Corrections

Figure 5. How Many Alaska Inmates Have Substance Abuse or Mental Health Disorders?



Sources: Alaska Department of Corrections; Alaska Mental Health Trust

Table 1. Current Size and Potential Expansion of Intervention and Prevention Programs^a

Programs	Currently serve	Reasonable expansion	Potentially eligible (2008)
Prison-based programs			
Education (adult basic; vocational)	More than 1,000	500	Almost all inmates (4,500)
Substance-Abuse (residential; intensive outpatient)	Close to 500	500	90% of inmates (approximately 4,000)
Sex-offender treatment ^b	0	50	10% of 500 eligible inmates
Transition from prison			
Transition for inmates with mental health disorders (Institutional Discharge Project)	70	100	36% of inmates (1,600)
Alternatives to incarceration			
Mental health, drug, alcohol courts; electronic monitoring; residential substance-abuse treatment	500	500	Approximately 5,000 ^c
Juvenile offenders			
Aggression replacement training; family therapy; residential treatment; institutional transition	Approximately 500	1,000	Approximately 3,000
Prevention			
Head Start for 3- and 4-year olds from low-income families ^d	3,025	450	Approximately 8,000 ^e

^aPrograms included in our final analysis are those for which we found evidence that expansion would have significant pay-offs for the state at a reasonable cost. We evaluated additional programs not included here, either because there wasn't sufficient evidence to assess their effectiveness or because they weren't feasible to implement in Alaska at this time.

^bTo effectively reduce crime, sex offender treatment programs need to be offered in both prison and the community. Treatment is currently available only in the community, so the number served in prison is currently zero—but there are proposals to add treatment in prison.

^cPeople facing low-level charges and with substance-abuse problems.

^dHead Start is a federal program, but the state supplements federal money and Governor Sarah Palin has proposed additional state funding.

^eWe assume all children from families with up to double the poverty-level income would be eligible.

We looked at but excluded other programs from our final analysis. The criminal justice working group decided that a few programs, while effective elsewhere, wouldn't be feasible to implement in Alaska at this time. For other programs, there wasn't enough available evidence to judge how effective they were in saving money or reducing crime, or the available evidence showed them to be largely ineffective.

How Do the Programs Compare?

As Figure 3 (front page) shows, expanding programs to serve more of the eligible people would save the state about \$321 million and reduce the projected number of inmates 10% by 2030. Figures 6 and 7 show how the various programs contribute to costs, savings, and reductions in the number of Alaskans behind bars.

- Education and substance-abuse treatment programs for inmates save two to four times what they cost, reduce recidivism by about four percentage points, and can reach the most people.

- Intervention programs for juveniles who have committed crimes are very effective at saving money and reducing recidivism, but they serve a much smaller number of people.

- Programs that set up transition services for inmates with mental-health disorders coming out of prison are among the most effective—but they can't readily be expanded to serve the many people who could benefit from them.

- Alternatives to prison for some people charged with lesser offenses save the state money right away, and almost all reduce recidivism. The exception is electronic monitoring, which is inexpensive but hasn't been shown to reduce future crime.

- Treatment programs for sex offenders do reduce crime, but they are very expensive and so don't save the state money.

- Programs that prevent future crime by helping very young at-risk children are the most effective. But the effects of spending for those programs aren't apparent until many years later.

Figure 6. How Effective Are Various Programs at Saving Money and Reducing Crime?

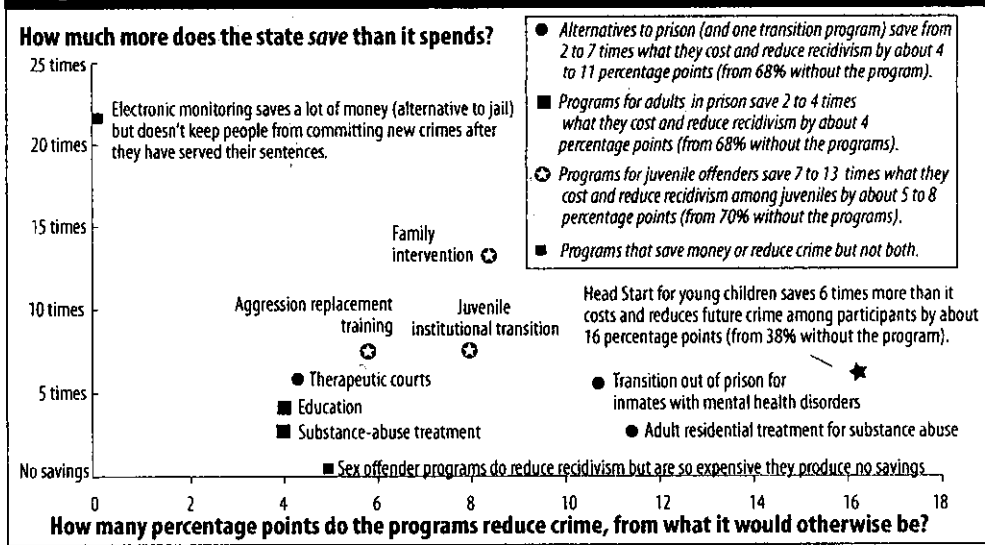
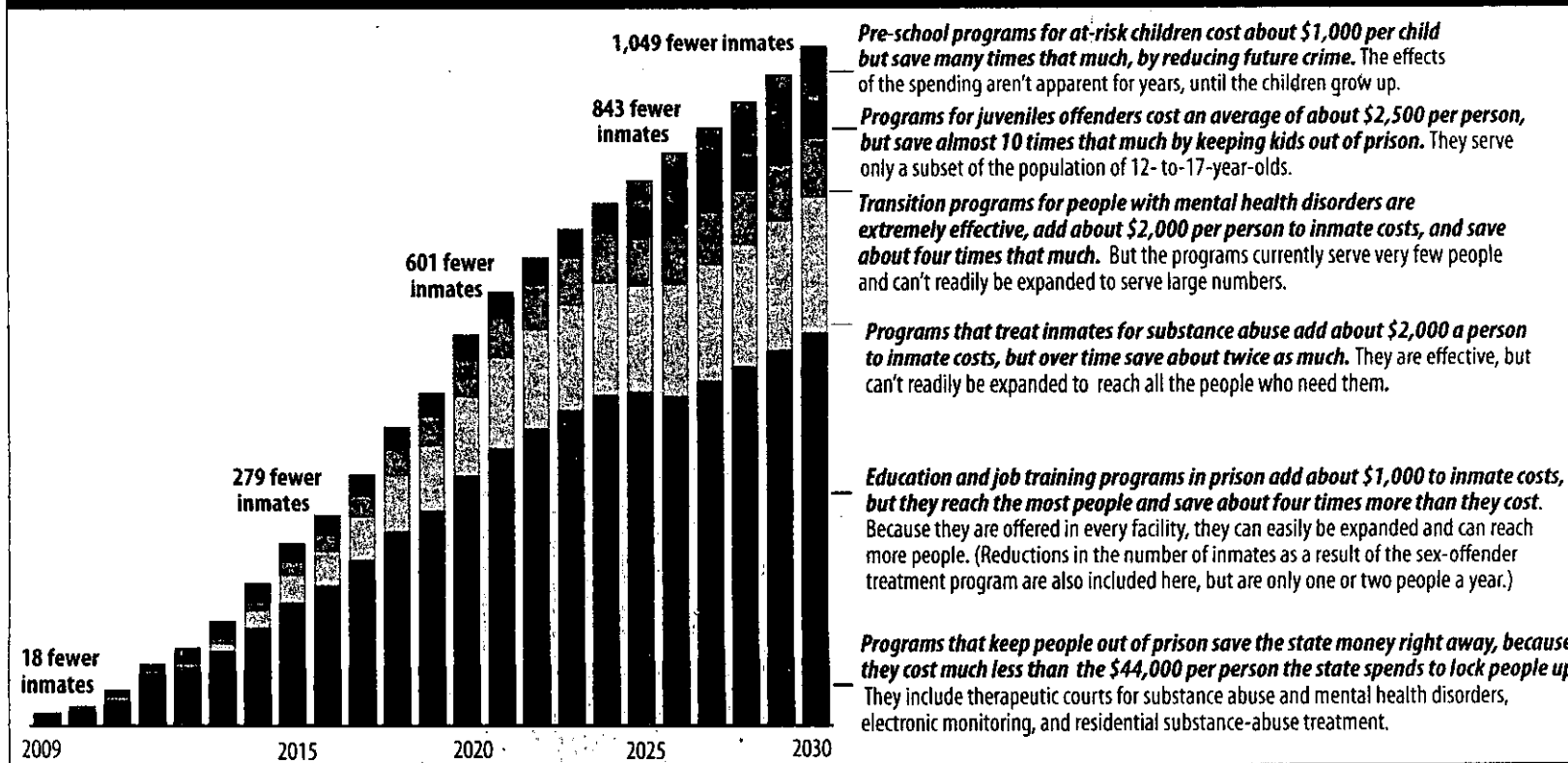


Figure 7. How Would Expanding Specific Programs Contribute to Reducing Growth in Numbers of Inmates?



CONCLUSION

In conclusion, Figure 8 shows how Alaska's corrections system got where it is and where it's likely to go—if intervention and prevention programs are kept at their current levels, and if the most effective programs are expanded to serve more of the eligible people.

We found that the state could both reduce the number of Alaskans in prison or jail and save considerable money over the next 20 years, by adding about \$4 million a year to the \$17 million it currently spends to keep people from returning to prison—or prevent them from ever going there at all.

Spending more for these programs even as oil prices and state revenues are falling may not seem like a good idea. But Alaska also needs to look to the future—and over time the benefits of strategically expanding those programs that reduce crime and keep more Alaskans out of prison far outweigh the costs.

METHOD OF ANALYSIS

Our job was to assess whether specific programs could reduce long-term state spending for corrections by reducing growth in the number of inmates. As a starting point, we needed evaluations of how effective various programs are at reducing future crime.

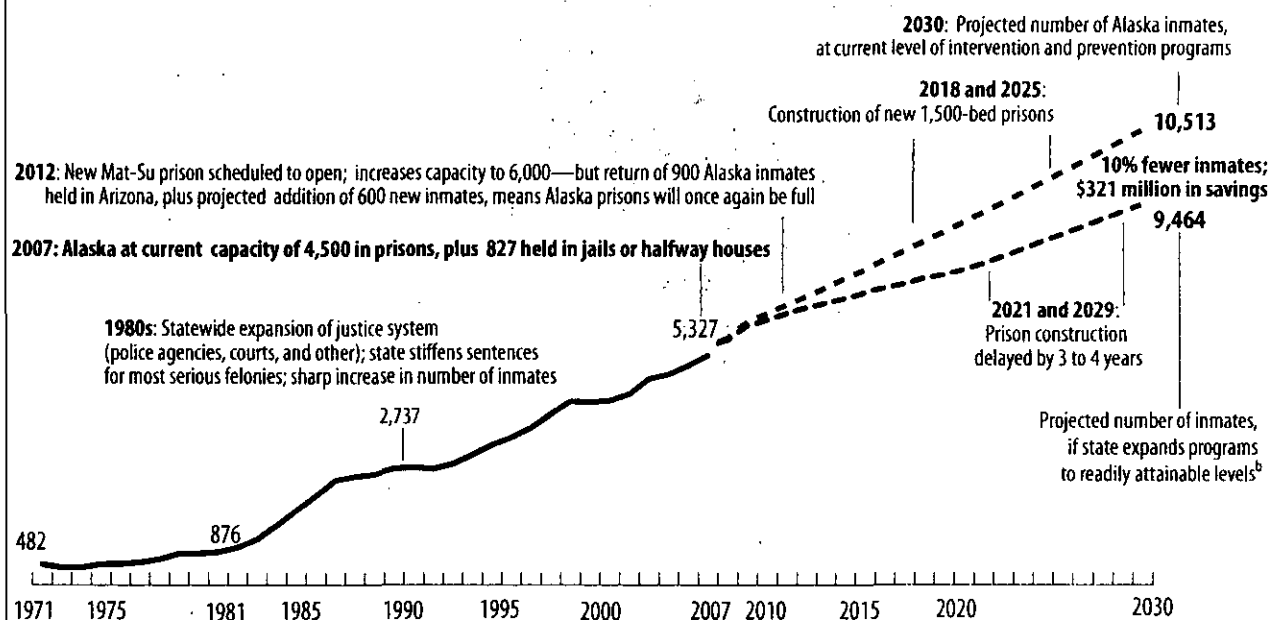
But except for some of the therapeutic court programs, most programs in Alaska have not been rigorously evaluated. Therefore, we used results of a Washington state assessment that systematically reviewed 571 program evaluations from around the country.

To be included, evaluations had to have carefully designed control groups, replicable results in multiple settings, and long-lasting effects. This method is evidence-based public policy, which merges research and practice. It is similar to clinical trials in medicine. Keep in mind that this is a new field, and only about 10% of programs in place nationwide have been evaluated at this standard.

With data from rigorous evaluations, the Washington State Institute of Public Policy created a model that estimated the effects of programs on recidivism—and then combined those results with a cost-benefit analysis to estimate the long-term effects on state spending and inmate populations.

We combined the institute's estimates of recidivism with Alaska data on program costs, eligible groups, and state population to estimate long-term effects on crime and state spending.

Figure 8. Average Number of Alaska Inmates,^a 1971-2007, and Projected Number, 2008-2030



^aAverage daily number of people in prisons, jails, and halfway houses. ^bThe number of people who could be readily added to program rolls varies considerably by program; see Table 1.
Sources: Alaska Department of Corrections; ISER projections of number of prisoners, based on Alaska Department of Labor projections of Alaska population 18-64 and assuming no change in current use of rehabilitation programs as well as expanded use; Washington State Institute of Public Policy

The authors thank the members of the Alaska Criminal Justice Working Group for their help in identifying programs to evaluate and for comments on drafts of this publication. The Alaska Legislature funded this group in 2007 and authorized the Alaska Judicial Council to act as its staff.

The group is chaired by a justice of the Alaska Supreme Court and Alaska's lieutenant governor. Other members include top policymakers from the departments of Corrections, Public Safety, Health and Social Services, and Law, as well as the Alaska Mental Health Trust Authority; the heads of the Alaska Public Defender Agency and the Office of Public Advocacy; the administrative and deputy directors for the Alaska Court System; the executive director of the Judicial Council, the U.S. attorney, and Anchorage's police chief.

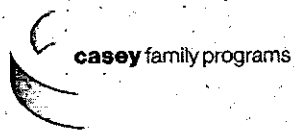
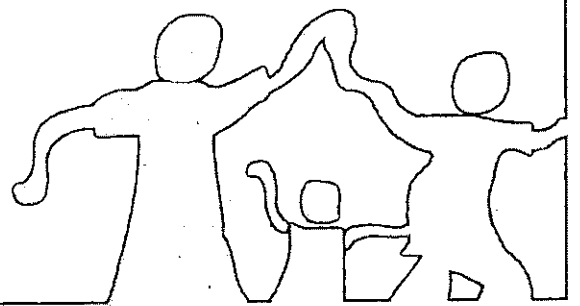
This group meets monthly to talk about long-term justice issues, as well as to resolve any inter-branch issues that come up among the many agencies and organizations that deal with aspects of Alaska's justice system.

The authors also thank Elizabeth Drake and Steve Aos of the Washington State Institute of Public Policy for developing the methods and models we used and for helping us apply them to Alaska. For more information go to www.wsipp.wa.gov.

This research summary and many other publications on a wide range of topics are available on ISER's Web site:

www.iser.uaa.alaska.edu

Alaskan Foster Care Alumni Study





Alaska Foster Care Alumni Study

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Academy
Co-Principal Investigator

THE UNIVERSITY OF ALASKA ANCHORAGE
School of Social Work, Child Welfare Evaluation
Program

CASEY FAMILY PROGRAMS

TRIBAL STATE COLLABORATION GROUP

STATE OF ALASKA
OFFICE OF CHILDREN'S SERVICES



Acknowledgements

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August 2005

Alaska Foster Care Alumni Study

Conducted by

THE UNIVERSITY OF ALASKA ANCHORAGE
School of Social Work
Child Welfare Evaluation Program

EXECUTIVE SUMMARY

Study Overview

The Alaskan Foster Care Alumni Study examined the outcomes of young adults who had "aged out" of State custody after spending much of their adolescence in foster care. The study team, composed of representatives from the State of Alaska Office of Children's Services, Casey Family Programs, the Tribal-State Collaboration Group, and the University of Alaska Anchorage, sought to answer the following questions about a cohort of Alaskan foster care alumni: where are they living, how they were faring socially, economically, and emotionally, and how do they perceived their experiences in foster care? Alumni eligible for the study were 19 to 29 years of age, had spent at least one continuous year in out-of-home care in state protective custody, with that year being between 15 and 18 years of age, and had left care on or after their 16th birthday. Of the 140 alumni who met these criteria, nearly 53% were female and 50% were Alaska Native. Sixty-six interviews were conducted between May and December 2004, representing an adjusted response rate of nearly 60%.

Findings

Despite the hardships of abuse and neglect, removal from biological family, multiple moves and transitions, and minimal preparation for adult living, many Alaskan foster care alumni were thriving. Through persistence, emotional support and connections, and their own resourcefulness and that of others, they have grown into contributing members of the communities where they live. The outcomes below represent both the successes and difficulties experienced by the Alaskan foster care alumni studied. Most participants spent their time in foster care before Chafee funds were readily available for educational and other transitional services. In addition, regional independent living services have recently been expanded by the State Office of Children's Services to provide more foster youth with the resources to successfully transition into adulthood.

Whole Population Outcomes:

- Nearly three-quarters of the foster care alumni remain in Alaska. These alumni were predominately clustered in the Southcentral region of the state, followed by the Southwestern and Southeastern regions.
- Nearly one in five alumni had been involved in the criminal justice system at some point in their lives.

Outcomes from Interviewed Alumni:

Socio-Emotional:

- Positive relationships formed while youth were in care continued to be an important source of support later in life. Nearly 76% of alumni reported having had a positive close relationship with an adult while in foster care. Almost three-quarters of these alumni reported still being in contact with these adults.
- Fewer than 10% of alumni were placed with their siblings in their first foster home. Nearly three-quarters of these alumni were *never* placed with their siblings. Study participants reported that sibling relationships continued to be important to them into adulthood.
- Rates of early parenthood were high. Nearly 10% of interviewed females became pregnant before age 17. By age 19, 57% of females and 41% of males were parents.
- Alumni reported having a wide social network of family and friends. The average number of friends alumni reported having was nearly eight. Contact with friends was frequent—82% reported talking on the phone or visiting with friends a few times a month or more, including 38% with daily contact.
- In general, most alumni reported being happy with their current living situations. More than 8 in 10 alumni reported feeling “happy” or “very happy” in each area of a life satisfaction rating. A relatively substantial proportion, however, reported extremely poor mental health.

Physical and Behavioral Health:

- Use of mental health resources among alumni was high. Nearly 80% reported lifetime use of behavioral or mental health services, including 35% reporting overnight treatment stays and 68% seeing a professional (such as a psychologist, social worker, or minister) outside of an overnight stay. About 27% reported using any of these services in the past year, while nearly 17% of the total reported that they were *currently* seeing a professional.
- Alcohol use by alumni was slightly below the average for statewide alcohol use figures for people of similar age, while their rates of marijuana use were slightly higher than the statewide rate. Although nearly 50% of alumni reported drinking in the past month, 21% reported being drunk during the same time period. Use of illicit drugs other than marijuana was rare.
- Most alumni rated their overall physical health at the same level as the general population. A small number, however, reported very poor health.

Education, Employment, and Health Insurance:

- Few alumni received financial, employment, or educational assistance as they made their transition out of state care to living on their own. Compared with the Wisconsin or the Northwest alumni studies, Alaskan alumni received fewer services in most areas as they exited state care. However, the exception was in finding contact persons to help with future problems.
- Nearly 38% of alumni reported being homeless after leaving care. This is higher than the homeless rates of 12-25% from other foster care alumni studies.

- The high school completion rate for foster care alumni was slightly below the statewide average. Many Alaskan alumni took longer to achieve their high school diploma (often finishing between 19 and 25 years of age), but few went on to complete post-secondary education.
- Many alumni were struggling financially. Although some were doing quite well, average income was low, and the proportion lacking health insurance coverage doubled state and national rates.

Costs to Society:

- * Nearly 30% of alumni were incarcerated for some period of time after leaving care. Nearly 21% of interviewed alumni reported being placed in juvenile corrections while in care, but only 64% of these were jailed again after leaving care.
- * Alumni reported a high utilization of public assistance resources in their households. Over 77% of alumni (including 73% of those who live alone and 78% of those living with others) reported that someone with whom they lived received some form of public assistance in the last six months.

Recommendations

The following recommendations address the outcomes revealed in this study. They are based on policies, programs, and practices that have been shown to be effective in other research. Stakeholders (representing members of the research partnership) participated in refining and clarifying these recommendations, as well as adding their own list of actions which they believe will improve foster care in Alaska.

- **Increase early intervention:** In general, early intervention efforts are recommended to minimize most of the poor outcomes described in this report. Research has shown, for example, that family support programs are more successful the younger the children are.
- **Involve youth in planning:** Simply being more informed can help increase a youth's sense of predictability, while having a say can increase the sense of control.
- **Provide comprehensive assessment:** A comprehensive assessment—covering physical and emotional development, cognitive functioning and academics, life-skills, social relationships and functioning, etc.—can result in a detailed service and support plan, a road map for all concerned with helping the youth return to an optimal developmental path.
- **Maximize placement stability:** A comprehensive assessment can help match youth to foster parents. Better matching can improve relationships with foster families, which in turn results in improved outcomes during and after care.
- **Encourage positive adult relationships:** The development of a consistent adult relationship can have a variety of positive effects, including socio-emotional, educational, and employment outcomes.
- **Promote legal ties, such as adoption and guardianship, throughout adolescence and even into adulthood:** Subsidized guardianship may be an especially appropriate choice of permanency options for adolescents and/or

children in kinship care placements, particularly in Native communities that might disapprove of termination of parental rights.

- **Support relationships with foster parents after youth reach 18:** In order to promote maintenance of adult connections, the State should work to remove barriers to having young people remain in the home or in contact after emancipation.
- **Promote sibling contact, as appropriate:** Optimally, sibling groups would remain intact. There is a slowly growing body of research supporting the benefits of keeping sibling groups together when appropriate.
- **Provide sexuality education to all foster youth:** Foster youth appear to be relatively likely to engage in early sex, often resulting in pregnancy and/or sexually transmitted diseases.
- **Provide parenting support for youth who do become parents:** Once a young person does have a child, they need support and training to avoid the poor outcomes common to young parents.
- **Improve mental health treatment:** Proper assessment can help develop a treatment plan to be implemented by caseworkers, foster parents, teachers, and others, in the home and out. Proper training, for example in cognitive-behavioral interventions, will maximize the effectiveness of this plan.
- **Extend foster care services:** Intact families do not expect their children to live alone at 18. Given the array of difficulties faced by foster children, as well as the negative short-term outcomes found in this and other studies (e.g., 30% homeless within a year of leaving care), some form of extended service is warranted.
- **Use the Chafee Medicaid option to extend health coverage:** Given the health problems, poor finances, and lack of health insurance experienced by many alumni, they appear to be at risk of joining the tens of thousands of Americans who die each year due to a lack of health insurance.
- **Develop a detailed transition plan with each youth:** Youth often express anxiety over the prospect of leaving care and being on their own. Having a plan can help alleviate that anxiety.
- **Facilitate communication across roles and functions:** The benefits of assessment and thorough planning can come only if parties communicate. Thus, information must pass from professional to professional and also from caseworker to foster parent, caseworker to new caseworker (if necessary), school to school, child welfare agency to educational system, caseworker and foster parent to therapist, and so on.
- **Support caseworkers in their efforts to help youth transition to adulthood:** Training should include developmental issues and information on accessing the wide variety of resources, within OCS and without, that are available. Only if a worker is aware of a service and of how to pay for it can a youth or young adult take advantage of opportunities that are available to them. Worker-youth relationships can also be improved by matching trained and interested workers with adolescents.

Stakeholder Recommendations: Strategies to Improve Foster Care in Alaska

In addition to the recommendations above, various advocates of improved foster care emphasized the following strategies to improve foster care in the state:

- Increase the number and cultural diversity of resource families.
- Expand targeted recruitment of resource families to reach underrepresented cultural groups, with particular emphasis on reaching out to Alaska Native families.
- Increase the number of resource families with the capacity and expertise to provide care to adolescents, with the goal of maintaining relationships into adulthood.
- Expand efforts to more carefully match children's needs with the culture, style, and capabilities of foster families
- Increase kinship care; provide support and training to families providing this care.
- Expand the use of the Team Decision Making model currently used in the Anchorage OCS office (from Family to Family by the Annie E. Casey Foundation). This process involves families and community members actively in case planning and decision-making.
- Reduce the reliance on emergency shelter care.
- Reduce the use of residential care.
- Provide more agency and respite support to resource families.
- Build academic support for foster children through working with schools and other community resources.
- Increase post-secondary education and vocational training for foster youth and alumni, including job training, job shadowing, and apprenticeships.
- Increase the number of safe, affordable transitional housing options for foster care alumni.

Conclusions

The intent of this study was to provide insight into the experiences of foster care alumni with the hopes of improving the lives of current and future generations of youth who find themselves removed from their birth families and placed in state custody. This responsibility does not rest solely with the State of Alaska, but with communities, families, caregivers, tribal programs, caseworkers, residential youth facilities, schools, and even the youth themselves. This study's findings support those of several other studies supporting the need to promote key ingredients that, if provided to youth early, can greatly enhance their chances of success.

These are, among many others: positive, consistent adult relationships; youth participating in their own planning; early and on-going preparation for independent living; on-going connection to family members when appropriate; and allowing youth to receive the economic and emotional benefits of remaining in care until 21. Care, support, mentoring, training, and financial assistance will ultimately benefit foster youth, their communities, and all of us.

Employment, finances, and health insurance

Nearly 6 in 10 respondents (58.5%) were working at the time of the interview, while 17% were not in the workforce. The unemployment rate among this sample was 29.6%, compared to a reported unemployment rate in Alaska of 7.1% in May 2004 and 7.6% in December 2004 (5.6% and 5.4%, respectively, in the US) (Robinson, 2004, 2005). (Note that while the interview asked if respondents were "looking for work" this may not meet the definition applied by the State and the Federal government, requiring an active attempt to find work, as reported to the unemployment office, in the past 4 weeks.) Among those who worked, the range of hours was from 8 to 60, with an average of 35 hours per week. Two respondents were reportedly permanently disabled.

Given the high rate of unemployment and low rates of college completion in this sample, average income was low. The average of approximately \$12,300 is a little more than half of the Census Bureau's 2003 estimate of per capita income for Alaska of \$24,361. The median income was \$9,500, equivalent to the Federal poverty level for a single person household in 2003 (DeNavas-Walt, Proctor, & Mills, 2004); only five alumni reported personal incomes above \$40,000. Approximately 39% of the respondents had no health insurance.

Cost to Society

Criminality

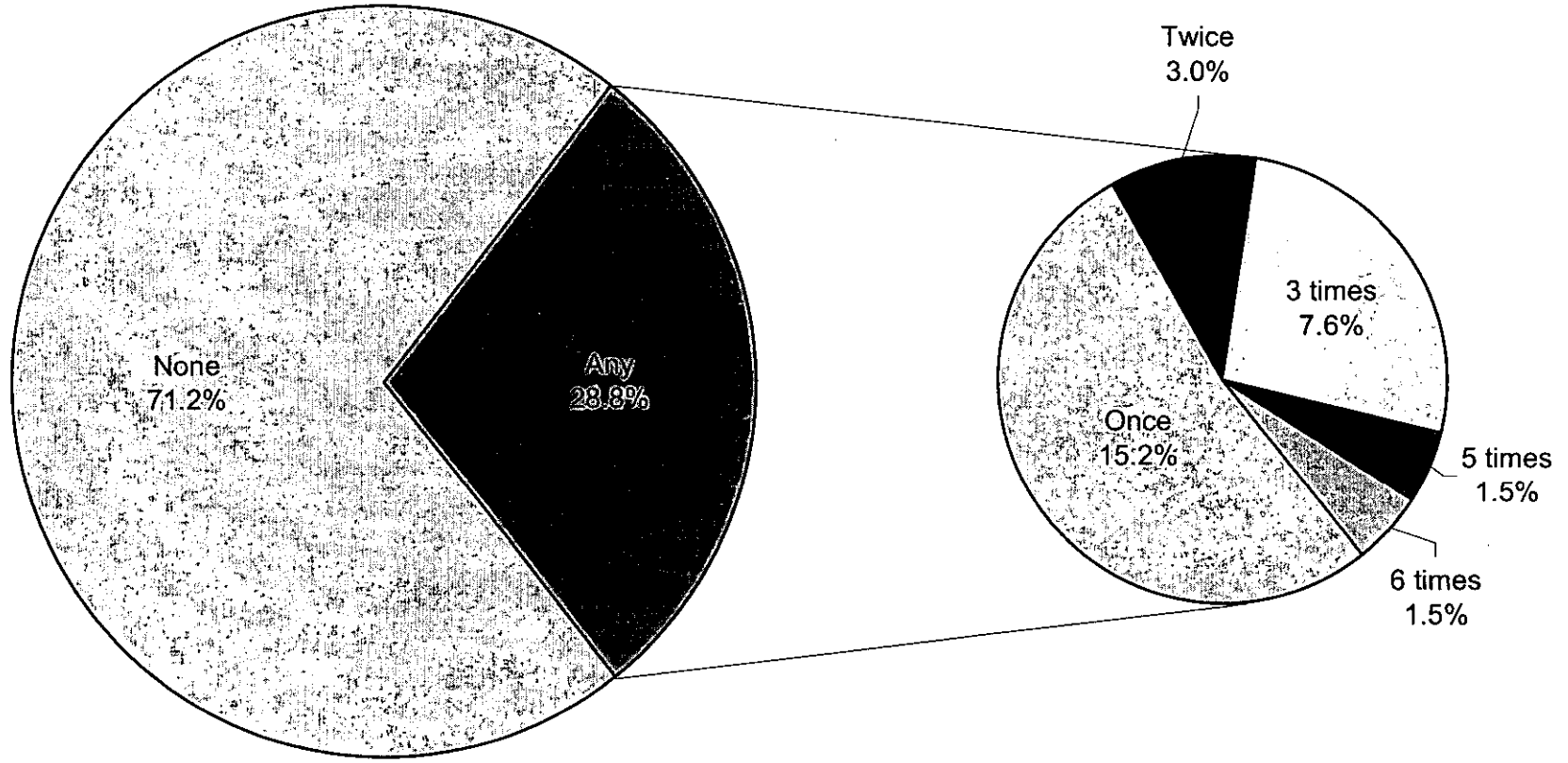
One in five alumni (14 alumni, or 21.2%) reported in the interview that they had experienced placement in a juvenile corrections facility before leaving care (and perhaps before entering care), starting at an average age of just over 15 years of age. The alumni reported an average total time in such placements of 27 days.

Several sources of information can be combined to examine alumni interactions with the criminal justice system after leaving care. State and federal records indicated that more than 1 in 5 alumni (21.4% of the entire population of 140) had some criminal record, including 15 alumni who were incarcerated throughout the interviewing period. Interview data revealed that more than half of the alumni had been arrested, which may have included while they were juveniles. Nineteen alumni (28.8% of those interviewed) reported being jailed after leaving care, including 9 of the 14 (64.3%) who reported spending time in juvenile detention. The average first age of imprisonment was 19.9, or less than 18 months after the average age of leaving care (18.5). The average number of incarcerations was 2.1, with an average longest stay of 53.5 days. More than half of those imprisoned after leaving care were jailed only once (see Figure 13). Combining interview data with government records indicated that 43% of the entire population of alumni had some interaction with the criminal justice system after leaving care.

Household public assistance use

Over 77% of alumni (including 73.3% of those who live alone and 78.4% of those living with others) reported that someone in their household received some form of public assistance in the last six months, including 32% receiving food stamps, 27% receiving Temporary Assistance to Needy Families aid, and 27% receiving help from the Women,

Figure 13. Times in jail since leaving care among interviewed alumni.



Infants, and Children program (see Table 15). Three alumni reported that someone in their household was receiving a foster care or adoption subsidy. Nearly 11% reported that someone in the household was receiving unemployment benefits. Five alumni (7.7%) reported that someone in their household was receiving financial aid to attend school.

Table 15. Household public assistance or aid program use, past 6 months.

Any program:	77.3%
Medicaid/Medicare	55.6%
Food stamps	31.8%
TANF	26.6%
WIC	27.3%
Supplemental Social Security	26.6%
Foster care or adoption subsidy	4.6%
Unemployment	10.6%
Public housing	9.4%
Energy program	7.6%
Child care subsidy	4.6%
Student financial aid	7.7%
Other aid	15.6%

DISCUSSION

Socio-emotional Outcomes

Supportive Adult Relationships

“Optimal child development occurs when a spectrum of needs are consistently met over an extended period” (American Academy of Pediatrics, 2000, p. 1146). Many youth in long-term foster care experience a host of disruptions to their relationships: removal from their birth family, new foster parents, new foster siblings, a new school, a new caseworker, and new guardian ad litem. These multiple disruptions make it difficult to develop trusting relationships (Briere, 1992; Chalk et al., 2002; Downs & Williams, 2003; Mech, 2003). Nearly a quarter of the Alaska alumni reported no close relationship with an adult while they were in care.

I think (my foster mom) has really helped with a lot of my successes. She's the only one that I can really pinpoint.
Study participant

The development of a consistent adult relationship, a constant through the storm of foster care, can have a variety of positive effects, including socio-emotional, educational, and employment outcomes. Positive adult relationships help youth develop into psychologically healthy adults (American Academy of Pediatrics, 2000). Viewing this

from the Assets Framework, trusting adult relationships and positive role models are protective factors that can promote the development of other assets: creative activities, high expectations and achievement motivation, interpersonal competence, self-esteem, etc. (Mannes, Roehlkepartain, & Benson, 2005; see the Search Institute website at www.search-institute.org/ for more information). An “available...and devoted” adult (Downs & Williams, 2003, p. 496) can be a foster parent, an elder or extended family member with whom the youth maintains contact, a dedicated caseworker, or some other mentor.

Mentors have been shown to be effective in helping produce positive outcomes in youth (see, for example, Grossman & Rhodes, 2002; Grossman & Tierney, 1998), particularly when mentors are trained and supported. Mech (2003) describes mentors as a form of social capital, a way to connect foster youth to resources—community resources, other helpful individuals, job and education resources, etc.—that can have positive returns for the individual and society, in the form of reductions in school dropouts, delinquency, and antisocial behavior; avoidance of adolescent pregnancy; prevention of family violence; and future taxable income. Mentors provide examples of functional adulthood and healthy relationships. They can reinforce the value of education and provide informal tutoring, supply job shadowing opportunities, and encourage youth to explore and learn. This was supported by a recent study of Alaskan youth ages 14-19 in state custody (Pope & Williams, 2005a) who reported that adult mentors, coaches, foster parents and other positive role models were essential to them as they acquired and practiced the skills they think are important to live as successful adults.

There has been increased discussion about connecting foster youth or alumni with adults (Collins, 2001), including adoption beyond what has been traditionally considered something of a deadline for adoption: the onset of adolescence. Alumni in the current project discussed the benefits of feeling like there was someone they could count on even after leaving their (last) foster home:

She was just such a cheery little person; you could talk to her about anything. I still go and visit her. She is just an awesome person. She is so much like what a mother should be, in my eyes. (Study participant)

In addition to individuals taking on this role spontaneously, formal efforts, such as the California Permanency for Youth Project (www.cypyp.org), are appearing around the country to promote permanency for older youth and even adult foster care alumni. Such programs are not intended to take the place of independent living preparation. The focus is less on independence and more on connections—personal and legal—with adults (Louisell, 2004). Alaska’s development of subsidized guardianship should provide another way to increase connections with adults. Guardianship may be an especially feasible choice for adolescents and/or those in kinship care situations (National Abandoned Infants Assistance Resource Center, 2003) by establishing connections without severing birth family ties.

No matter what form they take, encouraging the formation of positive, consistent adult relationships will have many preventive effects (Downs & Caldwell, 2003; Downs &

Williams, 2003; Mannes et al., 2005; Pecora et al., 2005a). Assets research has shown that maximizing the number of assets is related to increased thriving behaviors, decreased high-risk behaviors, and improved well-being (Mannes et al., 2005). Thus, concentrating on developing adult relationships among foster youth will in turn address many of the poor outcomes for which foster care alumni seem to be at risk: the Northwest Alumni Study report (Pecora et al., 2005a) recommendations discuss adult connections as being important for improving outcomes in mental health, education, and employment and finances. The current study, similar to others (Collins, 2001), documents that social contact and support appear to be strengths among foster care graduates (although no comparisons were made with the general population). Further analysis will illustrate the protective nature of this support for foster care alumni.

Sibling and Birth Family Contact

As demonstrated in Figure 6, too many of the alumni in this study lived through the experience of not only being separated from their parents, but also from their siblings. Although sibling contact appears to have been fairly well supported (71% of those not placed with siblings reported seeing them again at least once before leaving care), a number of responses to the open-ended question "*What could have been done to better help you while you were in care?*" indicated that for those who were unable to have contact with their siblings, this was a negative experience that left a major impression:

The people who cared for my brother and sister did not make an effort for us to see one another and we all lost communication.

I would have liked to have been closer to my siblings; they should have made a greater effort to keep me close to family.

I think I should have been kept with all my siblings. I was emotionally stressed about that; I loved my brothers and sisters.

[It would have been better to have] contact with my brothers more and family more and the social workers more.

There is a slowly growing body of research supporting the benefits of keeping sibling groups together when appropriate (Herrick & Piccus, 2005; Leathers, 2005; Tarren-Sweeney & Hazell, 2005). Siblings can provide a protective factor for adjusting to foster care and preventing placement change. By helping youth maintain these relationships, workers can increase the probability of a young person having supportive relationships upon leaving care.

Birth family contact can also be important when such contact is appropriate (American Academy of Pediatrics, 2000). Consistent with previous research, Leathers (2005) found that the frequency of maternal visitation among foster youth predicted chances for reunification. Birth family members are important for youth that do not reunify, as well. Many young people move in with birth parents or other relatives soon after leaving care, sometimes by default (Courtney et al., 2001; Courtney et al., 2005; McDonald et al., 1996). Foster youth struggle with being disconnected from people and resources and they

ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA

Sponsor Statement

HB 126: Success For Foster Youth

HB 126 is designed to fix some of the most glaring problems in our foster care system – problems that serve to deny opportunity and success to at risk foster youth. It is cost effective, and designed to supplement partial efforts that exist today. Given the number of foster youth in Alaska – approximately 2,000 – the cost of this effort will not be substantial, but the economic and human and opportunity cost of not passing it will be.

The legislation is an outgrowth of this past fall's bi-partisan legislative foster care conference, and work by Alaska's foster youth, who have become increasingly active in seeking solutions for the problems they face on a day to day basis.

Today roughly 40% of foster youth end up homeless at some point in their lives after leaving foster care. That's unacceptable, and HB 126 proposes cost effective solutions to that problems. It is estimated that less than 10% of our foster youth graduate from college. Foster youth end up in jail and on state-paid social services, and in social service treatment in greater numbers than their peers. Tolerating this costs Alaskans in terms of money, lost economic activity and human opportunity.

HB 126 does the following:

- It requires OCS to meet federal standards by requiring in person visits with foster children on a monthly basis. Many states impose such a requirement to spur compliance by their state agencies, and the language in HB 126 is taken from Minnesota. The most recent federal review of our system states that in roughly 1/3 of the cases OCS staff meet once every 8 months with foster youth. OCS is working on improving this, and OCS staff are eager to find ways to comply with the monthly visit standards that are so important if we are to protect our foster youth from harm, and learn their needs so they can succeed.
- It provides housing assistance to youth coming out of foster care, for up to a year. Current rules allow OCS to pay for one month of full rent, and then 2 months of rent at 50% of the youth's cost.
- It provides tuition and room and board for in-state job training and college. Currently there are a limited number of tuition-only scholarships available to youth, and some job training assistance. This provision would make that assistance complete. The room and

board component is crucial, as foster youth have no home they can live in after foster care ends.

- It requires that foster youth be allowed to remain in their current school when they suffer a foster family placement change. Bouncing youth between schools causes failure, and federal law provides partial funding to allow students to avoid school transfers.
- It requires that when foster youth are transferred to a new school, they be allowed to attend immediately, and requires that their transcript information be transferred to the new school within 7 days.

Federal funding is available for portions of this effort, and the limited number of foster youth in Alaska would make implementation of this effort relatively inexpensive. If we don't pursue this legislation, Alaska's foster youth will continue facing unfair barriers to their success – and that shouldn't be an acceptable option.

Please don't hesitate to contact us with questions.

ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA

MEMORANDUM

DATE: March 11, 2009

TO: Representative Wes Keller
Representative Bob Herron

FROM: Representative Les Gara

RE: Sectional Summary for CSHB126(EDC)

Section 1: Provides for the continuation of a public education in a student's school of origin for a homeless student under federal specifications. Provides exceptions for a move outside of a school district. Requires the transfer of a student's school records from the school of origin within seven days after notification of a school transfer. Modifies federal definition of homelessness to include students who are placed in out-of-home care by the state.

Section 2: Provides for a waiver of tuition, fees, and room and board expenses at a state-supported educational institution for a person who was placed in out-of-home care under specified circumstances for a person who is under 29 years of age. Provides an exception to educational institutions giving the waivers if insufficient funding is appropriated by the legislature.

Section 3: Defines out-of-home care for purposes of student loans and waivers.

Section 4: Replaces the term "foster care" for "out-of-home care" for purposes of grants and contracts.

Section 5: Amends the state's purpose and policy related to children to include education and intellectual development.

Section 6: Amends the legislative intent related to children to include providing a public education as provided under section 1.

Section 7: Replaces the term "foster homes" with "out-of-home care" for purposes of establishing medical assistance eligibility for certain persons and adds a category of eligibility for persons under 21 years of age who were in out-of-home care for a specified period of time on or after the person's 16th birthday.

Section 8: Defines "out-of-home care" for the purposes of medical assistance eligibility.

Section 9: Establishes mandatory monthly visits by social workers employed by the department to make monthly home visits, as described, to all children in the custody of the department.

Section 10: Amends the definition of "child" for purposes of the child in need of aid statutes.

Section 11: Defines "out-of-home care" for purposes of juvenile programs and institutions.

Section 12: Replaces the term "foster care" with "out-of-home care" for purposes of transition programs. Redefines the beneficiaries of those programs as individuals who have been in state custody and out-of-home care rather than "foster care".

Section 13: Increases the maximum eligibility age from 18 to 21 for purposes of the foster care transition program.

Section 14: Expands the recipients of state services to include children who were in state custody and placed in out-of-home care.

Section 15: Establishes a monetary stipend to be paid to persons who are eligible for the foster care transition program.

Section 16: Replaces the term "foster care" with "out-of-home care" for purposes of the transition program.

Section 17: Defines "out-of-home care" for the purposes of the transition program.

26-LS0309\P
Mischel
3/9/09

CS FOR HOUSE BILL NO. 126(EDC)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE EDUCATION COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GARA, Crawford, Kerttula

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to continuing the secondary public education of a homeless student;**
2 **relating to the purpose of certain laws as they relate to children; relating to tuition**
3 **waivers, loans, and medical assistance for a child placed in out-of-home care by the**
4 **state; relating to foster care; relating to children in need of aid; and relating to out-of-**
5 **home care transition to independent living."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1. AS 14.03 is amended by adding a new section to read:**

8 **Sec. 14.03.096. Continuing the public education of a homeless student. (a)**
9 **Except as provided in (b) and (d) of this section, the governing body of a school**
10 **district shall comply with the requirements for continuing the public education of a**
11 **homeless student in the student's school of origin and for providing transportation**
12 **services for the remainder of the current school year or, if the student is attending**
13 **school for a summer term, for the remainder of the summer term, under 42 U.S.C.**

1 11431 - 11435 (McKinney-Vento Homeless Education Assistance Improvement Act
2 of 2001), as those provisions existed on February 1, 2009.

3 (b) The requirements in (a) of this section do not apply if the student moves to
4 a school district other than the school district in which the student's school of origin is
5 located.

6 (c) If a homeless student is transferred to a school other than the student's
7 school of origin, the school of origin shall provide a copy of the student's records to
8 the student's new school within seven school days after notification of the transfer.
9 The student's new school shall allow the student to attend school while awaiting the
10 transfer of records under this subsection.

11 (d) A school district is required to comply with this section only

12 (1) if the legislature appropriates funds for the purpose; and

13 (2) to the extent possible using funds appropriated for the purpose.

14 (e) In this section,

15 (1) "homeless student" has the meaning given in 42 U.S.C. 11434a for
16 "homeless child or youth," and the phrase "awaiting foster care placement" in that
17 definition shall be interpreted to include all students who are placed in out-of-home
18 care and in the custody of the Department of Health and Social Services under
19 AS 47.10.080(c) or who are committed to the custody of the Department of Health and
20 Social Services under AS 47.12.120(b)(1) or (3);

21 (2) "school of origin" means the school in which the student was last
22 enrolled.

23 * Sec. 2. AS 14.43 is amended by adding a new section to read:

24 **Article 3A. Free Tuition for a Person Who Was in Out-of-Home Care.**

25 **Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home**
26 **care.** (a) A person who enrolls as a student in good standing in a state-supported
27 educational institution in the state is entitled to a waiver of tuition, fees, and room and
28 board expenses if the person provides adequate proof that the person

29 (1) was in the custody of the state under AS 47.10 or AS 47.14;

30 (2) was placed in out-of-home care for a period of not less than six
31 consecutive months on or after the person became 16 years of age;

1 (3) has applied for educational grants or scholarships that the person is
2 otherwise eligible for as recommended by the educational institution;

3 (4) has applied for an available federal education loan; and

4 (5) is under 29 years of age.

5 (b) The amount of the waiver to which a person is entitled under this section is
6 the amount of unmet need for tuition, room, and board expenses, as determined by the
7 commission, after deducting funding for the school year from education loans, grants,
8 or scholarships received by a person eligible for a waiver.

9 (c) The proceeds of an education loan, grant, or scholarship received by a
10 person eligible for a waiver under this section must be paid to the educational
11 institution to offset the person's tuition, fees, and room and board expenses.

12 (d) A state-supported educational institution in the state is required to provide
13 a waiver under (a) of this section only if the legislature appropriates funds for the
14 purpose of offsetting waivers under this section. If an appropriation is not sufficient to
15 fully offset waivers for each person entitled to a waiver under (a) of this section, the
16 institution may offer full or partial waivers to eligible applicants as funding permits
17 and at the discretion of the institution.

18 * Sec. 3. AS 14.43.160 is amended by adding a new paragraph to read:

19 (7) "out-of-home care" has the meaning given in AS 47.14.400.

20 * Sec. 4. AS 36.30.850(b)(42) is amended to read:

21 (42) grants and contracts with qualified entities for services under
22 AS 47.18.330 for the out-of-home [FOSTER] care transition program;

23 * Sec. 5. AS 47.05.060 is amended to read:

24 **Sec. 47.05.060. Purpose and policy relating to children.** The purpose of this
25 title as it relates to children is to secure for each child the care and guidance,
26 preferably in the child's own home, as well as an education, that will serve the moral,
27 emotional, mental, intellectual, and physical welfare of the child and the best interests
28 of the community; to preserve and strengthen the child's family ties unless efforts to
29 preserve and strengthen the ties are likely to result in physical or emotional damage to
30 the child, removing the child from the custody of the parents only as a last resort when
31 the child's welfare or safety or the protection of the public cannot be adequately

1 safeguarded without removal; and, when the child is removed from the family, to
2 secure for the child adequate custody, education, and care and adequate planning for
3 permanent placement of the child.

4 * Sec. 6. AS 47.05.065 is amended to read:

5 **Sec. 47.05.065. Legislative findings related to children.** The legislature finds
6 that

7 (1) parents have the following rights and responsibilities relating to the
8 care and control of their child while the child is a minor:

9 (A) the responsibility to provide the child with food, clothing,
10 shelter, education, and medical care;

11 (B) the right and responsibility to protect, nurture, train, and
12 discipline the child, including the right to direct the child's medical care and
13 the right to exercise reasonable corporal discipline;

14 (C) the right to determine where and with whom the child shall
15 live;

16 (D) the right and responsibility to make decisions of legal or
17 financial significance concerning the child;

18 (E) the right to obtain representation for the child in legal
19 actions; and

20 (F) the responsibility to provide special safeguards and care,
21 including appropriate prenatal and postnatal protection for the child;

22 (2) it is the policy of the state to strengthen families and to protect
23 children from child abuse and neglect; the state recognizes that, in some cases,
24 protection of a child may require removal of the child from the child's home; however,

25 (A) except in those cases involving serious risk to a child's
26 health or safety, the Department of Health and Social Services should provide
27 time-limited family support services to the child and the child's family in order
28 to offer parents the opportunity to remedy parental conduct or conditions in the
29 home that placed the child at risk of harm so that a child may return home
30 safely and permanently; and

31 (B) the state also recognizes that when a child is removed from

1 the home, visitation between the child and the child's parents or guardian and
2 family members reduces the trauma for the child and enhances the likelihood
3 that the child will be able to return home; therefore, whenever a child is
4 removed from the parental home, the Department of Health and Social
5 Services should encourage frequent, regular, and reasonable visitation of the
6 child with the child's parent or guardian and family members;

7 (3) it is the policy of the state to recognize that, when a child is a ward
8 of the state, the child is entitled to reasonable safety, adequate care, and adequate
9 treatment and that the Department of Health and Social Services as legal custodian and
10 the child's guardian ad litem as guardian of the child's best interests and their agents
11 and assignees, each should make reasonable efforts to ensure that the child is provided
12 with reasonable safety, adequate care, and adequate treatment for the duration of time
13 that the child is a ward of the state;

14 (4) it is in the best interests of a child who has been removed from the
15 child's own home for the state to apply the following principles in resolving the
16 situation:

17 (A) the child should be placed in a safe, secure, and stable
18 environment;

19 (B) the child should not be moved unnecessarily;

20 (C) a planning process should be followed to lead to permanent
21 placement of the child;

22 (D) every effort should be made to encourage psychological
23 attachment between the adult caregiver and the child;

24 (E) frequent, regular, and reasonable visitation with the parent
25 or guardian and family members should be encouraged; [AND]

26 (F) parents and guardians must actively participate in family
27 support services so as to facilitate the child's being able to remain in the home;
28 when children are removed from the home, the parents and guardians must
29 actively participate in family support services to make return of their children
30 to the home possible; and

31 (G) the child should continue to attend the child's school of

1 **origin as provided under AS 14.03.096;**

2 (5) numerous studies establish that

3 (A) children undergo a critical attachment process before the
4 time they reach six years of age;

5 (B) a child who has not attached with an adult caregiver during
6 this critical stage will suffer significant emotional damage that frequently leads
7 to chronic psychological problems and antisocial behavior when the child
8 reaches adolescence and adulthood; and

9 (C) it is important to provide for an expedited placement
10 procedure to ensure that all children, especially those under the age of six
11 years, who have been removed from their homes are placed in permanent
12 homes expeditiously.

13 * Sec. 7. AS 47.07.020(b) is amended to read:

14 (b) In addition to the persons specified in (a) of this section, the following
15 optional groups of persons for whom the state may claim federal financial
16 participation are eligible for medical assistance:

17 (1) persons eligible for but not receiving assistance under any plan of
18 the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act,
19 Supplemental Security Income) or a federal program designated as the successor to the
20 aid to families with dependent children program;

21 (2) persons in a general hospital, skilled nursing facility, or
22 intermediate care facility, who, if they left the facility, would be eligible for assistance
23 under one of the federal programs specified in (1) of this subsection;

24 (3) persons under 21 years of age who are under supervision of the
25 department, for whom maintenance is being paid in whole or in part from public
26 funds, and who are in out-of-home care [FOSTER HOMES] or private child-care
27 institutions;

28 (4) aged, blind, or disabled persons, who, because they do not meet
29 income and resources requirements, do not receive supplemental security income
30 under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not
31 receive a mandatory state supplement, but who are eligible, or would be eligible if

1 they were not in a skilled nursing facility or intermediate care facility to receive an
2 optional state supplementary payment;

3 (5) persons under 21 years of age who are in an institution designated
4 as an intermediate care facility for the mentally retarded and who are financially
5 eligible as determined by the standards of the federal program designated as the
6 successor to the aid to families with dependent children program;

7 (6) persons in a medical or intermediate care facility whose income
8 while in the facility does not exceed \$1,656 a month but who would not be eligible for
9 an optional state supplementary payment if they left the hospital or other facility;

10 (7) persons under 21 years of age who are receiving active treatment in
11 a psychiatric hospital and who are financially eligible as determined by the standards
12 of the federal program designated as the successor to the aid to families with
13 dependent children program;

14 (8) persons under 21 years of age and not covered under (a) of this
15 section [,] who would be eligible for benefits under the federal program designated as
16 the successor to the aid to families with dependent children program, except that they
17 have the care and support of both their natural and adoptive parents;

18 (9) pregnant women not covered under (a) of this section and who
19 meet the income and resource requirements of the federal program designated as the
20 successor to the aid to families with dependent children program;

21 (10) persons under 21 years of age not covered under (a) of this section
22 who the department has determined cannot be placed for adoption without medical
23 assistance because of a special need for medical or rehabilitative care and who the
24 department has determined are hard-to-place children eligible for subsidy under
25 AS 25.23.190 - 25.23.210;

26 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title
27 XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom
28 a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title
29 XVI, Social Security Act) because they meet all of the following criteria:

30 (A) they are 18 years of age or younger and qualify as disabled
31 individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

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(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as

1 defined by the United States Department of Health and Human Services and revised
2 under 42 U.S.C. 9902(2);

3 (15) persons who have been diagnosed with breast or cervical cancer
4 and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII);

5 (16) persons under 21 years of age who were in the custody of the
6 department under AS 47.10 or AS 47.14 and who were placed in out-of-home
7 care for a period of not less than six consecutive months on or after reaching 16
8 years of age.

9 * Sec. 8. AS 47.07.020 is amended by adding a new subsection to read:

10 (o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

11 * Sec. 9. AS 47.10.080 is amended by adding a new subsection to read:

12 (v) A social worker employed by or under contract with the department shall,
13 not less than monthly, conduct visits with a child committed to the custody of the
14 department under (c) of this section. The visits must be of sufficient substance and
15 duration to address issues pertinent to case planning and service delivery to ensure the
16 child's safety, permanency, and well-being. The majority of the visits conducted under
17 this subsection must be at the location of the child's current placement. Nothing in this
18 paragraph creates a private right of action against the department or the department's
19 contractors. In this subsection, "visit" means face-to-face contact between social
20 worker and child.

21 * Sec. 10. AS 47.10.990(3) is amended to read:

22 (3) "child" means a person who is

23 (A) under 18 years of age;

24 (B) [AND A PERSON] 19 years of age if that person was
25 under 18 years of age at the time that a proceeding under this chapter was
26 commenced; and

27 (C) under 21 years of age if that person is living in out-of-
28 home care;

29 * Sec. 11. AS 47.10.990 is amended by adding a new paragraph to read:

30 (33) "out-of-home care" has the meaning given in AS 47.14.400.

31 * Sec. 12. AS 47.18.300(a) is amended to read:

1 (a) The department, in coordination with local public and private agencies,
2 shall design, develop, and implement an out-of-home care [A FOSTER CARE]
3 transition program to provide support and services to individuals who

4 (1) reach or have reached the age of 16 or older while in state custody
5 and placed in out-of-home [FOSTER] care and have not yet reached 23 years of age;
6 and

7 (2) meet other eligibility criteria established by the department under
8 (b) of this section.

9 * Sec. 13. AS 47.18.310 is amended to read:

10 **Sec. 47.18.310. Program design.** The department, in coordination with local
11 public and private agencies, shall design the program as a continuation of the training
12 efforts related to independent living skills that were initiated for a child in state
13 custody who was placed in out-of-home care and [WHEN THE STATE FOSTER
14 CARE RECIPIENTS WERE] identified as being likely to remain in out-of-home
15 [STATE FOSTER] care until reaching not less than the age of 18. The program
16 design must require that program participants are directly involved in identifying the
17 program activities that will prepare them for independent living.

18 * Sec. 14. AS 47.18.320(a) is amended to read:

19 (a) Subject to the availability of an appropriation made for the purposes of
20 AS 47.18.300 - 47.18.390, the program may provide

21 (1) education and vocational training;

22 (2) assistance in obtaining basic education and training;

23 (3) career and employment services;

24 (4) training in basic life skills;

25 (5) housing and utility assistance;

26 (6) mentoring and counseling; and

27 (7) other appropriate services to complement the efforts of former state
28 foster care recipients or a child who was in state custody and placed in out-of-
29 home care to achieve self-sufficiency.

30 * Sec. 15. AS 47.18 is amended by adding a new section to read:

31 **Sec. 47.18.335. Monetary living expense stipend.** The department shall

1 provide to an individual receiving services under the program a monthly stipend in an
2 amount set by the department that is not less than the daily rate provided to a licensed
3 foster parent for necessary living expenses. The stipend shall continue for a period of
4 not more than one year after the individual leaves out-of-home care. The department
5 may adopt regulations to implement this section.

6 * Sec. 16. AS 47.18.390(1) is amended to read:

7 (1) "program" means the out-of-home [FOSTER] care transition
8 program authorized under AS 47.18.300 - 47.18.390;

9 * Sec. 17. AS 47.18.390(3) is repealed and reenacted to read:

10 (3) "out-of-home care" has the meaning given in AS 47.14.400.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSHB126(EDC)
() Publish Date: _____

Identifier (file name): HB126CS(EDC)-DHSS-CSM-02-25-09 Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless RDU: Children's Services
Component: Children's Services Management
Sponsor: Gara
Requester: House EDC Component Number: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personal Services							
Travel							
Contractual	204.2		0.0	0.0	0.0	0.0	0.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	204.2	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	73.5						
1003 GF Match	130.7						
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	204.2	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The intent of CS HB 126 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

The Office of Children's Services Online Resource for the Children of Alaska (ORCA) data base is mandated by the federal government and must be continuously updated to reflect changes in both state and federal law and policy. The following provides the estimated cost of ORCA updates that will be required to implement this bill.

Prepared by: Tammy Sandoval, Director Phone 465-3191
Division: Office of Children's Services Date/Time 2/20/09 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner Date 2/25/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. CS HB 126 (EDC)

ANALYSIS CONTINUATION

Requirement	Functional LOE (hours)	Development LOE (hours)	Total LOE (hours)	Cost
Update Services page for new services.	120	80	200	\$22,000.00
Update Education page with post-secondary educational institutions.	80	60	140	\$15,400.00
Update OHP for unlicensed independent living service categories and service types.	120	80	200	\$22,000.00
Update OHP for licensed service categories and service types over 18.	120	100	220	\$24,200.00
Update Ref Value for age change from 18 to 21	80	60	140	\$15,400.00
Update Eligibility page calculations for new age requirement.	180	160	340	\$37,400.00
Update Medicaid Eligibility page calculations for new page	180	160	340	\$37,400.00
Visitation Report	40	36	76	\$8,360.00
Hatch updates for OHP and Eligibility	40	160	200	\$22,000.00
Days:	960/8 = 120 days	896/8 = 112 days	1856/8 = 232 total days	Total Estimate \$204,160.00

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSHB126(EDC)
() Publish Date: _____

Identifier (file name): HB126CS(EDC)-DHSS-FCBR-02-25-09 Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless RDU: Children's Services
Component: Foster Care Base Rate
Sponsor: Gara
Requester: House EDC Component Number: 2236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims		725.0		445.2	445.2	445.2	445.2	445.2
Miscellaneous								
TOTAL OPERATING		725.0	0.0	445.2	445.2	445.2	445.2	445.2

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0		55.6	73.9	73.9	73.9	73.9
1003 GF Match	725.0		389.6	371.3	371.3	371.3	371.3
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	725.0	0.0	445.2	445.2	445.2	445.2	445.2

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The intent of CS HB 126 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

Sec. 11 amends AS 47.10.990 to change the definition of child to include under age 21 years if that person is living in out-of-home care as defined in AS 47.14.400.

Prepared by: Tammy Sandoval, Director Phone: 465-3191
Division: Office of Children's Services Date/Time: 2/23/09 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner Date: 2/25/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

BILL NO. CS HB 126 (EDC)

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Assumptions applied to this fiscal note:

Foster care reimbursement payments will be made available to care for children who remain in the custody of the state, who are age 18 through 20;

Approximately 15% (17 children) of the 110 that turn age 18 annually will chose to stay in foster care until age 19; 10% (10) to age 20; 5% to 21 (6); totaling 34 children. This is based simply on program experience and the assumption that most children will want to leave foster care at age 18, but that others who have stable homes will decide to stay with their foster families and that most of these children will attend post secondary education programs.

In addition to the 33 children who may wish to participate in the program in its initial year, approximately 12 of those special needs children who are 18 years of age, 6 at age 19, and 6 at age 20 will remain in care for 2010, bringing the total for 2010 to 57 children. This is based on the current numbers of children who age out with special needs. We estimate that 18 children with special needs age out annually, with 6 of them already staying in foster care until age 20, leaving 12 that may chose to stay in care.

For years 2011 - 2015, the number of participants has been reduced to 35, where it may stabilize because OCS speculates those children reaching the age of 19 or 20 will more likely opt to chose the monetary stipend in this bill.

Calculations are based on 360 days at an average base foster care base rate of \$35.33 a day $35.33 \times 30 = 1,060$. This calculation is used to equally distribute funding estimates, and makes very little difference to the resulting totals.

Currently, federal reimbursement for the extension of the foster program is not available, however, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to extend the assistance age through 20. This fiscal note assumes that option will be implemented when available October 1, 2010, therefore is available for the final three quarters of state fiscal year 2011 forward only.

SFY	# of Children	Age	Annual Cost Per Child	Total Est.	FFP	GF
2010	57	18, 19, 20	\$12,719	\$724,972	\$0	\$724,972
2011	35	18, 19, 20	\$12,719	\$445,158	\$55,631	\$389,527
2012	35	18, 19, 20	\$12,719	\$445,158	\$73,862	\$371,296
2013	35	18, 19, 20	\$12,719	\$445,158	\$73,862	\$371,296
2014	35	18, 19, 20	\$12,719	\$445,158	\$73,862	\$371,296
2015	35	18, 19, 20	\$12,719	\$445,158	\$73,862	\$371,296

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSHB126(EDC)
() Publish Date: _____

Identifier (file name): HB126CS(EDC)-DHSS-FP-02-25-09 Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless RDU: Children's Services
Component: Family Preservation
Sponsor: Gara
Requester: House EDC Component Number: 1628

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims		1,971.4		953.9	953.9	953.9	953.9	953.9
Miscellaneous								
TOTAL OPERATING		1,971.4	0.0	953.9	953.9	953.9	953.9	953.9

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			119.2	158.3	158.3	158.3	158.3
1003 GF Match			834.7	795.6	795.6	795.6	795.6
1004 GF	1,971.4						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	1,971.4	0.0	953.9	953.9	953.9	953.9	953.9

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The intent of CS HB 126 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

Sec. 14 amends AS 47.18 by adding a new section which will allow a monetary stipend, equal to the applicable foster care reimbursement rate, to individuals who are leaving foster care for a 1 year period only.

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services

Phone: 465-3191
Date/Time: 2/23/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date: 2/25/2009

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. CSHB126(EDC)

ANALYSIS CONTINUATION

Assumptions applied to this fiscal note:

The monetary stipends will be made available to children leaving out of home care, who are age 18 through 20, and does not need to be requested immediately upon leaving care;

70% of the 220 children currently participating in the Independent Living Program (IL) will become eligible for monetary stipends in FY 2010 (ages 18, 19, and 20) – equating to about 155 FTEs (full time equivalents), resulting in higher program costs the first year the stipends are available. FTEs help provide a more stable count as it is assumed that recipients will migrate on and off the program and not all will receive a full year's stipends;

After the first year of stipends, it is assumed that about 1/3 of the IL population will be eligible for and request monetary stipends annually equaling 75 FTEs, and that number will remain somewhat static;

Calculations are based on 360 days at an average base foster care base rate of \$35.33 a day $35.33 \times 30 = 1,060$.

Currently, federal reimbursement for the extension of the IL program is not available, however, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to extend the assistance age through 20 under certain conditions. This fiscal note assumes those conditions will be established in regulation and when met, IV-E reimbursement will apply. This option is available October 1, 2010, therefore is available for the final three quarters of state fiscal year 2011.

	FTEs	Cost Per Month	Total Cost	Estimated FFP	GF
SFY 2010	155	\$1,060	\$1,971,414	\$0	\$1,971,414
SFY2011	75	\$1,060	\$953,910	\$119,207	\$834,703
SFY2012	75	\$1,060	\$953,910	\$158,273	\$795,637
SFY2013	75	\$1,060	\$953,910	\$158,273	\$795,637
SFY2014	75	\$1,060	\$953,910	\$158,273	\$795,637
SFY2015	75	\$1,060	\$953,910	\$158,273	\$795,637

(3) Local educational agency requirements

(A) In general

The local educational agency serving each child or youth to be assisted under this part shall, according to the child's or youth's best interest -

(i) continue the child's or youth's education in the school of origin for the duration of homelessness -

(I) in any case in which a family becomes homeless between academic years or during an academic year; or

(II) for the remainder of the academic year, if the child or youth becomes permanently housed during an academic year; or

(ii) enroll the child or youth in any public school that nonhomeless students who live in the attendance area in which the child or youth is actually living are eligible to attend.

(B) Best interest

In determining the best interest of the child or youth under subparagraph (A), the local educational agency shall -

(i) to the extent feasible, keep a homeless child or youth in the school of origin, except when doing so is contrary to the wishes of the child's or youth's parent or guardian;

(ii) provide a written explanation, including a statement regarding the right to appeal under subparagraph (E), to the homeless child's or youth's parent or guardian, if the local educational agency sends such child or youth to a school other than the school of origin or a school requested by the parent or guardian; and

(iii) in the case of an unaccompanied youth, ensure that the homeless liaison designated under paragraph (1)(J)(ii) assists in placement or enrollment decisions under this subparagraph, considers the views of such unaccompanied youth, and provides notice to such youth of the right to appeal under subparagraph (E).

(5) Coordination

(A) In general

Each local educational agency serving homeless children and youths that receives assistance under this part shall coordinate -

(i) the provision of services under this part with local social services agencies and other agencies or programs providing services to homeless children and youths and their families, including services and programs funded under the Runaway and Homeless Youth Act (42 U.S.C. 5701 et seq.); and

(ii) with other local educational agencies on interdistrict issues, such as transportation or transfer of school records.

origin, as determined in paragraph (3)(A), in accordance with the following, as applicable:

(I) If the homeless child or youth continues to live in the area served by the local educational agency in which the school of origin is located, the child's or youth's transportation to and from the school of origin shall be provided or arranged by the local educational agency in which the school of origin is located.

(II) If the homeless child's or youth's living arrangements in the area served by the local educational agency of origin terminate and the child or youth, though continuing his or her education in the school of origin, begins living in an area served by another local educational agency, the local educational agency of origin and the local educational agency in which the homeless child or youth is living shall agree upon a method to apportion the responsibility and costs for providing the child with transportation to and from the school of origin. If the local educational agencies are unable to agree upon such method, the responsibility and costs for transportation shall be shared equally.

(2) COMPLIANCE-

(A) IN GENERAL- Each plan adopted under this subsection shall also describe how the State will ensure that local educational agencies in the State will comply with the requirements of paragraphs (3) through (7).

(B) COORDINATION- Such plan shall indicate what technical assistance the State will furnish to local educational agencies and how compliance efforts will be coordinated with the local educational agency liaisons designated under paragraph (1)(J)(ii).

(3) LOCAL EDUCATIONAL AGENCY REQUIREMENTS-

(A) IN GENERAL- The local educational agency serving each child or youth to be assisted under this subtitle shall, according to the child's or youth's best interest--

(i) continue the child's or youth's education in the school of origin for the duration of homelessness-OR OUT OF home or foster care

(I) in any case in which a family becomes homeless between academic years or during an academic year; or

(II) for the remainder of the academic year, if the child or youth becomes permanently housed during an academic year; or

(ii) enroll the child or youth in any public school that nonhomeless students who live in the attendance area in which the child or youth is actually living are eligible to attend.

(B) BEST INTEREST- In determining the best interest of the child or youth under subparagraph (A), the local educational agency shall--

(i) to the extent feasible, keep a homeless child or youth in the school of origin, except when doing so is contrary to the wishes of the child's or youth's ~~parent~~ guardian;

(ii) provide a written explanation, including a statement regarding the right to appeal under subparagraph (C), to the homeless child's or youth's ~~parent~~ guardian, if the local

(1)

School District

educational agency sends such child or youth to a school other than the school of origin or a school requested by the parent or guardian; and

(iii) in the case of an unaccompanied youth, ensure that the school district homeless liaison designated under paragraph (1)(J)(ii) assists in placement or enrollment decisions under this subparagraph, considers the views of such unaccompanied youth, and provides notice to such youth of the right to appeal under subparagraph

(E)

(C) ENROLLMENT- (i) The school selected in accordance with this paragraph shall immediately enroll the homeless child or youth, even if the child or youth is unable to produce records normally required for enrollment, such as previous academic records, medical records, proof of residency, or other documentation.

(ii) The enrolling school shall immediately contact the school last attended by the child or youth to obtain relevant academic and other records.

(iii) If the child or youth needs to obtain immunizations, or immunization or medical records, the enrolling school shall immediately refer the parent or guardian of the child or youth to the local educational agency liaison designated under paragraph (1)(J)(ii), who shall assist in obtaining necessary immunizations, or immunization or medical records, in accordance with subparagraph (D).

(D) RECORDS- Any record ordinarily kept by the school, including immunization or medical records, academic records, birth certificates, guardianship records, and evaluations for special services or programs, regarding each homeless child or youth shall be maintained--

(i) so that the records are available, in a timely fashion, when a child or youth enters a new school or school district; and

(ii) in a manner consistent with section 444 of the General Education Provisions Act (20 U.S.C. 1232g).

(E) ENROLLMENT DISPUTES- If a dispute arises over school selection or enrollment in a school--

(i) the child or youth shall be immediately admitted to the school in which enrollment is sought, pending resolution of the dispute;

(ii) the parent or guardian of the child or youth shall be provided with a written explanation of the school's decision regarding school selection or enrollment, including the rights of the parent, guardian, or youth to appeal the decision;

(iii) the child, youth, parent, or guardian shall be referred to the local educational agency liaison designated under paragraph (1)(J)(ii), who shall carry out the dispute resolution process as described in paragraph (1)(C) as expeditiously as possible after receiving notice of the dispute; and

(iv) in the case of an unaccompanied youth, the homeless liaison shall ensure that the youth is immediately enrolled in school pending resolution of the dispute.

(F) PLACEMENT CHOICE- The choice regarding placement shall be made regardless of whether the child or youth lives with the homeless parents or has been temporarily placed elsewhere.

and the person in charge of children's services for DHHS

2

Educational Stability for Youth in Foster Care

The McKinney-Vento Act¹ applies to many children in DFCS custody and provides those children with rights that promote educational stability.

What is the McKinney-Vento Act?

- ❖ McKinney-Vento is a federal law that promotes stability, access, and academic success for homeless youth. McKinney-Vento also provides assistance for homeless youth with enrollment in a new school, transportation to school, and other educational and supplemental services. It promotes educational stability by allowing homeless youth to remain in their school of origin even if homelessness has caused them to move outside the school district. School of origin is defined as the school a student attended before becoming homeless or the school where the student was last enrolled.

Are children in foster care homeless?

- ❖ In order to be eligible for the benefits and services provided for by the McKinney-Vento Act, a student must meet the criteria for homelessness. Some children in foster care meet the criteria and are therefore considered homeless under the Act.
- ❖ The McKinney-Vento Act defines homeless children and youth as "(A) individuals who lack a fixed, regular and adequate nighttime residence...; and (B) includes – (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; *are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement...*"² Thus, some children in DFCS custody are considered homeless for the purpose of the McKinney-Vento Act, specifically children living in shelters, abandoned in hospitals, and children awaiting foster care placement
- ❖ Using McKinney-Vento to secure rights for children in foster care helps to minimize educational disruption. The child is able to remain in the same school, continue with the current academic curriculum, and is less likely to fall behind academically.

Are children covered by McKinney-Vento after they move into a foster home?

- ❖ Once the provisions of McKinney-Vento have been met, an eligible child remains eligible for services for the remainder of that school year even if s/he moves into a foster home.
- ❖ When the next school year begins, if the child continues to live in a foster home, s/he will no longer qualify under McKinney-Vento and at that time may have to transfer to a school in the district where s/he is residing.

What about the documents schools require to enroll a child in school?

- ❖ McKinney-Vento requires schools to immediately enroll homeless children in school even without records normally required for enrollment, such as previous academic records, medical records including immunization records, proof of guardianship, and proof of residency.
- ❖ The enrolling school must contact the last school attended to obtain relevant records to facilitate enrollment and the school should refer the child to the school liaison for assistance in obtaining immunization records.

What if the child has moved out of district and the old school refuses to allow the child to continue to attend?

- ❖ All decisions about where a homeless child shall be allowed to go to school must be made according to the child's best interests. In determining best interests of the child, the local educational agency shall "to the extent feasible, keep a homeless child or youth in the school of origin, except when doing so is contrary to the wishes of the child's or youth's parent or guardian."³

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- ❖ Whenever there is a disagreement between a school and a parent, guardian, or youth, the school must:
 - Immediately enroll the student in the school the parent, guardian, or youth chooses;
 - Keep the student at that school until the disagreement is settled;
 - Explain, in writing, its decision and the right to have the disagreement settled; AND
 - Send the parent, guardian or youth to the Georgia Liaison/Coordinator of Education for Homeless Children and Youth to settle the disagreement quickly. Please see the contact information below.

What if it is best to transfer the child to a new school in the district where the foster parents or relative placement live?

- ❖ Homeless children and youth have the right to stay in the school they went to before they lost their housing, to stay at whatever school they were enrolled in last, or to attend the local school where they are now living.

Is there any help with transportation?

- ❖ If McKinney-Vento applies to the child, then the school district must provide or arrange transportation for the student to stay at the school of origin, even if the student moves to a different city, county, or school district.
 - If a student is living in the same school district as the school of origin, then that school district has to provide transportation. If the student moves across district lines, then both districts have to work together to provide transportation.

What type of transportation will the school provide?

- ❖ Schools can provide transportation in different ways, including:
 - Re-routing school buses and making sure buses go to shelters, group homes and other places where students live;
 - Providing passes for public buses and subways, including passes for caretakers when needed;
 - Using the transportation systems social services use;
 - Using approved van or taxi services;
 - Reimbursing parents, guardians or youth for gas;
 - Working with service providers and public assistance agencies to make transportation plans or provide transportation;
 - Getting local businesses or other agencies to help with transportation costs; and

Where can I get more information?

- ❖ The National Law Center on Homelessness & Poverty, www.nlchp.org.
- ❖ Georgia's Education for Homeless Children and Youth Coordinator is Mr. David Davidson. He can be reached at phone 404-651-7555 or e-mail ddavidso@doe.k12.ga.us.
- ❖ The Georgia Law Center for the Homeless, www.galawcenter.org, phone: 404-681-0680.

¹ The McKinney -Vento Act codified as amended at 42 U.S.C.A. §11432 through §11434a(2)(2004).

² 42 U.S.C.A. §11434a(2)(B)(2004)(emphasis added).

³ 42 U.S.C.A. §11432(3)(B)(i)(2004).

ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA

MEMORANDUM

DATE: March 11, 2009

TO: Representative Wes Keller
Representative Bob Herron

FROM: Representative Les Gara

RE: Departments affected by HB126

Department of Health and Social Services
Department of Education
University of Alaska

Facing Foster Care in Alaska **Policy Agenda 2008**

In May of 2008, the youth and alumni of Facing Foster Care in Alaska, (FFCA) came together from across the state and gathered in Anchorage to share their ideas and experiences about life in Alaska's foster care system. During their gathering youth/alumni brainstormed ideas on what they thought would be most beneficial to them and others in foster care in Alaska. As a result of these ideas, the members of FFCA voted to create this policy agenda.

Tuition Waivers for ALL foster youth in the state of Alaska

The University of Alaska Anchorage currently offers 10 Presidential Tuition Waivers a year to foster youth who are eligible for the OCS Independent Living Program. A young person must have been in foster care on or after their 16th birthday for six consecutive months in order to be eligible for the waiver program. Since these waivers are competing, not every young person in Alaska who applies will receive one. Youth who are placed in a guardianship, adopted, or reunified before age 16 are not eligible to apply for the waiver. Many states provide Tuition Waivers or other forms of reimbursement for college expenses to foster youth interested in pursuing post-secondary education. The youth and alumni of FFCA feel that by providing All of Alaska's foster youth with tuition waivers there would be a higher percentage of foster youth attending post-secondary education. Studies show that approximately 17% of young people who exit foster care pursue post-secondary education, and only about 1% graduate from a four year degree or certificate program. FFCA would like to see that All of Alaska's foster youth are provided with tuition waivers to reduce the stress of worrying about college expenses and knowing that they are guaranteed a higher education.

Support to foster youth pursuing post-secondary education

Many of the youth and alumni who attend post-secondary education programs in Alaska have complained about not having any supports to help them achieve their goals. FFCA members would like to see that universities and vocational programs have supports put in place for foster youth transitioning to higher education. FFCA members recommended adult or alumni mentors, a family to spend the holidays with, and someone within the

university or vocational program to talk with about stressors. If every youth in Alaska's foster care system made a permanent connection with a caring adult during their stay in foster care this would be less of an issue. FFCA members also recommended implementing the, "Circles of Support Program," to ensure youth in care are making permanent connections with caring adults before exiting from care.

More Independent Living Funds going to youth/alumni

The state of Alaska currently gets approximately \$500,000 a year (FY2008 \$518,814) in Federal Chafee funds to be used for youth in foster care to work toward independent living. There is currently no state match for this money and it is being stretched very thin as the states Independent Living Program grows, and begins to offer more programs and resources to youth in transition. The youth and alumni of FFCA would like to see that more of this money is offered to youth and alumni transitioning from foster care for housing, education, life skills training, and anything that may support them in becoming independent productive members of society. FFCA is also aware that many states provide a match for the Chafee dollars they receive and would like to see that this is made possible by the state of Alaska.

Transitional Living for youth

Alaska currently allows for youth who turn 18 in foster care the option to extend their time in state custody until the age of 20. There many states that allow for youth to extend custody until age 21, or to leave custody and re-enter if they are willing to pursue post-secondary education. According to the Alaskan Alumni Study 38% of Alaska's alumni reported being homeless after exiting foster care. The Covenant House Shelter in Anchorage reports that two-thirds of their current population is comprised of current and former OCS youth. The youth and alumni of FFCA would like to see a stronger focus in the area of transitional housing for youth who exit from the foster care system. FFCA members shared ideas and recommend allowing youth to remain in state custody while living in college dorms, apartments on their own, or other least restrictive environments outside of the traditional family foster home after reaching age 18.

Independent Housing Program

Some states currently allow for foster youth to live, "on their own," after reaching age 18, but to remain in state custody and receive foster care payments on behalf of themselves until the age of 21. This allows for foster youth to continue services with their social worker as well as other services offered to youth in custody, and learn to successfully transition out of state custody. The youth and alumni of FFCA would like to see a program such as this put into place in Alaska, or for the state to consider more creative placements for young people once they reach 18, but are not ready to exit from foster care.

Medicaid increased to age 21 under the Chafee Independence Act

There are currently 17 states that have chosen to enact the Chafee option to extend Medicaid to age 21 for former foster youth, Alaska is not one of these states. Currently, youth in Alaska's foster care system can receive Denali Kid Care until age 19 under the 1115 Waiver. After age 19 these young people can apply for adult Medicaid, but this holds them back from obtaining decent paying jobs and forces them to choose to go without medical coverage. Youth in foster care often attend counseling and have other medical needs, but they are forced to cut off many of these services when they leave custody. The youth and alumni of FFCA would like to see that Medicaid is increased for Alaska's foster youth to age 21 under the Chafee Foster Care Independence Act.

Braces covered under Medicaid

Children and youth in Alaska's foster care system often have only their Basic needs met because there is a strong emphasis on safety and permanency. There is little or no value put on whether a young person in custody needs braces, as this is usually a cosmetic procedure that parents would normally pay for. The youth and alumni of FFCA felt very strongly about this issue and believe that braces should be covered under Medicaid or by OCS. FFCA members discussed how braces could support higher self-esteem for a young person in foster care, and would give them one less thing to worry about besides the social pressures they face as a, "foster youth." FFCA is also aware that braces are covered under Medicaid in the state of Texas, so this could be an option for Alaska.

Decreased use of Psychotropic Medication for Alaska's foster youth

Many of Alaska's youth and alumni complain about being prescribed psychotropic medications after entering the foster care system for symptoms of depression, anxiety, trauma, attachment issues, and misbehavior. The youth and alumni of FFCA feel that these are all normal symptoms of child maltreatment and dealing with all that comes out of being placed in foster care. There has been a national focus on the use of psychotropic medications being over-prescribed for children and youth in foster care. FFCA members have also complained about side-effects caused by these medications resulting in a decreased ability to focus on their education as well as function in everyday society. The youth and alumni of FFCA would like to see that the prescription of psychotropic medications for Alaska's foster children and youth is decreased and reviewed more closely.

Definitions (according to FFCA)

Youth- A young person currently in state custody (foster care).

Alumni- A person who has spent any period of time in the foster care system

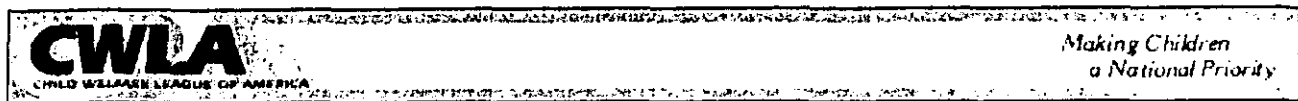
Facing Foster Care in Alaska (FFCA)

Mission Statement: Our mission is to improve the foster care system through sharing our experiences, supporting and educating youth and social services and implementing positive change in society as a whole.

FFCA is Alaska's only foster care advocacy organization completely run by youth and alumni of the foster care system. Since their inception in 2003, FFCA has been working to improve Alaska's foster care system by sharing their experiences with people who can create positive changes for Alaska's foster youth. FFCA is a statewide organization that provides support to Alaska's foster youth and alumni and, gives them the ability to share their voice and become leaders in their community.

Acknowledgements

This document was drafted using the feedback from the youth and alumni of Facing Foster Care in Alaska (FFCA). Statistics and information provided by Casey Family Programs and the Office of Children's Services as well as, various other child welfare resources. For questions regarding the content of this policy agenda contact: Amanda Metivier *FFCA President* Ametivier@casey.org



CWLA 2008 Children's Legislative Agenda

Youth Services

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Action

- Pass the Foster Care Continuing Opportunities Act.
- Pass the Medicaid Foster Care Coverage Act.
- Expand eligibility and improve services to youth in the child welfare system, or who were formerly in child welfare, through the John H. Chafee Foster Care Independence Program. Expand eligibility for independent living services to age 24, including room and board. Increase funding to at least \$200 million to support expansion of eligibility and services.
- Improve education opportunities for youth in foster care by making improvements to the Education and Training Voucher program. Increase funding for the voucher program to at least \$60 million and ensure all of the funds are used for this purpose.
- Include provisions in the reauthorization of the No Child Left Behind Act to enhance education supports for children in foster care.
- Provide the necessary resources for implementing the National Youth in Transition Database.

History

Federal support for independent living services for foster youth began in 1986 when Title IV-E was amended to include the Independent Living Program to assist youth who would eventually be emancipated from foster care. In 1993, Congress permanently extended the authority for independent living. Significant improvements were enacted in 1999 with passage of the John H. Chafee Foster Care Independence Program, in honor of the Rhode Island senator who was one of the law's sponsors and who died before it was enacted. The law allows states to extend Medicaid coverage to former foster children between 18 and 21 years old, and funding was doubled to \$140 million per year, which became effective in 2001. Also in 2001, Congress authorized an additional \$60 million in discretionary funds for education and training vouchers for youth who are eligible for the Foster Care Independence Program, as well as youth who are adopted from foster care after reaching age 16.

Foster Care Continuing Opportunities Act

Senator Barbara Boxer (D-CA) introduced the Foster Care Continuing Opportunities Act (S. 1512) on May 24, 2007. This legislation would extend Title IV-E foster care funding to age 21.

In 2005, 24,211 young people left foster care simply because they became too old. This is referred to as aging-out of foster care. Many young people transitioning out of the foster care system face great instability once finding themselves on their own, with few, if any, financial resources, no place to live, and little or no support from family, friends, and community. The experiences of these youth place them at higher risk for unemployment, poor educational outcomes, health issues, early parenthood, long-term dependency on public assistance, increased rates of incarceration, and homelessness.

This legislation would simply amend the current law that defines foster children to age 18. States would have an option to extend this to age 21. Under current law, limited funds are available under the John H. Chafee Foster Care Independence Program (*see below*).

Medicaid Foster Care Coverage Act

Rep. Dennis Cardoza (D-CA) introduced the Medicaid Foster Care Coverage Act (H.R. 1376) on March 7, 2007. This legislation amends title XIX of the Social Security Act to establish independent foster care adolescents as a mandatory category of individuals for coverage under state Medicaid programs.

For young people leaving foster care, lack of health care poses a substantial challenge. The Chafee Program allows states to extend Medicaid coverage to former foster children between ages 18 and 21. Despite Medicaid's tremendous advantage for youth in foster care, only 17 states had implemented the extension by early 2007.

Given the high rates of physical and mental health problems extensively documented among children and youth in foster care, access to health services is a critical factor as young people transition to adulthood. Because most children and youth in foster care are covered by Medicaid, use of the expansion option would allow a state to readily facilitate the transfer of a youth's Medicaid eligibility from one category to another without any gap in coverage as they exit foster care. Medicaid coverage should continue for all foster youth until at least age 21. Keeping medical records up to date and accessible is another challenge for young people involved with child welfare. Advances have been made in electronic record keeping, but more are needed.

John H. Chafee Foster Care Independence Program

The John H. Chafee Foster Care Independence Program helps states provide services to young people who are likely to remain in foster care until age 18, as well as former foster children beyond age 18. The program helps eligible children make the transition to self-sufficiency through such services as assistance in earning a high school diploma, support in career exploration, vocational training, job placement and retention, and training in daily living skills. In addition to the Medicaid coverage, the program allows up to 30% of the funds be used for room and board. Chafee is a capped entitlement with an annual ceiling of \$140 million, which has not been increased since 2001.

Adolescents constitute a major segment of the youngsters the child welfare system serves. Most youth enter out-of-home care as a result of abuse, neglect, and exploitation. Others have run away from home or have no home. Young people transitioning out of the foster care system are significantly affected by the instability that accompanies long periods of out-of-home placement during childhood and adolescence.

The resulting harm to the youth themselves, their communities, and the society at large is unacceptably high. To reduce these outcomes, outreach to youth and the quality of services provided need to be improved. In addition, expanding eligibility for critical support for young people leaving

foster care will ensure a successful transition to independence and self-sufficiency, and reduce the numbers of young people who become homeless, unemployed, incarcerated, and/or at high risk of becoming victims and victimizers. To accomplish this improvement and expansion, funding for the Chafee Foster Care Independence Program needs to be increased significantly.

Education

Reauthorizing the Title X, Part C of the No Child Left Behind (NCLB) McKinney-Vento Homeless Assistance Act (McKinney-Vento) is an opportunity to improve education outcomes for children and youth in foster care. McKinney-Vento provides access to essential federal education protections and rights for homeless children and youth. Children and youth who are eligible for McKinney-Vento have access to supports for school success that many children involved in child welfare lack: school stability or immediate enrollment if stability is not possible, school staff charged with ensuring their prompt enrollment, and more. While these protections currently apply to a subset of children involved in foster care, including those "awaiting foster care placement," states have defined this phrase differently. States vary widely in their application of these protections for this population. As a result, the opportunities for children and youth in foster care may depend on where they live. The reauthorization of McKinney-Vento provides an opportunity to ensure these protections are available to all children in foster care, with special accommodation for the needs and family dynamics that face children in foster care.

The Education and Training Voucher (ETV) program provides assistance of up to \$5,000 per year for the cost of attendance at an institution of higher education for youth who age out of foster care or are adopted after age 16. Funding for this program has never reached the amount requested by President Bush-\$60 million-which itself is not enough to meet the need. The ETV program began receiving funds in 2003 and was set at \$42 million. In 2005, funding increased to \$46.6 million; however, for FY 2008, funds were reduced to \$45.3 million. Funding for the ETV program should be expanded to at least the level proposed by the President. Further improvements to the ETV program are needed, including adjusting eligibility to include youth adopted after age 14, and requiring technical assistance for states to ensure funds are fully utilized. Also, instead of being returned to the federal treasury, unused state ETV funds should be transferred to other states' ETV programs with demonstrated unmet need.

National Youth In Transition Database

Congress should provide the resources necessary for implementation of the National Youth in Transition Database. This new initiative is a tremendous opportunity to provide valuable information that will inform future improvements in services to young people. The funds for implementation should be a priority for Congress and not come at the expense of existing services or supports or reduced services to adolescents receiving Chafee and ETV funding.

Key Facts

- In 2005, 24,211 children aged-out of out-of-home care. ^{1, 2}
- A study of young adults who had spent a year or more in foster care between age 14 and 18 found that 25% had experienced post-traumatic stress, compared to 4% of the general adult population. ³
- Three in 10 of the nation's homeless adults report foster care history. ⁴

- A recent study found that one-third of older youth in foster care were identified by caseworkers as having one or more special mental health, medical, pregnancy and parenting, substance abuse, or developmental needs that significantly interfered with their ability to live independently.⁵
- In Clark County, Nevada, 55% of former foster youth reported not having health insurance after leaving foster care.⁶
- Forty-four percent of former foster youth in Wisconsin reported difficulty accessing health and mental health services.⁷
- The rate at which foster youth complete high school (50%) is significantly below the rate of their peers (70%), and the rate at which college-qualified foster youth attend postsecondary education (20%) is substantially below the rate of their peers (60%).⁸
- The Census Bureau reports college graduates make \$23,000 more per year than those with high school diplomas.⁹

Sources

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CWLA Contact

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California's Fostering Connections to Success Act and the Costs and Benefits of Extending Foster Care to 21*

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EXECUTIVE SUMMARY

This report analyzes the potential costs and benefits of allowing foster youth to remain in care until age 21, the policy encouraged by the Fostering Connections to Success and Increasing Adoptions Act and proposed in California's Assembly Bill 12, the California Fostering Connections to Success Act. Our estimates of the costs of extending care are based on the experience of Illinois in providing care past age 18 and data on public assistance receipt by youth aging out of foster care. Our estimates of the potential benefits of extending care are based on college participation rates at age 21 suggestive of the effect of extending care on post-secondary educational attainment as well as data on increased work-life earnings associated with post-secondary education.

Our analyses lead to the following conclusions:

- We estimate that the average per youth cost of extending foster to age 21, net cost offsets associated with public assistance utilization when youth cannot remain in care, to be approximately \$37,948. Available state-level data on public assistance utilization suggest that the net cost of extending care in California may be a few hundred dollars less than our estimate. We would expect the Federal government to pay \$13,282, the State of California \$9,866, and the placing county \$14,800 per person to extend foster care in California to age 21.
- Our estimates of the benefits of extending care until age 21 on bachelor's degree completion range from approximately \$27,000 to \$196,000. The wide range reflects different assumptions about 1) college graduation by former foster youth generally and 2) the persistence over time of the educational advantages associated with remaining in care. Our best estimate is that the increase in bachelor's degree completion predicted to result from extending care to age 21 would increase per-person work-life earnings by approximately \$92,000. This represents about \$2.4 for every dollar spent.
- Even if we assume no continuation of the favorable educational trajectory observed at age 21 associated with the Illinois policy of extending care, we estimate that the per-person work-life earnings of foster youth making the transition to adulthood would increase by an average of \$84,000 as a result of allowing foster youth to remain in care until they are 21 years old. This conservative estimate is based only on the expected effect of extending care on the likelihood of completing at least some college and represents a return of over two dollars for every dollar spent.

There is good reason to believe that the stark differences in college attainment that we observe at age 21 and attribute to the extension of foster care in Illinois will, over time, result in advantages in terms of both degree completion and sub-baccalaureate attainment. Thus, it seems reasonable to assume that the average increase in work-life earnings that would result from extending foster care is substantially higher than either of our estimates suggest, although how much higher is not clear. Our estimates suggest that the costs associated with extending foster care to age 21--an option that is now much less costly to states as a result of the Fostering Connections Act--are more than offset by the potential benefits to foster youth and society.

Introduction

Although they make up a relatively small proportion of all children in foster care, foster youth approaching the transition to adulthood have, over the years, attracted considerable attention from policymakers. Title IV-E of the Social Security Act has been amended three times in the past twenty-five years as part of an effort to better support young people making this transition. The shift over time in federal policy arguably reflects an evolving understanding of normative transitions to adulthood, growing knowledge of the particular challenges faced by transitioning foster youth, and changing views of the state's role and responsibilities as corporate parent. In practice, few states allow young people to remain in care much beyond their eighteenth birthday largely because, until now, federal reimbursement for foster care maintenance and administration costs has been limited to youth under age 18, or until age 19 in the case of youth who are likely to graduate from high school or an equivalent program before their 19th birthday (Bussey et al., 2000).

However, the Fostering Connections to Success and Increasing Adoptions Act (Public Law 110-351, hereafter referred to as the "Fostering Connections Act"), passed unanimously in both houses of Congress and signed into law by President Bush in October 2008, amends Title IV-E of the Social Security Act to allow states, at their option, to care for and support foster youth until the age of 21 provided that the youth are either 1) completing high school or an equivalency program; 2) enrolled in post-secondary or vocational school; 3) participating in a program or activity designed to promote, or remove barriers to, employment; 4) employed for at least 80 hours per month; or 5) incapable of doing any of these activities due to a medical condition. Young people age 18 and older can be living independently in a supervised setting as well as placed in a foster home or group care setting, but the procedures afforded to state wards under age 18 (e.g., judicial or administrative case review every six months) would continue to apply. The Fostering Connections Act also requires child welfare agencies to help young people ages 18 and older develop a personal transition plan during the 90 days immediately before they exit care. The plan must be as detailed as the youth desires and include specific options for housing, health insurance, education, mentoring opportunities, continuing support services, workforce supports and employment services.

The Fostering Connections Act will begin reimbursing states that choose to extend foster care in fiscal year 2011 (i.e., October 2010).¹ In December 2008, California Assembly Bill 12, the California Fostering Connections to Success Act, was introduced. Among its provisions AB 12 would extend the California foster care program to age 21 in accordance with the provisions of the Fostering Connections Act. One factor that may help determine whether California policymakers decide to exercise this option is how the

¹ Depending on the state, the federal government provides reimbursement of 50% to 83% of foster care maintenance costs for children who are Title IV-E eligible, and states pay the rest. The federal portion or Federal Financial Participation (FFP) is the same as the state's Federal Medical Assistance Percentage (FMAP) and is based primarily on the state's per capita income. State with a higher per capita income have a lower FMAP. States are responsible for covering the entire cost of care for children who are not Title IV-E eligible. This would also apply to foster youth ages 18 and older.

benefits to foster youth and society compare with the costs to government. In this report, we provide some preliminary estimates of those benefits and costs using data from a variety of sources including the Midwest Evaluation of the Adult Functioning of Former Foster Youth ("Midwest Study"), the Illinois Department of Children and Family Services (DCFS), the 1988 National Education Longitudinal Study and the US Census Bureau.² We conclude that the benefits to foster youth and society of extending care outweigh the costs to government by a factor of at least two to one.

The Midwest Study

The Midwest Study is a collaborative effort among the public child welfare agencies in Illinois, Iowa, and Wisconsin, Chapin Hall at the University of Chicago, the University of Wisconsin Survey Center (UWSC), and Partners for Our Children (POC) at the University of Washington, Seattle. The Principal Investigator for the study, Mark E. Courtney, is currently Executive Director of POC and a Faculty Associate of Chapin Hall.

The Midwest Study is examining the transition to adulthood among foster youth from the three participating states who had entered care prior to their 16th birthday, were still in care at age 17, and whose primary reason for placement was not delinquency.³ Baseline interviews were conducted with 732 of the 758 young people eligible for the study, between May 2002 and March 2003 (63 from Iowa, 474 from Illinois, and 195 from Wisconsin) when they were 17 or 18 years old. That translates into a response rate of almost 97 percent. Eighty-two percent (n = 603) of this baseline sample (386 from Illinois, 54 from Iowa, and 163 from Wisconsin) were re-interviewed between March and December 2004 when nearly all (n = 575) were age 19. A third wave of survey data was collected between March 2006 and January 2007 from 81 percent (n = 591) of the baseline sample (364 from Illinois, 50 from Iowa, and 176 from Wisconsin) when almost all of the study participants were 21 years old. The interviews covered a variety of domains, including living arrangements, relationships with family of origin, social support, receipt of independent living services, education, employment, economic well-being, receipt of government benefits, physical and mental well-being, health and mental health service utilization, sexual behaviors, pregnancy, marriage and cohabitation, parenting, and criminal justice system involvement.

An important feature of the Midwest Study, and one that allows us to undertake this analysis, is that the three participating states have different child welfare policies regarding the age until which foster youth can remain in care. Foster youth in Iowa and

² This report was produced in response to a request from policymakers and advocates in California involved in developing legislation to extend foster care to age 21 in their state. The time constraints imposed by the legislative process meant that we needed to produce a best estimate of the potential benefits and costs associated with extending care using survey data from the Midwest Study. The authors of this report are engaged in a longer-term project aimed at a more thorough benefit-cost analysis of extending care than that reported here. We would like to thank the John D. and Catherine T. MacArthur Foundation and the Walter S. Johnson Foundation for their support of the work involved in producing this report.

³ For a more detailed description of the baseline study sample and procedures, see Courtney & Dworsky, 2006.

Wisconsin are generally discharged from care around the time of their 18th birthday and almost never after age 19. This is similar to what happens in most states. By contrast, Illinois is one of the few jurisdictions where foster youth can and routinely do remain in care until their 21st birthday.⁴ Despite some claims that many foster youth would choose not to remain under the care and supervision of the public child welfare agency and juvenile court beyond age 18 if given the opportunity, our data suggest that the opposite is true. Most of the young people from Illinois, who could have left care at any time after reaching the age of majority, were still in care on their 20th birthday, and many remained in care until age 21.

The Potential Costs of Extending Foster Care to 21

We estimate of the expected costs to government if foster care were extended until age 21 based on (1) the per day cost of caring for young people beyond their 18th birthday; (2) the average amount of time young people would remain in care after reaching age 18; and (3) the costs of public assistance that could be avoided if young people remained in care. The Illinois Department of Children and Family Services (DCFS) provided us with a weighted average of the per-day costs associated with different types of living arrangements (e.g., foster homes, supervised independent living, and subsidy payments for youth attending college) in 2007. Using their numbers, the average cost of keeping one Illinois youth in care after his or her 18th birthday is approximately \$20,800 per year.

We know from the Midwest Study that foster youth in Illinois are much older when they exit care than their counterparts in Iowa and Wisconsin. The average age at exit was 20 years old in Illinois compared with only 17.9 in Iowa and 17.8 in Wisconsin. This reflects the fact that all of the young people in the Wisconsin sample exited care before their 19th birthday as did nearly all of the young people in the Iowa sample. By contrast, more than half of the young people in the Illinois sample were still in care after their 20th birthday. Assuming that what happens in Illinois is similar to what would happen in other states if young people were allowed to remain in care until age 21, and that Iowa and Wisconsin are good examples of what happens in states that routinely discharge youth at age 18, extending care to age 21 would increase by about two years the average length of time states could expect to provide care. Multiplying the average estimated annual cost of extending care (i.e., \$20,800) by the average estimated increase in care years (2 years) produces an estimated average additional cost of \$41,600 per youth.

However, at least some of this cost would be offset by the avoidance of expenditures on public assistance. To estimate what those cost offsets might be, we draw primarily upon survey data collected from Midwest Study participants when they were 21 years old ($N = 555$). Table 1 shows both the percentage of study participants who reported that they

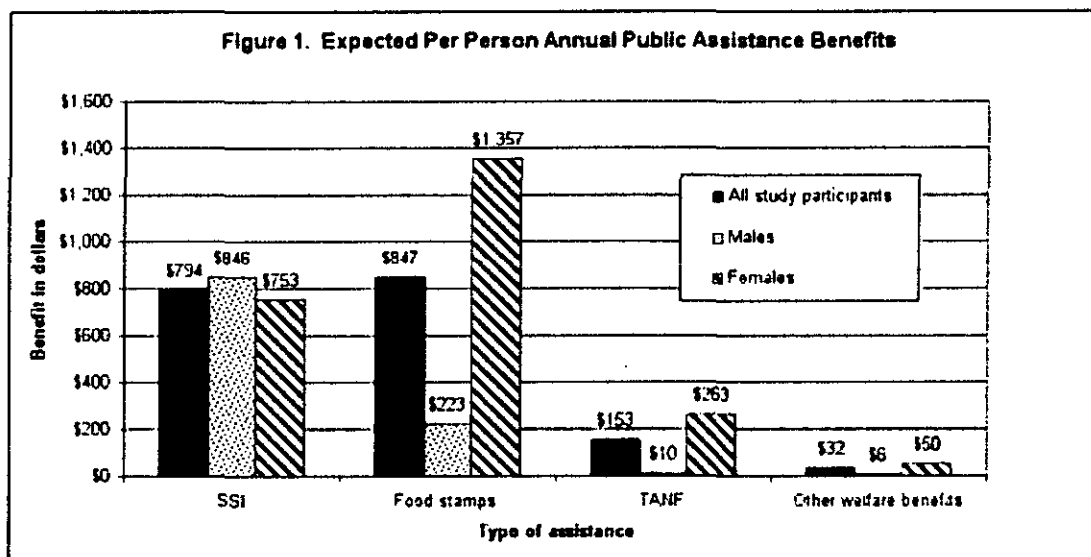
⁴ At the time these data were collected, Iowa foster youth could remain in care beyond their 19th birthday if the child welfare agency and juvenile court concluded that doing so would enable them to graduate from high school. However, only seven of the 63 Iowa youth in the Midwest Study sample were still in foster care at age 19.

were receiving public assistance as well as the mean benefit they were receiving each month.⁵

Table 1. Current Public Assistance Receipt at Age 21 (N = 555)

	% Receiving Assistance			Mean Monthly Benefit		
	Total	Male	Female	Total	Male	Female
SSI	11.9	12.8	11.2	\$555.90	\$550.59	\$560.00
Food stamps	32.5	9.9	50.2	\$217.24	\$187.33	\$225.31
TANF	2.9	0.4	4.8	\$440.13	\$200.00	\$456.13
Other cash welfare benefits	0.9	0.4	1.3	\$296.58	\$116.67	\$322.29

We used the reported monthly benefits to calculate what the annual benefits would be. If we assume that the percentage who were current recipients represents the probability of public assistance receipt, then the expected per person annual benefit is shown in Figure 1.



On average, Midwest Study participants received \$794 in SSI benefits, \$847 in food stamps benefits, \$153 in TANF benefits and \$32 in other welfare benefits, or a total of \$1,826 in benefits, over the course of a year. Because the young women were far more likely than young men to be custodial parents, and hence eligible for TANF, that value was considerably higher for females (\$2,423) and lower for males (\$1,083).⁶

Importantly, we limited our analysis to cash and “cash-like” (i.e., food stamp) benefits which were readily monetized. However, we know that some of these young people were receiving housing assistance (e.g., public housing, Housing Choice Vouchers) or benefits from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

⁵ “Other welfare benefits” would include SSI, general assistance, emergency assistance, or Cuban/Haitian or Indian assistance payments.

⁶ At age 21, 51 percent of the young women but only 11 percent of the young men were custodial parents.

If we had taken this other public assistance into account, the estimates shown in Figure 1 would have been higher.

Assuming average annual public assistance receipt of \$1,826 for each former foster youth between the ages of 18 and 21 and assuming that these costs are defrayed for two years on average when young people remain in care, the expected net cost of extending care would be reduced by \$3,652, or from \$41,600 to \$37,948. This is not a large reduction relative to the overall cost, but it should be acknowledged.

Estimating the Cost of Extending Care in California

It is important to consider whether the cost of extending care would be significantly different in California than in the three Midwest Study states. In the simplest terms, the cost to the California child welfare system of extending foster care from age 18 to 21 is a function of (1) the average cost per day of caring for young people age 18 and older in various placements under the new policy, (2) the number of youth in each kind of placement, and (3) the average increase in the number of days young people would remain in care beyond their 18th birthday. Unfortunately, these figures are unknown. In the absence of California-specific data, we assume that the per-day costs of extending care in California would be similar to the per-day costs in Illinois and that young people in California would behave like their Midwest Study counterparts and remain in care an average of two years longer than they do now. In other words, our best estimate of the additional costs to the California child welfare system of extending care would be \$41,600 per youth.

Although state-level data on public assistance receipt among 18-21 year olds, the population most affected by extending foster care, are not readily available, the cost offsets associated with the avoidance of public assistance receipt may be somewhat larger in California than the Midwest Study data would suggest. Between 2000 and 2002, the average percentage of low-income children receiving TANF benefits was 18 percent in California compared with only 11 percent in Illinois, 8 percent in Iowa, and 6 percent in Wisconsin (National Center for Children in Poverty, 2004). By contrast, Food Stamp receipt among low-income children varied relatively little across these states (National Center for Children in Poverty, 2004). Given that TANF benefits accounted for less than one-tenth of our estimated cost offset of \$3,652 per youth, the additional per youth cost offset in California is unlikely to exceed a few hundred dollars.

The costs of extending foster care to age 21 under the *Fostering Connections Act* will be shared among federal, state, and county governmental entities. In thinking about the fiscal implications of AB 12, California policy makers need to consider several factors: the state's Title IV-E reimbursement rate, the percentage of foster youth who would be Title IV-E eligible, and how costs are shared between counties and the state.

In California, for example, the proportion of foster children currently eligible for Title IV-E reimbursement is approximately 70 percent. Assuming that this proportion would be the same for foster youth between the ages of 18 and 21, the federal government would pay half of what it costs the state to keep 70 percent of these older foster youth in care, or 35 percent of the total. In addition, California has a county-administered child

welfare system, and foster care costs are shared between counties and the state, with counties paying 60 percent and the state paying 40 percent.

What this means in practice is that for the 30 percent of young people who would presumably not be eligible for Title IV-E reimbursement, foster care costs would be split between the county, which would cover 60 percent, and the state, which would cover 40 percent. By contrast, for the 70 percent of young people who would presumably be eligible for Title IV-E reimbursement, foster care costs would be divided among the county, which would cover 30 percent, the state, which would cover 20 percent, and the federal government, which would cover 50 percent. The overall breakdown is as follows:

Table 2: Allocation of the Costs of Extending Care Across Levels of Government

	Title IV-E Ineligible		Title IV-E Eligible		Total
Federal		+	50% * 70%	=	35%
State	40% * 30%	+	40% * 50% * 70%	=	26%
County	60% * 30%	+	60% * 50% * 70%	=	39%
Total	30%	+	70%	=	100%

The actual costs borne by each level of government would, of course, depend on the number of young people who choose to remain in foster care (as well as the number of years they choose to remain). Assuming the percentages listed in Table 2 and a total cost per person of extending care of \$37,948, we would expect the Federal government to pay \$13,282, the State of California \$9,866, and the placing county \$14,800 per person to extend foster care in California to age 21. Assuming that most foster youth in transition in California will remain in the state for most if not all of their lives, it is worth noting that the potential benefits to individuals and society of extending care in California are likely to be concentrated in California, even though the federal government assumes a significant proportion of the costs of extending care.

The Potential Benefits of Extending Foster Care to Age 21

The starting point for our analysis of the potential benefits of extending foster care were the findings that we described in *When Should the State Cease Parenting? Evidence from the Midwest Study* (Courtney, Dworsky, & Pollack, 2007), namely, that allowing young people to remain in care until age 21 was associated with increased post-secondary educational attainment, delayed pregnancy, higher earnings, and a greater likelihood of receiving independent living services. Because rigorous empirical studies have yet to demonstrate that receipt of independent living services has long-term positive effects (Montgomery, Donkoh, & Underhill, 2006), we had initially planned to estimate the potential monetary benefits associated with increased post-secondary educational attainment, delayed pregnancy, and higher earnings. However, further consideration led us to focus exclusively on the first. Before discussing the potential monetary benefits due to increased post-secondary educational attainment, we explain our decision not to include the potential monetary benefits due to increased earnings and delayed pregnancy in our estimate.

As Courtney and colleagues reported, each additional year young people remained in care beyond their 18th birthday was associated with an increase in earnings of between \$470 and \$924 (depending on the statistical model that was used) during the year before the wave three interview at age 21 relative to mean annual earnings of \$6,894 (Courtney, Dworsky, & Pollack, 2007). At first glance it might make sense to try to estimate how this early earnings differential might translate into higher earnings over a young person's work-life. However, as we describe below, work-life earnings are strongly associated with educational attainment. Although our models predicting earnings during the year before the wave three interview controlled for differences in human capital (e.g., grade retention and reading level) and college aspirations at ages 17 or 18, they did not control for changes in educational attainment that occurred after the baseline interview. Thus, some or all of the earnings differences we observed at age 21 may reflect the effects of being able to remain in care on educational attainment. For this reason we chose not to include the earnings estimates reported in *When Should the State Cease Parenting* in our estimate of potential monetary benefits.

Courtney and colleagues also reported a relationship between remaining in care and delayed pregnancy (Courtney, Dworsky, & Pollack, 2007). Specifically, they found that being in care was associated with a 38 percent reduction in the risk of becoming pregnant between the baseline interview and the wave two interview at age 19. Given the wide range of challenges facing foster youth during the transition to adulthood and the likelihood that those who become parents during this period will do so under very unfavorable conditions (e.g., unstable or no employment, economic insecurity, no spouse or stable partner to assist with parenting), it seems reasonable to argue that this reduction in the risk of pregnancy associated with being in care would benefit the young women involved as well as society (Courtney et al., 2007). However, a review of the literature on teenage pregnancy revealed that almost all of the monetary benefits associated with pregnancy prevention comes from delaying births that would have occurred before age 18 until age 20 or 21 (Hoffman, 2006; Hoffman & Maynard, 2008). Delaying births to young women at ages 18 or 19 may have monetary benefits that have not been measured but we cannot quantify them at this point in time. Consequently, we chose not to include the potential monetary benefits of delayed pregnancy in our estimate of the potential benefits associated with extending foster care.

The Benefits of Extending Foster Care to Age 21 on Higher Education

The advantages of post-secondary education are well established. A bachelor's degree in particular is regarded as an investment that yields large returns over the life of an individual. According to the National Center for Educational Statistics, young adults with at least a bachelor's degree earn significantly more than those with less education, and the gap in median income between college graduates and high school graduates has increased over time. In 2005, 25 to 34 year olds who had at least a bachelor's degree earned, on average, 61 percent more than those with only a high school diploma or GED (Planty, Provasnik, Hussar, Snyder, Kena, Hampden-Thompson, Dinkes & Choy, 2007).

We know that foster youth approach the transition to adulthood with significant educational deficits (Courtney, Terao, & Bost, 2004; Wolanin, 2005). For example, nearly two-fifths of Midwest Study participants were at least one year behind in school at age 17 or 18 (Courtney, et al., 2004), and one quarter did not have a high school diploma

or GED by age 21 compared to 11 percent of their peers in the general population (Courtney, Dworsky, Cusick, Havlicek, Perez, & Keller, 2007).

There is a lack of a consensus among researchers regarding college graduation rates for former foster youth, with estimates ranging from as low as 1 percent to as high as 11 percent (Emerson, 2006; Pecora, Williams, Kessler, Downs, O'Brien, Hiripi, & Morello, 2003; Wolanin, 2005). These estimates, however, are based on non-representative samples of former foster youth, nearly all of whom left care before federally-funded Education and Training Vouchers (ETVs) were made available through the John H. Chafee Foster Care Independence Program in 2002. Moreover, the studies on which these estimates are based often assessed educational progress too early in adulthood to provide valid data on college degree completion. Nevertheless, there is ample evidence that former foster youth lag considerably behind their peers with respect to post-secondary educational attainment.

The potential benefits of extending foster care resulting from an increase in educational attainment will depend on our answers to two questions:

- 1) What is the expected baseline rate of educational attainment for foster youth making the transition to adulthood if they are not allowed to remain in care until age 21?
- 2) How much higher do we expect that rate to be if young people are given the option to remain in care?

Our focus is on educational attainment beyond a high school diploma or the equivalent because the returns to post-secondary education are considerable.

Advantages of Extending Care Associated with a Baccalaureate Degree

We begin by estimating the potential benefits of extending care on bachelor's degree completion and the effects of BA completion on work-life earnings. Given the lack of consensus regarding college completion rates among former foster youth, we draw upon the 1988 National Education Longitudinal Study (NELS) to provide both lower and upper bounds.⁷ This study found that 29.6 percent of 26 year olds in the US had a bachelor's degree.⁸ However, that percentage varied considerably by socioeconomic status (SES).⁹ Most notably, only 7.3 percent of young people in the lowest SES quartile obtained a bachelor's degree by age 26. The NELS also found a relationship between number of

⁷ NELS involved a national probability sample of students from 1,057 public and private schools across all 50 states and the District of Columbia who were eighth graders in the spring of 1988 (US Department of Education, 2000).

⁸ Because the NELS estimates are based on educational attainment at age 26 and some individuals obtain college degrees after age 26, our figures most likely underestimate the percentage of adults who ultimately earn a bachelor's degree.

⁹ The NELS measure of SES is based on five equally weighted and standardized components: father's education, mother's education, family income, father's occupation, and mother's occupation.

“risk factors” and rates of college graduation.¹⁰ The graduation rate among young people with three or more risk factors was only 4.5 percent compared with 10.4 percent among young people with two, 22.0 percent among those with one, and 40.2 percent among those with none.

Most, but not all, transitioning foster youth are eligible for Title IV-E funding, which means that they come from low income families.¹¹ Moreover, they have typically been removed from homes because their safety and well being were significantly at risk. Averaging the NELS college graduation rates for those who were in the bottom SES quartile and those who had three or more risk factors, we estimate a lower bound for bachelor’s degree attainment of 5.9 percent. To estimate our upper bound, we use the average of the rate for the bottom three quartiles of the NELS SES distribution (18.6 percent) and the rate for youth with two risk factors (10.4 percent), or 14.5 percent. Taking the midpoint between these two estimates, we assume that approximately 10.2 percent of foster youth are likely to eventually earn a bachelor’s degree.¹²

Data from the Midwest Study indicate that college attendance among former foster youth is considerably higher in Illinois, where young people have the option to remain in care until the age of 21, than in Iowa and Wisconsin, where young people are routinely discharged from care on or close to their 18th birthday. Specifically, at age 21, young people who had aged out of foster care in Illinois were 2.25 times more likely than their counterparts from Iowa or Wisconsin to have completed at least one year of college (Courtney, Dworsky, & Pollack, 2007). Because between-state differences in foster youth populations could account for some or all of this difference in educational attainment, we estimated a multivariate model predicting at least one year of college completion that controlled for a range of foster youth characteristics that might be expected to be associated with college enrollment. However, controlling for these factors only *increased* the difference between states. In other words, despite exhibiting characteristics associated with *lower* rates of college enrollment, young people from Illinois had estimated odds of completing one or more years of college that were more than three times higher than the

¹⁰ Risk factors, measured in 8th grade, included living in a single-parent household; having a low-income family; having parents who had not graduated from high school; having an older sibling who dropped out of school; spending 3 or more hours alone at home after school per day; and having limited English proficiency.

¹¹ The Federal government reimburses states for the costs of foster care provided to children from low-income families through Title IV-E. For states to claim Title IV-E reimbursement, they must document that a child’s family would have been income-eligible for the state’s Aid to Families with Dependent Children (AFDC) under the criteria that existed before the program was eliminated in 1997. Although the percentage of children entering foster care who are Title IV-E eligible (commonly called the IV-E penetration rate) has always varied across states due to between-state differences in AFDC eligibility criteria, and have generally fallen since 1997, long-term national data on IV-E eligibility suggest that at least half of the children who enter foster care are IV-E eligible.

¹² Additional support for this figure comes from the Casey National Alumni Study (Pecora et al., 2003), the only study that provides reasonably recent data on college degree completion among former foster youth. Interviews were conducted with 1,087 young adults who had been in the care of Casey Family Programs in one of 13 states for at least one year between 1966 and 1998. Not all of these young adults had exited care by aging out, but most had spent time in care as adolescents and their average age at exit was 19 years old. Of the young adults who were age 25 or older, 10.8 percent had a BA degree. This is very similar to our midpoint estimate.

estimated odds of their peers in Iowa and Wisconsin (Courtney, Dworsky, & Pollack, 2007).

We base our estimates of the long-term benefits of extending care on bachelor's degree completion on this finding that former foster youth from Illinois were more than twice as likely as their Wisconsin and Iowa counterparts to have completed at least one year of college by age 21. Our best estimate is that allowing youth to remain in care is associated with a doubling of college degree attainment. This assumes that the difference in educational attainment that we observed at age 21 will be relatively stable over time. However, it could be argued that extending care has diminishing returns as young people can no longer rely on the state for care and supervision once they are 21 years old. We take this possibility into account by estimating the long-term benefits of extending care under the assumption that allowing youth to remain in care increases bachelor's degree completion by a factor of 1.5. It can also be argued that our best estimate is too low given the results of our multivariate analyses which suggest that extending care is associated with a tripling of the odds of completing at least one year of college. Thus, we also estimate the long-term benefits of extending care under the assumption that allowing youth to remain in care increases bachelor's degree completion by a factor of 2.5.

US Census Bureau data indicate that individuals with a bachelor's degree can expect to earn approximately \$2.1 million in 1999 dollars over the course of their work-life whereas those with only a high school diploma can expect to earn approximately \$1.2 million (Day & Newburger, 2002).¹³ This \$900,000 difference reflects the added value in work-life earnings of a bachelor's degree beyond the value of a high school diploma alone. To calculate the expected return in earnings if extending foster care to age 21 increased the rate of college graduation, we multiply the added value of a bachelor's degree by the difference between the predicted rate of college graduation under a policy of extended care and the estimated "baseline" rate of college graduation under the policy that currently exists in most states (i.e., discharge at age 18):

$$\begin{aligned} & \text{Estimated additional earnings per person from extending foster care to age 21} = \\ & \text{Lifetime return in earnings for a bachelor's degree (\$900,000) } \times \\ & (\text{Predicted graduation rate if foster youth are allowed to remain in care until age 21} - \\ & \text{Estimated baseline graduation rate}) \end{aligned}$$

The results of these calculations are illustrated in Figure 2. Note that the estimated additional earnings are heavily influenced by our assumptions about the baseline bachelor's degree completion rate and the increased bachelor's degree completion rate associated with extending care. The upper line represents the return in dollars if extending care increased the bachelor's degree completion rate by a factor of 2.5 and the lower line represents the return if extending care increased the bachelor's degree completion rate by a factor of 1.5. Our most realistic estimates are represented by the middle line which shows what would happen if extending care doubled the bachelor's

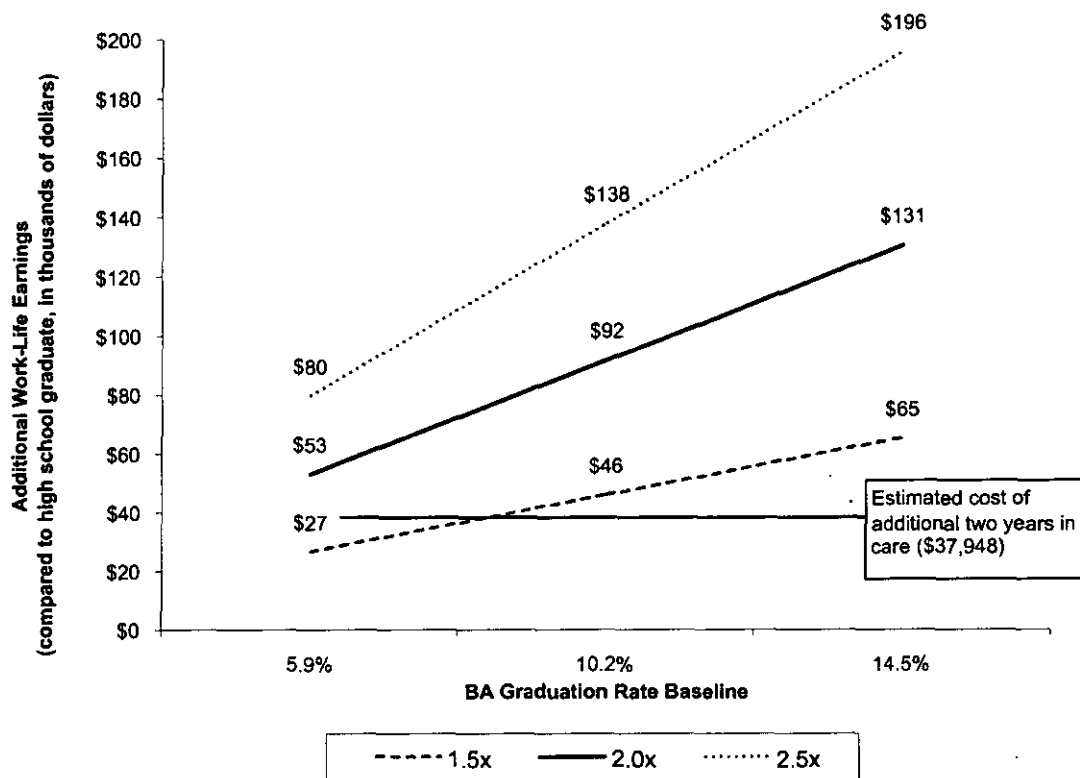
¹³ Day and Newburger (2002) estimated work-life earnings by summing age-specific average annual earnings for working people ages 25 to 64 years old. The total represents what similarly educated individuals could expect to earn, on average, in 1999 dollars, during a hypothetical 40-year working life.

degree completion rate---slightly lower than the difference observed in the Midwest Study.

Using our midpoint baseline college graduation estimate of 10.2 percent and our "best guess" that this rate will double if care is extended, we predict that 20.4 percent of foster youth would earn their baccalaureate degree if other states adopted Illinois' policy and allowed young people to remain in care until age 21. This is still considerably lower than the overall NELS estimate of 29.6 percent, but it does suggest that extending care would increase per person work-life earnings by an average of \$92,000.

Figure 2, which also shows the consequences of altering our assumptions regarding either the expected baseline rate of bachelor's degree completion or the effects of extending care on degree completion, indicates that the expected per-person work-life earnings increase associated with extending care ranges from a lower bound estimate of \$27,000 to an upper bound estimate of \$196,000. Note that for all but the estimate that assumes the lowest baseline graduation rate and the lowest projected increase in degree completion, the return in earnings exceeds the average cost of an additional two years in care (\$37,948), the average length of time that Illinois foster youth remain in care beyond their 18th birthday. Our midpoint (and most realistic) estimate translates into a benefit to cost ratio of \$2.4 dollars in increased earnings due to higher rates of degree completion for every dollar spent on extending foster care.

Figure 2: Estimated Earnings Benefits from Increased College Degree Attainment of Extending Foster Care to 21



Advantages of Extending Care Associated with Completing Any College

By limiting our estimates to the effects of completing a baccalaureate degree, we may be underestimating the benefits of extending foster care to age 21. Researchers have found “substantial and statistically significant” returns on sub-baccalaureate credentials, such as vocational certificates and associate degrees (Grubb, 1997, p241). For example, compared with individuals who have only a high school diploma, individuals with an associate’s degree earn an estimated 12 to 27 percent more (Surrette, 1997; Kane & Rouse, 1995). Moreover, according to Census Bureau estimates, completing any college increases work-life earnings by \$300,000, and completing an associate’s degree increases work-life earnings by \$400,000 relative to the work-life earnings of individuals with only a high school diploma (Day & Newburger, 2002).

This is important because data from the Midwest Study suggest that allowing youth to remain in care until age 21 is associated with significantly higher rates of college attendance (Courtney, Dworsky, & Pollack, 2007). Specifically, 58 percent of the former foster youth from Illinois had ever attended college by age 21 compared with only 29 percent of former foster youth from Iowa and only 31 percent of the former foster youth from Wisconsin. It is also associated with a greater likelihood of completing at least one

year of college. By age 21, 38 percent of the Illinois sample had completed at least one year of college compared with just 17 percent of the Wisconsin sample and 16 percent of the Iowa sample.

Given that post-secondary education can have benefits even if it does not result in a baccalaureate degree, and the fact that more follow-up data are needed to know whether Midwest study participants continue their educational trajectories, we also estimated the potential monetary benefits in terms of additional work-life earnings associated with extending care assuming that former foster youth terminate their education at age 21.¹⁴ This more conservative estimate represents the increase in per person work-life earnings we might expect due to the differences in educational attainment observed at age 21 between young people for whom remaining in care is an option and those for whom it is not:

$$\begin{aligned} & \text{Estimated additional earnings per person from extending foster care to age 21} = \\ & \text{Lifetime return in earnings for "some college" beyond HS (\$300,000) } \times \\ & (\text{Predicted college attendance if foster youth are allowed to remain in care until age 21} - \\ & \text{Estimated baseline college attendance rate}) \end{aligned}$$

Based on this formula, we estimate that the additional per-person work-life earnings associated with extending foster care would be \$84,000 (i.e., \$300,000 x (.58-.30)). In other words, even if former foster youth do not persist toward baccalaureate completion, the potential benefits of extending care exceed the costs by a factor of over 2 to 1.

Nonmarket Benefits of Post-Secondary Education

It is important to note that post-secondary education has a number of nonmarket benefits that are not easily monetized, at least not directly (Wolfe & Haveman, 2002; Baum & Ma, 2007). These benefits include improved personal and familial health, childbearing choices, and education choices of offspring. According to one estimate, if the "social gains from all of the categories of private nonmarket and external/public goods [...] are taken into account, their sum could equal estimates of the annual earnings impacts of an additional year of schooling" (Wolfe & Haveman, 2002, p118). Thus, if we were able to account for these nonmarket benefits in our estimates, extending foster care until age 21 could significantly increase the return to foster youth in transition and to society.

Limitations

Consideration of the conclusions reached in this report should take into account the limitations of the data and the methods that we used. First, our estimates of both the costs and benefits of extending care are largely based on observed differences between what happens in one state that allows young people to remain in care until age 21 and two other states with similar but not identical policies in which remaining in care until age 21 is not an option. Caution should be exercised in applying these estimates to other

¹⁴ Data from interviews conducted at age 23 will be available in summer 2009 and from interviews at age 25 in Spring 2011.

jurisdictions that take a different approach to extending care than Illinois or that provide a different set of aftercare services to support post-secondary education than either Iowa or Wisconsin.

Second, we attribute all of the between-state differences in post-secondary educational attainment that we observe at age 21 after controlling for foster youth characteristics measured at baseline to the fact that in one state people can remain in care until age 21 and in the two other states they cannot. This assumes that other between-state policy or contextual differences, as well as unmeasured between-state differences in foster youth characteristics, cannot account for the between-state differences we observed in post-secondary educational attainment. We are reasonably confident in making those assumptions for reasons discussed elsewhere (Courtney, Dworsky, and Pollack, 2007), but recognize the limitations of the non-experimental nature of our analyses.

Third, we rely on estimates of returns to post-secondary education among the general population (e.g., Day & Newburger, 2002). Our estimates will be biased to the extent that returns to post-secondary education are different for young people making the transition from foster care to adulthood.

Fourth, we have not accounted for all of the potential costs and cost offsets that might be associated with allowing young people to remain in care until age 21. For example, states' ability to extend Medicaid coverage to former foster youth until their 21st birthday will not change under the new law. Nonetheless, extending care could affect Medicaid expenditures. On the one hand, it could increase Medicaid expenditures if being in care results in greater attention to young people's health care needs and to a subsequent increase in their health care service utilization. On the other hand, it could improve young people's access to primary health care and hence reduce Medicaid expenditures on emergency treatment. Another cost that we have not taken into account is the cost of maintaining court supervision for as many as three additional years.

Finally, we have not exhausted the tools of benefit-cost analysis. For example, we have not adjusted for the fact that the data on which our estimates are based often come from different years. Our estimates of the costs of providing care and supervision to 18 to 21 year old foster youth in Illinois were based on 2007 data, our data on educational attainment at age 21 were collected in 2006, and our work-life earnings estimates were based on "present value" figures for 1999 (Day & Newburger, 2002). Although we do not believe that adjusting for these differences would substantively alter our conclusions, it could result in more precise estimates. Another convention of benefit-cost analysis is to allocate costs and benefits between society as a whole and the individuals affected by a policy or program. We have not tried to allocate our estimated benefits between individuals and society. Increased work-life earnings may appear to benefit only the individuals who are employed, but at least some of those earnings are returned to society in the form of tax revenues.

Conclusion

We analyzed the potential costs and benefits of allowing foster youth to remain in care until age 21, the policy option encouraged by the Fostering Connections Act and proposed in California's AB 12. We estimate that the average per youth cost of extending foster care for two years, net cost offsets associated with public assistance utilization when youth cannot remain in care, to be approximately \$37,948. This estimate is based on cost data from Illinois, observed between-state differences in the age at which youth left care in the Midwest Study states, and Midwest Study survey data on public assistance utilization. Available state-level data on public assistance utilization suggest that the net cost of extending care in California may be a few hundred dollars less than our estimate suggests. California-specific data pertaining to the costs of providing out-of-home care to transition-age youth and the length of time that youth are likely to remain in care beyond age 18 could improve our estimate, but in the absence of such data we believe it to be the best available.

Our analysis of the benefits of extending care focused on potential increases in work-life earnings owing to increased higher education. Our estimates are limited primarily by the fact that Midwest Study data are only available on the educational attainment of foster youth at age 21. However, even if we assume no continuation of the favorable educational trajectory associated with the Illinois policy of extending care, we estimate that the per-person work-life earnings of foster youth making the transition to adulthood would increase by an average of \$84,000 as a result of allowing foster youth to remain in care until they are 21 years old. This conservative estimate is based only on the expected effect of extending care on the likelihood of completing at least some college and represents a return of over two dollars for every dollar spent.

Our estimates of the benefits of extending care until age 21 on bachelor's degree completion are based on more tenuous assumptions because most young adults do not graduate from a four year college or university until they are least 22 years old. Our estimates of the increase in average per-person work-life earnings associated with the predicted increase in college graduation range from approximately \$27,000 to \$196,000. The wide range reflects different assumptions about 1) college graduation by former foster youth generally and 2) the persistence over time of the educational advantages associated with remaining in care. Our best estimate is that the increase in bachelor's degree completion predicted to result from extending care to age 21 would increase per-person work-life earnings by approximately \$92,000. This represents about \$2.4 for every dollar spent.

These two estimates of the benefit-cost ratio of extending care are not mutually exclusive. The former estimate assumes no benefit of extending care on college degree completion whereas the latter estimate does not take into account the positive effects of extending care on sub-baccalaureate attainment. There is good reason to believe that the stark differences in college attainment that we observe at age 21 and attribute to the extension of foster care in Illinois will, over time, result in advantages in terms of both degree completion and sub-baccalaureate attainment. Thus, it seems reasonable to assume that the average increase in work-life earnings that would result from extending foster care is

substantially higher than either of our estimates suggest, although how much higher is not clear. Future analysis of Midwest Study survey data being collected at ages 23 and 25 should reduce the need for speculation. In the meantime, our estimates suggest that the costs associated with extending foster care to age 21--an option that is now much less costly to states as a result of the Fostering Connections Act--are more than offset by the potential benefits to foster youth and society.

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State isn't equipped to give youths a hand after they turn 18

ELISE PATKOTAK
COMMENT

(03/10/09 18:51:28)

I've said it before and I'll say it again. The state makes a lousy parent. It rarely remembers your birthday and it almost never takes a turn having all the relatives over for the holidays. But if you're a kid stuck in state custody, it's often all you have in the way of a parent except maybe for an ever changing cast of foster parents.

This is not a condemnation of the state or its system of caring for children in its custody. Given the resources we are willing to provide for this service, and given the needs of the children who become part of the system, the Office of Children's Services is pretty much doing the best it can.

The problem has always been that words are much cheaper than actual actions. So we make a big fuss about children being our future and then try to meet the needs of the future on a shoestring budget. If you think about what it costs to raise a child from birth to maturity under the best of circumstances, you can pretty much quadruple that cost for a child coming out of a nightmarish family situation who may or may not be already damaged almost beyond repair. Quadrupling the cost is probable a conservative estimate.

For many of these kids, the future is predetermined way before the state is actively involved. Whether it's because mom drank during pregnancy and brought the child into the world with 10 strikes already against him or her, or whether mom and dad created such a hellish family life of physical, sexual and mental abuse that the child is totally screwed up before he or she is 5 years old, the result is pretty much the same. The child starts life at an extreme disadvantage.

Take that child and put him into a state system that tries to supply some stability but is often hampered by rules that require the child to be bounced back and forth between birth family and foster care multiple times before the state is allowed to terminate parental rights, and you have the recipe for total disaster.

Anytime a child comes out of this kind of background with his or her head screwed on right, still able to dream of a better life and future, mentally capable of grasping academic subjects and studying for a career in life outside of adult penal institutions, I must stand up in awe and wonder and applaud that child's resilience.

There is a move in our state Legislature to allow the state to provide graduates of foster care and family services a chance at a postsecondary education, complete with some funding to support their living needs while they get their education. This is nothing more nor less than what most families do for their children as they start the process of emancipation into productive adults.

But kids coming out of the state system usually don't have a family willing and able to pick up the slack while they get that education. They have no one to turn to who can guide them through the shoals of applying for housing, putting a budget together, or getting a part-time job to help meet expenses. These kids don't have something as simple as an adult they can shoot the breeze with

over the future and what's out there for them. You know, the kind of conversation you have with your kid while you're driving them to the movies or school or sitting around during the commercials on ESPN.

The state has already started to try and meet these needs through transitional living assistance to young people as they age out of the system. That's a great start. But it isn't enough, because once we wave goodbye to them when they turn 18, they are on their own at a time when most of us would have been hard pressed to make good decisions for our future without some continuing adult guidance.

That these kids survived despite what their birth families did to them is a miracle. That they can come out of the state system and still have dreams of a better future is astounding. That there is any debate at all that we should be doing all we can for them is mind-boggling.

Elise Patkotak is a writer who lives in Anchorage. Read her blog at www.elisepatkotak.com.

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Newsweek

Children of the System

New research supports a radical shift in child-welfare policy for the thousands of teens who 'age out' of foster care at age 18, only to face high rates of homelessness, unemployment and incarceration.

Daniel Heimpel
Newsweek Web Exclusive

Eighteen-year-old John Kyzer's blue eyes are bleary and the skin around them puffy as he paces a corner of Hollywood Boulevard in Los Angeles. Kyzer has been spending his nights on a bench in front of a Starbucks. And now, he is dangerously close to entering the ranks of dozens of other former foster youth who "cop a squat" (sit) on concrete stairwells and sleep in "abandos" (abandoned buildings) up and down the street.

Soon after his 18th birthday, the state of California "terminated" Kyzer's case and he was forced to leave his group home. He moved in with his girlfriend and their 4-month-old baby in the home she shared with three generations of her family. Wanting to help support his son, Kyzer got a job at Starbucks and worked as many hours as the boss would give him. For two months his confidence brimmed.

But then he did something many teenagers do. He blew off work and was fired. Now, the door to his girlfriend's house is shut. Kyzer is on his own.

For Kyzer and many of the more than 25,000 other foster youth in the United States who "age out" of the system every year, there is no family and no support network to pick you up when you fall. Within two years of emancipation, half of Los Angeles County's foster youth will be unemployed, one fifth will be homeless and a quarter will have been to prison, according to the Children's Law Center. Similar fates can be expected across the country for many of the 500,000 children who call the state their parents.

But a law signed by President Bush in the waning days of his administration could radically change the futures of these children. The Fostering Connections to Success and Increasing Adoptions Act of 2008 offers states matching federal funds to extend care to age 21 for all foster youth who choose to stay in the system after their 18th birthday. What's meant by "care" would vary state by state, but could include extending Medicaid coverage to age 21 (which about 20 states now do), providing housing vouchers or access to group homes, vocational training, educational funding and psychological counseling services.

"We have known for a long time that kids don't suddenly become self-sufficient at the age of 18," says the federal bill's sponsor, Rep. Jim McDermott of Washington state. "The law we passed last year finally recognized the need to better provide the building blocks of success to these children."

Research released Monday suggests that the approach makes financial sense for a government weighed down by the costs of incarceration, welfare, Medicaid and homelessness incurred by former foster youth who struggle after emancipation. Conducted by the University of Washington School of Social Work, the study finds that caring for young adults until age 21 will represent a return of \$2.40 on every government dollar spent in California.

Experts hope the report will lead more states to implement the federal law. But adding anything to

a state budget right now is a hard sell. Thus far only seven states have put forward such legislation, including California. And before the passage of the federal legislation, only two states had implemented comprehensive extended care for foster kids after age 18—Illinois and Vermont.

The study's leading researcher, Mark Courtney, director of Partners for Our Children, a public-private collaboration promoting child-welfare reform at the University of Washington, sees the federal legislation as the most radical shift in child-welfare policy in the last decade. "The government has been unwilling to help kids after 18 beyond teaching them independent-living skills," he says. "That is not what parents do. A parent is not happy to kick a kid out at 18 and say good luck."

Courtney's earlier work has shown significant long-term benefits for kids who get a few more years' care versus those who are pushed out of the system at 18. His hallmark "Midwest Study," published in 2005, was instrumental in shaping the current federal legislation. That report followed 732 foster youth through their 17th, 18th and 21st birthdays. It found that along with lower rates of incarceration, homelessness and unemployment, young people in a state like Illinois, which extends care until 21, were 3.5 times as likely to have completed a year of college than peers in states like Iowa and Wisconsin, which routinely cut care at 18. (Census data show that less than 3 percent of foster kids earn college degrees, compared with 28 percent of the population as a whole.)

"The minute we kick them out they start looking for their families," says Karen Bass, speaker of the California Assembly and coauthor of The California Fostering Connections to Success Act. The legislation plans to increase spending to \$70 million in California for youths age 18 to 21, largely through the newly available federal funds. "When they can't find their families, they make families of their own on Hollywood Boulevard. In L.A., they are couch surfing; you have groups of young people living together and it is homelessness, just a different form." Bass and coauthor Jim Beall say that despite the budget wrangle and deficits that California faces, the bill bears the name of 26 Assembly members, has wide cross-aisle support and will likely pass.

In this latest study of foster care, Courtney narrowed his focus on higher education. As he had already shown, young people in extended care were better equipped to pursue a higher level of education and thus vastly increased their lifetime earning potential. For an expenditure of \$37,948 over the course of extended care, Courtney concludes that those foster youth will earn \$92,000 more in their working life. "We are talking about spending \$38,000 over one to three years versus what it costs to incarcerate somebody for 20 to 30 years," says Bass. In California, the Department of Corrections anticipates the annual cost of incarceration will jump to \$53,000 in fiscal year 2009-10.

But these undeniable statistics are running headlong into the cold reality of a national financial crisis. "Here is the most significant piece of [foster-care] legislation in a decade and it may be slowed down by these economic times," says Kathi Crowe, executive director of the Foster Care Coalition. "It's almost too bad it is optional." Nonetheless, Courtney believes that the evidence he has presented along with the [National Youth in Transition Database](#), which will be implemented nationwide as of October 2010 and will track young people as they mature into adulthood, will force states to act. "At that point some states may be shamed into changing their laws if the outcomes of their former foster youth look much worse than the outcomes for youth in states that have extended care to 21."

But for Kyzer and the kids currently "copping a squat" on the streets, it may be too late. "I just wasn't ready," Kyzer says of being a father, holding a job and moving into his own place. Tonight he is couch surfing, but tomorrow, his only option may be an abando.

URL: <http://www.newsweek.com/id/188493>

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Anchorage School District

5530 E. Northern Lights Blvd.
Anchorage, Alaska 99504-3135
(907) 742-4000

March 11, 2009

To Members of the House Education Committee:

I am writing in support of CS for HB 126 (EDC) which relates to the education of students who are homeless or in foster care or awaiting foster care. As you know, we have a large and growing homeless population in our district; we also have a large and growing number of students awaiting placement in foster care or who are in foster care. One of the major challenges for these young people is finding stability in their lives, including being able to attend school on a regular basis.

It is a well-known fact that when students stay in the same school for the whole school year, there is more opportunity for the student to be academically successful. The Anchorage School District and School Board have worked for years to help parents understand the importance of keeping their children in the same school as long as possible. In the case of homeless students, and those in foster care or awaiting foster care placement, we feel strongly that we need to follow the requirements of the McKinney-Vento Act for homeless students, which requires us to provide transportation to and from the student's original school for the school year. In the case of foster children and those awaiting placement, we support the language in this proposed legislation as long as there is some funding for this requirement. The Anchorage School District provided \$150,000 to supplement federal funding for transportation last year and would anticipate an increase again this year.

I commend Representatives Gara, Crawford, and Kerttula for bringing this legislation forward and hope that you will support its passage.

Please feel free to contact me at comeau_carol@asdk12.org if you have need for more information.

Sincerely yours,

Carol Comeau
Superintendent



Crisis Center · Community Services Center · Transitional Living

Representative Les Gara and Senator Bettye Davis
State Capitol
Juneau, AK 99801

February 23, 2009

Dear Representative Gara and Senator Davis,

Thank you for introducing legislation to address the needs of foster care youth, both while they are in the state's custody and when they "age-out" of the current system. Providing resources and support to our foster care children decreases the need for long-term public assistance and criminal justice resources. Responding to research that clearly identifies proven strategies for assisting our youth to independent adulthood is not only compassionate, it is fiscally sound policy.

Between 35% and 50% of foster care youth become homeless after being released from care. Covenant House Alaska (CHA) serves the homeless and at-risk youth of our state through four main programs (50% of CHA youth have been involved in the foster care system). Our Crisis Center provides shelter, food, clothing, primary health care and support resources to homeless youth. Our Community Services Center is a drop-in center that provides case management, employment assistance, educational tutoring, counseling and substance abuse referrals and life skills training. Two different programs, Rights of Passage and Passage House help youth transition to independent living and self-sufficiency. Youth can participate in either program for 18 months with up to 12 months of additional aftercare.

Through these programs, CHA is certain that increased job training, educational opportunities, rental assistance and social worker visits will benefit children in foster care. Similarly, offering consistency whenever possible through maintaining one school for children despite changes in foster care placement is essential. CHA appreciates the multi-faceted approach HB 126 and SB 105 offers.

Thank you for sponsoring this legislation and providing a voice to youth in foster care.

Sincerely,

A handwritten signature in cursive script that reads "Deirdre Cronin".

Deirdre A. Cronin
Executive Director

Opening Doors for Homeless Youth

Facing Foster Care in Alaska (FFCA)
3108 W. 42nd Ave. #6
Anchorage, AK 99517
February 17, 2009

Representative
Les Gara
Alaska State Legislator
AK State Capitol Rm 500
Juneau, AK 99801

Dear Representative Gara:

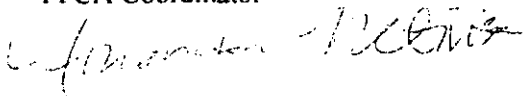
Your continued concern for Alaska's foster children and youth is admirable, and House Bill 126 demonstrates that concern.

As current and former foster youth of Alaska's child welfare system, we would like to thank you for your ongoing support in addressing the need for reform. Many of Alaska's foster children are being set up for failure due to a state system that is lacking many of the resources these young people need to succeed. Statistics show that youth who leave Alaska's foster care system become homeless at a rate of 40%, fall behind in their education, and have a high rate of adult incarceration. We wholeheartedly support your bill that creates opportunities for children and youth in foster care to succeed.

Thank you for your concern and your untiring pursuit to improve the lives of those who are less fortunate. You have our support.

Sincerely,

Amanda Metivier
FFCA Coordinator





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April 6, 2009

**The Honorable
Representative Les Gara
Alaska State Capitol
Room 500
Juneau, AK 99801**

Re: SUPPORT HB 126

Dear Representative Gara,

I am writing to express the support of Friends of Alaska CASA (FAC) for House Bill 126. This bill, as you know, will help foster youth transition more successfully from state care to independent living.

Currently 38% of foster youth aging out of the system end up homeless. This bill attempts to remedy this reality through several assistance measures, such as financial help for rent and other living expenses for up to a year after aging out, and tuition waivers for vocational or college education.

HB 126 will extend the applicability of transportation funding for foster youth so they can stay at the same school for an entire school year instead of transferring between different schools as is often the case. HB 126 will also require a quicker transfer of school records when kids do switch schools, thus easing the discomfort and disruption caused by the change.

Finally, HB 126 attempts to improve basic services within foster care. The most recent federal review of foster care in Alaska gave our state very low marks. HB 126 looks to set the bar higher by requiring the state meet federal once-a-month visit standards. Currently, some youth in care are only seen once every eight months, hardly sufficient to assist a young person with the myriad of difficult issues brought about by their unique circumstances.

Thank you for your consideration.

Sincerely,

Sallye Werner
President
Friends of Alaska CASA

Ryan Zinn
Program Director
Friends of Alaska CASA



Anchorage School District

5530 E. Northern Lights Blvd.
Anchorage, Alaska 99504-3135
(907) 742-4000

March 11, 2009

To Members of the House Education Committee:

I am writing in support of CS for HB 126 (EDC) which relates to the education of students who are homeless or in foster care or awaiting foster care. As you know, we have a large and growing homeless population in our district; we also have a large and growing number of students awaiting placement in foster care or who are in foster care. One of the major challenges for these young people is finding stability in their lives, including being able to attend school on a regular basis.

It is a well-known fact that when students stay in the same school for the whole school year, there is more opportunity for the student to be academically successful. The Anchorage School District and School Board have worked for years to help parents understand the importance of keeping their children in the same school as long as possible. In the case of homeless students, and those in foster care or awaiting foster care placement, we feel strongly that we need to follow the requirements of the McKinney-Vento Act for homeless students, which requires us to provide transportation to and from the student's original school for the school year. In the case of foster children and those awaiting placement, we support the language in this proposed legislation as long as there is some funding for this requirement. The Anchorage School District provided \$150,000 to supplement federal funding for transportation last year and would anticipate an increase again this year.

I commend Representatives Gara, Crawford, and Kerttula for bringing this legislation forward and hope that you will support its passage.

Please feel free to contact me at comeau_carol@asdk12.org if you have need for more information.

Sincerely yours,

Carol Comeau
Superintendent



**Alaska Native
Tribal Health Consortium**

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: April 8, 2009

RE: HB 168 – State certification and designation of trauma centers and creating the uncompensated trauma care fund
HB 169 – Appropriating \$5,000,000 to the uncompensated trauma care fund

POSITION: Support

ANTHC supports HB 168 and HB 169 as important steps in increasing the trauma care capacity in the state.

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally-recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC is the only Level II Trauma Center in the Indian Health Service/tribal health system nationally. ANMC is also the only Level II Trauma Center in Alaska. The nearest Level I Trauma Center is in Seattle.

Trauma system development is a public health priority. A comprehensive system of trauma care is an essential part of the public safety net. Regionalized trauma systems based on a network of coordinated Trauma Centers designated at the appropriate level improves health outcomes and reduces costs. ANMC, as the highest level designated Trauma Center in the State of Alaska, is the lynchpin for the state's trauma system, and provides the foundation for continued statewide system development.

Trauma Center designations were created as a way to improve outcomes for patients who face extraordinary medical issues. On balance, early and appropriate medical attention to life-threatening health issues reduces overall length of stay in the hospital and reduced complications for many patients. Without trauma care, the costs of health care for trauma patients will be greater, including trauma patients who are Medicaid eligible.

The cost of providing trauma care at ANMC has more than doubled over the past four years and funding has not kept pace. ANMC's Trauma Center simply cannot be maintained at current revenue levels. If ANMC's Trauma Center designation is discontinued because funding levels have rendered the service unsustainable, the hospital faces reductions in staffing. Diversions of patients to non-tribal providers would increase, and because the federal government reimburses 100% of the cost of services provided for Native clients at Native facilities but a smaller percentage at non-tribal providers, there would be an increased cost to the state's general fund budget.

ANTHC supports HB 168 and HB 169 as important steps by the State to encourage and support appropriate trauma care options for Alaskans. Because we are Alaska's only Level II Trauma Center we recommend removing the language in section (d) on Page 2, Line 11, that limits appropriations to any one facility to 25%.

Thank you for your consideration.

Matthew Johnson

From: butchr@gci.net on behalf of stacey david reay [butchr@gci.net]
Sent: Thursday, April 09, 2009 9:06 AM
To: Rep. Wes Keller
Subject: HB 126

- Mr. Keller: Please schedule a hearing for HB 126. As a licensed social worker who has worked with families involved with Office of Children's Services, I have become aware of the need for additional support for the foster youth aging out of the system. Please help support these kids.
-
- The primary intent with this bill is to help foster youth transition more successfully from state care to independent living. Currently between 30-40% of foster youth aging out of the system end up homeless. This bill attempts to remedy that through several assistance measures, such as financial help for rent and other living expenses for up to a year after aging out, and tuition waivers for vocational or college education.
- The bill also attempts to facilitate better academic success for foster youth, which has long term benefits through the transition out of care and into adulthood. HB126 will extend the applicability of transportation funding for foster youth so they can stay at the same school for an entire school year instead of bouncing around between different schools as is often the case. HB126 will also require a quicker transfer of school records when kids do switch schools, thus easing the discomfort and disruption caused by the change.
- The bill also attempts to improve basic services within foster care. The most recent federal review of foster care in Alaska gave our state very low marks. HB126 tries to set the bar higher by requiring the state meet federal once-a-month visit standards. Currently, some youth in care are only seen once every eight months, and this is hardly enough to know how a youth is coping with the myriad of difficult issues brought about by their unique circumstances.

Sincerely, Stacey David Reay, LCSW, 1941 Rebel Ridge, Anchorage, AK 99504, 907-337-6537

Matthew Johnson

From: Carol Ford [whoville@pobox.alaska.net]
Sent: Monday, April 13, 2009 2:29 PM
To: Rep. Wes Keller
Subject: HB 126

Dear Representative Keller,

I am writing today to let you know that I strongly support House Bill 126 which provides for necessary support to foster children making the transition from foster care to full adulthood. By definition, foster children have had many ups and downs in their lives under the best of conditions, and as a mother and an active member of my community in Kenai, I am well aware that the transition from teen to adult is a powerful, difficult, important, exciting and dangerous time for everyone regardless of circumstances. It is not the time for their support system to drop them and leave them to fend for themselves.

My own children are past this time, and still turn to their folks for strength and purpose in times of setbacks and questions. As guardians of these children, the State of Alaska has the privilege and duty to offer them support and guidance and in making the best choices available to these citizens. It'll not only give their lives more potential, but will strengthen our state and our nation now and for the next generations.

I urge you to vote yes on House Bill 126.

Carol Ford

Matthew Johnson

From: Gayle Roth [rothgrk@alaska.net]

Sent: Monday, April 13, 2009 2:12 PM

To: Rep. Wes Keller; Rep. Bob Lynn; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Lindsey Holmes;
Rep. Bob Herron

Subject: HR 126

I am in favor of HR 126.

As a 47 years resident of the State of Alaska and a CASA, I have concern for the children in foster care and feel this bill addresses some of their needs.

There are too many children in foster care. Let's give them the tools they need so they can make a difference in their own lives.

Respectfully,
Gayle Roth

Matthew Johnson

From: ViedeF97@aol.com
Sent: Monday, April 13, 2009 1:36 PM
To: Rep. Lindsey Holmes; Rep. Bob Herron; Rep. Wes Keller
Subject: House 126 - strong support for

Representatives-

Please vote to support our foster kids with the benefits this bill will provide. I have been many hours over the years working with children; special needs, homeless and fostered kids there is great need for these kids of services.

Our state of Alaska is one that must do more to help those kids that are having a hard start in life and this is one of those ways. Providing the services that will allow them to transition into 'adulthood' with additional help its critical.

My husband and I, as residents of a 'bush' village are doing more each year to offer support where we can do children in our area.

This particular group of kids covered by this bill could see great benefits from just this small effort.

Please support passage of this bill.

Victoria and Roland Briggs

King Salmon, AK 99613

The Average US Credit Score is 692. See Yours in Just 2 Easy Steps!

Matthew Johnson

From: maryla@alaska.com on behalf of Mary La Fever [maryla@alaska.com]
Sent: Monday, April 13, 2009 1:17 PM
To: Rep. Wes Keller
Subject: House Bill 126

Dear HHSS Committee Member Keller

Just want to let you know I am in SUPPORT of this bill. It seems to me that kids of all economic sectors need all the help we can give them these days, particularly those who are doing without daily.....any boost is helpful, and this bill addresses some important needs.

Thanks for your consideration,

Mary La Fever
41 year resident of Anchorage

Matthew Johnson

From: Britteny Cioni-Haywood [britteny.cioni@gmail.com]

Sent: Monday, April 13, 2009 12:08 PM

To: Rep. Bob Herron; Rep. Wes Keller; Rep. John Coghill; Rep. Bob Lynn; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Lindsey Holmes

Subject: HB126

Dear Members of the Health and Social Services Committee,

I am writing in support of the HB126 bill that is currently be reviewed and voted on this week. It is my understanding that approximately 40% of Alaska's foster youth end up homeless after coming out of foster care, and less than 10% end up going to college. This is not acceptable and we need to provide more support for those coming out of the foster care system. If we want productive, capable adults then let's help this group overcome the many obstacles that they face. Really the costs of this program will far outweigh the costs of doing nothing and putting this population in greater risk of ending up in the penal system or on social programs that will be much more costly over a lifetime. The loss of economic potential is enormous and we need to help these young adults become productive citizens of our state. Thank you for time and consideration of this legislation.

Sincerely,

Britteny A. Cioni
9093 Fireweed Lane
Juneau, AK 99801

Matthew Johnson

From: m.langdon@gci.net on behalf of Mary Langdon [m.langdon@gci.net]
Sent: Saturday, April 11, 2009 11:02 AM
To: Rep. Bob Herron; Rep. Wes Keller; Rep. John Coghill; Rep. Bob Lynn; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Lindsey Holmes
Cc: Rep. Les Gara
Subject: House Bill 126 "Success For Foster Youth"

Dear Representatives~ I am writing to strongly encourage all of you, as members of the House Health and Social Services committee, to vote to pass HB 126. I have read the sponsor statement. I can see only good coming from passing this bill, for individuals and for the State of Alaska.

Thank you for your consideration.

Best regards,
Mary Langdon, M.D.

Matthew Johnson

From: Patricia Abney [abney1@acsalaska.net]
Sent: Saturday, April 11, 2009 10:37 AM
To: Rep. Wes Keller
Subject: HB 126

Please support House Bill 126

It is so important that these young people become productive adults and not life long wards of the state.

I think Amanda says it well.

Amanda Metivier, who helped found Alaska's foster care advocacy and education organization, Facing Foster Care in Alaska, notes the effort aims to:

“create opportunities for young people who age-out of foster care to succeed in their adult lives by providing job training, higher education, housing assistance, and school stability. It gives hope to foster youth who have limited supports and resources after leaving custody.”

Sincerely,

Pat Abney

Matthew Johnson

From: Friedman_Jeff [Friedman_Jeff@asdk12.org]
Sent: Friday, April 10, 2009 9:28 AM
To: Rep. Bob Herron; Rep. Wes Keller; Rep. John Coghill; Rep. Bob Lynn; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Lindsey Holmes
Cc: Rep. Les Gara; Comeau_Carol; Siegfried_Robin
Subject: HB 126 Homeless Students

Dear Co-Chairs Herron and Keller, and Committee Members:

I am writing about CSHB 126 which will be heard by the House Health and Social Services Committee on Tuesday.

The Anchorage School District continues to support this bill, but some of the changes made by the Committee Substitute raise concerns.

1. The Committee Substitute added a provision requiring transportation during summer school. In the past, we have not provided transportation during summer school except for some of our Title I schools. Not all homeless students have a Title I school as their school of origin. In addition, not all schools of origin will be open during summer school. On its face, this language would require us to transport a homeless student to his or her school of origin even if the school of origin was closed for the summer.

Keeping a student in their school of origin during the regular school year is important. Keeping a student in the same school is less important during summer school because the teachers are different, the students in the school are different, and the curriculum is different. I ask that this new requirement be removed from the bill.

2. The Committee Substitute also removed a provision that currently exists in law and was in the original bill. That provision allowed for a waiver of the transportation requirement if the Superintendent found, in writing, that attending a different school was in the child's best interest. An example of when this waiver might be used is when a homeless child is living with relatives and the homeless student might be better off attending school with the other children in that household. A waiver could also be useful in a district like Kenai where it might not be in the student's best interest to be transported from Seward to the student's school of origin in Homer each day. Please re-insert the waiver provision that was in the original bill.

Thank you for your consideration.

Jeff Friedman
Anchorage School Board
1534 D Street
Anchorage, AK 99501
907-742-4699 (Home)

Matthew Johnson

From: Friedman_Jeff [Friedman_Jeff@asdk12.org]
Sent: Friday, April 10, 2009 5:55 PM
To: Friedman_Jeff; Rep. Bob Herron; Rep. Wes Keller; Rep. John Coghill; Rep. Bob Lynn; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Lindsey Holmes
Cc: Rep. Les Gara; Comeau_Carol; Siegfried_Robin; Sen. Bettye Davis
Subject: RE: HB 126 Homeless Students

Follow Up Flag: Follow Up
Flag Status: Red

I have received new information about this bill and wish to clarify my earlier e-mail. I have learned that a C version will be introduced that will eliminate the second concern listed below. In addition, I have learned from the sponsor that the reference to summer school is expected to be removed before this bill is finalized. With this new information, I can say that I fully support HB 126 and urge you to move it out of committee with a favorable recommendation. I apologize for any confusion my initial e-mail may have caused.

Jeff Friedman
Anchorage School Board
1534 D Street
Anchorage, AK 99501
907-742-4699 (Home)

From: Friedman_Jeff
Sent: Friday, April 10, 2009 9:27 AM
To: Representative_bob_herron@legis.state.ak.us;
Representative_wes_keller@legis.state.ak.us;
Representative_john_coghill@legis.state.ak.us; representative_bob_lynn@legis.state.ak.us;
representative_paul_seaton@legis.state.ak.us;
representative_sharon_cissna@legis.state.ak.us;
representative_lindsey_holmes@legis.state.ak.us
Cc: representative_les_gara@legis.state.ak.us; Comeau_Carol; Siegfried_Robin
Subject: HB 126 Homeless Students

Dear Co-Chairs Herron and Keller, and Committee Members:

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in a district like Kenai where it might not be in the student's best interest to be transported from Seward to the student's school of origin in Homer each day. Please reinsert the waiver provision that was in the original bill.

Thank you for your consideration.

Jeff Friedman
Anchorage School Board
1534 D Street
Anchorage, AK 99501
907-742-4699 (Home)

Matthew Johnson

From: David-----Mikell [alaskamd@yahoo.com]
Sent: Saturday, April 11, 2009 7:57 AM
To: Rep. Wes Keller
Subject: HB 126

As a former foster parent and high school teacher of many teenagers in foster care, I STRONGLY urge you to support the passage of HB 126. Our teenagers need more than the resources and assistance that are currently available to them in order to successfully transition from foster care to independent adulthood.

Thank you,
Mikell L. Murphy, Ed.D
2053 Cliffside Dr.
Anchorage, AK 999501

HB

130

ALASKA STATE LEGISLATURE

Interim:
P.O. Box 109
Wrangell, AK 99929
Phone: (907) 874-3088
Fax: (907) 874-3055



Session:
State Capitol, Room 406
Juneau, AK 99801-1182
Phone: (907) 465-3824
1-800-686-3824
Fax: (907) 465-3175

REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

SPONSOR STATEMENT House Bill 130

"An Act relating to questionnaires and surveys administered in the public schools."

HB 130 changes parental consent requirements for surveys in schools from active to passive for anonymous surveys. Written permission is still required for non-anonymous surveys. With this bill written denial of permission will be required for anonymous surveys.

School-based surveys are a reliable method for gathering valuable population-based information on youth that helps policy makers, educators, program planners and parents to better understand important health and social issues that affect their chances of program success.

Routine standardized surveys such as the national and state Youth Risk Behavior Survey track trends over time and help guide and evaluate important health and prevention programs. State and federal grant programs that rely on these surveys include tobacco prevention and control, obesity prevention, diabetes, heart disease and stroke, safe and drug free schools and other substance abuse prevention, injury prevention, including violence and suicide prevention, HIV and STD prevention, and more.

Current Alaska statute requires active parental consent on youth participation in surveys. Active parental consent requires written permission to participate in the survey. Active parental consent overburdens the school system and drastically increases the costs and labor involved in conducting student surveys.

Though research and experience suggests that the vast majority of parents would consent to their students participating in such surveys, many schools are unable to use the data they collect because there are not enough participants. Most of the research indicates parental failures to provide written permission are driven by apathy, oversight, or student error – not by refusal. With passive parental consent, the parent is notified and informed about the nature of the survey and allows for the parent to provide a written refusal to participate in the survey.

Notification of surveys and their content will still be sent to every parent of a child that is a candidate to participant in the survey. A parent will have the option of reviewing the entire survey and how it will be administered before it is administered. Any parent who doesn't want their child to participate will have the option to opt-out of the survey.

26-LS0405\E

ALASKA STATE LEGISLATURE

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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

Sectional Analysis

House Bill 130

“An Act relating to questionnaires and surveys administered in public schools.”

Section 1. Requires a school district to get written permission to administer a questionnaire or survey. It exempts anonymous surveys. Surveys that concern public information are also exempted.

Section 2. Requires a school district to provide a parent or guardian the opportunity to deny permission to take an anonymous questionnaire or survey. Written permission is not required.

Section 3. Defines a 2 week time frame for school districts to notice parents of an upcoming questionnaire or survey so that they may either deny permission, for anonymous, or grant permission, for non-anonymous, surveys.

Section 4. Defines what a written notice must contain.

Section 5. Adds language to current statute that defines how a parent can deny permission for student to participate in an anonymous survey.

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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

House Bill 130

"An Act relating to questionnaires and surveys administered in the public schools."

LIST OF WITNESSES

Kate Burkhart

Executive Director of Advisory Board on Alcoholism and Drug Abuse (ABADA) and Alaska
Mental Health Board (AMHB)
907-465-8920

Wilda Laughlin (*tentative*)

Leg. Liaison to Health & Social Services
907-465-1613

Emily Nennon

American Cancer Society
907-229-6962

Fr. Gordon Blue, M. Div

Sitka Counseling & Prevention Services
907-747-1430

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**REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2**

House Bill 130

"An Act relating to questionnaires and surveys administered in the public schools."

AFFECTED DEPARTMENTS

Department of Education and Early Development

Leg. Liaison: Marcy Herman, 907-465-2803

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: CSHB 130(EDC)
 (H) Publish Date: 4/10/09

Identifier (file name): HB130-EED-ESS-4-3-09 Dept. Affected: Education & Early Development
 Title: "An Act relating to questionnaires and surveys
administered in the public schools." RDU: Teaching and Learning Support
 Sponsor: Representative Wilson, Gardner Component: School & Student Achievement
 Requester: Education, Health and Social Services Component Number: 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

The Department of Education and Early Development is submitting a zero fiscal note for HB 130.

This legislation repeals and rewrites most of the initial language in AS 14.03.110 which deals in the approval process of administering questionnaires/surveys to students. It gives a parent or guardian the opportunity to submit a written denial of thier child to participate in the questionnaire/survey being administered by the principal or teacher.

Prepared by: Eddy Jeans, Director
 Division: School Finance
 Approved by: Larry LeDoux, Commissioner
Education & Early Development

Phone 465-8679
 Date/Time 4/3/09 12:00 AM
 Date 4/3/2009



Municipality of Anchorage

P.O. Box 196650 • Anchorage, Alaska 99519-6650 • 825 "L" Street • <http://www.muni.org>



Mayor Matt Claman

Health and Human Services Commission

Peggy Wilson, Representative
State Capitol, Room 408
Juneau, AK 99801-1182

March 11, 2009

Dear Representative Wilson,

I am writing to you as chair of the Municipality of Anchorage Health and Human Services Commission on behalf of our 15 members and the many health organizations we represent. We would like to thank you for all of your hard work and dedication to the state.

As the Health and Human Services Commission, our primary mission is to ensure the health and well-being of the Anchorage community. We rely on current information regarding the health and social status of the Anchorage community to determine our priorities and drive action. Critical to our mission is reliable community data including data about the health and well being of our City's youth.

The Municipality of Anchorage Health and Human Services Commission supports HB 130 "An Act relating to questionnaires and surveys administered in the public schools" to encourage greater participation in school-based surveys. Routine standardized surveys such as the national and state Youth Risk Behavior Survey track trends over time and help guide and evaluate important health and prevention programs. The overall statewide response rate to Youth Risk Behavioral Survey (YRBS) in 2005 was 55 percent, which did not meet the required response rate of 60 percent to make it a valid survey. The State was unable to use the data or publish the report since the data would not be representative of the high school population. Anchorage students are a critical sample for the success of YRBS because of they represent approximately 40% of all high school students in the state. The information gathered through school-based surveys is used to inform programs and initiatives about youth behavior that help drive prioritization of efforts to improve community health. An increase in survey participation improves the reliability and validity of survey responses significantly, which provides organizations like Municipality Department of Health and Human Services with critical, current information regarding the health and social status of youth in our community.

Again, thank you for your commitment to our state and its youth. I would appreciate the opportunity to talk with you on this matter at your convenience.

Sincerely,

Brian Saylor PhD MPH, Chair
Anchorage Health and Human Services Commission

Cc. Mayor Matt Claman
Diane Ingle, Director DHHS

Community, Security, Prosperity

2734

to... of... 20... 20... Op...

textbook, advocates religion is not unconstitutional censorship. State statutes and regulations allowing local school boards to review and approve textbooks do not, on their face, violate the right of parents or students to freely exercise their religion. September 20, 2007 Op. Atty Gen.
Collateral references. Constitutionality of teaching or otherwise promoting secular humanism in public schools. 103 ALR Fed. 538.
 Constitutionality of regulation or policy governing prayer, meditation, or "moment of silence" in public schools. 110 ALR Fed. 211.
 Distribution or use of Bibles in public schools—modern case. 111 ALR Fed. 121.

Part-time school attendance. (a) Except as provided in (b) of this section, upon request, allow a child, including a child who is also a home-schooled student, or is being home schooled, to be a student in the district. A governing body may not discriminate and admit students or require that part-time students be enrolled until enrollment is completed.
 A governing body is not required to allow part-time enrollment if it would be denied even if the enrollee were a full-time student; or if it would result in an expenditure of public funds for the direct benefit of the student.
 Time spent under this section does not constitute attendance for the purposes of interscholastic or extracurricular student activities. 72 and 73 Op. Atty Gen. 120 SLA 1998.

and so long as the practice is not used by private schools on a widespread basis to provide the curriculum requirements of the private school. Enrollment in extracurricular activities is similarly neither prohibited nor required. June 24, 1993 Op. Atty Gen.

Use of school facilities. The governing body of a school district may use school facilities for any legal gatherings or assemblies. The governing body shall exercise reasonable and impartial use of the facilities.

Liability of public schools and institutions. Tort liability of public schools and institutions for injuries or property damage occurring during use of premises and equipment for other than school purposes. 35 ALR3d 712.
 Validity and construction of statute or ordinance forbidding unauthorized persons to enter upon or remain in school building or premises. 50 ALR3d 340.

Search of school lockers. (a) Subject to (b) of this section, a locker or storage container owned by the school or the school district may be searched

(c) Nothing in this section limits the ability of a peace officer, chief of police, or other appropriate person, acting in compliance with local, state, or federal law, to search a locker or other container provided in a public or private school district. (§ 5 ch 33 SLA 1995)

HB 1307

Sec. 14.03.110. Questionnaires and surveys administered in public schools.

(a) A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into personal or private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or legal guardian.

(b) For an anonymous questionnaire or survey, written permission required under (a) of this section may be obtained annually and is valid until the commencement of the subsequent school year or until the parent or legal guardian who gave permission submits a written withdrawal of permission to the school principal. The school shall provide each student's parent or legal guardian at least two weeks' notice before administering a questionnaire or survey described under this subsection.

(c) If a school administers to a student a questionnaire or survey that is not anonymous, the school shall obtain the written permission required under (a) of this section from the student's parent or legal guardian at least two weeks before the questionnaire or survey is administered.

(d) The school shall give a student's parent or guardian an opportunity to review the questionnaire or survey described under (b) or (c) of this section and shall give the parent or guardian written notice regarding

- (1) how the questionnaire or survey will be administered to the student;
- (2) how the results of the survey or questionnaire will be used; and
- (3) who will have access to the questionnaire or survey.

(e) A student may refuse to participate in a questionnaire or survey administered in a public school. A student's parent or legal guardian may refuse to allow the student to participate in a specified questionnaire or survey.

(f) In this section, "questionnaire or survey" means a list of questions to, or information collected from, a class or group of students. (§ 1 ch 23 SLA 1979; am §§ 1, 2 ch 63 SLA 1999)

Opinions of attorney general. — AS 14.03.110 -- is long as survey questions are limited to the student's own activities and the survey does not ask the student questions about parents or other activities occurring within a student's home, the 1997 Youth

Behavior Risk Survey does not impermissibly invade the domain of the student's private 'family' affairs. September 28, 1998 Op. Atty Gen. (Issued before 1999 amendment to this section.)

Sec. 14.03.115. Access to school records by parent, foster parent, or guardian.

Upon request of a parent, foster parent, or guardian of a child under 18 years of age who is currently or was previously enrolled in a municipal school district or a school district that is a regional educational attendance area, the school district shall provide a copy of the child's record. This section does not apply to

(a) a record of a child who is an emancipated minor.



Planned Parenthood of the Great Northwest

March 9, 2009

The Honorable Peggy Wilson
Alaska State House Representative
State Capitol, Rm 403
Juneau, AK 99801-1182

Dear Representative Wilson:

On behalf of Planned Parenthood of the Great Northwest (PPGNW), I'm writing in support of House Bill 130, "*An Act relating to questionnaires and surveys administered in the public schools.*"

Planned Parenthood relies on the results of the school-based Alaska Youth Behavior Risk Survey to determine where our efforts should be in terms of education and STI prevention programs. For accurate survey results it's critical to get as many survey responses as possible. Planned Parenthood recognizes that the current regulations of active parental consent for anonymous surveys decrease the response rate significantly.

House Bill 130 will increase the accuracy of the vital information Planned Parenthood and many other organizations rely on to serve Alaska's young people. Thank you for addressing this issue.

Sincerely,

Clover Simon
Vice President of Alaska
Planned Parenthood of the Great Northwest
(907) 770-9705
clover.simon@ppgnw.org

Planned Parenthood of the Great Northwest
Alaska Administrative Office - 4001 Lake Otis Pkwy
Anchorage, AK 99508



Health and Health Care in Schools

A report on the policies, politics and financing of health programming in schools

Volume 4, Number 3

May 2003

Current issue
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Pupil Rights Law Allows Parents to Opt Students Out of Surveys

[EMAIL THIS ARTICLE \[1-1\]](#)

In this issue

Disclosure of Health Information Sends School District to Court

A 1998 federal law, the Protection of Pupil Rights Amendment (PPRA), allows parents to inspect instructional materials used in connection with any U.S. Department of Education-funded "survey, analysis, or evaluation." The law, often called the "Hatch amendment" or the "Grassley amendment" for the members of Congress who introduced it, also requires schools to obtain written parental consent before minor students participate in Education Department-funded surveys that ask questions about personal or family matters.

Pupil Rights Law Allows Parents to Opt Students Out of Surveys

As the result of recent amendments to PPRA in the No Child Left Behind education law (Public Law 107-110, signed January 8, 2002), parents have additional rights to examine materials with regard to the surveying of minor students, even when the surveys are not Education Department-funded, and to opt their children out of surveys and certain non-emergency medical examinations.

Report Cites Effects on Communities When Families Lack Health Insurance

Worth Noting

The Family Policy Compliance Office (FPCO) in the U.S. Department of Education, which administers the Family Educational Rights and Privacy Act (FERPA), has responsibility for the expanded Protection of Pupil Rights law, also known as the "Tiahrt amendment."

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The original PPRA law required schools and contractors to make educational materials available for inspection by parents and provided a list of survey questions that would trigger the need for written parental permission. Those requirements remain in place. The trigger questions include inquiries about:

Feedback
Comments & questions

1. political affiliations or beliefs of the student or the student's parent;
2. mental and psychological problems of the student or the student's family;
3. sex behavior or attitudes;
4. illegal, anti-social, self-incriminating, or demeaning behavior;
5. critical appraisals of other individuals with whom students have close family relationships;
6. legally recognized privileged or analogous relationships, such as those with lawyers, physicians, and ministers;
7. religious practices, affiliations, or beliefs of the student or student's parent; or
8. income, other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program.

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The PPRA compliance office in the U.S. Department of Education points out that these requirements apply when a survey is funded, at least in part, by any program administered by the U.S. Secretary of Education.

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Under the Tiahrt amendment that took effect in 2002, additional requirements are now in place, and they apply as well to surveys funded by sources other than the U.S. Department of Education. The law now requires public elementary and secondary schools to "develop and adopt policies—in conjunction with parents," regarding:

1. the rights of parents to inspect, upon request, a survey created by a third party before the survey is administered or distributed by a school to students;
2. arrangements to protect student privacy in a survey if it includes any of the eight items noted above;
3. the right of parents to inspect any instructional materials used as part of the education curriculum;
4. administration of physical examinations or screenings that the school may administer to students;
5. collection, disclosure, or use of personal information collected from students for the purpose of marketing, selling;
6. the right of parents to inspect any instrument used in collecting information for marketing or selling.

Schools must notify parents of their PPRA policies at least once annually and must give parents ample opportunity to opt out (remove their child) from participation in surveys containing one or more of the eight items of information specified in the original law.

Parents are also allowed to remove their children from any non-emergency invasive physical examination or screening that is required for attendance or is not necessary to protect the immediate health and safety of the student or other students.

Explanation of the Protection of Pupil Rights Amendment is posted on the Education Department's Family Policy Compliance Office website at

<http://web.archive.org/web/20041030221359/http://www.ed.gov/offices/OM/fpco/ppra/index.html>. The compliance office indicates it will publish regs covering the new parts of the law.

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ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA RESOLUTION 7-2008

Support for Passive Parental Consent for the Youth Risk Behavior Survey

Sponsor: Jayne Andreen

Whereas the Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system that was established in 1988 by the Centers for Disease Control and Prevention (CDC) to help monitor the prevalence of behaviors that put young people at risk for the most significant health and social problems that can occur during adolescence and adulthood.

Whereas the survey examines six categories of adolescent behavior including: 1) behaviors that result in unintentional and intentional injuries; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that can result in HIV infection, other sexually transmitted diseases (STD's) and unintended pregnancies; 5) dietary behaviors; and 6) physical activity.¹

Whereas Alaska's YRBS is a joint project between the Dept. of Education & Early Development and the Dept. of Health and Social Services and was established in Alaska in 1995.²

Whereas survey results are used at the national, state, and local level such as measuring progress towards the national Healthy People 2010 and the Healthy Alaskans 2010 health objectives.

Whereas, understanding the health risk behaviors of youth is critical for developing programs that address risk behaviors practiced and for measuring progress toward program goals.

Whereas Alaska's YRBS has been unable to collect reliable data consistently with the challenge of administering the survey under the active parental consent law AS 14.03.110, which requires written permission from all participating students' parents or legal guardians.²

Whereas employing active parental consent drastically increases costs and labor involved in conducting student surveys, and results in high failure rates for getting enough student responses to get usable data for larger surveys, and the potential for leading to inaccurate/misrepresentative data.³

ALPHA 7-2008
RESOLUTION 7

Whereas Alaska is one of only three states in the nation that has a school survey law requiring active parental consent for surveys of this type.³

Whereas most states employ passive parental consent when administering such surveys which involves notifying and informing the parents about the survey and assuming that students will participate unless the parent provides a written refusal to opt out of the survey.³

Whereas it is believed that the majority of parents consent to their students participating in such surveys and that most parental failures to provide active parental consent (written permission to participate) are driven by apathy, oversight, or student error, not by refusal.⁴

Whereas the survey is anonymous and voluntary.

Therefore be it resolved that the Alaska Public Health Association supports the content and the implementation of the Youth Risk Behavior Survey in Alaska with parental notification and passive parental consent

And be it further resolved that the Alaska Public Health Association supports changing the requirement for participation in the survey from active parental consent to passive parental consent.

References:

¹ Centers for Disease Control and Prevention. Retrieved November 2, 2008 from <http://www.cdc.gov/HealthyYouth/yrbs/brief.htm>

² State of Alaska, Department of Health and Social Services. Retrieved November 2, 2008 from <http://www.hhs.state.ak.us/dph/chronic/school/YRBS.htm>

³ Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. (2006) *Parental Permission and the Youth Risk Behavior Survey*. 2006

⁴ Ellickson P, Hawes JA. An assessment of active versus passive methods for obtaining parental consent. *Evaluation Review* 1989;13(1):45-55.

Alaska BRFSS HIGHLIGHTS 2007

Behavioral Risk Factor Surveillance System

Introduction

Modification of risk behaviors that contribute to chronic disease, premature death and impaired quality of life is an important public health challenge. The Behavioral Risk Factor Surveillance System (BRFSS) collects information on risk factors, chronic disease prevalence and preventive practices that is essential for the development of chronic disease prevention and health promotion efforts aimed at modifying key risk factors. The BRFSS is conducted in all 50 states, the District of Columbia, Guam, Puerto Rico and the US Virgin Islands and is now the longest running and largest telephone health survey in the world. The State of Alaska began surveillance using the BRFSS in 1991 and has continued yearly since. The Alaska BRFSS is a collaborative project of the Centers for Disease Control and Prevention and the Alaska Division of Public Health.



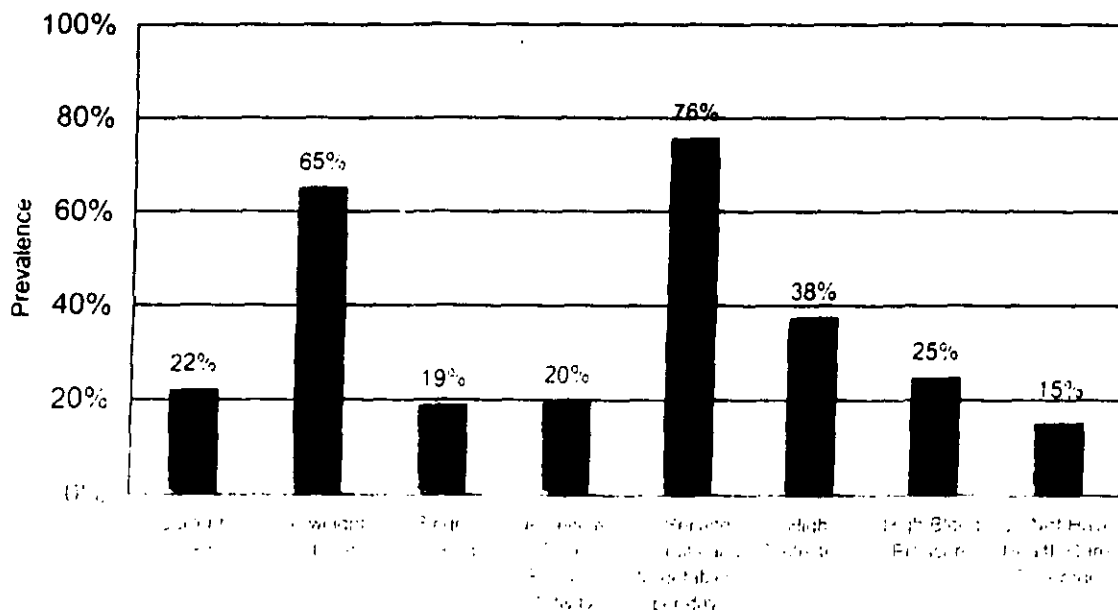
Sarah Palin, Governor
State of Alaska

Karleen K. Jackson, Ph.D., Commissioner
Department of Health and Social Services

Beverly K. Wooley, Director
Division of Public Health

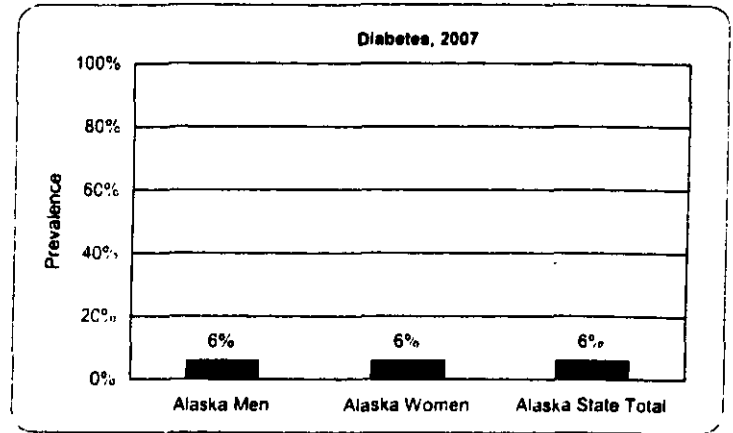
In 2007, 2,552 health interviews were conducted using a standardized BRFSS questionnaire. The interviews were conducted over the telephone from the Health Survey Lab in Juneau using randomly selected telephone numbers. Households were contacted and one adult 18 years of age or older per household was randomly selected to complete the survey. These data were weighted to represent the state's adult population. This report presents highlights from data collected in 2007.

Prevalence of Selected Risk Factors Among Alaskan Adults, 2007



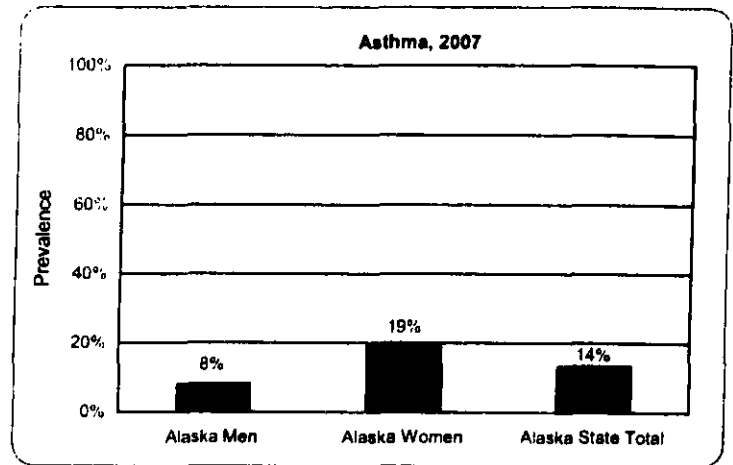
Diabetes

Diabetes increases the risk for heart disease and stroke and can result in blindness and renal disease. In 2007, 6% of Alaskan adults reported being told they have diabetes. There was no difference between men and women in the prevalence of diabetes.



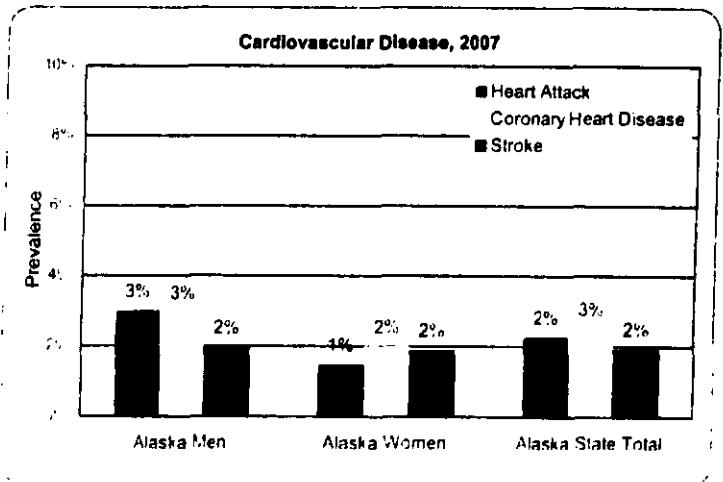
Asthma

Asthma is a leading cause of restricted activity. In 2007, 14% of Alaskan adults reported ever being told they have asthma. Significantly more women than men reported asthma.



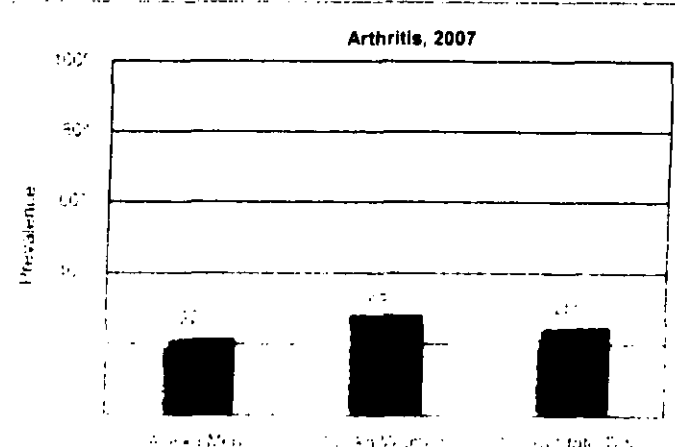
Cardiovascular Disease

Heart disease is a leading cause of death in Alaska and the US as a whole. The BRFSS asks respondents if they have ever been told they have had a heart attack, been told they have coronary heart disease or been told they had a stroke. In 2007, 2% of Alaskan adults said they have had a heart attack, 3% said they have coronary heart disease and 2% said they have had a stroke.



Arthritis

In 2007, 25% of Alaskan adults reported being told by a doctor that they had arthritis. Arthritis covers a variety of different joint conditions and can affect people of all ages.



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Anchorage Daily News

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Risky teen behavior***State law compromises ability to assess how safe our kids are***

(06/03/08 23:28:47)

Everyone needs to know how safe Alaska teenagers are.

Fortunately, there's a way to find out.

An anonymous, scientific survey of young people sponsored by the federal Centers for Disease Control and Prevention shows trends in teens' behavior, from cigarette, alcohol and drug use to sex.

The Youth Risk Behavior Survey, just out for 2007, is a tested longtime report with controls for accuracy.

It tells adults how well they're addressing kids' problems within each state as well as nationally: Are anti-tobacco programs aimed at Alaska kids working? Are we sending an effective message about declining to ride with an impaired driver on prom night?

But trend information on Alaska kids is spotty because the state has erected unreasonable hurdles to getting students to participate.

In 2001 and 2003, because of those hurdles, Anchorage failed to get enough responses for a valid local version of the study. In 2005, the state didn't get enough responses back.

It's time to get rid of the obstacles.

It used to be that districts had to notify parents and give them a chance to opt out of the survey. Any student who wanted to could opt out on his own.

That worked well. State and local districts were able to survey randomly selected students and know that they represented a larger group.

In 1999, responding to parental complaints that the survey is too invasive and personal, the Legislature passed a law saying school districts must get written permission from parents in advance before a student may participate in even an anonymous survey that asks personal questions.

Alaska has to get at least 60 percent of the statewide students chosen in a random sample to participate before the survey results are usable -- before they can be deemed representative of all Alaska students.

Anchorage, to get valid local results, has to do the same.

Both the state and Anchorage achieved it this year, but only by spending tremendous effort and money. The state gave \$70,000 to districts to help them get the responses and still came up with

GUIDELINES FOR PASSIVE CONSENT

Based on recent change to state law,¹ CDE has determined that under certain circumstances LEAs conducting the California Healthy Kids Survey (CHKS) have the option of using passive parental consent, rather than active (written) consent as previously required.² Under passive-consent procedures, parents/guardians inform the school only if they *don't want* their child to participate in a study (opt out).³ To adopt passive consent, the following conditions must be met:

- The survey is limited to grades 7 through 12. Passive consent cannot be used below grade 7.⁴
- It is anonymous, confidential, and voluntary. Active consent must still be used if respondent data are linked to a respondent's name in any form or manner, such as in longitudinal tracked surveys.
- The school board formally adopts, in consultation with parents, a written passive consent policy for the administration of the CHKS (and any other survey or test) consistent with California Education Code sections 51513 and 51938(b) and the federal Protection of Pupil Rights Act (PPRA), 20 USC 1232h.
- Parents/guardians are notified in writing at the beginning of the school year about the survey and when it is to be administered, and given a reasonable opportunity to review the survey and to decline their child's participation (opt out).
- Parents/guardians are notified of any substantive changes in survey policies, dates, or content that occur after the initial notification.
- The parental notice contains all the required elements specified in the CHKS Guidebook for protection of human subjects and in the federal Protection of Pupil Rights Act.
- Questions are not added to the survey that elicit reports of parental attitudes or behaviors or any other category that requires active consent under Ed Code 51513 but not exempted under Ed Code 51938.

The following guidelines are designed to help you determine whether you should switch from written to passive consent and the steps you should take if you decide to make the change.

Benefits of Passive Consent

- Passive consent involves less cost and labor, particularly for the classroom teacher.
- If you have *not* been successful in meeting your target sample using written consent, passive consent will likely increase your response rates.
- Research also suggests that passive consent will result in a more representative sample, as many hard-to-reach subgroups, including groups at high-risk of substance use and other problem behaviors, are underrepresented in written consent surveys.⁵

¹ See Education Code 51938(b), which stipulates: "Notwithstanding Section 51513, anonymous, voluntary, and confidential research and evaluation tools to measure pupils' health behaviors and risks, including tests, questionnaires, and surveys containing age appropriate questions about the pupil's attitudes concerning or practices relating to sex may be administered to any pupil in grades 7 to 12, inclusive, if the parent or guardian is notified in writing that this test, questionnaire, or survey is to be administered and the pupil's parent or guardian is given the opportunity to review the test, questionnaire, or survey and to request in writing that his or her child not participate."

² Written consent requirements and strategies are detailed in the CHKS Guidebook, available online at www.wested.or.hks

³ As described in the CHKS Guidebook, under active-consent procedures parents must confirm in writing that they consent or not, usually by signing and returning a form. If a form is not returned, it must be assumed that parental permission is not granted.

⁴ Education Code 51938(b) authorizes passive consent only for grades 7 through 12 (see note 1)

Considerations for Changing from Active to Passive Consent

- **Written consent provides extra protection** against surveying a student whose parents did not receive notification or did not approve of participation but failed to inform the school. This extra protection may be important if risk behavior surveys are a sensitive issue in your community.
- If passive consent reduces the burden on the classroom teacher, **schools must take special precautions** to demonstrate that they made every reasonable effort possible to inform parents about the survey (and any subsequent changes) and to give them opportunities to opt out.
- If your sample changes (e.g., becomes more representative), it will **complicate interpretation of current trends**. Did student behavior change or the sample? Most research suggests reported AOD use will increase. WestEd will provide talking points to address this issue.
- **If you have been meeting your target response rates using written consent**, you might want to continue using it to avoid the issues listed above, especially if your district will still need to use written consent with 5th grade.

Recommendations for Passive Consent Implementation

Survey procedures must ensure that parents receive the consent materials, pay attention to them, and have sufficient time and opportunities to refuse participation. To assure PPRA compliance and reduce the risk of inadvertently surveying a child without parent permission, we recommend the following:

- **Stress that survey participation is voluntary in all communications.** This is a key requirement for the use of passive consent procedures in the PPRA. Notify students in writing and verbally (before survey administration) that they have the right to decline participation and to not answer any question that makes them uncomfortable. Make sure nothing is done that might cause a student to feel uncomfortable if he doesn't want to participate.
- **Send all consent information and forms via a method that guarantees receipt**, such as by mail. Preferably, use a method that documents receipt. For example, the information can be put into a parent handbook that the parent signs for.
- **Use multiple contact techniques.** Do everything possible to insure parents receive notification.
- **Make sure all materials are language appropriate** for parents with limited English reading ability.⁹
- **Make disapproval notification convenient.** Again, use multiple venues: a written form that can be turned into a teacher, a phone number to call, or email address. Each channel should reach a single person or office, identified in district policies, responsible for monitoring consent. This will help avoid parent refusals from slipping through the cracks.
- **Document** all your efforts to notify parents.

*For more information about consent procedures,
call your regional CHKS advisor at 888.841.7536.*

⁹ The application of active consent procedures to among no is voluntary surveys with rigorous data safeguards and minimal risks to students—such as the CHKS—has been criticized for jeopardizing access to essential information by imposing overly rigid, time-consuming consent procedures.

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Office for Research Protections

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Newsletter : Issue 11 (04/2006 - 07/2006) : FAQs - Conducting In-School Surveys

FAQs - Conducting In-School Surveys Written by Tasha Snyder, Agricultural Sciences

The school setting is an optimal location to survey large numbers of students for research projects. Before planning a data collection study, however, it is important to be aware of federal guidelines and policies that contain regulations relevant for researchers conducting in-school studies of youth. These guidelines have implications for sampling, the informed consent process, and survey content.

Q: What federal regulations should I be aware of before planning an in-school study of youth?

A: The two key federal regulations you need to be familiar with are the Family Education Rights and Privacy Act (FERPA) and the Protection of Pupil Rights Amendment (PPRA). Both federal regulations apply to any institution receiving funds from the U.S. Department of Education.

FERPA

Initially signed into law in 1974, FERPA regulations are periodically updated, most recently under the No Child Left Behind Act of 2001. The main function of FERPA is to protect parent's rights regarding inspection and modification of their child's educational records. Under FERPA regulations parents have the right to inspect their child's educational records, request a correction to any errors in those records, and **parent's written permission must be sought before releasing their child's educational records**. Schools may release limited contact information for students (name, address, phone number, attendance record, date and place of birth, honors and awards) without written parental permission, but parents must be notified of these requests and given the opportunity to request that their child's information not be released.



PPRA

Part of the FERPA and No Child Left Behind legislation, PPRA is designed to protect parent's and pupil's rights regarding inspection of any materials - as part of the instructional curriculum or study instruments - to which students are exposed. Instructional and survey materials must be made available for parents to review, and **schools must obtain written parental consent before their minor students participate in any study that asks about the following:**

- political affiliations or beliefs of the student or student's parents;
- mental and psychological problems that are potentially embarrassing to the student and/or his or her family;
- sexual behaviors and attitudes;
- illegal, antisocial, self incriminating and demeaning behavior;
- critical appraisals of family members;
- legally protected relationships, such as those with lawyers, clergy and physicians;
- religious practices or beliefs of the student or student's parents; or
- income

acceptance rather than being synonymous with refusal. Thus, the active written parental consent process that is required by PPRA could result in an unnecessarily large non-response rate, preventing students from participating in studies.

Regarding sample bias, Esbensen et al. (1999) provide strong evidence that the characteristics of the students whose parents did not respond were different from those whose parents responded, thus introducing bias into their sample. Comparing the pre-test sample with the sample of responders to the active parental consent, including those who allowed their children to participate and those who did not, revealed that the sample of responders was more likely to be white, to come from intact homes (two married parents), and to have parents with more than a high school education. In addition, parents of "at-risk" youth (positive attitudes towards and engagement in delinquent behaviors) were less likely to return consent forms at all. This study documents a selection bias introduced by the active parental consent procedure, and recommends that a mailing be sent home to parents notifying them of the study, and that the parents be given 2-3 weeks to deny their child's participation in the study, after which time period the consent is implied.

More recently, similar findings were reported when Henry et al. (2002) conducted an in-school study of 7th grade students in nine school districts in rural Pennsylvania. Active written parental consent was required for all students participating in their study, however, the project was able to access secondary data on several student characteristics for all eligible students--including GPA and absence from school--which allowed them to determine whether and how their sample was biased on these important characteristics. This study further made comparisons between the consent, non-consent, and non-response groups and determined not only if bias was introduced into their sample, but whether it originated from the non-consent group, the non-response group, or both. Findings revealed that the students whose parents declined their consent did not differ significantly from those whose parents provided consent, but that the students with non-responding parents did differ significantly from those who consented on two key educational variables. The students whose parents provided consent had fewer days of school absence and higher grade point averages compared to the students with non-responding parents. Thus, comparisons of the three groups (consenters, decliners, and non responders) find that the students eliminated from the study because of the lack of permission due to non-responders is the source of sample bias, not the presence of decliners. The result is that the Henry et al. (2002) sample represents students who are less "at-risk" for poor outcomes, thus introducing sample bias.

Both of these studies employed the numerous strategies suggested to increase return rates for active written parental consent. **These strategies include designing effective informational and consent forms, working with key school personnel, multiple mailings to parents, providing rewards for classrooms that have high return rates (such as pizza or ice cream parties), and following up with non-responders** (Esbensen et al., 1999; Fletcher and Hunter, 2003; Henry et al., 2002). Even though these strategies were implemented, both studies report biased samples due to the high degree of non-response associated with written active parental consent procedures.

Q: Yikes! So, what's a child and youth researcher planning to use in-school data collection to do?

A: Well, there really isn't much you can do to completely avoid sampling bias with in-school youth surveys of sensitive topics where active written parental consent is required. The FERPA and PPRA regulations were developed and instituted with the goal of protecting the rights and privacy of parents and students, not to promote easier access to students for research purposes.

Following the suggestions outlined above will help reduce bias in your study. Also keep in mind that sampling bias is an issue for most primary data collection studies.

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Planned Parenthood of the Great Northwest

March 9, 2009

The Honorable Peggy Wilson
Alaska State House Representative
State Capitol, Rm 403
Juneau, AK 99801-1182

Dear Representative Wilson:

On behalf of Planned Parenthood of the Great Northwest (PPGNW), I'm writing in support of House Bill 130, "*An Act relating to questionnaires and surveys administered in the public schools.*"

Planned Parenthood relies on the results of the school-based Alaska Youth Behavior Risk Survey to determine where our efforts should be in terms of education and STI prevention programs. For accurate survey results it's critical to get as many survey responses as possible. Planned Parenthood recognizes that the current regulations of active parental consent for anonymous surveys decrease the response rate significantly.

House Bill 130 will increase the accuracy of the vital information Planned Parenthood and many other organizations rely on to serve Alaska's young people. Thank you for addressing this issue.

Sincerely,

Clover Simon
Vice President of Alaska
Planned Parenthood of the Great Northwest
(907) 770-9705
clover.simon@ppgnw.org

Planned Parenthood of the Great Northwest
Alaska Administrative Office - 4001 Lake Otis Pkwy
Anchorage, AK 99508



Municipality of Anchorage

P.O. Box 196650 • Anchorage, Alaska 99519-6650 • 825 "L" Street • <http://www.muni.org>



Mayor Matt Claman

Health and Human Services Commission

Peggy Wilson, Representative
State Capitol, Room 408
Juneau, AK 99801-1182

March 11, 2009

Dear Representative Wilson,

I am writing to you as chair of the Municipality of Anchorage Health and Human Services Commission on behalf of our 15 members and the many health organizations we represent. We would like to thank you for all of your hard work and dedication to the state.

As the Health and Human Services Commission, our primary mission is to ensure the health and well-being of the Anchorage community. We rely on current information regarding the health and social status of the Anchorage community to determine our priorities and drive action. Critical to our mission is reliable community data including data about the health and well being of our City's youth.

The Municipality of Anchorage Health and Human Services Commission supports HB 130 "An Act relating to questionnaires and surveys administered in the public schools" to encourage greater participation in school-based surveys. Routine standardized surveys such as the national and state Youth Risk Behavior Survey track trends over time and help guide and evaluate important health and prevention programs. The overall statewide response rate to Youth Risk Behavioral Survey (YRBS) in 2005 was 55 percent, which did not meet the required response rate of 60 percent to make it a valid survey. The State was unable to use the data or publish the report since the data would not be representative of the high school population. Anchorage students are a critical sample for the success of YRBS because of they represent approximately 40% of all high school students in the state. The information gathered through school-based surveys is used to inform programs and initiatives about youth behavior that help drive prioritization of efforts to improve community health. An increase in survey participation improves the reliability and validity of survey responses significantly, which provides organizations like Municipality Department of Health and Human Services with critical, current information regarding the health and social status of youth in our community.

Again, thank you for your commitment to our state and its youth. I would appreciate the opportunity to talk with you on this matter at your convenience.

Sincerely,

Brian Saylor PhD MPH, Chair
Anchorage Health and Human Services Commission

Cc. Mayor Matt Claman
Diane Ingle, Director DHHS

Community, Security, Prosperity

Youth Risk Behavior Survey Background

The Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system that was established in 1988 by the Centers for Disease Control and Prevention (CDC). Its purpose is to help monitor the prevalence of behaviors that put young people at risk for the most significant health and social problems that can occur during adolescence and adulthood. It is an anonymous school-based survey of high school students and it is administered on the national and state level every other year. The survey examines six categories of adolescent behavior:

- behaviors that result in unintentional and intentional injuries;
- tobacco use;
- alcohol and other drug use;
- sexual behaviors that can result in HIV infection, other sexually transmitted diseases (STD's) and unintended pregnancies;
- dietary behaviors; and
- physical activity.

Value of the YRBS

The YRBS is the largest and most respected source of data of its kind in the US. Survey results have tremendous value at the national, state, and local level such as measuring progress towards the national Healthy People 2010 and the state Healthy Alaskans 2010 health objectives. Results allow health and educational professionals to track the prevalence of youth risk behaviors over time, to compare their state to other states or to the nation, and when conducted on the local level it allows local communities to measure themselves compared to the rest of the state.

Understanding the health risk behaviors of youth is critical for developing programs that address risk behaviors practiced in their jurisdiction and for measuring progress toward program goals.

YRBS in Alaska

Alaska's YRBS is a joint project between the Dept. of Education & Early Development and the Dept. of Health and Social Services. Alaska first participated in the YRBS in 1995 and has attempted to conduct the survey most every other year since then, with varying degrees of success. Alaska has produced statewide reports in 1995, 1999 (without Anchorage), and in 2003.

Typically 42 schools (approximately 20 districts) in Alaska are scientifically selected from among the high schools in Alaska to participate in the statewide survey. With their cooperation, classrooms from within each school are randomly selected to participate in the survey which generally results in just over 2,000 high school students being eligible to participate. In addition, school districts are given the option to conduct a survey of their entire district in order to gain a better understanding and measure of risk behaviors in their communities. Up to 20 districts each survey year opt to take advantage of this opportunity with the service provided free of charge by the state. In total the YRBS program distributes approximately 12-13,000 surveys for this purpose. Strict precautions are in place to absolutely ensure student confidentiality and participation in the survey is completely voluntary. Students answer the multiple choice questions about their current and past risk behaviors, which are collected and sent to the state for processing. State results are then shared federally with CDC.

Response Rates

In order to ensure that the YRBS data are representative of high schools in Alaska, the majority of surveys need to be completed. Alaska sets a minimum overall response rate of 60% to be able to confidently report the results. The overall response rate is calculated by multiplying the rate of participation of schools with the student response rate. The higher the response rate the more accurate the results. In general, participation rates in Alaska have improved (more schools selected are cooperative) but the student response rate has declined and jeopardized the survey. In 1995, 82% of schools participated and 78% of students in those schools completed the survey resulting in an overall response rate of 64%. In 2005, 93% of the schools participated and 59% of students completed the survey resulting in a 55% overall response rate which was not adequate.

Barriers to Success

A major barrier to success has been the active parental consent law which went into effect at the end of 1999. Alaska's active parental consent law, AS 14.03.110, prohibits schools from administering surveys or questionnaires at public schools that inquire into personal or family affairs, or anything else that is not a matter of public record or readily observable in public (regardless of whether or not the surveys are anonymous and voluntary) without first getting written permission from all participating students' parents or legal guardians. Alaska is one of only two or three states in the nation that has a school survey law requiring active parental consent for surveys of this type. Most states employ passive parental consent when administering such surveys. Passive parental consent involves notifying and informing the parents about the survey and assuming that students will participate unless the parent provides a written refusal to opt out of the survey.

Advantages to active parental consent are greater parental involvement and less risk of students being included in surveys without parental approval. Disadvantages of active parental consent include the drastically increased costs and labor involved in conducting student surveys, the high failure rates for getting enough student responses to get usable data for larger surveys, and the potential for leading to inaccurate/misrepresentative data. Research and our experience suggests that the vast majority of parents consent to their students participating in such surveys and that most parental failures to provide written permission are driven by apathy, oversight, or student error, not by refusal.

Costs

In recent years (since the enactment of active parental consent) more and more resources (time and money) have been spent on YRBS. Since the process of active parental consent places more of a burden on the school administrators and staff, the EED has offered financial incentives to participating schools since 2003 and costs have more doubled. This money has helped schools implement the survey but has not guaranteed its success as far as student response rates. This does not include the basic expense of operating the YRBS, such as the costs for supplies, copying, shipping and staff time.

Support for YRBS in Alaska

The YRBS in Alaska is endorsed by:

- Association of Alaska School Boards
- Alaska Action for Healthy Kids
- All Alaska Pediatric Partnership
- American Heart Association, Pacific/Mountain Affiliate
- American Lung Association of Alaska
- American Cancer Society, Alaska
- Alaska Health Education Consortium
- Alaska Tobacco Control Alliance
- Alaska Native Tribal Health Consortium

For more information on YRBS[®] system visit <http://www.cdc.gov/healthyyouth/yrbs/index.htm> or <http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm> or contact Patty Owen, YRBS Coordinator, DHSS, Division of Public Health, 465-2768 or Patty_Owen@health.state.ak.us

Rebecca Rooney

From: Comeau_Carol [Comeau_Carol@asdk12.org]
Sent: Thursday, April 09, 2009 5:42 PM
To: Friedman_Jeff; Rep. Paul Seaton; Rep. Cathy Munoz; Rep. Bryce Edgmon; Rep. Wes Keller; Rep. Peggy Wilson; Rep. Bob Buch; Rep. Berta Gardner
Cc: Siegfried_Robin
Subject: RE: HB 130 & HB 215

I apologize for taking the easy way out on these bills, but I agree with School Board President Friedman on these issues. I would hope that some discussions during the interim would involve some serious looking at all aspects of a second count, or alternately, a separate fund like a grant for extra enrollment.

Thanks very much,
Carol

Carol Comeau, Superintendent
Anchorage School District
5530 E. Northern Lights Blvd.
Anchorage, AK 99504
Phone: 907-742-4312 Fax: 907-742-4318
comeau_carol@asdk12.org

"There can be no keener revelation of a society's soul than the way in which it treats its children."

Nelson Mandela

-----Original Message-----

From: Friedman_Jeff
Sent: Thursday, April 09, 2009 5:03 PM
To: Representative_paul_seaton@legis.state.ak.us;
Representative_cathy_munoz@legis.state.ak.us;
representative_bryce_edgmon@legis.state.ak.us;
Representative_wes_keller@legis.state.ak.us;
representative_peggy_wilson@legis.state.ak.us;
Representative_robert_buch@legis.state.ak.us;
Representative_berta_gardner@legis.state.ak.us
Cc: Comeau_Carol; Siegfried_Robin
Subject: HB 130 & HB 215

Dear Chair Seaton and Committee Members:

These two bills will be heard by the House Education Committee on Friday.

The Anchorage School Board is in favor of HB 130. We believe we need the flexibility to administer anonymous surveys without going to the expense of attempting to get parental permission from enough parents so the data collected is valid. It isn't that parents tend to object, it's just that the permission form sometimes gets lost along the way. We would still be required to notify parents so they had an opportunity to refuse permission. Parents who do object to these surveys tend to be well informed and get their objections in. The data from these surveys, when valid, helps us address serious social problems such as teen pregnancy and illegal drug use.

HB 215 is fairly new, and the Anchorage School Board has not had time to take a position on this bill. Our administration has noted some potential concerns. First, count periods cost money and time. Conducting a second count will divert resources from the classroom to various administrative functions in our Records, IT, Accounting, and other departments.

Second, there may not be sufficient time between submitting the second count on March 15 for DEED to do its OASIS verification before making its April 15 payment to districts.

This could result in double payments to districts for the same child.

A second count period certainly has some advantages. However, it must be remembered that most schools issue contracts to staff through the end of a school year. If we hire an aide in August to assist a special education student, we can not terminate that aide simply because the special education student moved to Palmer in February. On the other hand, the Mat-Su district can't get additional funding to hire an aide of its own when that student moves without a second count period. That is why ASD previously suggested a small discretionary fund within DEED that districts could apply for when students moved during the year. That might be a more equitable way to handle the movement of some of these more expensive children during the school year.

HB 215 is complex, and may have many consequences, both intended and unintended. I hope the committee takes time to analyze this bill thoroughly and gives districts time to weigh in on this over the interim before the bill moves on.

Jeff Friedman
Anchorage School Board
1534 D Street
Anchorage, AK 99501
907-742-4699 (Home)

These risk behaviors among high school students' ...

Unintentional Injuries and Violence

- 7% Rarely or never wore a seat belt
- 24% Rode with a driver who had been drinking alcohol, during the past month
- 24% Carried a weapon during the past month
- 29% Were in a physical fight during the past year
- 11% Attempted suicide during the past year

Alcohol and Other Drug Use

- 40% Drank alcohol during the past month
- 26% Reported episodic heavy drinking during the past month²
- 21% Used marijuana during the past month
- 8% Ever used cocaine
- 14% Ever used inhalants

Sexual Behaviors

- 45% Ever had sexual intercourse
- 13% Had sexual intercourse with ≥ 4 people
- 31% Had sexual intercourse during the past three months
- 39% Did not use a condom during last sexual intercourse³

Tobacco Use

- 53% Ever tried cigarette smoking
- 18% Smoked cigarettes during the past month
- 7% Smoked cigarettes on ≥ 20 days during the past month
- 10% Used smokeless tobacco during the past month
- 10% Smoked cigars during the past month

Dietary Behaviors

- 84% Ate fruits and vegetables < 5 times/day during the past 7 days
- 22% Drank soda or pop one or more times a day during the past 7 days (not including diet soda or pop)

Physical Activity

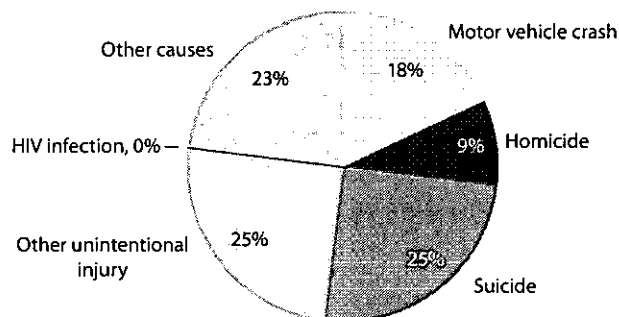
- 58% Did not meet currently recommended levels of physical activity⁴
- 53% Did not attend physical education class
- 82% Did not attend physical education class daily

Overweight

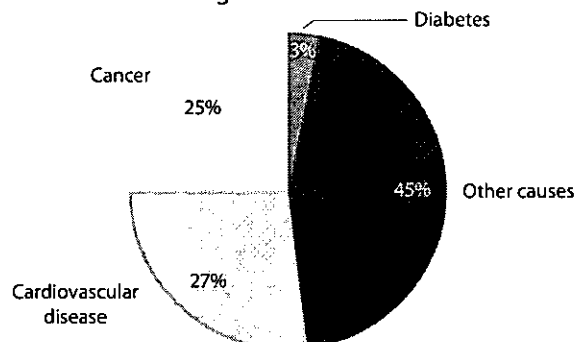
- 16% Were overweight⁵
- 11% Were obese⁶

... contribute to these leading causes of death⁷

Youth Aged 10-24 Years



Adults Aged 25 Years and Older



¹ High school students grades 9-12 in Alaska excluding alternative schools and boarding schools, weighted data.

² Students who had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the past 30 days

³ Among students who had sexual intercourse during the past 3 months.

⁴ Students who were not physically active for a total of at least 60 minutes per day on 5 or more days of the past 7 days.

⁵ Students who were at or above the 85th percentile but below the 95th percentile for body mass index by age and sex.

⁶ Students who were at or above the 95th percentile for body mass index by age and sex.

⁷ 2003-2005 Alaska mortality data, Centers for Disease Control and Prevention.

For more information visit www.hss.state.ak.us/dph/chronic

Or call 1-888-465-3140

The Alaska Youth Risk Behavior Survey is a joint project between the Department of Health and Social Services and the Department of Education & Early Development in cooperation with the Centers for Disease Control and Prevention



2009 Alaska Youth Risk Behavior Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to develop better health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

Directions

- Use a #2 pencil only.
- Make dark marks.
- Fill in a response like this: A B ● D.
- If you change your answer, erase your old answer completely.

1. How old are you?
 - A. 12 years old or younger
 - B. 13 years old
 - C. 14 years old
 - D. 15 years old
 - E. 16 years old
 - F. 17 years old
 - G. 18 years old
 - H. 19 years old or older

2. What is your sex?
 - A. Female
 - B. Male

3. In what grade are you?
 - A. 9th grade
 - B. 10th grade
 - C. 11th grade
 - D. 12th grade
 - E. Ungraded or other grade

4. Are you Hispanic or Latino?
 - A. Yes
 - B. No

5. What is your race? (Select one or more responses.)
 - A. American Indian or Alaska Native
 - B. Asian
 - C. Black or African American
 - D. Native Hawaiian or Other Pacific Islander
 - E. White

6. How tall are you without your shoes on?

Directions: Write your height in the shaded blank boxes. Fill in the matching oval below each number.

Example

Height	
Feet	Inches
5	7
③	⑩
④	①
●	②
⑤	③
⑦	④
	⑤
	⑥
	●
	⑧
	⑨
	⑩
	⑪

7. How much do you weigh without your shoes on?

Directions: Write your weight in the shaded blank boxes. Fill in the matching oval below each number.

Example

Weight Pounds		
1	5	2
①	⑩	⑪
●	①	①
②	②	●
③	③	③
	④	④
	●	⑤
	⑥	⑥
	⑦	⑦
	⑧	⑧
	⑨	⑨

8. During the past 12 months, how would you describe your grades in school?
- A. Mostly A's
 - B. Mostly B's
 - C. Mostly C's
 - D. Mostly D's
 - E. Mostly F's
 - F. None of these grades
 - G. Not sure

E. 6 or more times

The next 4 questions ask about safety.

9. **When you rode a bicycle during the past 12 months, how often did you wear a helmet?**
- A. I did not ride a bicycle during the past 12 months
 - B. Never wore a helmet
 - C. Rarely wore a helmet
 - D. Sometimes wore a helmet
 - E. Most of the time wore a helmet
 - F. Always wore a helmet
10. How often do you wear a seat belt when **riding** in a car driven by someone else?
- A. Never
 - B. Rarely
 - C. Sometimes
 - D. Most of the time
 - E. Always
11. During the past 30 days, how many times did you **ride** in a car or other vehicle **driven by someone who had been drinking alcohol?**
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times
12. During the past 30 days, how many times did you **drive** a car or other vehicle **when you had been drinking alcohol?**
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times

The next 10 questions ask about violence-related behaviors.

13. During the past 30 days, on how many days did you carry a **weapon** such as a gun, knife, or club?
- A. 0 days
 - B. 1 day
 - C. 2 or 3 days
 - D. 4 or 5 days
 - E. 6 or more days
14. During the past 30 days, on how many days did you carry a **gun**?
- A. 0 days
 - B. 1 day
 - C. 2 or 3 days
 - D. 4 or 5 days
 - E. 6 or more days
15. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club **on school property**?
- A. 0 days
 - B. 1 day
 - C. 2 or 3 days
 - D. 4 or 5 days
 - E. 6 or more days
16. During the past 30 days, on how many days did you **not** go to school because you felt you would be unsafe at school or on your way to or from school?
- A. 0 days
 - B. 1 day
 - C. 2 or 3 days
 - D. 4 or 5 days
 - E. 6 or more days
17. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club **on school property**?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or 7 times
 - F. 8 or 9 times

- G. 10 or 11 times
- H. 12 or more times

18. During the past 12 months, how many times were you in a physical fight?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or 7 times
 - F. 8 or 9 times
 - G. 10 or 11 times
 - H. 12 or more times
19. During the past 12 months, how many times were you in a physical fight in which you were injured and had to be treated by a doctor or nurse?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times
20. During the past 12 months, how many times were you in a physical fight on school property?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or 7 times
 - F. 8 or 9 times
 - G. 10 or 11 times
 - H. 12 or more times
21. During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?
- A. Yes
 - B. No
22. Have you ever been physically forced to have sexual intercourse when you did not want to?
- A. Yes
 - B. No

The next question asks about bullying. **Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.**

23. During the past 12 months, have you ever been bullied on school property?
- A. Yes
 - B. No

The next 5 questions ask about sad feelings and attempted suicide. **Sometimes people feel so depressed about the future that they may consider attempting suicide, that is, taking some action to end their own life.**

24. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
- A. Yes
 - B. No
25. During the past 12 months, did you ever seriously consider attempting suicide?
- A. Yes
 - B. No
26. During the past 12 months, did you make a plan about how you would attempt suicide?
- A. Yes
 - B. No
27. During the past 12 months, how many times did you actually attempt suicide?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times

28. **If you attempted suicide** during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?
- A. **I did not attempt suicide** during the past 12 months
 - B. Yes
 - C. No

The next 13 questions ask about tobacco use.

29. Have you ever tried cigarette smoking, even one or two puffs?
- A. Yes
 - B. No
30. How old were you when you smoked a whole cigarette for the first time?
- A. I have never smoked a whole cigarette
 - B. 8 years old or younger
 - C. 9 or 10 years old
 - D. 11 or 12 years old
 - E. 13 or 14 years old
 - F. 15 or 16 years old
 - G. 17 years old or older
31. During the past 30 days, on how many days did you smoke cigarettes?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
32. During the past 30 days, on the days you smoked, how many cigarettes did you smoke **per day**?
- A. I did not smoke cigarettes during the past 30 days
 - B. Less than 1 cigarette per day
 - C. 1 cigarette per day
 - D. 2 to 5 cigarettes per day
 - E. 6 to 10 cigarettes per day
 - F. 11 to 20 cigarettes per day
 - G. More than 20 cigarettes per day

33. During the past 30 days, how did you **usually** get your own cigarettes? (Select only **one** response.)
- A. I did not smoke cigarettes during the past 30 days
 - B. I bought them in a store such as a convenience store, supermarket, discount store, or gas station
 - C. I bought them from a vending machine
 - D. I gave someone else money to buy them for me
 - E. I borrowed (or bummed) them from someone else
 - F. A person 18 years old or older gave them to me
 - G. I took them from a store or family member
 - H. I got them some other way
34. During the past 30 days, on how many days did you smoke cigarettes **on school property**?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
35. Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?
- A. Yes
 - B. No
36. During the past 12 months, did you ever try **to quit** smoking cigarettes?
- A. I did not smoke during the past 12 months
 - B. Yes
 - C. No
37. During the past 30 days, on how many days did you use **chewing tobacco, snuff, or dip**, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
38. During the past 30 days, on how many days did you use **chewing tobacco, snuff, or dip on school property**?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
39. During the past 30 days, on how many days did you smoke **cigars, cigarillos, or little cigars**?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
40. During the past 7 days, on how many days were you in the same room with someone who was smoking cigarettes?
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
 - G. 6 days
 - H. 7 days

41. How much do you think people risk harming themselves (physically or in other ways), if they smoke one or more packs of cigarettes per day?
- A. No risk
 - B. Slight risk
 - C. Moderate risk
 - D. Great risk

The next 7 questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

42. During your life, on how many days have you had at least one drink of alcohol?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 9 days
 - D. 10 to 19 days
 - E. 20 to 39 days
 - F. 40 to 99 days
 - G. 100 or more days
43. How old were you when you had your first drink of alcohol other than a few sips?
- A. I have never had a drink of alcohol other than a few sips
 - B. 8 years old or younger
 - C. 9 or 10 years old
 - D. 11 or 12 years old
 - E. 13 or 14 years old
 - F. 15 or 16 years old
 - G. 17 years old or older
44. During the past 30 days, on how many days did you have at least one drink of alcohol?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days

45. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 to 5 days
 - E. 6 to 9 days
 - F. 10 to 19 days
 - G. 20 or more days

46. During the past 30 days, how did you **usually** get the alcohol you drank?
- A. I did not drink alcohol during the past 30 days
 - B. I bought it in a store such as a liquor store, convenience store, supermarket, discount store, or gas station
 - C. I bought it at a restaurant, bar, or club
 - D. I bought it at a public event such as a concert or sporting event
 - E. I gave someone else money to buy it for me
 - F. Someone gave it to me
 - G. I took it from a store or family member
 - H. I got it some other way

47. During the past 30 days, on how many days did you have at least one drink of alcohol **on school property**?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days

48. How much do you think people risk harming themselves (physically or in other ways), if they have one or two drinks of an alcoholic beverage (beer, wine, or liquor) nearly every day?
- A. No risk

- B. Slight risk
- C. Moderate risk
- D. Great risk

The next 5 questions ask about marijuana use. Marijuana also is called grass or pot.

- 49. During your life, how many times have you used marijuana?
 - A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 to 99 times
 - G. 100 or more times

- 50. How old were you when you tried marijuana for the first time?
 - A. I have never tried marijuana
 - B. 8 years old or younger
 - C. 9 or 10 years old
 - D. 11 or 12 years old
 - E. 13 or 14 years old
 - F. 15 or 16 years old
 - G. 17 years old or older

- 51. During the past 30 days, how many times did you use marijuana?
 - A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times

- 52. During the past 30 days, how many times did you use marijuana on school property?
 - A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times

- 53. How much do you think people risk harming themselves (physically or in other ways), if they smoke marijuana regularly?
 - A. No risk
 - B. Slight risk
 - C. Moderate risk
 - D. Great risk

The next 9 questions ask about other drugs.

54. During your life, how many times have you used **any** form of cocaine, including powder, crack, or freebase?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times
55. During the past 30 days, how many times did you use **any** form of cocaine, including powder, crack, or freebase?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times
56. During your life, how many times have you sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times
57. During your life, how many times have you used **heroin** (also called smack, junk, or China White)?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times

58. During your life, how many times have you used **methamphetamines** (also called speed, crystal, crank, or ice)?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times
59. During your life, how many times have you used **ecstasy** (also called MDMA)?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times
60. During your life, how many times have you used a needle to inject any **illegal** drug into your body?
- A. 0 times
 - B. 1 time
 - C. 2 or more times
61. During your life, how many times have you taken a **prescription drug** (such as OxyContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax) without a doctor's prescription?
- A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times
62. During the past 12 months, has anyone offered, sold, or given you an illegal drug **on school property**?
- A. Yes
 - B. No

The next 7 questions ask about sexual behavior.

63. Have you ever had sexual intercourse?

- A. Yes
- B. No

- 64. How old were you when you had sexual intercourse for the first time?
 - A. I have never had sexual intercourse
 - B. 11 years old or younger
 - C. 12 years old
 - D. 13 years old
 - E. 14 years old
 - F. 15 years old
 - G. 16 years old
 - H. 17 years old or older

- 65. During your life, with how many people have you had sexual intercourse?
 - A. I have never had sexual intercourse
 - B. 1 person
 - C. 2 people
 - D. 3 people
 - E. 4 people
 - F. 5 people
 - G. 6 or more people

- 66. During the past 3 months, with how many people did you have sexual intercourse?
 - A. I have never had sexual intercourse
 - B. I have had sexual intercourse, but not during the past 3 months
 - C. 1 person
 - D. 2 people
 - E. 3 people
 - F. 4 people
 - G. 5 people
 - H. 6 or more people

- 67. Did you drink alcohol or use drugs before you had sexual intercourse the **last time**?
 - A. I have never had sexual intercourse
 - B. Yes
 - C. No

- 68. The **last time** you had sexual intercourse, did you or your partner use a condom?

- A. I have never had sexual intercourse
- B. Yes
- C. No

69. The **last time** you had sexual intercourse, what **one** method did you or your partner use to **prevent pregnancy**? (Select only **one** response.)
- A. I have never had sexual intercourse
 - B. No method was used to prevent pregnancy
 - C. Birth control pills
 - D. Condoms
 - E. Depo-Provera (injectable birth control)
 - F. Withdrawal
 - G. Some other method
 - H. Not sure

The next 4 questions ask about body weight.

70. How do **you** describe your weight?
- A. Very underweight
 - B. Slightly underweight
 - C. About the right weight
 - D. Slightly overweight
 - E. Very overweight
71. Which of the following are you trying to do about your weight?
- A. **Lose** weight
 - B. **Gain** weight
 - C. **Stay** the same weight
 - D. I am **not trying to do anything** about my weight
72. During the past 30 days, did you **exercise** to lose weight or to keep from gaining weight?
- A. Yes
 - B. No
73. During the past 30 days, did you **eat less food, fewer calories, or foods low in fat** to lose weight or to keep from gaining weight?
- A. Yes
 - B. No

The next 9 questions ask about food you ate or drank during the past 7 days. Think about all the meals and snacks you had from the time you got up until you went to bed. Be sure to include food you ate at home, at school, at restaurants, or anywhere else.

74. During the past 7 days, how many times did you drink **100% fruit juices** such as orange juice, apple juice, or grape juice? (Do **not** count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)
- A. I did not drink 100% fruit juice during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
75. During the past 7 days, how many times did you eat **fruit**? (Do **not** count fruit juice.)
- A. I did not eat fruit during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
76. During the past 7 days, how many times did you eat **green salad**?
- A. I did not eat green salad during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
77. During the past 7 days, how many times did you eat **potatoes**? (Do **not** count french fries, fried potatoes, or potato chips.)
- A. I did not eat potatoes during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
78. During the past 7 days, how many times did you eat **carrots**?
- A. I did not eat carrots during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
79. During the past 7 days, how many times did you eat **other vegetables**? (Do **not** count green salad, potatoes, or carrots.)
- A. I did not eat other vegetables during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day

80. During the past 7 days, how many times did you drink a **can, bottle, or glass of soda or pop**, such as Coke, Pepsi, or Sprite? (Do **not** include diet soda or diet pop.)
- A. I did not drink soda or pop during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
81. During the past 7 days, how many times did you drink a **can, bottle, or glass of a sugar sweetened drink**, such as sports drinks, sweetened energy drinks, Snapple, fruit punch, Kool-Aid, Tang, or Capri-Sun? (Do **not** include soda or pop, diet drinks, or 100% fruit juice.)
- A. I did not drink sugar sweetened drinks during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
82. During the past 7 days, how many **glasses of milk** did you drink? (Include the milk you drank in a glass or cup, from a carton, or with cereal. Count the half pint of milk served at school as equal to one glass.)
- A. I did not drink milk during the past 7 days
 - B. 1 to 3 glasses during the past 7 days
 - C. 4 to 6 glasses during the past 7 days
 - D. 1 glass per day
 - E. 2 glasses per day
 - F. 3 glasses per day

The next 6 questions ask about physical activity.

83. During the past 7 days, on how many days were you physically active for a total of **at least 60 minutes per day**? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.)
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
 - G. 6 days
 - H. 7 days
84. On an average school day, how many hours do you watch TV?
- A. I do not watch TV on an average school day
 - B. Less than 1 hour per day
 - C. 1 hour per day
 - D. 2 hours per day
 - E. 3 hours per day
 - F. 4 hours per day
 - G. 5 or more hours per day
85. On an average school day, how many hours do you play video or computer games or use a computer for something that is not school work? (Include activities such as Nintendo, Game Boy, PlayStation, Xbox, computer games, and the Internet.)
- A. I do not play video or computer games or use a computer for something that is not school work
 - B. Less than 1 hour per day
 - C. 1 hour per day
 - D. 2 hours per day
 - E. 3 hours per day
 - F. 4 hours per day
 - G. 5 or more hours per day

86. In an average week when you are in school, on how many days do you go to physical education (PE) classes?
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
87. During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?
- A. I do not take PE
 - B. Less than 10 minutes
 - C. 10 to 20 minutes
 - D. 21 to 30 minutes
 - E. 31 to 40 minutes
 - F. 41 to 50 minutes
 - G. 51 to 60 minutes
 - H. More than 60 minutes
88. During the past 12 months, on how many sports teams did you play? (Include any teams run by your school or community groups.)
- A. 0 teams
 - B. 1 team
 - C. 2 teams
 - D. 3 or more teams

The next 3 questions ask about other health-related topics.

89. Have you ever been taught about AIDS or HIV infection in school?
- A. Yes
 - B. No
 - C. Not sure
90. Has a doctor or nurse ever told you that you have asthma?
- A. Yes
 - B. No
 - C. Not sure
91. Do you still have asthma?

- A. I have never had asthma
- B. Yes
- C. No
- D. Not sure

The next 8 questions ask about other health topics.

- 92. How often does one of your parents talk with you about what you are doing in school?
 - A. Never
 - B. Less than once a month
 - C. About once or twice a month
 - D. About once or twice a week
 - E. About every day

- 93. Do you agree or disagree that your teachers really care about you and give you a lot of encouragement?
 - A. Strongly agree
 - B. Agree
 - C. Not sure
 - D. Disagree
 - E. Strongly disagree

- 94. Besides your parents, how many adults would you feel comfortable seeking help from if you had an important question affecting your life?
 - A. 0 adults
 - B. 1 adult
 - C. 2 adults
 - D. 3 adults
 - E. 4 adults
 - F. 5 or more adults

- 95. During an average week, how many hours do you spend helping or volunteering at school or in the community (such as helping elders or neighbors; watching young children; teaching or tutoring; peer helping; mentoring; or helping out at local programs, health clinics, faith organizations, tribal organizations, or environmental organizations)?
 - A. 0 hours
 - B. 1 hour
 - C. 2 hours
 - D. 3 to 5 hours
 - E. 6 to 10 hours
 - F. 11 or more hours

96. During an average week, on how many days do you take part in organized after school, evening, or weekend activities (such as school clubs; community center groups; music, art, or dance lessons; drama; church; or cultural or other supervised activities)?
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
 - G. 6 days
 - H. 7 days
97. Do you agree or disagree that you feel alone in your life?
- A. Strongly agree
 - B. Agree
 - C. Not sure
 - D. Disagree
 - E. Strongly disagree

98. Do you agree or disagree that in your community you feel like you matter to people?
- A. Strongly agree
 - B. Agree
 - C. Not sure
 - D. Disagree
 - E. Strongly disagree
99. Do you agree or disagree that your school has clear rules and consequences for behavior?
- A. Strongly agree
 - B. Agree
 - C. Not sure
 - D. Disagree
 - E. Strongly disagree

**This is the end of the survey.
Thank you very much for your help.**



Health and Health Care in Schools

A report on the policies, politics and financing of health programming in schools

Volume 4, Number 3

May 2003

Current issue
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Pupil Rights Law Allows Parents to Opt Students Out of Surveys

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In this issue

Disclosure of Health Information Sends School District to Court

A 1998 federal law, the Protection of Pupil Rights Amendment (PPRA), allows parents to inspect instructional materials used in connection with any U.S. Department of Education-funded "survey, analysis, or evaluation." The law, often called the "Hatch amendment" or the "Grassley amendment" for the members of Congress who introduced it, also requires schools to obtain written parental consent before minor students participate in Education Department-funded surveys that ask questions about personal or family matters.

Pupil Rights Law Allows Parents to Opt Students Out of Surveys

Report Cites Effects on Communities When Families Lack Health Insurance

As the result of recent amendments to PPRA in the No Child Left Behind education law (Public Law 107-110, signed January 8, 2002), parents have additional rights to examine materials with regard to the surveying of minor students, even when the surveys are not Education Department-funded, and to opt their children out of surveys and certain non-emergency medical examinations.

Worth Noting

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The Family Policy Compliance Office (FPCO) in the U.S. Department of Education, which administers the Family Educational Rights and Privacy Act (FERPA), has responsibility for the expanded Protection of Pupil Rights law, also known as the "Tiahrt amendment."

Readers respond
Read comments from our readers

The original PPRA law required schools and contractors to make educational materials available for inspection by parents and provided a list of survey questions that would trigger the need for written parental permission. Those requirements remain in place. The trigger questions include inquiries about:

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1. political affiliations or beliefs of the student or the student's parent;
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8. income, other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program.

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The PPRA compliance office in the U.S. Department of Education points out that these requirements apply when a survey is funded, at least in part, by any program administered by the U.S. Secretary of Education.

[Return to front page](#)

Under the Tiahrt amendment that took effect in 2002, additional requirements are now in place, and they apply as well to surveys funded by sources other than the U.S. Department of Education. The law now requires public elementary and secondary schools to "develop and adopt policies—in conjunction with parents," regarding:

1. the rights of parents to inspect, upon request, a survey created by a third party before the survey is administered or distributed by a school to students;
2. arrangements to protect student privacy in a survey if it includes any of the eight items noted above;
3. the right of parents to inspect any instructional materials used as part of the education curriculum;
4. administration of physical examinations or screenings that the school may administer to students;
5. collection, disclosure, or use of personal information collected from students for the purpose of marketing, selling;
6. the right of parents to inspect any instrument used in collecting information for marketing or selling.

Schools must notify parents of their PPRA policies at least once annually and must give parents ample opportunity to opt out (remove their child) from participation in surveys containing one or more of the eight items of information specified in the original law.

Parents are also allowed to remove their children from any non-emergency invasive physical examination or screening that is required for attendance or is not necessary to protect the immediate health and safety of the student or other students.

Explanation of the Protection of Pupil Rights Amendment is posted on the Education Department's Family Policy Compliance Office website at

<http://web.archive.org/web/20041030221359/http://www.ed.gov/offices/OM/fpco/ppra/index.html>. The compliance office indicates it will publish regs covering the new parts of the law.

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Healthy Alaska

2007 YRBS Results
December 2007

Inside This Issue:

- 2007 Alaska YRBS – Weighted Data
- Alaska YRBS Comparison & Trends
- Leading causes of Death and YRBS Results
- Key Findings

2007 Alaska YRBS results are posted online at

<http://hss.state.ak.us/dph/chronic/school/yrbresults.htm>

2008 Alaska Reading First Summit

<http://www.eed.state.ak.us/tls/readingfirst/summit.html>



Brain Booster —

A sundial is said to be the timepiece with the fewest moving parts. What is the timepiece with the most moving parts?

2007 Alaska YRBS – Weighted Data

In 2003 Alaska became the first state with active parent consent required for participation in school surveys like the YRBS to ever collect enough responses to yield usable data on a statewide level, and with your help we did it again in 2007! Alaska needed 60% of all students selected for the survey to actually participate in the survey to achieve usable (representative) data and 60% is exactly what Alaska managed to collect. Had any of the participating schools chosen not to participate, or had the participating schools not worked so hard to collect signed permission slips, Alaska would have fallen short in its efforts. The YRBS represents Alaska's most comprehensive and reliable source of information on the prevalence of risk behaviors in Alaska's youth that contribute to the leading causes of death and disease in Alaskans. Countless health agencies, families, and school districts rely on the YRBS data when applying for competitive grants and also to measure whether or not their current intervention and prevention programming is working. Alaska now has usable data from 2007, 2003, and 1995 which allows it to understand and measure trends in youth risk behaviors across more than a decade. Great work!

Alaska YRBS Comparison & Trends

The 2007 Alaska YRBS results are very similar to the results of the 2003 Alaska YRBS. This is not surprising since changes are usually gradual. Over the last 12 years the prevalence of many risk behaviors has decreased. The prevalence of smoking cigarettes, drinking alcohol, using marijuana, and physical fighting seem to be going down. The percent of students that have ever had sexual intercourse or reported having sexual intercourse in the past three months has stayed about the same. Percentage of students taught about AIDS or HIV infection in schools has gone down.

The 2007 Alaska YRBS results are very similar to the national YRBS data from 2005 (which is the last available data – 2007 national survey results will be released next summer). Fewer students in Alaska reported being in a physical fight in the past 12 months compared to the national results (29.2% vs. 35.9%) but more students in Alaska reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the past 12 months (12.4% vs. 9.2%). The percent of Alaskan high school students attending daily PE is lower than the national average with only 17.7% of high school students attending daily PE in Alaska compared to 33% of those in the national 2005 YRBS survey.



**Brain Booster—
Answer:**

An hourglass—filled with many grains of sand or other granular material.

**Healthy Students
Learn Best – Boot
Camp for Teachers**

<http://www.eed.state.ak.us/tls/schoolhealth/>

Applications due
December 19th!

**AMSEA
Children & Youth
Educators Program**

<http://www.amsea.org/schools/index.html>

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To subscribe directly to our newsletter, visit us at:
www.eed.state.ak.us/tls/schoolhealth/subscribe.htm

*****FEEDBACK*****

We are looking for feedback! If there are any changes you would like to see made and/or suggestions for content of the newsletter, please send them to Sarah Schaal at:
sarah.schaal@alaska.gov

School Health Partners:



www.eed.state.ak.us/tls/schoolhealth/



www.hss.state.ak.us/dph/chronic/school/default.htm

Leading Causes of Death and YRBS Results

Suicide is the leading cause of death of Alaska youth (ages 15-19). The Alaska YRBS data indicates that 14.1% have made a plan about how they would attempt suicide and 10.7% actually attempted suicide one or more times in the past 12 months. Motor vehicle crashes are the second leading cause of death among Alaska youth. 23.5% of Alaska youth report having driven in a car by someone who had been drinking and 9.7% reported driving a car when they had been drinking.

Key Findings

The survey asked students to report certain risky behaviors. Key findings are listed below.

Alcohol and drug use:

- ❖ 39.7 percent of high school students had consumed alcohol within the past 30 days;
 - Compared to 38.7 percent in 2003 and 47.5 percent in 1995;
- ❖ 20.5 percent of high school students reported using marijuana in the past 30 days;
 - Compared to 23.9 percent in 2003 and 28.7 percent in 1995; and
- ❖ 25.1 percent of students were offered, sold or given an illegal drug by someone on school property during the past 12 months;
 - Compared to 28.4 percent in 2003 and 34.1 percent in 1995.

Violence and suicide:

- ❖ 29.2 percent of high school students had been in a physical fight during the past year;
 - Compared to 27.1 percent in 2003 and 35.8 percent in 1995;
- ❖ 12.4 percent had been physically hurt by a boyfriend or girlfriend in the past year;
 - Compared to 10.8 percent in 2003 (1995 numbers were not available); and
- ❖ 10.7 percent reported attempting suicide in the past 12 months;
 - Compared to 8.1 percent in 2003 and 9.4 percent in 1995.

Obesity:

The obesity epidemic in Alaska and the nation contributes to the risk of heart disease, stroke, diabetes, and other chronic diseases. Health habits such as good nutrition and being physically active are the key to maintaining a healthy weight.

- ❖ 84.3% of high school students do not eat the recommended daily servings of fruits and vegetables.
- ❖ 57.5% did not get the recommended 60 minutes of physical activity per day for most days of the week.
- ❖ 82.3% did not attend daily PE classes.
- ❖ 27.3 percent were overweight or at risk of being overweight.

Other behaviors that increase the risk of health problems:

- ❖ 45.1 percent of high school students have had sexual intercourse;
 - Compared to 39.6 percent in 2003 and 47.2 percent in 1995; and
- ❖ 17.8 percent of high school students smoked in the past 30 days;
 - Compared to 19.2 percent in 2003 and 36.5 percent in 1995.

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Fact Sheet

COMMISSIONER'S OFFICE

FOR IMMEDIATE RELEASE: Nov. 19, 2007

Fact Sheet: 2007 Youth Risk Behavior Survey (YRBS)

What is the Youth Risk Behavior Survey (YRBS)?

The Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system that was established in 1990 by the Centers for Disease Control and Prevention (CDC). It was developed to monitor health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include:

- Tobacco use;
- Unhealthy dietary behaviors;
- Inadequate physical activity;
- Alcohol and other drug use;
- Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; and
- Behaviors that contribute to unintentional injuries and violence.

What are the purposes of the YRBS?

- Determine the prevalence of health risk behaviors;
- Assess whether health risk behaviors increase, decrease, or stay the same over time;
- Provide comparable national, state and local data;
- Provide comparable data among subpopulations of youth; and
- Monitor progress toward achieving the Healthy People 2010 objectives and other program indicators.

How long has Alaska participated in the YRBS?

The YRBS high school survey was first implemented at the national level in 1990. Since that time CDC has sponsored national surveys from 1991 to the present on an every-other-year basis. Alaska first participated in the YRBS in 1995 and obtained representative statewide data. Due to external factors, the YRBS was not administered in 1997. It was administered in 1999; however the Anchorage School District did not participate. Without Anchorage the data were not representative of the state as a whole. The survey was administered in 2001, but unfortunately low student response rates rendered the data unusable. A major obstacle in 2001 was the constraint of the active parental consent law that had just gone into effect. In 2003 the survey was administered statewide with active parental consent and representative data were obtained, making this

the first statewide YRBS representative sample since 1995. The survey was again administered in 2005, however the response rate fell just below the target and the data was not used. In 2007, the survey was administered and achieved an adequate response rate, yielding important survey results.

What is the difference between active and passive consent?

Alaska's active parental consent law, AS 14.03.110, prohibits public schools from administering surveys or questionnaires that ask about personal or family affairs, or anything else that is not a matter of public record or readily observable in public, without first getting written permission from all participating students' parents or legal guardians. This law holds regardless of whether the surveys are anonymous and voluntary. Alaska is one of only a few states in the nation that has a school survey law requiring active parental consent for surveys of this type. Most states employ passive parental consent when administering such anonymous surveys. Passive parental consent involves notifying and informing the parents about the survey and assuming that students will participate unless the parent provides a written refusal to opt out of the survey.

How was the YRBS conducted?

A two-stage sample design was used to select the actual students for participation. The first stage consisted of selecting schools. Schools were selected with probability proportional to the size of their enrollment. Once a school was selected, classes were selected as the second stage. Eligible classes were those where a student would be enrolled in one and only one class at a time. For example second period or required English. This gave each student an equal opportunity of being selected. At any time a school district, an individual school, a student's parents, or a specific student had the opportunity to decline participation.

At the classroom level, teachers were given a script to read to students that established guidelines for student privacy and anonymity and the importance of the survey. Each student was given an unmarked envelope in which to seal his or her survey before turning it in. These survey envelopes remained sealed until received at a central state collection site. The Centers for Disease Control and Prevention and a CDC contractor analyzed the state survey data.

A national YRBS also was conducted in 2007, however, the results will not be available until early summer 2008. As a result, 2005 National YRBS results are being used for comparison purposes.

Who participated in the survey?

Forty one high schools from 19 districts were scientifically selected to be included in the survey. Thirty-eight (88 percent) schools participated and 1,318 (68 percent) students completed the survey resulting in an overall response rate of 60 percent. The CDC has determined that the overall response rate must be 60 percent or greater in order for the data to represent the high school population of the state. Therefore, these survey results represent 34,399 students grades 9 through 12 in public high schools (excluding private, alternative, boarding and correctional schools).

How are the data used?

The results of the YRBS are used to detect changes in risk behaviors over time and provide an important piece of program planning and evaluation, curriculum development and decision-making regarding the use of available resources. The information from the YRBS can be used to help schools and communities identify strengths and weaknesses in current programs and services. Additionally the results can be used by schools and communities when applying for grant funding to initiate or maintain programs that serve youth.

Who supported the YRBS in Alaska?

The YRBS in Alaska is a cooperative effort between the state departments of Health and Social Services and Education and Early Development. The survey is also endorsed by the following groups and boards:

- Association of Alaska School Boards
- Alaska Action for Healthy Kids
- All Alaska Pediatric Partnership
- American Heart Association, Pacific/Mountain Affiliate
- American Lung Association of Alaska
- American Cancer Society, Alaska
- Alaska Health Education Consortium
- Alaska Tobacco Control Alliance
- Alaska Native Tribal Health Consortium

Contact: Greg Wilkinson, HSS, (907) 269-7285, Cell (907) 382-7032
Ann Potempa, HSS, (907) 269-7957, Cell (907) 240-9158
Eric Fry, EED, (907) 465-2851

###

HB

141

ALASKA STATE HOUSE OF REPRESENTATIVES

**Contact:**

Interim Address:

3340 Badger Road
North Pole, AK 99705
(907)-488-5725
Fax# (907)-488-4271

Session

(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 214

REPRESENTATIVE JOHN COGHILL

Sponsor Statement HB 141

"An Act relating to the Interstate Compact for Juveniles; relating to the State Council for Interstate Adult Offender Supervision; amending Rules 4 and 24, Alaska Rules of Civil Procedure; and providing for an effective date."

This bill would enact the new Interstate Compact for Juveniles into law. This would replace the old compact which was created in 1955. The purpose of the Compact is to ensure the supervision of juvenile offenders and the return of runaways, escapees and absconders. The Compact provides the procedural means to regulate the movement of juveniles who are under court supervision across state lines. The Association of Compact Administrators estimates that the Interstate Compact on Juveniles is used in 20,000 to 30,000 transfer and supervision cases annually.

The new Compact ensures that all states will have identical language in their statutes which would help with compliance issues. The new Compact provides procedures for enforcement which the old Compact lacked. The Interstate Compact for Juveniles also provides for the collection of standardized information and information sharing systems.

This is a chance for the states to have the means to deal with state problems and enforce state solutions without having any federal intervention. 35 states have already passed this compact. If Alaska chooses not to enact this Compact the state would have to deal with every other state on a case-by-case basis which would cost the state more money than it would cost to implement the Compact.

The compact provides for the safety of the juvenile offender and the state as a whole. The importance of this compact cannot be overstated. This legislation is necessary to ensure the public safety and security of Alaskans. It will help ensure that Alaska receives notification about juveniles who are relocated or traveling to Alaska before they arrive here, and will expedite Alaska's ability to send juveniles from here to other jurisdictions.

February 20, 2009- HB

26-LS0576/R

ALASKA STATE HOUSE OF REPRESENTATIVES



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Session

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REPRESENTATIVE JOHN COGHILL

SECTIONAL

HB 141

"An Act relating to the Interstate Compact for Juveniles; relating to the State Council for Interstate Adult and Juvenile Offender Supervision; amending Rules 4 and 24(b), Alaska Rules of Civil Procedure; and providing for an effective date."

Section 1: AS 33.36.140 State Council:

- (a) Adds the words **and Juvenile** to the State Council for Interstate Offender Supervision. Adds a reference to the repealed and reenacted statute AS 47.15.010.

Section 2: AS 33.36.140

- (b) changes the number of council members from seven to **nine**.
(6) adds the position of **the commissioner of health and social services** and provides that the commissioner may appoint a designee to serve in his/her capacity.
(7) adds the position of the **compact administrator appointed under AS 47.15.020**.

Section 3: AS 44.21.410(a)

- (a) (5) deletes the word [UNIFORM], adds the word **for** and deletes the word [ON] in order to change the name of the Compact to the Interstate Compact for Juveniles.

Section 4: AS 47.15.010

The Execution of interstate compact is repealed and reenacted.

Section 5: AS 47.15.020

Changes the designator of the compact administrator from the Governor to the commissioner of health and social services and adds a comma to ensure proper grammar.

Section 6: AS 47.15

Adds a new section: AS 47.15.025 which designates the State Council for Interstate Adult and Juvenile Offender Supervision to serve as the state council under AS 47.15.010.

Section 7: AS 47.15

Adds a new section: AS 47.15.035 which allows the Department of Health and Social Services to adopt regulations to implement the provisions of this chapter.

Section 8: AS 47.15.070

Cleanup of section for clarity.

Section 9: AS 47.15.080

States that the short title of this chapter may be cited as the Interstate Compact for Juveniles.

Section 10: AS 47.15.050

Appointment of attorney or guardian provision is covered in AS 47.12.090.

Section 11: The uncodified law of the State of Alaska is amended by adding a new section:

- (1) Changes the name of the Compact to the Interstate Compact for Juveniles in Rule 4 in Alaska Rules of Civil Procedure.
- (2) Changes the name of the Compact to the Interstate Compact for Juveniles in Rule 24(b) in the Alaska Rules of Civil Procedure.

Section 12: The uncodified law of the State of Alaska is amended by adding a new section:

This section applies the old Compact to the states who do not opt to join the new Compact.

Section 13: The uncodified law of the State of Alaska is amended by adding a new section:

Court rule changes only take effect if it is approved by 2/3 of the majority of each house.

Section 14: The uncodified law of the State of Alaska is amended by adding a new section:

The Compact takes effect only if at least 34 other states ratify the Interstate Compact for Juveniles.

Section 15: Setting the effective date as either the day after the date on which the commissioner

of health and social services or the commissioner's designee notifies the revisor of statutes that at least 34 other states have ratified the new Compact or July 1, 2009 whichever is later.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB141
() Publish Date: _____

Identifier (file name): HB141-DHSS-PS-03-04-09 Dept. Affected: Health & Social Services
Title: Compact for Juveniles: Interstate Council RDU: Juvenile Justice
Component: Probation Services
Sponsor: Coghill
Requester: House HSS Component Number: 2134

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel	13.0		13.0	13.0	13.0	13.0	13.0	13.0
Contractual	27.0		27.0	27.0	27.0	27.0	27.0	27.0
Supplies	5.0		5.0	5.0	5.0	5.0	5.0	5.0
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	45.0	0.0	45.0	45.0	45.0	45.0	45.0	45.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF	45.0		45.0	45.0	45.0	45.0	45.0	45.0
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	45.0	0.0	45.0	45.0	45.0	45.0	45.0	45.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

Since 1960, the Interstate Compact on Juveniles has provided states, including Alaska, with the procedural means to regulate the movement of court-supervised juveniles across state lines. Approximately 160 juveniles under the supervision of the Department of Health and Social Services leave or enter Alaska each year. This bill would place a new, extensively revised compact into Alaska statute replacing the current compact. The new compact seeks to correct deficiencies in the existing compact that have been identified at the national level with regard to administration, rules, enforcement procedures, financial management, communications and data sharing.

(continued on next page)

Prepared by: Stephen F. McComb Phone 907-261-4335
Division: Juvenile Justice Date/Time 3/2/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 3/4/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. HB 141

ANALYSIS CONTINUATION

Participation in the new compact requires that the state council implement and oversee compact functions. However, because some of the membership requirements for the juvenile compact council are the same as those required for the Alaska State Council for Interstate Adult Offender Supervision, the state intends to have a single state council oversee both compacts. Combining the two responsibilities under the authority of a single council will save the state the effort and duplication of creating and managing two councils with similar functions.

Being part of the new compact will create additional costs to the division. Costs include the following:

- \$13.0 Travel associated with membership participation, including travel to required meetings by staff
- \$27.0 Membership Dues, teleconferences, overhead costs that include chargeback, etc.
- \$ 5.0 Supplies for staff and required meetings

Dues to participate in the current compact are \$400 per year. Dues to participate in the new compact are expected to be \$14,000 per year.

The cost estimates for the participation in the state council only reflect those anticipated for the operations for the juvenile justice compact and do not include operational and other costs associated with the ongoing adult council activities. The existing adult council has not had in-person meetings for several years, and at least initially the division anticipates that such meetings will be necessary to address the added juvenile justice functions. The travel costs reflected in this fiscal note are again only intended to portray the costs for the juvenile compact activities. The travel costs also reflect the intent that council members represent all areas of the state.

A possible one-time additional cost to the division may also be incurred by adoption of this bill. The new compact will require use of a national database management system that may need to communicate with the division's MIS. The national system is still under development. Without knowing when the new system will be available, or how difficult it will be to link the two systems, we are not prepared to estimate a cost at this time. The division may need to make a specific request to meet this cost at some point in the future.

In addition, the division will be monitoring the amount of additional staff time required to participate in the new compact. At some point an increment request may be needed to fund a position if absorption of these duties is too challenging for our existing staff. The division needs to ensure we do not hamper our ability to research, apply for, and successfully win grants, such as the federal Re-Entry and Gang Prevention grants that have been invaluable in improving public safety and helping the state monitor and improve its response to gang issues. If the increase in workload forces staff to spend less time involved in the management of existing programs (these include the federal Juvenile Justice and Delinquency Prevention Formula Program, the Enforcing Underage Drinking Laws program, Title V, Juvenile Accountability Block Grants, Bureau of Justice Assistance grant management, and Youth Court earmark) current federal funding that the division receives could be at risk.

List of People to Testify on HB 141

- Barb Murray or Anthony Newman
- Carol Brenkle
- Barb Tyndall
- Michael Jeffery

Departments Affected

- Department of Corrections: They will be sharing the duties of administering the interstate council

**RESOLUTION OF THE
AMERICAN PROBATION AND PAROLE ASSOCIATION**

“Interstate Compact for Juveniles”

Whereas, The Interstate Compact on Juveniles was established in 1955 and is the primary compact addressing the needs of juveniles within the justice system who move between states and has not been sufficiently amended in its 47-year existence; and

Whereas, This compact is the only vehicle for the controlled movement of juveniles released from custody or on probation across state lines; and

Whereas, The complexities of the compact have become more difficult to administer, and many jurisdictions have expanded supervision expectations to include currently unregulated practices such as victim input, victim notification requirements and sex offender registration; and

Whereas, After national surveys and a detailed study by a task force appointed by the Office of Juvenile Justice and Delinquency Prevention, the overwhelming recommendation has been to amend the document to bring about an effective management capacity that addresses public safety concerns, offender accountability and effective treatment needs.

BE IT THEREFORE RESOLVED, That the Board of Directors of the American Probation and Parole Association hereby endorses and recommends adoption of the amended and newly titled Interstate Compact for Juveniles by the 50 states and affected territories of the United States of America.

January 5, 2003

CSG GOVERNING BOARD/EXECUTIVE COMMITTEE

RESOLUTION ON

THE INTERSTATE COMPACT FOR JUVENILES

WHEREAS, The Interstate Compact on Juveniles was established in 1955 and is the compact addressing the needs of juveniles within the juvenile justice system who move between states and has not been sufficiently amended in its forty-seven (47) year existence; and

WHEREAS, This compact is the only vehicle for the interstate supervision of juvenile offenders, the return of absconders and escapees, and runaways; and

WHEREAS, The complexities of the compact have become more difficult to administer, and many jurisdictions have expanded supervision and program expectations to include currently unregulated practices such as victim input and notification requirements, sex offender registration, and age related issues; and

WHEREAS, After exhaustive research and detailed study, the Office of Juvenile Justice and Delinquency Prevention and The Council of State Governments convened an Advisory Group and Drafting Team to formulate recommendations and implement changes to the compact language to better address public safety, enforcement, accountability and communication concerns.

NOW THEREFORE BE IT RESOLVED, That The Council of State Governments hereby endorses and recommends adoption of the new compact entitled, "Interstate Compact for Juveniles" by the fifty (50) states, the District of Columbia, Puerto Rico and effected territories of the United States of America.

Adopted this 8th Day of December, 2002 at the
CSG Annual State Trends and Leadership Forum
In Richmond, Virginia

**Resolution of the
Association of Juvenile Compact Administrators**

“Interstate Compact for Juveniles”

Whereas, The Interstate Compact on Juveniles was established in 1955 and is the compact addressing the needs of juveniles within the juvenile justice system who move between states and has not been sufficiently amended in its forty-seven (47) year existence; and

Whereas, This compact is the only vehicle for the interstate supervision of juvenile offenders, the return of absconders and escapees, and runa ways; and

Whereas, The complexities of the compact have become more difficult to administer, and many jurisdictions have expanded supervision and program expectations to include currently unregulated practices such as victim input and notification requirements, sex offender registration, and age related issues; and

Whereas, After national surveys and a detailed study by a task force appointed by the Office of Juvenile Justice and Delinquency Prevention, the recommendation has been to rewrite the document to bring about an effective management capacity that addresses public safety concerns and juvenile accountability.

Be it therefore resolved, That the Association of Juvenile Compact Administrators hereby endorses and recommends adoption of the new compact entitled “Interstate Compact for Juveniles” by the fifty (50) states, the District of Columbia, and affected territories of the United States of America.

Adopted this 10th day of August, 2002.



Office of the President

National District Attorneys Association
99 Canal Center Plaza, Suite 510, Alexandria, Virginia 22314
703.549.9222 / 703.836.3195 Fax
www.ndaa-apri.org

February 19 , 2003

Mr. Daniel M. Sprague
Executive Director
The Council of State Governments
P.O. Box 11910
Lexington, KY 40578-8001

Dear Mr. Sprague:

On behalf of the Board of Directors of the National District Attorneys Association I want to offer our support for the Interstate Compact for Juveniles. Our Board unanimously voted to support your effort during our recent meeting in Texas.

As local prosecutors we have to work daily with juveniles that require the attention of our court system and we recognize the need for interstate supervision of juvenile offenders and for the return of those who have escaped, run away or fail to live up to release expectations.

We also recognize that the changes in the complexities of our society have made many of the provisions of the compact badly out dated. Ideas such as community corrections, sexual predator registrations and victims rights provisions all impact on the how states must relate to each other in dealing with criminal offenders and in this instance, juveniles.

The Board of Directors considered the importance of addressing consistent treatment of juveniles in need of both consequences and treatment. The proposed Compact language provides states with the means of accomplishing these goals.

Sincerely,

Daniel M. Alsobrooks
District Attorney General, 23rd Judicial District, Tennessee
President, National District Attorneys Association



Charles B. Wang International
Children's Building
699 Prince Street
Alexandria, VA 22314-3175
U.S.A.

Telephone 703.274.3900

Facsimile 703.274.2200

www.missingkids.com

November 1, 2002

Mr. Daniel M. Sprague
Executive Director
The Council of State Governments
Headquarters Office
P.O. Box 11910
Lexington, Kentucky 40578-8001

Dear Mr. Sprague:

The National Center for Missing & Exploited Children (NCMEC) is pleased to support the proposed Interstate Compact Initiative for Juveniles. As an organization that provides services to runaway youth and their families, we are pleased that this enhanced initiative will ensure consistent use of those policies governing the Compact.

Although, primarily designed to assist those organizations working within the juvenile justice, and social service systems, the Compact will assist NCMEC in it's work to bring children back home by providing law enforcement professionals with clear guidelines and procedures once a missing youth is recovered.

As you work to implement this initiative throughout the 50 states, please do not hesitate to let us know if we can be of further assistance in this most important venture.

Sincerely,

Ernie Allen
President & CEO
NCMEC

Branches
California
Florida
Kansas City
New York
South Carolina

EXECUTIVE COMMITTEE

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President
Frankfort, Kentucky

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Finance Manager

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(517) 432-1242

January 28, 2003

Chad S. Foster
Policy Analyst
The Council of State Governments
2760 Research Park Drive
PO Box 11910
Lexington, KY 40578-1910

Dear Mr. Foster:

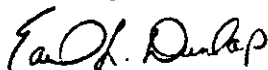
As one of participating entities, the National Juvenile Detention Association (NJDA) has been actively involved in the review and update of the Interstate Compact on Juveniles, originally established in 1955. The two-year effort to modernize the Compact has been thorough and comprehensive and has engaged the efforts of many practitioners from the juvenile justice field. The process addressed a multiplicity of issues regarding the Compact that have been identified as problematic or outdated in an effort to develop a document that meets the current needs of stakeholders in the signatory states.

The nation's detention centers deal with the Compact frequently as the entities responsible for housing juveniles found to be in violation of placement agreements or of state laws in the receiving states. The proposed modifications to the Compact should address many of the issues that have created problems for detention centers and will offer assistance to them in dealing with both sending and receiving states.

As the association serving juvenile detention nationally, NJDA supports the proposed changes to the Compact. The changes are designed to address the needs of the states, of the agencies within the states, and of the public in ensuring that placement agreements are complied with and community safety is ensured.

We are happy to offer assistance to you in your efforts to achieve adoption of the revised Interstate Compact for Juveniles.

Sincerely,



Earl L. Dunlap, Executive Director
National Juvenile Detention Association

cc: file
Executive Committee

AJJAC

ALASKA JUVENILE JUSTICE
ADVISORY COMMITTEE

Alaska Juvenile Justice Advisory Committee
P.O. Box 110635
Juneau, AK 99811-0635
Phone: (907) 465-3855
Fax: (907) 465-2333



March 4, 2009

Carol Brenckle
Chair

502 Hemlock
Kenai, AK 99611
Phone: (907) 283-4343

Alaska Legislature
Alaska State Capitol
Juneau, AK 99801

Barbara Tyndall
Secretary

P.O. Box 82977
Fairbanks, AK 99708
(907) 457-4673

Dear Legislators:

Members

Raelene Active
Chris Alkidge
Vicki Blankenship
Seth Church
John Combs
Kana Howarth
Richard Isett
Michael Jeffery
Beverly Jenkins
Larry LeDoux
Judy Norton-Eledge
Laura Ogan
Michael Reed
Samantha Wheaton
Tina Woods

The Alaska Juvenile Justice Advisory Committee (AJJAC) held an in-person meeting in Juneau on March 2-3, 2009. At the meeting Division of Juvenile Justice (DJJ) presented information on HB 141, which included the benefits of passing this legislation as well as the potential public safety issues if HB 141 does not pass.

After discussion, the AJJAC voted unanimously on March 2, 2009 to support HB 141, the Interstate Compact for Juveniles.

Please feel free to contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Carol Brenckle".

Carol Brenckle
AJJAC Chair

HB

168

CS FOR HOUSE BILL NO. 168(HSS)

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Kerttula

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to state certification and designation of trauma centers; creating the**
2 **uncompensated trauma care fund to offset uncompensated trauma care provided at**
3 **certified and designated trauma centers and including a portion of the tax levy on**
4 **alcohol as a source of money that may be appropriated to the trauma care fund; and**
5 **providing for an effective date."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1.** AS 18.08.082 is amended by adding a new subsection to read:

8 (c) The commissioner shall establish special designations in regulation for
9 varying levels of trauma care provided by a certified trauma center that shall be used
10 to set compensation eligibility and amounts under AS 18.08.085. The designations
11 shall be based on nationally recognized standards and procedures.

12 *** Sec. 2.** AS 18.08 is amended by adding a new section to read:

13 **Sec. 18.08.085. Uncompensated trauma care fund; creation.** (a) The

1 uncompensated trauma care fund is created. The purpose of the fund is to compensate
2 certified trauma centers in the state that receive a special designation under
3 AS 18.08.082(c) for care uncompensated by the person receiving the care or by any
4 other source.

5 (b) The fund consists of money appropriated to it by the legislature, including
6 donations, recoveries of or reimbursements for awards made from the fund, income
7 from the fund, and other program receipts from activities under this chapter.
8 Appropriations to the fund do not lapse.

9 (c) The commissioner shall administer the fund in accordance with the
10 provisions of this chapter. The commissioner shall spend money from the
11 uncompensated trauma care fund for the purpose established in (a) of this section. The
12 commissioner may establish and seek the advice of a special committee for review of
13 statewide trauma care and compensation standards.

14 (d) The commissioner may not provide more than 25 percent of the total
15 assets, including earnings, of the fund in a fiscal year to one trauma center.

16 * **Sec. 3.** AS 43.60 is amended by adding a new section to read:

17 **Sec. 43.60.055. Disposition of proceeds; availability for appropriation to**
18 **the uncompensated trauma care fund.** The portion of the tax collected under
19 AS 43.60.010 that is not separately accounted for under AS 43.60.050(a) may be
20 appropriated to the uncompensated trauma care fund (AS 18.08.085). Nothing in this
21 section creates a dedicated fund.

22 * **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

AMENDMENT

OFFERED IN THE HOUSE
TO: HB 168

BY REPRESENTATIVE HERRON

1 Page 1, line 3, following "centers":

2 Insert "**and including a portion of the tax levy on cigarettes as a source of money**
3 **for that fund**"

4

5 Page 2, following line 12:

6 Insert a new bill section to read:

7 "*** Sec. 3.** AS 43.50.190 is amended by adding a new subsection to read:

8 (f) A portion of the annual proceeds of the tax levied under (a) of this section
9 may be appropriated to the uncompensated trauma care fund established under
10 AS 18.08.085."

11

12 Renumber the following bill section accordingly.

TRAUMA CARE IN ALASKA



Creating a Trauma
Care Fund



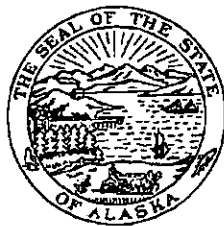
House Bill 168

Senate Bill 168

**ALASKA'S TRAUMA SYSTEM DEVELOPMENT FOLDER
TRAUMA LEGISLATION HOUSE AND SENATE BILLS 168**

SECTION	TOPIC
1	SPONSOR BACK UP & HB 168
2	TRAUMA FACT SHEET
3	TRAUMA CARE IN ALASKA 2009 SLIDES
4	TRAUMA MORTALITY RATES-ANCHORAGE
5	EMERGENCY TRAUMA CARE NEEDS IMPROVEMENT IN ALASKA LETTER
	ALASKA NEEDS A BETTER TRAUMA SYSTEM LETTER
6	AMERICAN COLLEGE OF SURGEONS RECOMMENDATIONS
7	TRAUMA SUSTEM CONSULTATION – STATE OF ALASKA, November 2008
8	APPENDIX
	-HARRIS POLL OBJECTIVES AND METHODOLOGY
	-ALASKA STATE MEDICAL ASSOCIATION (ASMA) LETTER OF SUPPORT
	-NATIONAL CONFERENCE OF STATE LEGISLATURES
	-TRAUMA SYSTEM FUNDING MECHANISMS BY STATE
	-UNCOMPENSATED TRAUMA CARE BY STATE
	-TRAUMA LEGISLATION STICKS FROM OTHER STATES

ALASKA STATE HOUSE OF REPRESENTATIVES



SENATOR JOHN COGHILL

HB 168 Certification and Designation of Trauma Centers

Sponsor Statement

This legislation would create a trauma care fund which could reimburse trauma centers for uncompensated or undercompensated services. The bill would create incentives for becoming a certified trauma center but does not force facilities to become certified trauma centers.

Trauma is the leading cause of death for Alaskans between the age of one and forty-four and more than 800 Alaskans are hospitalized each year for spinal cord and brain injuries.

There is a "golden hour" after the injury during which proper treatment and appropriate interventions will potentially save a patient's life and prevent further damage to an injured person. Personal trauma is any bodily injury from an external force including car crashes, shootings, falls, snow machine crashes, and stabbings.

A good trauma system is an organized multidisciplinary response to managing treatment of severely injured people and it spans the full spectrum from prevention and emergency care to recovery and rehabilitation. A trauma system enhances the chance of survival by making sure patients are brought to the most appropriate facility in the most efficient manner and that optimal care is delivered every step of the way. Alaska has many good parts to our trauma response but we must do better.

ALASKA STATE HOUSE OF REPRESENTATIVES



Contact:

Interim Address:

**3340 Badger Road
North Pole, AK 99705
(907)-488-5725
Fax# (907)-488-4271**

Session

**(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 214**

SENATOR JOHN COGHILL

HB 168 Designate Trauma Centers and the Uncompensated Trauma Care Fund

Sectional

Section 1. AS 18.08.082 currently prescribes by regulation criteria for training programs and for personnel involved in emergency medical services. This section adds a requirement for the commissioner of Health and Social Services establish special designations for varying levels of services offered by a certified trauma center.

Section 2. Establishes a trauma care fund to be used to compensate certified trauma centers for uncompensated trauma care. The fund can accept money appropriated by the legislature, which can include donations, income from the fund, and of the other designated receipts. The commissioner is given authority to establish a special committee for review of the program and limits are set on the distribution of the funds.

Section 3. The bill has an immediate effective date.

SENATE BILL NO. 168

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE BY REQUEST

Introduced: 3/27/09

Referred: Health and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state certification and designation of trauma centers; creating the
2 uncompensated trauma care fund to offset uncompensated trauma care provided at
3 certified and designated trauma centers; and providing for an effective date."

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 * **Section 1.** AS 18.08.082 is amended by adding a new subsection to read:

6 (c) The commissioner shall establish special designations in regulation for
7 varying levels of trauma care provided by a certified trauma center that shall be used
8 to set compensation eligibility and amounts under AS 18.08.085. The designations
9 shall be based on nationally recognized standards and procedures.

10 * **Sec. 2.** AS 18.08 is amended by adding a new section to read:

11 **Sec. 18.08.085. Uncompensated trauma care fund; creation.** (a) The
12 uncompensated trauma care fund is created. The purpose of the fund is to compensate
13 certified trauma centers in the state that receive a special designation under
14 AS 18.08.082(c) for care uncompensated by the person receiving the care or by any

1 other source.

2 (b) The fund consists of money appropriated to it by the legislature, including
3 donations, recoveries of or reimbursements for awards made from the fund, income
4 from the fund, and other program receipts from activities under this chapter.
5 Appropriations to the fund do not lapse.

6 (c) The commissioner shall administer the fund in accordance with the
7 provisions of this chapter. The commissioner shall spend money from the
8 uncompensated trauma care fund for the purpose established in (a) of this section. The
9 commissioner may establish and seek the advice of a special committee for review of
10 statewide trauma care and compensation standards.

11 (d) The commissioner may not provide more than 25 percent of the total
12 assets, including earnings, of the fund in a fiscal year to one trauma center.

13 * Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 168
 () Publish Date: _____

Identifier (file name): HB168-REV-TRS-2-8-10 Dept. Affected: Revenue
 Title: Uncompensated Trauma Care fund RDU: Taxation and Treasury
 Component: Treasury Division
 Sponsor: Representative Kerttula
 Requester: House Health and Social Services Component Number: 121

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

This bill establishes a fund to compensate certain certified trauma centers in Alaska for care uncompensated by the person receiving the care or by another source. This fund will be invested within the GeFonsi investment pool. No additional costs have been identified.

Prepared by: Pamela J. Leary, Comptroller
 Division: Treasury Division
 Approved by: Ginger Blaisdell, Director
Administrative Services Division

Phone 465-2300
 Date/Time 2-8-10; 10:01am
 Date 2/8/2010; 8:12pm

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB168
 () Publish Date: _____

Identifier (file name): HB168-DHSS-IPEMS-02-08-10 Dept. Affected: Health & Social Services
 Title: Trauma Care Centers/Fund RDU: Public Health
 Component: Injury Prevention/Emergency Medical Services
 Sponsor: Coghill
 Requester: House HSS Component Number: 2876

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB 168 establishes a mechanism to provide a financial incentive for hospitals to become designated as certified trauma centers in order to encourage their participation in a statewide trauma system, with the goal of improving delivery of trauma care in the Alaska medical system. This bill establishes a fund for reimbursement of trauma care for uninsured or underinsured patients, and allows designated trauma centers to apply for compensation of claims that are otherwise uncompensated by insurance or other funds.

The Department proposes to manage this fund using existing staff resources.

Prepared by: Ward B. Hurlburt, M.D., MPH, Chief Medical Officer / Director Phone 269-8126
 Division: Public Health Date/Time 2/4/10 1:13 PM
 Approved by: Alison Elgee, Assistant Commissioner Date 2/8/2010
DHSS Finance & Management Services

State of Alaska H&SS Public Notice myAlaska Health & Social Services find

IPEMS
Section of Injury Prevention & Emergency Medical Services

IPEMS UNITS
Emergency Medical Services Injury Surveillance & Prevention



Trauma-Emergency Medical Services System in Alaska

Background:

Alaska's Trauma-EMS System is a work in progress. A great deal has been accomplished since 1992 when the state received the first year of a three-year federal grant specifically targeted toward trauma care system development. Since federal funding has been re-instated, there has been further momentum in enhancing our system.

We currently have a committee the Alaska Trauma System Review Committee that assists the State in the development, enhancement, and evaluation of our Trauma-EMS System.

In 1993 Alaska passed enabling legislation for trauma care system development and accompanying regulations, ([AS 18.08.010-015](#), and [AAC 26.710-745](#)) were adopted in 1996.

Trauma Center Designation:

An important component of Alaska's trauma care system is certified trauma centers. Trauma centers provide an organized and timely response to traumatic injury. What this means in Alaska is:

- The hospital has demonstrated commitment to providing the best trauma care possible by allowing experts to review staffing and qualifications, procedures, protocols and resources;
- The hospital meets state and national standards for providing timely and optimal care for the trauma patient, and;
- The hospital is prepared to treat and transport trauma patients according to Alaska's system-wide plan.

There are four levels of trauma center designation/certification. Alaska has adopted the criteria set forth by the American College of Surgeons Committee on Trauma (ACSCOT). Prior to applying for state certification, Level I, II, and III

American College of Surgeons recommendations for a trauma system:

- [ACS Recommendations Presentation](#)

Trauma Training:

Continuing education training in trauma care for healthcare providers is an important component of a Trauma-EMS System.

Advanced Trauma Life Support (ATLS) Courses are offered periodically throughout the year in Anchorage at the Alaska Native Medical Center (ANMC) and occasionally in other areas of the state. For more information on the ATLS courses at ANMC, contact [Mary Leemhuis, RN](#) at (907) 729-2729; or [Casie Williams, RN](#) at (907) 729-2936. In addition, Providence Alaska Medical Center is providing ATLS courses. Contact [Jeanne Molitor, RN](#) for information.

Basic Trauma Life Support (BTLS) Courses are offered periodically through the EMS Regional offices. [Contact the nearest office](#) for more information.

Trauma Nursing Core Course (TNCC) and Emergency Nursing Pediatric Course (ENPC) are other courses available around the state. For more information contact [Jeanne Molitor, RN](#). For TNCC only contact [Mary Leemhuis, RN](#) or [Margaret \(Rocky\) Carlson, RN](#).

Trauma care continuing medical education training is often available at the State and Regional EMS Symposia. Click [HERE](#) for more information.

Alaska Trauma Registry:

Alaska is very fortunate to have a great

trauma centers must complete an application to ACSCOT and have a verification visit by a team from ACSCOT. Using ACSCOT criteria, Level IV trauma centers are verified by a state team, appointed by the Alaska Division of Public Health.

- **Level I – Regional Resource Center** – Level I Trauma Centers generally serve large cities or population-dense areas. A Level I Trauma Center is responsible for providing leadership in research, professional and community education. There are no Level I Trauma Centers in Alaska because, there are no trauma research and teaching facilities in Alaska.

- **Level II – Regional Trauma Centers** – A Level II Trauma Center provides comprehensive trauma care and serves as a lead trauma facility for a geographical area. A Level II Trauma Center provides educational outreach and prevention programs and assumes responsibility for trauma system leadership. There are emergency physicians and nurses in-house to initiate resuscitation and stabilization, with surgical teams on call and promptly available.

- **Level III – Area Trauma Center** – The Level III Trauma Center provides assessment, resuscitation, emergency surgery, and stabilization and, for the most critically injured patients, arranges for transfer to a Level I or Level II trauma center that can provide further definitive care. A general surgeon must be promptly available and the facility must be involved with prevention and have an active outreach program for its referring communities.

- **Level IV – Local Trauma Stabilization Center** – Level IV Trauma Centers are small rural facilities that provide initial evaluation and assessment of injured patients prior to transfer to a larger referral facility.

For more information, you can download a brochure about [Trauma Center Certification in Alaska](#).

Below are documents/links to assist hospitals interested in seeking Trauma Center Designation.

For the American College of Surgeons, Committee on Trauma (ACSCOT) Level I, II, III verification program visit:
<http://www.facs.org/trauma/verificationhosp.html>

For the pre-review questionnaire for Level I, II, and III verification visit:
<http://www.facs.org/trauma/prq.doc>

To request for a verification visit from ACSCOT visit:
<http://www.facs.org/trauma/sitevisitapplication1006.doc>

source of data through our [Alaska Trauma Registry](#).

Links:

[American College of Surgeons](#) is a scientific and educational association of surgeons founded to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The Committee on Trauma works to improve the care of injured and critically ill patients – before, en route to, and during hospitalization. Their web site has information on trauma center designation and Advanced Trauma Life Support courses.

[American Trauma Society](#) is dedicated to the prevention of trauma and improvement of trauma care. The society is a strong advocate for injury care and prevention and have numerous programs.

[American College of Emergency Physicians](#) promotes the highest standards of patient care through its advocacy and leadership efforts. Their web site has numerous resources on a variety of topics.

[TRAUMA.ORG](#) provides global education, information and communication resources for professionals in trauma and critical care.

Alaska Trauma/EMS List Server

Alaska Trauma/EMS program is pleased to announce the list server that we have developed to disseminate information from the federal and state Trauma/EMS programs. This forum can also be used to improve communication between the facilities and open opportunities for sharing. Please be advised that if you send a message via the list serve it will go to everyone that is a member.

To join this free list, send an e-mail message to:

list.manager@list.state.ak.us

The body of the message should be:

Subscribe ak-trauma

- Level IV Trauma center information
 - Pre-review Questionnaire (Level IV Trauma Center Checklist) [coming soon]
 - Level IV, Desirable and Expected Resources/Services
 - Level IV Request for a verification visit
 - Performance Improvement for Small Rural Hospitals in Alaska
 - Performance Improvements Sample meeting minutes

[IPEMS Extranet Home](#) | [IPEMS internet](#) | [State of Alaska](#) | [Department of Health & Social Services](#) | [Site Map](#)
[Emergency Medical Services](#) | [Injury Surveillance & Prevention](#)
[Webmaster](#) | [News](#) | [Contact Information](#)
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alaska brain injury network

Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S.

Thirty years ago, only half of all people with brain injury survived; now 78% survive. This means that many individuals now live with significant disability requiring a full range of services.

Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28% higher than the national average. The TBI rate in rural Alaska is one of the highest in the nation.

It is estimated that at least 10,000 Alaskans are living with brain injury today. The number keeps accumulating. Brain Injury can be a life-long disability

The Alaska Brain Injury Network, Inc. (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of Directors represent all regions of Alaska and the extended brain injury community – survivors, family members, service providers, health educators, researchers and those who write laws and policy.

ABIN works with the Alaska Mental Health Trust Authority, Department of Health and Social Services, and partner boards to advocate for policy changes, programs, and facilities to better serve the brain injury population.

ABIN connects survivors and family members with others. Please contact us to learn about brain injury programs in your region.

The goal for every brain injury survivor is the best possible recovery for a fulfilling and productive life. Achieving that goal requires full range of services close to home. This includes...

- Prevention
- Early identification and intervention
- Access to skilled specialists
- Community-based post injury services
- Continuing rehabilitation
- Brain injury support groups and in-state resources

What you can do...

- **Be aware of the fiscal and social burden of brain injury nationally and to the state of Alaska**
- **Become familiar with ABIN Priorities in the Governor's FY09 GF/MH Budget: Brain Injury Training for Providers.**
- **Support the Housing Trust, www.akhousingtrust.com**
- **Join Alaska Brain Matters listserve to meet Alaskans who have been touched by traumatic brain injury.**

ABIN Priorities

In-state rehab facility – many Alaskans are left in a hospital setting because there is no post-acute rehabilitation option in the State. Others are sent out of State. It is time for Alaskans to have treatment for their brain injury. Research shows outcomes improve with quality rehabilitation.

Brain Injury Waiver - recommendations for the current Medicaid waiver system to accommodate the services needed by brain injury survivors: neuropsychological assessment, cognitive and functional therapy, case management, counseling, home modifications, transportation, respite care, and more.



www.alaskabraininjury.net
3745 Community Park Loop, Ste 240
Anchorage, AK 99508
(907) 274-2824

Alaska Brain Injury Network, Inc. helps identify, develop, implement, and sustain needed programs and resources that promote prevention and expand treatment and service delivery to Alaskans who experience TBI and their families.

You KNOW us ...



The Public Health Burden of Brain Injury (prevalence)

5.3 million Brain Injuries

- 5 million persistent Mental Illness
- 4 million Alzheimer's
- 3 million Stroke
- 2 million Epilepsy
- 900,000 HIV/AIDS
- 500,000 Cerebral Palsy
- 400,000 Spinal Cord Injury

Brain injury accounts for more years of lost productivity than any other injury.

The Financial Burden of Brain Injury

- It is estimated that over a lifetime, it can cost between \$600,000 and \$1,875,000 to care for a survivor of severe TBI.
- Direct medical costs and indirect costs of TBI such as lost productivity totaled an estimated 60 billion dollars in the United States in 2000. (*Centers for Disease Control and Prevention*)
- Every dollar used for brain injury rehabilitation saves up to \$35 in future medical costs. (Rhode Island Brain Injury Association)

Prevention is the only cure for Brain Injury

- The three leading causes of brain injury nationally and in Alaska are:
1) motor vehicle crashes 2) falls and 3) assaults.
- One-third of all TBIs recorded in the Alaska Trauma Registry were alcohol related.
- The use of safety belts is the single most effective measure to prevent traumatic brain injuries.
- Helmets are estimated to be 37% effective in preventing fatal injuries to motorcyclists. (*National Highway Traffic Safety Administration*)
- Bicycle helmets are 85-88 percent effective in mitigating head and brain injuries. Every dollar spent on a bike helmet saves \$40 in direct medical costs and other costs to society. (*National Highway Traffic Safety Administration*)
- 60-67% of injured U.S. soldiers sent from Iraq to Walter Reed Army Medical Center have a TBI from blasts, severe falls and motor vehicle accidents. (*United Press International, July 2004*). These soldiers are now returning home to Alaska for continuing treatment and rehabilitation.

Traumatic Brain Injury is a beneficiary group participating in the Alaska Mental Health Trust Authority "You Know Me" Anti-Stigma Campaign.

Alaska Brain Injury Network			
Alaska Scorecard and TBI Dashboard – (DRAFT)			
DRAFT #1 – May 22, 2008			
○ Getting worse		↔ Not changing	● Improving
	5-year Trend	Current Data	Source
SCORECARD: A "scorecard" provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	●	98.6	1.a
Causes			
Falls	○	28.7	1.a
Motor Vehicle Transportation Occupant	●	24.7	1.a
Assault	●	12.2	1.a
ATV	○	6.5	1.a
Bicycle	●	4.5	1.a
Snowmachine	●	4.4	1.a
Pedestrian	●	3.6	1.a
Sports	●	1.8	1.a
Water Transport	↔	1.3	1.a
Suicide Attempt	●	.8	1.a
Gender			
TBI percentage among males		65.4 %	1.a
TBI percentage among females	↔	33.2 %	1.a
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	1.a
Percentage of TBI population that is White		53%	1.a
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	1.a
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	1.a
Females age 80+		217.2	1.a
Males age 70-79		215.7	1.a
Males age 15-19		200.9	1.a
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

- 1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
- 1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
- 1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
- 2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population

Settings Workspaces
 No. of Pages
 (1/1/2007)

Dashboard: Behavioral Health

TBI and Mental Health	Spot look trend	Current Data	Source
Percentage BH clients screening positive for TBI	↔	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	

Dashboard: Education

Special Education	Spot look trend	Current Data	Source
Number of children in Special Education statewide with TBI diagnosis (2007)	↔	66	5

Dashboard: Justice

Corrections	Spot look trend	Current Data	Source
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6

Dashboard: Employment

Vocational Rehabilitation	Spot look trend	Current Data	Source
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		\$12.54	7

Dashboard: Providence

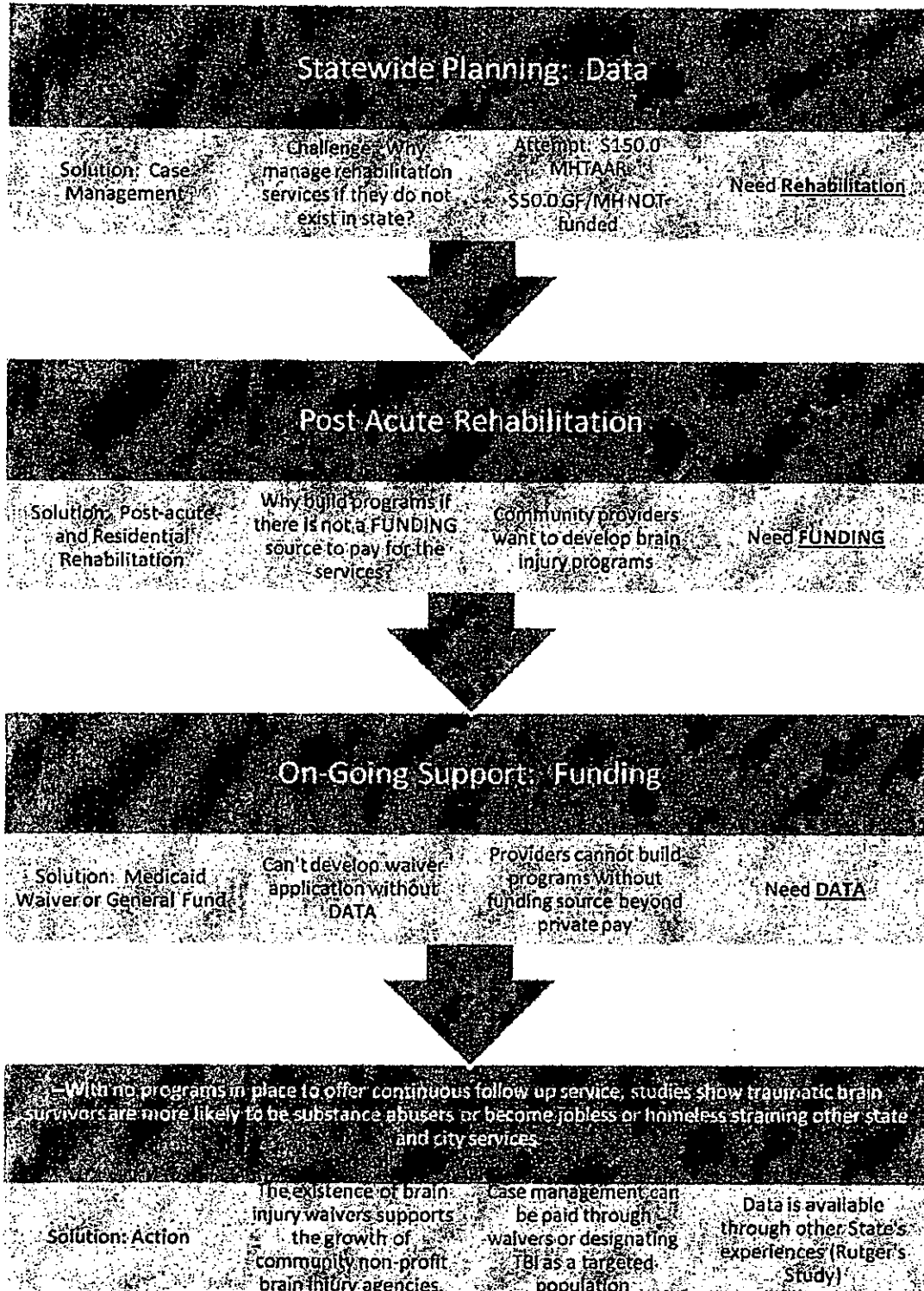
ImPACT Program	Spot look trend	Current Data	Source
Number of baselines (ImPACT)		57	8
Number of student/athletes seen in program (ImPACT)		25	8
Emergency Department			
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8

Dashboard: Alaska Brain Injury Network

TBI Advisory Board	Spot look trend	Current Data	Source
Est. Board Member Volunteer hours/year	↻	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation			
Average new consumer contacts per month	↻	30	9
Average unique visitors/month to ABIN website	↻	750	9
Number of people on Alaska Brain Matters Listserve	↻	100+	9

- 3 AKADMS
- 4 Suicide Follow-back Study
- 5 <http://www.eed.state.ak.us/stats/>
- 6 Trust/DOC Study 07
- 7 Division of Vocational Rehabilitation (FY07)
- 8 Providence Neuroservices
- 9 Alaska Brain Injury Network

For more information view the "10 Year Plan for TBI in Alaska" at www.alaskabraininjury.net



Alaska Trauma Hospitals as of April 2009

Name	Designation	Certification date	Certification due
Alaska Native Medical Center (Anchorage)	Level II	November 2006	2009
Mt. Edgecumbe Hospital (Sitka)	Level IV	April 2007	2010
Yukon-Kuskokwim Delta Regional Hospital (Bethel)	Level IV		2010
Sitka Community Hospital (Sitka)	Level IV	January 2007	2010
Norton Sound Regional Hospital (Nome)	Level IV	October 2006	2010

ALASKA COUNCIL ON EMERGENCY MEDICAL SERVICES



ACEMS
P.O. Box 110616
Juneau, AK 99811-0616
(907) 465-3027

April 9, 2009

Representative Coghill
Juneau, Alaska

Representative Coghill,

Trauma is any bodily injury from an external force. Trauma puts a tremendous burden on families and communities in Alaska. An average of 400 Alaskans die each year from trauma. For every death, 11 people are hospitalized. One in four hospital admissions is uncompensated which puts an additional burden on the State's health care system. HB 168 is offered to assist in this dilemma.

House Bill 168 provides the DHSS Commissioner authority to establish special designations in regulation for varying levels of trauma care so that a 'Certified Trauma Center' would be eligible to recoup expenses as a result of uncompensated care being rendered. The purpose of the fund is to reimburse certified trauma centers in the state for care uncompensated by the person receiving the treatment or by any other source. HB 169 would then set up the uncompensated trauma care fund that would help cover some of the losses suffered by the trauma center rendering the care.

The Alaska Council on EMS seeks your support for a fully functioning trauma system, including funding for the development of trauma centers and legislation addressing the issue of incentives for trauma center designation and uncompensated care of trauma patients. The added benefit of HB 168, we believe, would be an incentive for more hospitals in the state to become 'Certified Trauma Centers' thereby assisting in the development in a state wide trauma care system.

The American College of Surgeons met 11/08 in Anchorage to assess the States trauma system. The passage of HB 168 & 169 would provide support to address some of the areas that were noted in the report.

Thank you for your support of this critical issue.

A handwritten signature in black ink that reads "David Hull". The signature is written in a cursive, flowing style.

David Hull, Chair
Alaska Council on Emergency Medical Services

cc Bill Hogan, DHSS Commissioner
Dr. Jay Butler, Chief Medical Officer
Tim Bundy, Section Chief IPEMS



**Alaska Native
Tribal Health Consortium**

Administration • 4000 Ambassador Drive • Anchorage, Alaska 99508 • Phone: (907) 729-1900 • Fax: (907) 729-1901 • www.anthc.org

POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: April 8, 2009

RE: HB 168 – State certification and designation of trauma centers and creating the uncompensated trauma care fund
HB 169 – Appropriating \$5,000,000 to the uncompensated trauma care fund

POSITION: Support

ANTHC supports HB 168 and HB 169 as important steps in increasing the trauma care capacity in the state.

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally-recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC is the only Level II Trauma Center in the Indian Health Service/tribal health system nationally. ANMC is also the only Level II Trauma Center in Alaska. The nearest Level I Trauma Center is in Seattle.

Trauma system development is a public health priority. A comprehensive system of trauma care is an essential part of the public safety net. Regionalized trauma systems based on a network of coordinated Trauma Centers designated at the appropriate level improves health outcomes and reduces costs. ANMC, as the highest level designated Trauma Center in the State of Alaska, is the lynchpin for the state's trauma system, and provides the foundation for continued statewide system development.

Trauma Center designations were created as a way to improve outcomes for patients who face extraordinary medical issues. On balance, early and appropriate medical attention to life-threatening health issues reduces overall length of stay in the hospital and reduced complications for many patients. Without trauma care, the costs of health care for trauma patients will be greater, including trauma patients who are Medicaid eligible.

The cost of providing trauma care at ANMC has more than doubled over the past four years and funding has not kept pace. ANMC's Trauma Center simply cannot be maintained at current revenue levels. If ANMC's Trauma Center designation is discontinued because funding levels have rendered the service unsustainable, the hospital faces reductions in staffing. Diversions of patients to non-tribal providers would increase, and because the federal government reimburses 100% of the cost of services provided for Native clients at Native facilities but a smaller percentage at non-tribal providers, there would be an increased cost to the state's general fund budget.

ANTHC supports HB 168 and HB 169 as important steps by the State to encourage and support appropriate trauma care options for Alaskans. Because we are Alaska's only Level II Trauma Center we recommend removing the language in section (d) on Page 2, Line 11, that limits appropriations to any one facility to 25%.

Thank you for your consideration.

Rynnieva Moss

From: Christopher Clark [cgcalaska@yahoo.com]
Sent: Wednesday, March 11, 2009 8:44 AM
To: Tim Barry; John Bitney; Shannon Devon; Peter Fellman; Linda Hay; Paul Labelle; Karen Lidster; Tom Maher; John Manly; Rynnieva Moss; Jane Pierson; Chris Wyatt
Subject: Daily News editorial: Attracting doctors - Legislature can raise Alaska's stake in competition for docs; Obama right to nix mileage tax

Attracting doctors

Legislature can raise Alaska's stake in competition for docs

Published: March 10th, 2009 06:54 PM
Last Modified: March 10th, 2009 06:54 PM

Alaska's shortage of primary care doctors has been described as grim. A study two years ago found **we needed 400 more doctors to provide the same level of care as is available elsewhere in the country**. One result is that few doctors will accept the low rates paid by Medicare, the government insurance for those 65 and older. **It's a horrible situation for Alaska's senior citizens.**

Two bills introduced during this legislative session would help relieve the shortage of doctors and other health care workers, and both are worth passing.

Senate Bill 18 would increase the number of state-subsidized medical students in each class of the WWAMI program operated through the University of Washington. Alaska WWAMI students spend their first year of study at UAA.

These students offer an excellent return -- according to the Alaska Physician Supply Task Force study in late 2006, half of Alaska WWAMI students end up practicing in the state, and a few WWAMI students from other states join them.

The state raised the number of Alaska WWAMI students in each class to 20 in 2007.

SB 18 would increase the number by a modest amount, to 24. That's the most UAA can accommodate without incurring expensive overhead costs, said Sen. Bill Wielechowski of Anchorage, the bill's sponsor.

Adding the four students would cost the state little to no money the first year. But by the fourth year, when we would have an additional 16 Alaska students in med school, the state cost is estimated at \$550,000 per year.

A second bill, SB 139 [by Sen. Donny Olson], calls for the state to pay financial incentives to already-qualified doctors, nurses or other health workers if they take certain jobs in Alaska.

The bill, with a bipartisan group of sponsors, would carry out a plan developed by a group of health care professionals including representatives of the Alaska Primary Care Association and the Alaska State Hospital and Nursing Home Association.

The state would offer financial incentives to as many as 90 workers, from physicians to nurses, to come work in Alaska. Those who take hard-to-fill jobs, or treat a share of uninsured patients or those on Medicare or Medicaid, would get priority.

3/12/2009

Each person would be guaranteed the incentive for three years as long as they kept working here.

The state would either repay part of their student loans or, if the health worker didn't have loans, simply pay them directly. The individual payments would range from \$20,000 per year for nurses, physicians assistants and some others, to \$35,000 for doctors, pharmacists and dentists, to \$47,000 for doctors who accept the hardest-to-fill positions.

The state's cost for three years' worth of incentives would be \$7.5 million.

That sum is large enough to cause concern this year, with a big drop in state revenues anticipated.

But consider this: Forty-four of the 50 states already offer financial incentives to lure health workers. Alaska is not competitive for health care jobs, and people are suffering because of it.

BOTTOM LINE: The Legislature should pass two bills to relieve a critical shortage of health care workers in Alaska.

Not now

Obama right to nix mileage tax

States and the federal government rightly worry that they'll see less revenue to pay for road work as Americans turn to more fuel-efficient vehicles and future technology takes us further from the internal combustion engine.

One solution is a mileage tax, whereby vehicles would be equipped with GPS tracking devices and people would be taxed according to the miles they drive rather than the gallons of gasoline they purchase.

Oregon has already run a pilot program for such a tax, and a federal mileage tax has gained favor in the Democratic Congress despite the opposition of President Obama.

Concerns for revenue and how to pay for road building and maintenance are valid. But the mileage tax is the wrong solution, at least for now.

First, a major shift in transportation tax policy shouldn't be done on the fly in the middle of an economic crisis. There are too many unanswered questions. Among them:

- Is the ability to track people's driving one we want governments to have?
- How does such a tax encourage the use of higher-mileage vehicles? Is the owner of a hybrid getting 35 mpg going to pay the same tax as the owner of a gas-guzzling Hummer?
- Do we really want to charge people more for miles driven during rush hours, a premium that's been suggested in some states?

Raise the gasoline tax if necessary, but let's not be talking about a mileage tax until we've done a lot more research.

BOTTOM LINE: Mileage tax? Maybe down the road. Maybe.

3/12/2009

More Funding Needed To Fight Brain Injuries In Alaska

By Corey Allen-Young, CBS 11 News Reporter
KTVA

Posted:02/26/2009 05:34:33 PM AKST

Known as the silent epidemic, traumatic brain injury here in Alaska is the highest in the country. That's why partnerships are being made statewide to come up with solutions. The key word is solutions as leaders are looking for a permanent fix to decreasing traumatic brain injuries in Alaska. Experiencing a traumatic brain injury can change a life forever. "The recovery process after traumatic brain injury is journey that happens daily and it will continue," said Jill Hodges, of the Alaska Brain Injury Network. With 800 Alaskans being hospitalized or dying and over 10,000 Alaskans currently living with traumatic brain injuries, the consequences could be devastating.

"Yeah it will change your life and everybody else's around you," said Frank Box, who experienced a traumatic brain injury. "It can happen to you while you are walking across the street, you can fall and slip on the ice, or if you are playing a sport or riding a bicycle especially without a helmet, you can also suffer traumatic brain injury," said Christie Artuso, who is the director of the Providence Neuroscience Center. "My brother was a such a vibrant, outgoing person, and for this to happen to him is just unreal," said Duain White, whose brother suffered a traumatic brain injury in an ATV accident.

Taking into account that traumatic brain injuries are the leading cause of death and disability among children and young adults in Alaska, the need to be aware of what exactly can cause an injury is crucial. "We can't do that without the prevention needed and the education needed of our population to tell them about TBI (traumatic brain injury) and to also tell them on how to be healthy," said Don Kashevaroff, who is the CEO of the Alaska Native Tribal Health Consortium. "What we don't have in the state of Alaska is an effective rehabilitative program for people who have been afflicted with a traumatic brain injury can be helped with cognitive therapies, thru rehabilitative therapies to return to a normal functioning life," said Artuso.

Thirty years ago, one half of people who experienced a brain injury survived. Now the number has increased to 78 percent. But officials say the problem in our state is that traumatic brain injury survivors are not getting the services needed for life long living. While people who are victims of traumatic brain injuries do receive initial help there are many questions of what happens next for them. And with money in low supply to provide any additional support, officials say other agencies could be feeling the burden.

With over 10,000 Alaskans currently living with traumatic brain injuries, getting additional care and support is badly needed. "We were just released from the hospital and that was it there was no long term therapy, there was no where to go to offer cognitive therapy, long term physical therapy," said White. "We want to help them maintain their relationships, maintain their families, maintain their lifestyles," said Artuso. "What we need are community and governmental support to do that because currently there is no resources."

Adding more resources is what folks are banking on in helping their loved ones live normal functioning lives. "Is that all we can offer him, is that the best he's going to be doing the rest of his life, its very frustrating," said White. "Treatment, rehabilitation services are essential, they are the key to recovery and sometimes eventual abilities for our brothers or sisters, and family members," said Hodges. With no programs in place to offer continuous follow up service, studies show traumatic brain survivors are more likely to be substance abusers or become jobless or homeless straining other state and city services.

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Alaska Statewide Trauma System

Fact Sheet

What is Trauma?

Trauma is any bodily injury from external force. Although many people think of trauma as "accidents", it is better thought of as a disease. Like heart disease and cancer, trauma has identifiable causes and risk factors; and like these conditions, prevention is the best strategy. However, even with the best prevention efforts we still need to be able to take care of the seriously injured. We need to show the same commitment that we brought to cardiac and cancer treatment to trauma care. The seriously injured require timely diagnosis and treatment by health care professionals who are appropriately trained and provided with the necessary resources to reduce the risk of death or permanent disability.

Impact of Trauma in Alaska

Trauma is a tremendous burden on families and communities. In the 1990s, nearly 5,000 Alaskans died from trauma.

- For Alaskans, ages 1 to 44, trauma is the leading cause of death.
- On average, more than 400 Alaskans die from trauma each year. For every injury death, eleven people are hospitalized for trauma-related injuries. For every trauma death that occurs in the hospital, there are an estimated 3 people discharged with permanent disability.
- On average, more than 800 Alaskans are hospitalized each year for central nervous system injury (spinal cord and brain injuries).
- In 2004, motor vehicles were the leading cause of injury death (117), followed by firearm-related injuries (116).
- In 2004, the economic cost of hospital stay alone for trauma patients in Alaska was estimated at over \$73 million. One in four hospital admissions were uncompensated.

Years of Potential Life Lost to Trauma

Death from trauma is tragic at any age. Society's loss is especially great because so many young people die from trauma. The impact can be measured in "years of potential life lost:" the number of years between early death from injury and the average age of death at age 70. Using years of potential life lost, trauma is the leading cause of potential life lost for all Alaskans followed by cancer and heart disease.

What is a Trauma System?

A trauma system is a predetermined, organized, multidisciplinary response to managing the care and treatment of severely injured people. It spans the full spectrum of care; from prevention and emergency care to recovery and rehabilitation. Best practice standards guide each stage of care to ensure that injured patients are promptly transported to and treated at facilities appropriate to their severity of injury and that they receive optimal care at each stage of their treatment.

A statewide trauma system also provides a framework for disaster preparedness and response. As part of its activities, a trauma system coordinates and monitors the

movement and care of severely injured people. Ideally, the trauma system identifies the needs and resources available at any moment and responds to insure optimal care.

Why Have a Trauma System?

For a severely injured person, the time between an injury and receiving definitive care is the most important predictor of survival—the “golden hour.” The chance of survival diminishes with time, despite of the availability of resources and modern technology. A trauma system enhances the chance of survival by making sure that patients are brought to the most appropriate facility in the most efficient manner and that they receive optimal care each step of the way. Trauma systems benefit everybody regardless of income, race, party affiliation or locale. States with mature, comprehensive statewide trauma systems have experienced:

- A 9 percent decrease in motor vehicle crash deaths.
- A 15-20 percent increase in the survival rates of seriously injured patients.
- An increase in productive working years.
- An improvement in statewide disaster preparedness.

Disaster Preparedness

Trauma systems play a vital role in the community response to natural disasters or manmade incidents. Despite concerns over bioterrorism, experience has shown that the vast majority of terrorist attacks will involve explosive devices. We also do know that Alaska will experience major earthquakes in the future. A functioning trauma system is the framework for developing an organized coherent response to these incidents

Alaska's Trauma System

In 1990, state authority for designating trauma centers was created in Alaska. Under this statute hospital participation is entirely voluntary. Criteria were established and the process for designation at Levels I-IV outlined. Since the original legislation there have been only three hospitals that have been designated by the state. One level II and four level IV centers. Clearly to fully realize the benefits of a trauma system more widespread participation is needed. Alaska's trauma system is ideally an inclusive system, recognizing the vital role that rural communities, hospitals and health care professionals play in the care and management of the trauma patient. Wide-scale involvement is critical to get optimal outcomes for the seriously injured.

Review of Alaska Trauma Care by the American College of Surgeons November 2008

The Alaska Department of Health and Social Services (DHSS) recently contracted with the Committee on Trauma of the American College of Surgeons to review trauma care in Alaska. The full report is available on the DHSS website (www.chems.alaska.gov). It notes our strengths and weaknesses and makes recommendations for improving trauma care in our state.

Strengths include: well established injury prevention programs; extensive and creative networks for ground and air medical transport; medical subspecialty availability at three

Anchorage hospitals; and a good relationship with Harborview Medical Center (Level I trauma center) in Seattle.

Deficiencies include the lack of an additional Level II trauma center in Anchorage and the existence of two patterns of trauma care, one for Alaska natives that follows national standards and one for the rest of the state. The review team members noted that among the nontribal hospitals " few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care". They also noted that there is no statewide trauma plan and no incentive or requirements for hospitals to participate in the system. Additionally, there are few resources at the state level for trauma system management and coordination. Perhaps as important as any of the above, they noted that there seemed to be very little public awareness of trauma system issues.

The review team made 15 priority recommendations. Several involve better organization of state resources and development of a comprehensive statewide trauma plan. The most sweeping recommendation was that all acute care hospitals be required to become designated trauma centers at a level appropriate to their resources and size within two years. They further stated that there should be a second level II trauma center in Anchorage as soon as possible. In addition, an assessment of pediatric trauma care needs should be completed with the goal of developing at least one pediatric trauma center of excellence.

The Alaska Trauma Systems Review Committee oversees the statewide trauma system in Alaska. The system addresses four primary components: trauma hospital designation criteria; trauma registry (monitors system performance and provides feedback for improvement); EMS/pre-hospital triage and transport guidelines; and inter-facility (hospital to hospital) transfer guidelines.

Where To Go From Here

- Increased hospital participation is necessary for the statewide trauma system to function optimally.
- There need to be incentives for hospitals to provide the staff and resources required for trauma center designation.
- Legislation to cover the cost of uncompensated trauma care and to limit the medical liability for care given at designated trauma centers are two incentives that have been successful in other states.

House Bills 168 and 169 have been introduced by John Coghill to encourage hospitals to participate in the trauma system by covering some of the cost of uncompensated trauma care when it is given at designated trauma centers.

The goal of the statewide trauma system is to see every hospital in Alaska designated at an appropriate level.

- *Surveys show that the general public overwhelmingly supports having a hospital in their community that is prepared for and capable of effectively managing a seriously injured patient—and are willing to pay for it!

*2005 Harris Interactive poll, "The American Public's Views of and Support for Trauma Systems: A Congressional Briefing."

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- ## Goals
- Trauma as a public health problem here in the US and Alaska.
 - Trauma systems- Treating the severely injured.
 - American College of Surgeons Review: Trauma Care in Alaska.
 - The Future.

Introduction

"If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped."

C. Everett Koop M.D., ScDC, ScD
Former US Surgeon General
Former General Chairman, The National SafeKids Campaign

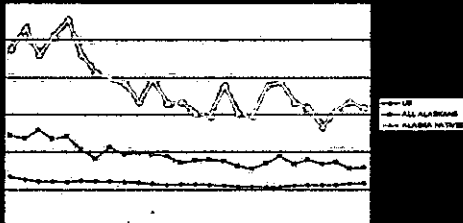
- ## Introduction
- Injury is a major public health problem
 - Leading cause of death in 1st 4 decades of life
 - Leading cause of loss of productivity
 - Despite the magnitude little public focus
 - The "neglected disease" since 1966
 - Significant progress in individual patient care
 - Trauma systems shown to save lives

- ## Trauma in Alaska
- Second highest trauma mortality in the US
 - Leading cause of death age 1-44.
 - 400-500 Alaskans die each year.
 - Over 5000 hospital admissions.
 - Over 1000 with permanent disability.

All Cause Mortality Alaska

Age Group	0-1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

Trauma Mortality in Alaska



Trauma in Alaska

- Motor vehicle crashes leading cause of death.
- Firearm related injuries, second.
- 2004 hospital cost for Alaska trauma patients over \$73 million.
- ~ 25% over trauma admissions uncompensated.

Trauma Systems

- Wounded in the remote jungle or rice paddy of Vietnam, an American citizen has a better chance for quick definitive surgical care by board certified specialists than were he hit on a highway near his home in the continental United States. Even if he were struck immediately outside the emergency room of most United States hospitals rarely would he be given such prompt, expert operative care as routinely is furnished from the site of combat wounding in Vietnam.

Eiseman, Journal of Trauma, 1967

Trauma Systems

- A trauma system consists of hospitals, personnel, and public service agencies with a preplanned response to caring for the injured patient.

Death from Trauma



Trauma Systems: Military Experience

- "The only victor in war is medicine"
Mayo brothers WWII

Vietnam and Iraq development of systems of care to ensure optimal care from injury to rehab.

Trauma Systems

"Getting the right patient to the right place in the right amount of time."

- ◆ Facilities (trauma center designation)
- ◆ Personnel (training)
- ◆ Patient transport
- ◆ Triage

Facilities-Trauma Centers

- Level I -Definitive subspecialty care, research.
- Level II – Definitive subspecialty care, surgery, orthopedics, neurosurgery.
- Level III- General surgery, orthopedics, no neurosurgery
- Level IV- Stabilization, limited or no surgical capacity

Trained Personnel

- ATLS
- TNCC
- PHTLS
- ETT first responders
- RTTDC

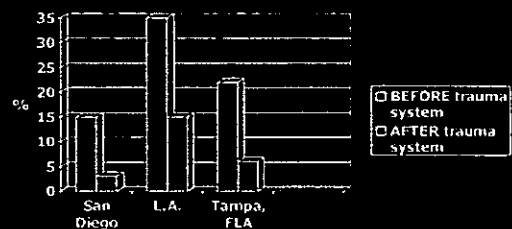
Transport and triage

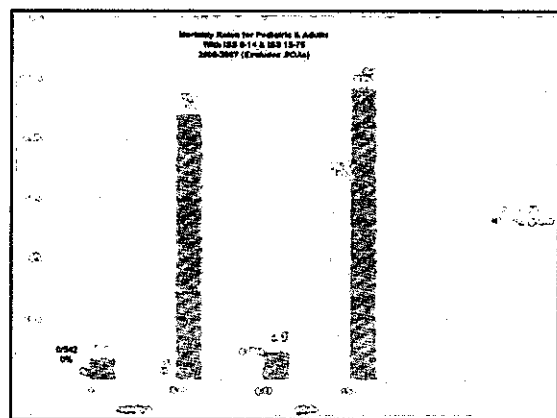
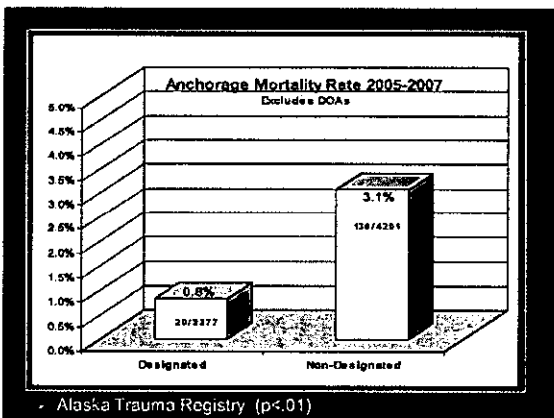
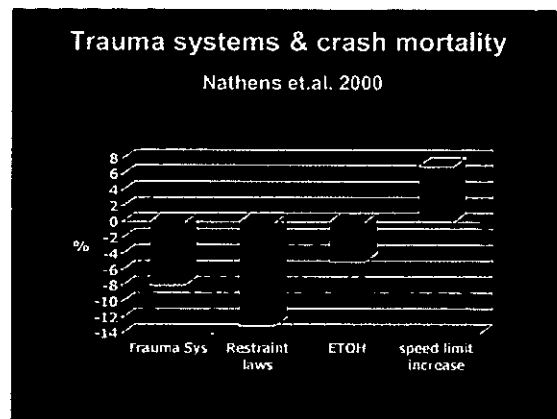
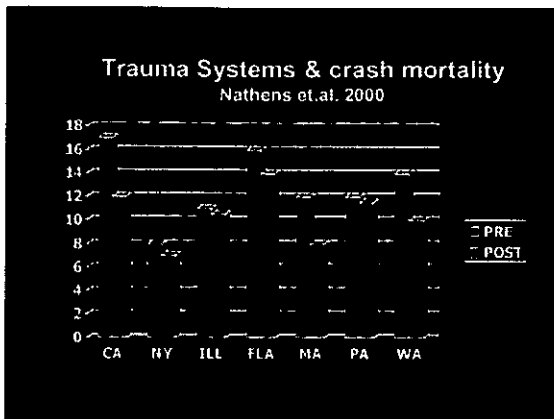
- Guidelines that take into account local resources and capabilities.
- Head Injury Guidelines.
- Burn Triage.

Trauma Systems

- 15-25% improvement in survival of the seriously injured.
- Increase productive working years
- Improve statewide disaster preparedness.
- Inclusive systems -best

Preventable Deaths: The impact of trauma systems

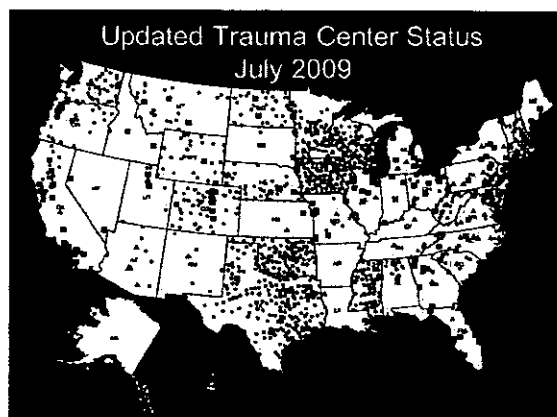


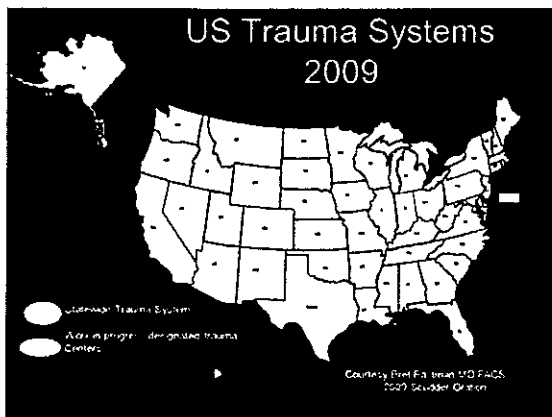


Trauma Center Growth Over Time

	1991	2002	2009
Level I	165	190	199
Level II	209	263	269
Level III	76	251	362
Level IV-V	21	450	748
Total	471	1,154	1,578
Pediatric Only			41

Courtesy Anthony Carlini ATS TIEP





Trauma Systems and the Public

- 2004 Harris poll to assess public Knowledge and perceptions on trauma and trauma care.
- Most Americans are not aware that injury is the leading cause of death for children, youth, and adults under the age of 34.

Harris Poll

- After hearing a description of a trauma center, almost all Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury.

Harris Poll

- Almost 9 out of 10 of Americans feel that having a trauma center nearby is as important as or more important than having a Fire Department or Police Department.

Harris Poll

- At the time of the survey although 75% thought there was a trauma system where they lived only about 20% actually lived in an area covered by a trauma system.
- Nearly all Americans *believe* that if they had a serious or life-threatening injury, they *would* be taken to the hospital that is best equipped to handle their specific injury in less than 1 hour.

Harris Survey- Conclusions

- The majority of the public thinks it is important to have a trauma system. (It is a nonpartisan issue.)
- Most people think they have it already.
- Many who think they are covered by a regional system are not.

Alaska Trauma System

- 1993 statute- EMS authority for designating trauma centers created.
- Hospital participation voluntary.
- Standards for trauma center designation follow American College of Surgeons criteria.

Alaska Trauma System

Verification of compliance by outside reviewers for Level I, II, III

- ◆ In-state review for Level IV

Current Status -16 Years Later

-24 hospitals in Alaska

Verified / Certified

- 1 Level II ANMC
- 4 Level IV centers- NSH -MEH - YKHC -SCH
- 9 other facilities with reviews or consultations.

Non-Verified

- 2 centers providing care for multiple trauma patients
- 6 centers that provide surgical capabilities
- 2 military hospitals

Alaska Trauma Facilities

- Alaska -Only state without a designated Level I or II trauma center that serves the majority of the population.
- Anchorage is the largest city in the US without a designated Level I or II center for the majority of the population.

Insanity

"Insanity is doing the same thing in the same way and expecting a different outcome"

- Old Chinese Proverb

State of Alaska DHSS
Trauma System Consultation
November 2-5 2008

ACS-COT Site Visit Team

- | | |
|-------------------------------|-----------------------------|
| • Reginald A. Burton, MD FACS | Team Leader, Trauma Surgeon |
| • Jane Ball, RN, DrPH | ACS Consultant |
| • Samir M. Fakhry, MD FACS | Trauma Surgeon |
| • Holly Michaels | ACS Program Coordinator |
| • Drexdal Pratt, CEM | State EMS Director |
| • Nels Sanddal, PhD, REMT-B | ACS Consultant |
| • James D. Upchurch, MD | Emergency Physician |

Objective

- To help promote a sustainable effort in the graduated development of an inclusive trauma system for Alaska
- Multidisciplinary review of the trauma system
- 17 states have been reviewed

Executive Summary

Advantages & Assets

- Committed individuals who use their time and expertise every day to serve Alaska citizens
- Extensive networks for transport
- 3 large medical centers with extensive subspecialty expertise within the state
- Large Level I trauma center in Seattle which freely accepts adult and pediatric trauma patients

Advantages & Assets

- One center maintains ACS Level II verification standards and others have obtained consultations and are working toward verification.
- Alaska Trauma Registry- all 24 acute care hospitals provide data.
- Injury prevention activities are well established.
- Initial efforts at legislative change.

Challenges and Vulnerabilities

- No trauma system plan
- Geography / Weather / Remote and isolated communities
- No standards for scene trauma triage or trauma inter-facility transfers
- Trauma system issues have limited visibility within state government.

Challenges and Vulnerabilities

Public not aware of trauma system issues.

Limited human resources.

Few incentives for hospitals to participate.

No statewide evaluation of system performance.

Trauma Care in Alaska 2009

- "There are two healthcare systems for injured patients. One for Alaska natives that adheres to national standards and another for the majority of the population"

ACS-COT Alaska Trauma Systems Review
11/2008

Executive Summary

- "Several Alaska Native facilities have sought and achieved verification and designation as trauma centers. To date few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care."

ACS-COT Alaska Trauma Systems Review
11/2008

Recommendations: Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for all Alaskans.

Recommendations: Definitive Care Facilities

- Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with ACS criteria to meet the existing volume and acuity demands.
- Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center designation appropriate to their capabilities.

Recommendations: Definitive Care Facilities

- Study pediatric trauma care needs and establish one or more in-state centers of excellence in pediatric trauma care.
- Determine a method of providing financial support for hospitals designated/certified by the state as trauma centers to assist with uncompensated care and the cost of readiness

Recommendations: System Coordination and Patient Flow

- Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).

Recommendations: Financing

- Provide state funding to hire a fulltime trauma system manager.
- Determine a method of providing financial support for hospitals designated/certified by the state as trauma centers to assist with uncompensated care and the cost of readiness.

Themes

- You are closer than you think – many of the components are already in place.
- Alaska is a unique environment different from anywhere else
- You have developed innovative solutions to your unique challenges.
- Despite differences amongst stakeholders, all agree with the need for a consensus developed and integrated trauma system.

ACS Recommendations- Actions

- Commitment by DHSS to create a trauma manager position and develop a statewide trauma plan.
- Trauma Systems Review Committee working to develop metrics to measure trauma system performance.
- Legislation to create incentives for facilities to participate.

Alaska Trauma Systems Review Committee

- MDs, nurses, administrative, and prehospital representation
- Oversight- Trauma Registry
 - Level IV Trauma verification
 - EMS triage and interfacility transfer guidelines
 - Trauma system performance improvement.

Alaska Trauma System: Facility Participation

- Increasing facility participation is essential.
- "Carrots and/or sticks"
- ACS recommends both
- Mandatory participation and payment for uncompensated care.

House and Senate Bills 168 and 169

- Introduced by Representative John Coghill(R) and Senator Bettye Davis(D) March 2009.
- Creates a fund to pay for uncompensated trauma care given at designated trauma centers.

Barriers

- Hospital Administration concerns
- Extra cost especially at Level IIs
 - Lack of physician support.
 - Lack of demand from the community.
- Provider Concerns
- Not needed " we do fine"
 - No financial incentive to do it.
 - More rules and regulations.

Social Change

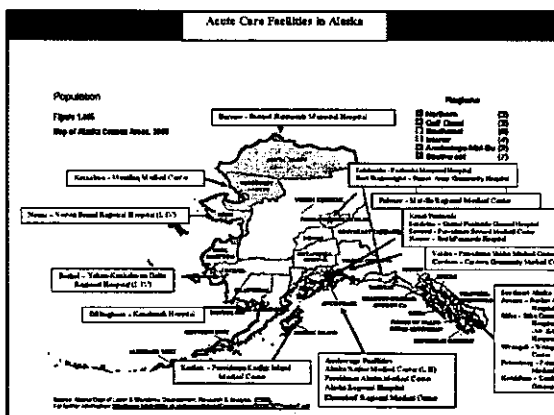
- **Pearl Harbor:** A sudden crisis causes fundamental change.
- **The Tipping Point:** Pressure builds to an inflection point of change.
- **Glacial Erosion:** A steady growth or pressure that is hard to resist or ignore.

Ian Morrison-Author: Futurist

How can you help?

The Tipping Point

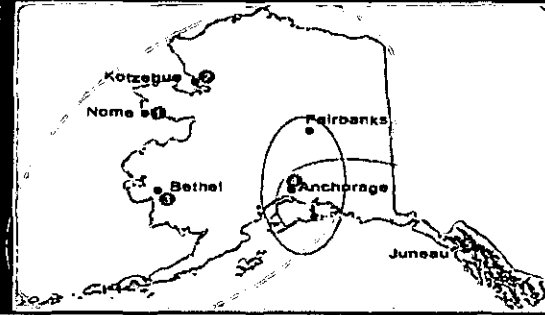
- Letters/emails to your legislators H.B. and S. 168 and 169.
- Letters/emails to your your hospital administration
- Ballot initiative?. (ie Arizona)



Vision

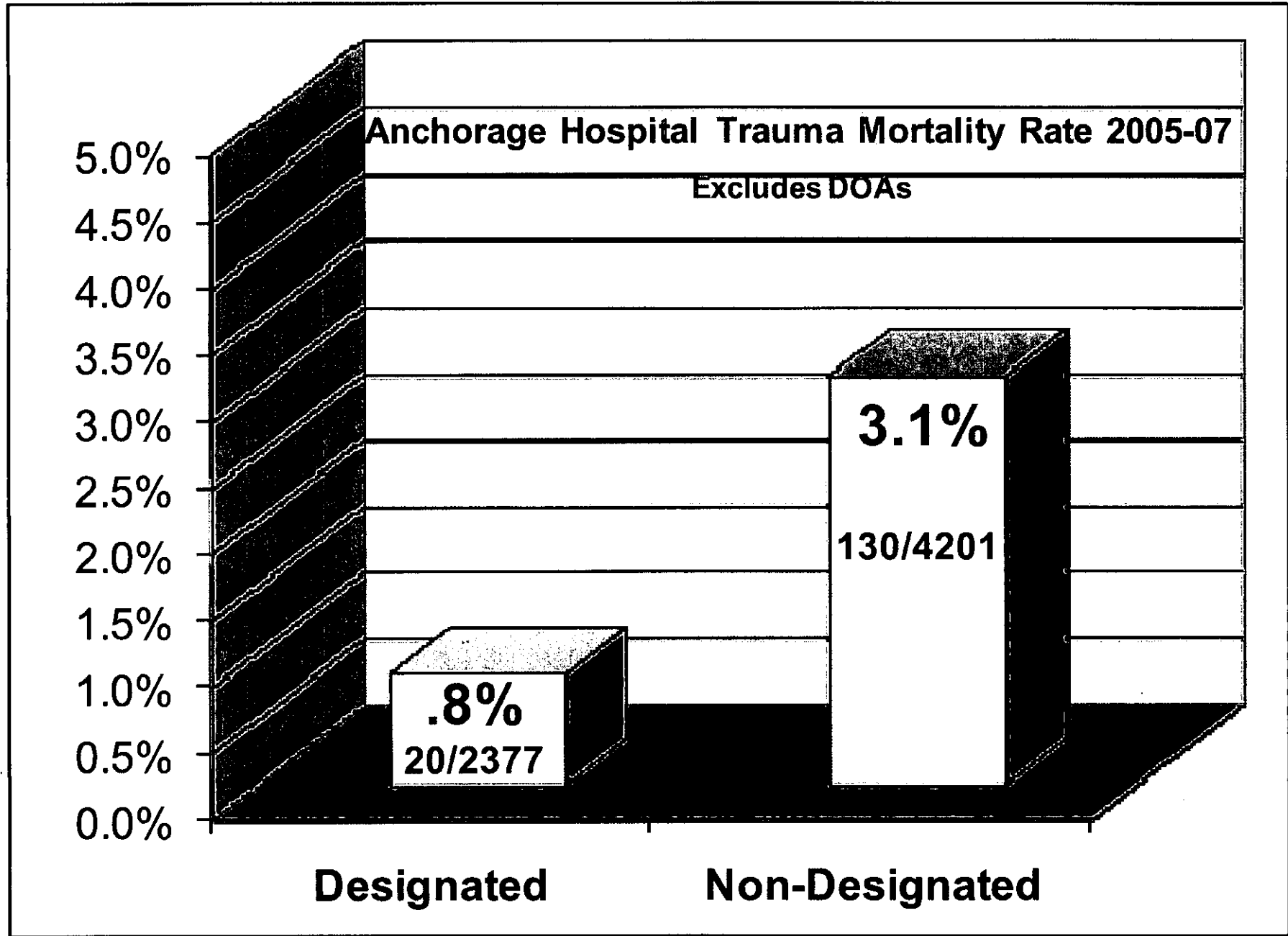
- An integrated system that addresses trauma from injury prevention through acute care and rehabilitation.

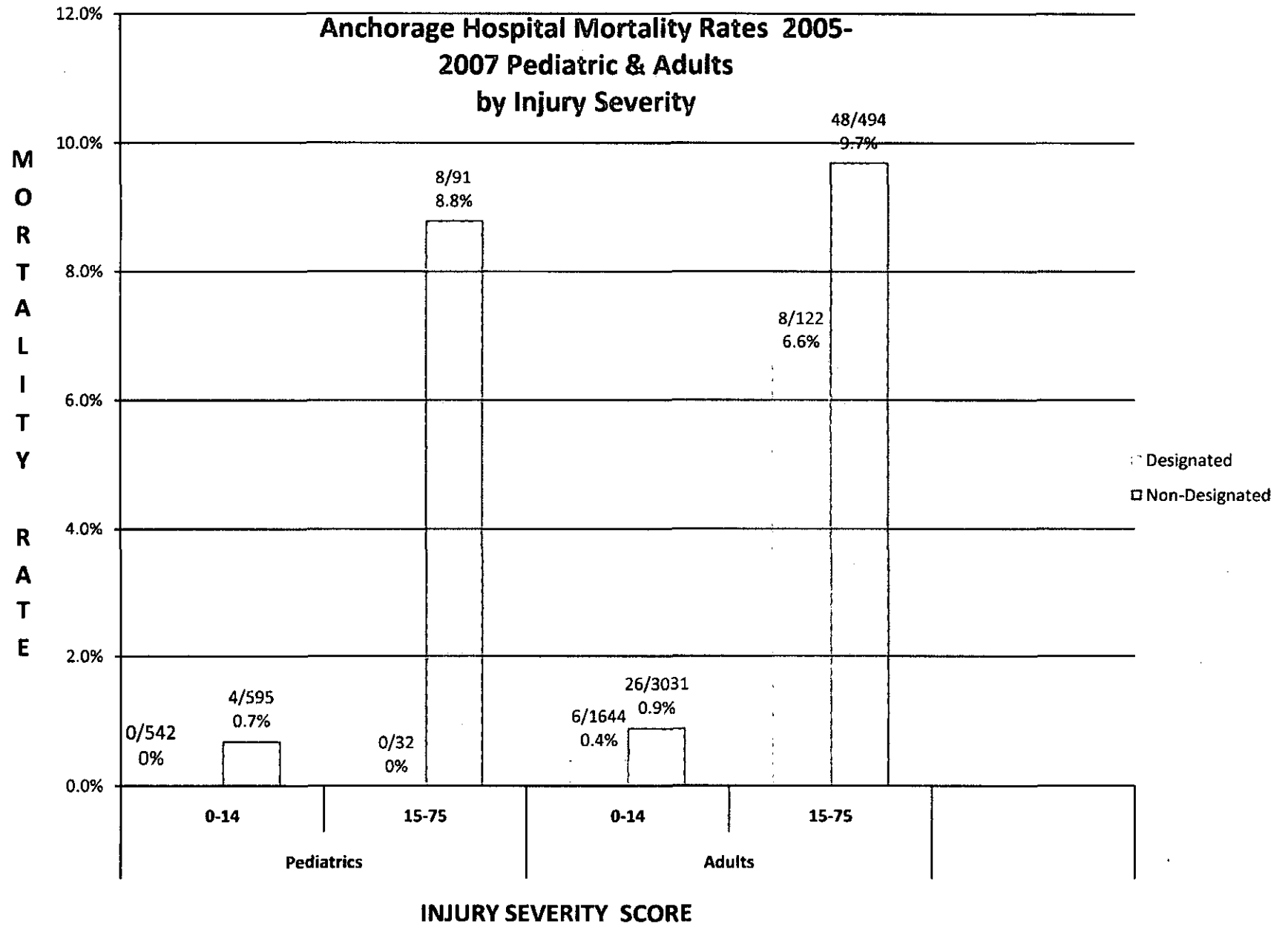
The Future: Alaska Trauma System(s)



Why is this important?

Because it makes a difference and it is the care you want for your family and neighbors if they are seriously injured.





Daily News Opinion

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COMPASS: Other points of view

Emergency trauma care needs improvement in Alaska

BY MARK S. JOHNSON and FRANK SACCO, M.D.
Imagine you and your family driving across Anchorage. As you pass through a major intersection, a drunk driver runs a red light and hits your vehicle broadside. In an instant, you and your passengers face a life-or-death situation. If you're still conscious, you may think, thank God this happened in Anchorage. Where we have state-of-the-art emergency medical services.



Johnson



Sacco



Johnson

...has excellent injury prevention programs, extensive and creative networks for ground and air medical transport medical specialists in Anchorage and a good relationship with Harborview Trauma Center (Level I) in Seattle.

...The Anchorage Fire Department has exceptional ambulance services staffed with well-trained paramedics. Local hospitals have sophisticated emergency departments staffed 24 hours a day with qualified emergency medicine physicians, nurses and support personnel.

...The Alaska Department of Health and Social Services recently contracted with the Committee on Trauma of the American College of Surgeons (ACS) to review Alaska's trauma care. That review notes Alaska's emergency medical services have been verified by the American College of Surgeons and certified by the State of Alaska as a trauma center (Level II). Neither Providence nor Alaska Regional Hospital has achieved this national standard.

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...We hope the scenario above never happens to you but, if it does, let's make sure that the care we expect for our loved ones is available for all Alaskans when we need it.

...Though Alaskans die from injury at the second highest rate in the U.S., there is no state-wide system of trauma care. In Anchorage, only the Alaska Native Medical Center

...The Alaska Department of Health and Social Services recently contracted with the Committee on Trauma of the American College of Surgeons (ACS) to review Alaska's trauma care. That review notes Alaska's emergency medical services have been verified by the American College of Surgeons and certified by the State of Alaska as a trauma center (Level II). Neither Providence nor Alaska Regional Hospital has achieved this national standard.

...The Alaska Department of Health and Social Services recently contracted with the Committee on Trauma of the American College of Surgeons (ACS) to review Alaska's trauma care. That review notes Alaska's emergency medical services have been verified by the American College of Surgeons and certified by the State of Alaska as a trauma center (Level II). Neither Providence nor Alaska Regional Hospital has achieved this national standard.

...We hope the scenario above never happens to you but, if it does, let's make sure that the care we expect for our loved ones is available for all Alaskans when we need it.

...Merit S. Johnson, MPA (retired as chief of Community Health and Emergency Medical Services for the State of Alaska in 2004), Frank Sacco, M.D., is chairman of the Alaska Trauma Systems Review Committee. The full report on Alaska's trauma care system is available at www.adn.com.

Daily News

ougherty
sident & Editor

Larry Persily
Editorial Page Editor

Norman C. Brown
ne Fanning, Editor and Publisher, 1971-1983
ca Fanning, Editor and Publisher, 1967-1971

OPINION

COMPASS: Points of view from the community

Alaska needs a better trauma system

By FRANK SACCO and MARK S. JOHNSON

Alaska is much safer than it was a generation ago. From 1980 to 2004, the unintentional injury death rate dropped more than 50 percent. Without this improvement, an additional 300 Alaskans would have died in 2004. However, Alaska's 2004 rate remained 30 percent above the national average.

We are all aware of the terrible toll of cancer and cardiovascular diseases, but the leading cause of death for people younger than 44 is injury. It remains a major cause of death and disability for all age groups. For every death approximately three people are left with permanent disabilities.

As with other diseases, prevention is preferable to treatment. Alaska's dramatic reduction in injury deaths is largely attributable to prevention, including use of child restraints and safety belts, reduced rates of drunken driving, and increased use of personal flotation devices. Though prevention is paramount, we also must be prepared to provide the best possible care for those who become injured.

A trauma system is an organized, state-coordinated effort to deliver the full spectrum of care to injured people. The integration of EMS systems, public safety agencies, air medical services and health care facilities ensures that patients receive the most efficient, effective care possible from time of injury through rehabilitation. Trauma systems have been shown to reduce death from injury by as much as 25 percent and are recognized as an integral part of a state's EMS and disaster response system.

According to a 2004 Harris poll, most people want a comprehensive trauma system in their area. Throughout the United States, 83 percent of those surveyed felt a trauma system was as essential as having a fire department and 80 percent were willing to pay extra for it. Interestingly, though 75 percent thought there was a trauma system in their state, only eight states have fully functioning systems and 15 states have



Sacco

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured.



Johnson

no system.

Where do we stand? In 1993, the Alaska Legislature provided authority to the Department of Health and Social Services to verify and certify trauma centers. The statute does not require, or provide incentives for, hospital participation. It does state that no hospital can represent itself as a trauma center unless certified by the state.

Regulations adopted in 1996 require trauma centers to meet standards developed by the American College of Surgeons. Four levels are recognized, from Level I (highest) to Level IV (trauma stabilization facility). There are adequate medical resources to establish Level II trauma centers in Anchorage. In addition, it is feasible to establish Level III and IV centers throughout the state. Because of long transport times, centers of all levels are essential for improving outcomes.

Since the statute and regulations were enacted, only three of 24 eligible hospitals have successfully completed the verification and certification process. (Alaska Native Medical Center — Level II, Yukon-Kuskokwim Regional and Norton Sound Regional Hospitals — Level IV).

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured. In recent years there have been

times when critical specialties such as neurosurgery and vascular surgery have been unavailable for emergencies, necessitating transfer of some critical patients to Seattle.

Here are four steps to improve trauma care in Alaska.

1. Residents need to let legislators know that quality trauma care is important.
 2. The Legislature should put teeth and incentives in the current statute. Successful approaches in other states include requiring trauma center certification at some level as a condition for hospital licensing and limiting medical liability for injuries treated at trauma centers.
 3. Tertiary hospitals should ensure availability of critical sub-specialists 24 hours a day, seven days a week.
 4. Local EMS and medical providers should organize regional trauma systems and integrate them with the statewide system.
- Developing a comprehensive statewide trauma system, and expanding injury prevention efforts, will make Alaska a safer, healthier place to live.

■ Dr. Frank Sacco is chief of surgery at the Alaska Native Medical Center and chairman of the Alaska Chapter of American College of Surgeons Committee on Trauma. Mark S. Johnson was chief of Emergency Medical Services in the Department of Health and Social Services from 1979 until he retired in 2004.

Trauma System Consultation
State of Alaska
Anchorage, Alaska

November 2nd -5th, 2008
American College of Surgeons
Committee on Trauma

PRIORITY RECOMMENDATIONS AMERICAN COLLEGE OF SURGEONS ALASKA TRAUMA SYSTEM REVIEW

November 2-5 2008

Definitive Care Facilities

- Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.
- Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center certification/designation appropriate to their capabilities.
 - Facilities should seek trauma center designation at a level appropriate for their capabilities.
 - Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.
- Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

Lead Agency and Human Resources Within the Lead Agency

Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.

Trauma System Plan

- Develop a comprehensive trauma system strategic plan consistent with the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

System Integration

- Ensure that the Injury Prevention and Emergency Medical Services

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(IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.

Financing

- Provide state funding to hire a fulltime trauma system manager.

Emergency Medical Services

- Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources in near real-time.

System Coordination and Patient Flow

- Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).

Disaster Preparedness

- Integrate all components of the trauma system into state and local disaster planning activities.

System-wide Evaluation and Quality Assurance

- Develop an initial set of 3-5 statewide system performance indicators from among the list of nine provided in the Pre-Review Questionnaire.

Trauma Management Information Systems

- Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are included and functional in the new trauma registry and are consistent with the National Trauma Data Standard definitions.

Statutory Authority and Administrative Rules

System Leadership

- Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and certification, injury prevention and control, public policy, and research.

• Enact legislation to expand the membership of the ACEMS to represent the trauma system and to include the following members appointed as follows:

- One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.
- One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.
- One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.
- One member, appointed by the Alaska Legislature, upon the recommendation of the Speaker of the House of Representatives.
- One member, appointed by the Alaska Legislature, upon the recommendation of the President of the Senate.



Objectives and Methodology

- The Coalition for American Trauma Care commissioned Harris Interactive to conduct a survey of the public's views of and support for trauma systems.
- Telephone interviews were conducted with a nationally representative sample of 1000 adults aged 18 and over, between November 3rd and 14th, 2004.
- Final data were weighted by age, education, gender, income, and region, where necessary, using 2003 Current Population Survey data to adjust for sampling biases, if any.
- With 1,000 respondents, the sampling error is +/- 3%.



Key Topics

- Knowledge about leading causes of death
- Perceived value of and expectations about trauma centers
- Perceived value of and expectations about trauma systems
- Willingness to support funding of trauma centers and systems
- Disaster preparedness and trauma systems



Harris Interactive Ground Rules For Publicly Released Surveys

- Harris Interactive Inc. has very strong ground rules for surveys which may be publicly released. No other survey firm has stronger rules.
- Our **Five Rules** ensure that our surveys are never used to lead or mislead policymakers or the public. We do not do “hired gun surveys.”
 1. **The survey must be fair, balanced and comprehensive.**
 2. **If the survey is publicly released, the full survey report must be released.**
 3. We will not include questions for possible publication about our clients' company or their products or brand names, or the names of their competitors. (The one exception: we sometimes do readership surveys or audience measurement surveys which ask about our clients.)
 4. **The survey must not be used to mislead the public, the media, policymakers or anyone else.**
 5. **We need to review the information that is being released prior to its release in order to check for accuracy.**



Overview

- Most Americans are not aware that injury is the leading cause of death for children, youth, and adults under the age of 34.
- After hearing a description of a trauma center, Americans value them highly and appreciate the importance of having one within easy reach.
 - Almost all Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury.
 - Nearly nine in ten Americans think it is extremely or very important for an ambulance to take them to a trauma center in the event of a life-threatening injury, even if it is not the closest hospital.
 - Nearly all Americans *believe* that if they had a serious or life-threatening injury, they *would* be taken to the hospital that is best equipped to handle their specific injury in less than 1 hour.
- Majorities of Americans feel that having a trauma center nearby is as important as or more important than having a Fire Department or Police Department.

ALASKA STATE HOUSE OF REPRESENTATIVES

**Contact:**

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3340 Badger Road
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Session

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State Capitol
Room 204

REPRESENTATIVE JOHN COGHILL

Date: March 17, 2009

To: Representative Wes Keller, Co-Chair, HSS Committee
Representative Bob Herron, Co-Chair, HSS Committee

From: Representative John Coghill

Handwritten signature of John Coghill, consisting of the initials "JC" in a stylized, cursive font.

Re: HB 168 Trauma Centers

I am requesting the Health & Social Services Committee schedule HB 168 "An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

I have attached backup materials for the bill.

Ryniewa

Karen 6848

3764

ALASKA STATE HOUSE OF REPRESENTATIVES

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Room 214**

REPRESENTATIVE JOHN COGHILL

HB 168 Certification and Designation of Trauma Centers

Sponsor Statement

Trauma injuries can within moments take a person from perfect health to a critical life threatening condition. Trauma is any bodily injury from an external force including car crashes, shootings, falls, snow machine crashes, and stabbings. There is a "golden hour" after the injury during which proper treatment and appropriate interventions will potentially save a trauma patient's life and prevent further damage to the injured person.

Trauma is the leading cause of death for Alaskans between the age of one and forty-four and more than 800 Alaskans are hospitalized each-year for spinal cord and brain injuries.

A trauma system is an organized multidisciplinary response to managing treatment of severely injured people and it spans the full spectrum from prevention and emergency care to recovery and rehabilitation. A trauma system enhances the chance of survival by making sure patients are brought to the most appropriate facility in the most efficient manner and that optimal care is delivered every step of the way.

Texas, Oklahoma, California, Alabama, Washington and Mississippi have implemented programs to address uncompensated trauma services. This legislation would recreate a trauma care fund which could reimburse trauma centers for uncompensated or undercompensated services. The bill would create an incentive for becoming a certified trauma center but does not force facilities to become certified trauma centers.

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REPRESENTATIVE JOHN COGHILL

Designate Trauma Centers and the Uncompensated Trauma Care Fund

Sectional

Section 1. AS 18.08.082 currently prescribes by regulation criteria for training programs and for personnel involved in emergency medical services. This section adds a requirement for the commissioner of Health and Social Services establish special designations for varying levels of services offered by a certified trauma center.

Section 2. Establishes a trauma care fund to be used to compensate certified trauma centers for uncompensated trauma care. The fund can accept money appropriated by the legislature, which can include donations, income from the fund, and of the other designated receipts. The commissioner is given authority to establish a special committee for review of the program and limits are set on the distribution of the funds.

Section 3. The bill has an immediate effective date.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 168
 () Publish Date: _____

Identifier (file name): HB168-DHSS-IPEMS-04-07-09 Dept. Affected: Health and Social Services
 Title: Trauma Care Centers/Fund RDU: Public Health
 Component: Injury Prevention/Emergency Medical Services
 Sponsor: HSS by Request
 Requester: House HSS Component Number: 2876

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

HB 168 establishes a mechanism to provide a financial incentive for hospitals to become designated as certified trauma centers in order to encourage their participation in a statewide trauma system, with the goal of improving delivery of trauma care in the Alaska medical system. This bill establishes a fund for reimbursement of trauma care for uninsured or underinsured patients, and allows designated trauma centers to apply for compensation of claims that are otherwise uncompensated by insurance or other funds.

The Department proposes to manage this fund using existing staff resources.

Prepared by: Beverly Wooley, Director Phone 465-3092
 Division: Public Health Date/Time 4/7/09 12:00 AM
 Approved by: Alison Elgee, Assistant Commissioner Date 4/7/2009
DHSS Finance & Management Services

HOUSE BILL NO. 169

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE COGHILL

Introduced: 3/9/09

Referred: Finance

Funding Information:	General Fund	\$	5,000,000
	Other Funds		-0-
	Total	\$	5,000,000

A BILL**FOR AN ACT ENTITLED**

1 "An Act appropriating \$5,000,000 to the uncompensated trauma care fund; and
2 providing for an effective date."

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** The sum of \$5,000,000 is appropriated from the general fund to the
5 uncompensated trauma care fund (AS 18.08.085) to capitalize the fund.

6 * **Sec. 2.** The appropriation made by sec. 1 of this Act is for the capitalization of a fund and
7 does not lapse.

8 * **Sec. 3.** **CONDITIONAL EFFECT.** The appropriation made by sec. 1 of this Act takes
9 effect only if an Act enacted by the Twenty-Sixth Alaska State Legislature establishing the
10 uncompensated trauma care fund becomes law.

11 * **Sec. 4.** If this Act takes effect under sec. 3 of this Act, it takes effect July 1, 2009.

Alaska Brain Injury Network			
Alaska Scorecard and TBI Dashboard – (DRAFT)			
DRAFT #1 – May 22, 2008			
○ Getting worse		↔ Not changing	⊙ Improving
	5-year Trend	Current Data	Source
SCORECARD: A “scorecard” provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	⊙	98.6	1
Causes			
Falls	○	28.7	1
Motor Vehicle Transportation Occupant	⊙	24.7	1
Assault	⊙	12.2	1
ATV	○	6.5	1
Bicycle	⊙	4.5	1
Snowmachine	⊙	4.4	1
Pedestrian	⊙	3.6	1
Sports	⊙	1.8	1
Water Transport	↔	1.3	1
Suicide Attempt	⊙	.8	1
Gender			
TBI percentage among males		65.4 %	1
TBI percentage among females	↔	33.2 %	1
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	1.a
Percentage of TBI population that is White		53%	1.a
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	1.a
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	1
Females age 80+		217.2	1
Males age 70-79		215.7	1
Males age 15-19		200.9	1
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

- 1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
 1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
 1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
 2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population

○ Getting worse ⇔ Not changing ○ Improving

Dashboard: Behavioral Health

TBI and Mental Health	Spot look trend	Current Data	Source
Percentage BH clients screening positive for TBI	⇔	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	1
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	4

Dashboard: Education

Special Education	Spot look trend	Current Data	Source
Number of children in Special Education statewide with TBI diagnosis (2007)	⇔	66	5

Dashboard: Justice

Corrections	Spot look trend	Current Data	Source
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6

Dashboard: Employment

Vocational Rehabilitation	Spot look trend	Current Data	Source
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		\$12.54	7

Dashboard: Providence

ImPACT Program	Spot look trend	Current Data	Source
Number of baselines (ImPACT)		57	8
Number of student/athletes seen in program (ImPACT)		25	8
Emergency Department			
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8

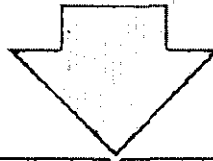
Dashboard: Alaska Brain Injury Network

TBI Advisory Board	Spot look trend	Current Data	Source
Est. Board Member Volunteer hours/year	⊕	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation			
Average new consumer contacts per month	⊕	30	9
Average unique visitors/month to ABIN website	⊕	750	9
Number of people on Alaska Brain Matters Listserve	⊕	100+	9

- 3 AKAIMS
- 4 Suicide Follow-back Study
- 5 <http://www.eed.state.ak.us/stats/>
- 6 Trust/DOC Study 07
- 7 Division of Vocational Rehabilitation (FY07)
- 8 Providence Neuroservices
- 9 Alaska Brain Injury Network

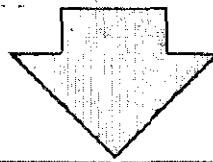
Statewide Planning: Data

Solution: Case Management	Challenge: Why manage rehabilitation services if they do not exist in state?	Attempt: \$150.0 MHTAAR \$50.0 GF/MH NOT funded	Need Rehabilitation
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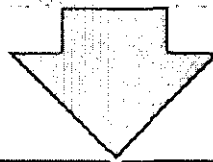
Post Acute Rehabilitation

Solution: Post-acute and Residential Rehabilitation	Why build programs if there is not a FUNDING source to pay for the services?	Community providers want to develop brain injury programs	Need FUNDING
-----------------------------------------------------	------------------------------------------------------------------------------	-----------------------------------------------------------	---------------------



On-Going Support: Funding

Solution: Medicaid Waiver or General Fund	Can't develop waiver application without DATA	Providers cannot build programs without funding source beyond private pay	Need DATA
-------------------------------------------	-----------------------------------------------	---------------------------------------------------------------------------	------------------



-With no programs in place to offer continuous follow up service, studies show traumatic brain survivors are more likely to be substance abusers or become jobless or homeless straining other state and city services.

Solution: Action	The existence of brain injury waivers supports the growth of community non-profit brain injury agencies.	Case management can be paid through waivers or designating TBI as a targeted population	Data is available through other State's experiences (Rutger's Study)
------------------	----------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------	----------------------------------------------------------------------



alaska brain injury network

Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S.

Thirty years ago, only half of all people with brain injury survived; now 78% survive. This means that many individuals now live with significant disability requiring a full range of services.

Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28% higher than the national average. The TBI rate in rural Alaska is one of the highest in the nation.

It is estimated that at least 10,000 Alaskans are living with brain injury today.

The Alaska Brain Injury Network, Inc. (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of Directors represent all regions of Alaska and the extended brain injury community – survivors, family members, service providers, health educators, researchers and those who write laws and policy.

ABIN works with their Alaska Mental Health Trust Authority partner boards to advocate for policy changes, programs, and facilities to better serve the brain injury population.

ABIN's staff focuses on early identification, connecting brain injury survivors with services, providing support and education for families, and bringing professional training to Alaska.

The goal for every brain injury survivor is the best possible recovery for a fulfilling and productive life. Achieving that goal requires full range of services close to home. This includes...

- Prevention
- Early identification and intervention
- Access to skilled specialists
- Community-based post injury services
- Continuing rehabilitation
- Brain injury support groups and in-state resources

What you can do...

- **Be aware of the burden of brain injury nationally and to the state of Alaska**
- **Support a TBI Resolution for Brain Injury Awareness Month.**
- **Become familiar with ABIN Priorities in the GF/MH Budget; Prevention, Training, and Resource Navigation**

Upcoming ABIN Priorities

In-state rehab facility – for neurobehavioral beneficiaries.

Brain Injury Waiver - recommendations for the current Medicaid waiver system to accommodate the services needed by brain injury survivors: neuropsychological assessment, cognitive and functional therapy, case management, counseling, home modifications, transportation, respite care, and more.

TBI Screening and early intervention – promotes better recovery and saves money.



www.alaskabraininjury.net
3745 Community Park Loop, Ste 240
Anchorage, AK 99508
(907) 274-2824

Alaska Brain Injury Network, Inc. helps identify, develop, implement, and sustain needed programs and resources that promote prevention and expand treatment and service delivery to Alaskans who experience TBI and their families.

ALASKA COUNCIL ON EMERGENCY MEDICAL SERVICES

ACEMS
P.O. Box 110616
Juneau, AK 99811-0616
(907) 465-3027



April 9, 2009

Representative Coghill
Juneau, Alaska

Representative Coghill,

Trauma is any bodily injury from an external force. Trauma puts a tremendous burden on families and communities in Alaska. An average of 400 Alaskans die each year from trauma. For every death, 11 people are hospitalized. One in four hospital admissions is uncompensated which puts an additional burden on the State's health care system. HB 168 is offered to assist in this dilemma.

House Bill 168 provides the DHSS Commissioner authority to establish special designations in regulation for varying levels of trauma care so that a 'Certified Trauma Center' would be eligible to recoup expenses as a result of uncompensated care being rendered. The purpose of the fund is to reimburse certified trauma centers in the state for care uncompensated by the person receiving the treatment or by any other source. HB 169 would then set up the uncompensated trauma care fund that would help cover some of the losses suffered by the trauma center rendering the care.

The Alaska Council on EMS seeks your support for a fully functioning trauma system, including funding for the development of trauma centers and legislation addressing the issue of incentives for trauma center designation and uncompensated care of trauma patients. The added benefit of HB 168, we believe, would be an incentive for more hospitals in the state to become 'Certified Trauma Centers' thereby assisting in the development in a state wide trauma care system.

The American College of Surgeons met 11/08 in Anchorage to assess the States trauma system. The passage of HB 168 & 169 would provide support to address some of the areas that were noted in the report.

Thank you for your support of this critical issue.

A handwritten signature in black ink that reads 'David Hull'. The signature is written in a cursive, flowing style.

David Hull, Chair
Alaska Council on Emergency Medical Services

cc Bill Hogan, DHSS Commissioner
Dr. Jay Butler, Chief Medical Officer
Tim Bundy, Section Chief IPEMS



**Alaska Native
Tribal Health Consortium**

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: April 8, 2009

RE: HB 168 – State certification and designation of trauma centers and creating the
uncompensated trauma care fund
HB 169 – Appropriating \$5,000,000 to the uncompensated trauma care fund

POSITION: Support

ANTHC supports HB 168 and HB 169 as important steps in increasing the trauma care capacity in the state.

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally-recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC is the only Level II Trauma Center in the Indian Health Service/tribal health system nationally. ANMC is also the only Level II Trauma Center in Alaska. The nearest Level I Trauma Center is in Seattle.

Trauma system development is a public health priority. A comprehensive system of trauma care is an essential part of the public safety net. Regionalized trauma systems based on a network of coordinated Trauma Centers designated at the appropriate level improves health outcomes and reduces costs. ANMC, as the highest level designated Trauma Center in the State of Alaska, is the lynchpin for the state's trauma system, and provides the foundation for continued statewide system development.

Trauma Center designations were created as a way to improve outcomes for patients who face extraordinary medical issues. On balance, early and appropriate medical attention to life-threatening health issues reduces overall length of stay in the hospital and reduced complications for many patients. Without trauma care, the costs of health care for trauma patients will be greater, including trauma patients who are Medicaid eligible.

The cost of providing trauma care at ANMC has more than doubled over the past four years and funding has not kept pace. ANMC's Trauma Center simply cannot be maintained at current revenue levels. If ANMC's Trauma Center designation is discontinued because funding levels have rendered the service unsustainable, the hospital faces reductions in staffing. Diversions of patients to non-tribal providers would increase, and because the federal government reimburses 100% of the cost of services provided for Native clients at Native facilities but a smaller percentage at non-tribal providers, there would be an increased cost to the state's general fund budget.

ANTHC supports HB 168 and HB 169 as important steps by the State to encourage and support appropriate trauma care options for Alaskans. Because we are Alaska's only Level II Trauma Center we recommend removing the language in section (d) on Page 2, Line 11, that limits appropriations to any one facility to 25%.

Thank you for your consideration.



**Trauma System Consultation
State of Alaska
Anchorage, Alaska**

**November 2nd-5th, 2008
American College of Surgeons
Committee on Trauma**

A multidisciplinary working group prepared this document based on the consultation visit that took place on November 2nd-5th, 2008 in Anchorage, Alaska and included the following members:

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Executive Summary

American College of Surgeons Trauma System Consultation Visit Alaska Department of Health and Social Services November 2nd-5th, 2008

The American College of Surgeons, Trauma Systems Evaluation and Planning Committee (TSEPC) is honored to have been invited to the largest state in the nation and to have listened as the state's impassioned health care providers and public servants discussed their success and remaining challenges. We are pleased to provide this report and to encourage you to implement the key recommendations to improve the system of trauma care for all Alaskans and visitors, regardless of where that injury may occur.

It is clear that Alaska recognizes the significance of its injury problem as witnessed both by epidemiological descriptions of fatal and non-fatal injury and by the extensive focus on injury prevention programs across the state. Alaska's current trauma system is a testament to the adage that "necessity is the mother of invention". Clearly the "Last Frontier" is challenged with issues of geography, remoteness, inclement weather and limited health care resources. State and regional leaders, along with a wide ranging cadre of health care providers are to be congratulated for their efforts to achieve the trauma system mantra of "getting the right patient to the right place in the right amount of time". Whether this has involved training a hunting buddy to be an Emergency Trauma Technician, or a local aviation service has figured out how to carry a litter in a small aircraft, or a rural Critical Access Hospital has strived to become certified or designated as a Level IV trauma center, clear progress has been demonstrated toward the betterment of trauma care in Alaska.

The achievements to date have largely been unplanned with limited coordination. As a result, incongruity exists within the current trauma system. Several Alaska Native facilities have sought and achieved verification/designation as trauma centers. These facilities are to be commended for their dedication and commitment to trauma care and the trauma system. To date, few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care.

The current leadership of the Alaska Department of Health and Social Services recently made a commitment to trauma system development by making this a priority project in the 2009 work plan. This represents an opportunity to begin the process to coordinate, systematize and institutionalize these efforts so that, regardless of where someone is injured in Alaska or what their racial and ethnic heritage might be, all have equal access to optimal trauma care. Alaska must make a commitment of resources, both fiscal and human, to achieve the recommendations outlined in this document. The consultation team encourages the state to retain the opportunity for system ingenuity when addressing the challenges that Alaska's geography and environment impose when increasing the standardization of trauma system processes.

Advantages and Assets of the Alaska Trauma System

- The lead agency for trauma is identified. Statute designates the Alaska Council on EMS (ACEMS) as an advisory group with responsibility for trauma.
- The state has very committed individuals who use their time and expertise every day to serve Alaska citizens.
- The state has extensive and creative networks for transport.
- Three large medical centers with extensive subspecialty expertise exist within the state.
- A large Level I trauma center in Seattle freely accepts adult and pediatric trauma patients.
- One medical center maintains ACS Level II verification standards and other facilities have obtained consultation and are working toward verification.
- All 24 acute care hospitals provide data to the Alaska trauma registry.
- Injury prevention activities are well established.
- The EMS Goals document categorizes communities by size and remoteness and identifies the resources that should be available for health care and trauma care.
- The state created the Emergency Trauma Technician program to prepare community members to provide initial trauma care.

- Initial efforts have been made to obtain legislative change.

Challenges and Vulnerabilities of the Alaska Trauma System

- The state has many challenges due to geography, weather, and remote and isolated communities.
- No trauma system strategic plan has been developed.
- No standards exist for scene trauma triage or trauma inter-facility transfers.
- Trauma system issues receive limited attention by the Alaska Council on EMS, and thus little visibility within the Department of Health and Social Services.
- The general public is not aware of trauma system issues.
- The state has limited human resources for the provision of trauma care. The lead agency also has limited human resources for trauma system management.
- The ACEMS has no formal trauma representatives.
- There are two healthcare systems for trauma care, one for Native Alaskans and one for other Alaskans.
- Few incentives exist for hospitals to participate in the trauma system.
- No statewide evaluation of system performance is conducted.
- The trauma registry data are not current.

Priority Recommendations Summary

This report contains more than seventy recommendations. Of these, the TSEPC team felt that the following were the most critical to the system's short and long-term success.

Statutory Authority and Administrative Rules

- **Enact legislation to expand the membership of the ACEMS to represent the trauma system and to include the following members appointed as follows:**
 - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.**
 - **One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.**
 - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.**
 - **One member, appointed by the Alaska Legislature, upon the recommendation of the Speaker of the House of Representatives.**
 - **One member, appointed by the Alaska Legislature, upon the recommendation of the President of the Senate.**
- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame.**
 - **Facilities should seek trauma center designation at a level appropriate for their capabilities.**
 - **Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.**

System Leadership

- **Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and certification, injury prevention and control, public policy, and research.**

Coalition Building and Community Support

- **Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.**

Lead Agency and Human Resources Within the Lead Agency

Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.

Trauma System Plan

- **Develop a comprehensive trauma system strategic plan consistent with the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.**

System Integration

- **Ensure that the Injury Prevention and Emergency Medical Services (IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.**

Financing

- **Provide state funding to hire a fulltime trauma system manager.**

Emergency Medical Services

- **Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources in near real-time.**

Definitive Care Facilities

- **Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.**
- **Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center certification/designation appropriate to their capabilities.**
- **Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.**

System Coordination and Patient Flow

- **Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).**

Disaster Preparedness

- **Integrate all components of the trauma system into state and local disaster planning activities.**

System-wide Evaluation and Quality Assurance

- **Develop an initial set of 3-5 statewide system performance indicators from among the list of nine provided in the Pre-Review Questionnaire.**

Trauma Management Information Systems

- **Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are included and functional in the new trauma registry and are consistent with the National Trauma Data Standard definitions.**

Trauma System Assessment

Injury Epidemiology

Purpose and Rationale

Injury epidemiology is concerned with the evaluation of the frequency, rates, and pattern of injury events in a population. Injury pattern refers to the occurrence of injury-related events by time, place, and personal characteristics (for example, demographic factors such as age, race, and sex) and behavior and environmental exposures, and, thus, it provides a relatively simple form of risk-factor assessment.

The descriptive epidemiology of injury among the whole jurisdictional population (geographic area served) within a trauma system should be studied and reported. Injury epidemiology provides the data for public health action and becomes an important link between injury prevention and control and trauma system design and development. Within the trauma system, injury epidemiology has an integral role in describing the root causes of injury and identifying patterns of injury so that public health policy and programs can be implemented. Knowledge of a region's injury epidemiology enables the identification of priorities for directing better allocation of resources, the nature and distribution of injury prevention activities, financing of the system, and health policy initiatives.

The epidemiology of injury is obtained by analyzing data from multiple sources. These sources might include vital statistics, hospital administrative discharge databases, and data from emergency medical services (EMS), emergency departments (EDs), and trauma registries. Motor-vehicle crash data might also prove useful, as would data from the criminal justice system focusing on interpersonal conflict. It is important to assess the burden of injury across specific population groups (for example, children, elderly people and ethnic groups) to ensure that specific needs or risk factors are identified. It is critical to assess rates of injury appropriately and, thus, to identify the appropriate denominator (for example, admissions per 100,000 population). Without such a measure, it becomes difficult to provide valid comparisons across geographic regions and over time.

To establish injury policy and develop an injury prevention and control plan, the trauma system, in conjunction with the state or regional epidemiologist, should complete a risk assessment and gap analysis using all available data. These data allow for an assessment of the "injury health" of the population (community, state, or region) and will allow for the assessment of whether injury prevention programs are available, accessible, effective, and efficient.

An ongoing part of injury epidemiology is public health surveillance. In the case of injury surveillance, the trauma system provides routine and systematic data collection and, along with its partners in public health, uses the data to complete injury analysis, interpretation, and dissemination of the injury information. Public health officials and trauma leaders should use injury surveillance data to describe and monitor injury events and emerging injury trends in their jurisdictions; to identify emerging threats that will call for a reassessment of priorities and/or reallocation of resources; and to assist in the planning, implementation, and evaluation of public health interventions and programs.

OPTIMAL ELEMENTS

I. There is a thorough description of the epidemiology of injury in the system jurisdiction using population-based data and clinical databases. **(B-101)**

- a. There is a through description of the epidemiology of injury mortality in the system jurisdiction using population-based data. **(I-101.1)**
- b. There is a description of injuries within the trauma system jurisdiction, including the distribution by geographic area, high-risk populations (pediatric, elderly, distinct cultural/ethnic, rural, and others), incidence, prevalence, mechanism, manner, intent, mortality, contributing factors, determinants, morbidity, injury severity (including death), and patient distribution using any or all the following: vital statistics, ED data, EMS data, hospital discharge data, state police data (data from law enforcement agencies), medical examiner data, trauma registry, and other data sources. The description is updated at regular intervals. **(I-101.2)**
Note: Injury severity should be determined through the consistent and system-wide application of one of the existing injury scoring methods, for example, Injury Severity Score (ISS).
- c. There is comparison of injury mortality using local, regional, statewide, and national data. **(I-101.3)**
- d. Collaboration exists among EMS, public health officials, and trauma system leaders to complete injury risk assessments. **(I-101.4)**
- e. The trauma system works with EMS and public health agencies to identify special at-risk populations. **(I-101.7)**

II. Collected data are used to evaluate system performance and to develop public policy. **(B-205)**

- a. Injury prevention programs use trauma management information system data to develop intervention strategies. **(I-205.4)**

III. The trauma, public health, and emergency preparedness systems are closely linked. **(B-208)**

- a. The trauma system and the public health system have established linkages, including programs with an emphasis on population based public health surveillance and evaluation for acute and chronic traumatic injury and injury prevention. **(I-208.1)**

IV. The jurisdictional lead agency, in cooperation with the other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**

- a. The lead agency, along with partner organizations, prepares annual reports on the status on injury prevention and trauma care in the state, regional, or local areas. **(I-304.1)**
- b. The trauma system management information system database is available for routine public health surveillance. There is concurrent access to the databases (ED, trauma, prehospital, medical examiner, and public health epidemiology) for the purpose of routine surveillance and monitoring of health status that occurs regularly and is a shared responsibility. **(I-304.2)**

CURRENT STATUS

Injury is the leading cause of death for Native Alaskans of all ages. Injury is the third leading cause of death for all Alaskans. Like the remainder of the United States, injury is the leading cause of death for the population between 1 and 44 years of age. Leading mechanisms for unintentional injury include the following: motor vehicle crash, falls, airplane crash, fire, all terrain vehicles, snow machine, and firearms. Suicide is a leading cause of injury death for ages 15 to 64 years. Injury mortality is significantly higher in Alaska than in the remainder of the United States where injury is the fifth leading cause of death; however it was reported that the state's injury mortality rate has decreased significantly over the last 30 years.

Healthy Alaskans 2010 describes significant injury prevention objectives for the state, with indicators identified for unintentional injury, occupational fatalities, attempted suicide, nonfatal, hospitalized traumatic brain injury, prenatal physical abuse, population using seatbelts, and households keeping firearms locked and loaded. A strategic plan for addressing these injury prevention objectives was not identified.

A dedicated staff working on epidemiology is assigned to the Department of Health and Social Services (DHSS) Injury Prevention and EMS (IPEMS) Section to coordinate the data analysis for various injury focus areas. Additionally, the Native Alaska Epidemiology Center analyzes data related to injury among the native population. A report on Native Alaskan injury morbidity and mortality was published in 2008.

Access to numerous population-based databases (e.g., vital statistics, fatal analysis reporting system, public safety information system, civilian fire fatality statistics, uniform crime reporting, medical examiner case database, and hospital discharge data system) are readily available for study of the injury problem.

Funding from grants and other state agencies has been obtained and creatively used to support injury surveillance. The state has many population-based injury databases used to describe the injury problem. Numerous injury surveillance activities are ongoing, such as the violent deaths reporting, occupational injuries, motor vehicle crashes, and traumatic brain injuries. The Alaska trauma registry which has data from all 24 acute care hospitals has been used extensively to describe the patterns of injury in the state.

The state had a State and Territorial Injury Prevention Directors Association (STIPDA) assessment conducted in 2003. Work was reported to be still in progress to address many of the recommendations included in the report.

The state has a wealth of data about the injury problem. Primary injury prevention has been the priority focus of information shared with the public and members of the injury coalition. The data have been used to compete successfully for numerous federal grants and state agency projects.

The state website has fairly recent information and reports about injury trends for selected injuries, particularly regarding injury mechanisms for which the state has grant funding. Several publications were reported to be in draft stage related to grant funded activities, but no general description of the injury problem in the state has been published since *Healthy Alaskans 2010*.

No apparent linkage has been made between injury prevention and injury control, which would integrate secondary and tertiary prevention (or the care provided after the patient is injured) in the injury epidemiology focus. Alaskans have not been informed about the injury problem, its relationship to trauma care, and the need for a trauma system.

RECOMMENDATIONS

- Develop fact sheets for public education regarding injuries that require hospitalization and a trauma system.
- Expand the focus of injury epidemiology to report on trauma patient outcomes and the relationship to the trauma system.

Indicators as a Tool for System Assessment

Purpose and Rationale

In the absence of validated national benchmarks, or norms, the benchmarks, indicators and scoring (BIS) process included in the Health Resources and Services Administration's *Model Trauma System Planning and Evaluation* document provides a tool for each trauma system to define its system-specific health status benchmarks and performance indicators and to use a variety of community health and public health interventions to improve the community's health status. The tool also addresses reducing the burden of injury as a community-wide public health problem, not strictly as a trauma patient care issue.

This BIS tool provides the instrument and process for a relatively objective state and sub-state (regional) trauma system self-assessment. The BIS process allows for the use of state, regional, and local data and assets to drive consensus responses to the BIS. It is essential that the BIS process be completed by a multidisciplinary stakeholder group, most often the equivalent of a state trauma advisory committee. The BIS process can help focus the discussion on various system strengths and weaknesses, can be used to set goals or benchmarks, and provides the opportunity to target often limited resources and energies to the areas identified as most critical during the consensus process. The BIS process is useful to develop a snapshot of any given system at a moment in time. However, its true usefulness is in repeated assessments that reveal progress toward achieving various benchmarks identified in the previous application of the BIS. This process further permits the trauma system to refine goals to be attained before future reassessments using the tool.

OPTIMAL ELEMENT

- I. Assurance to constituents that services necessary to achieve agreed-on goals are provided by encouraging actions of others (public or private), requiring action through regulation, or providing services directly. **(B-300)**

CURRENT STATUS

In early 2007, the Benchmark, Indicators and Scoring (BIS) document from the *Model Trauma System Planning and Evaluation* document was distributed to the Trauma System Review Committee (TSRC). Seven of the sixteen members completed the BIS scoring. Results were compiled and means were calculated for each indicator. Those summary scores were presented to the TSRC at their May, 2007, meeting. The TSRC selected benchmarks 205, 206 and 208 for improvement over the succeeding year.

Specifically, the TSRC identified three tactics to improve scores for identified benchmarks. These tactics included:

1. Select three measures of patient care that can be reviewed by the committee.
2. Compare and contrast transfers from designated Level IV facilities with those from non-designated facilities.
3. Review deaths in transport and deaths within 24 hours of admission.

When queried about the status of these tactical objectives, the TSRC members noted that little progress has been made in completing those processes. Initial data were reviewed from the state trauma registry to begin the process. However, the consensus was that the data needed additional cleaning, so the project was placed on hold and has not been revisited.

Those who had participated in the BIS review relayed some frustration about the process, stating that they did not have sufficient information to answer each of the indicators. Other states that have completed the BIS process in the same individual process have had similar experiences; however, when states have completed the BIS in a facilitated group process, individuals from across the trauma system spectrum learn a great deal about other areas of the trauma system. These facilitated processes have been conducted in many different formats, including audio teleconferencing, segmentation of the BIS by section, and in face-to-face retreats.

When participants were asked about whether the BIS might be revisited, little enthusiasm was expressed for undertaking the process, probably due to the frustration associated with the initial process and the low perceived value of the outcome.

RECOMMENDATIONS

- Select and complete one of the three tactical objectives identified in the May, 2007, TSRC meeting.
- Secure funding to support a facilitated trauma system assessment utilizing the Benchmark, Indicators and Scoring (BIS) process with the newly formed Alaska Trauma Advisory Committee (ATAC) and other trauma system stakeholders and state partners.
- Repeat the BIS process at regular intervals (e.g., every two years) as a means of establishing and monitoring system benchmarks

Trauma System Policy Development

Statutory Authority and Administrative Rules

Purpose and Rationale

Reducing morbidity and mortality due to injury is the measure of success of a trauma system. A key element to this success is having the legal authority necessary to improve and enhance care of injured people through comprehensive legislation and through implementing regulations and administrative code, including the ability to regularly update laws, policies, procedures, and protocols. In the context of the trauma system, comprehensive legislation means the statutes, regulations, or administrative codes necessary to meet or exceed a predescribed set of standards of care. It also refers to the operating procedures necessary to continually improve the care of injured patients from injury prevention and control programs through post injury rehabilitation. The ability to enforce laws and rules guides the care and treatment of injured patients throughout the continuum of care.

There must be sufficient legal authority to establish a lead trauma agency and to plan, develop, maintain, and evaluate the trauma system during all phases of care. In addition, it is essential that as the development of the trauma system progresses, included in the legislative mandate are provisions for collaboration, coordination, and integration with other entities also engaged in providing care, treatment, or surveillance activities related to injured people. A broad approach to policy development should include the building of system infrastructure that can ensure system oversight and future development, enforcement, and routine monitoring of system performance; the updating of laws, regulations or rules, and policies and procedures; and the establishment of best practices across all phases of intervention. The success of the system in reducing morbidity and mortality due to traumatic injury improves when all service providers and system participants consistently comply with the rules, have the ability to evaluate performance in a confidential manner, and work together to improve and enhance the trauma system through defined policies.

OPTIMAL ELEMENTS

- I. Comprehensive state statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight, and future development. **(B-201)**
 - a. The legislative authority states that all the trauma system components, emergency medical services (EMS), injury control, incident management, and planning documents work together for the effective implementation of the trauma system (infrastructure is in place). **(I-201.2)**

- b. Administrative rules and regulations direct the development of operational policies and procedures at the state, regional, and local levels. **(I-201.3)**

II. The lead agency acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the trauma system. **(B-311)**

- a. Laws, rules, and regulations are routinely reviewed and revised to continually strengthen and improve the trauma system. **(I-311.4)**

CURRENT STATUS

The IPEMS Section has served as the administrative unit for trauma and emergency medical services (EMS) since 1977. The Alaska State Statutes (AS 18.08.010), related to EMS and Trauma as revised in 1993, provide the agency with authority for the development, implementation, and maintenance of a statewide comprehensive EMS system. Historically the IPEMS has provided leadership with dedicated individuals who have committed themselves to the improvement of trauma and emergency care for the state. Leadership within the IPEMS has experienced changes beginning in 2004 due to the retirement of its Chief and reorganization within the DHSS.

A significant strength for the IPEMS Section is that it currently has support from the senior leadership within the DHSS to provide for the development and regulatory oversight of the state's EMS and trauma system. The statutory authority and departmental support provide an opportunity for the IPEMS Section to identify and collaborate with the numerous stakeholders for trauma and EMS to include the Alaska Hospital Association, the Native Alaskan healthcare providers, prehospital provider organizations, health professional organizations, and numerous governmental and non-governmental entities.

The Alaska Council on Emergency Medical Services (ACEMS) was established in statute (AS 18.08.020). The council has eleven members appointed by the Governor, and it is charged with advising the Commissioner of DHSS and Governor regarding the planning and implementation of a statewide EMS system. Membership of the council includes prehospital professionals, other healthcare professionals, an EMS administrator, a hospital administrator and members of the public. The ACEMS currently has no required surgical, pediatric, or legislative representation on the council.

The Trauma System Review Committee (TSRC) is appointed by the Commissioner of DHSS. It is comprised of physicians and other healthcare professionals tasked to review the trauma system data. The committee is a legal medical review organization under statute AS 18.23.010-070, and membership is approved by the State Medical Board.

The TSRC's work in reviewing the trauma registry data and monitoring the care being delivered to the state's citizens and visitors is provided confidentiality and liability protection in statute AS 18.23.020. This represents another significant strength in the state's EMS and trauma system. The committee's role beyond the review of trauma registry data is not clearly defined and no direct connection to the ACEMS currently exists.

Recently the TSRC proposed a legislative effort titled the Alaska Trauma Improvement Act, but insufficient legislative support was obtained for passage in the last (2006) legislative session. The efforts and success of the TSRC to promote improvements in trauma care for all Alaskans is commendable and can be attributed to the vision and leadership provided by its chair Dr. Frank Sacco and to the dedication of its membership. Currently hospital participation in the statewide trauma system is voluntary and no incentives are provided to promote participation. For an inclusive trauma system approach and to improve trauma care statewide all hospitals should be required to participate, not only by submission of trauma data, but at some level of trauma system participation.

The state EMS medical director's current role does not include medical oversight of the trauma system. The state does not have a trauma medical director or advisor identified to provide the IPEMS Section with guidance in the development and oversight of the trauma system. The designation of a trauma surgeon to such a role would increase the state's ability to fully integrate all phases of care, including prehospital, into a statewide inclusive trauma system.

RECOMMENDATIONS

- **Enact legislation to expand the membership of the ACEMS to represent the trauma system and include the following members appointed as follows:**
 - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.**
 - **One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.**
 - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.**
 - **One member, appointed by the Alaska Legislature upon the recommendation of the Speaker of the House of Representatives.**
 - **One member, appointed by the Alaska legislature upon the recommendation of the President of the Senate.**
- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame.**

- **Facilities should seek trauma center designation at a level appropriate for their capabilities.**
- **Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.**
- Require all hospitals and clinics to submit data to the state trauma registry.
- Amend the Alaska Administrative Code (AAC) to give the IPEMS Section responsibility for development of a statewide plan for the implementation and monitoring of an inclusive trauma system.

System Leadership

Purpose and Rationale

In addition to lead agency staff and consultants (for example, trauma system medical director), there are other significant leadership roles essential to developing mature trauma systems. A broad constituency of trauma leaders includes trauma center medical directors and nurse coordinators, prehospital personnel, injury prevention advocates, and others. This broad group of trauma leaders works with the lead agency to inform and educate others about the trauma system, implements trauma prevention programs, and assists in trauma system evaluation and research to ensure that the right patient, right hospital, and right time goals are met. There is a strong role for the trauma system leadership in conveying trauma system messages, building communication pathways, building coalitions, and collaborating with relevant individuals and groups. The marketing communication component of trauma system development and maintenance begins with a consensus-built public information and education plan. The plan should emphasize the need for close collaboration between coalitions and constituency groups and increased public awareness of trauma as a disease. The plan should be part of the ongoing and regular assessment of the trauma system and be updated as frequently as necessary to meet the changing environment of the trauma system.

When there are challenges to providing the optimal care to trauma patients within the system, the leadership needs to effect change to produce the desired results. Broad system improvements require the ability to identify challenges and the resources and authority to make changes to improve system performance. However, system evaluation is a shared responsibility. Although the leadership will have a key role in the acquisition and analysis of system performance data, the multidisciplinary trauma oversight committee will share the responsibility of interpreting those data from a broad systems perspective to help determine the efficiency and effectiveness of the system in meeting its stated performance goals and benchmarks. All stakeholders have the responsibility of identifying opportunities for system improvement and bringing them to the attention of the multidisciplinary committee or the lead agency. Often, subtle changes in system performance are noticed by clinical care providers long before they become apparent through more formal evaluation processes.

Perhaps the biggest challenge facing the lead agency is to synergize the diversity, complexity, and uniqueness of individuals and organizations into a finely tuned system for prevention of injury and for the provision of quality care for injured patients. To meet this challenge, leaders in all phases of trauma care must demonstrate a strong desire to work together to improve care provided to injured victims.

OPTIMAL ELEMENTS

- I. Trauma system leaders (lead agency, trauma center personnel, and other stakeholders) use a process to establish, maintain, and constantly evaluate and improve a comprehensive trauma system in cooperation with medical, professional, governmental, and other citizen organizations. **(B-202)**
- II. Collected data are used to evaluate system performance and to develop public policy. **(B-205)**
- III. Trauma system leaders, including a trauma-specific statewide multidisciplinary, multiagency advisory committee, regularly review system performance reports. **(B-206)**
- IV. The lead agency informs and educates state, regional, and local, constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

CURRENT STATUS

The IPEMS Section of the DHSS is the lead agency charged with development, implementation, and maintenance of a statewide comprehensive EMS system, including trauma care. The DHSS has identified the development of a statewide trauma system as one of its 2009 priorities. Both the DHSS Commissioner and Chief Medical Officer were supportive of obtaining an American College of Surgeons (ACS) Trauma Systems Consultation, and both attended. Alaska has not established a clear process for developing, maintaining and continually evaluating a comprehensive trauma system, and this, in part, was the impetus for this consultative visit.

The Alaska Trauma Registry Review Committee was created to review registry data, provide guidance for trauma registry improvement, and review and approve requests for release of registry data. The TSRC role has broadened over the years to include reviewing trauma registry data, making recommendations for trauma system improvement, and reviewing facilities for Level IV trauma center designation. The name has also changed, to become the Trauma Systems Review Committee (TSRC). The TSRC has multidisciplinary membership appointed by the IPEMS Section and approved by the Alaska Medical Board. The chairperson of the Alaska Chapter of the American College of Surgeons Committee on Trauma (ACS-COT) is currently a member of the TSRC.

The TSRC has been attempting to effect change by conducting selected studies from the trauma registry to evaluate trauma care, and then developing care guidelines, such as the head injury management guidelines for rural facilities.

Recommendations from the TSRC that have been transmitted to the lead agency have not always resulted in action or change, and the TSRC is not empowered to make changes in the trauma system. Individuals from the committee are also active in proposing new trauma system improvement legislation.

By statute the ACEMS is charged with advising the Governor and the Commissioner of DHSS with regard to the planning and implementation of a statewide EMS system that by definition includes trauma. From a review of ACEMS minutes, this council has primarily addressed prehospital issues with little focus on issues related to the broader trauma system. The Chair of the Alaska Chapter of the ACS-COT regularly attends meetings of ACEMS, and he has reported trauma system issues and advances to the council. The Alaska COT has been active in proposing trauma system improvements and change.

While the surgeons of the Alaska Native Healthcare System are very active in trauma systems development and performance improvement, other community surgeons in Anchorage are not as actively engaged. The trauma nurse coordinators from the hospitals throughout the state appear to be experienced, knowledgeable, and active in trying to improve the trauma system.

The state does not have a group of multidisciplinary trauma stakeholders; however the large number of participants present at the trauma system consultation (TSC) demonstrates that the state has interested stakeholders. No forum exists for trauma system problem resolution. A state trauma advisory body that serves as a subcommittee of the ACEMS is a recommended strategy for giving stakeholders an opportunity to participate in trauma system development.

RECOMMENDATIONS

- **Form the Alaska Trauma Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions of the trauma system: trauma system planning, data systems, systemwide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and designation, injury prevention and control, public policy, and research.**
- Ensure that the Alaska Trauma Advisory Committee (ATAC) has a broad multidisciplinary membership that might include legislative personnel and representation from the Alaska Native Healthcare System, the public sector hospital systems, the Alaska Hospital Association, emergency nurses, prehospital providers, and the media.
- Develop trauma stakeholder discussion groups (e.g., trauma medical directors, trauma coordinators, trauma registrars) to provide direction and

broad-based, multidisciplinary and multi-committee support for trauma system development.

- Make the existing TSRC a subcommittee of the ATAC, sanctioned by the Alaska Medical Board and narrow its focus to specifically concentrate on issues of system performance and improvement.

Coalition Building and Community Support

Purpose and Rationale

Coalition building is a continuous process of cultivating and maintaining relationships with constituents (interested citizens) in a state or region who agree to collaborate on injury control and trauma system development. Key constituents include health professionals, trauma center administrators, prehospital care providers, health insurers and payers, data experts, consumers and advocates, policy makers, and media representatives. The coalition of key constituents comprises the trauma system's stakeholders. The involvement of these key constituents is important for the following:

- Trauma system plan development
- Regionalization: promoting collaboration rather than competition between trauma centers
- System integration
- State policy development: authorizing legislation and regulations
- Financing initiatives
- Disaster preparedness

The coalition should be effectively organized through the formation of multidisciplinary state and regional advisory groups to coordinate trauma system planning and implementation efforts. Constituents also communicate with elected officials and policy leaders regarding the development and sustainability of the trauma system. Information and education are needed by constituents to be effective partners in policy development for trauma system planning. Regular communication about the status of the trauma system helps these key partners to recognize needs and progress made with trauma system implementation.

One of the most effective ways to educate elected officials and the public is through an organized public information and education effort that may involve a media campaign about the burden of injury in the state and the need for trauma system development. Information and education are important to reduce the incidence of injury in all age groups and to demonstrate the value of an effective trauma system when a serious injury occurs.

OPTIMAL ELEMENT

- I. The lead agency informs and educates state, regional, and local constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

CURRENT STATUS

Alaska does not currently have a coalition of trauma stakeholders who meet or communicate about the trauma system. It was reported that a prior trauma stakeholder group, associated with federal grant funding, had met but was disbanded when federal funding ended. This trauma system consultation was one of the first opportunities for health professionals, acute care facility administrators, state agency representatives, prehospital providers, and data managers to meet and focus on aspects of the trauma system.

The most significant barrier to sustaining a trauma stakeholder group was identified as geography and the high cost associated with travel to a central location. Alternate mechanisms of communication such as an electronic listserv or web-based conferencing have not been investigated. Another barrier is the lack of a state trauma manager with adequate time to facilitate communication among stakeholders interested in trauma care issues.

Developing a trauma system has only recently become a priority goal of the DHSS. It was reported that Alaskans have an expectation that they will be cared for in the event of injury, and they believe the resources of a trauma system are in place. No public education regarding trauma care and the need for a trauma system has yet been initiated. Some education of elected state officials has been initiated, but it may be challenging to make the trauma system a priority without strong public support.

RECOMMENDATIONS

- **Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.**
- Establish a mechanism of communication (e.g., electronic listserv or discussion group) for stakeholders with an interest in trauma system development.
 - Ensure that information about planning meetings is posted and accessible to stakeholders in a timely manner.
- Identify mechanisms for interested individuals to participate in trauma system planning from remote locations (e.g., web-based teleconferencing).

Lead Agency and Human Resources within the Lead Agency

Purpose and Rationale

Each trauma system (state, regional, local, as defined in state statute) should have a lead agency with a strong program manager who is responsible for leading the trauma system. The lead agency, usually a government agency, should have the authority, responsibility, and resources to lead the planning, development, operations, and evaluation of the trauma system throughout the continuum of care. The lead agency, empowered through legislation, ensures system integrity and provides for program integration with other health care and community-based entities, namely, public health, EMS, disaster preparedness, emergency management, law enforcement, social services, and other community-based organizations.

The lead agency works through a variety of groups to accomplish the goals of trauma system planning, implementation, and evaluation. The ability to bring multidisciplinary, multiagency advisory groups together to accomplish trauma system goals is essential in developing and maintaining the trauma system and is part of providing leadership to evolving and mature systems.

The lead agency's trauma system program manager coordinates trauma system design, the adoption of minimum standards (prehospital and in-hospital), and provides for overall system evaluation through performance indicator assessment and assurance. In addition to a trauma program manager, the lead agency must be sufficiently staffed to actively participate in each phase of development and in maintaining the system through a clearly defined structure for decision making (policies and procedures) and through proactive surveillance and evaluation. *Minimum* staffing usually consists of a trauma system program manager, data entry and analysis personnel, and monitoring and compliance personnel. Additional staff resources include administrative support and a part-time commitment from the public health epidemiology service to provide system evaluation and research support.

Within the leadership and governance structure of the trauma system, there is a role for strong physician leadership. This role is usually fulfilled by a full- or part-time trauma medical director within the lead agency.

OPTIMAL ELEMENTS

- I. Comprehensive state statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight, and future development. **(B-201)**
 - a. The legislative authority (statutes and regulations) plans, develops, implements, manages, and evaluates the trauma system and its component parts, including the identification of the lead agency and the designation of trauma facilities. **(I-201.1)**
 - b. The lead agency has adopted clearly defined trauma system standards (for example, facility standards, triage and transfer guidelines, and data collection standards) and has sufficient legal authority to ensure and enforce compliance. **(I-201.4).**
- II. Sufficient resources, including financial and infrastructure-related, support system planning, implementation, and maintenance. **(B-204)**

CURRENT STATUS

The role of the IPEMS Section in trauma system development is clearly stated in state statutes; however, better definition of how the agency integrates trauma care into the overall EMS program is needed, such as through the development of a statewide trauma strategic plan (See Trauma System Plan).

The trauma system is currently managed by a trauma system manager (0.2 full-time equivalent [FTE]) and a trauma registrar (1.0 FTE). The trauma registrar is supported by two contracted positions. The trauma registrar also has computer and epidemiology support from the National Institute for Occupational Safety and Health (NIOSH) Field Station staff. The IPEMS Section also has an impressive injury prevention program and staffing. However, the lead agency is not adequately staffed to meet the demands of developing and maintaining a statewide trauma system through trauma program assessment, policy development, and performance improvement activities.

The present job classification for the trauma manager is a Public Health Specialist II position which does not specify any education or experience requirements related to emergency health care. The present job description identifies the additional duties and responsibilities for the state trauma manager to include serving as the state Emergency Medical Services for Children (EMSC) program manager and the manager of grants for the state rural automated external defibrillator program. Additional duties and responsibilities for this position include analyzing the continuing education needs and soliciting

educational sessions for the annual EMS Symposium. It was reported that the EMSC responsibilities have now been shifted to another position. However, the remaining responsibilities would significantly impact the individual's ability to focus on trauma system development.

Staffing is currently insufficient within the lead agency to encourage and support trauma stakeholders in building a statewide inclusive trauma system. A qualified trauma manager is needed to facilitate the development of a statewide trauma system plan. As the position is currently vacant, the timing is optimal to revise the job description and job classification to enable recruitment of an individual who is a health professional (e.g., nurse with a BSN or MSN) with experience in trauma or emergency health care.

Additionally, the trauma system has no designated physician to provide medical oversight. The IPEMS Section has a designated emergency physician serving as the State EMS Medical Director, but this individual has no responsibilities for trauma system medical control and oversight. If a Trauma Medical Director can not be recruited and hired, potentially a Trauma Medical Oversight Subcommittee of the ATAC could be created to fulfill this responsibility and support the State EMS Medical Director.

RECOMMENDATIONS

- **Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.**
- Recruit a trauma manager.
- Develop a mechanism for trauma system medical oversight (e.g., hire a Trauma Medical Director, develop a subcommittee of the Alaska Trauma Advisory Committee).
- Ensure that the trauma system has trauma medical direction.

Trauma System Plan

Purpose and Rationale

Each trauma system, as defined in statute, should have a clearly articulated trauma system planning process resulting in a written trauma system plan. The plan should be built on a completed inventory of trauma system resources identifying gaps in services or resources and the location of assets. It should also include an assessment of population demographics, topography, or other access enhancements (location of hospital and prehospital resources) or barriers to access. It is important that the plan identify special populations (for example, pediatric, elderly, in need of burn care, ethnic groups, rural) within the geographic area served and address the needs of those populations within the planning process. A needs assessment (or other method of identifying injury patterns, patient care review/preventable death study) should also be completed for initial trauma system planning and updated periodically as needed to assess system changes over time.

The trauma system plan is developed by the lead trauma agency based on the results of a needs assessment and other data resources available for review. It describes the system design, integrated and inclusive, with adopted standards of care for prehospital and hospital personnel and a process to regularly review the plan over time. The plan is built on input from trauma advisory committees (or stakeholder groups) that assist in analyzing data, identifying resources, and developing system standards of care, including system policies and procedures and overall system design. Ideally, although every stakeholder group may not be satisfied with the plan or system design, the plan, to the extent possible, should be based on consensus of the advisory committees and stakeholder groups. These advisory groups should be able to review the plan before final adoption and approve the plan before it is submitted to the lead agency with authority for plan approval.

The trauma system plan is used to guide system development, implementation, and management. Each component of the trauma system (for example, prehospital, hospital, communications, and transportation) is clearly defined and an established service level identified (baseline) with goals for enhancement (benchmark). Within the plan are incorporated other planning documents used to ensure integration of similar services and build collaboration and cooperation with those services. Service plans for emergency preparedness, EMS, injury prevention and control, public health, social services, and mental health are examples of services for which the trauma system plan should include an interface between agencies and services.

OPTIMAL ELEMENT

I. The state lead agency has a comprehensive written trauma system plan based on national guidelines. The plan integrates the trauma system with EMS, public health, emergency preparedness, and incident management. The written trauma system plan is developed in collaboration with community partners and stakeholders. **(B-203)**

- a. The trauma system plan clearly describes the system design (including the components necessary to have an integrated and inclusive trauma system) and is used to guide system implementation and management. For example, the plan includes references to regulatory standards and documents and includes methods of data collection and analysis. **(I-203.4)**

CURRENT STATUS

In 1993, Alaska secured funding from HRSA to develop a statewide trauma system plan. A task force was created to draft a trauma plan within the existing *Alaska EMS Goals* document. The 1992 Health Resources and Services Administration (HRSA) *Model Trauma Care System Plan* draft was utilized as the basis for the development of this trauma system plan. The grant funding also enabled the state to develop two additional documents: Trauma Triage, Transport and Transfer Guidelines and a Guide on Rehabilitation Services. No mention was made of work performed during federal trauma grant funding from 2002 to 2004.

The *Alaska EMS Goals* document is a guide for the development of EMS and trauma systems by categorizing communities throughout the state by remoteness and resources that should be available. The document identifies specific challenges that Alaska communities face such as access and availability of care, limited road access, availability of training, and recruitment and retention of EMS volunteers. The classifications of communities can also be used to identify levels of care and capabilities to manage the trauma patient.

The *Alaska EMS Goals* document provides a brief overview of EMS system needs in Alaska and lists the state's priorities for grant funding. The integration and consideration of special organizations such as rural health networks, critical incident stress management teams, community injury prevention organizations and local emergency preparedness councils are reflected in the document, along with topics such as seasonal impacts, special populations, hazardous materials, injury prevention, air medical transportation, communications, trauma care, and quality assurance.

An assessment tool called the EMS Community Checklist is available to communities in order to determine their current status in meeting EMS and Trauma system goals within a specified community classification. It is unclear if the data from the assessment tools have been collated and utilized for state system planning.

The community classification in the goals document references classification levels from rural to urban using a 1-5 numbering system. This numbering system is inconsistent with the ACS standards for level of trauma center verification which are in reverse order by facility capabilities.

The TSRC has adopted the *ACS Resources for Optimal Care of the Injured Patient for Acute Care Facilities*, as the standard for trauma center certification (the term used by Alaska for designation). The *Alaska EMS Goals* document clearly specifies the adoption of these standards within each community categorization. The document also promotes the utilization of the various triage and treatment guidelines for the trauma patient. In addition, the guide specifies the importance of establishing an inclusive trauma system and the utilization of trauma registry data to assess the effectiveness of the system.

The *Alaska EMS Goals* document was last updated in 2003, making it consistent with planning and evaluation standards of the time. The guide does not incorporate the 2006 *HRSA Model Trauma System Planning and Evaluation* document that promotes a public health approach to trauma system development.

Overall, the *Alaska EMS Goals* document provides the necessary and comprehensive guidelines for the development and enhancement of the components of a state trauma system. A state assessment to determine at what level the communities have met the goals, has not been accomplished to determine the current needs or trauma resources and assets available.

The IPEMS Section has established five reasonable goals for the trauma system with the limited state resources that are available. Though the goals appear to be achievable, it is unclear how the needs for these goals were determined and how they will be measured and accomplished.

The state has seven EMS regions and EMS Councils. Specific areas of the *Alaska EMS Goals* document recognize the importance of these regional and local assets. However, utilization of these resources for trauma system assessment and strategic planning has not been clearly demonstrated.

RECOMMENDATIONS

- **Develop a comprehensive trauma system strategic plan based on the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.**
- Consider revising the *Alaska EMS Goals* document by reversing the community classification numbering system to be consistent with the American College of Surgeons Committee on Trauma (ACS-COT) trauma center verification levels (e.g., urban is 1 and isolated community is 5).
- Ensure that the comprehensive trauma system plan is integrated and made consistent with the 2003 *Alaska EMS Goals* document, the state health plan, the injury prevention plan, the rural health plan and disaster preparedness plans.

System Integration

Purpose and Rationale

Trauma system integration is essential for the daily care of injured people and includes such services as mental health, social services, child protective services, and public safety. The trauma system should use the public health approach to injury prevention to contribute to reducing the entire burden of injury in a state or region. This approach enables the trauma system to address primary, secondary, and tertiary injury prevention through closer integration with community health programs and mobilizing community partnerships. The partnerships also include mental health, social services, child protection, and public safety services. Collaboration with the public health community also provides access to health data that can be used for system assessment, development of public policy, and informing and educating the community.

Integration with EMS is essential because this system is linked with the emergency response and communication infrastructure and transports severely injured patients to trauma centers. Triage protocols should exist for treatment and patient delivery decisions. Regulations and procedures should exist for online and off-line medical direction. In the event of a disaster affecting local trauma centers, EMS would have a major role in evacuating patients from trauma centers to safety or to other facilities or to make beds available for patients in greater need.

The trauma system is a significant state and regional resource for the response to mass casualty incidents (MCIs). The trauma system and its trauma centers are essential for the rapid mobilization of resources during MCIs. Preplanning and integration of the trauma system with related systems (public health, EMS, and emergency preparedness) are critical for rapid mobilization when a disaster or MCI occurs. The extensive impact of disasters and MCIs on the functioning of trauma centers and the EMS and public health systems within the affected region or state must be considered, and joint planning for optimal use of all resources must occur to enable a coordinated response to an MCI. Trauma system leaders need to be actively involved in emergency management planning to ensure that trauma centers are integrated into the local, regional, and state disaster response plans.

OPTIMAL ELEMENTS

I. The state lead agency has a comprehensive written trauma system plan based on national guidelines. The plan integrates the trauma system with EMS, public health, emergency preparedness, and incident management. The written trauma system plan is developed in collaboration with community partners and stakeholders. **(B-203)**

- a. The trauma system plan has established clearly defined methods of integrating the trauma system plan with the EMS, emergency, and public health preparedness plans. **(I-203.7)**

II. The trauma, public health, and emergency preparedness systems are closely linked. **(B-208)**

CURRENT STATUS

The two groups involved with EMS and trauma are the ACEMS and the TSRC. Membership on the ACEMS is dictated in statute and consists of two physicians with experience in either emergency medicine or trauma, emergency nurses, prehospital providers, an EMS administrator, a hospital administrator, and consumers. Currently the only formal trauma involvement is the Chair of the ACS-COT who serves in a liaison capacity. TSRC membership includes a trauma registrar, epidemiologist, surgeon, emergency physician, hospital administrator, hospital trauma director, all Anchorage trauma nurse coordinators, two prehospital EMS personnel, a pediatrician, and six other miscellaneous members.

Little apparent integration occurs between other trauma stakeholders. Even with EMS representation on the TSRC and a trauma liaison on ACEMS, an EMS participant reported continuing issues regarding communications with the hospitals providing trauma care in Anchorage. Issues were said to involve diversion status and availability of specialty care providers, stemming from the differing level of commitment to trauma care by the facilities.

No integration was reported between the state trauma system and other related services, such as public safety or law enforcement agencies, mental health services, and social services. While psychiatric and social services consultations are available within the verified trauma care center and remaining two hospitals providing trauma care, there was no evidence of ongoing discussions regarding ways to improve interactions or for planning better system integration in the future.

Integration with the Office of Rural Health to support trauma education across the state was described. Integration with numerous other agencies was demonstrated by the transfer of funds for specific program support (see the Financing Section).

The membership of the future ATAC should include representation from fire, law enforcement, social services, injury prevention, mental health, and protective services, in addition to health professionals involved in trauma care. Having a consumer of trauma care or their family member would also bring the public perspective to issues. Legislative representatives would bring much needed insight into legal methods of change. Agencies that could also be included as formal or liaison members include the Office of Rural Health, the Alaska Native Healthcare System, and disaster preparedness agencies. The broader the representation working on the trauma system, the broader the attack base for resolution.

RECOMMENDATIONS

- **Ensure that the Injury Prevention and Emergency Medical Services (IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.**

Financing

Purpose and Rationale

Trauma systems need sufficient funding to plan, implement, and evaluate a statewide or regional system of care. All components of the trauma system need funding, including prehospital, acute care facilities, rehabilitation, and prevention programs. Lead agency trauma system management requires adequate funding for daily operations and other important activities such as advisory committee meetings, development of regulations, data collection, performance improvement, and public awareness and education. Adequate funding to support the operation of trauma centers and their state of readiness to care for seriously injured patients within the state or region is essential. The financial health of the trauma system is essential for ensuring its integrity and its improvement over time.

The trauma system lead agency needs a process for assessing its own financial health, as well as that of the trauma system. A trauma system budget should be prepared, and costs should be reported by each component, if possible. Routine collection of financial data from all participating health care facilities is encouraged to fully identify the costs and revenues of the trauma system, including costs and revenues pertaining to patient care, administrative, and trauma center operations. When possible, the lead agency financial planning should integrate with the budgets and costs of the EMS system and disaster, rehabilitation, and prevention programs to enable development of a comprehensive financial health report.

Trauma system financial planning should be related to the trauma plan outcome measures (for example, patient outcome measures such as mortality rates, length of stay, and quality-of-life indicators). Such information may demonstrate the value added by having a trauma system in place.

OPTIMAL ELEMENTS

- I. Sufficient resources, including financial and infrastructure-related, support system planning, implementation, and maintenance. **(B-204)**
 - a. Financial resources exist that support the planning, implementation, and ongoing management of the administrative and clinical care components of the trauma system. **(I 204.2)**
 - b. Designated funding for trauma system infrastructure support (lead agency) is legislatively appropriated. **(I-204.3)**

- c. Operational budgets (system administration and operations, facilities administration and operations, and EMS administration and operations) are aligned with the trauma system plan and priorities. **(I-204.4)**

II. The financial aspects of the trauma systems are integrated into the overall performance improvement system to ensure ongoing fine tuning and cost-effectiveness. **(B-309)**

- a. Collection and reimbursement data are submitted by each agency or institution on at least an annual basis. Common definitions exist for collection and reimbursement data and are submitted by each agency. **(I-309.2)**

CURRENT STATUS

Although Alaska has no designated state funding for the development and maintenance of a statewide trauma system, the IPEMS Section has been creative in leveraging funding to support various aspects of the trauma system. The IPEMS Section receives significant funding from several sources (primarily federal grants and other state allocations) that is being used to support the state's efforts to maintain the trauma system. However, many of these funding sources will only provide short term assistance. The current funding sources include the following:

- Community Health Grants to support Community Health Aide Training and medical supervision of the community health aides throughout the state based on a formula defined in AS 18.28.010.
- Rural Health Flexibility Funding is used to provide trauma training to Critical Access Hospitals and emergency services.
- The state provides capital project funding to support the communication needs of emergency responders for the maintenance and replacement of communications equipment.
- HRSA's Emergency Medical Services for Children program funding pays a portion of the salary support for the individual filling the part-time trauma manager position.
- Centers for Disease Control (CDC) Disaster Preparedness funds were used to pay for the ACS-COT trauma system consultation visit.
- NIOSH provides funding for one FTE and two contractors to support the trauma registry.

- Federal Emergency Preparedness Grants are pass-through funds used to develop and implement fire and burn injury prevention strategies. Recipients include the Municipality of Anchorage, the Alaska Native Tribal Health Consortium, and the Alaska State Hospital and Nursing Home Association.
- The state also provides funding to local agencies from the Code Blue Project Funds to provide EMS equipment and ambulances for local communities. With the assistance of the Department of Agriculture (USDA), the Rasmusson Foundation, and the Denali Commission, approximately \$14 million was received to provide new EMS equipment in 2008. A local match is required for the foundation funding and is key to the success of the project.
- The state also provides resources to regional EMS agencies to develop a comprehensive EMS system as outlined in the Alaska EMS Goals document.

Currently, the state does not employ either the State EMS Medical Director or a Trauma Medical Director. However, they contract with an MD, on a part-time basis to, serve as the State EMS Medical Director. State funding to support EMS and trauma system medical direction is critical to the development and maintenance of a statewide inclusive trauma system.

The state does not charge fees for the designation of trauma center site visits. However, charging a fee for trauma center certification/designation would likely go directly to the state general fund due to the state's constitutional requirement prohibiting dedicated funds for program support. In addition, given the fact that trauma center certification/designation is currently voluntary, charging fees may be an impediment to implementing the state's inclusive trauma system.

Levels I-III trauma centers are verified by the ACS after which the state certifies/designates them as trauma centers at these levels. Level IV certifications/designations are conducted by the IPEMS based on meeting the criteria of the ACS Committee on Trauma. No state funding is available to support trauma center readiness or uncompensated care.

The trauma registry includes a mechanism to collect financial data regarding trauma patients, and all the hospitals participate in the registry. The data are not submitted from all hospitals in a timely manner, and the information is not currently being used for financial planning or evaluation of the statewide system.

RECOMMENDATIONS

- **Provide state funding to hire a fulltime trauma system manager.**
- Provide state funding to ensure sufficient medical direction for the trauma and EMS programs.
- Determine a method of providing financial support for hospitals certified/designated by the state as trauma centers to assist with uncompensated care and the cost of readiness.
- Encourage the use of FLEX grant funding for the preparation of eligible facilities to become certified/designated as Level IV trauma centers.

Trauma System Assurance

Prevention and Outreach

Purpose and Rationale

Trauma systems must develop prevention strategies that help control injury as part of an integrated, coordinated, and inclusive trauma system. The lead agency and providers throughout the system should be working with business organizations, community groups, and the public to enact prevention programs and prevention strategies that are based on epidemiologic data gleaned from the system.

Efforts at prevention must be targeted for the intended audience, well defined, and structured, so that the impact of prevention efforts is systemwide. The implementation of injury control and prevention requires the same priority as other aspects of the trauma system, including adequate staffing, partnering with the community, and taking advantage of outreach opportunities. Many systems focus information, education, and prevention efforts directly to the general public (for example, restraint use, driving while intoxicated). However, a portion of these efforts should be directed toward emergency medical services (EMS) and trauma care personnel safety (for example, securing the scene, infection control). Collaboration with public service agencies, such as the department of health is essential to successful prevention program implementation. Such partnerships can serve to synergize and increase the efficiency of individual efforts. Alliances with multiple agencies within the system, hospitals, and professional associations, working toward the formation of an injury control network, are beneficial.

Activities that are essential to the development and implementation of injury control and prevention programs include the following:

- A needs assessment focusing on the public information needed for media relations, public officials, general public, and third-party payers, thus ensuring a better understanding of injury control and prevention
- A needs assessment for the general medical community, including physicians, nurses, prehospital care providers, and others concerning trauma system and injury control information
- Preparation of annual reports on the status of injury prevention and trauma care in the system
- Trauma system databases that are available and usable for routine public health surveillance

OPTIMAL ELEMENTS

I. The lead agency informs and educates state, regional, and local constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

- a. The trauma system leaders (lead agency, advisory committees, and others) inform and educate constituencies and policy makers through community development activities, targeted media messaging, and active collaborations aimed at injury prevention and trauma system development. **(I-207.2)**

II. The jurisdictional lead agency, in cooperation with other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**

- a. The lead agency, along with partner organizations, prepares annual reports on the status of injury prevention and trauma care in state, regional, or local areas. **(I-304.1)**

III. The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area. **(B-306)**

- a. The trauma system is active within its jurisdiction in the evaluation of community based activities and injury prevention and response programs. **(I-306.2)**
- b. The effect or impact of outreach programs (medical and community training and support and prevention activities) is evaluated as part of a system performance improvement process. **(I-306.3)**

CURRENT STATUS

The state is to be commended for recognizing the significant problem and impact of injury on Alaskans. The IPEMS Section within DHSS is the primary focus area for injury epidemiology and injury prevention in the state. Numerous programs and sources of funding from other agencies and from grant funding (e.g., NIOSH, Maternal and Child Health, Department of Highway Safety, Medicaid, and CDC) support injury program efforts. Documents provided to the consultant team identified an injury program manager and 8 additional staff members in IPEMS.

The state has numerous groups with which it works successfully to implement injury prevention programs. The Alaska Native Tribal Health Consortium Injury Prevention Program works to develop and disseminate culturally appropriate injury prevention programs. Acute care facilities were reported to be implementing brief alcohol screening and intervention programs.

The Alaska Injury Prevention Center is an example of a coalition formed to promote injury prevention outreach by the Anchorage acute care facilities. This center has progressed beyond its original Anchorage outreach focus to become a nonprofit organization that can develop, implement, and evaluate injury program interventions across the entire state.

The state has been an acknowledged leader in the development of injury prevention programs, such as the Kids Don't Float program that has reduced drowning deaths among children. This program is now sustained through partnerships with the Coast Guard and SafeKids. The state often serves as a facilitator for injury program implementation through its many partnerships, such as Injury Prevention in a Bag with EMTs in small communities. Information about 16 injury mechanisms, their prevention strategies, and resources for injury prevention programs are available on the IPEMS website.

Several state agencies collaborate with IPEMS in conducting injury surveillance and in implementing injury prevention strategies, such as the Alaska Marine Safety and Education Association, Alaska Highway Safety Office, Alaska Division of Fire and Life Safety.

The EMS Goals document describes the importance of implementing injury prevention programs in all communities across the state. Injury prevention education is targeted to prehospital providers during the annual EMS conference, and continuing medical education units are provided. Prehospital providers have been engaged in implementing the Injury in a Bag program as well as other injury prevention programs.

The focus of the state and its extensive programming for primary injury prevention is exemplary. Injury prevention is an important component of the trauma system. An opportunity now exists to expand the primary injury prevention focus to the broader concept of injury control so that this emphasis can be integrated with the future state trauma system.

RECOMMENDATIONS

- Ensure representation of an injury prevention representative on the Alaska Trauma Advisory Council (ATAC).
- Incorporate the concept of "injury control" into the prevention activities to raise awareness of the need for a comprehensive and integrated trauma system.

Emergency Medical Services

Purpose and Rationale

The trauma system includes, and/or interacts with, many different agencies, institutions, and systems. The EMS system is one of the most important of these relationships. EMS is often the critical link between the injury-producing event and definitive care at a trauma center. Even though at its inception the EMS system was a very broad system concept, over time, EMS has come to be recognized as the prehospital care component of the larger emergency health care system. It is a complex system that not only transports patients, but also includes public access, communications, personnel, triage, data collection, and quality improvement activities.

The EMS system medical director must have statutory authority to develop protocols, oversee practice, and establish a means of ongoing quality assessment to ensure the optimal provision of prehospital care. If not the same individual, the EMS system medical director must work closely with the trauma system medical director to ensure that protocols and goals are mutually aligned. The EMS system medical director must also have ongoing interaction with EMS agency medical directors at local levels, as well as the state EMS for Children program, to ensure that there is understanding of and compliance with trauma triage and destination protocols.

Ideally, a system should have some means of ensuring whether resources meet the needs of the population. To achieve this end, a resource and needs assessment evaluating the availability and geographic distribution of EMS personnel and physical resources is important to ensure a rapid and appropriate response. This assessment includes a detailed description of the distribution of ground ambulance and air medical locations across the region. Resource allocations must be assessed on a periodic basis as needs dictate a redistribution of resources. In communities with full-time paid EMS agencies, ambulances should be positioned according to predictable geographic or temporal demands to optimize response efficiencies. Such positioning schemes require strong prehospital data collection systems that can track the location of occurrences over time. Periodic assessment of dispatch and transport times will also provide insight into whether resources are consistent with needs.

Each region should have objective criteria dictating the level of response (advanced life support [ALS], basic life support [BLS]), the mode of transport, and the disposition of the patient based on the location of the incident and the severity of injury. A mechanism for case-based review of trauma patients that involves prehospital and hospital providers allows bidirectional information sharing and continuing education, ensuring that expectations are met at both ends. Ongoing review of triage and treatment decisions allows for continuing quality improvement of the triage and prehospital care protocols. A more detailed discussion of in-field (primary) triage criteria is provided in the section titled: System Coordination and Patient Flow.

Human Resources

Periodic workforce assessments of EMS should be conducted to ensure adequate numbers and distribution of personnel. EMS, not unlike other health care professions, experiences shortages and misdistribution of personnel. Some means of addressing recruitment, retention, and engagement of qualified personnel should be a priority. It is critical that trauma system leaders work to ensure that prehospital care providers at all levels attain and maintain competence in trauma care. Maintenance of competence should be ensured by requiring standards for credentialing and certification and specifying continuing educational requirements for all prehospital personnel involved in trauma care. The core curricula for First Responder, Emergency Medical Technician (EMT) Basic, EMT-Intermediate, EMT Paramedic, and other levels of prehospital personnel have an essential orientation to trauma care for all ages. However, trauma care knowledge and skills need to be continuously updated, refined, and expanded through targeted trauma care training such as Prehospital Trauma Life Support®, Basic Trauma Life Support®, and age-specific courses. Mechanisms for the periodic assessment of competence, educational needs, and education availability within the system should be incorporated into the trauma system plan.

Systems of excellence also encourage EMS providers to go beyond meeting state standards for agency licensure and to seek national accreditation. National accreditation standards exist for ground-based and air medical agencies, as well as for EMS educational programs. In some states, agency licensure requirements are waived or substantially simplified if the EMS agency maintains national accreditation.

EMS is the only component of the emergency health care and trauma system that depends on a large cadre of volunteers. In some states, substantially more than half of all EMS agencies are staffed by volunteers. These agencies typically serve rural areas and are essential to the provision of immediate care to trauma patients, in addition to provision of efficient transportation to the appropriate facility. In some smaller facilities, EMS personnel also become part of the emergency resuscitation team, augmenting hospital personnel. The trauma care system program should reach out to these volunteer agencies to help them achieve their vital role in the outcome of care of trauma patients. However, it

must be noted that there is a delicate balance between expecting quality performance in these agencies and placing unrealistic demands on their response capacity. In many cases, it is better to ensure that there is an optimal BLS response available at all times rather than a sporadic or less timely response involving ALS personnel. Support to volunteer EMS systems may be in the form of quality improvement activities, training, clinical opportunities, and support to the system medical director.

Owing to the multidisciplinary nature of trauma system response to injury, conferences that include all levels of providers (for example, prehospital personnel, nurses, and physicians) need to occur regularly with each level of personnel respected for its role in the care and outcome of trauma patients. Communication with and respect for prehospital providers is particularly important, especially in rural areas where exposure to major trauma patients might be relatively rare.

Integration of EMS Within the Trauma System

In addition to its critical role in the prehospital treatment and transportation of injured patients, EMS must also be engaged in assessment and integration functions that include the trauma system and also public health and other public safety agencies. EMS agencies should have a critical role in ensuring that communication systems are available and have sufficient redundancy so that trauma system stakeholders will be able to assess and act to limit death and disability at the single patient level and at the population level in the case of mass casualty incidents (MCIs). Enhanced 911 services and a central communication system for the EMS/trauma system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants are important for integrating a system's response. Wireless communications capabilities, including automatic crash notification, hold great promise for quickly identifying trauma-producing events, thereby reducing delays in discovery and decreasing prehospital response intervals.

Further integration might be accomplished through the use of EMS data to help define high-risk geographic and demographic characteristics of injuries within a response area. EMS should assist with the identification of injury prevention program needs and in the delivery of prevention messages. EMS also serves a critical role in the development of all-hazards response plans and in the implementation of those plans during a crisis. This integration should be provided by the state and regional trauma plan and overseen by the lead agency. EMS should participate through its leadership in all aspects of trauma system design, evaluation, and operation, including policy development, public education, and strategic planning.

OPTIMAL ELEMENTS

I. The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated. **(B-302)**

- a. There is well-defined trauma system medical oversight integrating the specialty needs of the trauma system with the medical oversight for the overall EMS system. **(I-302.1)**
- b. There is a clearly defined, cooperative, and ongoing relationship between the trauma specialty physician leaders (for example, trauma medical director within each trauma center) and the EMS system medical director. **(I-302.2)**
- c. There is clear-cut legal authority and responsibility for the EMS system medical director, including the authority to adopt protocols, to implement a performance improvement system, to restrict the practice of prehospital care providers, and to generally ensure medical appropriateness of the EMS system. **(I-302.3)**
- d. The trauma system medical director is actively involved with the development, implementation, and ongoing evaluation of system dispatch protocols to ensure they are congruent with the trauma system design. These protocols include, but are not limited to, which resources to dispatch, for example, ALS versus BLS, air ground coordination, early notification of the trauma care facility, pre-arrival instructions, and other procedures necessary to ensure that resources dispatched are consistent with the needs of injured patients. **(I-302.4)**
- e. The retrospective medical oversight of the EMS system for trauma triage, communications, treatment, and transport is closely coordinated with the established performance improvement processes of the trauma system. **(I-302.5)**
- f. There is a universal access number for citizens to access the EMS/trauma system, with dispatch of appropriate medical resources. There is a central communication system for the EMS/trauma system to ensure field- to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants. **(I-302.7)**
- g. There are sufficient and well-coordinated transportation resources to ensure that EMS providers arrive at the scene promptly and expeditiously transport the patient to the correct hospital by the correct transportation mode. **(I-302.8)**

II. The lead trauma authority ensures a competent workforce. **(B-310)**

- a. In cooperation with the prehospital certification and licensure authority, set guidelines for prehospital personnel for initial and ongoing trauma training, including trauma-specific courses and courses that are readily available throughout the state. **(I-310.1)**
- b. In cooperation with the prehospital certification and licensure authority, ensure that prehospital personnel who routinely provide care to trauma patients have a current trauma training certificate, for example, Prehospital Trauma Life Support or Basic Trauma Life Support and others, or that trauma training needs are driven by the performance improvement process. **(I-310.2)**
- c. Conduct at least 1 multidisciplinary trauma conference annually that encourages system and team approaches to trauma care. **(I-310.9)**

III. The lead agency acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the trauma system. **(B-311)**

- a. Incentives are provided to individual agencies and institutions to seek state or nationally recognized accreditation in areas that will contribute to overall improvement across the trauma system, for example, Commission on Accreditation of Ambulance Services for prehospital agencies, Council on Allied Health Education Accreditation for training programs, and American College of Surgeons (ACS) verification for trauma facilities. **(I-311.6)**

CURRENT STATUS

The lead agency for Alaska EMS is the IPEMS Section under the authority of the DHSS. The EMS system is comprised of seven EMS regions that span a huge geographic area with extreme terrain and weather variations. These regions receive varying degrees of funding from the state. The state has approximately 3,300 Emergency Medical Technicians (EMTs), 175 Mobile Intensive Care Paramedics (MICPs) and unknown numbers of first responders.

When injured or ill patients require treatment not available locally, they may be transported by ground (ambulance, privately owned vehicle, snow machine, dog sled), by water (U.S. Coast Guard, fishing boat) or air (rotor or fixed wing, medical private or commercial). EMS ground services in Alaska include five BLS, 39 ALS with occasional BLS, and 33 ALS services. Air medical services include eight Medevac and 10 Critical Care Air Ambulance services with one service also certified as a Perinatal Specialty Air Medical Transport Service. Each of the regional hub cities has at least one air medical service. There are approximately

180 certified and uncertified first responder services across the state, however not all communities are covered.

EMT levels are as follows:

- EMT I (EMT Basic, 1994 U.S. Department of Transportation (DOT) National Standard Curriculum (NSC) with medication module but not manual defibrillation or advanced airway module);
- EMT II (EMT I plus 50 additional hours of training; exceeds EMT Intermediate 85, can administer intravenous fluids (5% dextrose in water, crystalloid volume-replacement solutions) and selected medications (50% dextrose in water and naloxone hydrochloride);
- EMT III (EMT I plus EMT II plus 50 hours of additional training; can administer EMT II medications plus lidocaine, atropine, morphine, and epinephrine 1:1000/1:10,000; apply electrodes, monitor cardiac activity and provide countershock for ventricular fibrillation and pulseless ventricular tachycardia).
- Defibrillator Technician training is available for EMT I and II levels that allows them to perform manual defibrillation.

EMT levels II and III function under direct or indirect supervision of a physician, and if they do not have a medical director they must function at the EMT I level. EMT I, II and III personnel are certified by the IPEMS Section. The local medical director may expand the scope of an EMT I, II or III after approval by the IPEMS Section and submission of a training and evaluation plan. The local medical director is responsible for the expanded care provided.

The Mobile Intensive Care Paramedic (MICP) is licensed by the Alaska State Medical Board which requires completion of training that follows the U.S. DOT NSC for paramedics, successful completion of the National Registry paramedic examination, and obtaining a physician sponsor approved by the Alaska State Medical Board.

First Responders are not certified by the state, including the Alaska Emergency Trauma Technician (ETT). The ETT is trained via a 44 hour course developed by the Public Safety Academy to cover emergency trauma care, medical communication, and Medevac preparations.

Most isolated communities have Community Health Aids (CHA) who are trained and function as the primary care provider either under the distant supervision of a physician or the direct supervision of a nurse practitioner or physician assistant located in the community. CHA's are First Responder or ETT trained with many at the EMT I level or higher. Due to the limited access to roads and a transportation system that depends on air or water and good weather, the injured

patient may be in the care of the CHA for up to 72 hours. It is essential that these communities have optimal communications capabilities for access to physicians and regional medical facilities. Due to the high turnover rate of the CHAs, the state will need to continue to make training programs available so this level of care can continue to be provided in these isolated communities.

The state contracts with an emergency physician on an as needed basis to perform selected duties of the state EMS medical director, and a federally-funded Alaska Native Health Service Medical Director oversees the Indian Health Service/Public Health Service medical directors. Regional and local physician medical directors are largely volunteers. A regional or local medical director for state certified EMT II or III personnel, training programs or courses (EMT II, EMT III or manual defibrillator technician training) or for a service (basic life support (BLS), advanced life support (ALS) or air medical) must be an Alaska licensed physician or a physician working in the regular medical service of the U.S. Armed Services or the U.S. Public Health Service. The medical director must participate in an orientation provided by the IPEMS Section within one year after accepting the responsibility of medical direction. Medical directors of an ALS ground service or air medical service have additional requirements.

Medical director responsibilities for the certified EMT include the following:

- supervise the medical care,
- establish and annually review treatment protocols,
- approve advanced life support standing orders for each state-certified EMT,
- provide quarterly critiques of patient care,
- schedule quarterly on-site supervision, and
- approve a program of continuing medical education for each state-certified EMT supervised.

The licensed MICP functions under a physician sponsor as noted above. While the responsibilities of the medical director of an MICP service are defined, the responsibility of the physician sponsor for the individual MICP is not. The IPEMS Section suggests that the MICP physician sponsor should follow the guidelines outlined for medical directors of certified EMTs. Local and regional EMS medical directors are provided liability coverage for their EMS duties, but their time is not compensated by the state.

Resources for regional and local EMS medical directors include an Alaska Medical Director's Handbook, a physician track during the annual State EMS Symposium, and an EMS Medical Directors' meeting during the symposium, both facilitated by the state EMS medical director.

Online medical direction for EMS providers in rural and remote locations is provided by the hospital or clinic in that region via phone (some locations have limited telemedicine capability). Often the communications system is solely dependent on satellite access. The regional facility will decide on patient disposition and help arrange transport to the most appropriate health care facility. Patient transport may involve multiple transfers requiring various modes of travel.

Alaska's 27 largest communities have Enhanced 911 services. Wireless E-911 is available in Anchorage and Juneau with limited availability in Fairbanks and Kenai. The service is Phase II compliant (Phase II rules require wireless carriers to begin providing more precise Automatic Location Identification). Alaska has uniform minimum standards for training and certification of Emergency Medical Dispatchers.

RECOMMENDATIONS

- **Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (i.e. load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources.**
- Continue to support the Emergency Trauma Technician training and maximize course availability.
- Develop a program of prehospital continuing education for trauma that includes special populations such as geriatrics and pediatrics.
- Develop a medical director's listserv as a method to disseminate information in a timely manner and encourage interaction among medical directors.
- Continue to develop a National EMS Information System (NEMSIS) - compliant electronic EMS database to support evaluation of the EMS system and as a quality improvement tool for patient care.

Definitive Care Facilities

Purpose and Rationale

Inclusive trauma systems are the systems that include all acute health care facilities, to the extent that their resources and capabilities allow and in which the patient's needs are matched to hospital resources and capabilities. Thus, as the core of a regional trauma system, acute care facilities operating within an inclusive trauma system provide definitive care to the entire spectrum of patients with traumatic injuries. Acute care facilities must be well integrated into the continuum of care, including prevention and rehabilitation, and operate as part of a network of trauma-receiving hospitals within the public health framework. All acute care facilities should participate in the essential activities of a trauma system, including performance improvement, data submission to state or regional registries, representation on regional trauma advisory committees, and mutual operational agreements with other regional hospitals to address interfacility transfer, educational support, and outreach. The roles of all definitive care facilities, including specialty hospitals (for example, pediatric, burn, severe traumatic brain injury [TBI], spinal cord injury [SCI]) within the system should be clearly outlined in the regional trauma plan and monitored by the lead agency. Facilities providing the highest level of trauma care are expected to provide leadership in education, outreach, patient care, and research and to participate in the design, development, evaluation, and operation of the regional trauma system.

In an inclusive system, patients should be triaged to the appropriate facility based on their needs and facility resources. Patients with the least severe injuries might be cared for at appropriately designated facilities within their community, whereas the most severe should be triaged to a level I or II trauma center. In rural and frontier systems, smaller facilities must be ready to resuscitate and initiate treatment of the major injuries and have a system in place that will allow for the fastest, safest transfer to a higher level of care.

Trauma receiving facilities providing definitive care to patients with other than minor injuries must be specifically designated by the state or regional lead agency and equipped and qualified to do so at a level commensurate with injury severity. To assess and ensure that injury type and severity are matched to the qualifications of the facilities and personnel providing definitive care, the lead agency should have a process in place that reviews and verifies the qualifications of a particular facility according to a specific set of resource and quality standards. This criteria-based process for review and verification should be consistent with national standards and be conducted on a periodic cycle as determined by the lead agency. When centers do not meet set standards, there should be a process for suspension, probation, revocation, or dedesignation.

Designation by the lead agency should be restricted to facilities meeting criteria or statewide resource and quality standards and based on patient care needs of the regional trauma system. There should be a well-defined regulatory relationship between the lead agency and designated trauma facilities in the form of a contract, guidelines, or memorandum of understanding. This legally binding document should define the relationships, roles, and responsibilities between the lead agency and the medical leadership from each designated trauma facility. The number of trauma centers by level of designation and location of acute care facilities must be periodically assessed by the lead agency with respect to patient care needs and timely access to definitive trauma care. There should be a process in place for augmenting and restricting, if necessary, the number and/or level of acute care facilities based on these periodic assessments. The trauma system plan should address means for improving acute care facility participation in the trauma system, particularly in systems in which there has been difficulty addressing needs.

Human Resources

The ability to deliver high-quality trauma care is highly dependent on the availability of skilled human resources. Therefore, it is critical to assess the availability and educational needs of providers on a periodic basis. Because availability, particularly of subspecialty resources, is often limited, some means of addressing recruitment, retention, and engagement of qualified personnel should be a priority. At this time, there are no fellowship trained trauma surgeons in Alaska. Periodic workforce assessments should be conducted. Maintenance of competence should be ensured by requiring standards for credentialing and certification and specifying continuing educational requirements for physicians and nurses providing care to trauma patients. Mechanisms for the periodic assessment of ancillary and subspecialty competence, educational needs, and availability within the system for all designated facilities should be incorporated into the trauma system plan. The lead trauma centers in rural areas will need to consider teleconferencing and telemedicine to assist smaller facilities in providing education on regionally identified needs. In addition, lead trauma centers within the region should assist in meeting educational needs while fostering a team approach to care through annual educational multidisciplinary trauma conferences. These activities will do much to foster a sense of teamwork and a functionally inclusive system.

Integration of Designated Trauma Facilities Within the Trauma System

Designated trauma facilities must be well integrated into all other facets of an organized system of trauma care, including public health systems and injury surveillance, prevention, EMS and prehospital care, disaster preparedness, rehabilitation, and system performance improvement. This integration should be provided by the state and/or regional trauma plan and overseen by the lead agency.

Each designated acute care facility should participate, through its trauma program leadership, in all aspects of trauma system design, evaluation, and operation. This participation should include policy and legislative development, legislative and public education, and strategic planning. In addition, the trauma program and subspecialty leaders should provide direction and oversight to the development, implementation, and monitoring of integrated protocols for patient care used throughout the system (for example, TBI guidelines used by prehospital providers and nondesignated transferring centers), including region specific primary (field) and secondary (early transfer) triage protocols. The highest level trauma facilities should provide leadership of the regional trauma committees through their trauma program medical leadership. These medical leaders, through their activities on these committees, can assist the lead agency and help ensure that deficiencies in the quality of care within the system, relative to national standards, are recognized and corrected. Educational outreach by these higher level centers should be used when appropriate to help achieve this goal.

OPTIMAL ELEMENTS

I. Acute care facilities are integrated into a resource efficient, inclusive network that meets required standards and that provides optimal care for all injured patients. **(B-303)**

- a. The trauma system plan has clearly defined the roles and responsibilities of all acute care facilities treating trauma and of facilities that provide care to specialty populations (for example, burn, pediatric, SCI, and others). **(I-303.1)**

II. To maintain its state, regional, or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes. **(B-307)**

- a. The trauma system engages in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and of designated trauma hospitals. Such evaluation involves independent external reviews. **(I-307.1)**

III. The lead trauma authority ensures a competent workforce. **(B-310)**

- a. As part of the established standards, set appropriate levels of trauma training for nursing personnel who routinely care for trauma patients in acute care facilities. **(I-310.3)**
- b. Ensure that appropriate, approved trauma training courses are provided for nursing personnel on a regular basis. **(I-310.4)**

- c. In cooperation with the nursing licensure authority, ensure that all nursing personnel who routinely provide care to trauma patients have a trauma training certificate (for example, Advanced Trauma Care for Nurses, Trauma Nursing Core Course, or any national or state trauma nurse verification course). As an alternative after initial trauma course completion, training can be driven by the performance improvement process. **(I-310.5)**
- d. In cooperation with the physician licensure authority, ensure that physicians who routinely provide care to trauma patients have a current trauma training certificate of completion, for example, Advanced Trauma Life Support® (ATLS®) and others. As an alternative, physicians may maintain trauma competence through continuing medical education programs after initial ATLS completion. **(I-310.8)**
- e. Conduct at least 1 multidisciplinary trauma conference annually that encourages system and team approaches to trauma care. **(I-310.9)**
- f. As new protocols and treatment approaches are instituted within the system, structured mechanisms are in place to inform all personnel about the changes in a timely manner. **(I-310-10)**

CURRENT STATUS

Facilities

Alaska has an inclusive, voluntary trauma system. There are 24 hospitals, two of which are military facilities. Five hospitals are certified/designated trauma centers:

- Level II trauma center: Alaska Native Medical Center
- Level IV trauma centers : Norton Sound Regional Hospital
Yukon Kuskokwim Delta Regional Hospital
Mt. Edgecumbe Hospital
Sitka Community Hospital

Harborview Medical Center in Seattle, WA is the Level I trauma center that supports Southeast Alaska, and often patients from other areas of the state.

The hospitals caring for the largest volume of trauma patients are concentrated in Anchorage:

- Alaska Native Medical Center (certified/designated Level II)
- Providence Alaska Medical Center (not designated), private not-for-profit
- Alaska Regional Hospital (not designated), for-profit

The only other community with more than one hospital is Sitka (Sitka Community Hospital and Mt. Edgecumbe Hospital, both level IV trauma centers).

Large portions of the state are in remote, austere areas with low population, no roads and minimal health care availability. These areas are essentially isolated in periods of bad weather and must rely on local resources for emergency care for extended periods of time.

For purposes of health care delivery, the two distinct populations in Alaska (not including the military), are Native Alaskans and all other Alaskans. Native Alaskans generally receive care via the Alaska Tribal Health System/Alaska Native Tribal Health Consortium, an integrated network of facilities and providers that deliver care to defined beneficiaries. At the local level, community clinics staffed by Community Health Aides or mid-level providers are sources of healthcare in small communities. These clinics are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center (Level II trauma center), providing the entire spectrum of acute trauma care. The community clinics and Community Health Aides/mid-level providers assume a significant role for the stabilization and early management of trauma patients prior to transport, and when patients cannot be transported out to larger facilities because of weather or other conditions.

Perception of incentives for hospitals to become certified/designated as trauma centers vary. The Alaska Tribal Health System/ Alaska Native Tribal Health Consortium has recognized the burden of injury on Native Alaskans, leading to the support of trauma center certification/designation of the Alaska Native Medical Center and some level IV facilities. Despite the financial costs associated with verification and certification, participants reported collateral benefits of trauma center certification/designation, including contributing to an overall elevation of the quality of care at that institution and providing service to their community. Although the private non-profit hospitals that serve Alaskans recognize that trauma care is an important contribution to the community, these facilities are reluctant to pursue certification/designation without the support of their medical staffs.

Human Resources

Human resources are limited, and significant problems exist for recruitment and retention of physicians and nurses. The shortages of physicians and nurses will likely worsen in the coming years (Alaska Physician Supply Task Force report, 2006). Since Alaska has no medical school, the option of "growing our own" which has been somewhat successful for other states, will not work without strong collaboration with the University of Washington's WWAMI program, partnership between the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana, and Idaho. For example, there are currently no trauma fellowship trained general surgeons in the state, in any facility. There are surgeons who do trauma surgery. Alaska Native Medical

Center has 3 surgery residents rotating from Phoenix. Providence Alaska Medical Center has family practice residents on rotation.

Several surgical specialties are in jeopardy including pediatric surgery and vascular surgery. One of 2 pediatric surgeons in the state has recently retired, prompting the remaining pediatric surgeon to make tentative plans to leave Alaska. The situation for neurosurgery and orthopedics appears more stable with sufficient numbers in Anchorage to support current volumes. Patients requiring re-implantation and many requiring burns are transported to centers outside Alaska. Among general surgeons taking emergency department call in non-designated hospitals with significant trauma volumes, participants expressed concern regarding the burden of trauma call and identified emerging requests for financial support for taking trauma call.

Among nurses, high turnover rates and staffing with travelers are commonplace challenges. Given the national outlook for nursing shortages, this will likely worsen with time. Critical care nurse staffing levels are especially low and contribute to bypass decisions.

Integration of Designated Trauma Facilities Within the Trauma System

Diversion or inability to accept trauma patients reportedly occurs regularly and appears most often due to emergency department capacity issues, ICU bed availability, or the lack of staffed beds secondary to nursing shortages. On occasion, all 3 emergency departments in Anchorage have closed for trauma at the same time, which prompts the automatic re-opening of all the facilities and trauma patient transports in rotation. No state data are available to describe the frequency of such closings. The impact on EMS has been significant by their report, and this is compounded by challenges in communication about the rotation schedule.

Nondesignated hospitals provide the majority of trauma care in Alaska. Significant concerns were expressed by Fire and EMS crews regarding challenges they have faced when delivering patients to high-volume, nondesignated hospitals in Anchorage. Among these concerns expressed were that the nondesignated hospitals do not have the "system" in place to bring in the personnel resources needed for optimal care in a timely and efficient manner.

RECOMMENDATIONS

- **Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.**

- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center designation appropriate to their capabilities.**
- **Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.**
- Develop a memorandum of understanding between certified/designated hospitals and the state lead agency describing mutual roles and responsibilities.
- Support designated trauma center and affiliated physician readiness/standby costs and uncompensated trauma care costs through an identified state funding mechanism.
- Establish a mechanism to routinely track data on emergency department closures or bypass, and develop notification plans that include EMS and hospital stakeholders.
- Pursue a focused, well-funded strategy to recruit trauma surgeons and trauma prepared nurses to the state.
- Increase the number of physician resident positions at Alaska hospitals to encourage potential candidates to relocate to the state.

System Coordination and Patient Flow

Purpose and Rationale

To achieve the best possible outcomes, the system must be designed so that the right patient is transported to the right facility at the right time. Although on the surface this objective seems relatively straightforward, patients, geography, and transportation systems often conspire to present significant challenges. The most critically injured trauma patient is often easy to identify at the scene by virtue of the presence of coma or hypotension. However, in some circumstances, the patients requiring the resources of a Level I or II center may not be immediately apparent to prehospital providers. Primary or field triage criteria aid providers in identifying which patients have the greatest likelihood of adverse outcomes and might benefit from the resources of a designated trauma center. Even if the need is identified, regional geography or limited air medical (or land) transport services might not allow for direct transport to an appropriate facility.

Primary triage of a patient from the field to a center capable of providing definitive care is the goal of the trauma system. However, there are circumstances (for example, airway management, rural environments, inclement weather) when triaging a patient to a closer facility for stabilization and transfer is the best option for accessing definitive care. Patients sustaining severe injuries in rural environments might need immediate assessment and stabilization before a long-distance transport to a trauma center. In addition, evaluation of the patient might bring to light severe injuries for which needed care exceeds the resources of the initial receiving facility. Some patients might have specific needs that can be addressed at relatively few centers within a region (for example, pediatric trauma, burns, severe TBI, SCI, and reimplantation). Finally, temporary resource limitations might necessitate the transfer of patients between acute care facilities.

Secondary triage at the initial receiving facility has several advantages in systems with a large rural or suburban component. The ability to assess patients at non-designated or level III to V centers provides an opportunity to limit the transfer of only the most severely injured patients to level I or II facilities, thus preserving a limited resource for patients most in need. It also provides patients with lesser injuries the possibility of being cared for within their community.

The decision to transfer a trauma patient should be based on objective, prospectively agreed-on criteria. Established transfer criteria and transfer agreements will minimize discussions about individual patient transfers, expedite the process, and ensure optimal patient care. Delays in transfer might increase mortality, complications, and length of stay. A system with an excess of transferred patients might tax the resources of the regional trauma facility. Conversely, inappropriate retention of patients at centers without adequate

facilities or expertise might increase the risk of adverse outcomes. Given the importance of timely, appropriate interfacility transfers, the time to transfer, as well as the rates of primary and secondary overtriage and undertriage, should be evaluated on a regular basis, and corrective actions should be instituted when problems are identified. Data derived from tracking and monitoring the timeliness of access to a level of trauma care commensurate with injury type and severity should be used to help define optimal system configuration.

A central communications center with real-time access to information on system resources greatly facilitates the transfer process. Ideally, this center identifies a receiving facility, facilitates dialogue between the transferring and receiving centers, and coordinates interfacility transport.

To ensure that the system operates at the greatest efficiency, it is important that patients are repatriated back to community hospitals once the acute phase of trauma care is complete. The process of repatriation opens up the limited resources available to care for severely injured patients. In addition, it provides an opportunity to bring patients back into their local environment where their social network might help reintegrate patients into their community.

OPTIMAL ELEMENTS

I. The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated. **(B-302)**

- a. There are mandatory systemwide prehospital triage criteria to ensure that trauma patients are transported to an appropriate facility based on their injuries. These triage criteria are regularly evaluated and updated to ensure acceptable and system-defined rates of sensitivity and specificity for appropriately identifying a major trauma patient. **(I-302.6)**
- b. There is a universal access number for citizens to access the EMS/trauma system, with dispatch of appropriate medical resources. There is a central communications system for the EMS/trauma system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants. **(I-302.7)**
- c. There is a procedure for communications among medical facilities when arranging for interfacility transfers, including contingencies for radio or telephone system failure. **(I-302.9)**

II. Acute care facilities are integrated into a resource-efficient, inclusive network that meets required standards and that provides optimal care for all injured patients. **(B-303)**

- a. When injured patients arrive at a medical facility that cannot provide the appropriate level of definitive care, there is an organized and regularly monitored system to ensure that the patients are expeditiously transferred to the appropriate system-defined trauma facility. (I-303.4)

CURRENT STATUS

In Alaska, prehospital trauma care and patient triage is highly variable and dependent on location of injury, regional resources and local protocols. As stated in the PRQ:

"There are no statewide protocols for prehospital triage. The Trauma Triage, Transport & Transfer Guidelines developed by the Trauma System Planning and Development Task Force in 1993 and revised in 2002, offers guidelines to assist local EMS agencies and hospitals in developing local protocols. The protocols themselves are developed locally and approved by their medical director."

Trauma care delivery (as most health care in Alaska) is closely tied to geographic location which dictates resources, communication, and transportation. At least three distinct areas are identified based on models of trauma care delivery:

- *Bush area:* these remote areas are geographically isolated and have unique challenges including weather, no roads, and basic health care capabilities with few hospitals.
- *Anchorage area:* this urban environment is the major population center of the state and has several acute care hospitals, advanced infrastructure, and system redundancy in several segments. It is the primary health care referral area for the state for all Alaskans.
- *Southeast:* this area has intermediate capabilities compared to the 2 areas listed above and has a special relationship with Harborview Medical Center (Level I trauma center) in Seattle.

In addition to the geographic differentiation mentioned above, Alaska health care delivery can also be viewed in the context of populations (excluding the military):

- *Native Alaskans:* health care delivery to this population occurs across all geographic regions and is organized and administered by Alaska Tribal Health System/ Alaska Native Tribal Health Consortium, an integrated network of facilities and providers that deliver care to Native Alaskans as defined beneficiaries.

- Alaskans: health care delivery to this population occurs along more typical lines and involves a variety of hospitals and providers in varying density dependent on location and funding source.

Care to Native Alaskans and other Alaskans in the bush is overlapping, as many Alaskans receive primary and emergency care in Alaska Native clinics and hospitals when they are the only resources available. To a degree, some overlapping of trauma care for Native Alaskans and other Alaskans occurs within the Anchorage hospitals when by-pass or diversion causes a trauma patient to be directed to Alaska Native Medical Center or one of the non-certified/designated hospitals.

Many remote areas of the state are faced with unique challenges in the provision of trauma care. Providers and facilities have demonstrated creativity and resourcefulness in their attempt to overcome the problems of distance, limited resources, and communication challenges. This innovation and flexibility is to be commended, and it has been valuable and necessary.

In the more urban regions, such as Anchorage, the transition to more organized, efficient and coordinated systems of patient flow has not been complete. This has been reflected in frustrations expressed by local EMS services, referring physicians from outlying facilities, and members of the local physician provider community. Physicians described the problem of making multiple calls for transfer of a patient to an Anchorage hospital. In some cases Anchorage is by-passed and the patient is sent to Seattle. While there are two pediatric intensive care units in Anchorage hospitals, beds are sometimes unavailable, and children are sometimes sent to Seattle as well.

The situation is further complicated by the co-existence in the Anchorage area of a higher level of organized trauma care at the Alaska Native Medical Center (including a pediatric ICU), while the private not-for-profit hospitals (Providence Alaska Medical Center and Alaska Regional Hospital) maintain non-certified/designated trauma care facilities. All three hospitals serve as regional referral facilities for large areas of the state with Providence Alaska Medical Center receiving the largest volume of patients, including pediatrics. Local EMS as well as referring facilities throughout the state are faced with at least two differing sets of referral guidelines and triage criteria (for Native Alaskans and other Alaskans), as well as varying abilities to provide care to special populations (including burns, pediatrics, and vascular surgery).

In addition to the lack of statewide triage protocols, the flow of patients within the major treating facilities varies greatly. Available trauma registry data from 2006 show that at the designated Level II hospital, Alaska Native Medical Center, the majority of patients are admitted to surgical services. In contrast, at hospitals serving Alaskans, such as Providence Alaska Medical Center, which has the largest trauma patient volume, substantial numbers of patients are admitted to

non-surgical services. With the increase in hospital-based medical specialists (e.g., hospitalists), these trends are likely to have become pronounced. The care of trauma patients on non-surgical services without an organized trauma service is inconsistent with national guidelines, and it likely contributes to inferior outcomes such as longer ICU and hospital stays, higher complication and mortality rates, lower patient and provider satisfaction scores, and increased costs.

Significant divergence of opinion is apparent among providers at the private nonprofit hospitals in Anchorage regarding the need for, and value of, trauma center certification/designation and an organized trauma system. Emergency physicians expressed the opinion that they are able to deliver all aspects of initial care and obtain prompt surgical support, as well as the opinion that there were significant deficiencies in the availability and involvement of surgical specialists. As noted above, EMS services and referring physicians at outlying facilities participating in the TSC supported the latter perspective. Surgeons also expressed divided opinions regarding trauma center designation – surgeons at designated trauma centers are supportive while those at the non-designated facilities expressed serious concerns. Participants indicated that the provision of financial support for on-call responsibilities would facilitate the participation of private surgeons in meeting the certification/designation standards. The support of these groups of physicians would likely facilitate improvements in system coordination and patient flow.

It is recognized that Harborview Medical Center in Seattle provides important referral care for Alaska, especially for special populations (e.g., pediatrics, burns, reimplantation, and rehabilitation). Patient flow to Harborview appears to be relatively straightforward thanks to significant efforts by the receiving facility to treat Alaska patients preferentially and by the placement of fixed-wing aircraft in Southeast Alaska.

Within the state there are 79 ground ambulance units, 19 primarily fixed-wing air services, as well as civilian, Coast Guard, and military helicopters. Many of these units function under very difficult circumstances and succeed because of experience and innovation. No central coordinating agency or mechanism to manage these resources exists, and no easily accessible resource describing runways and equipment that can be used in each location is available.

Repatriation rarely occurs in this system, particularly for patients treated in Seattle.

RECOMMENDATIONS

- **Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).**

- Preserve the flexibility and encourage the innovation for trauma care that exists in the remote regions of the state.
- Develop an online resource describing available patient transport resources across the state.
- Encourage the adoption of standardized, evidence-based, in-hospital trauma team activation protocols.
- Develop inter-facility transfer criteria to ensure that patients with specialized needs are sent to facilities with matching resources.
- Maintain the existing effective relationship with Harborview Medical Center and develop strategies to improve Medicaid funding for transfers.

Rehabilitation

Purpose and Rationale

As an integral component of the trauma system, rehabilitation services in acute care and rehabilitation centers provide coordinated care for trauma patients who have sustained severe or catastrophic injuries, resulting in long-standing or permanent impairments. Patients with less severe injuries may also benefit from rehabilitative programs that enhance recovery and speed return to function and productivity. The goal of rehabilitative interventions is to allow the patient to return to the highest level of function, reducing disability and avoiding handicap whenever possible. The rehabilitation process should begin in the acute care facility as soon as possible, ideally within the first 24 hours. Inpatient and outpatient rehabilitation services should be available. Rehabilitation centers should have CARF (Commission of Accreditation of Rehabilitation Facilities) accreditation for comprehensive inpatient rehabilitation programs, and accreditation of specialty centers (SCI and TBI) should be strongly encouraged.

The trauma system should conduct a rehabilitation needs assessment (including specialized programs in SCI, TBI, and for children) to identify the number of beds needed and available for rehabilitation in the geographic region. Rehabilitation specialists should be integrated into the multidisciplinary advisory committee to ensure that rehabilitation issues are integrated into the trauma system plan. The trauma system should demonstrate strong linkages and transfer agreements between designated trauma centers and rehabilitation facilities located in its geographic region (in or out of state). Plans for repatriation of patients, especially when rehabilitation centers across state lines are used, should be part of rehabilitation system planning. Feedback on functional outcomes after rehabilitation should be made available to the trauma centers.

OPTIMAL ELEMENTS

- I. The lead agency ensures that adequate rehabilitation facilities have been integrated into the trauma system and that these resources are made available to all populations requiring them. **(B-308)**
 - a. The lead agency has incorporated, within the trauma system plan and the trauma center standards, requirements for rehabilitation services, including interfacility transfer of trauma patients to rehabilitation centers. **(I-308.1)**

- b. Rehabilitation centers and outpatient rehabilitation services provide data on trauma patients to the central trauma system registry that include final disposition, functional outcome, and rehabilitation costs and also participate in performance improvement processes. **(I-308.2)**
- II. A resource assessment for the trauma system has been completed and is regularly updated. **(B-103)**
- a. The trauma system has completed a comprehensive system status inventory that identifies the availability and distribution of current capabilities and resources. **(I-103.1)**

CURRENT STATUS

While rehabilitation resources are available in Alaska, they are relatively limited in scope and capacity. The 20 inpatient rehabilitation beds in Alaska are all in the Anchorage (10 at Alaska Regional Hospital and 10 at Providence Alaska Medical Center). No pediatric rehabilitation beds for children under age 14 years exist in the state. Limited individual outpatient rehabilitation programs exist to support defined patient groups (e.g., traumatic brain injury [TBI]) at hospitals and in the community.

Patients with traumatic brain injury (adult and children 14 years and older) commonly utilize these rehabilitation beds in Anchorage, while most patients with spinal cord injury (SCI) are sent to spinal cord rehabilitation facilities in the lower 48 states. It was reported that patients wait approximately two days for an inpatient rehabilitation bed for TBI, and about 20 days for SCI; however this varies by patient status and availability of a funding source.

Harborview Medical Center in Seattle, WA provides significant support for rehabilitation services to injured patients from Alaska, including pediatric patients. This relationship is longstanding and well-developed, especially with acute care facilities in the Southeastern Alaska. Because Alaska Medicaid reimbursement rates are reportedly lower than Washington Medicaid rates, much of the care provided to patients with Alaska Medicaid transferred to Seattle is uncompensated or undercompensated.

Repatriation of patients transferred to rehabilitation centers is difficult and complicated by many variables (e.g., the cost of travel home, finding a physician to assume care responsibility). It was reported that patients transported out-of-state for rehabilitation frequently do not return to Alaska and that patients who are brought to Anchorage for rehabilitation services are likely to remain in the area.

No state data are available to evaluate the status of rehabilitation in Alaska. No needs assessment has been conducted to identify the rehabilitation needs of trauma patients in the state. Few data describe utilization, ultimate outcomes and dispositions of trauma patients requiring rehabilitation services. It is not clear that efforts are being made to include rehabilitation data and patient outcomes in the state trauma registry.

No rehabilitation specialist (physiatrist) sits on the TSRC.

RECOMMENDATIONS

- Include rehabilitation outcomes in the trauma registry.
- Perform a needs assessment for rehabilitation of trauma patients in Alaska.
- Develop a comprehensive plan to provide a continuum of rehabilitation services from acute care settings to inpatient rehabilitation to outpatient services, especially for traumatic brain injury, spinal cord injury, and pediatric trauma.
- Appoint a rehabilitation specialist to membership in the newly formed Alaska Trauma Advisory Committee (ATAC).
- Encourage rehabilitation centers to attain CARF (Commission of Accreditation of Rehabilitation Facilities) accreditation.
- Evaluate repatriation options for patients transferred to Anchorage or out-of-state.

Disaster Preparedness

Purpose and Rationale

As critically important resources for state, regional, and local responses to MCIs, the trauma system and its trauma centers are central to disaster preparedness. Trauma system leaders need to be actively involved in public health preparedness planning to ensure that trauma system resources are integrated into the state, regional, and local disaster response plans. Acute care facilities (sometimes including one or more trauma centers) within an affected community are the first line of response to an MCI. However, an MCI may result in more casualties than the local acute care facilities can handle, requiring the activation of a larger emergency response plan with support provided by state and regional assets.

For this reason, the trauma system and its trauma centers must conduct a resource assessment of its surge capacity to respond to MCIs. The resource assessment should build on and be coupled to a hazard vulnerability analysis. An assessment of the trauma system's response to simulated incident or tabletop drills must be conducted to determine the trauma system's ability to respond to MCIs. Following these assessments, a gap analysis should be conducted to develop statewide MCI response resource standards. This information is essential for the development of an emergency management plan that includes the trauma system.

Planning and integration of the trauma system with plans of related systems (public health, EMS, and emergency management) are important because of the extensive impact disasters have on the trauma system and the value of the trauma system in providing care. Relationships and working cooperation between the trauma system and public health, EMS, and emergency management agencies support the provision of assets that enable a more rapid and organized disaster response when an event occurs. For example, the EMS emergency preparedness plan needs to include the distribution of severely injured patients to trauma centers, when possible, to make optimal use of trauma center resources. This plan could optimize triage through directing less severely injured patients to lower level trauma centers or nondesignated facilities, thus allowing resources in trauma centers to be spared for patients with the most severe injuries. In addition, the trauma system and its trauma centers will be targeted to receive additional resources (personnel, equipment, and supplies) during major MCIs.

Mass casualty events and disasters are chaotic, and only with planning and drills will a more organized response be possible. Simulation or tabletop drills provide an opportunity to test the emergency preparedness response plans for the trauma system and other systems and to train the teams that will respond. Exercises must be jointly conducted with other agencies to ensure that all aspects of the response plan have the trauma system integrated.

OPTIMAL ELEMENTS

I. An assessment of the trauma system's emergency preparedness has been completed, including coordination with the public health agency, EMS system, and the emergency management agency. **(B-104)**

- a. There is a resource assessment of the trauma system's ability to expand its capacity to respond to MCIs in an all-hazards approach. **(I-104.1)**
- b. There has been a consultation by external experts to assist in identifying current status and needs of the trauma system to be able to respond to MCIs. **(I-104.2)**
- c. The trauma system has completed a gap analysis based on the resource assessment for trauma emergency preparedness. **(I-104.3)**

II. The lead agency ensures that its trauma system plan is integrated with, and complementary to, the comprehensive mass casualty plan for natural and manmade incidents, including an all-hazards approach to planning and operations. **(B-305)**

- a. The EMS, the trauma system, and the all-hazards medical response system have operational trauma and all-hazards response plans and have established an ongoing cooperative working relationship to ensure trauma system readiness for all-hazards events. **(I-305.1)**
- b. All-hazards events routinely include situations involving natural (for example, earthquake), unintentional (for example, school bus crash), and intentional (for example, terrorist explosion) trauma-producing events that test the expanded response capabilities and surge capacity of the trauma system. **(I-305-2)**
- c. The trauma system, through the lead agency, has access to additional equipment, materials, and personnel for large-scale traumatic events. **(I-305.3)**

CURRENT STATUS

Alaska has an active geological environment with frequent earthquakes, extensive volcano eruptions, huge avalanches, periodic flooding and large expanses of fresh and salt water, all of which invite potential disaster. Two-thirds of Alaska is without roads and Alaskans are dependent on air travel for routine and emergent travel. Communication capabilities and disaster resources decrease as distance from population centers increases.

The lead agency for disaster preparedness is the Division of Emergency Services which resides within the Department of Military and Veterans Affairs, Division of Homeland Security and Emergency Management. The DHSS has primary functional responsibility for mass casualty events. Both agencies recognize the need for an effective trauma system as an integral component of disaster capability.

A recent full scale exercise, Alaska Shield/Northern Edge 2007 demonstrated strengths that included effective local interoperable communications equipment. However this interoperability does not necessarily transfer to the majority of the state. Weaknesses identified were lack of coordination of air transports and local/state/military resources, as well as lack of interagency coordination for resource requests and allocation during mass casualty events.

The state has no registry for volunteer medical providers, except for the Alaska Board of Nursing that maintains a registry of nurses who would volunteer to respond to a disaster. There are two Medical Reserve Corps in Alaska, but they are not functional due to lack of funding.

Some EMS providers have received disaster training, but they are not required to obtain or maintain such training.

RECOMMENDATIONS

- **Integrate all components of the trauma system into state and local disaster planning activities.**
- Perform a detailed statewide communication assessment.
- Provide basic all-hazards disaster training for all prehospital providers that can be delivered via a variety of formats.

Systemwide Evaluation and Quality Assurance

Purpose and Rationale

The trauma lead agency has responsibility for instituting processes to evaluate the performance of all aspects of the trauma system. Key aspects of systemwide effectiveness include the outcomes of population based injury prevention initiatives, access to care, as well as the availability of services, the quality of services provided within the trauma care continuum from prehospital and acute care management phases through rehabilitation and community reintegration, and financial impact or cost. Intrinsic to this function is the delineation of valid, objective metrics for the ongoing quality audit of system performance and patient outcomes based on sound benchmarks and available clinical evidence. Trauma management information systems (MISs) must be available to support data collection and analysis.

The lead agency should establish forums that promote inclusive multidisciplinary and multiagency review of cases, events, concerns, regulatory issues, policies, procedures, and standards that pertain to the trauma system. The evaluation of system effectiveness must take into account the integration of these various components of the trauma care continuum and review how well personnel, agencies, and facilities perform together to achieve the desired goals and objectives. Results of customer satisfaction (patient, provider, and facility) appraisals and data indicative of community and population needs should be considered in strategic planning for system development. System improvements derived through evaluation and quality assurance activities may encompass enhancements in technology, legislative or regulatory infrastructure, clinical care, and critical resource availability.

To promote participation and sustainability, the lead agency should associate accountability for achieving defined goals and trauma system performance indicators with meaningful incentives that will act to cement the support of key constituents in the health care community and general population. For example, the costs and benefits of the trauma system as they relate to reducing mortality or decreasing years of productive life lost may make the value of promoting trauma system development more tangible. A facility that achieves trauma center verification/designation may be rewarded with monetary compensation (for example, ability to bill for trauma activation fees) and the ability to serve as a receiving center for trauma patients. The trauma lead agency should promote ongoing dialog with key stakeholders to ensure that incentives remain aligned with system needs.

OPTIMAL ELEMENTS

- I. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**
 - a. The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data, as well as provider data, to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority. **(I-301.1)**
- II. The jurisdictional lead agency, in cooperation with other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**
- III. The financial aspects of the trauma system are integrated into the overall performance improvement system to ensure ongoing fine tuning and cost-effectiveness. **(B-309)**
 - a. Financial data are combined with other cost, outcome, or surrogate measures, for example, years of potential life lost, quality-adjusted life years, and disability adjusted life years; length of stay; length of intensive care unit stay; number of ventilator days; and others, to estimate and track true system costs and cost- benefits. **(I-309.4)**

CURRENT STATUS

According to the PRQ, the TSRC is charged with "ongoing monitoring and evaluating of the trauma system". Even though the actions of the TSRC are exempt from discovery, it is unclear that the TSRC has truly been empowered or authorized to perform its system evaluation and quality improvement functions. No clear line of authority could be identified in provided documentation for the TSRC to recommend or impose system change. The PRQ illustrates this challenge in the following statement:

"The TSRC has reported findings to the Lead Agency, ACEMS and liaisons, EMS regional coordinators, and trauma care providers via the Annual EMS Symposium... In special circumstances, such as the advancement of a Trauma System Improvement Act, members of the TSRC have shared information with legislators... The TSRC may make recommendations to the Lead Agency and constituent members of the trauma system".

The uncertainty of lines of authority is further exacerbated by the fact that the TSRC formally operates under the aegis of the Alaska State Medical Board.

When asked about specific evaluation and quality assurance processes, the stakeholders present acknowledged that they have neither determined Alaska's preventable mortality rate nor quantified the opportunities for improvement by phase of care.

The TSRC has made significant contributions to the standardization of care through the development of documents such as "Guidelines for the Management and Transfer of Head Injury Patients in Remote and Rural Alaska". However, the impact of this and other guidelines has not been monitored, and adherence to the guidelines was reported as variable. There has not been "loop closure" on these efforts.

The TSRC identified nine indicators of interest and initiated efforts to examine the data necessary to determine the status of those indicators. However, during the first pass of the data, it was reported that the data were of insufficient quality to answer the questions posed by the indicator. Additional data cleaning was needed.

While it was reported that a major impediment to system evaluation and quality assurance was either the lack or quality of data, the ACS team was able to request and receive trauma registry data (2006) that was sufficiently detailed to engage in rudimentary evaluation processes, e.g., stratification of trauma patients by facility and by ISS. While the data are aging, these data serve as a fundamental building block of a system evaluation process.

RECOMMENDATIONS

- **Develop an initial set of 3-5 statewide system performance indicators from among the list of 9 provided in the Pre-Review Questionnaire (PRQ).**
- Examine available data points and definitions, and develop indicators for performance improvement that can be determined on the basis of those data points.
- Formally review the data associated with each indicator on a quarterly to annual basis and start a benchmarking process.
- Report the results of all evaluation and quality assurance processes in an annual report that is presented to all system stakeholders, including the new Alaska Trauma Advisory Committee (ATAC) and Alaska Council on Emergency Medical Services (ACEMS).

Trauma Management Information Systems

Purpose and Rationale

Hospital-based trauma registries developed from the idea that aggregating data from similar cases may reveal variations in care and ultimately result in a better understanding of the underlying injury and its treatment. Hospital-based registries have proven very effective in improving trauma care within an institution but provide limited information regarding how interactions with other phases of health care influence the outcome of an injured patient. To address this limitation, data from hospital-based registries should be collated into a regional registry and linked such that data from all phases of care (prehospital, hospital, and rehabilitation) are accessible in 1 data set. When possible, these data should be further linked to law enforcement, crash incident reports, ED records, administrative discharge data, medical examiner records, vital statistics data (death certificates), and financial data. The information system should be designed to provide systemwide data that allow and facilitate evaluation of the structure, process, and outcomes of the entire system; all phases of care; and their interactions. This information should be used to develop, implement, and influence public policy.

The lead agency should maintain oversight of the information system. In doing so, it must define the roles and responsibilities for agencies and institutions regarding data collection and outline processes to evaluate the quality, timeliness, and completeness of data. There must be some means to ensure patient and provider confidentiality is in keeping with federal regulations. The agency must also develop policies and procedures to facilitate and encourage injury surveillance and trauma care research using data derived from the trauma MIS. There are key features of regional trauma MISs that enhance their usefulness as a means to evaluate the quality of care provided within a system. Patient information collected within the management system must be standardized to ensure that noted variations in care can be characterized in a similar manner across differing geographic regions, facilities, and EMS agencies. The composition of patients and injuries included in local registries (inclusion criteria) should be consistent across centers, allowing for the evaluation of processes and outcomes among similar patient groups. Many regions limit their information systems to trauma centers. However, the optimal approach is to collect data from all acute care facilities within the region. Limiting required data submission to hospitals designated as trauma centers allows one to evaluate systems issues only among patients transported to appropriate facilities. It is also important to have protocols in place to ensure a uniform approach to data abstraction and collection. Research suggests that if the process of case abstraction is not routinely calibrated, practices used by abstractors begin to drift.

Finally, every effort should be made to conform to national standards defining processes for case acquisition, case definition (that is, inclusion criteria), and registry coding conventions. Two such national standards include the National Highway Traffic Safety Administration's National Emergency Medical Services Information System (NEMSIS), which standardizes EMS data collection, and the American College of Surgeons National Trauma Data Standard, which addresses the standardization of hospital registry data collection. Strictly adhering to national standards markedly increases the value of state trauma MISs by providing national benchmarks and allowing for the use of software solutions that link data sets to enable a review of the entire injury and health care event for an injured patient.

To derive value from the tremendous amount of effort that goes into data collection, it is important that a similar focus address the process of data reporting. Dedicated staff and resources should be available to ensure rapid and consistent reporting of information to vested parties with the authority and vision to prevent injuries and improve the care of patients with injuries. An optimal information reporting process will include standardized reporting tools that allow for the assessment of temporal and/or system changes and a dynamic reporting tool, permitting anyone to tailor specific "views" of the information.

OPTIMAL ELEMENTS

I. There is an established trauma MIS for ongoing injury surveillance and system performance assessment. **(B-102)**

- a. There is an established injury surveillance process that can, in part, be used as an MIS performance measure. **(I-102.1)**
- b. Injury surveillance is coordinated with statewide and local community health surveillance. **(I-102.2)**
- c. There is a process to evaluate the quality, timeliness, completeness, and confidentiality of data. **(I-102.4)**
- d. There is an established method of collecting trauma financial data from all health care facilities and trauma agencies, including patient charges and administrative and system costs. **(I-102.5)**

II. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**

- a. The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data, as well as provider data, to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority. **(I-301.1)**

- b. Prehospital care providers collect patient care and administrative data for each episode of care and not only provide these data to the hospital, but also have a mechanism to evaluate the data within their own agency, including monitoring trends and identifying outliers. (I-301.2)
- c. Trauma registry, ED, prehospital, rehabilitation, and other databases are linked or combined to create a trauma system registry. (I-301.3)
- d. The lead agency has available for use the latest in computer/technology advances and analytic tools for monitoring injury prevention and control components of the trauma system. There is reporting on the outcome of implemented strategies for injury prevention and control programs within the trauma system. (I-301.4)

CURRENT STATUS

The State of Alaska has worked diligently over several decades to develop, maintain, and improve a systemwide trauma registry. This has meant an evolutionary process involving at least two vendors and substantial challenges in linking disparate computer languages that exist in the Native Alaskan and other Alaskan record keeping systems. The State is to be commended for its persistence in this regard.

The lead agency maintains a full-time trauma registrar which represents, in fact, the most significant personnel commitment dedicated to the trauma program. Funds to support this position come from external sources (NIOSH).

Currently all hospitals contribute to the statewide trauma registry. For the larger facilities, this involves electronic data transfer. However, for the smaller facilities, the process involves on-site abstraction of records, completion of a data abstract summary, and manual input into the system. A contract employee is assigned the responsibility of facilitating this process. She described multiple challenges at some of the smaller hospitals, such as limited personnel resources for abstracting, enormous travel distances and costs for her to visit the hospitals, a reluctance by the hospitals to ask for or accept consultative help, and persistent turnover of data registrars at the hospitals. These challenges result in a significant delay (up to 2 years) in acquiring trauma data from all acute care facilities. In some cases, the consultant performs data abstraction at some of the smaller hospitals in an effort to get data submission caught up.

A second contract employee is used to clean and validate the data. She demonstrated significant adeptness with the system registry data by fulfilling several requests of the ACS team during their deliberations. For example, she was able to easily stratify injury severity by hospital and track transfers in an out of each facility. The contract employees are responsible for an annual training of trauma registrars.

During the discussion of the management information system, it was revealed that recently a new trauma registry vendor has received the Alaska contract. There was substantial discordance with the manner in which the vendor was selected, with the end-users (e.g., registrars, trauma managers, trauma directors, and the TSRC) having little to no input into the process. While data input into the new system is tentatively scheduled to begin January 1, 2009, concern was expressed by participants that during the transition period there was the potential for data to be delayed or, perhaps, even lost. Several participants suggested that they might maintain their current system in lieu of using the newly acquired system.

One of the perceived advantages of the new trauma system is that it can, and will, be linked with electronic prehospital data since the same vendor holds a single contract for the provision of both systems. The effectiveness of this linkage could not be fully ascertained at the time of the ACS visit since the systems were only then "coming on-line". However, it is important to note that similar efforts by other states to link the trauma registry and prehospital data systems have not been universally successful, even when the same vendor has been used for each system. The IPEMS Section will need to work closely with the vendor to monitor progress in meeting contract expectations. The state is to be commended for obtaining a grant that will enable the lead agency to perform additional linkage with other, free standing, data sets such as the traffic crash database.

Alaska has a data rich environment. Numerous other databases exist and have been used for epidemiologic and prevention activities. However, they have only been used in a limited capacity to help steer and manage the trauma system.

Specific policies and procedures have been developed by the TSRC concerning the release of trauma registry data. Several researchers have accessed the data system following these guidelines.

RECOMMENDATIONS

- **Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are evident and working in the new trauma registry and are consistent with the National Trauma Data Standard (NTDS) definitions.**
 - This should be tasked to a peer review protected subcommittee, (e.g. the Trauma System Review Committee) of the Alaska Technical Advisory Committee (ATAC), in collaboration with the trauma registrar, trauma registrar contract employees, and the vendor.
- Safeguard the legacy data by maintaining the current software system separately and discretely from the new system until a legacy data transfer has occurred and validation queries have been completed.

- Minimize gaps and delays in data during the trauma registry transition process by maintaining dual systems until the transfer of legacy and concurrent data has been completed and validated.
- Establish mechanisms for capturing data from remote facilities in a timely manner, e.g., provide scanners and/or encrypted methods of electronic transmission of records in lieu of travel to each facility.
- Submit statewide trauma registry data to the National Trauma Data Bank (NTDB) on an annual basis.
- Achieve linkage and integration with other data sets, specifically, prehospital and hospital discharge data (UB 92/04).
- Use existing data, beginning immediately, for system development and quality improvement activities, in spite of its acknowledged imperfections.
- Provide reports on at least a quarterly basis to all stakeholders.

Research

Purpose and Rationale

Overview of Research Activity

Trauma systems are remarkably diverse. This diversity is simply a reflection of authorities tailoring the system to meet the needs of the region based on the unique combination of geographic, economic, and population characteristics within their jurisdiction. In addition, trauma systems are not fixed in their organization or operation. The system evolves over years in response to lessons learned, critical review, and changes in population demographics. Given the diversity of organization and the dynamic nature of any particular system, it is valuable when research can be conducted that evaluates the effectiveness of the regional or statewide system. Research drives the system and will provide the foundation for system development and performance improvement. Research findings provide value in defining best practices and might alter system development. Thus, the system should facilitate and encourage trauma-related research through processes designed to make data available to investigators. Competitive grants or contracts made available through lead authorities or constituencies should provide funds to support research activities. All system components should contribute to the research agenda. The extent to which research activities are required should be clearly outlined in the trauma system plan and/or the criteria for trauma center designation.

The sources of data used for research might be institutional and regional trauma registries. As an alternative, population-based research might provide a broader view of trauma care within the region. Primary data collection, although desirable, is expensive but might provide insights into system performance that might not be otherwise available.

Trauma Registry-based Research

Investigators examining trauma systems can use the information recorded in trauma registries to great advantage to determine the prevalence and annual incidence rate of injuries, patterns of care that occur to injured patients in the system's region, and outcomes for the patients. These data can be compared with standards available from other trauma registries, such as the NTDB. Such comparisons can then enable investigators to determine if care within their region is within standards and can allow for benchmarking. Initiating and sustaining injury prevention initiatives is a vital goal in mature trauma systems. Investigators can take a leadership role in performing research using trauma registry data that identify emerging threats and instituting public health measures to mitigate the threats. For example, a recent surge in death and disability related to off-road

vehicles can be identified and the scope of the problem defined in terms of who, where, and how riders are injured, and then, through presentations and publications, the public can be informed of a new threat.

Trauma system administrators have a responsibility to control investigators' access to the registry. The integrity and reliability of data in a trauma systems registry are essential if accurate research and valid conclusions are to be reached using the data. Trauma system administrators should have a process that screens data entered into the system's composite registry from individual institutions. There should be a mechanism that ensures that the information is stored in a secure manner. Investigators who seek access to the trauma registry must follow a written policy and procedure that includes approval by an authorized institutional review board. Trauma registry data may include unique identifiers, and system administrators must ensure that patient confidentiality is respected, consistent with state and federal regulations.

Population-based Trauma System Research

A major disadvantage of using only trauma registry data to conduct research that evaluates injured patients in a region is the bias resulting from missing data on patients not treated at trauma centers. Specifically, most registry data are restricted to information from hospitals that participate in the trauma system. Although ideally all facilities participate in the form of an inclusive system, many systems do not attain this goal. Thus, a population-based data set provides investigators with the full spectrum of patients, irrespective of whether they have been treated in trauma centers or nondesignated centers or were never admitted to the hospital owing to death at the scene of incident or because their injuries were insufficiently severe to require admission. The state and national hospital discharge databases are examples of population-based data. These discharge databases contain information that was abstracted from medical records for billing purposes by hospital employees who enter these data into an electronic database. For investigators seeking a wider perspective on the care of injured patients in their region, these more inclusive data sets, compared with registries, are essential tools. Other population based data that may be of help include mortality vital statistics data recorded in death certificates. Selected regions might have outpatient data to capture patients who are assessed in the ED and then released.

Investigators can use these population-based data to study the influence of a regional trauma system on the entire spectrum of patients within its catchment area.

Participation in Research Projects and Primary Data Collection

Multi-institutional research projects are important mechanisms for learning new knowledge that can guide the care of injured patients. Investigators within trauma systems can participate as co-investigators in these projects. Investigators can participate by recruiting patients into prospective studies, being leaders in the design and administration of grants, and preparing manuscripts and reports. Evidence of this collaboration is that investigators within a trauma system are recognized in announcements of grants or awards. Lead agency personnel should identify and reach out to resources within the system with research expertise. These include academic centers and public health agencies.

Measures of Research Activity

Research can be broadly defined as hypothesis-driven data analysis. This analysis leads the investigators to a conclusion, which might become a recommendation for system change. Full manuscripts published in peer reviewed research journals are an exemplary form of research activity. Research reported in annual reviews or in public information formats intended to inform the trauma system's constituency can also be considered legitimate research activity.

OPTIMAL ELEMENTS

- I. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**
 - a. The lead agency has available for use the latest in computer/technology advances and analytic tools for monitoring injury prevention and control components of the trauma system. There is reporting on the outcome of implemented strategies for injury prevention and control programs within the trauma system. **(I-301.4)**

- II. The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area. **(B-306)**
 - a. The trauma system has developed mechanisms to engage the general medical community and other system participants in their research findings and performance improvement efforts. **(I-306.1)**

 - b. The effect or impact of outreach programs (medical community training/support and prevention activities) is evaluated as part of a system performance improvement process. **(I-306.3)**

- III. To maintain its state, regional, or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes. **(B-307)**

- a. The trauma system implements and regularly reviews a standardized report on patient care outcomes as measured against national norms. (I-307.2)

CURRENT STATUS

A specific research agenda has not been developed for the Alaska trauma system. However, a reasonable representation of trauma-related literature can be found using an electronic medical literature search. Several articles use the trauma registry as a basis of data. Unfortunately, most of the articles are aging. Several are published in *Alaska Medicine*, which reportedly is changing from a quarterly publication to an annual publication.

A wealth of scientific and technical publications has been produced in the Alaska injury prevention literature. Again several of these publications use trauma registry data, at least partially, as a basis for the publications.

The University of Alaska – Anchorage currently offers a Master of Public Health (MPH) degree within its Department of Health Sciences. Linkages between the MPH program and the trauma system were not discussed. The lead agency has direct access to a staff epidemiologist.

RECOMMENDATIONS

- Establish a collaborative relationship between the University of Alaska-Anchorage's public health program and the lead agency's epidemiologist and the Alaska Trauma Advisory Committee (ATAC).
- Develop, jointly, a research agenda that can build on the current trauma registry data and expand to include more rigorous research projects.
- Attempt to minimize Institutional Review Board approval challenges while still maintaining full protection of any/all subjects.

Focus Questions

1. How can Alaska attain full participation of hospitals in the statewide trauma system?

Trauma centers and trauma systems have been demonstrated to decrease mortality following injury.^{1,2,3} All of the acute care hospitals in Alaska are currently providing care for injured patients. However; trauma patients in Alaska who are not Native Alaskans do not have routine access to a verified/designated Level I or II trauma center. A trauma system will fully attain the benefits of improved patient care and superior outcomes only when all facilities institute and follow evidence-based guidelines to decrease variability in care and deviations from the standard of care. Central to this evolution is the implementation of a rigorous, multidisciplinary performance improvement program. A coordinated system of trauma care within acute care facilities accomplishes the following:

- improved communications,
- streamlined coordination of care issues,
- increased physician satisfaction,
- a sense of pride in trauma care providers throughout the facility, and
- the community is reassured that everything possible is being done to provide them state-of-the art trauma care.

Trauma systems have been well studied, and these studies form the basis for the recommendations and guidelines found in the ACS-COT *Resources for Optimal Care of the Injured Patient* document.

Hospitals, healthcare providers, and physicians in Alaska are already providing trauma care. The adoption of an inclusive trauma system with verified/designated trauma centers would enable facilities in the state to provide trauma care to all Alaskans with less variability in care, better patient outcomes, lower resource utilization, and higher patient and provider satisfaction. In many cases, trauma care within an organized and verified trauma center also results in lower costs as evidence-based practice replaces less efficient practice patterns.

Only five hospitals are currently verified/designated trauma centers in Alaska. Reasons expressed by participants for not becoming verified and designated are varied but fall into two main categories:

- Administrator's concerns regarding increased costs to be borne by the hospital and the potential impact on the medical staff
- Lack of broad physician support

Administrators' concerns

Administrators' concerns involve a number of issues related to trauma center verification:

- Multi-system trauma patients require an organized system of care for optimal outcomes which increases institutional readiness costs.
- "Poor" uninsured case mix of trauma patients.
- Effect on hospital operations such as disruption of operating room schedules, filling ICU beds, etc.
- Physicians tend to be reluctant to participate and may elect to abandon a hospital that seeks designation.

Lack of physician support

Medical staff support for trauma center verification tends to be lukewarm at private hospitals for a number of reasons:

- Trauma patients have higher rates of uncompensated care than "elective" patients.
- Trauma patients are more likely to sue a physician (unfounded).
- The care of trauma patients imposes undue burdens including night and weekend work, and this care is generally disruptive of elective practices.

To address the above mentioned concerns, a number of issues should be openly discussed by key representatives of the identified groups, and a variety of solutions should be considered. It is likely that no one answer fits every situation and a combination of flexibility and transparency is needed.

While it is true that verification/designation as a trauma center requires commitment by administration and medical staffs, the benefits in improved patient outcomes, decreased complication rates and length of stay, and increased patient and provider satisfaction can outweigh the costs. In the case of the hospitals and physicians in Alaska who are already providing trauma care, an inclusive trauma system would likely make trauma care easier and less costly.

The cost of readiness is significant in trauma centers and may be addressed through several means. The recently introduced trauma activation fees using the 68x designation on the UB 92/UB 04 form can relieve a significant portion of these costs. Trauma activation fees can only be submitted if the center is verified/designated. A number of states have provided financial support to their trauma centers through legislation or appropriations. State financial support for trauma care is usually linked to trauma center verification/designation and continued participation in an organized trauma system. Trauma center verification/designation carries important benefits to hospitals in terms of disaster

preparedness, and this may be especially relevant in Alaska given its unique geography and circumstances.

The issues of poor case mix and disruption of hospital operations are best addressed by considering the impact of verification/designation on hospital functions. For a hospital that is already caring for trauma patients, the introduction of a trauma system will likely mean an overall increase in the efficiency of caring for these patients, secondary to improvements required in the verification process. Decreased ICU and hospital length of stay, lower resource consumption and lower rates of complications will improve hospital bottom lines while increasing patient and provider satisfaction.

Physician concerns should be carefully addressed as a functional trauma system requires broad physician support. This is especially true for the specialties of general surgery (including pediatric surgery), orthopedic surgery, neurosurgery, anesthesia and emergency medicine. The Anchorage area hospitals have ample physician specialization to provide optimal care with the following estimated numbers:

- 30 surgeons, many sub-specialized.
- 40 orthopedists
- 6 neurosurgeons
- 4 cardiac surgeons
- 2 pediatric surgeons

Education can alleviate the concerns that trauma patients are more litigious than average.

The concerns regarding reimbursement and work hours are real and require more focused solutions. Trauma patients do, in fact, have higher rates of uncompensated care than elective patients in almost all regions of the United States. They are also more likely to arrive during evening and night hours.⁴ The specific concerns of physicians should be acknowledged and actions should be taken to address them. For hospitals, actions may include one or more of the following options:

- Provide an on-call stipend to cover the perceived burden of trauma call. This would include high volume specialists who are not ordinarily in-house and who agree to participate in the activities of the trauma center, including performance improvement and continued medical education (CME). Most frequently this would include general surgery, orthopedics, and neurosurgery.

- Recruit one or more trauma/surgical critical care specialists to provide the core trauma care functions. Such individuals would support the private physicians and decrease their burden by providing back-up, assuming the care of patients admitted to the hospital, and taking responsibility for organizing the requisite activities for verification. By providing an actual trauma service with a specialized team led by a trauma/surgical critical care boarded specialist, the community surgeon can transfer patient care the following morning and feel confident the patient will receive state-of-the-art care. This frees the private physician to continue with his/her surgical practice. The specialist-led trauma service would improve care by decreasing variability, complications, length of stay and dissatisfaction.
- Support the private physicians through CME expenses, liability coverage, or a fund to cover a portion of uncompensated care exposure.

While this will require substantial financial support from hospital administration initially, the improvement in outcomes and the increase in patient and provider satisfaction should return at least a portion of the investment. Additional revenue through activation fees and state support would also contribute to deferring any start-up and readiness costs. Providing hospitals and physicians with financial support as part of a proposed inclusive trauma system plan will likely facilitate the adoption of trauma center verification/designation.

In addition, the implementation of an inclusive trauma system in Alaska with broad hospital participation would provide a critical element in disaster preparedness.⁵ The vital role of trauma centers in support of disaster management should also be a central part of any funding requests to the legislature.

RECOMMENDATIONS:

- Verify/designate all the medical facilities in Anchorage who wish to provide trauma care at levels commensurate with these resources and commitment
- Develop city-wide trauma triage guidelines for Anchorage with further application to the needs of in-coming transfer patient.
 - Establish a predetermined plan that accounts for subspecialty needs of the patient matched with the hospitals' capabilities.
 - Establish trauma diversion guidelines with back-up plans.

- Develop evidence-based trauma team activation criteria
 - Use the “status 1” only when there is prehospital physiologic evidence that the patient requires an immediate surgical response.
 - Start tracking surgical response times for “status 1” patients from time of notification. Benchmark to the ACS verification guideline of a surgeon being present on arrival of patient or within 15 minutes of notification. The threshold is to meet this 80% of the time.
 - Study outcomes associated with used of the criteria to further refine them for optimal patient outcomes with minimal physician encumbrance.
- Identify physician leadership – trauma champions
 - Encourage Level II trauma centers (or hospitals that seek to become Level II trauma centers) to consider recruiting a trauma/surgical critical care specialist who can provide a knowledgeable back-up for sub-specialized surgeons who may or may not be comfortable with caring for a multi-system critically injured patient.
- Develop trauma chart forms
 - Establish standardized trauma patient admission orders. Establish automatic orders for glucose monitoring and control, peptic ulcer prophylaxis, deep vein thrombosis prophylaxis and surveillance, head injury protocols, etc.
 - Ensure that trauma history and physical forms have prompts for problem documentation areas such as Glasgow Coma Scale scores, procedures performed, notification and arrival times, critical care times, etc.
- Address finance issues
 - Encourage medical facilities to invest in the trauma service to obtain and maintain verification/designation.
 - Recruit and retain trauma/critical care specialists.
 - Initiate discussions with general surgeons to identify their needs to be able to provide the call coverage and to identify patient care issues.
 - Track costs that can be recouped by improved patient length of stay, decreased cost of care, and the value of improved medical staff satisfaction.
 - Charge trauma activation fees (can only be charged by verified/designated centers).
 - Seek legislation to include assistance for uncompensated care and readiness fees for verified/designated trauma centers.

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2. How can Alaska better coordinate resources, especially air medical, for every day trauma responses, as well as disaster response?

Assessment:

Alaskans depend on aircraft for routine travel and medical transport, especially those who reside in the isolated two-thirds of the state without roads. At any given place or time, local providers are familiar with local resources available, but may not know about back-up resources available in the region. Local providers may then be challenged to make multiple calls when their primary local air medical resource is not available.

Coordinating trauma care resources in the state of Alaska requires current knowledge of the status of those resources, e.g., personnel, equipment, communication, facilities. To date, a comprehensive needs or resource assessment of the trauma system has not been conducted. While some of this information is available, such as for facilities, it is lacking for other aspects of the trauma system, such as air medical resources.

Policy Development:

Once an air medical resource assessment has been completed, information collected about all trauma system resources (including military, National Guard, and Coast Guard) should be organized by region and made available to users in an easily retrieved format. A central coordination center could then be created to track the air medical assets available and in use throughout the state, and this information could potentially be available on-line. Likewise, the EMS regions could develop and maintain a regional resource information database that could be updated regularly.

The next step could be the establishment of a regional "one call does all" service. Such services could assist a referring provider to obtain the aircraft that matches the patient's need and local landing restrictions. The regional service could also help direct community-based air medical resources to available and appropriate facilities and assist in the coordination of ramp transfers. The "one call does all" concept includes the identification of the receiving trauma facility that best matches the patient's needs.

The regional centers would feed information about the aircraft deployed to the central coordination hub. This coordination hub would be useful in a state disaster, and could potentially be maintained by the state's emergency management system. This type of statewide system status coordination hub would need to be operable and accessible at all hours and be updated in near real-time.

Another problem that the state faces is the lack of comprehensive guidelines for the indications of air medical transport. The reality is that urgent or even routine, non-emergent medical care not available in the local community may require air

travel. Development of guidelines will help ensure the optimal use of the air resources in a safe and efficient manner.

Assurance:

This service could optimize resource utilization locally and statewide on a continuous basis. Performance improvement could be conducted using trauma registry data to determine changes in time to transfer, and appropriateness of facility selection.

Recommendations

- Decrease patient transfer times by developing a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, and landing requirements).
 - Monitor the availability and location of air resources.
 - Provide availability status to users.
 - Coordinate air medical resources in a disaster situation.
- Develop regional system status databases of current trauma resources that are utilized to provide a 'one call does all' service for referring providers and support a statewide trauma resources data bank.
- Develop a state registry for disaster volunteers, similar to the Emergency System for Advanced Registration of Volunteer Health Professionals.
- Update and keep current the Trauma Triage, Transport and Transfer Guidelines.
- Use the Guidelines for the Management of Head Injuries in Remote and Rural Alaska as a template to develop other transport guidelines to optimize resources.
- In more populated areas with more than one healthcare facility, develop a tracking system of real time bed capacity for time sensitive diseases (trauma, ST elevated myocardial infarction [STEMI], stroke, etc.) and share that information with EMS dispatch in order to prevent delays or mistakes in patient destination (right patient to right facility).

Acronyms and Glossary

AAC - Alaska Administrative Code
ACEMS - Alaska Council on Emergency Medical Services
ACS – American College of Surgeons
ACS-COT- American College of Surgeons Committee on Trauma
ALS – advanced life support+
ATAC - Alaska Trauma Advisory Committee
ATLS – Advanced Trauma Life Support

BIS – Benchmarks, Indicators, and Scoring
BLS – basic life support

CARF - Commission on Accreditation of Rehabilitation Facilities
CDC – Centers for Disease Control
CHAs – Community health aides
CME – continuing medical education

DHSS – Department of Health and Social Services
DOT – US Department of Transportation

EMS – Emergency Medical Services
EMSC – Emergency Medical Services for Children
EMTs – Emergency medical technicians

FTE – full-time equivalent

HRSA - Health Resources and Services Administration

ICU – intensive care unit
IPEMS – Injury Prevention and Emergency Medical Services Section

MICPs – Mobile intensive care paramedics
MPH – Master of Public Health degree

NEMSIS – National EMS Information System
NIOSH - National Institute for Occupational Safety and Health
NSC – National Standard Curriculum for EMTs
NTDB – National Trauma Data Bank
NTDS – National Trauma Data Standard

PHTLS – Prehospital Trauma Life Support

SCI – spinal cord injury
STEMI - ST-Segment Elevation Myocardial Infarction
STIPDA – State and Territorial Injury Prevention Directors Association

TBI – traumatic brain injury
TNCC – Trauma Nurse Core Curriculum
TSC – Trauma system consultation
TSRC - Trauma System Review Committee

Alaska Council on Emergency Medical Services **(ACEMS)**

The mission of the Emergency Medical Services program in Alaska is to reduce both the human suffering and economic loss to society resulting from premature death and disability due to injuries and sudden illness. The Governor's Alaska Council on Emergency Medical Services, also known as "ACEMS," provides the Commissioner of the Department of Health and Social Services and the Governor with recommendations related to all aspects of EMS, including distribution of funding, and policy development. The Council:

- brings together technical resources, experience, and knowledge to assist and advise on the continued development of the EMS and trauma system in Alaska;
- advises the state EMS staff and EMS regional directors regarding public education and generation of broad community support for the goals of the EMS program;
- provides recommendations regarding EMS program policy and priorities; and
- reviews EMS or EMS-related program proposals on request of the Commissioner of the Department of Health and Social Services, the Director of the Division of Public Health, and Section of Injury Prevention and EMS staff.

ACEMS was established by Alaska Statute 18.08 and meets two times a year to take action on issues affecting EMS in Alaska.

Alaska Council on Emergency Medical Services
As of 9/2008

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Appendix A: Site Visit Team Biographical Sketches

REGINALD A BURTON, MD, FACS- TEAM LEADER

Dr. Burton started his Trauma career while in high school when he got his first EMT certification. He worked as an EMT throughout college and medical school to offset his tuition. He and his wife, Dr. Snyder, moved to Ohio after finishing his residency in Surgery in 1992.

Dr. Burton was very active in the establishment of the Trauma System in Ohio. He developed and was the Trauma Director of the first ACS verified level III trauma center in Ohio, while continuing to participate in trauma call at the Level I trauma center in Dayton. He gave numerous lectures throughout the state on trauma center development, trauma center Performance Improvement programs, and EMS/Hospital integration of trauma plans. He became the medical director for the Fire/EMS services in two surrounding cities and sat on the regional EMS Council. He was the Co-Chairman of the Southwest Ohio Regional Trauma System from 1997 until 2002. He was the Chairman of the Region 2 Physician Advisory Board to the Ohio State Trauma Board for 5 years until he moved to Nebraska. He sat on the Data Committee of the Ohio Trauma Board during the statewide trauma registry development, and helped work out many issues enabling it to start functioning 2000.

Dr. Burton took a sabbatical and did a Trauma/Surgical Critical Care Fellowship at the renowned R. Adams Cowley Shock Trauma Center in Baltimore Maryland in 2006-7, and is currently the Director of Trauma and Surgical Critical Care at Bryan LGH Medical Center in Lincoln, Nebraska. He is a Clinical Associate Professor in Surgery at the University of Nebraska. He is the Medical Director of Region 2 in the Nebraska Statewide Trauma System, Chair of the Nebraska Statewide Trauma Data and Performance Improvement Committee, and the author of the Nebraska Trauma Performance Improvement training workshop. His team developed a web-based trauma registry reporting system that has enabled small critical access hospitals in rural Nebraska to report their trauma data to the Nebraska Statewide Trauma Registry, and thus also to the National Trauma Data Bank.

Dr. Burton has been a site visitor for the ACS Verification Committee since 2000. He became the Chairman of the Nebraska ACS Committee on Trauma in 2002, and is the current Regional Chief of Region 7 (Nebraska, Kansas, Missouri, and Iowa). Dr. Burton was also involved in the ACS Political Action Taskforce briefing on trauma issues to state senators and congressmen in Washington, D.C. in March, 2005. He was the ACSCOT representative to the National EMS Workforce Stakeholders Meeting and the HHS State Trauma Leadership meeting in 2006. He represented rural trauma physicians in the National Rural Health Association's meeting with federal partners in Washington, D.C. this year. Dr. Burton has always been an outspoken advocate for Trauma System Development.

JANE W. BALL, RN, DRPH

Dr. Jane W. Ball served as the Director of the National Resource Center (NRC) at the Children's National Medical Center in Washington, D.C. from 1991 through 2006. The NRC provided support to two Federal Programs in the U. S. Department of Health and Human Services' Health Services and Resources Administration (HRSA): the Emergency Medical Services for Children (EMSC) Program and the Trauma-Emergency Medical Services Systems Program. As director of the NRC, she coordinated the support provided to the Federal Program Directors as well as the provision of technical assistance to state grantees. Support to the Federal Program Directors often included meeting facilitation, preparation of special reports (such as the Model Trauma Systems Evaluation and Planning document), and consultation on Program issues. Technical assistance often included strategic planning, providing guidance in securing funding, developing and implementing grants, developing injury prevention plans and programs, building coalitions, shaping public policy, conducting training, and producing educational resource materials.

Dr. Ball has authored numerous articles and publications as well as several health care textbooks, including Mosby's Guide to Physical Examination (6 editions), Child Health Nursing (first edition), Pediatric Nursing: Caring for Children (4 editions), Maternal and Child Nursing (2 editions), and Pediatric Emergencies: A Manual for Prehospital Care Providers (2 editions). One of these texts, Pediatric Nursing: Caring for Children, received the 1999 and 2001 Robert Wood Johnson Foundation Last Acts Coalition Outstanding Specialty Book Award. As an expert in the emergency care of children, Dr. Ball has frequently been invited to join committees and professional groups that address the unique needs of children.

Dr. Ball recently completed her term as the President of the National Academies of Practice, an organization composed of distinguished health care practitioners from 10 disciplines that promote education, research, and public policy related to improving the quality of health care for all through interdisciplinary care. She currently serves as the organization's Immediate Past President.

Dr. Ball graduated from the Johns Hopkins Hospital School of Nursing. She obtained her master's degree and doctorate in Public Health from John Hopkins University School of Hygiene and Public Health. She is a Certified Pediatric Nurse Practitioner.

SAMIR M. FAKHRY, MD, FACS

Dr. Fakhry graduated from the American University of Beirut, School of Medicine in 1981. He completed his residency in general surgery and his fellowship in critical care and trauma at the University of North Carolina at Chapel Hill and North Carolina Memorial Hospital, Chapel Hill, N.C. in 1987.

From 1988 until 1991 he led the trauma program as Director for Trauma Services at George Washington University Medical Center in Washington D.C. In 1991, he accepted a position as Director, Surgical Critical Care Services at UNC Hospitals in Chapel Hill, NC. While at UNC, he rose to the rank of Associate Professor of Surgery with Tenure and was awarded several teaching awards by the medical students and the surgical residents. He remained there until 1997 when he was recruited to the Inova Regional Trauma Center at Inova Fairfax Hospital in Falls Church, Virginia as the Chief of Trauma Services.

Since 1997 he has held the position of Chief, Trauma and Surgical Critical Care Services at the Inova Regional Trauma Center. Additionally, he holds the positions of Associate Chair for Research and Education, Department of Surgery; Medical Director for the Inova Regional Trauma Center Injury Prevention Program; Professor of Surgery, VCU, Inova Campus; Clinical Professor of Surgery at Georgetown University School of Medicine; and is the immediate past Chair of the American College of Surgeons Washington DC Committee on Trauma.

Dr. Fakhry has been heavily involved in trauma and surgical critical care research. He has numerous peer-reviewed publications, abstracts and book chapters to his credit. He is a member of many national societies and serves on several national committees and boards. He is a frequent speaker locally as well as nationally.

Dr. Fakhry maintains a high interest in all aspects of trauma. He has been Principal Investigator (PI) for the Crash Injury Research and Engineering Network (CIREN) Center at Inova Fairfax Hospital since May, 2000. With injury prevention as a goal he has worked closely with The National Highway Traffic Safety Administration (NHTSA), automobile manufacturers and bio-engineers to help produce safe vehicles. In addition to the CIREN project, he has been awarded funding for numerous projects in areas of injury prevention, surgical critical care and trauma. These include medical informatics applications, head trauma, intestinal injury, aggressive driving, teen DUI prevention and surgical education.

DREXDAL PRATT

Chief Drexdal Pratt heads the Office of Emergency Medical Services in the Division of Health Service Regulation of the North Carolina Department of Health and Human Services. His agency manages Emergency Medical Services and Trauma and the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Cooperative Agreement.

Mr. Pratt is a graduate of the Institute of Government at the University of North Carolina at Chapel Hill, the EMS Management Institute at the University of North

Carolina at Charlotte, and Forsyth Technical Community College. He is also a Certified Emergency Manager (CEM) and a Certified Public Manager (CPM).

Mr. Pratt joined the North Carolina Office of Emergency Medical Services in 1987 as a Regional Coordinator. He was promoted through the ranks, first to Regional Supervisor, and then to Chief of the agency in 1999.

Mr. Pratt served two terms as Chair of the Region I EMS Advisory Council. He received the National Association of County Commissioner's Achievement Award for coordinating the development of the Stokes County NC computer-aided dispatch program.

Currently, Chief Pratt serves as a Commissioner on the Governor's State Emergency Response Commission and serves as Chairman of the Commission's Homeland Security Medical Committee. In addition, Mr. Pratt serves as Chairman of the NC Hospital Preparedness Committee.

NELS D. SANDDAL, MS, REMT-B

Mr. Sanddal is currently the president of the Critical Illness and Trauma Foundation (CIT), in Bozeman, Montana. CIT is a non-profit organization dedicated to improving the outcomes of people who are injured in rural America through programs of prevention, training, and research. He recently completed a detachment as the Director of the Rural EMS and Trauma Technical Assistance Center which was funded by the Department of Health and Human Services, Health Resources and Services Administration. Mr. Sanddal worked as the training coordinator for the EMS and Injury Prevention Section of the Montana Department of Public Health and Human Services in the late 1970's. He has served as the Chairperson of the National Council of State EMS Training Coordinators and as the lead staff member for that organization, as well as the National Association of EMT.

Mr. Sanddal has been a co-investigator for six state or regional rural preventable trauma mortality studies and has conducted research in the area of training for prehospital and nursing personnel as well as in rural injury prevention and control. He is a core faculty member for the NHTSA Development of Trauma Systems course and has conducted several statewide EMS assessments for NHTSA. Mr. Sanddal served on the IOM Committee on the Future of Emergency Care in the U.S.

He received his EMT training in Boulder, Montana, in 1973 and has been an active EMT with numerous volunteer ambulance services since that time. He currently responds with the Gallatin River Ranch Volunteer Fire Department where he serves as the Medical Officer and Assistant Chief.

He completed his undergraduate work at Carroll College, received his Master's degree in psychology from Montana State University and is currently completing his doctorate in Health and Human Behavior from Walden University.

JIM UPCHURCH, MD, MA, REMTP

Dr. Upchurch began his medical career in 1971 as a Special Forces Medic courtesy of the US Army. He graduated from the University of Texas Medical Branch at Galveston in 1982 and completed a Family Practice residency from the University of Oklahoma in 1985. Since 1985, he has served as an Indian Health Service (IHS) Physician on the Crow Indian Reservation in Montana. The majority of his clinical practice involves emergency medicine (EM), Emergency Medical Services (EMS), surgery and obstetrics. He maintains current National Registry certification and state licensure as a paramedic. In 2003, he completed a masters degree in educational technology from George Washington University.

Dr. Upchurch is a long-standing member of the National Association of EMS Physicians and the American College of Emergency Physicians. Since 1986, he has functioned as EMS medical director for Big Horn County in Montana and guided their basic care program to the advanced life support level, including critical care interfacility transport. He also provides EMS medical direction for Big Horn Canyon National Park and the Incident Medical Specialist Program, US Forest Service, Region I.

Dr. Upchurch is director of a small non-profit organization, EMS Education & Training. They offer distance and face-to-face educational opportunities to rural and frontier EMS personnel in Montana who desire to advance their level of care. He is an active ACLS, ACLS EP, ATLS and PHTLS instructor. Recently, he authored the Geriatric chapter for the sixth edition of *Nancy Caroline's Emergency Care in the Streets*, released in 2007.

Although Montana has no recognized state EMS medical director, Dr. Upchurch has served in that function for many years and represents Montana on the National Council of State EMS Medical Directors of the National Association of State EMS Officials. He functions at the IHS national level as a consultant on EM and EMS issues. He also sits on the Montana Board of Medical Examiners and on the board for the Critical Illness and Trauma Foundation.

JOLENE R. WHITNEY, MPA

Jolene R. Whitney has worked with the Bureau of Emergency Medical Services, Utah Department of Health for 27 years. She spent the first 6 years of her career as a regional EMS consultant. She became Assistant Training Coordinator in 1986. She has been a program manager for EMS systems and trauma system development since 1991. She is currently a Deputy Director for the Bureau of EMS and Preparedness, which includes Trauma System Development, Chemical

Stockpile Emergency Preparedness, Hospital Disaster Planning, ED, Trauma and Pre-hospital databases, EMS Licensing and Operations, CISM, and EMS for Children.

She spent 250 hours in the Olympic Command Center, serving as an EMS liaison for the 2002 Winter Olympics in Salt Lake City, Utah. She has been involved with all aspects of EMS including ambulance licensure, EMS councils, certification and training, computer testing, and curricula development. She has experience in statute and rule development, grant writing, system plan development, coalition building, and disaster preparedness. She has served on several national committees and teams, including a state EMS system assessment for NHTSA, reviewing rural trauma grant applications, developing the HRSA model trauma system plan and the NASMESO trauma system planning guide, and the NHTSA curriculum for an EMT refresher course.

Jolene has a Masters in Public Administration from Brigham Young University and a B.S. in Health Sciences, with an emphasis in Community Health Education from the University of Utah. She was certified as an EMT-Basic in 1979. She also obtained certification as an EMT instructor and became certified as an EMT III (Intermediate) in 1983. She has attended numerous conferences, courses, and workshops on EMS, trauma and disaster planning and response. She also completed a course for investigator training from CLEAR. Jolene is a co-author of three publications on domestic violence and hospital surge capacity planning.

She is the current Chair for the National Council of State Trauma System Managers/NASEMSO. She is a member of the American Trauma Society, previous member of the National Association of State EMS Training Coordinators.

In 2005, she was nominated by her staff and received a Utah Manager of the Year Nominee Award from the Governor. She also received recognition from the Utah Association of Emergency Medical Technicians in 2006.

Appendix B: List of Participants

TraumaSystems evaluation & planning Committee



American College of Surgeons
Trauma Systems Consultation
November 2nd-5th, 2008

Name	Title	Organization
Abbott, Sally	SOA Preparedness Coordinator	SOA (State of Alaska)
Allard, Faith	RNFP Director	SOA
Andraschko, Andrea	Communication Specialist	ARH (Alaska Regional Hospital)
Barros, Nancy	SOA Program Manager	SOA
Bowman MD, J. Dani	Pediatrician	ANMC (Alaska Native Medical Center)
Brown MD, Ken	Planning Manager	BRH (Bartlett Regional Hospital)
Bryson, George	Staff Writer	Anchorage Daily News
Bundy, Tim	Section Chief, EMS	IPEMS (Injury Prevention & Emergency Medical Services) SOA
Butler MD, Jay	Chief Medical Officer	SOA- DHSS
Carr, Pat	Section Chief	SOA Health Planning and Systems Development
Chennault MD, Regina	Surgeon	ANMC
Coopes MD, B.J.	Director of Pediatric ICU	TCHAP (The Children's Hospital at Providence)
Crum RN, Bev	ER Manager	Ketchikan General Hospital
Davis, Rick	COO	ARH (Alaska Regional Hospital)
Derring RN, Shelly	Director of Clinical Operations	Airlift Northwest
DeGreef RN, Margie	Assistant with Administrative Services	PKIMC (Providence Kodiak Island Medical Center)

Name	Title	Organization
Fisher, Bryan	Chief of Operations	ADHSEM (Alaska Division of Homeland Security and Emergency Management)
Funk, Beth	State Epidemiologist	DHSS (SOA Department of Health and Social Services)
Gariepy RN, Debbie	TNC- Nurse	ARH
Gilkey, Ed	Chief Physician Executive	ANMC
Godfrey, Gerad	Chair	Violent Crimes Compensation Board
Goodrich, Craig	Fire Chief	Anchorage Fire Department
Greenberg MD, Matt	ED Director	YKHC (Yukon Kuskokwim Health Corporation)
Hecks, Sue	Director	Southern Region EMS
Hilgendorf, Rebecca	Acting Director	DSDS (Division of Senior and Disabilities Services) SOA
Hoebelheinrich MD, S. Roger	MD	CPGH (Central Peninsula General Hospital)
Hull-Jilly, Debra	IPU Unit Manager	IPEMS (Injury Prevention & Emergency Medical Services) SOA
Ives, George	Program Manager	PH- SOA
Jessop, Dan	Administrator	ANMC
Johnson, Mark	Volunteer	Former SOA Section of Community Health and EMS
Lamb, Ed	CEO	ARH
Lamoureux, Bruce	Senior Administrator	PAMC (Providence Alaska Medical Center)
Leemhuis RN, Mary	Trauma Program Manager, Nurse	ANMC
Leighty, Bobbi	Director of SE Region EMS	SEREMS (S.E. Region EMS)
Lerner MD, Deborah	Pediatrician	PAMC
Levy MD, Mike	Emergency Medicine Physician	ARH
Mackin, Jim	Preparedness Director	SOA/DHSS

Name	Title	Organization
Mandsager MD, Richard	TCHAP Director	PAMC
Maskay, Raj	Public Health Specialist	Section of Injury Prevention and EMS, SOA
Molitor RN, Jeanne	Course Director	SOA
Olliff, Terry	EMS Unit Manager	SOA IPEMS
Parks MD, Stephen	MD	PAMC/Lifemed
Poggi, Stephen R.	EMS	AFD (Anchorage Fire Department)
Potashnik, Dave	Emergency Medical Service Officer/Assistant Chief	North Slope Borough Fire Department- Barrow
Potts, Joanne	Program Manager	ARH
Robinette MD, Danny	MD	Northern Alaska Medical Surgical
Sacco MD, Frank	Trauma Systems Review Committee Chair/Surgeon	ANMC
Scandling, Bruce	Program Manager/Legislative Liaison	SOA Division of Public Health
Searles MD, Grant	MD	Anchorage Surgical and Bariatric
Simonsen RN, Barb	State Trauma Analyst/Nurse	IPEMS
Smith MD, Linda	ED Physician	ARH
Somervell, Philip	Epidemiologist	NIOSH (National Institute for Occupational Safety and Health)
Thompson RN, Mary	Trauma Program Manager	PAMC
Wilder MD, Norman	Chief Medical Officer	ARH
Wooley, Bev	Director PH, DHSS	SOA
Zafren MD, Ken	SOA EMS Medical Director	SOA

AMENDMENT

OFFERED IN THE HOUSE
TO: HB 168

BY REPRESENTATIVE HERRON

1 Page 1, line 3, following "centers":

2 Insert "**and including a portion of the tax levy on alcohol as a source of money**
3 **that may be appropriated to the trauma care fund**"

4

5 Page 2, following line 12:

6 Insert a new bill section to read:

7 **** Sec. 3.** AS 43.60 is amended by adding a new section to read:

8 **Sec. 43.60.055. Disposition of proceeds; availability for appropriation to**
9 **the uncompensated trauma care fund.** The portion of the tax collected under
10 AS 43.60.010 that is not separately accounted for under AS 43.60.050(a) may be
11 appropriated to the uncompensated trauma care fund (AS 18.08.085). Nothing in this
12 section creates a dedicated fund."

13

14 Renumber the following bill section accordingly.

TESTIMONY ON HOUSE BILL 168
February 8, 2010

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

ASHNHA's membership supports **HB 168**.

This incentive based approach to increasing trauma treatment capability in Alaska is well reasoned and addresses one key barrier that discourages facilities from seeking trauma designation. A key barrier not addressed by HB 168 is the availability and cost associated with assuring certain physician specialties are on hand to deal with trauma cases. This barrier will continue to limit the ability of hospitals to achieve optimal trauma designation levels unless it too is addressed. In order to solve this problem Alaska's physician community will have to be included in the discussion.

A possible approach might be to broaden Section 18.08.085 to allow the Commissioner of DHSS discretion to use the 'fund' to help offset costs incurred to meet physician staffing requirements necessary to achieve trauma designation. We understand other states are deploying innovative strategies to address the physician staffing challenge which Alaska could possibly learn from and incorporate into this incentive based program if the language of Section 18.08.085 were broader.

ASHNHA supports **HB 168** and urges its passage from House HSS to the next committee of referral at the earliest possible time. Thank you for the opportunity to present this testimony.

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.

ASHNHA Contact: Rod Betit • rbetit@ashnha.com • 907 586-1790

CS FOR HOUSE BILL NO. 168(HSS)

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES COGHILL, Kerttula

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to state certification and designation of trauma centers; creating the**
2 **uncompensated trauma care fund to offset uncompensated trauma care provided at**
3 **certified and designated trauma centers and including a portion of the tax levy on**
4 **alcohol as a source of money that may be appropriated to the trauma care fund; and**
5 **providing for an effective date."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1.** AS 18.08.082 is amended by adding a new subsection to read:

8 (c) The commissioner shall establish special designations in regulation for
9 varying levels of trauma care provided by a certified trauma center that shall be used
10 to set compensation eligibility and amounts under AS 18.08.085. The designations
11 shall be based on nationally recognized standards and procedures.

12 *** Sec. 2.** AS 18.08 is amended by adding a new section to read:

13 **Sec. 18.08.085. Uncompensated trauma care fund; creation.** (a) The

1 uncompensated trauma care fund is created. The purpose of the fund is to compensate
2 certified trauma centers in the state that receive a special designation under
3 AS 18.08.082(c) for care uncompensated by the person receiving the care or by any
4 other source.

5 (b) The fund consists of money appropriated to it by the legislature, including
6 donations, recoveries of or reimbursements for awards made from the fund, income
7 from the fund, and other program receipts from activities under this chapter.
8 Appropriations to the fund do not lapse.

9 (c) The commissioner shall administer the fund in accordance with the
10 provisions of this chapter. The commissioner shall spend money from the
11 uncompensated trauma care fund for the purpose established in (a) of this section. The
12 commissioner may establish and seek the advice of a special committee for review of
13 statewide trauma care and compensation standards.

14 (d) The commissioner may not provide more than 25 percent of the total
15 assets, including earnings, of the fund in a fiscal year to one trauma center.

16 * **Sec. 3.** AS 43.60 is amended by adding a new section to read:

17 **Sec. 43.60.055. Disposition of proceeds; availability for appropriation to**
18 **the uncompensated trauma care fund.** The portion of the tax collected under
19 AS 43.60.010 that is not separately accounted for under AS 43.60.050(a) may be
20 appropriated to the uncompensated trauma care fund (AS 18.08.085). Nothing in this
21 section creates a dedicated fund.

22 * **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

AMENDMENT

OFFERED IN THE HOUSE
TO: HB 168

BY REPRESENTATIVE HERRON

1 Page 1, line 3, following "centers":

2 Insert "and including a portion of the tax levy on alcohol as a source of money
3 that may be appropriated to the trauma care fund"

4

5 Page 2, following line 12:

6 Insert a new bill section to read:

7 **** Sec. 3.** AS 43.60 is amended by adding a new section to read:

8 **Sec. 43.60.055. Disposition of proceeds; availability for appropriation to**
9 **the uncompensated trauma care fund.** The portion of the tax collected under
10 AS 43.60.010 that is not separately accounted for under AS 43.60.050(a) may be
11 appropriated to the uncompensated trauma care fund (AS 18.08.085). Nothing in this
12 section creates a dedicated fund."

13

14 Renumber the following bill section accordingly.

HB

187

Alaska State Legislature

State Capitol, Suite 422
Juneau, AK 99801-1182
Phone: 465-4939
Fax: 465-2418
Toll Free: (800) 465-4939
Representative_Pete_Petersen@legis.state.ak.us



716 W. 4th Ave, Suite 380
Anchorage, AK 99501-2133
Phone: 269-0265
Fax: 269-0264

Representative Pete Petersen
Representative Chris Tuck
Representative Les Gara

MEMORANDUM

DATE: January 28, 2010

TO: Rep. Wes Keller, Co-Chair
Rep. Bob Herron, Co-Chair
House Health and Social Services Committee

FROM: Rep. Pete Petersen

RE: Changes in the draft Committee Substitute for HB 187

The draft Committee Substitute I am submitting contains the following changes from the original bill.
Thank you for your consideration.

- The definition of "medically necessary" was moved to sec. 21.42.397(e) to clarify that the requirement that covered treatment be medically necessary applies to the whole bill. The phrase "medically necessary" was also added to subsection (b)(5) to clarify that treatment coordinated with education plans would only be covered if they are medically necessary.
- The definition of "autism service provider" was expanded to be more specific. This new language was taken from Colorado statutes.
- The date in the effective date, and the date for inflation adjustment was changed to reflect the fact that this bill did not pass last year.

26-LS0641\P
Bailey
1/27/10

CS FOR HOUSE BILL NO. 187()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES PETERSEN, Dahlstrom, Peggy Wilson, Gruenberg, Muñoz, Kerttula, Gara, Kawasaki, Johansen

A BILL
FOR AN ACT ENTITLED

1 **"An Act requiring insurance coverage for autism spectrum disorders, describing the**
2 **method for establishing a treatment plan for those disorders, and defining the treatment**
3 **required for those disorders; and providing for an effective date."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1.** AS 21.42 is amended by adding a new section to read:

6 **Sec. 21.42.397. Coverage for autism spectrum disorders.** (a) Except for a
7 fraternal benefit society, a health care insurer that offers, issues for delivery, delivers,
8 or renews a health care insurance plan in this state shall provide coverage for the costs
9 of the diagnosis and treatment of autism spectrum disorders. Coverage for the cost of
10 treatment required by this subsection must cover the treatment of the disorders
11 prescribed by a licensed physician or psychologist and provided by an autism service
12 provider as identified in a treatment plan developed following a comprehensive
13 evaluation. A treatment plan developed under this subsection must identify the
14 medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative

1 care, and therapeutic care required. In this subsection,

2 (1) "rehabilitative care" means professional counseling, guidance
3 services, and treatment programs, including applied behavior analysis necessary to
4 develop, restore, and maintain the functioning of an individual to the maximum extent
5 practicable; in this paragraph, "applied behavior analysis" means the design,
6 implementation, and evaluation of environmental modifications, using behavioral
7 stimuli and consequences, including direct observation, measurement, and functional
8 analysis of the relationship between environment and behavior, to produce socially
9 significant improvement in human behavior or to prevent the loss of an attained skill
10 or function;

11 (2) "therapeutic care" means services provided by or under the
12 supervision of a speech-language pathologist licensed under AS 08.11 or an
13 occupational therapist or physical therapist licensed under AS 08.84.

14 (b) Coverage under this section

15 (1) is required to be provided only to individuals under 21 years of
16 age;

17 (2) must provide a maximum benefit of \$36,000 a year, adjusted
18 annually, beginning January 1, 2012, by the percentage change in the Consumer Price
19 Index for all urban consumers compiled by the United States Department of Labor,
20 Bureau of Labor Statistics; payments made by an insurer on behalf of a covered
21 individual for treatment of a medical condition unrelated to the individual's autism
22 spectrum disorder may not be applied toward the maximum benefit established in this
23 paragraph;

24 (3) may not limit the number of visits to an autism service provider for
25 treatment;

26 (4) is subject to copayment, deductible, and coinsurance provisions,
27 and other general exclusions or limitations included in a health insurance policy to the
28 same extent as other health care services covered by the policy; and

29 (5) must cover medically necessary treatment that is coordinated with
30 an education program, but may not be contingent on the coordination of treatment
31 with an education program.

1 (c) This section does not limit benefits that are otherwise available to an
2 individual under a health care insurance plan.

3 (d) A health care insurer may not terminate, refuse to deliver, execute, issue,
4 amend, or renew coverage to an individual because the individual is diagnosed with or
5 received treatment of autism spectrum disorders.

6 (e) In this section,

7 (1) "autism service provider" means an individual who provides direct
8 services to a person with autism spectrum disorder, is licensed, certified, or registered
9 by the applicable state licensing board or by a nationally recognized organization, and
10 who qualifies under one of the following:

11 (A) has received a doctoral degree with a specialty in
12 psychiatry, medicine, or clinical psychology, is actively licensed in the
13 specialty, and has one year of direct experience in behavioral therapies that are
14 consistent with best practice and research on effectiveness for people with
15 autism spectrum disorders;

16 (B) has received a doctoral degree in behavioral or health
17 sciences and has completed one year of experience in behavioral therapies that
18 are consistent with best practice and research on effectiveness for people with
19 autism spectrum disorders;

20 (C) has received a master's degree or higher in behavioral
21 sciences and is nationally certified as a board certified behavior analyst or
22 certified by a similar nationally recognized organization;

23 (D) has received a master's degree or higher in behavior or
24 health sciences, is licensed as a physical therapist, occupational therapist, or
25 speech-language pathologist, and has completed one year of directly
26 supervised experience in behavioral therapies for people with autism spectrum
27 disorders;

28 (E) has received a baccalaureate degree or higher in behavioral
29 sciences and is nationally certified as a board certified associate behavior
30 analyst or certified by a similar nationally recognized organization;

31 (2) "autism spectrum disorders" are those defined by the current

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edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified;

(3) "health care insurance plan" has the meaning given in AS 21.54.500;

(4) "health care insurer" has the meaning given in AS 21.54.500;

(5) "medically necessary" means any care, treatment, intervention, service, or item prescribed by a licensed physician or psychologist in accordance with accepted standards of practice that will, or is reasonably expected to,

(A) prevent the onset of an illness, condition, injury, or disability;

(B) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;

(C) assist in achieving or maintaining maximum functional capacity in performing daily activities;

* Sec. 2. The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 21.42.397, enacted by sec. 1 of this Act, applies to a health insurance policy that is offered, issued for delivery, delivered, or renewed on or after January 1, 2011.

* Sec. 3. This Act takes effect immediately under AS 01.10.070(c).



The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 152

March 2009

The Growing Trend Toward Mandating Autism Coverage

Autism and treatment for its various complications is becoming one of the most discussed and demanded state benefit mandates. But there is a growing debate over whether, and to what extent, autism is a health-related condition as opposed to a behavioral condition or educational challenge. While health insurance does and should cover health-related aspects of autism, policymakers who want to ensure that families facing the real financial and other challenges posed by autism should develop safety net programs that meet their needs, rather than trying to impose autism-related costs on health insurance.

Mental Health or Habilitative Services? Currently, health insurance does and should cover physical medical conditions faced by those with autism. In addition, it will often cover many mental health-related conditions. However, autism advocates want to require health insurance to cover therapies more accurately described as educational.

One problem is how to categorize autism treatment: Does it fall under mental health or habilitative services? If autism is a mental health condition, it is more likely to be covered by health insurance. If under habilitative services, then it should be considered long term care.

A mental health benefit mandate provides for the payment of mental health evaluation and treatment, but sometimes at a higher out-of-pocket cost for the patient, or limitations are imposed on the coverage. Historically, mental health services have higher patient cost-sharing and shorter visit limits than services for physical illness or injury. Mental health parity laws try to minimize or eliminate this difference by requiring the same limitations and cost-sharing for mental health as for traditional medical care.

Habilitative services treatments, by contrast, include occupational, physical and speech therapies for children with a congenital or genetic birth defect, including autism. The goal of such services is to enhance the child's ability to function.

Coverage for Autism. Under a federal law passed in 2004, the Individuals with Disabilities Education Act, or IDEA, public early intervention and special education programs must provide related services and treatments to children with autism. However, only roughly 3 percent of autistic children's needs are met under IDEA, and President Obama has expressed support for even more comprehen-

State legislatures traditionally have grouped autism in the broader category of mental health, but one of the latest state legislative trends is to pass an autism mandate separately from mental health benefit mandates.

Autism support groups want mandate legislation that provides for evaluation and treatment of autism, as well as specific services such as school mainstreaming.

Which States Cover Autism? The question of whether autism is a mental health condition covered under health insurance varies from state to state. One of the problems is that scientists and doctors are not certain what causes autism, and so historically treatment differs from one person to the next. Plus autism-coverage advocates often vary in how they interpret existing laws.

- For example, Autism Speaks reports eight states with health insurance autism benefits.
- However, several autism blogs report a higher figure and point to a Connecticut Office of Legislative Research (OLR) report dated December 2006 that says 17 states have some level of coverage for autism, including 10 that require coverage for autism through their laws mandating mental illness coverage. Six of those states have specific autism laws.
- In July 2008, the Connecticut OLR came out with an additional report that broke down the autism mandate differently. Researchers reported that 22 states besides Connecticut mandate some amount of coverage for the treatment of autism — which is consistent with CAHI's own tracking of the autism mandate. Of these, eight require coverage for behavioral treatment services for autism (Arizona, Florida, Indiana, Kentucky, Louisiana, Pennsylvania, South Carolina and Texas) and five plus Connecticut require other coverage related to autism (Colorado, Georgia, Maryland, New York and Tennessee). Nine states and Connecticut include autism in their mental health mandate laws (California, Illinois, Iowa, Kansas, Maine, Montana, New Hampshire, New Jersey and Virginia).

The Autism Society of America is more consistent with the Connecticut OLR report and several autism blogs. The Society's scope is broader than Autism Speaks, and it includes all types of coverage that addresses autism benefits,

CAHI has tracked 39 states that have mental health benefit mandates on their books (of which 30 specifically include autism), 47 that have state mental health parity laws and at least three have habilitative services for children.

There was additional autism-mandate activity during the 2008 legislative session. For example, Arizona, Connecticut, Florida, Illinois, Louisiana, Pennsylvania and South Carolina now have state mandate laws. And Hawaii adopted a resolution that requests a study of the social and financial impact of adding an autism mandate to health insurance coverage.

Even so, states are increasingly looking to insurers to cover more — or all — of the costs of caring for autistic children. Not because health insurers have any particular expertise in, or even responsibility for, autism. Legislators want insurers to cover more of the costs simply so the state doesn't have to.

The Push for Expanded Autism Coverage. Autism is a serious problem in the country, and we still don't understand the causes or the cure. The Centers for Disease Control reported in 2007 that one in 150 children has this disorder. And there is a growing recognition that autism should be identified early and treated — hence the American Academy of Pediatrics' recent recommendation that all U.S. children be formally screened for autism twice by the age of two.

We do know these children need significant amounts of care. That's why Wisconsin's approach, which set up the Children's Long-Term Care Community-Based Waiver (or CTLS) to provide a range of services to qualifying individuals, makes the most sense. It provides more integrated care than could possibly be provided by health insurance.

In addition, autism support groups and their families are looking for more financial relief from and coverage for Applied Behavior Analysis and other therapies which, according to proponents, contain some of the most effective forms of treatment, best outcomes and long term economic benefits. Proponents believe that health insurance companies should assume the financial burden — typically in the range of \$50,000 per year per child — for autistic children that families and school districts have borne.

Insurance carriers argue that most medically related treatments are already covered for autism. In addition, they note that autism is an individually based disorder, and so there is often no clear standard of care to determine the appropriate therapy. Further, some see behavioral therapy not as a medical benefit but an educational one. For example, "play therapies" can require up to 10 separate interactions per day, ensuring the child remains focused on the world around him. The therapy may be provided by unlicensed care providers (and/or parents) who can be trained to use the methods very effectively. Some of the other

therapies address developmental delays, which are not typically covered under health insurance.

While various educational therapies for autism may be beneficial, and while we recognize that many families struggle under the related financial burdens associated with autism, we question whether some of these therapies are within the scope of traditional health insurance.

The Cost of Autism Coverage. CAHI's actuarial working team estimates that an autism mandate increases the cost of health insurance by about 1 percent. But they caution us that figure may be rising for two reasons. The incidence of autism appears to be growing, and there is a trend to cover more services, which will drive up the cost of each covered individual. If these trends continue, as we expect, the cost of mandating coverage will move into the 1-to-3 percent range.

Conclusion. Private health insurance, with companies and individuals frequently changing plans or health care networks, doesn't provide the consistent care autistic children need. If legislators want to help these families, they should create programs specifically targeted to meet their needs and properly fund them from general revenues — better than Congress did under the IDEA program — rather than try to force the costs onto health insurance, which will just increase everyone's premiums.

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HB 187 Questions

Note: Answers provided by the Governor's Council on Disabilities & Special Education with assistance from the Division of Public Health, Section on Women, Children and Family Health, the Center for Human Development at the University of Alaska Anchorage and Jim Boudier

1. **Who will do the recruitment, training and deployment? What has been done to date? Are there any specific strategies for recruitment, training, deployment?**

Presently, there are four coordinated initiatives to prepare personnel to more effectively serve infant, toddlers, children and youth with Autism. The first 3 are being conducted through one state funded project – Capacity Building for Autism Interventions Project, through the UAA Center for Human Development (CHD). They also directly relate to services provided through insurance funding. The fourth, more targeted, is being funded through the AK Part C Program.

- (1) A total of 15 **Autism Specialists**, (i.e., advanced graduate professional responsible for planning, implementation and monitoring of intensive services), are being trained through a 2-year program of study. Eight are beginning their studies through the CHD project, cooperatively delivered with Northern Arizona University. Seven others are at least ½-way through their programs and are closing on the required 1500 clock hours of supervised field work. One Alaskan professional is currently nationally credentialed in this manner (i.e., Board Certified Applied Behavior Analysts – BCBA- through the international division of A.B. A., of the American Psychological Association), though she soon will be retiring. Based on the current population size, Alaska has need for at least 30 of these BCBA specialists.

It is anticipated that a new cohort of at least 6 graduate students will begin their 2-year studies fall 2010. Students who already have Master's degrees must take the 5 graduate courses, complete the intensive 1500 hr field experience, and pass the national examination before becoming certified. Recruitment takes place through the numerous professional and parent Autism groups (e.g., CAII, Autism Alliance, state/local chapters of Autism Speaks and ASA) along with state and private Behavioral Health, Developmental Disability, Education and Infant Learning agencies.

- (2) **Certified direct service personnel**, both on an undergraduate degree and paraprofessional basis, are needed to implement the services designed by the Autism Specialist. An Occupational Endorsement certificate program is currently being designed and submitted for approval by the Capacity Building for Autism Interventions Project of CHD, in cooperation with the UAA Department of Human Services. This 6 course, 18-credit program is being designed to (a) stand alone as an Occupational Endorsement, or

(b) partially fulfill A.A. or B.A. degree requirements. Initial recruitment will be through similar markets as the Autism Specialist training, as well as conventional UAA channels, with the program anticipated in starting by fall 2010.

- (3) **Ongoing Autism professional and paraprofessional training** through a regular week-long Summer Institute was begun by the Capacity Building for Autism Interventions Project the summer of 2009. A total of 42 professionals and paraprofessionals from state and private DD and Infant Learning Program agencies participated. Topics are limited to specific interventions directly relevant to the provision of intensive intervention services. The 2009 Institute focused solely on the needs of infants, toddlers and young children. Plans for 2010 training are to broaden the scope to include strategies for serving teens and young adults with ASD, with special relevance to those youth with Autism, targeted by BTKH for return to Alaska.
- (4) **Training of Infant Learning Provider staff.** Beginning the summer of 2010, specialized training is being provided by the Part C Program to ILP staff. This 3-day training will take place in Fairbanks and will focus on the evidenced-based strategies to promote social and communication skill acquisition by very young children.

2. Have there been any projections of how much money would be spent for travel and lodging compared to how much would be spent for actual treatment?

At this time, the only travel and lodging associated with the ASD services from the bill potentially relate to those costs associated obtaining a diagnosis when parents chose out-of-state services, as opposed to obtaining that determination here in Alaska. It is anticipated however that most families will already have a diagnosis and not need special travel. Workers who are being prepared to serve with these youth are receiving training primarily either via distance-based delivery systems or coordinated Institutes or Conferences here in Alaska.

Insurance companies do not generally cover the cost of travel and lodging although individual providers who travel to deliver services may build these costs into their indirect rate.

3. What is the projected cost per insured at a prevalence of 1:100?

- With an average of 11,000 births in Alaska a year (2) an estimated 111 children (1) will receive an autism diagnosis this year.
- Direct annual average costs related to the medical/behavioral interventions for an autism diagnosis is approximately \$48,000
- These 111 children will cost the State of Alaska \$3.3 million annually for each year of their life [*if they do not receive treatment that provides them a reasonable independent lifestyle*] (3)

- (1) American Academy of Pediatrics (2009)
- (2) State of Alaska Bureau of Vital Statistics (2008)
- (3) Ganz, M Understanding autism: from basic neuroscience to treatment

According to a recent report (Brief Report: Quantifying the Impact of Autism Coverage on Private Insurance Premiums by James N. Boudier, Stuart Spielman, David S. Mandell), **“Our analyses imply that the percentage increases in healthcare premiums changed linearly based on changes in assumptions in annual costs and treated prevalence. It is important to note, however that the treated prevalence and the per-child expenditures may interact. That is, as treated prevalence increases, the proportion of children with less intensive medical needs may increase, thereby reducing the average per-child expenditure.”** (Page 4, column 2, paragraph 2).

Only about 10% of children with ASD diagnoses in the Pennsylvania Medicaid system expend more than \$36,000 per year (**Note:** \$36,000 is the private insurance cap in Pennsylvania). Given the higher cost of health services in Alaska, it may make sense to bump the cap to \$50,000 because the additional impact on premiums will be negligible.

4. **How much actual total premium increases are we talking about in Alaska? How many children total and how many of them would require coverage?**

The total premium increase is estimated to be no more than \$3.60 per member per month. This estimate is consistent with findings in other states. Alaska currently has 1,512 children and youth under the age of 21 who have autism; approximately 454 or 30.2% need significant clinical treatment.

5. **Please describe the “Applied Behavior Analysis Treatment.” Is any physician or psychologist qualified to administer this treatment?**

Applied Behavioral Analysis (ABA) describes a number of empirically validated strategies and interventions that are used to promote learning and/or change or reduction of behavior. These methods have been authenticated through hundreds of empirical studies that have demonstrated that new behaviors will happen more frequently if they are regularly reinforced, while previously demonstrated behaviors or skills will diminish if they are not. These ABA interventions achieve these outcomes by systematically responding to a child’s needs through a process of rigorous data collection and analysis. Recently, the 30 member team of National Autism Standards Project (National Autism Center, <http://www.nationalautismcenter.org/>) developed criteria and resource lists of evidence-based interventions, suggested from over 950 studies conducted with child, youth and adults with autism. All of those assessed by this national body as being “established” empirically validated treatments were ones that were ABA-based interventions.

Applied Behavior Analysis is often employed within a highly structured context and in an intensive manner (i.e., 1:1 or small group), relying heavily on the determination of the function of behaviors or skills as a first step to selection of a specific package of interventions. Key to the child's success is s/he developing the ability to recognize (discriminate) when and how to behave (respond). For a young child with Autism, this typically first means responding consistently, correctly and quickly to simple prompts, cues or directions given by an adult. It requires teaching the child, on a 1:1 basis, to attend or jointly attend with the adult, to specific objects or actions. The interventionist chooses and delivers cues, directions or actions precisely, and consistently uses positive reinforcement to strengthen and shape the child's correct responses. Doing so increases the child's ability to participate in typical social, home, and school settings as a function of his/her regular demonstration of those skills or behaviors that are contextually applicable or appropriate there. Progress is monitored through data collected on each target skill or behavior, with performance graphed over time.

There are a large number of tested interventions based on the principles of Applied Behavioral Analysis. While many have been validated for use with children with challenging behaviors and/or autism, others have been developed for behavior change by different populations, such as for parenting, weight loss, cessation of smoking, and other major life issues or behaviors. An effective Behavior Analyst systematically selects from different ABA assessment, data analysis, and planning methods as tools in the delivery of services, so as to ensure that the match between the interventions, schedule of service activities, the delivery of services and the child's home, school and community environments are optimal for learning. While many practitioners employ ABA methods, quality is controlled through a national process of certification, through the Behavior Analyst Certification Board, Inc, (BACB), an organization with roots within the Association for Behavior Analysis, International. The graduate level certification standards and credentialing from BACB is endorsed by the Association of Professional Behavior Analysts, the Association for Behavior Analysis International and Division 25 (Behavior Analysis) of the American Psychological Association.

Typically, ABA is provided by OT/PT staff or other master-prepared staff. Physicians and psychologists do NOT typically provide this intensive therapeutic intervention.

6. Please describe the approved screening process/practice. (no biological markers)

A flow chart that outlines the screening process/practice used in Alaska is attached.

In FY09, 105 children were referred to the pediatric neurodevelopmental outreach clinics for screenings; 85 were actually scheduled for appointments 34 of whom were presenting autism symptoms. 17 of the 34 (50%) were referred for a full diagnostic workup at Providence Autism Diagnostic Network; 9 were placed in a "watchful waiting" status.

Additionally, 128 children received a full diagnostic workup at the Providence Autism Diagnostic Network. Of the 128 children, 57 (44.3%) were diagnosed with an Autism Spectrum Disorder and an additional 5 (3.9%) were diagnosed with Asperger's Syndrome. 9 (7%) were diagnosed with a mental health diagnosis and 57 (44.3%) were diagnosed with other neurological disorders.

During the most recent quarter (10/1-12/31/09), 97% of children referred were referred suspecting Autism Spectrum Disorder or Asperger's Syndrome. 56% received a final diagnosis of autism or Asperger's; 44% have a diagnosis of another neurological disorder or mental health condition.

A word of caution: these numbers should not be used as a proctor to calculate prevalence or incidence. They are only what the outreach clinics and the Providence Autism Diagnostic Network are experiencing. Many kids referred with a suspected autism diagnosis or "looking like autism" are not screening positive definitely and some of the younger kids screened at the outreach clinics are placed in a "watchful waiting" status – a conservative approach but in their best interests.

Additionally, without a surveillance system, we do not know how many children are being diagnoses by other providers in-state nor the number who move to the state of Alaska who were diagnosed in other states.

7. How does the education mandate apply? What percentage of children with autism qualify as special education students – intensive needs students? Would there be a duplication of services?

Special education services and related services (e.g., occupational therapy, speech therapy) are provided to children with a disability whose disability is interfering with their ability to receive an education. The presence of a disability is not sufficient to establish eligibility for special education. The disability must result in an educational deficit that requires specially designed instruction (special education). Special education services are provided according to each student's Individualized Education Plan during the child's school day.

On October 1, 2008, 607 children were receiving specialized education services based on a diagnosis of autism. Because the current definition of autism is restrictive, the majority of these children is on the severe end of the autism spectrum and most likely qualifies as special education intensive needs students. Children with less severe autism often receive special education services based on other categories (e.g., multiple disabilities, other health impaired, emotional disturbances, learning disabilities).

Many children with autism, particularly those who need significant clinical intervention, require services beyond the school day; these are the services that would be covered through health insurance. Ideally, both education and health insurance services are coordinated so that they are complementary of one another, build upon what each system covers, are not duplicative and ensure that the individualized needs of each child are met.

The goals of special education and the goals of health care are not one and the same. The goal of special education is to enable a child with a disability to access the regular education curriculum to the maximum extent appropriate. The goals of health care are to relieve pain, cure disease, and improve functioning. There is no Federal mandate (or state mandate I'm aware of) that requires schools to treat the symptoms of a child's disability – this remains the domain of health care. In the case of children with autism, educational benefit can be realized as a result of treating and ameliorating the varied symptoms of autism. For the most part, clinicians are generally better trained to address the clinical needs of children with autism than special educators. This is not to say that quality special education programs are not important or beneficial – but clinical services delivered under a medical model of care are necessary for many children with autism and, especially when delivered in cooperation with special education, will improve the child's overall outcome.

To sum up, clinical applications of ABA are aimed at improving the functioning of people with autism, whereas special education aims at enabling the child to make meaningful educational progress. I believe these are distinct goals, but the first certainly effects the second. Also, ABA is a psychological discipline with a broad array of applications, including (not surprisingly) clinical applications.

ABA-BASED INTERVENTIONS FOR YOUNG CHILDREN WITH AUTISM SPECTRUM DISORDERS

As research and services are evolving relative to understanding and meeting the needs of young children with autism, several practices have emerged as being key to success. First, rarely do methods other than those that are evidence-based work with these children (i.e., shown effective with this population of children and then replicated through additional rigorous research). Second, when one examines the body of strategies that have been scientifically validated, one sees that the vast majority of these interventions have one common characteristic – each has been designed on, and to later adhere to, core principles of Applied Behavior Analysis, or ABA. A large number of ABA-based strategies have been developed, tested and employed, with some designed to have a generalized impact on the child's functioning, while other methods intended to address specific language, social or behavioral needs of these children. Lastly, evidenced-based methods have generally been shown to be far more effective the sooner and more intensively they are employed.

ABA is a scientifically-driven and validated approach to learning and/or change of behavior. The core ABA principles are based on Operant Learning Theory, which states that new behaviors will happen more frequently if they are regularly reinforced, while previously demonstrated behaviors or skills will diminish if they are not. Applied Behavior Analysis is often employed within a highly structured context and in a systematic manner, relying heavily on the regular observation of overt behaviors as a first step to individualization of intervention. Key to the child's success is s/he developing the ability to discriminate (recognize) when and how to respond (behave). For a young child with ASD, this typically first means responding consistently and quickly to simple cues and directions provided by an adult. This requires teaching the child, on a 1:1 basis, to attend or jointly attend with the adult, to specific objects or actions. The interventionist chooses and delivers cues, directions or actions precisely, and consistently uses positive reinforcement to strengthen and shape the child's correct responses. Doing so increases the child's ability to participate in typical social, home, and school settings as a function of his/her regular demonstration of those skills or behaviors that are contextually applicable or appropriate there. Progress is monitored through data collected on each target skill or behavior, with performance graphed over time.

While a Behavior Analyst who uses ABA tends not to speculate on the non-overt, internalized changes taking place with children with autism, the fact is that successful intervention often results in increased fluency and duration of responding to both verbal and visual cues (i.e., natural characteristics of an object, item or setting such as the shape of a letter, color of a ball, or correspondence of a top button to a top button hole). Doing so increases the probability of independent performance by the child in the future (maintenance of acquired skills), and tends to promote his/her use of these acquired skills in new and different settings (generalization).

There are a large number of tested interventions based on the principles of Applied Behavioral Analysis. While many have been validated for use with children with challenging behaviors and/or autism, others have been developed for behavior change by different populations, such as for parenting, weight loss, cessation of smoking, and the such. An effective Behavior Analyst systematically selects from different ABA assessment, data analysis, and planning methods as tools in the delivery of services, so as to ensure that the match between the interventions, schedule of service activities, the delivery of services and the child's home, school and community environments are optimal for learning. While many practitioners employ ABA methods, quality is controlled through a national process of certification, through the Behavior Analyst Certification Board, Inc. (BACB), an organization with roots within the Association for Behavior Analysis, International. The graduate level certification standards and credentialing from BACB is endorsed by the Association of Professional Behavior Analysts, the Association for Behavior Analysis International and Division 25 (Behavior Analysis) of the American Psychological Association.

Service delivery and workforce development needs

Autism Spectrum Disorders impacts each child uniquely. Age of onset, intensity of intervention and turn-around time between the date that the child is diagnosed and when services are initiated may response to intervention or the level of care needed. However, in most cases, the child him/herself will be the primary barometer to determine intensity and scope of services. For example, most children with autism discontinue

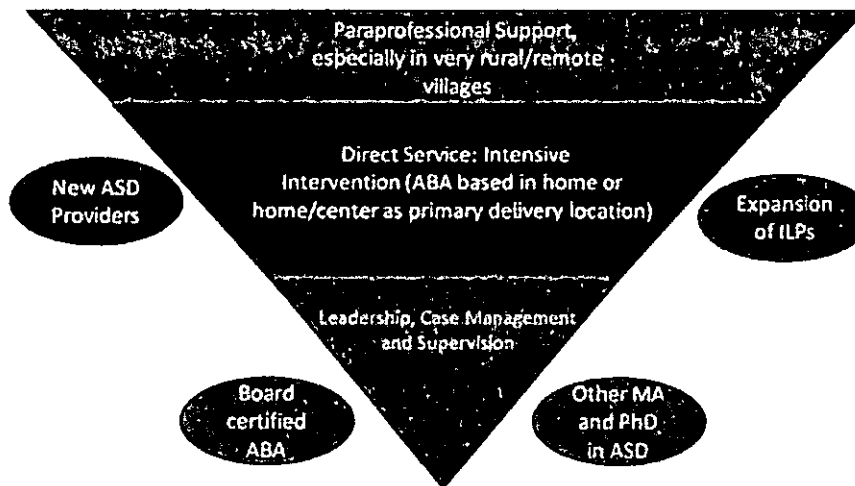
using all oral language, while some toddlers do not lose any ability to communicate whatsoever. The same variation can be said about the disorder's impact on social or behavioral functioning. It is truly a spectrum disorder, with some children demonstrating immediate benefit from conventional Early Intervention services (in Alaska, Infant Learning Programs), while others in need a highly structured daily routine of 1:1 intervention-based services, provided at home and/or in a center-based program, for up to 40 hours a week.

Professionals must guide and oversee the quality and continuity of services for these young children. Typically, Board Certified Behavior Analysts (BCBA) are employed to provide that leadership role. However, those children who require the most intense early intervention may also need services from several types of professionals beyond just those that provide daily intervention. For example, the Kansas Medicaid Waiver for young children with Autism specifies the following services:

1. Determination of eligibility (evaluation by state or contracted provider, called a *Functional Eligibility Specialist*, to determine Level of Care Determination);
2. Intensive Early Intervention, based on an annual plan of care is developed by the *Autism Specialist* (master's level) and implemented by full and part time *Behavior Specialists*
3. Respite Care
4. Consultative Clinical and Therapeutic Services by the Autism Specialist
 - Case management
 - Training and oversight of direct service staff
 - Monitoring and reporting of progress
5. *Parent Support and Training Provider* (the peer-to-peer KS equivalent to Parent Navigation and Training Services now provided through Stone Soup, Inc)
6. *Family Adjustment Counseling* – services for parents and siblings

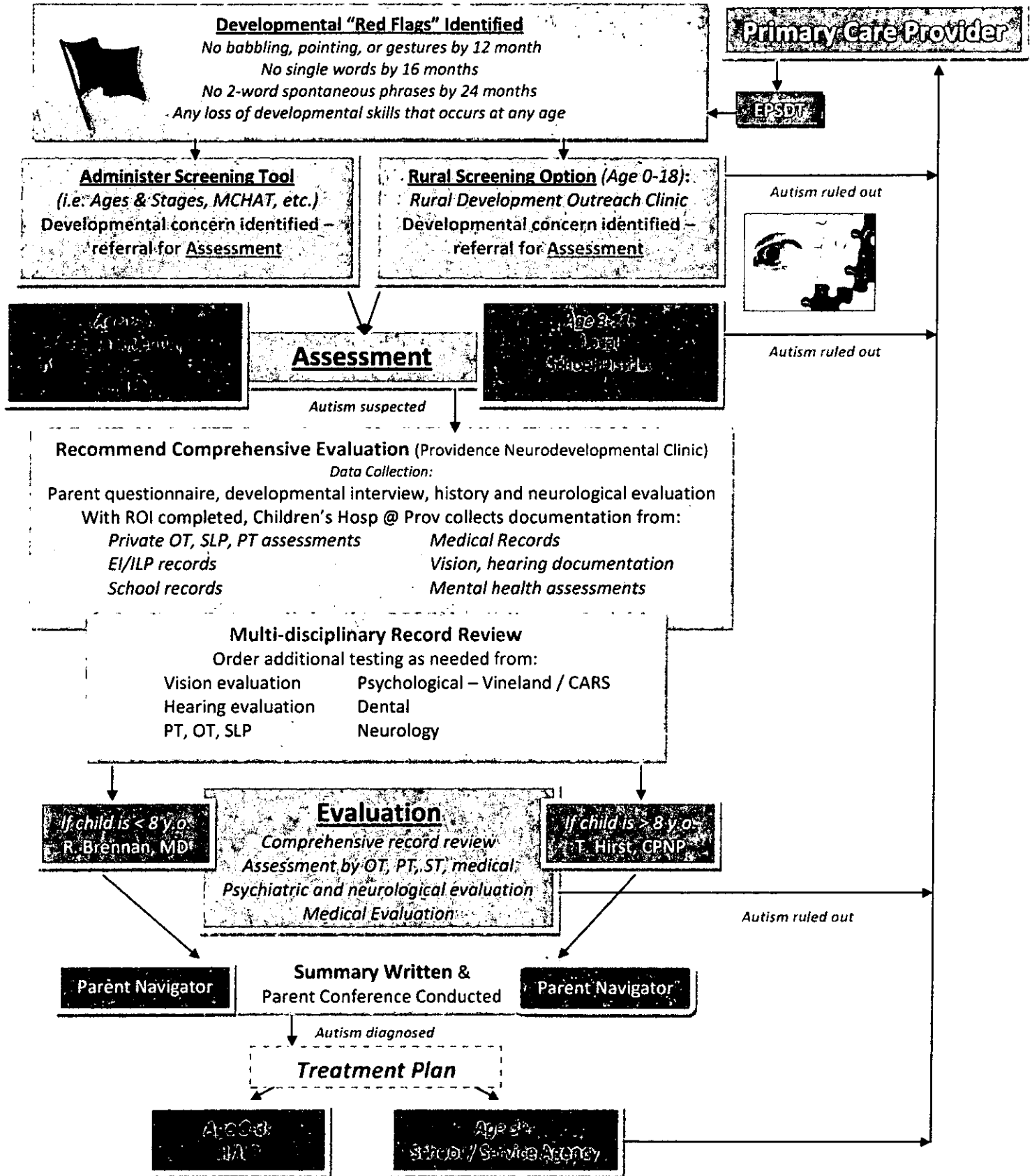
Four of the six services (i.e., #1, 2, 4, and 6) potentially require a credentialing review prior to their delivery. Intensive intervention (2) is planned and supervised by a BCBA, and implemented either by a bachelor's level full time behavior specialist (certification not required) or a part-time paraprofessional in that same capacity. Other disciplines, including professionals who provide Speech and Language Therapy, Occupational Therapy and Social Work are often needed for these support services.

Intensive Early Intervention Workforce Development Needs



Alaska's Goals in Response to Autism

2009



Brief Report: Quantifying the Impact of Autism Coverage on Private Insurance Premiums

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Abstract Many states are considering legislation requiring private insurance companies to pay for autism-related services. Arguments against mandates include that they will result in higher premiums. Using Pennsylvania legislation as an example, which proposed covering services up to \$36,000 per year for individuals less than 21 years of age, this paper estimates potential premium increases. The estimate relies on autism treated prevalence, the number of individuals insured by affected plans, mean annual autism expenditures, administrative costs, medical loss ratio, and total insurer revenue. Current treated prevalence and expenditures suggests that premium increases would approximate 1%, with a lower bound of 0.19% and an upper bound of 2.31%. Policy makers can use these results to assess the cost-effectiveness of similar legislation.

Keywords Health services · Insurance ·
Autistic disorder · Economics

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Introduction

Empirical studies of healthcare expenditures find that those of children with autism spectrum disorders (ASD) range from three to ten times those of other children, depending on the sample and methods (Croen et al. 2006; Leslie and Martin 2007; Liptak et al. 2006; Mandell et al. 2006). Synthetic estimates find even higher increases in relative expenditures, especially when categories such as educational expenditures and labor force participation are taken into account (Ganz 2006; Jarbrink and Knapp 2001). Relative to costs associated with other health conditions that manifest in childhood, the healthcare costs associated with ASD are disproportionately borne by families (Fujiura et al. 1994; Jarbrink 2007; Jarbrink et al. 2003; Krauss et al. 2003) and, in the United States, by the Medicaid system (Krauss et al. 2003), regardless of family income (Birenbaum et al. 1990; Braddock 2002; Walsh et al. 1997).

The dramatic increase in the number of children and adults diagnosed with ASD (Centers for Disease Control and Prevention 2007; Fombonne 2003, 2005), combined with the high cost of their care, has caused many states to consider other alternatives to pay for this care (Shattuck and Grosse 2007). Some states have increased the public contribution to these services. For example, Colorado, Indiana, Kansas, Maine, Maryland, Pennsylvania and Wisconsin, have or are considering Medicaid waivers, which would allow states to use Medicaid funds to pay for services not included in their Medicaid plan, or to cover individuals that otherwise would not be Medicaid eligible. Other states have increased the private contribution to these services. Many private insurance companies severely limit coverage of behavioral health services for individuals with autism or exclude coverage altogether. In response,

Arizona, California, Indiana, Kentucky, Louisiana, Mississippi, Pennsylvania, South Carolina, Texas, West Virginia and Wisconsin all recently considered legislation that would mandate private insurance companies to pay for autism-related healthcare services. This legislation has met with varying degrees of success, with legislation not passing in Mississippi, West Virginia or Wisconsin. Successful legislation has varied tremendously in the ages of covered individuals, the types and quantity of covered services, and annual caps on associated expenditures. As of this writing, many other states, including Connecticut, Florida, Illinois, Michigan, Missouri, and Oklahoma, recently have introduced similar legislation.

A major challenge to these insurance mandates has been the concern that they will result in increased premiums for policy holders. Since most policy holders are employers, increases in premiums may be passed onto employees in the form of a net loss of wages or loss of employment, although the effect of mandates on both has been debated in the literature (Collins et al. 2005; Hopkins and Zweifel 2005; Klerman and Goldman 1994; Sommers 2005; Wolaver et al. 2003). Insurance companies therefore have argued that an autism insurance mandate would result in a burdensome rate increase. Autism advocates, on the other hand, have argued that the burden associated with a rate increase would be outweighed by the benefits to individuals with autism and their families.

To help inform the debate surrounding autism insurance mandates, one of the authors (JB) developed an equation to estimate the effect of mandates on premiums, using information easily available on the Internet. In the following, we present the general equation and rationale, and use data from Pennsylvania, which has recently passed legislation, House Bill (HB) 1150, as an example. HB 1150 requires insurance companies to cover healthcare services for children with autism, from birth up to age 21. Specifically mentioned in HB 1150 are behavioral interventions such as applied behavior analysis. Annual per capita expenditures are capped at \$36,000.

Methods

Percentage rate impact (%RI) was calculated as a function of the prevalence of autism, which we calculated using a range based on reports of community and treated prevalence. This was multiplied by the number of insured children in Pennsylvania, the average annual medical expenditure for children with autism, which we derived from published studies (see Table 1), and the cost to insurance companies of administering this new mandate. The product of these four numbers was divided by the proportion of revenues from health insurance premiums

spent on medical services covered by the plan. This number was then divided by the total revenue to private insurance companies in Pennsylvania. More specifically, we used the formula:

$$\%RI = \frac{\left(\frac{f}{sf} \times F\right) \times (\bar{x} \times A) \div MLR}{PR}$$

where f is number of children in the state with autism, ages 2–20 years. This number was estimated using several strategies, ranging from the treated prevalence observed in recent studies using private insurance billing data (2 per 1,000) to the CDC-estimated prevalence (6.7 per 1,000).

Sf is number of all children in state, ages 2–20 years. This number was abstracted from US Census data.

F is number of insured children in Commonwealth, ages 2–20 years, with non-ERISA exempt healthcare insurance coverage. This number was derived from the percentage of uninsured children and youth living in Pennsylvania as reported by the Centers for Disease Control and Prevention (Cohen and Martinez 2007) and from the percentage of private-sector enrollees that are enrolled in self-insured plans at business firms offering health insurance in Pennsylvania, as reported in the Medical Expenditure Panel Survey (*Medical Expenditure Panel Survey-Insurance Component* 2005). Using these sources, the number of children and youth between the ages of 2 and 20 living in Pennsylvania and covered under state-regulated insurance plans, was estimated at 1.37 million.

\bar{x} is mean annual per capita expenditure for autism-related services. This number was estimated from existing studies of healthcare utilization, and ranged from the \$2,900 found by (Croen et al. 2006) to the \$36,000 cap proposed by the Pennsylvania legislation. Only estimated annual expenditures of \$10,000 and higher are presented here. A summary of this literature is presented in the table.

A is assumed load factor for the first year's administrative and incidental costs associated with the mandate. This number was obtained from insurer comments filed with the Pennsylvania Health Care Cost Containment Council in regard to the implementation of new insurance mandates, and assumed to be 10% of total provider payments attributable to the mandated benefits.

MLR is medical loss ratio. The MLR refers to the proportion of revenues from health insurance premiums spent on medical services covered by the plan. The MLR was calculated by dividing the total medical losses incurred by total premium revenue collected by insurers. The MLR is used to convert increased medical/clinical costs to a revenue requirement needed to encompass both the hard and soft costs attributable to administering health care coverage. An MLR of 85%, considered the industry standard, was used for these calculations (Robinson 1997).

Table 1 Summary of cost and expenditure studies for individuals with autism; all monetary amounts converted to 2006 \$^a

	Data source	Treated prevalence	Sample	Grand total	Medical					
					Total	Inpatient	Meds	Other	School	Other
(Mandell et al. 2006)	Allegheny County, PA Medicaid data 1994–1999	2.0/1,000	334 Children with autism diagnosis	\$12,000	\$12,000	\$8,300	–	\$3,700	–	–
(Croen et al. 2006)	Kaiser Permanente, Northern CA 2003–2004	–	3,053 Children with autism diagnosis	\$2,900	\$2,900	\$1,500	\$770	\$600	–	–
(Liptak et al. 2006)	National sample from MEPS 1997–2000	2.1/1,000	31 Children with autism diagnoses	\$7,400	\$7,400	\$880	\$1,170	\$5,300	–	–
(Leslie and Martin 2007)	Large US self-insured employers 2000–2004	Per 1,000: 0.9 (2000) 1.3 (2001) 1.8 (2002) 2.1 (2003) 1.9 (2004)	256,646 Children diagnosed with a mental disorder 2000–2005	\$4,965 (2000) \$5,979 (2004)	–	–	–	–	–	–
(Ganz, 2006)	Synthetic estimate	–	–	Lifetime: \$3,439,800	Lifetime: \$333,000	Lifetime: \$39,400	Lifetime: \$6700	Lifetime: \$286,800	Lifetime: \$163,800	Lifetime: \$2,943,000
(Jarbrink and Knapp 2001)	Center of Economics data & survey of 250 parents	–	228 Children with autism or high functioning autism (HFA)	Autism: \$1,834,600 HFA: \$687,200	Autism: \$237,500 HFA: \$164,000	Autism: \$62,200 HFA: \$71,800	Autism: \$8,000 HFA: \$19,400	Autism: \$167,300 HFA: \$72,900	Autism: \$418,600 HFA: \$254,100	Autism: \$941,000 HFA: \$1,400

^a All studies present average per person annual expenditures, with the exception of Ganz (2007) and Jarbrink and Knapp (2001), which present average per person lifetime expenditures

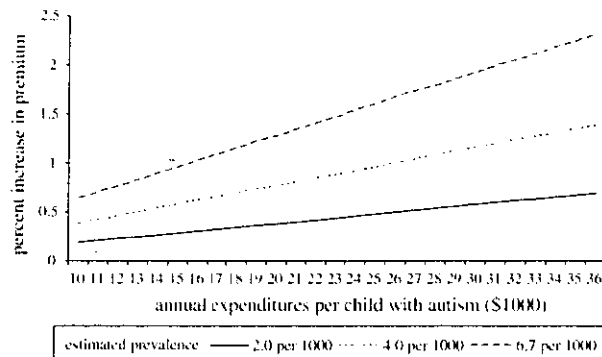


Fig. 1 Estimated increase in healthcare insurance premiums as a result of an insurance mandate requiring coverage of autism treatment

PR is total health insurer premium revenue, which was obtained from an October 2007 publication of the Pennsylvania Health Care Cost Containment Council (*Critical Condition. The State of Health Care In Pennsylvania 2007*), which aggregated premium revenue data that Pennsylvania insurers report on their annual NAIC filings. This sum was adjusted to reflect premium revenue derived from plans subject to HB 1150, as it was originally submitted for review to the Pennsylvania Health Care Cost Containment Council. This adjustment produces a total of \$18.44 billion in premium revenue collected for plans subject to HB 1150.

Results

The figure presents the results of this formula based on different assumptions regarding autism prevalence and associated healthcare expenditures. The x-axis presents annual expenditures ranging from \$10,000 to \$36,000. Estimated increases in healthcare premiums ranged from 0.19% (assuming a treated prevalence of 2 per 1,000 children and annual expenditures of \$10,000), to 2.31% (assuming a treated prevalence of 6.7 per 1,000 children and annual expenditures of \$36,000; Fig. 1).

Discussion

The results of this analysis suggest that even dramatic increases in the treated prevalence of autism and associated annual healthcare expenditures would result in relatively small increases to healthcare insurance premiums. The average family healthcare insurance plan in the United States costs \$1,009 per month, of which families pay an average of 28% (Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2005, 2007). Our

analysis suggests that, using current treated prevalence estimates and an annual expenditure for children with autism of \$10,000, the average family would pay an additional \$0.54 a month, or \$6.44 a year. If current treated prevalence were to double as a result of the new benefit and annual expenditures rose to \$20,000, families' annual increased contribution would be \$26.10. Even in the unlikely event that treated prevalence were to rise to the accepted community prevalence of 1 in 150 children, and per capita expenditures rose to \$36,000 per year, the increase in the family contribution would reach \$6.53 a month, or \$78.31 per year.

Our analyses imply that the percentage increases in healthcare premiums changed linearly based on changes in assumptions in annual costs and treated prevalence. It is important to note, however that the treated prevalence and the per-child expenditures may interact. That is, as treated prevalence increases, the proportion of children with less intensive medical needs may increase, thereby reducing the average per-child expenditure.

Two study limitations should be noted. First is that these calculations were based on data from existing literature. Dramatic changes in payment available for services to individuals with ASD may affect the treated prevalence and on the provider market. While we attempted to model changes in prevalence up to the accepted community prevalence (Centers for Disease Control and Prevention 2007), we did not model any changes to the provider market. Second, estimated changes to healthcare insurance premiums were based on total costs for children with ASD, not incremental increases, because there is little information on current expenditures for children with ASD not associated with an ASD diagnosis per se (Leslie and Martin 2007; Mandell et al. 2006). Many children with ASD may receive services that are associated with a different diagnosis, as clinicians may assign diagnoses that result in a higher probability of reimbursement. To that extent, the estimates presented here may overestimate actual increases to premiums, given that some healthcare expenditures would remain the same but now would be associated with an ASD diagnosis.

Despite these limitations, the estimates present here offer an important starting point for discussion among policy makers considering the impact of changing insurance regulation. The Pennsylvania legislation upon which these calculations were based has been described as the most generous insurance mandate in the country, in terms of the age group and scope of services covered, as well as the annual expenditure cap. The more limited legislation proposed in other states should be considered in this light, weighing the relatively minimal impact on all insurance premium payers against the potential benefit for children with ASD and their families.

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January 25, 2010



Representative Wes Keller
Alaska State Capitol – Room 13
Juneau, AK 99801

Jack C. McRae
Senior Vice President

Dear Representative Keller:

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our concerns with HB 187 which mandates coverage for autism spectrum disorders (ASD).

We, too, are concerned with the challenges faced by children with autism and their families. We want to approach this issue in a manner that is in their best interest as well as all of the members we serve.

Of serious concern to us is the cost impact for employers and families already struggling to afford healthcare coverage. Our analysis of this mandate projects a rate increase of at least 3 % to our Alaska members.

Every benefit mandate adds to the overall cost of healthcare and insurance premiums. And, during a time when we are collectively looking to make healthcare more affordable, we believe employers should be able to determine their own benefit plans without additional state mandates. Financial impacts must be strongly considered for any benefit mandate proposal, especially given the current economic conditions, and the fact that many families and employers already face difficulties in affording coverage. Furthermore, this mandate will not impact self-funded plans in Alaska, which are not regulated by the state.

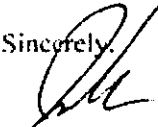
While the proposed mandate would provide some financial relief to families impacted by ASD whose employers can continue to afford coverage, there will be an unfortunate tradeoff for those families who would no longer be able to afford medical coverage at all, including families with ASD affected children. With an increasing load of mandates, employers may be forced to drop health insurance benefits altogether.

Also of particular concern is potentially requiring medical plan coverage for services that are essentially educational in nature, such as Applied Behavior Analysis (ABA) therapy. These services are provided by individuals with backgrounds and training in the field of education, not medical or mental health. We also question the appropriateness of mandating educational services, designed to assist with behaviors such as getting dressed, eating meals, brushing teeth, or sitting still during classes, to be included as part of medical program coverage. This would establish an inappropriate precedence. In addition, numerous reviews of ABA therapy by objective parties have concluded that evidence for the effectiveness of ABA therapy is contradictory, and at best, modest. We would recommend not mandating this therapy in the benefit.

To ensure quality treatment and patient safety, it is important that any person or entity providing treatment of ASD be licensed or certified. The definition of an ASD provider included in HB 187 is overly broad to include any person, entity, or group that provides treatment of ASD. We would recommend that providers treating ASD demonstrate specific training and experience, and that ABA therapy be provided by behavior specialists who are board certified, such as by the Behavior Analyst Certification Board.

Thank you for considering our concerns on this issue.

Sincerely,



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Senior Vice President

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Background

Employee health insurance is a major business and political issue. Virtually everyone agrees that restraining the rate of health care cost (and resultant health insurance price) increases as well as expanding health insurance coverage are pressing matters. The disagreement occurs over the means to reach those objectives. Small businesses are near the center of this controversy. Their employee health insurance costs are rising much faster than inflation. Further, their health insurance dollar purchases relatively fewer benefits. One result is that small employers are less likely to purchase employee health coverage than large employers or public entities. Recent trends only exacerbate these problems, raising serious question about the long-term viability of the entire employer-based health insurance system. Purchasing Health Insurance is a key background component to the employer-based system of employee health insurance and the subject of this issue of the *National Small Business Poll*.

It is well known that about half of employing small businesses offer employee health insurance and the other half does not. It is also well known that provision of employee health insurance is tied to employee size of business, even within the small business population. The data from this survey reflect both. Forty-seven (47) percent of small employers offer employee health benefits and 52 percent do not (Q#1). Those employing 20 or more people are more than twice as likely to offer employee health benefits as those with fewer than 10. Further, 36 percent offer the benefit to *all* or *most* full-time employees and another 5 percent offer it to *some* or a *few*. However, provision of employee health insurance is not synonymous with provision of

employee health benefits. About one in 10 small employers who offer employee health benefits (6%) offer premium reimbursement for health insurance purchased by employees on their own rather than through the business.

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Dropping Insurance or Never Buying It

Good employees are difficult to attract and keep. Provision of benefits is one method small employers use to compete for them. So, most are reticent to antagonize employees by eliminating a benefit or privilege once given; it is much better for morale to have not given the benefit or privilege in the first place. At the same time, small firms experience considerable turmoil in their early years. They often experience cash flow problems and are reluctant to incur marginally necessary expenses. Just short of half survive the first five years, though the odds of exit in any one year decline progressively as businesses age. These two seemingly unrelated facts lead to the hypothesis that stagnation and/or decline in the number of small businesses offering employee health insurance stems not so much from some small employers dropping insurance altogether as from newcomers introducing the benefit relatively late or not at all. The evidence gathered here suggests that the hypothesis is correct.

Twenty (20) percent of small firms offering employee health insurance started offering the benefit in the last three years (Q#1a). The proportion initiating it compared to those already offering it declines as businesses age even though the total percentage offering rises. Unfortunately, we have no benchmark to compare these numbers over time. The data cannot tell us, therefore, if small employers are introducing employee health insurance as a benefit later at the present time than they did in the past. However, 9 percent of those not now offering health insurance (5% of all employing, small businesses) offered it within the last three years (Q#1b). About one third (34%) of those dropping it moved to premium reimbursement rather than eliminating the health benefit altogether. The remainder eliminated the benefit entirely. The consequence is about 3 – 4 percent of all small employers dropped employee health insurance in the last three years (or 1 – 2% a year). One percent annually means virtually no small businesses drop employee health insurance, though they may increase the cost share, etc. If virtually no firm drops employee health insurance and the trend in its provision is stable to lower, new small firms are likely to be slower on the uptake than in the past.

The importance of this point is that it exhibits rising small employer resistance to offering the benefit. As the small business population turns over (and assuming the trend continues), the share of small employers adopting this view will grow. Growing reluctance to initially offer will reduce the pool of potential employees from which to choose, dampening the trend. But, a shrinking pool will also direct small business recruiting efforts toward people who are willing to trade relatively higher wages (or premium reimbursement) for health insurance. This situation is not beneficial to either the small employer or their employees, but it represents the direction current conditions are driving them.

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Shopping for Health Insurance

The overwhelming majority of small employers think that the cost of health insurance is a serious business problem. The logical consequence is that large numbers should be out shopping for a new or different plan, a better buy, or just certainty that they enjoy the best in a series of bad alternatives. Yet, aggressive shopping is not necessarily occurring, particularly among owners of the smallest businesses. Forty-eight (48) percent of all small employers indicate that they or someone on their behalf shopped for employee health insurance in the last three years (Q#2). Owners of the smallest (1 – 9 employees) shopped in only 43 percent of cases compared to 78 percent among the largest (20 – 250 employees).

Not all small employers with insurance shopped nor did all small employers without insurance not shop. Still, the trend was strongly in that direction. Seventy-five (75) percent offering insurance to *all* or *most* full-time employees shopped, compared to 68 percent offering health insurance to *some* or *a few*. Sixty-one (61) percent offering premium reimbursement shopped, but only 26 percent offering neither did. The reason 61 percent of non-shoppers offering insurance gave for not exploring options was that they simply renewed the policy or plan they had (Q#2a). Apparently, they were satisfied or thought they couldn't do any better. Another 29 percent did not shop because they were locked into a longer term commitment. The latter group seems to have avoided the problem of cost uncertainty, a major concern of small employers.

The two principal reasons small-business owners shopped were to look for a lower per employee cost (45%) and just to see what was available (42%) (Q#4). Only 5 percent searched for a different benefit package and 1 percent a different provider network. Three percent searched specifically to cut administrative cost and hassle. The two major reasons for shopping, one

specific and one general, were associated with offers of insurance. Over 60 percent of those offering health insurance shopped for a lower per employee cost, while over 60 percent of those offering premium reimbursement or not offering were looking to see what was available.

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a. Who Shops

The most frequent shopper is the business owner or manager. He or she was the shopper on the firm's behalf in 46 percent of cases (Q#3). This was particularly common among owners of the smallest (52%) though much less so among owners of the largest (28%). Still, half engaged either an employee (23%) or an agent or broker (27%) on their behalf. The largest employers were much more likely to use them (an employee, 33% - an agent or broker, 36%) for the task than the smallest (an employee, 23% - an agent or broker, 27%).

The amount of time small employers spend shopping for employee health insurance (including learning about different plans, analyzing options, making inquiries, and determining employee needs) is limited. The median is about six hours (Q#3a). However, 26 percent spend two hours or less while 13 percent spend 16 hours (2 full days) or more. While the number of respondents is thin, shoppers offering health insurance appear to shop longer than shoppers not offering it and owners of larger firms appear to spend more time than owners of smaller firms. Still, it seems odd that small employers spend so relatively little time on a major cost item with which they are generally displeased. It also challenges the idea that small employers are better consumers of employee health insurance than is the employee him/herself.

The search time data do not account for the time employees or outside agents spend shopping for employee health insurance on the firm's behalf. That means the calculation is dominated by the smallest employers. As a result, the calculation is not equivalent to the total time spent searching for employee health insurance.

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b. Exploring Options

Small employers searching for employee health insurance can investigate a broad variety of information sources to help them. One of the most accessible and intriguing is the Internet. Yet, relatively few small employers use the Internet to explore their options for purchasing employee health insurance. Just 24 percent used the Internet for that purpose in the last three years (Q#5). Reversing the typical distribution of Internet use, shoppers from the smallest firms (employing 1 - 9 people) used the Internet more frequently than did others. Twenty-nine (29) percent of owners with the smallest businesses explored the Internet for information on their employee health insurance options compared to 12 percent of owners with the largest. These numbers are somewhat deceptive since owners of larger firms more often delegate responsibility for shopping. Survey respondents may not be familiar with the agent's search process in those instances.

Another area of potential search is directly with a network of health care providers, such as an HMO. Contacting Kaiser directly is an example. Nearly half (48%) took this step in the search process (Q#6). Differing from the Internet, employee size-of-business was not associated with these contacts. But while making this contact twice as frequently as searching the Internet, few small employers actually purchase their health insurance from a provider network.

State governments have increasingly become active in efforts to help small employers obtain employee health insurance. They range from matching services, such as in Maryland, to subsidized products, such as in Tennessee. These activities appear to be generating interest. Sixteen (16) percent of small employers explored options in a government-organized or sponsored small-business health insurance program (Q#7), though a very small percentage participate as will be seen later.

The survey asked those who did not explore the potential government option, why they had not done so. The most common answer (60%) was that they did not know of any (Q#7a). This response reflects the limited help that most states provide; it does not constitute out-of-hand rejection of them. Twenty-one (21) percent do reject them. These owners say that they would not participate in a government program. Nine percent did not explore such options because they believed better options exist in the commercial market and 6 percent think they are not eligible to participate.

Another source of employee health insurance might be a business trade organization or association. About half of all small employers belong to such organizations. Legislation was recently impeded by the Congress that would have allowed associations of small businesses to broaden insurance pools, effectively giving them greater market access. Still, many

business groups have arrangements with insurers to sell small employers employee health insurance. Thirty-four (34) percent of small employers explored the trade association option the last time they shopped for health insurance (Q#8).

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c. Agents and Brokers

The insurance agent or broker dominates the insurance knowledge base and insurance transactions of most small employers when they shop for employee health insurance. Eighty-seven (87) percent of those who either have employee health insurance or who have shopped for it in the last three years have discussed their options with an insurance agent or broker (Q#9). The employee size of the employer's enterprise is unrelated to the likelihood of discussing options with these insurance professionals.

Most small employers speak with a limited number of agents or brokers. Thirty-one (31) percent discuss their options with a single agent or broker, though discussions with two (27%) or three (26%) are common (Q#9a). Few shop with more. Owners currently covering all or most full-time employees constitute the group most likely to consult only one.

The relationship between agents/brokers and small employers vary, though the former is obviously always a potential vendor and the latter is always a potential customer. Asymmetric information and a lack of competition can influence and even effectively change those roles, however. Such changes appear more than hypothetical. The small employer appears to dominate the relationship in 15 percent of cases, telling the agent/broker what he/she wanted and giving him/her a budget within which to work (Q#10). Another 22 percent simply told the agent/broker what he wanted. These situations are what one would expect in a vendor/customer relationship except under conditions of scarcity. Save the 3 percent who offered another answer or did not know, the agent/broker appeared to dominate the relationship in the remainder of cases. Twenty-four (24) percent had the agent/broker simply explain the available options. A plurality (35%) had the agent/broker explain the available options and make a recommendation. The result is that in 37 percent of cases, the small employer told the agent/broker what he/she wanted. In 59 percent of cases, the agent/broker told the small employer what was available.

The presence of Health Savings Accounts (HSAs) in discussions of potential employee health insurance puts dominance in the relationship in perspective. Health Savings Accounts (HSAs) are an insurance option that is attractive to some, though not all, small employers. It offers them the prospect of considerable cost saving and the possibility of offering some employee health insurance coverage when they otherwise might not. So, HSAs should be at least a topic for discussion between agents/brokers in their role of advisor and their small-business customers. That often does not happen. Forty-six (46) percent of small employers report that in such discussions, the topic never arose; HSAs were not mentioned (Q#11). Still, 30 percent thoroughly discussed HSAs and another 18 percent mentioned them. Among the 48 percent who discussed HSAs, however, small employers were the party who raised the subject in one of three cases (Q#11a). Thus, agents/brokers did not raise the HAS option 59 percent of the time; raised it in 29 percent of cases; and, no information is available on the remaining 12 percent. Since agents/brokers have little financial incentive to sell HSAs compared to traditional insurance, the failure of almost three in five to mention the HSA option suggests the agent/broker role is more a role of vendor than a role of advisor/information provider.

Insurance is not the only industry where asymmetric information puts the vendor in an advantageous business position. The vendor is often, if not usually, more likely to know more about the product or service than the customer, particularly when the purchase is infrequent, small or both. The cost of employee health insurance argues that the owner or a designee should not be in a position where the information asymmetries are not as great as they currently appear to be.

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d. Employee Input

A majority of small employers (55%) asked for employee input when shopping for or making decisions about employee health insurance (Q#12). Forty-five (45) percent did not.

According to small employers who engage their employees, employees were more likely to express concern about cost than any other aspect of health insurance. Half (50%) of the small employers who asked for employee input got the general sense that employees most wanted low out-of-pocket costs (Q#12a). They, therefore, preferred things like minimal cost sharing, modest deductibles and co-pays, etc. Another 20 percent wanted substantial benefits in their plan. The word substantial is open

to interpretation, but it is clear this segment of employees focused on the benefit package. Eleven (11) percent just wanted some health insurance coverage. Presumably, this group wanted to be covered in case of a financially consequential event. Such a preference was typically expressed by employees in firms without coverage. Eight percent of small employers discovered no discernable employee consensus in benefit preference. That number appears modest given the diversity of employees in many small businesses, e.g., young and old, and the inability to offer no more than one plan. Another 7 percent reported that their inquiries yielded little or no employee interest in health insurance. Only 2 percent volunteered other interests with a different provider network scarcely ever mentioned.

The reasons small employers gave for not gathering employee input, when they did not, varied much more than the small employer summation of employee preferences. The most frequent response, though registered by only 12 percent, is that they did not want employee input (Q#12b). To paraphrase one employer comment, I pay for it so I decide what it will be. Another 12 percent reported that they did not ask employees because they did not want to raise employee hopes when it was not yet clear what they would do, i.e., have a plan or not. Eight percent thought employees would not know what they wanted (so, why ask?); another 8 percent cited various cost issues; 7 percent believed the decision time was too short to ask; 6 percent were concerned that employees would have different preferences and the business could only offer a single option; and, another 6 percent had a plan and presumably did not want to change it. The remaining reasons created a groaning smorgasbord as 30 percent were clumped in the "Other" category with no single component constituting even 5 percent.

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Purchasing Health Insurance

Seven of 10 (71%) small employers offering employee health insurance purchased their coverage through an insurance agent or broker (Q#13). The next most frequent source was directly from an insurer, not over the Internet. Still, just 11 percent purchased their employee health insurance in that manner. Through a business organization or trade group was the third most frequent (8%) followed by direct purchase from an association of providers (5%). Finally, only 1 percent purchased theirs directly from an insurer over the Internet.

Though nearly 12 percent of small employers explored government options when searching for employee health insurance, few purchases either directly or indirectly involved government. Just 2 percent of purchases involved some government program such as sponsoring or organizing a program, matching businesses with private insurers, etc. (Q#13a).

While the present focus is on the purchase of employee health insurance, some small employers purchase other forms of employee health care and wellness. Thirteen (13) percent of small employers, including 23 percent employing more than 20 people, provide full-time employees health benefits other than health insurance or premium reimbursement (Q#14). These benefits usually are over-and-above the health insurance or premium reimbursement already given rather than in lieu of them. In other words, they are not substitutes, but complements to the more conventional health benefits offered.

The specific additional health benefits offered vary notably. Various types of reimbursements head the list of the largest share (57%), followed by health club memberships (18%), and paid physicals or screenings, e.g., blood pressure, cholesterol (9%) (Q#14a).

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The Magic 7.5 Percent of Payroll

Some authority apparently suggested that 7.5 percent of payroll is the "right" amount for an employer to spend on employee health care benefits. Though entirely arbitrary and arguable, the 7.5 percent figure has found its way into legislative ideas and proposals. So, the question for present purposes becomes: how much are small businesses spending for employee health care?

Forty-three (43) percent of small businesses offering employee health insurance or premium reimbursement spend 7.5 percent or more of payroll on employee health benefits (Q#15). Thirteen (13) percent do not know, underscoring the artificiality of the number. But assuming those not offering either health insurance or premium reimbursement do not have employee health care spending that reaches that magic number, no more than 20 percent of small, employing businesses pass the spending litmus test. Twenty-seven (27) percent of those spending at least 7.5 percent of payroll or about one in 20 small employers actually spend 15 percent or more of payroll on employee health benefits (Q#15a).

Reaching the 7.5 percent spending level is not associated with providing employee health insurance to *all* or *most*, rather than

some or few, of one's full-time employees. But it is associated with premium reimbursement. Those who offer premium reimbursement have proportionally fewer who reach the 7.5 percent threshold than those who offer insurance regardless of the proportion of full time employees covered.

Treatment of part-time employees and their share of payroll can exercise an enormous influence on calculating the 7.5 percent. Part-time employees can be included, included on a pro-rata basis or excluded. The choice is significant in numerous ways given that 47 percent of small employers not offering employee health insurance currently have part-time employees only (Q#16). These firms accounted for one-third of the employees (full-time and part-time) within small businesses that do not offer health insurance. The figures presented here intuitively seem high. The apparently large percentage could be explained by allowing the respondent to define the term "part-time" and the difference in the concepts of currently having part-time employees only and having only part-time employees throughout the year. Regardless, there is no doubt part-time employees are staples in many small businesses. Keeping the survey numbers and excluding firms currently with part-time employees only, means that the proportion of small employers affected by a 7.5 percent of payroll mandate falls from about 80 percent of the population to between 60 and 65 percent.

The survey asked small employers not offering either employee health insurance or premium reimbursement or whose firms do not consist entirely of part-time employees their reaction to two basic legislative approaches to increasing health care coverage. The first involved requiring small employers to spend at least 7.5 percent of payroll on employee health benefits or pay a tax amounting to 7.5 percent of payroll. The idea would apply to full-time employees only. The term of art for the generic proposal is "pay or play."

The most frequently mentioned reaction (25%) to a pay or play proposal (7.5% of payroll qualifies as playing) is to shift some full-time employees to part-time work (Q#17). The purpose of shifting an employee(s)' status would be to avoid counting them either for insurance or tax purposes thereby eliminating new payroll costs. The second most frequent reaction (20%) to the pay or play proposal is to increase payroll and health benefits to 7.5 percent of payroll as proponents of such a proposal hope. But, 13 percent indicate that they will eliminate some employees altogether; 13 percent more indicate that they would not increase payroll costs, but would pay for the 7.5 percent in health care by shifting non-health benefits and/or wages into health; and 10 percent would pay the tax. Six percent volunteered other reactions, though they did not include offering health insurance. Still, another 10 percent were not certain what they would do and 4 percent volunteered they would have to close. Those figures sum to 33 percent who would likely institute health coverage and 57 percent who likely would not (10% undecided). They also sum to 30 percent who expect to directly increase their costs in the short term and 54 percent who expect to directly shift the cost to their employees (in the form of less employment and/or reallocated compensation) in the short term (6% not clear and 10% undecided). While it is doubtful those expected compensation shifts could always be made immediately, they will likely be made on an expedited schedule with employees paying the bill sooner rather than later.

Some small employers may combine their first course of action with a second. But in this instance, 48 percent who identified a course of action to the pay or play proposal indicate that they would use only the first one they selected (Q#18). Another 9 percent were undecided. The remaining responses were scattered, but more often focused on eliminating employees and/or shifting hours than paying the tax or increasing insurance offerings.

A variant of the prior pay or play proposal would require small employers to offer employee health insurance and pay a specified minimum, in this case 60 percent of the premium, or pay a tax, in this case 7.5 percent of payroll. The choice was presented small employers not offering either employee health insurance or premium reimbursement, or whose firms consist entirely of part-time employees. No option to adjust was included; the choice was simply to buy insurance or pay the tax. Thirty (30) percent selected the purchase health insurance option of which half said they would do so definitely (Q#19). Thirty-six (36) percent chose to pay the tax, 13 percentage points said they would do so definitely. Again, 11 percent did not know what they would do under the circumstances and 5 percent created alternatives to the direct choice. But 20 percent, one in five, volunteered that neither was possible; they could not do either; they would be forced out of business. That is 20 percent of the number who do not already offer or whose firms do not currently consist exclusively of part-time employees. Still, the figure is in the high single digits (6 - 9%) of the small employer population.

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Final Comments

A small, but likely growing, segment of the small-business population is moving toward a defined contribution-type funding mechanism for their employee health insurance. The current survey shows about 6 percent of the population (almost 13 percent of those funding insurance) adopt this course. Some analysts think the practice may not be legal under HIPPA, but without a

definitive legal ruling to the contrary the practice will continue and grow. As a practical matter in addition, the practice is almost impossible to regulate as premium reimbursement could appear in an infinite variety of forms. The lack of a tax exclusion for employees (differing from those obtaining insurance through their employer) is a financial handicap, limiting use of the option. Equalizing the tax treatment of health insurance through private purchase would change the incentive structure both for employers and employees to encourage greater use of it and create more equitable treatment for those exercising the option. But this development, coupled with new firms being more reluctant to introduce the benefit, argues that market conditions are pushing small employers in new and different directions in their relationship to employee health insurance.

Shopping for employee health insurance is infrequent (48% shopped over the last three years) and limited (the median shopping time for owners being about five to six hours) considering the significant costs involved. These responses to a real problem are counter-intuitive. The question then becomes: why? Why is it that small employers do not spend more time and effort shopping when the cost for employee health insurance is so high? There are two likely answers, neither of which is encouraging. The first is that insurance is so complicated and the owner is so busy that they cannot allocate enough time to become sufficiently knowledgeable. One manifestation is that the owner designates someone to shop on the firm's behalf. In 30 percent of cases that person is not associated with the firm and is almost always a vendor. The second is that there is effectively no difference in plans. They all provide about the same benefits and at very high prices. There is no choice, no competition. And, in fact, the small group market in many states has a limited number of competitors and is all but dictated by a Blues monopoly. So, why shop?

The relationship between small-business owners and their insurance agents or brokers, many of which are small-business owners themselves, is curious and not necessarily healthy. Small-business owners typically lack knowledge about insurance and do not help themselves by avoiding that readily available on the Internet to neutralize the information asymmetry. Still, insurance professionals often provide valuable information not unlike other professionals in their specialties. So, the question becomes: when is the agent working in the client's best interests and when is he working in his own? There is no good answer. But the small-business owner must understand enough insurance to suspect he knows the answer in his particular case.

Finally, pay or play legislative proposals are likely to encounter the law of unanticipated consequences, at least for many proponents. When presented a choice that they might face under such proposals, comparatively few small employers chose the insurance option and comparatively many chose the employment reduction (hours or people) option. Moving people to part-time work is a particularly attractive option. In fact, the treatment of part-time employees will have an enormous influence on the response of small-businesses to any pay or play proposal. The treatment of these employees will alter relative costs in one direction or the other, providing small employers' strong relative incentive to change employment among the two groups. If part-time employees are included, small employers have an incentive to eliminate as many part-time employees as possible and spread a fixed health care cost over full-time employees. If part-time employees are excluded, small employers have an incentive to curb full-time employment and transform them into part-time positions. The capacity to eliminate full-time employees and substitute part-timers was illustrated earlier by the number of firms that currently have no full-time employees. This trade-off raises an interesting policy dilemma, one that has drawn little attention to date. But the idea that pay or play will yield huge new numbers of covered employees or vast sums to pay to cover the uninsured is likely a panacea.



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Sponsor Statement

HB 187 INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

Autism is a devastating disorder affecting at least 1 in 100 children, accounting for 1% of America's youth and 1 in 58 boys, according to the most recent study by the Center for Disease Control and Prevention. Despite being treatable, many children diagnosed with an Autism Spectrum Disorder (ASD) never receive the treatment they need. Families go bankrupt mortgaging their future, trying to provide their children with the treatment to ameliorate their condition. Families are forced to dig into their savings, retirement funds, and their other children's college savings because ASD is not covered by insurance plans. In fact, most insurance plans explicitly exclude the treatment of ASD, even when the service is otherwise covered by the health plan.

HB 187 would require insurance coverage for autism spectrum disorders, including the behavior therapies that after 30 years of study have shown to be the only effective treatment of these disorders. Treatment has been shown to improve the symptoms of ASD and in some cases even eliminate the need for special education services for a child with ASD. The cost savings in special education alone would amount to approximately \$208,500 per capita during the school years. This number rises to over \$1.08 million over the autistic person's lifespan.

The incremental societal cost of not treating autism has been estimated by Michael Ganz, a Harvard economist, to be approximately \$3.2 million per capita. The cost to policy holders to implement such coverage is minimal: estimated at less than a 1% increase in their premiums, or \$3.60 per member per month.

Furthermore, President Obama has stated the coverage of treatment and other types of funding for ASD would be a priority of his administration. Sens. Durbin, Casey and Menendez introduced the Autism Treatment Acceleration Act of 2009 in April, mandating the insurance coverage of ASD. While the federal legislation is currently pending, HB 187 allows Alaska to start this process on our own terms, and gives the state the needed time to meet the demands created in HB 187.

Implementing this legislation in Alaska before a federal mandate is enacted would bring well-paying healthcare jobs to the state and bring those interested in this field to Alaska. It is in the best interest of Alaska and autistic Alaskans to have this implemented as soon as possible.

Since HB 187 was introduced in March of 2009, 11 states have passed legislation regarding mandatory insurance coverage of treatment for ASD, with 8 states having enacted legislation prior to March of 2009. The District of Columbia, Puerto Rico and 19 additional states currently have similar legislation pending. These enacted and pending bills and the pending Autism Treatment Acceleration Act demonstrate the nationwide need for relief for families of autistic individuals. Autism is not a state- or region-specific condition. Families burdened with the costs of autism are unlikely to relocate to one of those 11 states that require insurance companies to cover the cost of ASD treatment. Families of any state should not be burdened with the great cost of treating a disorder they could not prevent or predict; they should not find themselves a victim of discrimination by health insurance companies.

Insurance coverage of ASD would not only provide a much needed service to those families burdened with the effects of a child with autism, but also save the state and taxpayers exponentially over the lifespan of those diagnosed with autism. Though there is no cure for ASD, this legislation would help significantly to treat those suffering from these disorders. In addition, a state that covers ASD treatment will be desirable to those in the field and will bring jobs and professionals in the field to Alaska. It will also allow more flexibility for families with autistic children who wish to move to Alaska to do so. Prompt passage of this legislation would allow the state to reap the health and economic benefits that would result from being among the first states to cover ASD.

I respectfully ask for your careful consideration and support of HB 187.

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Representative Pete Petersen
District 19

MEMORANDUM

TO: Members of the House Health & Social Services Committee

FROM: Representative Pete Petersen

DATE: January 18, 2010

RE: Redistribution of April 3, 2009, memo regarding hearing held March 24, 2009

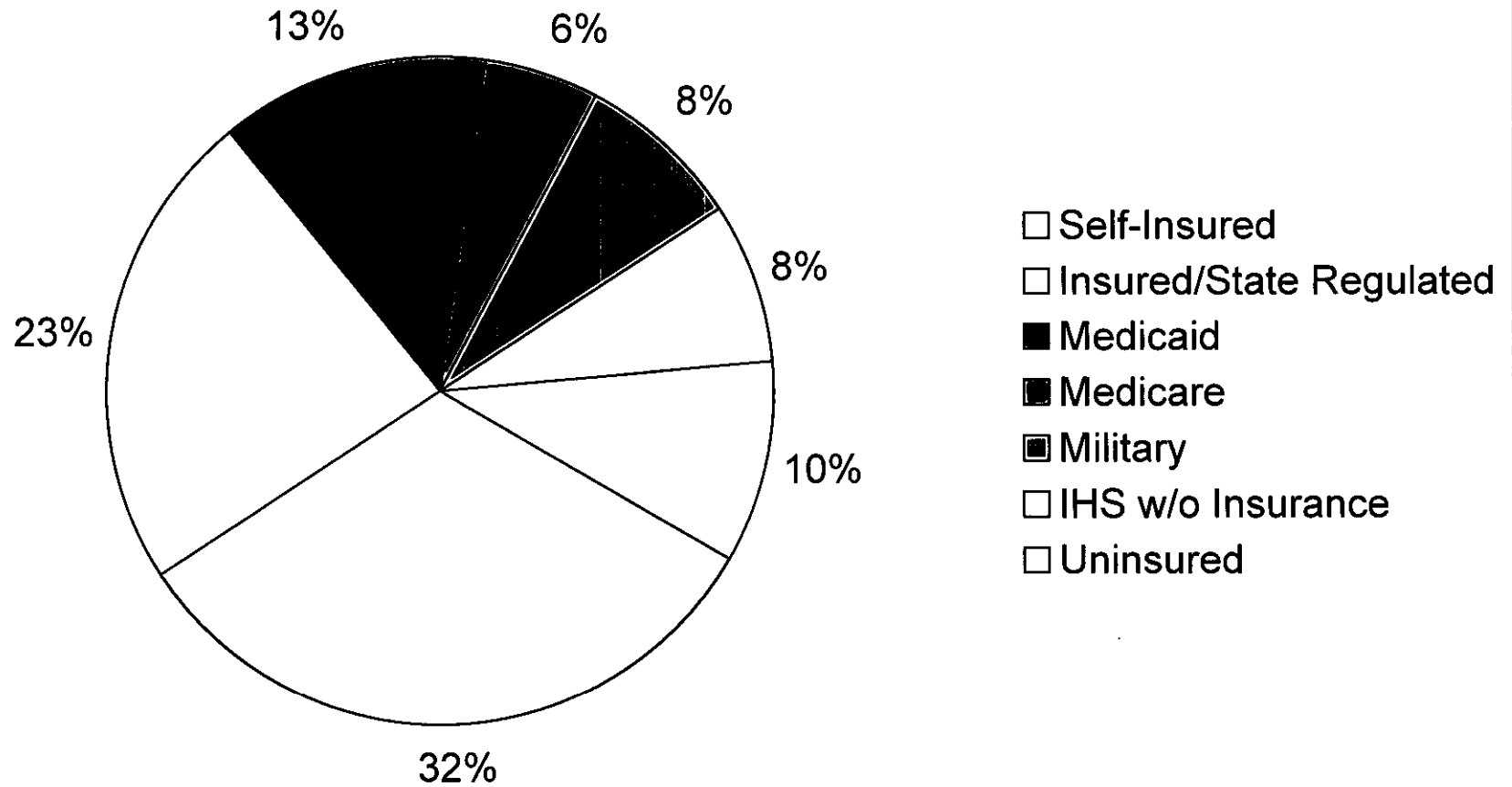
The following information pertains to questions received during the (H) HSS meeting held on March 24, 2009:

1. RE: Age of covered participants. The bill allows those under the age of 21 to access services for Autism Spectrum Disorders (ASD). This age is consistent with both Medicaid coverage in Alaska, and is a reasonable age in regards to private insurance coverage. Many plans cover dependent children up to a certain age, generally through the college years. Therefore 21 is a reasonable age at which to discontinue these services.
2. RE: out-of-state coverage. If services rendered out-of-state were not available in Alaska, yes, insurance companies would have to cover those out-of-state services—just like they cover those services not available here in Alaska for any number of other health related issues. However, the claims cap would still remain at \$36,000 per year per child. As noted by many of the parents who testified, even the \$36,000 doesn't always cover the needs of the child. Seeking services outside of Alaska would raise the cost for services, and that \$36,000 would not go very far. In addition, except for children who require hospitalization care, ABA is best delivered in the child's own environment which could include home or school. Behavioral treatment sought outside of Alaska would likely be for the most severe cases, including aggression and self-injury, that could not be managed in facilities in the state. Moreover, it is unlikely these more costly forms of treatment would be sought out-of-state due to the nature of such treatment. While ABA

professionals may have to come into the state from outside for the initial treatment plan prescription, the 1-on-1 services are customarily given by someone in the child's immediate community. The treatment is then monitored by the ABA professional, a process that could be done utilizing telemedicine.

3. RE: Sustainable market for ASD service providers. There was a question posed as to whether the percentage of Alaskans covered by this legislation would be enough to sustain the industry of autism service providers. For this question I think it is important to refer to the pie chart provided by Linda Hall at the Division of Insurance (attached). This chart identifies the types of insurance held by Alaskans. The original report containing this breakdown of Alaska's population was done in 2003. However, the division has adjusted the numbers for the 2008 population. I will discuss each section beginning with the Self-Insured at the top of the key:
 - a. Self-Insured plans are not currently subject to state mandates. They are protected, as was stated in the committee, by Federal ERISA preemption. There is a Federal ERISA mandate that was filed on April 2, 2009, that made this 32% of Alaskans subject as well, and allow those families to access services.
 - b. Insured/State Regulated are the plans that are directly affected by HB 187. This 23% is very close to the 25.3% projected by the cost analysis done by Jim Boudier. His figure of 45.5% was in reference to group-insured Alaskans, which fall under HB 187, and contains about 25.3% of the total population of Alaska—not far off from the 23% cited by the Division of Insurance.
 - c. Medicaid in Alaska currently provides some treatment for ASD. It is the primary method by which Alaskan families access these services, however limited the coverage might be. Many families, as we heard, are fully insured, but don't have coverage for the treatments their children need. These families persistently apply for Medicaid waivers to access these funds, but the waiting list can be years, which is not time that autistic children have to spare. In addition, insured families are adding stress to what is already an overburdened system.
 - d. Medicare would likely not be a significant contributor to or drawer from any of these services.
 - e. Military families already have access to some ASD treatments, including ABA as provided in the federal TRICARE ECHO program for families with children with disabilities.
 - f. IHS, or Indian Health Services, is a benefits program for American Indians and Alaskan Natives. IHS draws funds to cover treatment, for those who qualify, from several different sources including Medicaid and private health insurance. The issue of coverage for the treatment of ASD has not come up with IHS due to the fact that they currently draw from places like Medicaid and private insurance to cover other services and it is likely they would do the same for services requested to treat ASD.
 - g. HB 187 would not affect the uninsured group of Alaskans.

Health Coverage of Alaska Population



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Archive for Monday, October 05, 2009

CDC survey finds higher incidence of autism 1 in 100 8-year-olds in U.S. diagnosed

By Trine Tsouderos
October 05, 2009

About 1 in 100 8-year-old children in the U.S. have been diagnosed with autism spectrum disorder, according to U.S. Centers for Disease Control and Prevention researchers who will be releasing details of their study later this year.

The rate – significantly higher than the government's 2007 estimate of 1 in 150 – is sure to make waves in the world of autism and beyond, prompting advocates and researchers to call for more research and more funding for services.

Calling autism "an urgent public health concern," CDC Deputy Director Dr. Ileana Arias said the agency considers the disorder "a significant issue that needs immediate attention."

But researchers cautioned that the higher rate might not mean that more kids have autism spectrum disorder.

"It is not entirely clear what (the) increase is due to," said Dr. Thomas Insel, director of the National Institute of Mental Health. "It is not clear more children are affected rather than just changes in our ability to detect."

The rate, calculated by reviewing records in communities across the U.S., echoes findings of a national telephone survey of parents that is being published Monday in the journal *Pediatrics*.

The survey, conducted by the CDC and the Health Resources and Services Administration, asked parents of 78,000 children ages 3 to 17 whether a health care worker or doctor had ever told them their child had autism spectrum disorder.

Parents of 1 in 91 children said yes and also said their child currently has the disorder. For boys, the figure was 1 in 58.

Dr. Steven Goodman, an epidemiologist with Johns Hopkins Bloomberg School of Public Health, said he agrees prevalence is higher than years ago and merits concern, but warned against panic.

"This has the tremendous potential to scare people," Goodman said. "It is very unlikely that there has been an explosive increase in the way that has been portrayed in the media."

Autism has no known cause and no cure. Scientists think it may be many distinct problems that manifest themselves similarly. Children afflicted often have trouble communicating and socializing, and can exhibit repetitive, rigid behavior.

Diagnosing autism relies on observation, behavioral checklists and expert assessment rather than lab tests or X-rays, making it hard to determine how common it is.

Interpreting data can be a thicket too. Growing awareness, wider screening and a push to identify children earlier accompany the rise in the rate, but scientists have not figured out whether other factors are also at play.

Advocates in the autism community called for more funding for research.

"We have this amazing terrible national health crisis on our hands at this moment," said Lee Grossman, president of the Bethesda, Md.-based Autism Society and the father of a child with autism. "We have millions of people affected by this, and the services and supports available to them are inappropriate and inadequate and in some cases a detriment."

The grandfather of a child with autism, Bob Wright, co-founder of New York City-based Autism Speaks, said: "We are trying desperately to have the health and research assets to be aligned with the prevalence of autism and so far they are way behind."

ttsouderos@tribune.com

Doing the math

The researchers' new estimate would mean about 673,000 U.S. children have autism. Previous estimates put the number at about 560,000.

But figuring out how many children have autism is difficult because diagnosis is based on behavior, said Dr. Susan Levy of the Children's Hospital of Philadelphia and the American Academy of Pediatrics subcommittee on autism.

"As of yet, there's no consistent biologic marker we can use to make the diagnosis of autism," Levy said.

President Barack Obama has made autism a priority for research, said Dr. Thomas Insel, director of the National Institute of Mental Health. Federal stimulus money has been earmarked for autism.

And before Obama took office, a 2006 law pumped millions in federal money into research, screening and treatment. For more information on autism go to:

American Academy of Pediatrics: www.aap.org

CDC: www.cdc.gov/ncbddd/autism/

Health Resources and Services Administration www.hrsa.gov/

— Associated Press

Contact the Senator font size:



ON WORLD AUTISM DAY, DURBIN, CASEY, MENENDEZ INTRODUCE BILL TO ESTABLISH A NATIONAL COMPREHENSIVE AUTISM STRATEGY

Legislation would require insurers to cover autism diagnosis and treatment

April 2, 2009

WASHINGTON, DC- On a day designated by the United Nations to highlight the growing global health crisis of autism, Assistant Senate Majority Leader Dick Durbin (D-IL) and U.S. Senators Bob Casey (D-PA) and Robert Menendez (D- NJ) today introduced legislation that would create a comprehensive strategy to address the needs of families affected by autism spectrum disorder. The Autism Treatment Acceleration Act requires health insurers to provide coverage for the diagnosis and treatment of autism and authorizes federal funding for a wide range of service, treatment, support and research initiatives.

"Almost 26,000 families in Illinois struggle with autism," said Durbin. "Because the cost of autism-related services is so overwhelming for these families, Illinois passed legislation last year requiring health plans to provide coverage for the diagnosis and treatment of autism. It's time now for the federal government to renew and build upon the commitments it has already made in helping the millions of families across the nation struggling with autism. Our legislation would do that."

"Children and adults with autism spectrum disorders and their families have long struggled to get the services and treatment they need to lead rich and productive lives," said Casey. "Today, we launch a momentous effort to change an unacceptable status quo for the 18,500 children who are diagnosed in Pennsylvania each year with autism spectrum disorders and the hundreds of thousands of additional individuals across the country. This bill will help children get the services and treatment they need for the most positive life outcomes, for young adults and adults to have the support they need for satisfying and independent lives, and for families to have the peace of mind to provide and afford the proven treatments that will allow their children and loved ones to reach their fullest

04/02/09 ON WORLD AUTISM DAY, DURBIN, CASEY, MENENDEZ INTRODUCE BILL TO ESTABLISH A NATIONAL COMPREHENSIVE AUTISM STRATEGY -

04/02/09 Casey, Snowe Launch Effort to Expand and Enhance Recovery.gov -

04/02/09 Casey Carbon Capture Amendment Passes Senate -

04/01/09 Casey Applauds Tax Break for 4.8m Pennsylvania Families -

04/01/09 Casey Bill Would Improve the Lives of Older Citizens and Direct Care Workers -

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potential."

"With the growing reach of this disorder, millions of families are personally affected by autism and millions more new families are wondering if they will be too. Nowhere is this felt more than in my home state of New Jersey, where we have the highest rate of autism in the country at an astounding one in every 94 children. We badly need a national strategy that will ensure families affected by autism not only have a strong support structure but also are not left to drown in the financial costs of caring for their loved ones. From services to insurance coverage to public awareness, this legislation would make a real difference in the lives of these families, and we are hopeful that we can get it passed into law," said Menendez.

Today's legislation builds on the Combating Autism Act, signed into law in December 2006. That bill called on the federal government to increase research into the causes and treatment of autism, and to improve training and support for individuals with autism and their caretakers. This bill demonstrated the commitment of Congress to begin to delve deeper into this critically important issue for millions of families.

The Centers for Disease Control (CDC) estimate that approximately 1 in 150 people in the United States has autism or autism spectrum disorder. Individuals with autism often need assistance in the areas of comprehensive early intervention, health, recreation, job training, employment, housing, transportation, and early, primary, and secondary education. Greater coordination within these service delivery systems will enable individuals with autism and their families to access the best and most current treatment, services and research for their individualized needs - and to do so throughout the lifespan of individuals.

The Autism Treatment Acceleration Act aims to meet the comprehensive needs of, and improve the quality of life for, individuals with autism and their families by:

- Requiring that insurers provide coverage for the diagnosis and treatment of autism including Applied Behavioral Analysis therapy and assistive communication devices;

- Creating a demonstration project to develop Autism Care Centers. These centers would provide a full array of medical, behavioral, mental health, educational and family care services to individuals and families in a single location. These comprehensive treatment facilities would increase access to quality health care services and communication among health care providers, educator and other providers of services;

- Creating a demonstration project to provide a full array of services to adults with autism to improve their quality of life and enable them to live as independently as possible;

- Establishing a voluntary population-based autism case registry to help understand the root causes, rates, and trends of autism;

- Developing a national multi-media campaign to increase public education and

awareness about healthy developmental milestones and autism throughout the lifespan;

- Establishing an Interdepartmental Coordinating Committee - consisting of representatives from relevant governmental agencies, researchers and the public - to coordinate government activities relating to autism;

- Establishing a national autism network to strengthen linkages between research and service initiatives at the federal, regional, state and local levels and facilitate the translation of research on autism into services and treatments that will improve the quality of life for individuals with autism and their families;

- Creating a national training initiative on autism and a technical assistance center to develop and expand interdisciplinary training and continuing education on autism.

"Autism Speaks is proud to have worked with Senators Durbin, Casey and Menendez on this legislation, which represents a remarkable leap forward in the federal government's commitment to addressing the challenges faced by individuals with autism and their families," said Elizabeth Emken, Autism Speaks vice president of Government Relations. "The insurance reform section of the bill, in particular, will have an enormous impact by finally requiring insurers to cover therapies that are literally causing families across the country to go broke as they try to provide their children with the services they need and deserve."

"This is the bill we have been waiting for for generations," said Lee Grossman, President and CEO of the Autism Society of America. "The adult services focus, care centers, national teacher training, and insurance components of this bill will complement and strengthen the important research currently underway. Moreover, this bill creates opportunities for states to develop solutions that are locally driven and relevant. As an advocate, and as a father, my heartfelt thanks to Senators Durbin, Casey, and Menendez for their efforts to help the millions of Americans affected by autism today."

Children and adults with autism spectrum disorders can show difficulties in verbal and nonverbal communication, social interactions, and sensory processing. Symptoms and behaviors may range from mild to significant, and require varying degrees of support from friends, families, service providers, and communities. There is strong consensus within the research community that intensive treatment as soon as possible following diagnosis not only can reduce the cost of lifelong care by two-thirds, but also yields the most positive life outcomes for children with autism spectrum disorders. These individuals have a right to live lives that are as full, productive and independent as possible - and with the right services, support, and treatments, they can do just that.

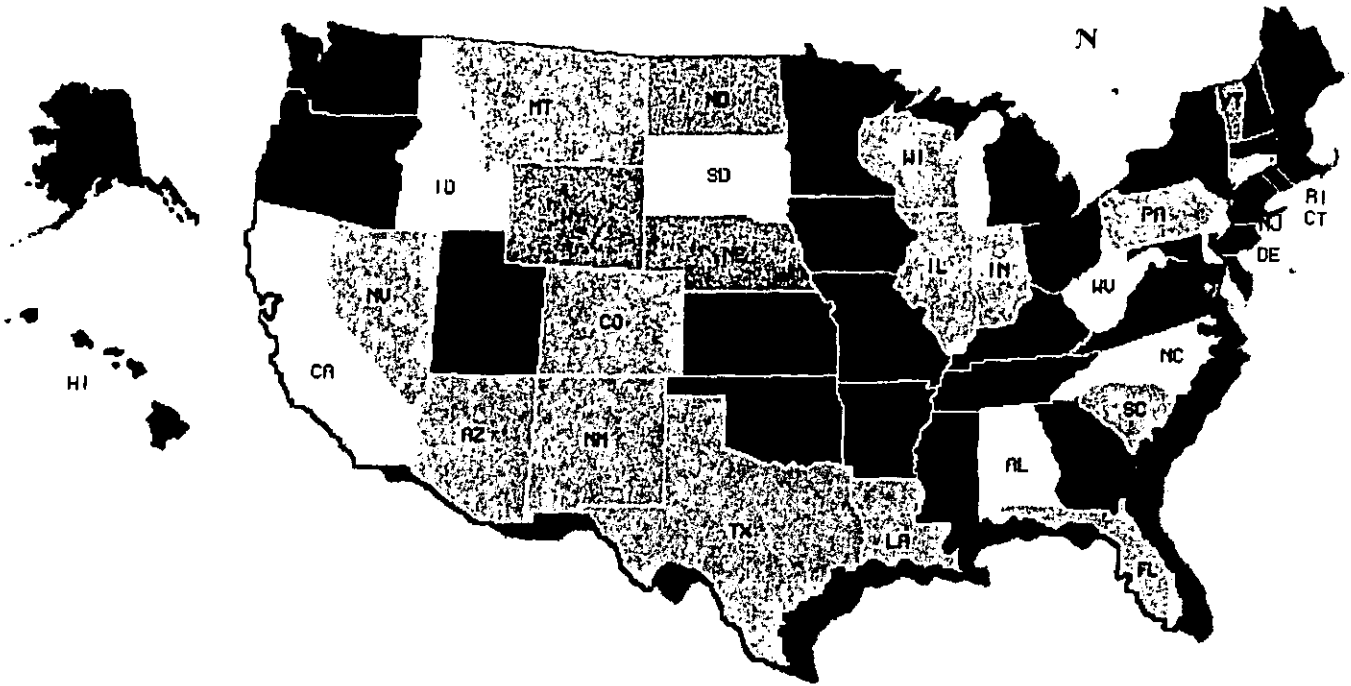
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Autism Speaks 2009 State Autism Insurance Reform Initiatives



				States with Pending Autism Insurance Reform Bills		
Arizona	Maine	Alaska	Alabama	Nebraska		
Colorado	Massachusetts	Arkansas	California	North Dakota		
Connecticut	Michigan	Georgia	Delaware	Rhode Island		
Florida	New Hampshire	Hawaii	Idaho	Vermont		
Illinois	New York	Iowa	North Carolina	Wyoming		
Indiana	Ohio	Kansas	South Dakota			
Louisiana		Kentucky	Wash., DC			
Montana		Maryland	West Virginia			
Nevada		Minnesota				
New Jersey		Mississippi				
New Mexico		Missouri				
Pennsylvania		Oklahoma				
South Carolina		Oregon				
Texas		Tennessee				
Wisconsin		Utah				
		Virginia				
		Washington				

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Representative Pete Petersen
District 19

MEMORANDUM

TO: Representative Wes Keller, Co-Chair
Representative Bob Herron, Co-Chair
Health & Social Services Committee

FROM: Representative Pete Petersen

DATE: March 13, 2009

RE: Hearing Request for HB 187

Dear Representatives Keller and Herron,

I respectfully ask that you schedule a hearing for **HB 187 Insurance Coverage: Autism Spectrum Disorders**, in the House Health and Social Services Committee. Attached is the information requested. Please feel free to contact my aide Ashley Rousson at 465-4939 if you need anything further.

Thank you for your consideration of HB 187.

Alaska State Legislature

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Representative Pete Petersen
District 19

MEMORANDUM

TO: House Health & Social Services Committee

FROM: Representative Petersen

DATE: 3 March 2009

RE: HB 187

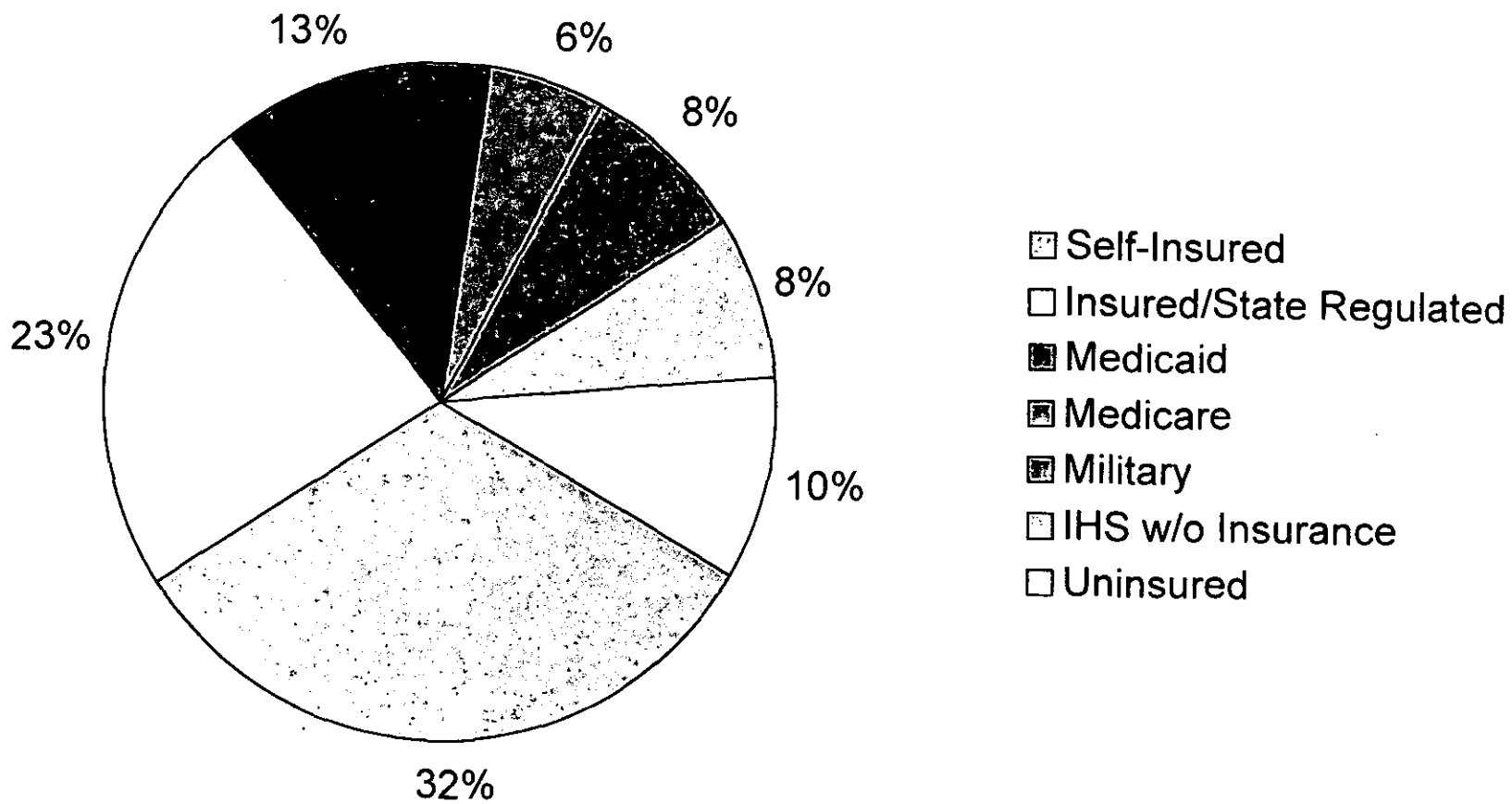
Thank you for considering HB 187 Insurance Coverage: Autism Spectrum Disorders. The following information for the House Committee on Health & Social Services pertains to questions received in the March 24th, 2009 hearing on HB 187. I have a diagnostic model forthcoming, to help explain the process of diagnosis. Please contact me or my aide Ashley Rousson 465-4939, if you have any further questions or concerns. We would be happy to work with members on this important piece of legislation.

1. Regarding the age of covered participants. The bill allows those under the age of 21 to access services for Autism Spectrum Disorders (ASDs). This age is consistent with both Medicaid coverage in Alaska, and is a reasonable age in regards to private insurance coverage. Many plans cover dependant children up to a certain age generally through the college years. Therefore, 21 is a reasonable age at which to discontinue these services.
2. Regarding out of state coverage. The answer to whether insurance companies would have to cover services out of state, if those services were not available in Alaska is, yes—just like they cover those services not available here in Alaska for any number of other health related issues. However, the claims cap would still remain at \$36,000 per year per child. Seeking services out of state would raise the cost for services, and that \$36,000 would not go very far. In addition, except for children who require hospitalization care ABA is best delivered in the child's own environment which could include home or school. Behavioral treatment sought outside AK would likely be for the most severe cases including aggression and self-injury that could not be managed in facilities in the state. Moreover, it is unlikely that these more costly forms of treatment would be sought out of state, due to the nature of such treatment. While ABA professionals may have to come into the state from outside for

the initial treatment plan prescription, the 1 to 1 services are customarily given by someone in the child's immediate community. The treatment is then monitored by the ABA professional; a process that could be done utilizing telemedicine.

3. Regarding a sustainable market for ASD service providers. There was a question posed as to whether the percentage of Alaskans covered by this legislation would be enough to sustain the industry of autism service providers. For this question I think it is important to refer to the pie chart provided by Linda Hall at the Division of Insurance. This chart identifies the types of benefits by percentage that Alaskans draw from. The report that contained this breakdown of Alaska's population is from 2003 however the division has adjusted the numbers for the 2008 population. I will discuss each section beginning with the self-insured at the top of the key.
 - Self-insured plans are not currently subject to state mandates. They are protected, as was stated in the committee, by Federal ERISA preemption. There is a Federal ERISA mandate that has been filed just this Thursday that would make this 32% of Alaskans subject as well, and allow those families to access services.
 - Insured/state regulated are the plans that are directly affected by HB 187. This 23% is very close to the 25.3% projected by the cost analysis done by Jim Boudier. His figure of 45.5% which he cited, was in reference to group-insured Alaskans. 45.5% of group-insured Alaskans fall under HB 187, which is about 25.3% of the total population of Alaska—not far off from the 23% cited by the Division of Insurance.
 - Medicaid in Alaska currently provides some treatment for ASDs. It is the primary method by which Alaskan families access these services, however limited the coverage might be. Many families, as we heard, are fully insured, but don't have coverage for the treatments their children need. These families resort to applying for Medicaid waivers to access these funds, but the waiting list can be years. Time that these kids don't have. In addition, insured families are adding stress to what is already an overburdened system.
 - Medicare would likely not be a significant contributor to, or drawer from any of these services.
 - Military families already have access to some ASD treatments including applied behavior analysis (ABA) as provided for in the Federal Government's TRICARE ECHO program for military families who have children with disabilities.
 - IHS or Indian Health Services is a benefits program for American Indians and Alaskan Natives. IHS draws funds to cover treatment, for those who qualify, from several different pots including Medicaid, and private health insurance. The issue of coverage for the treatment of ASD has not come up with IHS, however, due to the fact that they currently draw from places like Medicaid and private insurance to cover other services, it is likely they would do the same for services requested to treat ASDs.
 - Uninsured is the category that unfortunately we have no bearing on.

Health Coverage of Alaska Population



What is ABA?

ABA is a science devoted to the understanding and improvement of human behavior, and has been used effectively as a treatment for the symptoms of Autism for more than 20 years. ABA focuses on shaping behavior systematically, often in a highly structured environment. Every skill a child with autism does not demonstrate - from relatively simple responses like looking at others to more complex acts like spontaneous communication and social interaction - is broken down into small steps. Successful completion of each step is rewarded to encourage its mastery and data is carefully taken and evaluated to ensure the fastest rate of skill acquisition. Problematic behavior, such as tantrums, self-injury, and withdrawal, are analyzed to determine what functions they serve and plans are developed to replace the challenging behavior with more functional, contextually appropriate behavior. By tailoring reinforcement to each child, and by teaching replacement skills, many problem behaviors can be reduced or eliminated and many new skills gained.

*The Vista School website (www.thevistaschool.org)



Alaska

March 16, 2009

**The Honorable Pete Petersen
Alaska House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182**

RE: House Bill 187

Dear Representative Petersen,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to House Bill 187. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately HB 187 mandates coverage for autism spectrum disorders that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health

**National Federation of Independent Business — ALASKA
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The Honorable Pete Peterson
March 20, 2009
Page 2

insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

HB 187 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities, unions, or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,



Dennis L. DeWitt
Alaska State Lobbyist

✓cc: Health and Social Services Committee

Alaska State Legislature

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Representative Pete Petersen District 19

Sponsor Statement

HB 187 INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

Autism is a devastating disorder affecting at least 1 in 150 children. Despite being treatable, many children diagnosed with an Autism Spectrum Disorder (ASD) never receive the treatment they need. Families go bankrupt, mortgaging their future, trying to provide their children with the treatment to ameliorate their condition; paying down their savings, retirement funds, and college savings plans for their other children because ASDs are not covered by insurance plans. In fact, most insurance plans explicitly exclude the treatment of ASDs, even when the service is otherwise covered by the health plan.

HB 187 would require insurance coverage for autism spectrum disorders, including the behavior therapies that after 30 years of study have shown to be the only effective treatment of these disorders. Treatment has been shown to improve, sometimes significantly, the symptoms of ASD and in some cases even eliminate the need for special education services for a child with ASD. The cost savings in special education alone, during the school years, amounts to approximately \$208,500 per capita. This number rises to over \$1.08 million over the autistic person's lifespan.

As well, the incremental societal cost of not treating autism has been estimated by Michael Ganz, a Harvard economist to be approximately \$3.2 million per capita.

The cost to policy holders to implement such coverage is minimal; estimated at less than a 1% increase in their premiums, or \$3.60 per member per month. That's less than the cost of a latte, per month to allow coverage for ASDs.

Furthermore, it has been stated by President Obama, that coverage of treatment, and other types of funding for ASDs would be a priority of his administration. It is likely that we will see a Federal law mandating the coverage of ASDs. This legislation allows Alaska to start this process on our own terms, and gives the state the needed time to build capacity within our state to meet the

demands created HB 187. Establishing this legislation in Alaska before a possible Federal mandate, would bring well paying jobs to the state, and bring those interested in this area of the health field to Alaska as well. The Governor has already included funding in her budget for programs at the University level to help establish a greater field of masters level autism service providers that would help to meet the need, should HB 187 be passed.

Coverage of ASDs by insurers would not only provide a needed service to those families suffering directly from the affects of a child with autism, but saves the state, and taxpayers exponentially over the lifespan of those diagnosed with autism. Though there is no cure for ASDs, this legislation would help significantly to treat those suffering from these disorders. In addition, a state that covers ASDs treatment will be desirable to those in the field and will bring jobs, and professionals in the field to Alaska. Prompt passage of this legislation would allow the state to reap the health and economic benefits that would result from being among the first few states to cover ASDs.

Therefore, I respectfully ask for your careful consideration and support of HB 187.

Alaska State Legislature

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Representative Pete Petersen District 19

Sectional Analysis HB 187 Insurance Coverage: Autism Spectrum Disorders

Sec. 1: Amends current insurance statute (AS 21.42) to include coverage for autism spectrum disorders.

- Must cover treatment of the disorders as prescribed by a licensed physician or psychologist.
- The treatment will be provided by an autism service provider.
- The treatment will be outlined in a treatment plan (prescribed by the physician or psychologist) following a comprehensive evaluation
- Treatment includes: medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care, and therapeutic care

Coverage includes those under the age of 21 years, and there is a maximum yearly benefit of \$36,000, adjusted annually for inflation.

Sec. 2: Regarding applicability: applies to policies issued on or after January 1, 2010.

Alaska State Legislature

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Representative Pete Petersen District 19

Departments Affected by HB 187

- Health & Social Services
- Commerce, Community and Economic Development: Division of Insurance

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Representative Pete Petersen District 19

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2. Autism Speaks 2009 State Initiatives Map
3. Autism Speaks—8 Arguments in support of Insurance Coverage for Autism-Related Services
4. Definitions of Autism Spectrum Disorders from the DSM-IV, as referenced in HB 187
5. Biosketch for Dr. Gina Green
6. Letter from Dr. Green to U.S. Assistant Secretary of Defense for Health Affairs
7. Power Point—Dr. Gina Green
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10. Letters of Support

James N. Boudier, MPA
7 South Main Street, 2nd Floor
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(717) 808-9910
jboudier@ptd.net

March 9, 2009

The Honorable Pete Petersen
Alaska State Capitol
Juneau, AK 99801

VIA FIRST CLASS MAIL

**RE: Cost Analysis – Alaska House Bill 187 pertaining to Insurance
Coverage for Autism Diagnosis and Treatment**

Dear Representative Petersen:

I thank you for the opportunity to complete an analysis of the likely effect of insuring the treatment of autism on commercial insurance rates in the State of Alaska. I am pleased to provide you with this information to assist you and your colleagues in making an informed public policy decision with regard to this proposed legislation. As you are aware, autism is a serious developmental disability that affects approximately 1 in 150 children across the United States. The cause is uncertain, but a significant research base indicates that the most debilitating symptoms of autism can be remediated using intensive services based on the principles of Applied Behavior Analysis (“ABA”). If enacted, House Bill 187 would require insurance policies to provide coverage for the diagnosis and treatment of autism spectrum disorder (“autism” or “ASD”), including coverage for behavioral therapy.

Based on my review of the available data and literature, I estimate that the likely effect on commercial insurance rates in Alaska will be approximately 0.92% or \$3.60 per member per month (“pmpm”). This estimate is consistent with my findings in other states and with the actuarial findings pertaining to similar legislation recently enacted or pending in Pennsylvania, Arizona, Georgia, Louisiana, Maryland, and Virginia. A detailed narrative describing my findings is set forth below.

Also, as requested, I assessed the likely claims increase that could be expected should Alaska extend this coverage to children of Alaska state employees. I found that the State of Alaska could expect approximately \$543,000 in additional claims, which translates into approximately \$3.02 per government employee per month.

Again, I thank you for this opportunity. Should you require copies of any studies cited, please do not hesitate to contact me. I hope you find this information helpful. If you have any questions or would like additional information, please feel free to contact me at (717) 808-9910 or by email at jbouder@ptd.net.

With Kind Regards,

James N. Bouder, MPA

Cc: The Honorable Nancy Dahlstrom

Cost Analysis – Alaska Autism Insurance Coverage

James N. Boudier, MPA

- ⌘ **Autism** is a devastating disorder affecting at least 1 in 150 children, with approximately 1 in 500 requiring significant clinical treatment;
- ⌘ **Autism is treatable** – with treatment, 30 years of research has shown us that many children overcome the severe symptoms of their disorder, but most private insurance policies specifically exclude coverage for treating autism, even when the service is otherwise covered by the health plan;
- ⌘ The coverage of autism treatment in Alaska will enable many children to access services they need;
- ⌘ The maximum likely cost of such coverage to the private insurance ratepayer is approximately **0.92%** or **\$3.60** per policyholder per month;
- ⌘ If the State of Alaska chooses to extend this coverage to dependents of state employees, this will likely result in an increase in claims costs of approximately **\$3.02** per government employee per month;
- ⌘ **Other States Confirm this Finding:** The Pennsylvania Insurance Department found that similar legislation will result in a rate impact of **at or less than 1%**; in **Arizona**, an independent actuary forecasted a cost impact of **0.501%**; in **Louisiana**, the consulting actuaries for the **Louisiana Office of Group Benefits** forecast a cost impact of **less than 0.50%**; in Oklahoma, the **Oklahoma State Education Employees Group Insurance Board** estimated a cost impact between **one-third of 1% and 1%**; and in the most comprehensive actuarial report on autism coverage to date, **Mercer** reported to the **Maryland Health Care Commission** an estimated premium increase of approximately **0.85%**
- ⌘ With treatment, Alaska can save approximately **\$208,500 per capita** in avoided special education costs during the school years alone and **\$1.08 million per capita** during the autistic person's lifespan;
- ⌘ The incremental societal cost of not treating autism has been estimated by Michael Ganz, a Harvard economist, to be **approximately \$3.2 million per capita**.

Section 1. Private Insurance Premium Rate Impact

The likely, maximum premium impact of autism coverage will be less than 1%, amounting to approximately \$3.60 per member per month (pmpm) for single policy rates and \$9.49 pmpm for family rates.

Number of Eligible Beneficiaries of Autism Coverage in Alaska

My first task in estimating the likely cost of extending treatment to Alaskans with autism is to determine how many people in Alaska are eligible for and likely to utilize the benefits mandated by the bill.

According to estimates provided by the U.S. Census Bureau, there are approximately 190,947 persons living in Alaska between the ages of 2 and 20 who could be eligible for the benefits under the House Bill 187.¹ It is also estimated that approximately 66.6% of children with special health care needs living in Alaska under the age of 18 have private health insurance and approximately 55.9% of such children living in Alaska are insured under group health insurance plans.² The number of persons living in Alaska between the ages of 2 and 20 who are insured under group plans, therefore, is approximately 106,664.

Based on information published by the Medical Expenditures Panel Survey ("MEPS"), 54.6% of private-sector enrollees working in Alaska are enrolled in self-insured plans (MEPS 2005 Report, p. 1).³ The potential pool of beneficiaries between age 2 and 20, therefore, after accounting for ERISA preemption and the uninsured, is approximately 48,425.

Treated Prevalence Rate of Children with Autism in Alaska

Actuarial analyses and insurer criticisms of bills similar to the bill contemplated for Alaska often utilize the CDC's statistic on community prevalence in pricing such bills, notwithstanding actual treated prevalence rates within existing systems or present in the research record. Recently, the Commonwealth of Pennsylvania Insurance Department utilized the 1 in 150 statistic in deriving their estimated rate impact of approximately 1.1%, with regard to very similar legislation introduced in that state.

While the latter example reports an estimated rate impact that is very low, utilizing a 1 in 150 prevalence rate demonstrates a lack of understanding of the range of symptom severity exhibited by people with ASD, and thus overstates the

¹ U.S. Bureau of the Census, "Table DP-1. Profile of General Demographic Characteristics: 2006 Population Estimates."

² Health and Disability Working Group. "The Catalyst Center: Improving Financing of Care for Children and Youth with Special Health Care Needs." Boston University School of Public Health, Boston, MA (2007), p. 43.

³ See The Kaiser Family Foundation State Health Facts Website:
<<http://www.statehealthfacts.org/profileind.jsp?ind=236&cat=4&rgn=50>>

number of persons with autism likely to require and seek significant clinical treatment.

Several examinations of health care utilization and expenditures associated with treating autism have been published in recent years that call into question the appropriateness of using epidemiological prevalence data to forecast the magnitude of health care utilization resulting from passage of House Bill 187. In 2007, Douglas L. Leslie and Andres Martin compiled data from the Thomson/Medstat MarketScan database, "which compiles claims information from private health insurance plans of large employers ... across the United States ... [with] covered individuals includ[ing] employees, their dependents, and early retirees" (Leslie, p. 351).⁴ Leslie et al. note that the *treated prevalence* of autism in the claims database was 19.2 per 10,000 (*i.e.*, 1 in 520.83) (p. 352). Independently, Gregoral S. Liptak et al. obtained data from three national surveys and identified a treated prevalence of autism of 21 in 10,000 (*i.e.*, 1 in 476.19) (Liptak et al., p. 872).⁵ Similarly, in a previous article, David S. Mandell et al. reported a treated prevalence rate of youth diagnosed with autism in Allegheny County, PA of 0.2% (*i.e.*, 1 in 500) (Mandell et al., p. 477).⁶ More recently, Shimabukuro et al.'s examination of MarketScan® data found a treated prevalence rate of 1.9 per 1,000 (or approximately 1 in 526) (p. 549).⁷ Most recently, the nationally recognized actuarial firm, Mercer, completed an evaluation of Maryland's proposed autism insurance mandate, which is substantively similar to House Bill 187, but has a \$50,000 annual cost cap.⁸ Mercer included both treated prevalence rates and cost per treated child estimates broken down by age bands to establish low, mid, and high estimates of premium impact, resulting in a mid-range estimate of 0.85%.

These findings are consistent with other medical conditions, which present with a treated prevalence rate much lower than the community prevalence rate. The consistency of these data suggest that the treated prevalence of autism is a better measure to apply to premium impact analyses because, unlike community prevalence data, which simply report the number of persons satisfying the diagnostic criteria for Autism Spectrum Disorders, treated prevalence accounts for those persons with autism actually seeking and consuming health care services related to their disorder.

⁴ Leslie, Douglas L. and Andres Martin (2007) "Health Care Expenditures Associated with Autism Spectrum Disorders." *Archives of Pediatric and Adolescent Medicine*. Vol. 161, Apr. 2007, pp. 350-355.

⁵ Liptak, Gregory S., Tami Stuart, and Peggy Auinger (2006). "Health Care Utilization and Expenditures for Children with Autism: Data from U.S. National Samples." *Journal of Autism and Developmental Disorders*. Vol. 36, pp. 871-879.

⁶ Mandell, David S., Jun Cao, Richard Ittenbach, and Jennifer Pinto-Martin (2006). "Medicaid Expenditures for Children with Autistic Spectrum Disorders: 1994 to 1999." *Journal of Autism and Developmental Disorders*, Vol. 36, No. 4, pp. 475-485.

⁷ Shimabukuro, Tom T., Scott D. Grosse, and Catherine Rice (2008). "Medical Expenditures for Children with an Autism Spectrum Disorder in a Privately Insured Population" *Journal of Autism and Developmental Disorders*, Vol. 38, No. 4, pp. 546-552.

⁸ Mercer/Oliver Wyman (2008) *Annual Mandated Health Insurance Services Evaluation, Coverage for Autism Spectrum Disorder*, pp. 3-33.

Assumptions

While much of the data included in this analysis was derived from primary sources, some assumptions were necessary due to my inability to independently confirm certain data elements from primary sources or required statistical calculations to forecast future sums. These assumptions are set forth below.

- Using data published by the Alaska Division of Insurance, I estimate a premium base of \$346.0 million in 2009.⁹
- Based on claims history of insurers in Alaska, I assumed an 85% Medical Loss Ratio, which is considered an industry standard. The Medical Loss Ratio was used to convert cost effect to revenue requirement.
- 45.4% of health insurance plans offered by private firms in Alaska that are not subject to ERISA preemption remains an accurate figure, as reported by the MEPS for 2005 (cited above).
- In order to produce a conservative estimate, 100% of likely, increased costs attributable to services provided under House Bill 187 will be passed on to private insurance ratepayers participating in eligible plans (*i.e.*, private insurers will choose not absorb any additional costs).
- Calculations assume an adequate provider network is in place on the legislation's effective date to meet the demand for services.

Cost Analysis

The next step in my cost analysis is to establish the likely cost of covering these services and their potential rate effect. In the interest of providing a range of rate impact resulting from the coverage of services contemplated for Alaska autism coverage, I have provided calculations based on a number of variables. I attempted to do so using credible data available to the general public. For your convenience, attached is a spreadsheet detailing the likely range of impact the covered services will have on private insurance ratepayers in Alaska (**See Exhibit "A" attached**).

The most likely scenarios are derived in part from peer-reviewed research evaluating real-life data concerning the treated prevalence of autism and average expenditures per treated person with autism and prevalence rates assumed by Mercer in their actuarial estimate of increased costs associated with a similar bill pending in Maryland (cited above). Persons living with autism present with varied symptoms requiring differing levels of attention based on the severity of symptoms. The more severe symptoms requiring intensive behavioral health and other clinical interventions are not necessarily present in every person diagnosed with an Autistic Spectrum Disorder, especially when those less severely affected reach the school age. This is evidenced by the treated prevalence rates reported in Mandell et al (2006), Leslie et al. (2007), Liptak et al. (2007), and Shimabukuru et al. (2008) noted and cited above, which consistently report a treated prevalence rate of

⁹ Report of the Alaska Division of Insurance (2008), retrieved from <<http://www.commerce.state.ak.us/insurance/>>

approximately 1 in 500 (or 0.20%). One should expect, therefore, that actual utilization rates will track more closely along treated prevalence rates noted in the abovementioned reviews of actual health care utilization data than community prevalence rates reported from epidemiological studies such as the recent report of the CDC.

While I was unable to locate any Alaska-specific data on average treatment costs, the findings of the Mercer actuaries in Maryland are instructive. Relying on the research of Harvard economist Michael Ganz, Mercer recognized that the heaviest utilization of services would fall in the preschool years, and drop considerably as the child reaches school age and approaches adulthood. Mercer assumed a cost per treated child between the ages of 18 and 20 to be from \$2,525 to \$3,500, as the biggest cost drivers for adult services are vocational support and supported housing (i.e., non-medical expenses).¹⁰

Three possible expenditure scenarios are included in my cost analysis, establishing Low, Mid, and High Estimates, using the treated prevalence rates and cost per treated child estimates similar to those Mercer relied upon in Maryland. Overall, the treated prevalence rates for Low, Mid, and High estimates were 1:400, 1:325, and 1:250, respectively.

Table 1 below illustrates the likely utilization rates and cost per treated person by age band. Based on these assumptions, the percentage increase in premium costs for Alaska falls in the 0.57% to 1.49% range, with a mid-range estimate of 0.92% (see attached **Exhibit "A"** attached for more detail).

¹⁰ Ganz, Michael L. (2007). "The Lifetime Incremental Societal Costs of Autism." *Archives of Pediatric and Adolescent Medicine*. Vol. 161, Apr. 2007, pp. 343-349.

TABLE 1: Treated Prevalence and Cost per Treated Person Assumptions.

<u>Low Estimate</u>		
Age Band	ASD Treated Prevalence for Age Band	Cost per Treated Person
2 to 4	0.25%	\$30,000
5 to 9	0.35%	\$19,660
10 to 14	0.25%	\$6,758
15 to 19	0.20%	\$2,525
20 years	0.20%	\$2,525
Premium Increase % of Premium		0.57%
<u>Mid Estimate</u>		
Age Band	ASD Treated Prevalence for Age Band	Cost per Treated Person
2 to 4	0.30%	\$36,000
5 to 9	0.45%	\$26,200
10 to 14	0.30%	\$9,000
15 to 19	0.25%	\$3,500
20 years	0.20%	\$3,500
Premium Increase % of Premium		0.92%
<u>High Estimate</u>		
Age Band	ASD Treated Prevalence for Age Band	Cost per Treated Person
2 to 4	0.45%	\$36,000
5 to 9	0.67%	\$30,500
10 to 14	0.35%	\$12,000
15 to 19	0.30%	\$3,500
20 years	0.25%	\$3,500
Premium Increase % of Premium		1.49%

Based on statistical data published by the Kaiser Family Foundation reporting average annual single and family policy rates in 2008, single policy rates will likely experience an increase no greater \$3.60 per member per month (pmpm) and \$9.49 pmpm for family rates as a result of implementing coverage provided by the proposed legislation.¹¹

¹¹ As cited above, see the *Kaiser Family Foundation and Health Research and Educational Trust* publication, "Employer Health Benefits - 2008 Annual Survey," which reports that the average annual total premium cost for single coverage in the Western United States is \$4,683 and \$12,351 for family coverage.

Section 2. State Employee Cost Impact

The likely, cost impact of autism coverage for dependents of state workers will be approximately \$554,000, which is less than 1% over current claims experience.

Not all state employees in Alaska receive health insurance coverage through the state's health care plan (Select Benefits), but rather through self-funded union trust plans ("Union Plans") that are primarily funded through state contributions. While I was not able to obtain copies of financial statements for the various Union Plans, I was able to obtain claims and census data for the Select Benefits plan and determine the total number of full-time government employees from the 2008 Comprehensive Annual Financial Report to be approximately 15,000.¹² Together, this information provided me with sufficient data to estimate the total added claims that the State of Alaska could anticipate if it decided extend coverage mandated by House Bill 187 to dependents of state employees.

According to the State of Alaska, Department of Administration, Division of Retirement and Benefits, approximately 40% of Alaska's +/- 15,000 state employees are insured under the Select Benefits plan, which includes approximately 6,000 employees. The Division of Retirement and Benefits also provided me with the numbers of insured children by age band between the ages of 2 and 20 as follows:

TABLE 2: # of Children by Age Band (Aged 2 to 20) Participating in Select Benefits¹³

Insured Dependents by Age Band	%	# Children
2 to 4 years	9.68%	428
5 to 9 years	20.90%	924
10 to 14 years	27.65%	1,222
15 to 19 years	35.34%	1,562
20 years	6.43%	284
TOTAL		4,420

Based on data provided by the Division of Retirement and Benefits, I was able to determine that the average household of employees participating in the State of Alaska's Select Benefits plan has 0.74 children (derived from the estimated 6,000 employees participating in the plan and 4,420 dependents between the ages of 2 and 20 who are also covered). Additionally, according to the Division of Retirement and Benefits, total claims paid by the Select Benefits plans in 2008 were \$62.4 million.

This data provides a sufficient sample to estimate the likely number of dependents between the ages of 2 and 20 who are insured by either the Select Benefits or Union Plans as follows:

¹² 2008 Alaska Comprehensive Annual Financial Report, p. 252.

¹³ Source: Personal Correspondence with the Division of Retirement and Benefits.

TABLE 3: Estimated # Children Insured Under Both Select Benefits and Union Plans

Insured Dependents by Age Band	%	# Children
2 to 4 years	9.68%	1,070
5 to 9 years	20.90%	2,310
10 to 14 years	27.65%	3,055
15 to 19 years	35.34%	3,905
20 years	6.43%	710
TOTAL		11,050

Additionally, knowing that 40% of state employees and their dependents are enrolled in the Select Benefits plan, it is reasonable to assume that approximately 40% of claims funded by state contributions are paid for claims incurred by enrollees in the Select Benefits plan. Therefore, I estimate total claims paid for both Select Benefits and Union Plans in 2008 were approximately \$155.9 million.

With this data and prevalence and per capita expenditure assumptions used to estimate the rate effect of House Bill 187 in **Section 1** above (See **Table 1**), I estimate the total increased claims for all state employees in **Table 4** below (see also **Exhibit "B"** attached for more detail). This fiscal impact translates into approximately \$1.86 to \$4.86 per government employee per month, with a mid-range estimate of \$3.02 per government employee per month.

TABLE 4: Total Estimated Claims by Age Band

Low Estimate		
Age Band	ASD Treated Prevalence for Age Band	Cost per Treated Person
2 to 4	0.25%	\$30,000
5 to 9	0.35%	\$19,660
10 to 14	0.25%	\$6,758
15 to 19	0.20%	\$2,525
20 years	0.20%	\$2,525
Total Increased Claims		\$334,990
Mid Estimate		
Age Band	ASD Treated Prevalence for Age Band	Cost per Treated Person
2 to 4	0.30%	\$36,000
5 to 9	0.45%	\$26,200
10 to 14	0.30%	\$9,000
15 to 19	0.25%	\$3,500
20 years	0.20%	\$3,500
Total Increased Claims		\$543,384

High Estimate		
Age Band	ASD Treated Prevalence for Age Band	Cost per Treated Person
2 to 4	0.45%	\$36,000
5 to 9	0.67%	\$30,500
10 to 14	0.35%	\$12,000
15 to 19	0.30%	\$3,500
20 years	0.25%	\$3,500
Total Increased Claims		\$875,452

Section 3. Long Term Considerations

The long-term savings attributable to effectively treating children with autism is significant, with cost-benefit peer review studies estimating a per capita avoided special education cost savings of \$208,500 and over \$1 million in total avoided human service cost savings per person over the lifespan.

In April 2007, Michael L. Ganz published an article in *Archives of Pediatric and Adolescent Medicine* entitled "The Lifetime Distribution of the Incremental Societal Costs of Autism," which sets forth his findings in describing "the age-specific and lifetime incremental societal costs of autism in the United States" (p. 343).¹⁴ Ganz determined that the "lifetime per capita incremental societal cost of autism is \$3.2 million" and that "[l]ost productivity and adult care are the largest components of costs" (p. 343). Based on the extant literature demonstrating the efficacy of behavioral interventions, we believe that the "lifetime per capita incremental societal cost of autism" can be mitigated substantially by services included in House Bill 187. In short, autism left untreated will result in substantial financial consequences for both public agencies and families with loved ones diagnosed with autism.

Regarding the cost-benefit of intensive ABA services, two analyses, one completed in Pennsylvania and the other in Texas, examined the future cost savings to government units resulting from investment in intensive behavioral interventions for people with autism.

The first such work, completed by John W. Jacobson, James A. Mulick, and Gina Green in 1998, notes that an abundance of research demonstrates the efficacy of early, intensive behaviorally-based interventions to enable substantial numbers of children with autism to "attain intellectual, academic, communication, social, and daily living skills within the normal range" (p. 201).¹⁵ Using representative costs

¹⁴ Ganz, Michael L. (2007). "The Lifetime Incremental Societal Costs of Autism." *Archives of Pediatric and Adolescent Medicine*. Vol. 161, Apr. 2007, pp. 343-349.

¹⁵ Jacobson, John W., James A. Mulick, and Gina Green (1998). "Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism - General Model and Single State Case." *Behavioral Interventions* 13, 201-226.

from Pennsylvania, including costs for special educational and adult special needs services, they found that, "At varying rates of effectiveness and in constant dollars, this model estimates that cost savings range from \$187,000 to \$203,000 per child for ages 3-22 years, and from \$656,000 to \$1,082,000 per child for ages 3-55 years (Jacobson, et al., p. 201).

More recently, Gregory S. Chasson, Gerald E. Harris, and Wendy J. Neely compared the costs of early intensive behavioral intervention ("EIBI") and special education for children with autism (cited above). Alluding to recent comparison studies that strongly suggest that "eclectic" special education programs are materially ineffective for many children with autism, the authors note that the human cost of failing to provide EIBI services is considerable. Consistent with Jacobson's et al.'s findings, Chasson et al. found that "the state of Texas would save \$208,500 per child across eighteen years of education with EIBI" (p. 401). Based on their estimate that the average annual cost associated with EIBI is approximately \$22,500, and the average duration of service is three years (see p. 402), the return on the health care investment would be 308% in avoided special education costs to the local and state taxpayer during the education years alone. It is important to note that, without treatment, persons with autism will grow to become adults dependent on publicly-funded services for their lifespan. For another third of those receiving such services early, the intensity of publicly-funded services needed in adulthood would be considerably reduced. For just less than half of those children receiving intensive EIBI services early, opportunities to be gainfully employed contributors to the tax base will only increase the return on that initial three-year investment. As Chasson et al. put it, "By implementing EIBI with all children with autism, as a way to prevent the need for special education, the investment not only produces a sizeable savings after 18 years, but it maximizes the likelihood that most of these children will return a profit long after maturation" (p. 410).

Chasson et al. posit that, "For this reason, it would behoove policy makers to reconsider the role of educational services with children with developmental disabilities. Indeed, it may mean a minimization of the education system's role in providing services and a maximization of population-specific treatment implementation by mental health practitioners. Following from this, special education would then have expanded resources to serve children who failed to mainstream into typical education despite implementation of appropriate interventions" (p. 411). "The bottom line," they write, "is that a simple change in policy could drastically improve functioning and quality of life for thousands of children with autism in Texas. As a bonus, the taxpayers could potentially save over \$2 billion across 18 years (p. 412).

Applying similar assumptions to the population served by the proposed legislation indicates that Alaska's taxpayers could save millions in avoided special education costs during the school years alone and hundreds of millions in avoided human services costs over the autistic person's lifespan.

Section 4. Other State Cost Estimates Associated with Similar Legislation

While a number of factors unique to individual states can influence the cost effect of legislation that is similar to House Bill 187, a review of cost estimate findings in states where similar legislation has been enacted, offered by proponents, opponents, and neutral sources, can reveal a useful trend to lawmakers in Alaska. During the past two years, several states have enacted legislation similar to House Bill 187, including South Carolina, Arizona, Florida, Louisiana, and Pennsylvania. Additionally, numerous other states with sophisticated mandate review processes have examined the likely cost effect resulting from mandating similar coverage. These states include Maryland, Virginia, and Oklahoma.

Due to differences in coverage criteria (e.g., ages of those covered and annual and lifetime limits), cost estimates in other states would not be directly comparable to Alaska's House Bill 187. The cost analyses completed for Pennsylvania, Maryland, and Virginia would be most instructive due to similar age limitations, amount of annual benefit limitation, and the lack of a lifetime limit, although South Carolina's costs would also be similar to Alaska's due to the relatively low per capita expenditure expected for children with autism age 16 and over. A consistent theme emerging from proponents, opponents, and independent sources, including nationally trusted actuarial firms such as Mercer, Aon, and Oliver Wyman, is that the likely cost of insuring the treatment of children with autism is relatively low, and is consistently reported to be at or below 1%. (See TABLE 5 and TABLE 6 below).

TABLE 5: Rate and/or Cost Effect of Similar Mandates Enacted in Other States

State/Party	Eligibility/Disposition	Annual Cap	Lifetime Limit	Estimated % Premium Increase
Arizona	Birth to 16 yrs	\$50,000 to age 9, \$25,000 ages 10-16	None	
Key HealthCare Concepts, LLC ¹⁶	Independent			0.33%-0.69%
Florida	< 18 yrs or 18 yrs & older if in HS & have a DD dx by age 8	\$36,000	\$200,000	
Bouder, James N. ¹⁷	Proponent			0.27%-0.56%
Louisiana	< 17 yrs	\$36,000	\$144,000	
Bouder, James N. ¹⁸	Proponent			0.27%-0.56%
Louisiana Office of Group Benefits ¹⁹	Independent			0.29%
Pennsylvania	< 21 yrs	\$36,000	None	
Abt Associates ²⁰	Independent			+/- 1%
Blue Cross of Northeastern PA ²¹	Opponent			+/- 0.50%
Bouder, JN et al. ²²	Proponent			+/- 1%
Highmark Blue Shield ²³	Opponent			+/- 0.50%
PA Department of Insurance ²⁴	Independent			+/- 1%
South Carolina	< 16 yrs & Dx w/ ASD at age 8 or younger	\$50,000	None	
Governor Sanford (Veto Letter)	Opponent			+/- 1%

¹⁶ Key HealthCare Concepts, LLC (2008), *Actuarial Report Regarding Financial Impacts* [Regarding private insurance coverage for autism treatment], p. 4.

¹⁷ Bouder, JN for Autism Speaks (2008) [Financial Impact Section Only], *Report Under § 624.215(2), Fla. Stat. (2007), Assessing the Social and Financial Impacts of House Bill 1291 and Senate Bill 2654*, retrieved from <<http://www.autismvotes.org>>

¹⁸ Bouder, JN (2008), *Cost Analysis - HB 958 of 2008 (As Amended 4/30/08)* (2008), pp. 2-7, retrieved from <<http://www.autismvotes.org>>

¹⁹ *Ibid*, pp. 7-9 and Exhibit "C-2"

²⁰ Abt Associates, Inc. (2008), *Autism Spectrum Disorders Mandated Benefits Review Panel Report: Evidence Submitted Concerning Pennsylvania HB 1150*, Prepared for the Pennsylvania Health Care Cost Containment Council, retrieved from <<http://www.phc4.org>>

²¹ See Mercer (2008), *Annual Mandated Health Insurance Services Evaluation, Section 1, Coverage for Autism Spectrum Disorders*, prepared for the Maryland Health Care Commission, p. 23, evaluating Highmark Blue Shield's cost estimate submitted to the Pennsylvania Health Care Cost Containment Council.

²² Bouder, JN, Stuart Spielman, David S. Mandell (2009). *Brief Report: Quantifying the Impact of Autism Coverage on Private Insurance Premiums*, *Journal of Autism and Developmental Disorders*.

²³ See Mercer (2008), *Annual Mandated Health Insurance Services Evaluation, Section 1, Coverage for Autism Spectrum Disorders*, prepared for the Maryland Health Care Commission, p. 23, evaluating Blue Cross of Northeastern Pennsylvania's cost estimate submitted to the Pennsylvania Health Care Cost Containment Council.

²⁴ Commonwealth of Pennsylvania Insurance Department (2008), regarding the effect of Pennsylvania House Bill 1150 on commercial insurance rates, p. 8.

TABLE 6: Rate and/or Cost Effect of Similar Mandates Proposed in Other States

State/Party	Eligibility/ Disposition	Annual Cap.	Lifetime Limit	Estimated % Premium Increase
Georgia	Not Specified	\$55,000	None	
Oliver Wyman ²⁵	Proponent			0.63%
Maryland	< 21 yrs	\$50,000	None	
Mercer/Oliver Wyman ²⁶	Independent			0.52%-1.22%
New Jersey	Not Specified	None	None	
Mandated Benefits Advisory Comm. ²⁷	Independent			1%
Oklahoma	< 21 yrs	\$75,000	None	
Aon (for OSEEGIB) ²⁸	Independent			0.34%-1.00%
Virginia	< 21 yrs	\$36,000	None	
Oliver Wyman ²⁹	Proponent			0.60%
West Virginia	< 24 yrs	\$75,000	None	
Bouder, James N. ³⁰	Proponent			0.82%
Public Employees Insurance Agency ³¹	Independent			1.54%

²⁵ Oliver Wyman (2009), *Actuarial Cost Estimate: Georgia Senate Bill 161 – An Act Related to Insurance Coverage for Autism*, p. 13.

²⁶ Mercer (2008), *Annual Mandated Health Insurance Services Evaluation, Section 1, Coverage for Autism Spectrum Disorders*, prepared for the Maryland Health Care Commission, pp. 30-31.

²⁷ New Jersey Mandated Benefits Advisory Commission (2006), *Evaluation of the Impact of Autism Mandated Benefits contained in Assembly Bill A-999*.

²⁸ Aon (2009), *Memorandum Regarding the Cost Impact of Oklahoma SB 1 on the Office of State Education Employees Group Insurance Board's Health Plans*.

²⁹ Oliver Wyman (2009), *Actuarial Cost Estimate: Virginia House Bill 1588 – Coverage for the Diagnosis and Treatment of Autism Spectrum Disorder*, p. 12.

³⁰ Bouder, JN (2009), *Cost Analysis – House Bill 4091 Pertaining to Private Insurance Coverage for Autism Diagnosis and Treatment*.

³¹ West Virginia Public Employee Insurance Agency (2008), *Fiscal Note Summary on Effect HB 4091 will have on Costs and Revenues of State Government*.

Conclusion

Based on my review of House Bill 187, Alaska's commercial premium and claims data and state employees' health benefits data, I believe it is reasonable to conclude that the likely cost impact of mandating coverage for the diagnosis and treatment of autism will be less than 1%, even after a sufficient provider network is established to meet the demands for services. Furthermore, given significant evidence concerning the efficacy of Applied Behavior Analysis in treating the varied symptoms of autism, Alaska can expect significant future savings in avoided special education and human services costs. Lastly, expected premium and cost impacts relating to the Alaska House Bill 187 are consistent with similar legislation enacted or pending in at least 10 other states.

Please note that my cost analysis assumes that a provider network capable of meeting the needs of all children with autism who require and seek treatment is prepared to deliver services during the first year of implementation of House Bill 187. As a practical matter, however, it takes time for providers to recruit, train, and deploy professionals, especially in markets that lack a pre-existing provider base like Florida and Pennsylvania, which the Behavior Analyst Certification Board ("BACB") reports have approximately 1,800 and 300 Board Certified Behavior Analysts ("BCBA"), respectively. By comparison, the BACB reports that the State of Alaska has two (2) BCBA's. The existence of alternative funding streams in the former two states encouraged the aggressive proliferation of Behavior Analysts, and the same can be expected in Alaska once a reliable funding stream is established. Therefore, it could be several years before Alaska experiences the full cost impact associated with House Bill 187.

It is also important to note that other factors may further reduce first year claims. House Bill 187 is currently written to require coverage for plans offered, issued for delivery, delivered, or renewed in Alaska on or after January 1, 2010. Assuming open enrollment trends in Alaska are similar to those in other states, approximately 80% of health plans renew on January 1. This could also translate into a lower claims experience during the first year of implementation.

Exhibit "A"

James N. Boudier, MPA

Forecasted Rate Impact of Alaska House Bill __

	Medical Loss Ratio	\$ Cost	% Cost
	85%		
Low Estimate		1,987,483	0.57%
Mid Estimate		3,189,512	0.92%
High Estimate		5,147,242	1.49%

Total Alaska Premiums Collected (est. 2010)* 345,975,804

% of Population Covered by ERISA Plans *** 54.6%
 % Population Covered by Non-ERISA Plans 45.4%

	Avg./Yr.	Avg./Mo.	PMPM \$ PMPM \$ Rate Impact (Low)	PMPM \$ Rate Impact (Mid)	PMPM \$ Rate Impact (High)	PMPY \$ Rate Impact (Low)	PMPY \$ Rate Impact (Mid)	PMPY \$ Rate Impact (High)
Average Individual Policy \$	4,683	390	\$ 2.24	\$ 3.60	\$ 5.81	26.90	43.17	69.67
Average Family Policy \$	12,351	1,029	\$ 5.91	\$ 9.49	\$ 15.31	70.95	113.86	183.75

NOTE: Source of average annual premiums from Kaiser Family Foundation "Employer Health Benefits - 2008 Annual Survey"

Population Estimate (2006)**	Total Population by Age Band	Total Insured Population by Age Band 55.9%	Total Full Insured Population by Age Band 45.4%	Age Band % of Population	ASD Treated Prevalence			Cost per Treated Person			Total \$ Cost		
					for Age Band Low	for Age Band Mid	for Age Band High	Low	Mid	High	Low	Mid	High
2 to 4 years	29,863	16,681	7,573	15.64%	0.25%	0.30%	0.45%	30,000	36,000	36,000	567,999	817,918	1,226,877
5 to 9 years	47,169	26,349	11,962	24.70%	0.35%	0.45%	0.67%	19,660	26,200	30,500	823,127	1,410,357	2,444,498
10 to 14 years	50,714	28,329	12,861	26.56%	0.25%	0.30%	0.35%	6,758	9,000	12,000	217,292	347,256	540,176
15 to 19 years	52,627	29,398	13,346	27.56%	0.20%	0.25%	0.30%	2,525	3,500	3,500	67,400	116,782	140,138
20 years	10,575	5,907	2,682	5.54%	0.20%	0.20%	0.25%	2,525	3,500	3,500	13,543	18,773	23,466
TOTAL UNDER 20	190,947	106,664	48,425	100.00%							1,689,361	2,711,085	4,375,156

	Low (1:400)	Mid (1:325)	High (1:250)
Average Treated Prevalence Assumption	0.25%	0.30%	0.40%
Average Per Capita Expenditure	12,294	15,640	17,100

Alaska % Insured

% Children in Alaska with Private Health Insurance (CYSHCN) ****	66.6%
% Children in Alaska with Individual Private Health Insurance	10.7%
% Children in Alaska with Group Private Health Insurance	55.9%

Sources

* Estimate derived from 2008 Report of the Alaska Division of Insurance retrieved from <http://www.commerce.state.ak.us/insurance/>

** United States Census Bureau <http://factfinder.census.gov/>

*** Medical Expenditure Panel Survey Report <http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/instr/state/series_2/2005/tib2b1.pdf>

**** Catalyst Center State-at-a-Glance Chartbook on Coverage and Financing for Children and Youth with Special Health Care Needs, p. 43

Exhibit "B"

James N. Boudier, MPA

State Worker Autism Coverage Claims Impact

Select Benefits

Category	# State Employees	Assumed # Children (State Employees)	Total Claims Paid (2008)	Total Operating Expenses	% Operating Expenses/Total Claims	Total Increase In Claims	\$ PMPM
State employees	6,000	4,420	62,360,104	4,143,000	6.6%		
Prevalence Rate							
Low (1:400)						133,996	\$ 1.86
Mid (1:325)						217,354	\$ 3.02
High (1:250)						350,181	\$ 4.86

Select Benefits Data (1)

State Workers by Age Band	Age Band %	Estimated # Children by Age Band (State Employees)	ASD Treated Prevalence for			Cost per Treated Person			Total \$ Cost		
			Age Band Low	Age Band Mid	Age Band High	Person Low	Person Mid	Person High	Low	Mid	High
2 to 4 years	9.68%	428	0.25%	0.30%	0.45%	30,000	36,000	36,000	32,100	46,224	69,336
5 to 9 years	20.90%	924	0.35%	0.45%	0.67%	19,660	26,200	30,500	63,580	108,940	188,819
10 to 14 years	27.65%	1,222	0.25%	0.30%	0.35%	6,758	9,000	12,000	20,646	32,994	51,324
15 to 19 years	35.34%	1,562	0.20%	0.25%	0.30%	2,525	3,500	3,500	7,888	13,668	16,401
20 years	6.43%	284	0.20%	0.20%	0.25%	2,525	3,500	3,500	1,434	1,988	2,485
TOTAL UNDER 20		4,420							125,648	203,813	328,365

(4) Source: Personal correspondence with State of Alaska - Department of Administration, Division of Retirement and Benefits

% of State Workers Insured by Select Benefits 40.00%

Total State Worker Assumptions

Category	# State Employees	Assumed # Children (State Employees)	Total Claims Paid (2008)	Total Operating Expenses	% Operating Expenses/Total Claims	Total Increase In Claims	\$ PMPM
State employees	(2) 15,000	11,050	155,900,260	(3) 10,357,500	6.6%		
Prevalence Rate							
Low (1:400)						334,990	\$ 1.86
Mid (1:325)						543,384	\$ 3.02
High (1:250)						875,452	\$ 4.86

(2) FTE Alaskan State Employees per 2008 Alaska Comprehensive Annual Financial Report, p. 252

Total State Worker Claims Data Estimate

State Workers by Age Band	Age Band %	Estimated # Children by Age Band (State Employees)	ASD Treated Prevalence for			Cost per Treated Person			Total \$ Cost		
			Age Band Low	Age Band Mid	Age Band High	Person Low	Person Mid	Person High	Low	Mid	High
2 to 4 years	9.68%	1,070	0.25%	0.30%	0.45%	30,000	36,000	36,000	80,250	115,560	173,340
5 to 9 years	20.90%	2,310	0.35%	0.45%	0.67%	19,660	26,200	30,500	158,951	272,349	472,049
10 to 14 years	27.65%	3,055	0.25%	0.30%	0.35%	6,758	9,000	12,000	51,614	82,485	128,310
15 to 19 years	35.34%	3,905	0.20%	0.25%	0.30%	2,525	3,500	3,500	19,720	34,169	41,003
20 years	6.43%	710	0.20%	0.20%	0.25%	2,525	3,500	3,500	3,586	4,970	6,213
TOTAL UNDER 20		11,050							314,121	509,533	820,914

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Representative Pete Petersen
District 19

MEMORANDUM

DATE: March 30, 2010
FROM: Rep. Pete Petersen
TO: Rep. Wes Keller
RE: Coverage of autism spectrum disorders under new federal health care reform

According to our research and consultations with health policy experts, the Health Care Education and Affordability Reconciliation Act of 2010 improves accessibility of treatment for autism spectrum disorders, **but not for the majority of families**. As such, HB 187 is still necessary to allow families not affected by the new Act to receive adequate coverage, which would save hard-earned money for themselves *and* the State.

Here are some of the problems the Act has in providing treatment for autism spectrum disorders:

- There is no specific mention of or guidelines for “autism” or “autistic spectrum disorders” or “pervasive developmental disorders” in the Act. Anywhere it says “behavioral health treatment,” it is assumed it *may* apply to autism spectrum disorders.
- The pool of insurers obligated to offer the “behavioral health treatments” mandated by the Act is small: it does not cover “large group plans” - that is, families whose insurance plans are provided by employers of 50 or more people.
- Discrimination against treating autism spectrum disorders is not rectified. While discrimination against “pre-existing conditions” may now be addressed, this doesn’t matter to the families whose insurance coverage will not cover treatment for autism spectrum disorders and are not required to do so under the new Act.
- Individuals and small-businesses can purchase insurance plans that offer specific coverage for autism which are exchanged over state lines, but this does not take effect until 2014. This is also assuming the appropriate legislation has passed and guidelines have been established to allow Alaskan families and small businesses to participate in these exchanges.
- While some families affected by autism will be able to receive health insurance coverage for behavioral health treatments, the majority of families will remain without this coverage. Those who can receive it may not be able to take advantage of it for several more years and then miss that window of opportunity for early intervention.

Attached are a few of our sources and supplements to this information. Please feel free to contact me or my staff with any additional questions. Thank you for your consideration.



It's time for lawmakers to listen.



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News Center

Health Care Reform: What does it mean for the Autism Community?

Families caring for a child with autism often have health insurance, but most of these plans explicitly exclude coverage of the treatments their child needs. Since 2007, Autism Speaks has been working with grassroots partners on autism insurance reform in states across the country with the goal of enacting legislation that would end marketplace discrimination on the basis of an autism diagnosis. To date, 15 states have passed reform measures that specifically require insurers to provide coverage of evidence-based, medically necessary treatments including behavioral therapies, such as Applied Behavioral Analysis (ABA). Similar legislation is pending in about two dozen additional states.

From the beginning we knew that passage of state laws was only a first step – albeit a critical one – and that true autism insurance reform would demand a federal law requiring all types of health plans to cover autism treatments. President Obama even made a campaign pledge during the 2008 election that he would support a federal mandate requiring coverage of autism treatments.

With today's historic signing of health care reform legislation by President Obama, people are asking "What does this mean for autism insurance reform?" As many know, Autism Speaks, the autism grassroots community, and our supporters in Congress, especially Congressman Mike Doyle (PA) in the House and Senators Robert Menendez (NJ) and Chris Dodd (CT) in the Senate, worked very hard during the past year to include in health care reform legislation language that would address the insurance inequities many families have endured for decades. This language makes behavioral health treatments a part of the essential health benefits that must be included in certain health plans.

There are many questions about what health care reform WILL and WON'T do to help your family cover the cost of the medically necessary, evidence-based behavioral therapies. Let's consider where things stand.

Will health care reform directly benefit the autism community?

The new health care reform law will curb abusive practices like pre-existing condition exclusions, excessive waiting periods for coverage, and rescissions of coverage. Some insurers will be limited in their ability to set lifetime or annual limits on the dollar value of benefits. This may affect caps on autism insurance benefits in some states.

Does it apply to all insurers?

While the new health care reform law will extend autism insurance reform to some families, not all insurance plans will be required to cover behavioral health treatment. That's because only certain types of health plans will be required, beginning in 2014, to cover the list of essential benefits, including behavioral health treatment. The types of plans included under this provision are: (1) plans offered by state-based exchanges, through which individuals and small businesses can purchase coverage; and (2) plans offered in the individual and small group markets outside the exchange. Existing coverage, plans offered in the large group market outside exchanges, and self-insured plans (plans under which an employer assumes direct financial responsibility for the costs of enrollees' medical claims, or sometimes referred to as "ERISA plans") will not be required to provide the essential benefits package. This last exception is especially significant because 57% of workers who are currently covered by their employers' health benefits are enrolled in a plan self-insured by the employer.

How does health care reform impact the state autism insurance reform effort?

Autism Speaks is committed to autism insurance reform that includes coverage of all medically necessary, evidence-based treatments for all people living with autism spectrum disorders. While passage of health care reform will bring some relief to families caring for a child with autism, there is still much work to be done in state legislatures and in Congress to make effective health care coverage a reality for the autism community and to bring about an end to discrimination of individuals with autism by the insurance industry.

We all know families who have gone to extreme measures, including mortgaging their homes and the futures of other children, in order to provide the best possible services for their child with autism. According to research, families living with autism have far greater medical expenditures and out-of-pocket costs and are far less likely to report that health insurance meets their child's needs when compared to families living without autism. Health care reform will not end these problems, but it may lessen their severity. That's why Autism Speaks will continue its efforts to make autism insurance reform a reality for all Americans living with autism.

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U.S. HOUSE PASSES HEALTH CARE REFORM BILL CONTAINING PROVISION FOR AUTISM INSURANCE



25 March , by *Christine Kennedy*



Autism Speaks, the nation's largest autism science and advocacy organization, today pledged to continue the battle to end insurers' discrimination against individuals with autism at both the state and federal levels. While praising elements of the Health Care Education and Affordability Reconciliation Act of 2010 - passed over the weekend by the U.S. House - that could result in improved access to care for individuals with autism and their families, the bill still falls short of eliminating marketplace discrimination for coverage of medically necessary autism treatments. The reconciliation bill will now move to the Senate for consideration.

Through the efforts of Autism Speaks, the autism grassroots community and supporters in Congress, especially Congressman Mike Doyle (PA) in the House and Senators Robert Menendez (NJ) and Chris Dodd (CT) in the Senate, behavioral health treatment is included as part of the essential health benefits package required in certain health plans. Behavioral health treatments were added to ensure that people with autism are provided with insurance coverage of medically necessary, evidence-based behavioral treatments, such as applied behavior analysis (ABA) therapy.



While the Health Care and Education Affordability Reconciliation Act will extend autism insurance reform to some families, not all health plans will be required by the bill to cover behavioral health treatment. The reconciliation bill will require the following health plans to offer at least the essential benefits package: (1) plans offered by state-based exchanges, through which individuals and small businesses can purchase coverage; and (2) plans offered in the individual and small group markets outside the exchange.

Therefore, while some families affected by autism will be able to receive health insurance coverage for behavioral health treatments, the majority of families will remain without this crucial coverage.

"We are grateful to our supporters in Congress who fought so hard to make sure that families dealing with autism are a part of larger

health care reform," said Peter Bell, Autism Speaks executive vice president for programs and services. "Though passage of this bill does not end autism insurance discrimination for all families, Autism Speaks will continue to work for autism insurance reform in state legislatures and in Congress until all those touched by autism no longer face discrimination from the insurance industry."



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March 24, 2010

Recent healthcare reform dictates that we intensify state mandate efforts for ABA therapy

Filed under: [Obama Initiative](#) — admin @ 6:59 pm

The following is a message from Autism Speaks...

Families caring for a child with autism often have health insurance, but most of these plans explicitly exclude coverage of the treatments their child needs. Since 2007, Autism Speaks has been working with grassroots partners on autism insurance reform in states across the country with the goal of enacting legislation that would end marketplace discrimination on the basis of an autism diagnosis. To date, 15 states have passed reform measures that specifically require insurers to provide coverage of evidence-based, medically necessary treatments including behavioral therapies, such as Applied Behavioral Analysis (ABA). Similar legislation is pending in about two dozen additional states.

From the beginning we knew that passage of state laws was only a first step – albeit a critical one – and that true autism insurance reform would demand a federal law requiring all types of health plans to cover autism treatments. President Obama even made a campaign pledge during the 2008 election that he would support a federal mandate requiring coverage of autism treatments.

With today's historic signing of health care reform legislation by President Obama, people are asking "What does this mean for autism insurance reform?" As many know, Autism Speaks, the autism grassroots community, and our supporters in Congress, especially Congressman Mike Doyle (PA) in the House and Senators Robert Menendez (NJ) and Chris Dodd (CT) in the Senate, worked very hard during the past year to include in health care reform legislation language that would address the insurance inequities many families have endured for decades. This language makes behavioral health treatments a part of the essential health benefits that must be included in certain health plans.

There are many questions about what health care reform WILL and WON'T do to help your family cover the cost of the medically necessary, evidence-based behavioral therapies. Let's consider where things stand.

Will health care reform directly benefit the autism community?

The new health care reform law will curb abusive practices like pre-existing condition exclusions, excessive waiting periods for coverage, and rescissions of coverage. Some insurers will be limited in their ability to set lifetime or annual limits on the dollar value of benefits. This may affect caps on autism insurance benefits in some states.

Does it apply to all insurers?

While the new health care reform law will extend autism insurance reform to some families, not all insurance plans will be required to cover behavioral health treatment. That's because only certain types of health plans will be required, beginning in 2014, to cover the list of essential benefits, including behavioral health treatment. The types of plans included under this provision are: (1) plans offered by state-based exchanges, through which individuals and small businesses can purchase coverage; and (2) plans offered in the individual and small group markets outside the exchange. Existing coverage, plans offered in the large group market outside exchanges, and self-insured plans (plans under which an employer assumes direct financial responsibility for the costs of enrollees' medical claims, or sometimes referred to as "ERISA plans") will not be required to provide the essential benefits package. This last exception is especially significant because 57% of workers who are currently covered by their employers' health benefits are enrolled in a plan self-insured by the employer.

How does health care reform impact the state autism insurance reform effort?

Autism Speaks is committed to autism insurance reform that includes coverage of all medically necessary, evidence-based treatments for all people living with autism spectrum disorders. While passage of health care reform will bring some relief to families caring for a child with autism, there is still much work to be done in state legislatures and in Congress to make effective health care coverage a reality for the autism community and to bring about an end to discrimination of individuals with autism by the insurance industry.

We all know families who have gone to extreme measures, including mortgaging their homes and the

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futures of other children, in order to provide the best possible services for their child with autism. According to research, families living with autism have far greater medical expenditures and out-of-pocket costs and are far less likely to report that health insurance meets their child's needs when compared to families living without autism. Health care reform will not end these problems, but it may lessen their severity. That's why Autism Speaks will continue its efforts to make autism insurance reform a reality for all Americans living with autism.

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Sponsor Statement

HB 187 INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

Autism is a devastating disorder affecting at least 1 in 100 children, accounting for 1% of America's youth and 1 in 58 boys, according to the most recent study by the Center for Disease Control and Prevention. Despite being treatable, many children diagnosed with an Autism Spectrum Disorder (ASD) never receive the treatment they need. Families go bankrupt mortgaging their future, trying to provide their children with the treatment to ameliorate their condition. Families are forced to dig into their savings, retirement funds, and their other children's college savings because ASD is not covered by insurance plans. In fact, most insurance plans explicitly exclude the treatment of ASD, even when the service is otherwise covered by the health plan.

HB 187 would require insurance coverage for autism spectrum disorders, including the behavior therapies that after 30 years of study have shown to be the only effective treatment of these disorders. Treatment has been shown to improve the symptoms of ASD and in some cases even eliminate the need for special education services for a child with ASD. The cost savings in special education alone would amount to approximately \$208,500 per capita during the school years. This number rises to over \$1.08 million over the autistic person's lifespan.

The incremental societal cost of not treating autism has been estimated by Michael Ganz, a Harvard economist, to be approximately \$3.2 million per capita. The cost to policy holders to implement such coverage is minimal: estimated at less than a 1% increase in their premiums, or \$3.60 per member per month.

Furthermore, President Obama has stated the coverage of treatment and other types of funding for ASD would be a priority of his administration. Sens. Durbin, Casey and Menendez introduced the Autism Treatment Acceleration Act of 2009 in April, mandating the insurance coverage of ASD. While the federal legislation is currently pending, HB 187 allows Alaska to start this process on our own terms, and gives the state the needed time to meet the demands created in HB 187.

Implementing this legislation in Alaska before a federal mandate is enacted would bring well-paying healthcare jobs to the state and bring those interested in this field to Alaska. It is in the best interest of Alaska and autistic Alaskans to have this implemented as soon as possible.

Since HB 187 was introduced in March of 2009, 11 states have passed legislation regarding mandatory insurance coverage of treatment for ASD, with 8 states having enacted legislation prior to March of 2009. The District of Columbia, Puerto Rico and 19 additional states currently have similar legislation pending. These enacted and pending bills and the pending Autism Treatment Acceleration Act demonstrate the nationwide need for relief for families of autistic individuals. Autism is not a state- or region-specific condition. Families burdened with the costs of autism are unlikely to relocate to one of those 11 states that require insurance companies to cover the cost of ASD treatment. Families of any state should not be burdened with the great cost of treating a disorder they could not prevent or predict; they should not find themselves a victim of discrimination by health insurance companies.

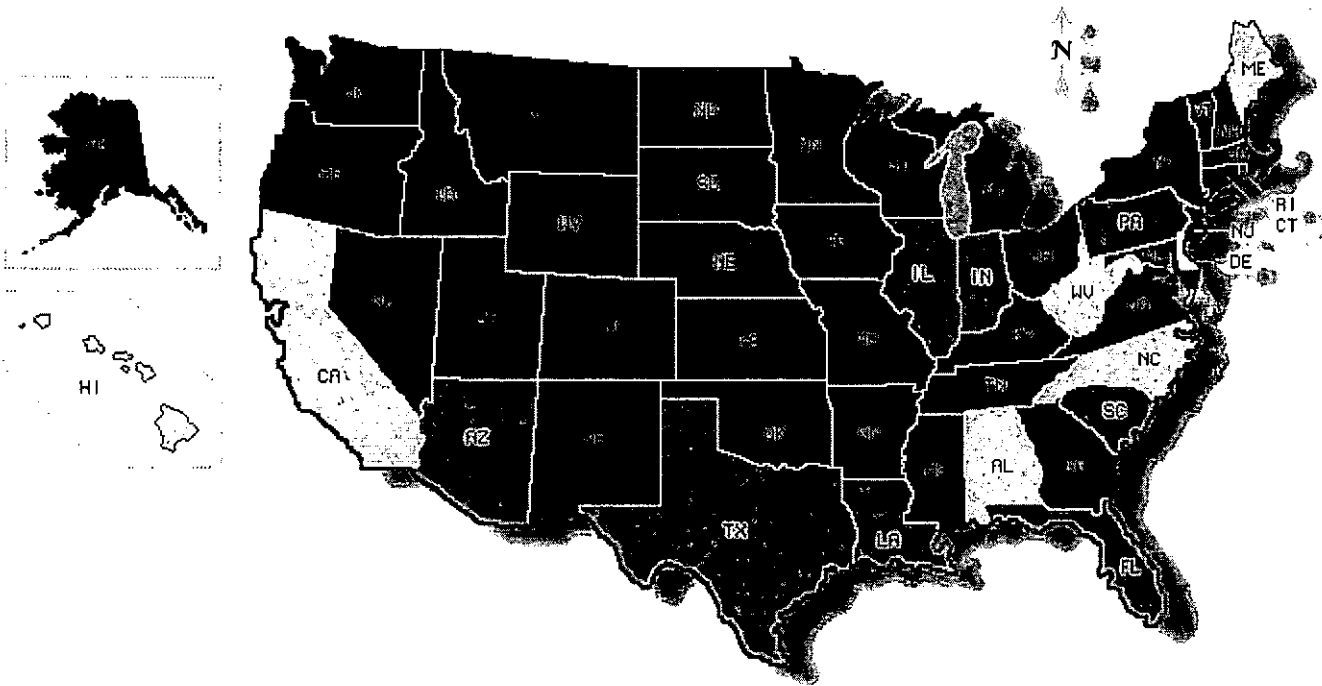
Insurance coverage of ASD would not only provide a much needed service to those families burdened with the effects of a child with autism, but also save the state and taxpayers exponentially over the lifespan of those diagnosed with autism. Though there is no cure for ASD, this legislation would help significantly to treat those suffering from these disorders. In addition, a state that covers ASD treatment will be desirable to those in the field and will bring jobs and professionals in the field to Alaska. It will also allow more flexibility for families with autistic children who wish to move to Alaska to do so. Prompt passage of this legislation would allow the state to reap the health and economic benefits that would result from being among the first states to cover ASD.

I respectfully ask for your careful consideration and support of HB 187.



Autism Speaks 2009 State Initiatives

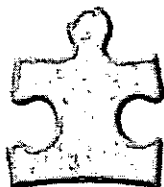
UPDATED



States with Autism Legislation	Legislation not Enforced	Legislation under Review	Bill Under Development		
Arizona Florida Illinois Indiana Louisiana Pennsylvania South Carolina Texas	Alaska Arkansas Connecticut Colorado Georgia Iowa Kansas Kentucky Maryland Massachusetts Michigan Minnesota	Mississippi Missouri Montana Nevada New Jersey New Mexico New York Ohio Utah Virginia Washington Wisconsin	New Hampshire Oklahoma Oregon Tennessee	Alabama California Delaware Hawaii Maine North Carolina Wash., DC West Virginia	Idaho Nebraska North Dakota Rhode Island South Dakota Vermont Wyoming

Autism Speaks

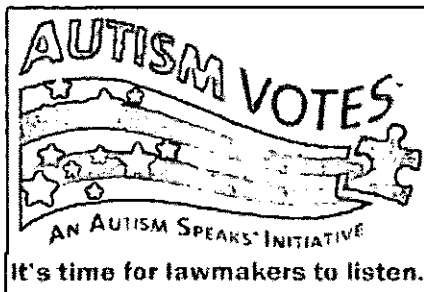
Arguments in Support of Private Insurance Coverage of Autism-Related Services



AUTISM SPEAKS™
It's time to listen.

Eight arguments defining the
justification for autism insurance
reform legislation

February 2009



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Executive Summary

Autism is a complex neurobiological disorder and is the fastest-growing serious developmental disability in the U.S. The Centers for Disease Control estimates that 1 in 150 children have autism. These children require extensive services from medical professionals. Early intervention is critical to gain maximum benefit from existing therapies. Most private health insurance plans do not provide coverage for Applied Behavioral Analysis (ABA) and other autism-related services.

This document contains eight arguments in favor of requiring private health insurance policies to cover the diagnosis and treatment of autism spectrum disorders for individuals under the age of 21. These arguments are based on epidemiological, social, and economic studies of the children and families affected by autism and prove the significant long-term financial and public health benefits of this requirement.

We first point out that children with autism have substantial medical needs and have a difficult time accessing necessary treatments through Medicaid and private health insurance. Most insurance policies contain specific exclusions for autism. This is a hardship for many families, who are often forced to cope with delayed, inadequate, and fragmented care through the Medicaid system. Often, families must pay for costly treatments out-of-pocket or forego them.

We then review some of the many studies and reports that document the effectiveness of intensive behavioral therapies in the treatment of autism. An autism insurance mandate should specifically target coverage of Applied Behavior Analysis (ABA) and other structured behavioral therapies, which are the most effective forms of treatment and have the best outcomes, both in human costs and in long-term economic benefits.

We then comment on the experiences of several states with insurance reform. Their experiences show that the policy holder costs resulting from the passage of legislation requiring comprehensive autism services have been relatively small.

Finally, we point out that the mandate offers hope that children with autism will need less intensive care in the future. They will, in short, have a better chance at a normal life.

What is Autism Speaks?

Autism Speaks is an organization dedicated to increasing awareness of autism spectrum disorders, to funding research into the causes, prevention, treatments, and cure for autism, and to advocating for the needs of affected families. The organization was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Bob Wright is Vice Chairman, General Electric, and served as chief executive officer of NBC for more than twenty years. Autism Speaks has merged with both the National Alliance for Autism Research (NAAR) and Cure Autism Now (CAN), bringing together the nation's three leading autism advocacy organizations.

What is Autism?

Autism is a complex neurobiological disorder that typically lasts throughout a person's lifetime. It is part of a group of disorders known as autism spectrum disorders (ASD). Today, 1 in 150 individuals is diagnosed with ASD, making it more common than pediatric cancer, diabetes, and AIDS combined. It occurs in all racial, ethnic, and social groups and is four times more likely to strike boys than girls. Autism impairs a person's ability to communicate and relate to others. It is also associated with rigid routines and repetitive behaviors, such as obsessively arranging objects or following very specific routines. Symptoms can range from very mild to quite severe.

Argument 1: Mandated private health insurance coverage will provide services that are desperately needed by children with autism, who have greater health care needs than children without autism.

Children with autism have a tremendous need for services from trained medical professionals. These children are at risk for a range of other medical conditions, including behavioral or conduct problems, attention-deficit disorder or attention-deficit/hyperactivity disorder, stuttering, stammering, and other speech problems, depression and anxiety problems, bone, joint, or muscle problems, ear infections, hearing and vision problems, allergies (especially food allergies), and frequent and severe headaches. These problems greatly affect their overall health and their need for and use of health care services.

A recent study by James G. Guerney and others¹ highlights the broad medical needs of children with autism. Using data from the National Survey of Children's Health, Guerney showed that relative to children without autism, children with autism require more services for physical, occupational, and speech therapy. Children with autism are also much more likely to have poor health, to require medically necessary care for behavioral problems, and to be using medications. As evidenced in the chart below taken from the study, parents of children with autism were more likely to report the presence of a variety of concurrent medical conditions and the need for more visits to a range of medical service providers than parents of children without autism.

Table 2. Parental Description of Health Status and Therapy and Services Use, From the National Survey of Children's Health

Variable	Children With Autism (n = 324 000)*	Children Without Autism (n = 11 100 000)*	OR (95% CI)†
Would you say your child's health is:			
Excellent	33.7	60.2	1.0
Very good	22.9	22.5	1.0 (1.2-2.7)
Good	32.7	12.0	5.0 (3.0-8.1)
Fair	7.4	2.0	7.7 (4.3-13.6)
Poor	3.5	0.4	21.1 (0.3-47.0)
Does the child use more medical care, mental health, or educational services than is usual for most children of the same age?	88.6	11.8	32.8 (24.7-40.4)
Is the child limited or prevented in the ability to do the things most children the same age can do?	68.6	5.7	35.2 (24.9-52.6)
Does the child get special therapy, such as physical, occupational, or speech therapy?	76.0	6.3	44.4 (21.9-61.8)
Does the child have any emotional, developmental, or behavioral problem for which she needs treatment or counseling?	75.4	7.0	35.0 (23.7-53.1)
Does the child currently need or use medicine prescribed by a doctor, other than vitamins?	54.7	21.1	3.5 (2.6-4.7)
If yes, is this for a condition expected to last 12 mo or longer?	31.4	14.5	11.0 (1.6-76.0)

Abbreviations: CI, confidence interval; OR, odds ratio.

*Data are given as the percentage of each group and are based on sampling fractions and weighted extrapolation from parent report of 453 children with autism and 84 797 children without autism.

†Data are adjusted for sex, primary language, age, insurance, and household educational attainment.

This reform of private health insurance coverage will address the broad medical needs of children with autism. It will ensure that these children will receive the full range of therapies necessary to ameliorate their condition.

Argument 2: Treatments for autism are difficult to access, often inadequate, and frequently delayed. Denied coverage by private group health insurance companies, parents are often forced either to pay out-of-pocket or forego the treatments their children need.

Children with autism face barriers in accessing early intensive behavioral treatments and other therapies. According to the Institute of Medicine, the term “access” is defined as “the timely use of personal health services to achieve the best possible health outcomes.”² For a child with autism, lack of access to services can be the cause of inconsistent and uncoordinated care. Children with autism often experience barriers to access with even greater frequency than children with other special health care needs. In fact, one study found that “over one-third of the children with autism were reported to have experienced an access problem with respect to specialty care from a medical doctor in the preceding 12 months.”³ A study of the Tennessee Medicaid system, TennCare, found that for children with autism, “the rate of service use was only one tenth what should be expected based on prevalence rates.” The chart below illustrates these results and the significantly lower rates of service access for children with autism.

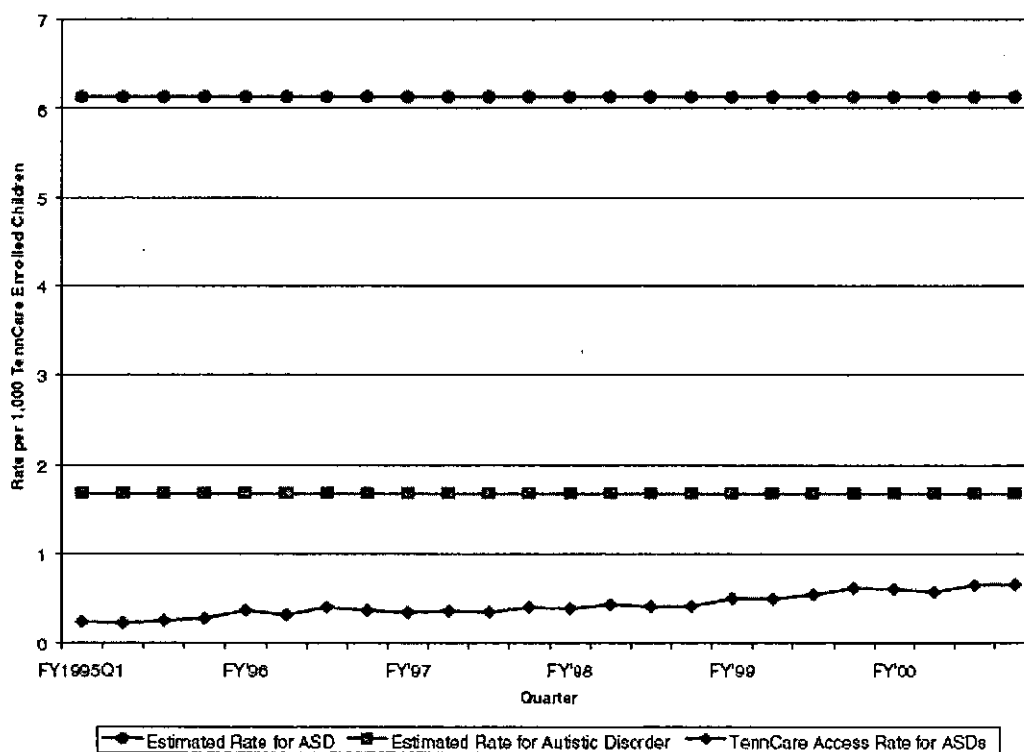


Fig. 1. Estimated incidence rates vs. service rates of autism spectrum disorders (ASDs) in TennCare for children ages 0-17 years, by quarter.

Within the Medicaid system, the amount of public money spent for services for developmental disabilities including autism is now eight times the rate of spending just a few decades ago.⁴ Medicaid accounts for 75% of all funding for services for the developmentally disabled, making it the largest single public payer of behavioral health services.⁵ Children with disabilities comprise a significant portion (15%) of all Medicaid recipients, and an even more significant portion (31%) of disabled children use the Medicaid system as their primary insurer.

Medicaid suffers from very low reimbursement rates that make it difficult for many locations to retain service providers. Moreover, services that can be accessed through the Medicaid system are often inadequate at meeting the specific needs of a child with autism. The system operates as a short-term service provider, tending to push children through treatment as quickly as possible. The success of the Applied Behavior Analysis, however, depends in part, on the amount of time the child with autism spends with the provider of the therapy.⁶

The failings of Medicaid point to the importance of the private health care system in providing services to children with autism. But nationwide there are very few private insurance companies or other employee benefit plans that cover Applied Behavior Analysis and other behavioral therapies. Most insurance companies designate autism as a diagnostic exclusion, "meaning that any services rendered explicitly for the treatment of autism are not covered by the plan, even if those services would be covered if used to treat a different condition."⁷ A 2002 study by Pamela B. Peele and others of 128 behavioral health plans administered by one of two large managed behavioral health organizations found that all the plans had some type of limit on benefits for behavioral therapies – over half of the plans had limits on the number of annual outpatient sessions and 65 percent of the plans imposed limits on the number of inpatient days covered per year.⁸

Families that refuse to allow their children to suffer through the inadequate Medicaid system and are denied coverage by their private health insurance carriers often end up paying for therapies out of their own pockets. For these families, the financial burden is immense. Without the negotiating powers of an insurance company behind them, out-of-pocket prices are extremely high. Parents can often spend upwards of \$50,000 per year on autism-related therapies, often being forced to wager their own futures and the futures of their non-autistic children to pay for necessary autism-related therapies. Children whose parents cannot afford to pay for behavioral and other therapies and who cannot access adequate therapies through the Medicaid system simply go without these interventions.

Argument 3: Mandated private insurance coverage will bring effective autism services within the reach of the children who need them. The efficacy of Applied Behavior Analysis (ABA), the centerpiece of this legislative mandate's benefits, has been established repeatedly.

Private health insurance coverage of autism services will allow children with autism to access Applied Behavior Analysis (ABA), a proven treatment for their condition. Several studies have shown that as many as 47 percent of the children that undergo early intensive behavioral therapies achieve higher education placement and increased IQ levels. A significant portion of children who receive ABA are placed into mainstream educational settings. Children who begin their treatment with minimal IQ levels end treatment with substantially higher levels of intellectual functioning. These results have been shown to last well beyond the end of treatment. As such, the effectiveness of ABA therapy has allowed many children to forego costly intensive special education in the future.

Lovaas:

The most famous study of the effectiveness of behavioral modification treatments was conducted in 1987 by O. Ivar Lovaas.⁹ Lovaas's study showed that when compared with other treatment programs that provide minimal therapy, Applied Behavior Analysis is extremely effective in helping many children struggling with autism, providing gained capacity for intellectual functioning and allowing a child to progress educationally.

Lovaas conducted his study of the effectiveness of behavioral modification treatments on very young children affected by autism. For his study, Lovaas split his 38 subjects into two groups: 19 subjects were put into an intensive-treatment experimental group that received more than 40 hours of one-to-one treatment per week, and 19 subjects were placed in a minimal-treatment control group that received 10 hours or less of one-to-one treatment per week. Both groups were identical at intake in terms of intellectual functioning abilities, and both received their assigned treatment for 2 or more years.

Upon follow-up at age 7, the experimental group attained significantly higher results on education placement and IQ levels than the control group. According to the results of Lovaas's study, the 19-subject experimental group showed nine children (47%) who successfully passed through normal first grade in a public school and obtained an average or above average score on IQ tests.

McEachin:

Lovaas's landmark 1987 study was followed in 1993 by another study of these same 38 subjects. The objective of John J. McEachin's study was to discover the long-term effects of Lovaas's early intensive behavioral treatment and to find out if the results of the experimental group were preserved over time.¹⁰

For this study, Lovaas's original subjects were evaluated at a mean age of eleven-and-a-half years. The study was presented in two parts: the first examined whether the experimental group had maintained its treatment gains, the second part focused on the nine subjects who had achieved the greatest gain in the original study and examined the extent to which they "could be considered free of autistic symptomology."

McEachin's follow-up resulted in findings in three different categories: school placement, intellectual functioning, and presence of adaptive and maladaptive behaviors. In terms of class placement, the study found that "the proportion of experimental subjects in regular classes did not change from the age 7 evaluation (9 of 19, or 47%). In the control group, none of the 19 children were in a regular class, as had been true at the age 7 evaluation." (McEachin, *supra* note 10) In terms of intellectual functioning, the study found that "the experimental group at follow-up had a significantly higher mean IQ than did the control group... indicating that the experimental group had maintained its gains in intellectual functioning between age 7 and the time of the current evaluation." Finally, in terms of presence of adaptive and maladaptive behaviors, "the findings indicate that the experimental group showed more adaptive behaviors and fewer maladaptive behaviors than did the control group." (McEachin, *supra* note 10)

Based on these findings, the effectiveness of ABA and other structured behavioral programs, as provided by the proposed benefit, would be experienced in the short-term as well as the long-term.

Argument 4: Government and scientific organizations have endorsed Applied Behavior Analysis (ABA) and other structured behavioral therapies.

ABA is the treatment of choice for autism. Its efficacy has been recognized in a number of prominent reports, including the following:

- ❖ **The 2001 U.S. Surgeon General's Report on Mental Health**, which states, "Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment. Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."¹¹
- ❖ **The New York State Department of Health** assessed interventions for children ages 0-3 with autism, and recommended that "behavioral interventions for reducing maladaptive behaviors be used for young children with autism when such behaviors interfere with the child's learning or socialization or present a hazard to the child or others."¹²
- ❖ **The Maine Administrators of Services for Children with Disabilities** notes in their report that "There is a wealth of validated and peer-reviewed studies supporting the efficacy of ABA methods to improve and sustain socially significant behaviors in every domain, in individuals with autism. Importantly, results reported include 'meaningful' outcomes such as increased social skills, communication skills academic performance, and overall cognitive functioning. These reflect clinically-significant quality of life improvements. While studies varied as to the magnitude of gains, all have demonstrated long term retention of gains made."¹³
- ❖ **The National Institute of Mental Health** reports, "The basic research done by Ivar Lovaas and his colleagues at the University of California, Los Angeles, calling for an intensive, one-on-one child-teacher interaction for 40 hours a week, laid a foundation for other educators and researchers in the search for further effective early interventions to help those with ASD attain their potential. The goal of behavioral management is to reinforce desirable behaviors and reduce undesirable ones."¹⁴
- ❖ **The National Institute of Child Health and Human Development** lists Applied Behavior Analysis among the recommended treatment methods for Autism Spectrum Disorders.¹⁵
- ❖ **The National Research Council's** 2001 report on Educating Children with Autism acknowledged, "There is now a large body of empirical support for more contemporary behavioral approaches using naturalistic teaching methods that demonstrate efficacy for teaching not only speech and language, but also communication."¹⁶

- ❖ **The Association for Science in Autism Treatment** recommends ABA-based therapies, stating, “ABA is an effective intervention for many individuals with autism spectrum disorders.”¹⁷

Argument 5: To combat the difficulty many families face in accessing Applied Behavior Analysis (ABA) and other structured behavioral treatments through public insurance, three states have passed autism insurance mandates that specifically require private insurance companies to provide coverage of these therapies, thus creating a public-private partnership for the provision of care.

While there are several states that have passed autism specific private insurance mandates, very few states specifically mandate coverage for ABA and other structured behavioral therapy programs. Without coverage of these crucial, medically necessary, evidence based therapies, the effectiveness of most mandates is severely diminished. For this reason, we have concluded that only the following states have passed autism insurance legislation:

South Carolina:

Senate Bill 20, better known as Ryan's Law, was passed by both the South Carolina House of Representatives and Senate on May 31, 2007.¹⁸ The bill was then vetoed by Governor Mark Sanford on June 6. On June 7, the bill was brought back to the House and Senate floors, and unanimous votes in both chambers overrode the Governor's veto. This law goes into effect in July 2008.

Coverage Includes: Treatments, including behavioral therapies, which are prescribed by the individual's treating medical doctor in accordance with a treatment plan.

Age Range: An individual must be diagnosed with autistic spectrum disorder at age eight or younger. The coverage must be provided to any eligible person less than sixteen years of age.

Dollar Cap: Coverage for behavioral therapy is subject to a \$50,000 maximum benefit per year.

Texas:

On June 15, 2007, Texas enacted House Bill 1919, effective September 1, 2007.¹⁹ While the Texas bill limits the ages for children who can benefit from coverage, it goes further than some other states in spelling out exactly what kinds of services are covered. The bill's text specifically cites which kinds of autism-related services are examples of treatments that must be covered.

Coverage Includes: Evaluation and assessment services, A BA, behavior training and behavior management, speech therapy, occupational therapy, physical therapy, medication or nutritional supplements used to address symptoms of autism spectrum disorder.

Age Range: An individual must be between ages three and five to receive this

coverage.

Dollar Cap: Same as afforded to physical illnesses

Indiana:

In 2001, the Indiana enacted House Bill 1122, requiring insurers that issue accident and sickness insurance policies on an individual basis to provide coverage for the treatment of autism spectrum disorders.²⁰

Coverage Includes: Treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. The statute thus allows many different professionally accepted therapies, such as ABA, speech therapy, occupational therapy, physical therapy, and medications to address symptoms of autism.

Age Range: All ages are allowed coverage

Dollar Cap: Same as afforded to physical illnesses

Argument 6: The costs of the proposed benefit are small and will have very little impact on the cost of health insurance premiums for the individual consumer.

Earlier this year, The Council for Affordable Health Insurance, a research and advocacy association of insurance carriers, released its annual report on state health insurance mandates, *Health Insurance Mandates in the States 2007*.²¹ The report defined a mandate as “a requirement that an insurance company or health plan cover (or offer coverage for) common – but sometimes not so common – health care providers, benefits and patient populations.” (Bunce, *supra* note 21) Using this definition, the report identified legislative mandates for autism benefits in ten states: Colorado, Delaware, Georgia, Iowa, Indiana (which, as we have noted, provides comprehensive benefits), Kentucky, Maryland, New Jersey, New York, and Tennessee. The report assessed the incremental cost of state mandated benefits for autism in these ten states *as less than one percent*.

The Council’s modest estimate of incremental premium costs is consistent with state government estimates across the country. Prior to enactment of Indiana’s sweeping legislation, the Indiana Legislative Services Agency estimated additional premium costs as ranging from \$.44 per contract per month to \$1.67 per contract per month.²² In vetoing Ryan’s Law in South Carolina, Governor Mark Sanford estimated that the bill, with its \$50,000 maximum yearly benefit for behavioral therapy, would add \$48 annually to insurance policies.²³ And in Wisconsin, where pending Assembly Bill 417 would provide the same broad coverage Indiana’s statute mandates, the Department of Administration estimates policy increments of between \$3.45 and \$4.10 per month – about the same as Governor Sanford’s estimate for Ryan’s Law.²⁴

The cost estimates for Indiana, South Carolina, and Wisconsin – all states whose legislation allows a maximum benefit that can be considered high – suggest that an average autism insurance coverage mandate will cost approximately \$50 annually per policy holder. For only a modest effect on premium cost, this insurance reform holds the promise of significantly improving the lives of thousands of children.

Argument 7: By improving outcomes for children with autism, mandated private insurance coverage will decrease the lifetime costs of treating and providing services and will actually result in an overall cost savings in the long-run.

A 1998 study by John W. Jacobson and others titled, *Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case*, examined the cost/benefit relationship of early intensive behavioral intervention treatment at varying levels of treatment success.²⁵ The study used estimates of costs for early intensive behavioral interventions (EIBI) from childhood (age three) through adulthood (age 55) based on prices in the Commonwealth of Pennsylvania and compared these costs with the expected amount of income the child would earn later in life to arrive at an estimated cost savings.

With a success rate of 47 percent for early intensive behavioral intervention therapy (as determined by Lovaas), Jacobson's study found that cost savings per child served are estimated to be from \$2,439,710 to \$2,816,535 to age 55.

Table 6. Financial benefits at different levels of effectiveness, age 3–55 years, per 100 children served and per child served—Pennsylvania model

	<i>Inflated total</i>	<i>1996 \$ total</i>	<i>Inflated/ student</i>	<i>1996 \$/ student</i>
At 20% normal range				
20 norm range vs. partial effect	96,085,200	36,654,400	4,804,260	1,832,720
70 partial vs. minimal effect	72,520,910	28,984,130	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	168,606,110	65,638,530	1,686,061	656,385
At 30% normal range				
30 norm range vs. partial effect	144,127,800	54,981,600	4,804,260	1,832,720
60 partial vs minimal effect	62,160,780	24,843,540	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	206,288,580	79,825,140	2,062,886	798,251
At 40% normal range				
40 norm range vs. partial effect	192,170,400	73,308,800	4,804,260	1,832,720
50 partial vs. minimal effect	51,800,650	20,702,950	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	243,971,050	94,011,750	2,439,710	940,118
At 50% normal range				
50 norm range vs. partial effect	240,213,000	91,636,000	4,804,260	1,832,720
40 partial vs. minimal effect	41,440,520	16,562,360	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	281,653,520	108,198,360	2,816,535	1,081,984

Note: This table presents a comparison of financial benefits at different levels or rates of achievement of normal skills or functioning achieved by EIBI, for people ages 3–55 years, ranging from 20% of children achieving normal range skills or functioning (an assumed minimal rate) to 50% of children. At each level of effectiveness, differing rates of normal range functioning, as well as partial benefit are estimated. Costs are shown in terms of the aggregate of 100 children served, and averages per person served, with inflation and in 1996 dollars.

The study also accounts for the initial investment in early intervention by concluding that, with an initial annual cost of \$32,820, the total cost-benefit savings of EIBI services per

child with autism or PDD for ages 3-55 years averages from \$1,686,061 to \$2,816,535 with inflation.

According to a 2005 Government Accounting Office (GAO) report, "the average per pupil expenditure for educating a child with autism was more than \$18,000 in the 1999-2000 school year. This amount was almost three times the average per pupil expenditure of educating a child who does not receive any special education services."²⁶ With this insurance reform in place, more children would be able to access the early intervention services they need. That investment will, in the long run pay benefits, both economic and social, to the greater population.

Argument 8: Without passage of legislation requiring private health insurance coverage for autism, the costs associated with autism will continue not only to affect families, but will have far reaching social effects as well.

The cost of autism is borne by everyone. Michael L. Ganz's study of the societal costs of autism, *The Lifetime Distribution of the Incremental Societal Costs of Autism*, examined how the large financial burdens of autism affect not only families with an autistic child but society in general.²⁷

Ganz broke down the costs associated with autism into two distinct categories, direct costs and indirect costs. Direct costs include direct medical costs, such as physician, outpatient, clinic services, dental care, prescription medications, complementary and alternative therapies, behavioral therapies, hospital and emergency services, allied health, equipment and supplies, home health, and medically related travel, as well as direct nonmedical costs, such as child care, adult care, respite and family care, home and care modification, special education, and supported employment. Indirect costs include productivity losses for people with autism (calculated by combining standard average work-life expectancies for all men and women with average income and benefits and estimated age and sex specific labor force participation rates).

According to Ganz's study, direct medical costs reach their maximum during the first five years of life, averaging around \$35,000. As the child ages, direct medical costs begin to decline substantially and continue to decline through the end of life to around \$1,000. Ganz goes on to report, "The large direct medical costs early in life are driven primarily by behavioral therapies that cost around \$32,000 during the first 5-year age group and decline from about \$4,000 in the 8-to 12-year age group to around \$1,250 for the 18- to 22-year age group." (Ganz, *supra* note 27)

In terms of direct medical costs "the typical American spends about \$317,000 over his or her lifetime in direct medical costs, incurring 60% of those costs after the age of 65 years. In contrast, people with autism incur about \$306,000 in incremental direct medical costs, which suggests that people with autism spend twice as much as the typical American over their lifetimes and spend 60% of those incremental direct medical costs after age 21 years." (Ganz, *supra* note 27)²⁷

The study also found the indirect costs of autism to be significant as well. While in the first 22 years of life, indirect costs are mostly associated with lost productivity for the parents of a child with autism, the costs from age 23 on are associated with lost productivity of the actual individual with autism as depicted in the chart below taken from the study. The impact of this lost productivity can have enormous ramifications for the tax base of an entire society and the future of the older generation as their children with autism transition into adult care.

Table 4. Age-Specific and Lifetime per Capita Incremental Societal Indirect Costs of Autism*

Age Group, y	Average per Capita Cost per Age Group	
	Direct Indirect	Net Direct Indirect
3-7	0	49056
8-12	0	41138
13-17	0	38453
18-22	0	36020
23-27	32,703	19036
28-32	32,620	3136
33-37	30,852	0
38-42	29,132	0
43-47	26,600	0
48-52	24,534	0
53-57	17,776	0
58-62	0	0
63-66	0	0
Total lifetime costs	221,072	104,526

*Costs presented in 2012 dollars. Costs for age 4 years and older are discounted to 2009 dollars using a discount rate of 3%. Life expectancy for men is age 65 years and for women, age 65 years.

Ganz posited that direct medical costs “combined with very limited to non-existent income for their adult children with autism combined with potentially lower levels of savings because of decreased income and benefits while employed, may create a large financial burden affecting not only those families but potentially society in general.”(Ganz, *supra* note 27)

Without the help of private insurance coverage, families affected by autism may never be able to pull their heads above water and provide their children with the medically necessary, evidence-based treatments that they need. It is to the advantage of these families, to the 1 in 150 children affected by autism, and to all of society that private health insurance coverage is provided for these services.

Conclusion

A legislative mandate for coverage of autism asks private insurance companies to make a limited, but significant, contribution to help pay for medically necessary, evidence-based treatments that have been established to be of the greatest impact in fighting this terrible disorder.

Unbelievably, it is not uncommon for insurance carriers to have line-item exclusions for treatment of individuals diagnosed with autism. Across the nation, children with autism are routinely denied insurance benefits for treatment of their disorder. We believe that private insurance companies must contribute their fair share and partner in the financial burdens with these families.

With every new child diagnosed with autism costing an estimated \$3 million over his or her lifetime, the current practices are both unfair and not cost effective in the long run for states and their citizens. Autism Speaks is confident that many more state governments will recognize the significant long-term cost benefits found in these legislative measures, will do what is right for their constituents, and will pass legislation requiring private health insurance coverage of autism services.

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DSM-IV Definitions

Defining Autism Pervasive Developmental Disorder Learn the Signs Related Disorders
Facts and Statistics

Pervasive Development Disorders (PDD)

The term "PDD" is widely used by professionals to refer to children with autism and related disorders; however, there is a great deal of disagreement and confusion among professionals concerning the PDD label. Diagnosis of PDD, including autism or any other developmental disability, is based upon the *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV)*, published by the American Psychiatric Association (Washington, DC, 1994), and is the main diagnostic reference of mental health professionals in the U.S.

According to the *DSM-IV*, the term "PDD" is not a specific diagnosis, but an umbrella term under which the specific diagnoses are defined.

Diagnostic labels are used to indicate commonalities among individuals. The key defining symptom of autism that differentiates it from other syndromes and/or conditions is substantial impairment in social interaction (Frith, 1989). The diagnosis of autism indicates that qualitative impairments in communication, social skills, and range of interests and activities exist. As no medical tests can be performed to indicate the presence of autism or any other PDD, the diagnosis is based upon the presence or absence of specific behaviors. For example, a child may be diagnosed as having PDD-NOS if he or she has some behaviors that are seen in autism, but does not meet the full criteria for having autism. **Most importantly, whether a child is diagnosed with a PDD (like autism) or a PDD-NOS, his/her treatment will be similar.**

Autism is a spectrum disorder, with symptoms ranging from mild to severe. As a spectrum disorder, the level of developmental delay is unique to each individual. If a diagnosis of PDD-NOS is made, rather than autism, the diagnosticians should clearly specify the behaviors present. Evaluation reports are more useful if they are specific and become more helpful for parents and professionals in later years when reevaluations are conducted.

Ideally, a multidisciplinary team of professionals should evaluate a child suspected of having autism. The team may include, but may not be limited to, a psychologist or psychiatrist, a speech pathologist and other medical professionals, including a developmental pediatrician and/or neurologist. Parents and teachers should also be included, as they have important information to share when determining a child's diagnosis.

In the end, parents should be more concerned that their child find the appropriate educational treatment based on their needs, rather than spending too much effort to find the perfect diagnostic label. Most often, programs designed specifically for children with autism will produce greater benefits, while the use of the general PDD label can prevent children from obtaining services relative to their needs.

Also within each diagnosis is the ASA Panel of Professional Advisors' recommended definition of the autism spectrum and related syndromes and conditions, which is not to be used for research purposes but rather for defining the demographics of the ASA's membership. The ASA is not attempting to represent individuals with related syndromes or conditions who do not also have autism, but rather those where autism is present in related syndromes and conditions, and where autism is the defining syndrome (e.g., autism-Asperger's). The rationale for this position is due to the unique service needs that are imperative for individuals with autism that may not

be required of the cohort disability. (See also "General Standards of Care for Individuals with Autism Throughout the Lifespan.")

- Autistic Disorder (299.00 DSM-IV)
- Asperger's Disorder (299.80 DSM-IV)
- Rett's Disorder (299.80 DSM-IV)
- Childhood Disintegrative Disorder (299.10 DSM-IV)
- PDD-NOS (299.80 DSM-IV)

Autistic Disorder (299.00 DSM-IV)

The central features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication, and a markedly restricted repertoire of activity and interest. The manifestations of this disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as Early Infantile Autism, Childhood Autism, or Kanner's Autism (page 66).

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:
 - Marked impairment in the use of multiple nonverbal behaviors such as eye to-eye gaze, facial expression, body postures, and gestures to regulate social interaction .
 - Failure to develop peer relationships appropriate to developmental level
 - A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - Lack of social or emotional reciprocity
2. Qualitative impairments in communication as manifested by at least one of the following:
 - Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)
 - In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - Stereotyped and repetitive use of language or idiosyncratic language
 - Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - Encompassing preoccupation with one or more stereotyped patterns of interest that is abnormal either in intensity or focus
 - Apparently inflexible adherence to specific, nonfunctional routines or rituals
 - Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - Persistent preoccupation with parts of object

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:

- Social interaction
- Language as used in social communication

- Symbolic or imaginative play

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

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Asperger's Disorder (299.80 DSM-IV)

The essential features of Asperger's Disorder are severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interest, and activity. The disturbance must clinically show significant impairment in social, occupational, and other important areas of functioning. In contrast to Autistic Disorder, there are no clinically significant delays in language. In addition there are no clinically significant delays in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior, and curiosity about the environment in childhood.

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

- Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- Failure to develop peer relationships appropriate to developmental level
- A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
- Lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- Apparently inflexible adherence to specific, non-functional routines or rituals
- Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- Persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years)

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

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Rett's Disorder (299.80 DSM-IV)

The essential feature of Rett's Disorder is the development of multiple specific deficits following a period of normal functioning after birth. There is a loss of previously acquired purposeful hand skills before subsequent development of characteristic hand movement resembling hand wringing or hand washing. Interest in the social environment diminishes in the first few years after the onset of the disorder. There is also significant impairment in expressive and receptive language development with severe psychomotor retardation. (Page 71)

A. All of the following:

- Apparently normal prenatal and prenatal development
- Apparently normal psychomotor development through the first 5 months after birth
- Normal head circumference at birth

B. Onset of all of the following after the period of normal development:

- Deceleration of head growth between ages 5 and 48 months
- Loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand-wringing or hand washing)
- Loss of social engagement early in the course (although often social interaction develops later)
- Appearance of poorly coordinated gait or trunk movements
- Severely impaired expressive and receptive language development with severe psychomotor retardation

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Childhood Disintegrative Disorder (299.10 DSM-IV)

The central feature of Childhood Disintegrative Disorder is a marked regression in multiple areas of functioning following a period of at least two years of apparently normal development. After the first two years of life, the child has a clinically significant loss of previously acquired skills in at least two of the following areas: expressive or receptive language; social skills or adaptive behavior; bowel or bladder control; or play or motor skills. Individuals with this disorder exhibit the social and communicative deficits and behavioral features generally observed in Autistic Disorder, as there is qualitative impairment in social interaction, communication, and restrictive, repetitive and stereotyped patterns of behavior, interests, and activities. (Page 73)

A. Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

B. Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:

- Expressive or receptive language
- Social skills or adaptive behavior

- Bowel or bladder control
- Play
- Motor skills

C. Abnormalities of functioning in at least two of the following areas:

- Qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)
- Qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)
- Restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, including motor stereotypes and mannerisms

D. The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia.

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PDD-NOS (299.80 DSM-IV)

The essential features of PDD-NOS are severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills; and stereotyped behaviors, interests, and activities. The criteria for Autistic Disorder are not met because of late age onset; atypical and/or sub-threshold symptomatology are present. (Page 77-78)

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism"-- presentations that do not meet the criteria for Autistic Disorder because of late age of onset, atypical symptomatology, or sub-threshold symptomatology, or all of these.

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Last updated: 30 January 2008

Biosketch

Gina Green received a PhD in Psychology (Analysis of Behavior) from Utah State University in 1986 following undergraduate and master's degree studies at Michigan State University. She has been a faculty member in Behavior Analysis and Therapy at Southern Illinois University; Director of Research at the New England Center for Children in Southborough, Massachusetts; Associate Scientist at the E.K. Shriver Center for Mental Retardation in Waltham, Massachusetts; and Research Associate Professor of Psychiatry and Pediatrics, University of Massachusetts Medical School. Dr. Green is currently the Executive Director of the Association of Professional Behavior Analysts, a consultant in private practice in San Diego, a lecturer in Special Education at San Diego State University, and an Adjunct Professor in the Department of Behavior Analysis, University of North Texas. She has authored numerous publications on the treatment of individuals with developmental disabilities and brain injuries, as well as the experimental analysis of behavior. Dr. Green co-edited the books *Behavioral Intervention for Young Children with Autism* and *Making a Difference: Behavioral Intervention for Autism*. She serves or has served on the editorial boards of several professional journals in developmental disabilities and behavior analysis. Dr. Green also serves on the Autism Advisory Group of the Cambridge Center for Behavioral Studies and the advisory boards of several autism programs and organizations. She is a Board Certified Behavior Analyst, former president of the Association for Behavior Analysis and the California Association for Behavior Analysis, a former member of the Board of Directors of the Behavior Analyst Certification Board, a founding Director of the Association of Professional Behavior Analysts, and a Fellow of the American Psychological Association and the Council for Scientific Medicine and Mental Health. *Psychology Today* named her "Mental Health Professional of the Year" in 2000. In 2005 she received an honorary Doctor of Science degree from The Queen's University of Belfast, Northern Ireland for her work in autism. Dr. Green lectures and consults widely on autism and related disorders, behavioral research, and effective interventions for people with disabilities.

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September 2, 2008

The Honorable S. Ward Casscells, MD
Assistant Secretary of Defense for Health Affairs
1200 Defense Pentagon, Room 3E1082
Washington, DC 20301-1200
Via FAX: 703-697-4197

Dear Dr. Casscells:

As a long-time autism researcher and practitioner, I am writing to offer some information in support of your efforts to make effective treatment more widely and easily accessible to military children with autism spectrum disorders (ASD). In addition to having worked in this field for more than three decades, it has been my privilege over the past couple of years to work with some extraordinary military families who are advocating for coverage of effective treatment for ASD by TRICARE. They have taught me a great deal and have won my everlasting admiration, so I am grateful to have this opportunity to help them by providing expert opinion on the efficacy and medical necessity of applied behavior analysis (ABA) treatment for ASD.

As you know, ASDs are neurodevelopmental conditions that affect virtually all aspects of everyday functioning to some degree. Difficulties are typically seen in communication, social interaction, intellectual functioning, play and leisure skills, academics, and self-care skills. Many individuals with ASD also exhibit behavior disorders that interfere with their acquisition of useful skills and put them and others at risk of physical harm. Without effective intervention to help them build the skills required for everyday living and to reduce problem behaviors, many people with ASD suffer needless injuries and illnesses, and require extensive – and expensive – specialized services throughout the lifespan. That takes an enormous toll on their families, on healthcare and human service systems, and on society as a whole. Fortunately, research has shown that much of that toll can be alleviated for people with ASD who receive competently delivered applied behavior analysis (ABA) intervention.

Behavior analysis is a natural science approach to understanding how behavior interacts with environmental variables. In this scientific discipline, “behavior” means anything done by living organisms (not just misbehavior), and “environment” includes all types of physical and social events that might change or be changed by an individual’s behavior. Like many other sciences, behavior

analysis has conceptual, experimental, and applied branches. The basic science focuses on discovering principles (that is, general laws) about how behavior works, or how learning takes place. For example, one principle of behavior analysis is positive reinforcement: When a behavior is followed by a consequence that is valued by the individual, that behavior is likely to be repeated in the future. Applied behavior analysis (ABA) is the use of the principles and methods derived from research to bring about meaningful changes in socially important behaviors. The applied component of the field was originally created by blending the experimental analysis of behavior – the basic science – with research on human development. Through nearly five decades of laboratory and field research, the discipline of behavior analysis has developed many techniques for increasing useful behaviors and reducing those that may be harmful or that interfere with learning. Some of the many areas in which this science has been applied fruitfully include developmental disabilities, education, brain and spinal cord injury rehabilitation, communication disorders, public health, substance abuse, business and industry, safety, child abuse and neglect, parenting, gerontology, and of course, ASD.

Numerous reviews of scientific research have identified ABA as a proven, safe, and effective approach to ASD intervention. Several of those reviews have cited the hundreds of published studies documenting the efficacy of a variety of ABA techniques for increasing a wide array of specific skills and decreasing a wide array of problem behaviors in people with ASD of all ages. In addition to those focused interventions, comprehensive, intensive early intervention programs using combinations of many ABA techniques have been shown to produce large improvements in multiple skill domains in many young children with ASD, more modest but still clinically important improvements in many other children. Those effects have been obtained when ABA intervention was designed and overseen by qualified professional behavior analysts. Among those who have recognized competently delivered ABA as an evidence-based approach to ASD intervention are the U.S. Surgeon General, New York State Department of Health, U.S. Department of Defense, American Academy of Pediatrics, Association for Science in Autism Treatment, and Autism Speaks.

I understand that in the course of deliberations about TRICARE policies, questions have arisen about the medical necessity of ABA intervention for ASD and whether that intervention is special education. I hope the following points of information will help ease concerns you and others may have about those issues.

ABA is medically necessary treatment for ASD

- Unfortunately, many people with ASD engage in behaviors that jeopardize their safety and health, such as self-injury, pica (ingesting inedible items), elopement (running away), flopping (throwing themselves on the ground), aggression, sleep disorders, and severely restricted eating. Several studies have found that such behaviors lead to disproportionate numbers of emergency room visits, hospitalizations, and prescriptions of psychotropic drugs for people with ASD, with the associated high costs. Extensive

research by behavior analysts has shown that those behaviors are often learned, and are triggered and reinforced by environmental events. Behavior analysis methods have proved effective not only for identifying those environmental events, but also for reducing problem behaviors and developing appropriate alternative behaviors, such as requesting help with a task instead of eloping or aggressing, eating a healthy diet, and sleeping through the night.

- Although some drugs can reduce some of the problem behaviors just mentioned, relatively few psychotropic medications have been tested adequately with children with ASD. Further, as the American Academy of Pediatrics noted recently, no drugs ameliorate the core symptoms of ASD, and many drugs that are prescribed for problem behaviors have negative side effects. For example, the only drug that has been approved by the FDA to date for the treatment of ASD – risperidone -- has been shown to reduce irritable and agitated behavior. But risperidone is not 100% effective, and its negative side effects include incontinence and weight gain, which increases the risk of diabetes and other health problems. ABA methods, on the other hand, can effectively reduce problem behaviors without adverse physical side effects.
- The behavioral excesses and deficits exhibited by people with ASD often hamper the delivery of health care services to this population. Communication difficulties and fearful responses to unfamiliar situations, for example, can make routine medical and dental checkups major ordeals for people with ASD and their families. Studies have shown that with ABA intervention, people with ASD can learn to communicate and cooperate with health care professionals, to comply with medical and dental care routines, and to undergo medical procedures like scans and EEGs.
- In a related vein, a variety of ABA techniques have proved effective for building self-care, hygiene, and personal safety skills in people with ASD, thus enhancing their health and reducing their risk of injury.
- Many people with ASD have difficulty recognizing and responding appropriately to situations that put them at risk of harm. Research has shown that ABA methods are effective for teaching people with ASD to be aware of and to avoid potentially hazardous situations, to seek help when necessary, and to communicate essential information to individuals who can assist them.
- In sum, ABA intervention for ASD is similar to certain treatments that are commonly provided to children and adults with other neurological disorders to develop or restore independent functioning. Those treatments are covered under many health insurance plans. With competently delivered ABA intervention, many people with ASD can enjoy safe and healthy lives. The earlier a child with ASD receives effective intervention, the more likely she is

to achieve large improvements in multiple skill areas, and the less likely it is that health-threatening problem behaviors will develop. Adolescents and adults with ASD can also benefit from ABA intervention. TRICARE insurance coverage to make this medically necessary treatment available to military children with ASD and their families will not only enhance the lives of those individuals, it will also reduce their need for health care services and the associated costs.

ABA is not special education

- Although ABA intervention methods are effective for building academic and other skills, and certainly could be used by properly trained teachers and other school personnel serving students with ASD, applied behavior analysis is increasingly recognized as a unique and distinct professional practice. In fact, in its 2007 report on autism, the U.S. Department of Defense described applied behavior analysis as an “emerging profession.” There is an accredited international certification program for practitioners, managed by the Behavior Analyst Certification Board (see www.BACB.com). Some Board Certified Behavior Analysts and Board Certified Assistant Behavior Analysts work in special education, but the BACB certification is not an education credential per se. University training in behavior analysis is provided in a wide range of academic departments (e.g., behavior analysis, psychology, human development, public health, criminal justice, education, special education). Unfortunately, however, most special education teacher certification programs provide little, if any, training in ABA; very few provide all of the didactic training and supervised practical experience that the discipline deems necessary to practice ABA at even a rudimentary level.
- ASDs affect multiple areas of functioning, not just the skill domains that are typically addressed by the education system. Further, schools typically serve students with ASD for just a few hours each weekday for 9 months of the year. As noted previously, many people with ASD have difficulties with eating, sleeping, self-care, and personal safety. Those difficulties are most salient – and are best addressed – in home and community settings. Indeed, the need for intervention to build crucial skills of all kinds and to reduce problem behaviors does not stop with the end of the school day, the school week, or the school year. Abundant research shows that in order to generalize learned skills, people with ASD need carefully planned, consistently delivered behavior analytic intervention throughout each day, 7 days a week, year around, in multiple environments. Behavior analysts have developed specific techniques for promoting skill generalization. Importantly, those techniques include training family members to prompt and reinforce functional skills and to manage problem behaviors in a variety of everyday settings. The education system unfortunately lacks the resources to provide that kind of intervention. Therefore, if the responsibility for treating ASD is placed entirely on the schools, most people with ASD will not receive effective treatment so will

require substantial and expensive health care and other services throughout their lives.

- To expand upon a previous point, ABA intervention for ASD parallels the intensive speech, occupational, and physical therapies that are provided to children and youths with other neurological disorders to build or rebuild communication, cognitive, self-care, academic, and other skills. Those therapies are often delivered in schools, yet they are not narrowly construed as "special education." On the contrary, they are deemed medically necessary, and are covered by most health insurance plans. ABA intervention should be granted the same status.

With effective treatment, military children and youths with ASD can lead happier and healthier lives than they would otherwise. ABA is an effective and safe treatment for ASD when it is designed and overseen by qualified professional behavior analysts. If this medically necessary treatment is delayed or is provided at suboptimal levels, the health and wellbeing of the child with ASD and his family will be affected negatively in both the short and the long run. Failure to cover ABA treatment under the basic TRICARE program will not only add to the already heavy burden carried by military families of children with ASD, it will also add to the costs of health care and other services for those military dependents for years to come. I urge you to head off those tragedies by correcting the Code of Federal Regulations and TRICARE policies to include coverage of ABA treatment for ASD.

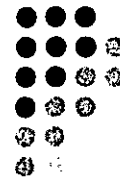
Very respectfully,

Gina Green, PhD, BCBA

cc: Karen Driscoll (Karen0622@aol.com)
MG Elder Granger, Deputy Director, TRICARE (fax: 703-681-3665)

Applied Behavior Analysis in the Treatment of Autism

Gina Green, PhD, BCBA
Association of Professional Behavior Analysts
San Diego, CA • gggreen3@cox.net



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Topics

- Overview of applied behavior analysis (ABA) intervention for autism
 - What ABA is
 - What is known from research on
 - Focused ABA interventions for autism
 - Intensive, comprehensive ABA intervention for young children with autism
- Health insurance coverage of ABA intervention for autism
 - Rationale
 - Self-insured companies
 - TRICARE demonstration program
 - State mandates
 - Proposed federal mandate
- Summary and conclusions



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Applied behavior analysis



- Behavior (*not* "behavioral") analysis: a natural science approach to understanding and changing behavior; focus is on relations between behavior and environment
 - A scientific discipline with
 - Conceptual, experimental, and applied components
 - Unique research methodology
 - Professional journals and organizations
 - Professional credentialing program for practitioners
 - Managed by Behavior Analyst Certification Board (see www.BACB.com)
 - Accredited by National Commission for Certifying Agencies
- Applied behavior analysis (ABA): Application of scientific principles of behavior discovered through basic research (e.g., reinforcement) to improve socially significant behavior to a meaningful degree
 - *Many* applications in addition to autism
 - Based on the work of many researchers and practitioners

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ABA



- An approach comprising many evidence-based techniques or procedures for changing behavior
- Effective for building skills and reducing problematic behaviors in people of all ages, with and without disabilities
- Stresses positive reinforcement and scientific demonstrations of effectiveness
- Highly individualized
- Flexible and dynamic; intervention is adjusted continuously based on data
- Continuously evolving

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Behavior analysis research methods



- Direct observation and measurement of behavior, and single-case research designs
 - Intensive study of individual behavior interacting with environmental variables over time under control and treatment conditions
- Akin to methods used in other natural sciences, and by some medical researchers
- Focus is on *clinically important changes in individual behavior over time*, not statistical comparisons of group average scores
- Included in several protocols for developing evidence-based practice guidelines for behavioral interventions (e.g., American Psychological Association, National Association of School Psychologists) and for interventions for autism (e.g., New York State Department of Health Early Intervention Program, National Autism Center's National Standards Project, California Department of Developmental Services ASD Guidelines Project).

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ABA for autism: Research on focused interventions



- Hundreds of published studies document effectiveness of many ABA techniques for developing many important skills in people with autism *of all ages* (e.g., Matson et al., 1996; New York State Department of Health, 1999; Wolery, Barton, & Hine, 2005; *Journal of Applied Behavior Analysis*):
 - Learning to learn: looking, listening, imitating, following instructions, discriminating and matching stimuli, etc.
 - Communication: verbal and nonverbal; comprehension and production; from simple to complex
 - Social : simple reciprocal exchanges, playing with peers, sharing, expressing emotions, empathizing, dramatic play, etc.
 - Self-care: hygiene, personal safety, community living, dental and healthcare routines, etc.
 - Academics
 - Motor and leisure
 - Vocational
- Hundreds more document effectiveness of ABA methods for reducing problem behaviors (e.g., see Campbell, 2003)

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Early intensive ABA for autism: Treatment model



- *Early*: generally, children enter treatment before age 6
- *Intensive*: 25-40 hrs/wk, year around, 1- 4 yrs
- *Comprehensive*:
 - Addresses skills in all domains -- "learning to learn," communication, social, self-care (e.g., safety, hygiene, eating, sleeping), cognitive, preacademic, play -- broken down into small components or steps
 - Many evidence-based ABA techniques used to develop functional skills, reduce problem behaviors
- Usually started in home, but can be done in centers
- Highly individualized to child and family needs and characteristics
- Treatment program designed and overseen by professional behavior analyst with at least a master's degree and specific training in autism

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Early intensive ABA (cont'd)

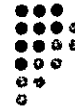


- Each learner's strengths and weaknesses assessed by direct observation and measurement
- Each component skill developed via many carefully planned learning opportunities
 - in both structured and naturalistic situations
 - using written protocols
 - with lots of repetition and positive reinforcement
 - in 1-to1 format initially; gradually changed to small group
- Problem behaviors are not reinforced; appropriate alternative behaviors are
- Where possible, child makes gradual transition to regular preschool or elementary school program

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Early intensive ABA (cont'd)



- Behavior analyst
 - Designs treatment program (goals and objectives, intervention methods) in collaboration with parents and other team members
 - Trains parents and "tutors" or "therapists" to deliver most intervention, under close supervision
 - Reviews graphed data on every skill and problem behavior at least weekly, modifies intervention methods as needed
 - Determines when objectives have been obtained or need to be modified
- Treatment goal: help child develop skills that enable safe, successful, independent functioning, both in the short and the long run

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Research on early intensive ABA for autism



- Summaries that follow are drawn from published studies with
 - Treatment group that received ABA intervention *directed by qualified behavior analysts* and one or more comparison groups of similar children
 - Intensive ABA: 25 - 40 hrs/wk
 - Low-intensity ABA: less than 20 hrs/wk
 - Children in *all groups* had autism or PDD-NOS, average developmental rates of about .50 in most skill domains except motor skills pre-treatment
 - ABA intervention provided mainly by tutors, college students, paraprofessionals, and parents trained by the behavior analysts
 - Comparison groups received interventions (e.g., "eclectic" or mixed-method intervention, standard early intervention) from qualified professionals trained in autism

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Research on early intensive ABA for autism



- Excluded: studies with other populations; single-group studies (e.g., Weiss, 1999); studies with "ABA" intervention directed by individuals with inadequate or unknown training in behavior analysis (e.g., Magiati, Charman, & Howlin, 2007; Sheinkopf & Siegel, 1998).
- Tables of effectiveness data show average gains [+] and losses [-] on standardized tests of developmental levels/cognitive skills, communication skills, social skills, and adaptive skills administered by independent evaluators in most studies
 - Several researchers also measured academic skills, educational placement, problem behaviors, autism characteristics, parental stress, etc. -- data not shown in tables

Between-groups studies of intensive ABA - UCLA model

Study	Group assignment	Tx Gp (Int ABA)	Comp Gp 1	Comp Gp 2
Lovaas (1987); McEachin, Smith, & Lovaas (1993) [US]	Case control (therapist availability)	N = 19 40 hrs/wk, 2+ yrs In homes	N = 19 ABA 10 hrs/wk + spec ed	N = 21 Standard spec ed
Sallows & Graupner (2005) [US]	Random*	N = 13 38 hrs/wk, 2+ yrs In homes	N = 10 <i>Parent-managed</i> ABA, 31 hrs/wk, 2+ yrs	
Cohen, Amerine-Dickens, & Smith (2006) [US]	Case control (IFSP/IEP teams)	N = 21 35-40 hrs/wk, 3+ yrs In homes	N = 21 Standard spec ed	
Eikeseth, Smith, Jahr, & Eldevik (2002, 2007) [Norway]	Case control (supervisor availability)	N = 13 28 hrs/wk 1 yr, 18 hrs/wk 2nd yr In classrooms	N = 12 Int eclectic, 29 hrs/wk 1 yr, 16 hrs/wk 2nd yr	
Smith, Groen, & Wynne (2000) [US]	Random	N = 15 25 hrs/wk, 33m In homes	N = 13 <i>Parent-managed</i> ABA, 10 hrs/wk + spec ed, 33m	

*Both groups received intensive ABA

Between-groups studies of intensive ABA - other models

Study	Group assignment	Tx Gp (Int ABA)	Comp Gp 1	Comp Gp 2
Howard, Sparkman, Cohen, Green, & Stanislaw (2005) [US]	Case control (IFSP/IEP teams)	N = 29 25-40 hrs/wk, 14m In homes	N = 16 Int eclectic, 25-30 hrs/wk, 14m	N = 16 Nonint eclectic, 15 hrs/wk, 14m
Zachor, Ben-Itzhak, Rabinovitch, & Lahat (2007) [Israel]	Case control	N = 20 35 hrs/wk, 1 yr In classrooms	N = 19 Eclectic/developmental 35 hrs/wk, 1 yr	
Remington, Hastings, Kovshoff, Espinosa, Jahr, Brown, Alsford, Lemaic & Ward (in press) [UK]	Case control (parent selected)	N = 23 25 hrs/wk, 2 yrs In homes	N = 21 Standard spec ed 16 hrs/wk, 2 yrs	

Effectiveness: Intensive ABA vs. parent-managed ABA or special ed

Study	Measures	Mean Changes - ABA Tx Gp	Mean Changes - Comp Gp 1	Mean Changes - Comp Gp 2
Lovaas (1987)	IQ*	+20	Low-int ABA +spec ed 0	Standard spec ed 0
Sallows & Graupner (2005)	IQ* Nonverbal IQ* Rec lang* Exp lang* Adaptive*	+22.2 + 7.0 +17.0 + 5.4 + 9.5	Parent-mgd int ABA +27.5 + 6.7 +27.0 +10.8 + 5.8	
Cohen et al (2006)	IQ* Nonverbal IQ* Rec lang* Exp lang* Adaptive*	+25 +13 +20 +25 + 9	Standard spec ed +14 +13 + 9 +15 - 4	
Smith, Groen & Wynne (2000)	IQ* Nonverbal IQ** Rec lang** Exp lang** Adaptive*	+16.0 +42.7 +29.4 +29.4 -02.2	Parent-mgd ABA - 01.0 +27.3 +19.3 +19.9 - 06.7	
Remington et al. (in press)	IQ* Adaptive***	+12.0 + 88.1	Standard spec ed - 2.2 + 69.3	

*Standard scores; **age equivalent scores; ***raw scores

Effectiveness: Intensive ABA vs. eclectic intervention

Study	Measures	Mean Changes - ABA Tx Gp	Mean Changes - Comp Gp 1	Mean Changes - Comp Gp 2
Eikeseth et al (2002, 2007)	IQ*	+25	Intensive eclectic + 7	
	Adaptive*	+11	-10	
Howard et al (2005)	IQ*	+29.7	Intensive eclectic +8.4	Nonint eclectic +8.9
	Nonverbal IQ*	+20.6	+6.1	+2.3
	Rec lang*	+20.2	+3.9	- 4.8
	Exp lang*	+20.1	+3.8	- 4.5
	Adaptive*	+10.5	- 0.6	- 2.8

*Standard scores

Note: Zachor et al. (2007) not included because authors did not use same standardized tests as in other studies, but they did find that intensive ABA produced greater reductions in autism symptoms than intensive eclectic/developmental intervention, based on the Autism Diagnostic Observation Survey.

Between-groups studies of low-intensity ABA

Study	Group assignment	Tx Gp (Int ABA)	Comp Gp
Birnbrauer & Leach (1993) [Australia]	Case control (supervisor availability)	N = 9 18.7 hrs/wk, 2 yrs In homes	N = 5 Standard special ed, hrs/wk, 2 yrs
Eldevik, Eikeseth, Jahr, & Smith (2006) [Norway]	Case control (education teams)	N = 13 12.5 hrs/wk, 20m In classroom	N = 15 Eclectic, 12 hrs/wk, 21m

Effectiveness: Low-intensity ABA vs. special ed and intensive eclectic intervention

Study	Measures	Mean Changes - ABA Tx Gp	Mean Changes - Comp Gp
Birnbrauer & Leach (1993)	IQ*	+ 7	Standard spec ed NT
	Nonverbal IQ*	+ 29	NT
	Lang*	+ 6	- 8
	Adaptive*	- 5	- 7
Eldevik et al (2006)	IQ*	+ 8.2	Nonint eclectic - 2.9
	Nonverbal IQ*	+ 8.6	- 10.5
	Rec lang*	+ 6.8	- 7.7
	Exp lang*	+ 11.0	- 6.4
	Adaptive*	- 0.2	- 4.8

*Standard scores; NT = untestable

Main findings

- Professionally directed early intensive ABA (25-40 hrs/wk) produced larger improvements than typical EI/special ed, eclectic interventions, and low-intensity ABA in
 - Cognitive skills (full-scale and nonverbal IQ)
 - Communication skills (receptive and expressive)
 - Social skills
 - Play skills
 - Academic skills
 - Adaptive and self-care skills
 - Problem behaviors
 - Autism characteristics
 - Parental stress
- Just under 50% of children receiving early intensive ABA made large gains in multiple skill domains, achieved normal or near-normal functioning
 - ~ 40% made modest gains and ~10% made small gains as measured on standardized tests



Main findings

- Proportions of children who moved from delayed to normal range on IQ (all between-groups studies combined):
 - Intensive ABA: 61/133 = 46%
 - Typical special ed: 14/79 = 18%
 - Intensive eclectic: 4/28 = 14%
- Largest gains occurred when intervention was most intensive (≥ 30 hrs/wk)
- Parent-managed ABA (with consultation) produced mixed results

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Main findings

- Low-intensity ABA produced smaller gains than intensive ABA (not clinically significant), but larger than typical and eclectic intervention
- Other interventions produced negligible gains or losses in most studies
 - Eclectic intervention (mixture of developmental, TEACCH, sensory integration, speech therapy, PECS, and/or ABA methods) was largely ineffective *even when individualized and intensive*
 - *Intensity alone isn't sufficient; type of intervention matters*
- Several uncontrolled studies and case reports with objective measures corroborate effectiveness of early intensive ABA

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Health insurance coverage of ABA treatment for autism: Rationale (Autism Speaks)



- Children with autism have greater health care needs than children without autism.
- Treatments are difficult to access, often inadequate and delayed; parents must pay out of pocket or children must go without needed treatment.
- Mandated insurance coverage will bring effective treatment to children who need it. ABA has proved effective.
- Several government and scientific organizations endorse ABA.
- Cost of insurance coverage of ABA is relatively small, will result in savings by improving outcomes for children and reducing lifetime cost of care.

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Health insurance coverage of ABA treatment for autism



- At least 20 self-insured companies provide ABA benefit, recognize Board Certified Behavior Analysts (BCBAs) as providers
 - Includes Microsoft, Home Depot, Intel, Cisco Systems, Eli Lilly, Mayo Clinic
- U.S. military's insurance (TRICARE) provides ABA benefit under a "demonstration program"
- Medicaid provides some coverage in some states, but typically inadequate for children to make meaningful improvements

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Health insurance coverage of ABA treatment for autism



- 8 states have legislation mandating private health insurance coverage of ABA
 - IN - dollar limits cannot be less favorable than those for physical illnesses
 - SC - up to \$50k per year through age 16
 - TX - up to \$50k per year, ages 3-6
 - FL - up to \$36k per year, \$200k lifetime
 - AZ - up to \$50k per year through age 8, \$25k per year ages 9-16
 - LA - up to \$36k per year, \$144k lifetime
 - PA - up to \$36k per year, no lifetime cap
 - IL - up to \$36k per year through age 21
 - Most place no limits on number of visits for ABA
- Bills planned for 26 states this year (see www.autismvotes.org)
- President-elect Obama has proposed federal mandate

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Summary and conclusions



- Contemporary ABA intervention for autism rests on more than 40 years of scientific research
 - At present, no other approach to autism intervention has comparable scientific support (Eikeseth, 2008; Myers et al/AAP, 2007; New York State Department of Health, 1999).
- Best available evidence indicates that *competently directed and delivered* early intensive ABA intervention is especially effective (Dawson, 2008; Eikeseth, 2008; Myers et al/AAP, 2007; New York State Department of Health, 1999; Rogers & Vismara, 2008; U.S. Department of Defense, 2007; U.S. Surgeon General, 1999).

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Summary and conclusions



- Estimated savings from investment in early intensive ABA:
 - At least \$2 million per individual in childhood and adult services costs combined [using 1996 Pennsylvania costs] (Jacobson, Mulick, & Green, 1998)
 - Millions in health care costs over the lifespan (e.g., Leslie & Martin, 2007; Mandell, 2007)
- Focused ABA interventions are also effective for building specific skills and reducing problem behaviors -- thereby reducing health care costs -- for people with autism of all ages

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For more information on ABA for autism, please see...



- www.behavior.org/autism (Cambridge Center for Behavioral Studies)
- www.autismspeaks.org/whattodo/what_is_ab_a.php (Autism Speaks)
- www.apbahome.net (Association of Professional Behavior Analysts)
- www.asatonline.org (Association for Science in Autism Treatment)

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For qualifications to practice applied behavior analysis, please see...



- Behavior Analyst Certification Board -- www.BACB.com
- Association of Professional Behavior Analysts -- www.APBAhome.net
- Association for Behavior Analysis Autism Special Interest Group Consumer Guidelines - <http://www.autismsig.org>
- American Psychological Association Specialty in Behavioral Psychology -- <http://www.apa.org/crsppp/archivbehav.html>



Mandates don't work against, but for, consumers

By Jeff Raymond

State view

March 13, 2009 04:30 pm

— It's practically an article of faith that mandates to cover specific conditions, drugs and treatments increase costs and lead to a greater number of uninsured.

What's often overlooked is that mandates may, in the long run, save money.

Oklahoma has required insurers to cover the cost of diabetic testing and treatment since 1996. The cost of covering diabetic supplies pales in comparison to the cost of caring for diabetics who haven't managed the condition.

Consider breast cancer: A mammogram costs \$50 to \$150. The average cost of breast cancer treatment is more than \$20,000, according to the National Cancer Institute. Catching tumors early saves considerable money later, not to mention women's lives.

In 2006, according to state Health Department data, 67.7 percent of Oklahoma women over age 40 reported having had a mammogram during the previous two years. In 1996, 59.5 percent reported having had a mammogram during previous two years. In 1988 the number was 42.9 percent.

Required coverage of mammograms has been on the books in Oklahoma since 1988.

The increase in mammography rates has come about because of many factors, including better education and increased availability. But we owe it to ourselves to consider the effect of requiring the procedure to be covered.

Oklahoma's mandate count, 36, falls in the middle. Requirements range from hearing aids to well child care. Interestingly, some states that have far more mandates have more affordable insurance and/or a lower rate of uninsured.

Opponents of mandates focus on their aggregate cost. Yet pinning down the cost of mandates is notoriously difficult. Estimates are unreliable, as the wildly varying estimates of the cost of autism coverage have shown. We should begin looking at mandates as a reflection on the high cost and disappointing quality of health care rather than their cause. If health insurance companies would serve policyholders rather than block the care they seek, average Oklahomans wouldn't seek redress through the legislative process.

Insurance companies' routine refusal to cover common-sense medical care, especially cost-saving preventative care, has led to mandates. It's time for Oklahomans to look at mandates as a way to improve health care for much less cost than ultimately caring for the sick.

The huge shift in political support for mental health parity illustrates this. Many researchers now accept that it's cheaper to treat someone for mental illness than suffer lost work and productivity.

The National Association of Health Underwriters claims the more groups demand specialized mandates, the more "the train gets a full head of steam" and can't be stopped. Disease- and condition-specific lobbies will queue up and demand coverage as well.

The organization slips into old scare tactics. With health care premiums for an Oklahoma family increasing by 62 percent from 2000-2007, requiring more in return isn't asking too much.

Because coming up quickly with tens of thousands of dollars is impossible for most of us, the end result of requiring insurance companies to do less is to shift the cost to taxpayers.

Opponents of mandates argue that nothing is free. They're right: Someone pays for health care. It's just a question of whom — taxpayers or insurance companies.

Jeff Raymond is executive director of OKWatchdog in Oklahoma City. Call it at (405) 824-2382.

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From: **AUTISM SPEAKS**



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FOR IMMEDIATE RELEASE

AUTISM SPEAKS ENDORSES ALASKA AUTISM INSURANCE REFORM BILL

House Bill 187 Would End Health Care Discrimination Against Children with Autism by Requiring Coverage of Diagnosis and Treatment

Juneau, AK (March 19, 2009) – Autism Speaks, the nation's largest autism advocacy organization, today announced its support for House Bill 187, also known as the autism insurance reform bill. The legislation would require private health insurance companies to cover the diagnosis, testing and treatment of autism spectrum disorder (ASD). The maximum benefit would be \$36,000 per year.

Sponsored in the Alaska State House of Representatives by State Representative Pete Petersen (D-19) HB 187 includes coverage of Applied Behavior Analysis (ABA), an evidence-based, medically-necessary autism therapy.

"We applaud and thank Representative Petersen for his leadership on this issue of critical concern to thousands of Alaska families," said Elizabeth Emken, Autism Speaks Vice President of Government Relations. "Autism Speaks joins Alaska's autism community in calling on the legislature to pass HB 187 and join the growing number of states that have ended healthcare discrimination against children with autism."

Most states do not require private insurance companies to cover even essential autism treatments and services. In the absence of coverage, families often pay as much as they can out-of-pocket for services that can cost upwards of \$50,000 per year. In the process, many risk their homes and the educations of their unaffected children – essentially mortgaging their entire futures.

Eight states – Arizona, Florida, Louisiana, Illinois, Indiana, Pennsylvania, South Carolina and Texas -- have enacted autism insurance reform legislation. Several other state legislatures will vote on similar legislation during the current session.

To learn more about Autism Votes, an initiative of Autism Speaks focused on federal and state legislative advocacy, please visit www.autismvotes.org.

About Autism

Autism is a complex brain disorder that inhibits a person's ability to communicate and develop social relationships, and is often accompanied by behavioral challenges. Autism spectrum disorders are diagnosed in one in 150 children in the United States, affecting four times as many boys as girls. The prevalence of autism has increased tenfold in the last decade. The Centers for Disease Control and Prevention have called autism a national public health crisis whose cause and cure remain unknown.

About Autism Speaks

Autism Speaks is dedicated to increasing awareness of autism spectrum disorders, to funding research into the causes, prevention and treatments for autism, and to advocating for the needs of individuals with autism and their families. It was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Bob Wright is Senior Advisor at Lee Equity Partners and served as vice chairman, General Electric, and chief executive officer of NBC and NBC Universal for more than twenty years. Autism Speaks merged with both the National Alliance for Autism Research (NAAR) and Cure Autism Now (CAN), bringing together the nation's three leading autism advocacy organizations. To learn more about Autism Speaks, please visit www.autismspeaks.org

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January 30, 2009

**Actuarial Cost Estimate:
Virginia House Bill 1588 -
Coverage for the Diagnosis
and Treatment of Autism
Spectrum Disorder**

OLIVER WYMAN

Prepared By:

Marc Lambright, FSA, MAAA



MARSH MERCER KROLL
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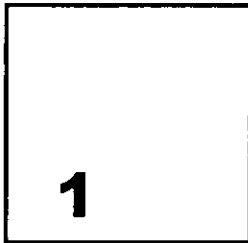
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Background

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman or We) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of mandated insurance benefits for Autism Spectrum Disorders (ASD) on insurance premiums. As part of this work, Oliver Wyman has developed a range of independent estimates of the impact on insurance premiums for the benefits mandated by Virginia HB 1588 offered January 14, 2009 which provides coverage for the diagnosis and treatment of autism spectrum disorder in individuals under the age of 21.

Oliver Wyman is a part of the Marsh & McLennan (MMC) family of companies. With over 60 members of the American Academy of Actuaries, Oliver Wyman is one of the largest actuarial practices in North America. Oliver Wyman's health practice, which has twelve credentialed actuaries, advises insurers, regulators, governments, interest groups, and others.

This report, along with its supporting analysis, was developed by Marc Lambright, a Principal and consulting health actuary in Oliver Wyman's Philadelphia office. Marc is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and is professionally qualified to analyze the cost impact of HB 1588 and provide the estimates shown in this report. As part of Oliver Wyman's quality assurance process, the underlying analysis and this report were independently peer reviewed by another credentialed Oliver Wyman actuary.

2

Scope and Limitations

The intent of this analysis is to provide a reasonable range of estimates for the insured costs of the mandated ASD benefits provided for in HB 1588 and the associated premium impact on the markets affected by HB 1588. This analysis makes no attempt to quantify potential offsetting cost savings associated with successful ASD treatment, nor does it include the any estimate of the potential reduction in other government expenditures associated with providing ASD services that might overlap with the benefits provided by this mandate. Therefore, the reader is cautioned that this report should only be considered a cost analysis, and not be misconstrued as a cost-benefit analysis when assessing the merit of HB 1588.

We note that cost estimates for autism mandates have varied widely. The JLARC analysis of the impact of Virginia HB 83 showed a range of per member per month (PMPM) group standard premium impact estimates made by 20 Virginia insurers that varied by a factor of 154¹. This variability of the cost estimates in the JLARC report is not entirely inconsistent with the variance in estimates for similar mandated autism benefits in other states. The reason for this variability is that the largest component of the increase in costs under the HB 1588 mandated ASD benefits is for Applied Behavior Analysis (“ABA”), which is almost universally excluded from health coverage, and therefore essentially no insured data exists for use in developing credible utilization and unit cost estimates for ABA.

¹ JLARC: *Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders*. September 2008, p. 8.

The reader is cautioned that the ultimate cost of covering ABA benefits is uncertain; however, this analysis attempts to reflect the likely behavior of consumers, providers and insurers of ABA services in developing the assumptions underlying the cost estimates. Likewise, the additional costs for mandated medical services other than ABA are difficult to quantify. Insurance policies often cover some services for children diagnosed with an ASD, although the mandate could cause the costs for certain services to increase because ASD exclusions are common, and certain services that may have been denied or terminated following utilization review might be covered due to the mandate.

3

Description of Key HB 1588 Provisions and their Impact on Covered Benefits

Insurance Markets Covered by Mandate

Section F outlines which markets are excluded from the mandate, of particular note is F(iii) which notes the exclusion of *policies, contracts, or plans issued in the individual market or small group markets to employers with 25 or fewer employees*. In our modeling we are assuming that this means that the individual market would not be subject to this mandate, and that the statutory small group (2-50 employees) market would be covered by the mandate. Therefore, our analysis is based on the commercial insured market, which includes both the small group (2-50 employees) and large group (51+ employees) markets. We note that our estimates of the impact on premium are nearly identical for the large and small group markets.

Covered Benefits

The mandate provides *coverage for the diagnosis and treatment of autism spectrum disorder in individuals under the age of 21*. Treatment includes: (i) *habilitative or rehabilitative care*; (ii) *pharmacy care*; (iii) *psychiatric care*; (iv) *psychological care*; and (v) *therapeutic care*.

The definition of *habilitative or rehabilitative care* is especially important since it includes applied behavioral analysis (ABA). The coverage of ABA has the most significant impact on cost of any mandated service. ABA programs are marked by intensive therapy that may include 30-40 hours of therapy a week under the most intensive programs, though many programs would not utilize that level of resources. Key assumptions underlying our ABA cost estimates are outlined in Section 5.

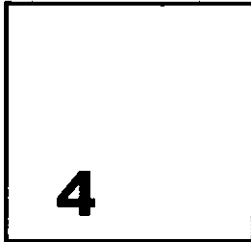
Annual Maximum Benefit of \$36,000

The annual coverage maximum is important as it has the effect of capping costs for the heaviest users of ASD services. From a practical standpoint, this would generally apply to children whose therapy includes an intensive ABA program.

Medical Necessity and Treatment Review

The bill does allow for *undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of autism spectrum disorder.*

This is important as insurers will develop protocols to review treatments and manage care which will limit unnecessary treatments if reviews are done appropriately.



Modeling Methodology

The following outlines the general modeling methodology used to develop the cost estimates. Estimates were developed both on a PMPM basis, and as a percentage of average annual premiums as shown in Section 6. Details of key assumptions are discussed in Section 5 and illustrated graphically in the exhibits shown in Appendix 1.

Modeling Perspective

In general, the model was developed to produce costs under the assumption that sufficient providers would be available to meet the demand for autism services, especially with regard to ABA services. It also assumes that there would be sufficient awareness of autism and motivation (primarily by parents) to seek treatment so that the diagnosis and treatment of ASDs would be more in line with the often cited CDC estimated prevalence of ASD of 1 in 150. We would expect that it would take at a minimum several years for both the supply of providers to meet the demand for mandated ASD services and for parents of autistic children to aggressively seek diagnosis and treatment of their children's disorders.

In spite of these real limitations that will likely limit short-term costs associated with mandated autism benefits, we feel that it is appropriate from a public policy perspective to look at the costs from a longer term perspective and assume that both awareness of ASDs will increase and that supply and demand for ASD services would eventually be in balance. We have developed our estimates with this in mind.

In the near term we would note that the supply of ABA service providers, specifically credentialed Board Certified Behavior Analysts (BCBAs) and Board Certified Associated Behavior Analysts (BCaBAs) would not be sufficient to meet the demand for ABA programs if ABA benefits are mandated. There are currently about 122² certified BCBAs and BCaBAs in Virginia, which translates to less than one therapist per 100 autistic

² BACB Certificant Registry: http://www.bacb.com/cues/frame_about.html, accessed January 2009.

children in Virginia assuming a 1 in 150 prevalence rate for autism. While it is true that not all autistic children will have an ABA program, it is also true that behavioral analysts provide services to individuals other than autistic children. It is reasonable to conclude that demand for ABA services, at least initially, would exceed supply should health care coverage similar to that mandated by HB 1588 become typical.

It is also instructive to look at some of the limited evidence available related to actual costs of ABA mandated benefits in other states. Aetna noted in December 2008 that it had tracked the cost of the autism mandate in Texas for its first year of existence and found that it increased costs for policyholders who filed autism-related claims by \$379 a month. A total of 235 policy holders had filed autism claims in the state as of the time the data was released. At that time, the company had not decided whether to pass those costs on to the policyholders because the cost of the mandate might change after the first year.³ While this is only first year experience for a single insurer, it illustrates that initial mandate costs are likely low. Aetna's Texas block of business is quite large (approximately \$1.5 - 2.0 billion in premium⁴), so the statistics provided indicate a mandate cost of less than 0.1% of premium.

General Modeling Process

The modeling process employed to develop our cost estimates was as follows:

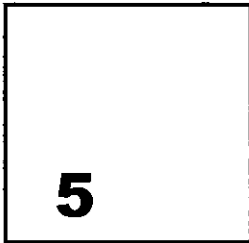
1. Prevalence rates were developed so that overall ASD prevalence is equal to the CDC 1 in 150 ASD prevalence estimate for the United States.
2. Prevalence rates by diagnostic subtype (autistic disorder, PDD-NOS, Asperger's Syndrome) were estimated separately as diagnosis patterns and service utilization could reasonably be expected to vary by diagnostic subtype.
3. The percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average age of diagnosis implicit in the modeling is consistent with publicly available age at diagnosis statistics⁵.
4. The percentage of diagnosed children who could be expected to have an ABA program was estimated for each age based on assumptions regarding how many children would start a program and typical program continuance.
5. A distribution of the number of annual hours for an ABA program was developed based on ABA provider input and an assumption that utilization review by insurers would impact utilization to some degree.
6. Based on the assumed treatment prevalence, likelihood of having an ABA program, assumed distribution of ABA program hours, and estimated ABA program cost per hour of therapy, ABA cost estimates by age were developed and adjusted to reflect the impact of the annual \$36,000 cap.

³ Lawmaker: Oklahoma autism bill has momentum. Associated Press. December 4, 2008. <http://newsok.com/article/3327594> accessed January 2009.

⁴ NAIC Annual Statements for 2007.

⁵ IAN database. <http://dashboard.ianexchange.org/StateStatsAdvanced.aspx?A1=VA&ADU=T>. Accessed January 2009.

7. Non-ABA costs were estimated based upon studies of medical costs for ASD children and judgment regarding the increase in costs that could be expected due to the mandated benefits.
8. Based on Census demographic data and the cost estimates for mandated ASD services by age as outlined in 1-7 above, an annual cost per covered individual was developed.
9. The cost of services was increased to reflect administrative and other insurer costs or profit charges.
10. The estimated size of the covered market was developed based on Census, Medical Expenditure Panel Survey (MEPS) enrollment and premium information for Virginia, and Kaiser Family Foundation coverage data. These assumptions are further documented in the following section.
11. The cost of the mandated services per covered person and as a percentage of premiums were calculated based on the model cost estimates and market data.



Summary of Key Assumptions

Key assumptions underlying the cost estimates for the mandated benefits are summarized in this section. Appendix 1 further illustrates these assumptions.

Treated Prevalence and Age at Diagnosis

Overall prevalence is based on a 2007 CDC⁶ study, with prevalence by diagnostic subtype estimated based on an academic study published in the American Journal of Psychiatry⁷.

As noted in the previous section, the percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average age of diagnosis implicit in the modeling is consistent with publicly available age at diagnosis statistics.

The base model assumptions for Virginia are shown below:

<u>Diagnostic Subtype</u>	<u>Prevalence</u>	<u>Average Age at Diagnosis</u>
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's Syndrome	1 in 900	6
All ASD	1 in 150	

⁶ Centers for Disease Control. Morbidity and Mortality Weekly Report. February 9, 2007.

⁷ Fombonne, E. and S. Chakrabarti. American Journal of Psychiatry. June 2005.

ABA Program Utilization and Cost

ABA Program Utilization by Age

ABA programs require a significant commitment from affected children, as well as their families. It is likely that a significant number of ASD children will not have an ABA program regardless of the availability of a provider. For this reason, we have assumed that two-thirds of diagnosed children will begin an ABA program. ABA programs are generally geared towards addressing deficits in younger children and are generally not intended to be continued indefinitely. For this reason, we have assumed that no programs would terminate prior to school age, that a large percentage of ABA programs would terminate at ages six and seven when an autistic child could be expected to enter elementary school, and thereafter programs would terminate gradually until only a small percentage of children have ABA programs in their teenage years. Programs could be expected to terminate if a child has experienced sufficient progress so that a program is no longer necessary, or if the insurer or family sees no progress, as well as for other reasons.

The assumed percentage of children diagnosed with ASD that have an ABA program is shown in the table below:

% of Diagnosed Children with an ABA Program by Age	
6 and Under	66.7%
6	50.0%
7	33.3%
8	30.0%
9	26.7%
10	23.3%
11	20.0%
12	16.7%
13	13.3%
14	10.0%
15 and Over	6.7%

ABA Program Annual Number of Hours

In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and reviewed some benefit materials from one of the few large self-insured employers who offers ABA benefits. For three age bands, we developed a distribution of expected hours that resulted in the annual averages shown in the table below.

Average ABA Program Hours by Age	
Ages Under 8	1,509
Ages 8 to 12	781
Ages 13 to 20	401

The general assumption is that pre-school aged children will have programs for 20 to 40 hours a week, averaging about 30 hours a week. This time will be reduced by roughly half by age eight when children would be expected to be in school and the school system would be required to provide services during the school day, and then would be cut in half again at age 13 as the child ages and ABA programs would be expected to be less time consuming and address a smaller number of behavioral deficits.

Cost per Hour of ABA Service

In developing the costs per hour, we reviewed ABA program staffing information and ABA provider wage and overhead cost assumptions. We developed an average cost for the entire United States and then adjusted this for Virginia, based on Bureau of Labor Statistics⁸ health care wage data. The resulting average cost per hour of ABA therapy is \$45.45.

Other (than ABA) Medical Costs

Based on several studies⁹, we estimated that children with ASDs used approximately three times the non-inpatient medical services (other than ABA) under current benefit programs. It is also clear that the mandate would mean that services that an insurer could currently deny or exclude would now be covered. In our base estimate, we assumed that the mandate would result in additional insured medical costs equal to the current level of covered non-inpatient costs for services to children diagnosed with an ASD.

Administrative Costs

Typically, group medical claims costs could be expected to be 80 to 90% of premiums, meaning 10 to 20% of premiums are available for administration, profit, or other costs, often collectively referred to as "retention." We have estimated the incremental retention charge to be 15% of premium under our base cost assumption.

Virginia Market Data

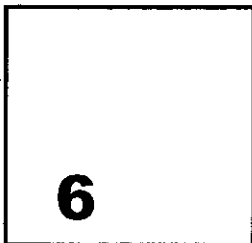
The MEPS survey provides average premiums, enrollees, offer rates, take-up rates, and self-insured percentages by employer size for healthcare coverage sponsored by privately insured employers. From this data we can estimate the size of the privately insured small group, insured large group, and self-insured markets. State specific premium data for Virginia was available for 2006¹⁰, so we trended this based on average recent employer premium increases provided from the Kaiser Family Foundation HRET¹¹ survey to estimate the 2009 average annual premium per member necessary to compute the cost of mandated benefits as a percentage of annual premiums.

⁸ BLS wage data. <http://www.bls.gov/guide/geography/wages.htm> accessed January 2009.

⁹ Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

¹⁰ MEPS state survey data. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=-1&year=-1. Accessed January 2009.

¹¹ Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2008 Annual Survey.



Cost Estimates

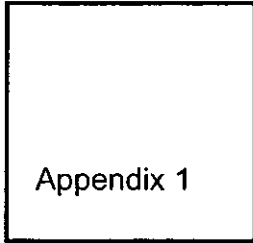
Base Cost Estimate

The table below summarizes the mandate costs and impact on small and large group premiums under the base assumptions outlined in Section 5. The base estimate is that the long-term cost of the mandated benefits provided by HB 1588 would be about 0.60% of insured premiums, though this cost would likely initially be lower in the years immediately following the passage of the mandate.

	Market		
	Small Group	Large Group	All
Covered Persons	649,000	1,061,000	1,710,000
Average Premium per Person	\$3,900	\$3,800	\$3,838
Annual Mandate Claim Cost per Covered Person	\$19.50	\$19.50	\$19.50
Claim Cost as a Percentage of Premium	0.50%	0.51%	0.51%
Estimated Premium Increase with Admin @ 15%	22.90	22.90	\$ 22.90
Premium Increase as a Percentage of Premium	0.59%	0.60%	0.60%

Scenario Estimates

As discussed in Section 1, very little insurance data exists that can be used to directly estimate the costs of ABA benefits mandated by HB 1588. This causes uncertainty in developing actuarial assumptions and cost estimates. Due to this uncertainty, it is useful to develop cost estimates for additional scenarios using more optimistic and pessimistic assumptions. A reasonable range of the long-term impact of the mandated HB 1588 benefits is that premiums would increase 0.45% to 0.75% with a \$36,000 annual benefit maximum, or cap. A reasonable estimate of the impact of mandated HB 1588 benefits assuming no annual cap is that premiums would increase 0.90%.



Cost Assumptions – Illustrative Exhibits

EXHIBIT I - SUMMARY OF HB 1588 ASSUMPTIONS AND COSTS

<u>State</u>	Virginia	<u>Key Assumptions:</u>		
<u>Mandate Market</u>		<u>Diagnostic Subtype</u>	<u>Ultimate Prevalence</u>	<u>Average Age of Diagnosis</u>
Individual	No	Autistic Disorder	1 in 450	3
Small Group	Yes	PDD-NOS	1 in 300	3
Large Group	Yes	Asperger's	1 in 900	6
Self-Insured (ERISA)	No	All ASD	1 in 150	
State and Local Govt	No			
				<u>% of Diagnosed Children w/ ABA</u>
				6 and Under 66.7%
				6 50.0%
				7 33.3%
				8 30.0%
				9 26.7%
				10 23.3%
				11 20.0%
				12 16.7%
				13 13.3%
				14 10.0%
				15 and Over 6.7%
<u>Age Limits for Autism Benefits</u>		<u>Additional Annual Medical Costs for Non ABA Services</u>		
Minimum	0	All Ages \$	3,900	
Maximum	20			
<u>Annual Maximum</u>				<u>Average ABA Program Hours</u>
All Autism Services	\$36,000			Ages Under 8 1,509
				Ages 8 to 12 781
				Ages 13 to 20 401
<u>Annual Limits by Covered Service</u>				<u>Cost per ABA Hour:</u> \$45.45
	<u>Hours Limit</u>	<u>Max Hours</u>	<u>Dollar Limit</u>	
ABA	No	-	Yes	\$36,000

Market	Coverage Estimates			Costs Excluding Administrative Expense			Premium Increase including Admin @ 15%		
	Number of Persons Covered	Premium (Per Person)	Total Premium	Costs	Costs (% of Premium)	Cost (Per Covered Person)	Incremental Premium	Premium Increase %	Annual Increase per Covered Person
Individual									
Small Group	649,000	3,900	2,531,100,000	12,655,500	0.50%	19.50	14,889,000	0.59%	22.90
Large Group	1,061,000	3,800	4,031,800,000	20,689,500	0.51%	19.50	24,341,000	0.60%	22.90
Self-Insured (ERISA)									
State, Local and Federal									
Total	1,710,000	\$ 3,838	\$ 6,562,900,000	\$ 33,345,000	0.51%	\$ 19.50	\$ 39,229,000	0.60%	\$ 22.90

Exhibit II - Treated Prevalence by Age

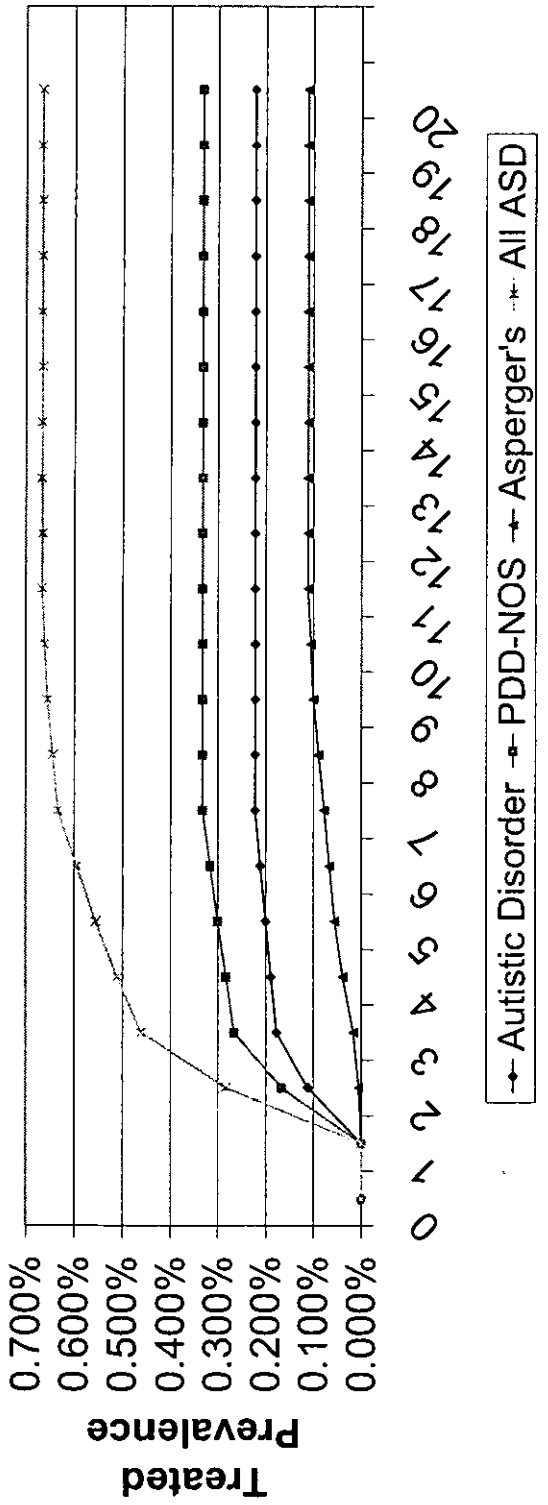
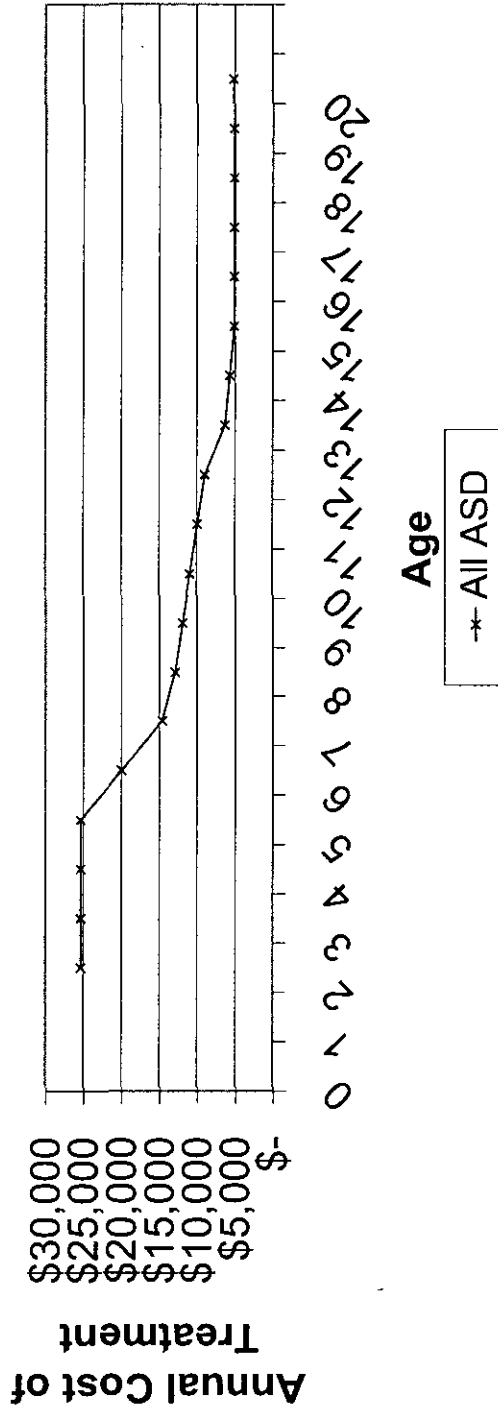


Exhibit III - Annual Cost Per Diagnosed/Treated Child



Age

-* All ASD

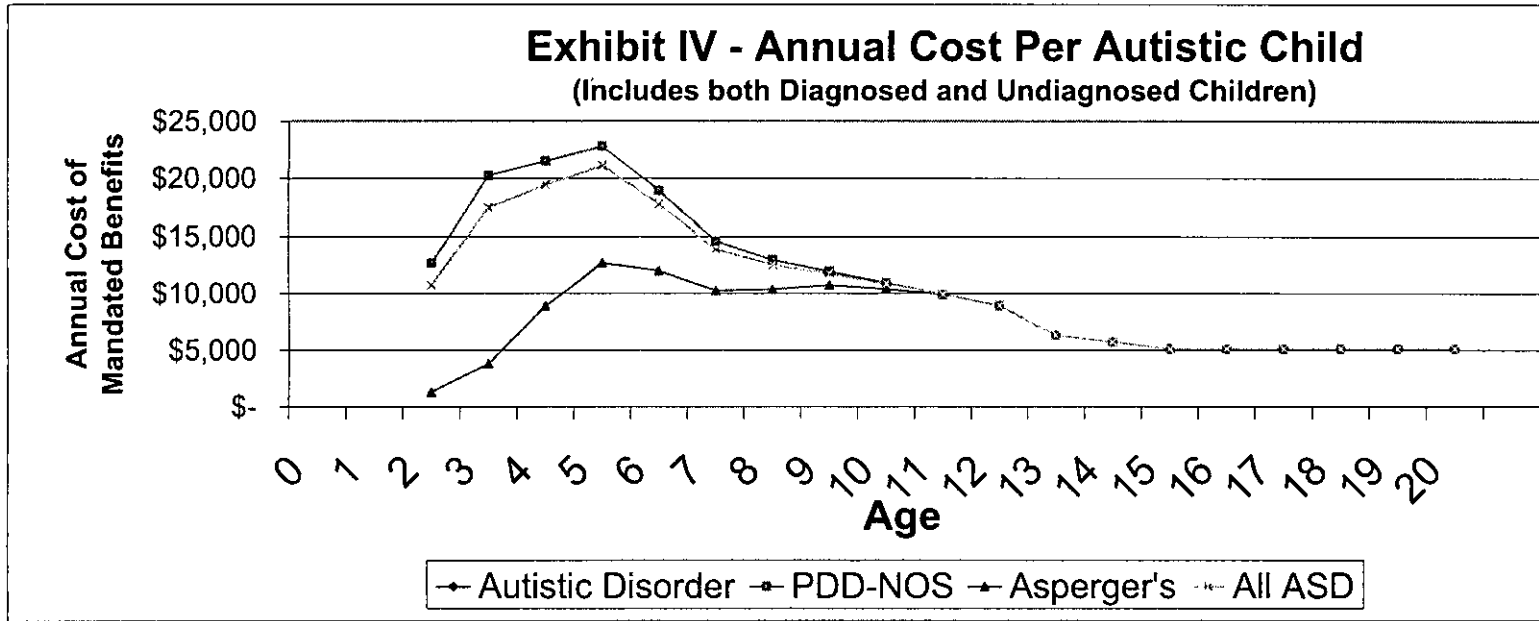


Exhibit V - ABA Utilization vs. Treated Prevalence

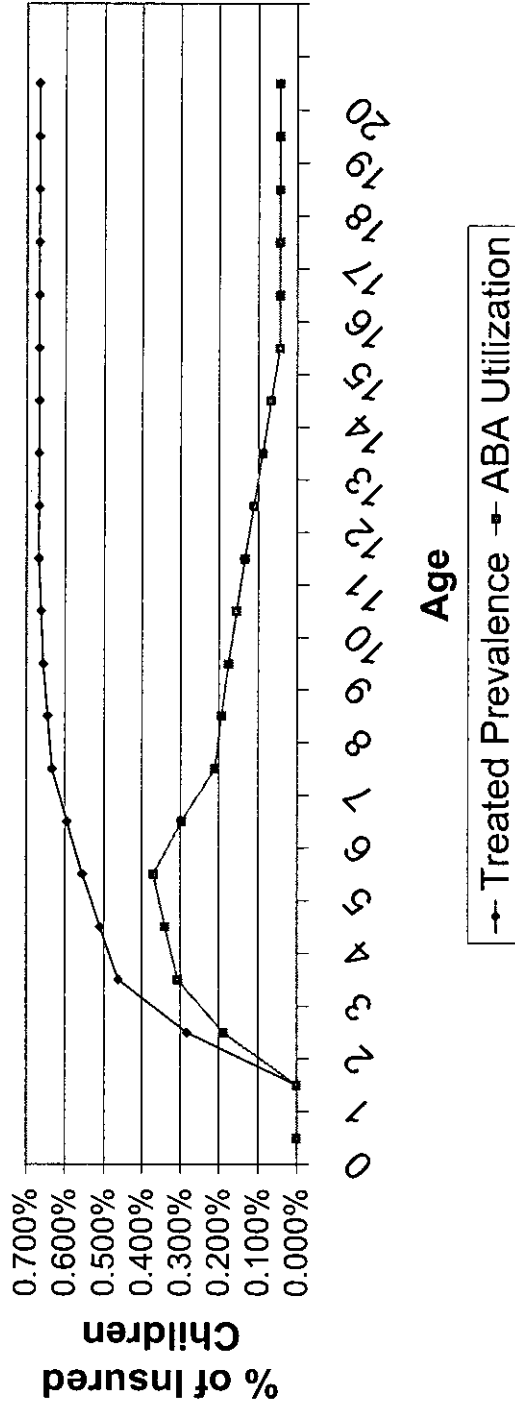
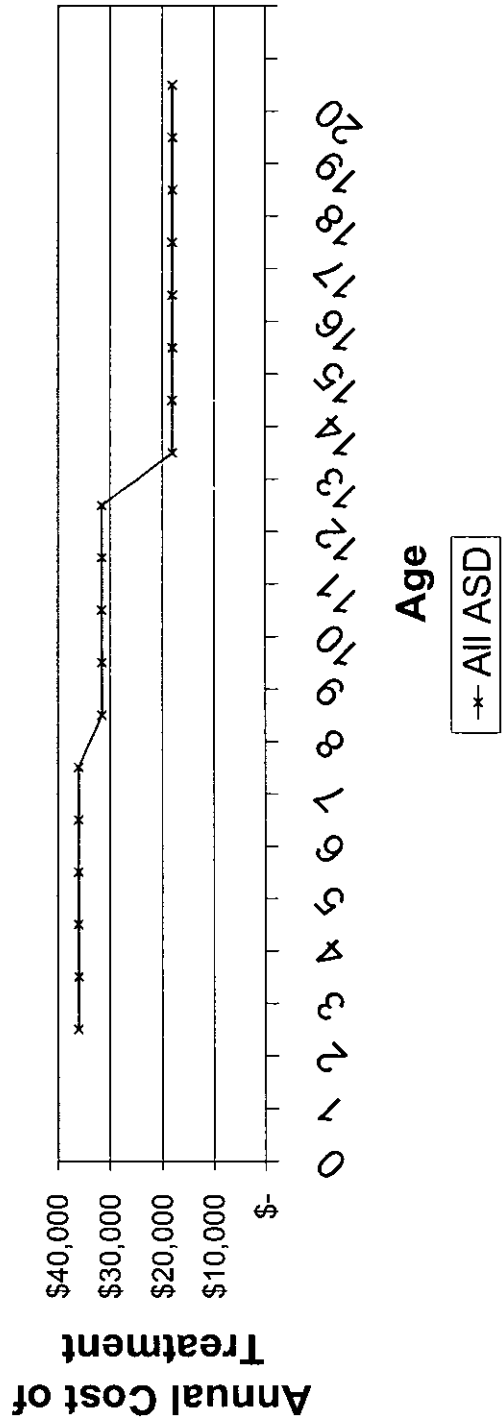


Exhibit VI - Annual Cost per Child With ABA Program



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15 March 2009

The Honorable Pete Petersen
Alaska State Capitol
Juneau, AK 99801

Letter of Endorsement -- HB 187

ASA strongly endorses Alaska House Bill 187 since this legislation offers clear and practical solutions that will enable Alaska families to have equal access to appropriate treatments and services that would be covered by private health insurance if it were not for the diagnosis of an autism spectrum disorder (ASD).

BACKGROUND

Autism is a complex neurodevelopmental disability that typically appears during the first two years of life and affects a person's ability to communicate and interact with others. ASA estimates the lifetime cost of care for an individual with autism at \$3.5 to \$4 million; with access to early diagnosis and intervention, these costs can be reduced by two-thirds. However, appropriate, effective and evidenced-based interventions are costly – upwards of \$50,000 a year – and frequently not covered by private health insurance plans. Many families simply cannot afford to give their children the treatments that could help affected individuals reach their fullest potential and enjoy a happy and productive life.

Although there is no known "cure", autism is treatable. According to the American Academy of Pediatrics (AAP), "early diagnosis resulting in early, appropriate, and consistent intervention" is "associated with improved long-term outcomes."

Autism Spectrum Disorder (ASD) includes three diagnoses as defined in the *Diagnostic and Statistical Manual (DSM IV)* of the American Psychiatric Association:

1. Autism: Difficulty in the developmental areas of communication, socialization and repetitive/restricted interests and behaviors.
2. Asperger's Syndrome: Similar characteristics to autism but do not have a significant delay in language.

3. Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS): This term is used when an individual displays developmental deficits but does not meet diagnostic criteria for the other two ASD diagnoses.

ASD is now the number one childhood developmental disability with 1 of every 150 children in the US being diagnosed (CDC 2007). 26,670 children born in the US this year will eventually be diagnosed with ASD (CDC, 2007), making the diagnoses more common than all types of pediatric cancer, AIDS, and diabetes combined. According to the American Academy of Pediatrics, 44% of primary care physicians reported that at least ten of their patients have ASD.

Males are four (4) times more likely to be diagnosed than females; in contrast, females are more likely to be severely impacted by autism when a diagnosis exists. Females are also more likely than males to have a co-diagnosis of mental retardation (58.2% and 41.8%, respectively [CDC, 2007]). Younger siblings of children diagnosed with an ASD are 20 times more likely to be diagnosed, resulting in families with up to five children known to be on the autism spectrum in the US. A recent study highlights the fact that relative to children without autism, children with autism are much more likely to have poor health, to require medically necessary care for behavioral problems, and to be using medications.

Societal Impact of ASD

ASD results in annual societal costs of \$35 billion per year, or over \$60,000 per person per year, for services, education and other publicly funded supports. (Ganz, 2006) Over the lifespan, the average societal cost of caring for one person with autism is \$3.2 million. (Harvard School of Public Health, 2006) Comprehensive intervention programs for preschool aged children with autism, including behavioral and speech therapies, may cost up to \$50,000 per year. (New York Times 2006) Comprehensive intervention programs for young children, including behavioral therapies, may cost up to \$100,000 per year.

Autism first became a special education classification under the Individuals with Disabilities Education Act (IDEA) in 1991. Between 1991 and 1999, the number of persons receiving special education services for autism increased 500% (CDC, 2007). In 2005, approximately 224,000 children were served under the autism classification in US schools. To describe the estimates of per pupil expenditures for educating children with autism, we reviewed data collected and analyzed by the Special Education Expenditure Project (SEEP). (GAO-05-220, Special Education Report to Congress 2005)

The average per pupil expenditure for educating a child with autism was estimated by SEEP to be over \$18,000 in the 1999-2000 school year, the most recent year for which data were available. This estimate was nearly three times the expenditure for a typical regular education student who did not receive special education services and was among the highest per pupil expenditures for school-age children receiving special

education services in public schools. In contrast, the cost of a typical child's education was \$5,000. (Senate Education Committee, 2006) Many, who are employed, tend to be underemployed in dead end or entry level positions. For the population with autism, the number of individuals unemployed has been estimated to be as high as 90% (New Jersey Autism Society). Without effective intervention, that means that of the 560,000 children currently living with autism, 504,000 may be unemployed in adulthood. This would obviously be a human tragedy.

Effective Treatment for ASD

Early Intervention

The CDC reports that "early identification and participation in intervention can improve the long term outcome for children with an ASD" (2007). The Harvard School of Public Health corroborates, writing that "improving behavioral and educational therapies for autistic children may not only lessen these costs but also improve quality of life" (Ganz, 2005).

The National Research Council report offered several key features of successful approaches to the education of children with autism, including early intervention soon after the diagnosis of autism, which can generally occur by the age of 3. The report also offered guidelines regarding educational objectives for children with autism, including the development of social skills and expressive and receptive language and communication skills. (GAO-05-220, Special Education Report to Congress 2005)

Despite the research supporting early intervention, the 2007 CDC study suggests a significant nationwide lag between the first sign of developmental delay and the receipt of an autism diagnosis and subsequent interventions, which may compromise children's potential progress, and increase their likelihood to require publicly funded supports over the lifetime. If such barriers can be eliminated, however, a child's prognosis improves dramatically. In many cases, by a certain age, children with an ASD diagnosis no longer require treatment, thereby reducing or eliminating associated costs to society.

Effective Therapeutic Interventions for ASD

While treatment plans for individuals with ASD are individually tailored to each person's unique needs according to the severity of their deficits and any co-occurring diagnoses, persons with ASD typically require a combination of medical, psychological, psychiatric, physical therapy (PT), occupational therapy (OT), speech therapy (ST), behavioral therapies (ABA) and other developmentally-based interventions. Individuals with ASDs should be engaged in functional and appropriate activities as much as possible. In 2001, the National Research Council Report recommended a minimum of 25 hours per week and the American Academy of Pediatrics recommends 20 hours or more of active engagement in evidence-based interventions. Behavioral therapy typically comprises the largest proportion of therapeutic hours, with children receiving between 10-35 hours per week in most cases. Other therapies, such as speech, PT, and OT, are generally

required for 1-2 hours per week per child. Michael L. Ganz's study of the societal costs of autism supports the fact that ASD treatment costs decline over time. According to Ganz, direct medical costs reach their maximum during the first five (5) years of life.

As the child ages, direct medical costs begin to decline substantially and continue to decline through the end of life. Ganz goes on to report, "The large direct medical costs early in life are driven primarily by behavioral therapies that cost [an average of] \$32,000 during the first 5-year age group and decline from about \$4,000 in the 8-to 12-year age group to around \$1,250 for the 18- to 22-year age group."

Behavioral Therapy

Behavioral therapies for ASD are derived from behavioral science, which is the examination of human and animal behavior using the principles of science, including observation, reproduction, testing, objectivity, etc. Behavioral therapy is also commonly known as, or otherwise includes, Lovaas therapy, early intensive behavioral intervention, applied behavior analysis (ABA), pivotal response treatment, or other similar terms.

ABA is the application of behavioral science in order to improve socially important behaviors and establish new skills. ABA-based procedures apply behavioral principles of skill development to increase or decrease a particular behavior, improve the quality of a behavior, stop an old behavior, or teach a new behavior.

Effective behavioral-based programs include intervention that is:

1. Implemented early (ideally, before school age)
2. Intensive with respect to the number of hours children are actively engaged
3. Provided in natural environments (i.e. home, school, community)
4. Actively involving of families.

Evidence Supporting Behavioral Therapy's Effectiveness with ASDs

Behavioral-based interventions are based upon decades of scientific investigation with individuals affected by a wide range of behavioral and developmental disorders, including autism. Specifically for children with autism, research demonstrates the efficacy of ABA in teaching complex communication, social, play, and self-help skills, and in reducing disruptive behaviors. The seminal article on this type of intervention was published by Ivar Lovaas at UCLA in 1987. This controlled, long-term study found that 47% of children with autism achieved normal intellectual educational functioning after treatment intensive behavioral treatment, compared to only 2% in the control group.

Since the Lovaas article was published, 20 years of research and over 500 studies continues to support the effectiveness of behavioral therapy for autism.

Lovaas's landmark 1987 study was followed in 1993 by another study of these same 38 subjects. The objective of John J. McEachin's study was to discover the long-term effects of Lovaas's early intensive behavioral treatment and to find out if the results of the experimental group were preserved over time. In terms of intellectual functioning, the study found that "the experimental group at follow-up had a significantly higher mean IQ than did the control group... indicating that the experimental group had maintained its gains in intellectual functioning between age 7 and the time of the current evaluation... [and] ... the experimental group showed more adaptive behaviors and fewer maladaptive behaviors than did the control group."

In another study, more than 50% of children with autism who participated in comprehensive treatment programs using ABA were successfully integrated into typical classrooms, with many requiring little ongoing treatment. (Harris and Handleman, 1994) Only four behavioral interventions are scientifically validated for the treatment of ASD, and all of these are derived from the principles of ABA, according to Simpson (2005).

Scientifically validated behavioral-based interventions for autism include:

1. Applied Behavior Analysis (ABA)
2. Discrete Trial Teaching (DTT)
3. Pivotal Response Treatment (PRT), and
4. Learning Experiences: An Alternative Program for Preschoolers & Parents (LEAP).

Reasons to support private health insurance coverage for ASD:

HB 187--Update of Coverage – less of a mandate

- It wasn't long ago that the medical community erroneously believed autism was untreatable. Today, research has proven otherwise. We are asking insurers to simply update their coverage to reflect the widely held belief in the scientific community that autism is treatable.

Reducing the financial burden on Alaskan Families

- Since insurance coverage is not available, families incur significant financial burdens to pay for necessary and appropriate services, sometimes as much as \$50,000 a year, if not more. No family can support this burden.
- In addition to the crushing financial burden placed on families affected by autism, the time, energy, stress and emotional commitment can become absolutely overwhelming and, if left unchecked, can adversely impact employment, health and the marriage.

Cost/Benefit Analysis

- Actuarial and economic studies done in Alaska and other State's indicate adding coverage would increase policy premium costs less than 1%
- A 1998 study by John W. Jacobson and others titled, *Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case*, examined the cost/benefit relationship of early intensive behavioral intervention treatment at varying levels of treatment success. The study used estimates of costs for early intensive behavioral interventions (EIBI) from childhood (age 3) through adulthood (age 55) based on prices in the Commonwealth of Pennsylvania and compared these costs with the expected amount of income the child would earn later in life to arrive at an estimated cost savings. The Jacobson's study found that cost savings per child served are estimated to be from \$2,439,710 to \$2,816,535 to age 55.
- The benefit to Alaskan taxpayers, families and the school system is clear—spend a little now or, spend a lot later.

Consequences for the Status Quo

Without treatment, the taxpayers of Alaska will certainly bear the enormous financial burden of a life-time of care for children who live a normal life span and often need round the clock care. In contrast, many children who receive effective, intensive and evidenced-based treatments require less support in school and go on to lead productive lives as taxpayers.

President Obama and Federal Policy

Autism is a National health care crisis. President Obama is committed to supporting Americans with ASDs, their families, and their communities. There are a few key elements to their support, which are as follows:

1. President Obama supports increased funding for autism research, treatment, screenings, public awareness, and support services. There must be research of the treatments for, and the causes of, ASD.
2. The Obama administration supports improving life-long services for people with ASD for treatments, interventions and services for both children and adults with ASD.
3. The Obama administration supports comprehensive autism services legislation, funding of the Combating Autism Act and working in a bi-partisan fashion with Congress, parents and ASD experts to determine how to further improve federal and state programs for ASD.
4. The Obama administration supports universal screening of all infants and re-screening for all two-year-olds, the age at which some conditions, including ASD, begin to appear. These screenings will be safe and secure, and available for

every American that wants them. Screening is essential so that disabilities can be identified early enough for those children and families to get the support and services they need.

Other States

- Ten (10) states specifically require insurers to provide coverage for the treatment of autism. Eight (8) states enacted such legislation during the 2007-2008 legislative sessions: Arizona, Connecticut, Florida, Illinois, Louisiana, Pennsylvania, South Carolina and Texas. Thirty-four (34) others have reform measures pending.

Thank you for your strong leadership. If I can be of further assistance, please feel free to contact me.

Sincerely,



Jeff Sell, Esq.
Vice President of Advocacy & Public Policy

American Academy of Pediatrics (2001). Policy Statement: The Pediatrician's Role in the Diagnosis and Management of Autistic Spectrum Disorder in Children (RE060018) *Pediatrics*, 107, 1221-1226.
Committee on Children With Disabilities (2001). Technical Report: The Pediatrician's Role in the Diagnosis and Management of Autistic Spectrum Disorder in Children. *Pediatrics*, 107, e85.

Plauch, Chris, and Aae Johnson, MD, MEd. Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*. Vol. 120, No. 5. American Academy of Pediatrics, November 2007.

James G. Gurney, Melissa L. McPheeters, Matthew M. Davis, Parental Report of Health Conditions and Health Care Use Among Children With and Without Autism, 160 *Archives of Pediatric and Adolescent Medicine*, 825-30 (2006).

Lovaas Institute for Early Intervention. See
<http://www3.scoe.net/npsa/index/index.cfm?fuseaction=basicDetails&id=420&searchType=adv>.

Michael L. Ganz, *The Lifetime Distribution of the Incremental Societal Costs of Autism*. 161 *Archives of Pediatric and Adolescent Medicine*, 343-49 (2007). Retrieved from www.archpediatrics.com.

J. J. McEachin, T. Smith, O. Ivar Lovaas, Long-term Outcome for Children with Autism Who Received Early Intensive Behavioral Treatment, 97 *American Journal on Mental Retardation*, 359-72 (1993).

Douglas L. Leslie, Andres Martin, Health Care Expenditures Associated with Autism Spectrum Disorders, 161 *Archives of Pediatric and Adolescent Medicine*, 350-55 (2007).

ALTCS eligibility is determined according to a subjective determination of whether an individual is "at-risk for institutionalization." For autism, this criterion is not appropriate. The "PAS" tool, which ALTCS

administers during the screening process, is weighted to provide more emphasis on items such as feeding tubes; in fact, the tool provides ZERO points for a diagnosis of autism.

Approximately 50% of personal bankruptcy cases are due at least in part to medical costs. See "Too Great a Burden: Arizona's Families at Risk." Publication No. 07-112AZ. Families USA, December 2007.

Myers, Scott M. Management of Children with Autism Spectrum Disorders. American Academy of Pediatrics, October 29, 2007.

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John W. Jacobson, James A. Mulick, Gina Green, Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case. 13 Behavioral Interventions, 201-26 (1998).



Sarah Palin, Governor
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

P.O. Box 240249 • Anchorage, Alaska 99524-0249 • Phone: 907-269-8990 • Fax: 907-269-8995 • Toll Free 888-269-8990

20 March 2009

The Honorable Pete Petersen
State Capitol Room 422
Juneau AK 99801-1182

Re: HB 187 Private Autism Insurance Coverage

Dear Representative Petersen,

The Governor's Council on Disabilities and Special Education appreciates your efforts to ensuring that children in Alaska who experience autism receive the supports they need to live productive lives. We wholeheartedly support HB 187, which mandates that private insurance companies cover autism spectrum disorders.

In Alaska today 1,512 children and young people have autism, of whom approximately 454 need significant clinical treatment. Thirty years of research demonstrates that with intensive early intervention, these children could gain a significant number of IQ points, and half of them could achieve normal functioning. With treatment, Alaska will see a savings of \$208,500 per capita in avoided special education costs and lifetime savings of \$1.08 million per capita. According to Michael Ganz, a Harvard economist, without treatment it is estimated it will cost the state \$3.2 million per capita. By requiring that private insurance policies include coverage for treating autism, we can help many children access the services they need and live more productive lives.

We appreciate your advocacy on behalf of Alaskan children with autism and look forward to continuing to work with you on this issue.

Respectfully,

A handwritten signature in black ink, appearing to read "Stacey Messerschmidt".

Stacey Messerschmidt, Chair
Governor's Council on Disabilities and Special Education

Creating Change That Improves The Lives Of People With Disabilities

Ashley Rousson

From: Jon Lyon [jlyon@LatouchePediatrics.net]
Sent: Tuesday, March 24, 2009 12:26 PM
To: Ashley Rousson
Subject: HB187

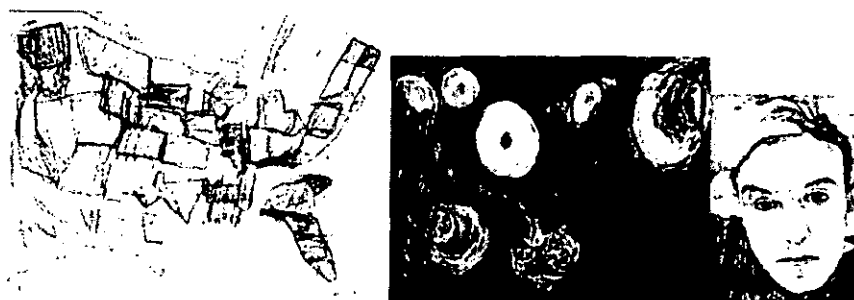
This letter is in support of HB 187.

As a pediatrician practicing in Anchorage for the past 33 years, I treat many children with Autism and I recognize the tremendous energy expended by these childrens' parents and the increased cost of medical care. I see HB 187 as a positive and needed approach and should facilitate the care for these children with very special needs.

W Jon Lyon MD, FAAP

BIOSKETCH

James N. Boudier graduated from The Pennsylvania State University with a Master of Public Administration, with course concentrations in budgeting, finance, and accounting. He is currently the Chief Operating Officer of The Vista School® and The Vista Foundation®, and serves as the Director of Collaboration and Development for the Central Pennsylvania Autism Regional Center. In 2004, he served as the Chairman of the Pennsylvania Autism Task Force's Funding Streams Subcommittee and was the principal author of the Subcommittee's *Final Recommendations*. He is also a principal author of Pennsylvania Act 62 of 2008 (House Bill 1150 of 2007) pertaining to private health insurance coverage for children with Autism Spectrum Disorders, which has become a national model for autism coverage across the United States. In 2007, Mr. Boudier developed an accurate cost model for estimating premium increases associated with mandating private insurance coverage for treating Autism Spectrum Disorders, which contributed to the Pennsylvania Health Care Cost Containment Council's finding that autism insurance coverage in Pennsylvania is cost effective. Since that time, he has completed cost analyses for autism insurance coverage legislation enacted in Pennsylvania, Louisiana, and Florida, has presented cost analysis testimony before legislative bodies in three states, and has also provided volunteer cost analysis services for autism insurance legislation pending in five other states. Mr. Boudier's work regarding the cost and benefit of private insurance coverage for autism diagnosis and treatment is published in the *Journal of Autism and Developmental Disorders* and the *Speaker's Journal* of the Pennsylvania House of Representatives.



Benefit-Cost Analysis of Alaska Insurance Coverage – H.B. 187

Jon Hockenyos
Resources for Hope

January 2010

Note: Pictures shown above were produced by children with autism, and are taken from the Autism Society website at <http://www.autism-society.org>

Executive Summary

- Although the Centers for Disease Control recently lowered the estimate of community prevalence of autism at 1 in 110 people, the actual rate of individuals who are treated is much lower. The assumption in this analysis relies on a midpoint estimate from an analysis conducted by Jim Boudier in March 2009 (Boudier analysis) of approximately 1 in 500 of the entire population (the equivalent 1 in 250 for eligible individuals covered by group insurance plans).
- Increased insurance premium costs associated with greater coverage under H.B. 187 were estimated at the midpoint by the Boudier analysis at 0.92 percent, the equivalent of \$3.60 per member per month.
- The majority of children with autism who receive appropriate intervention and treatment experience marked improvement – 47% recover “typical” function, 40% make significant improvement, and the remaining 13% make little progress.
- There are significant lifetime costs associated with autism related to direct medical expenses, direct non-medical expenses, and indirect expenses (lost productivity). These children and their lifetime costs can be divided into four distinct groups (“cohorts”):
 - Cohort 1: Children who receive treatment and recover to “typical” function = \$603,448
 - Cohort 2: Children who receive treatment and make significant improvement = \$1,926,790
 - Cohort 3: Children who receive treatment and make little progress = \$3,697,979
 - Cohort 4: Children who receive no treatment = \$3,439,065
- The blended weighted average cost of Cohorts 1, 2, and 3 (children who receive treatment) is \$1,535,074. This blended cost compared with the cost of Cohort 4 (children who receive no treatment) results in an overall benefit-cost ratio of 2.24.
- Under the midpoint assumptions, the Boudier analysis indicates that a total of 351 individuals will be covered by H.B. 187. The difference between the lifetime costs of children who receive no intervention (Cohort 4) and the blended weighted average of Cohorts 1-3 is \$1,903,991 per child. Multiplying these two figures together creates total social benefits in Alaska of \$667.7 million.

Benefit – Cost Analysis

Aside from moral and emotional concerns, policymakers are justified in asking what are the measurable longer-term costs and benefits associated with appropriate intervention to treat autism. Perhaps the most fundamental issue is related to outcomes – i.e., do children who receive appropriate treatment get better, and, if so, what does “getting better” actually entail? The results summarized in Chasson, et al. suggest that “getting better” is not only possible but likely and that the vast majority of children who receive appropriate intervention experience marked improvement.¹ In particular, the findings of Chasson and others indicate that approximately 47% of the children recover “typical” function; an additional 40% make “significant” improvement, although do not they do not reach “typical” function, and the remaining 13% make little progress. Clearly, this work provides strong justification for intervening as soon as possible.

A second question concerns the lifetime costs associated with autism. In April 2007, Ganz set forth his findings in describing “the age-specific and lifetime incremental societal costs of autism in the United States” (p. 343).² Ganz determined that the “lifetime per capita incremental societal cost of autism is \$3.2 million” and that “[l]ost productivity and adult care are the largest components of costs” (p. 343). These figures were expressed in \$2003; using the national Consumer Price Index, the figure rises to \$3.7 million in \$2008.

Based on the extant literature demonstrating the efficacy of behavioral interventions, we believe that the “lifetime per capita incremental societal cost of autism” can be mitigated substantially by services included in H.B. 187 pending before the Alaska State Legislature. In short, autism left untreated will result in unwelcome financial consequences for families with loved ones diagnosed with autism, public agencies, and society as a whole. The following outlines a methodology and findings that substantiate this claim.

Overall Cost-Benefit

Chasson and Ganz’s work can be adapted to calculate the overall cost benefit of appropriate intervention to treat autism. Ganz grouped costs into three broad categories: Direct Medical, Direct NonMedical, and Indirect. The items included in each category are as follows, along with the lifetime breakdown. Details as to the timing and level of annual costs are included in the Appendix.

Direct Medical:

- Physicians/dentists
- Pharmaceuticals
- Alternative therapies
- Behavioral interventions
- Emergency room/Hospital
- Home healthcare
- Travel

¹ Chasson, Gregory S., Harris, Gerald E., & Neely, Wendy J. (2007). “Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism.” *Journal of Child and Family Studies*. Vol 16, pp. 401-413.

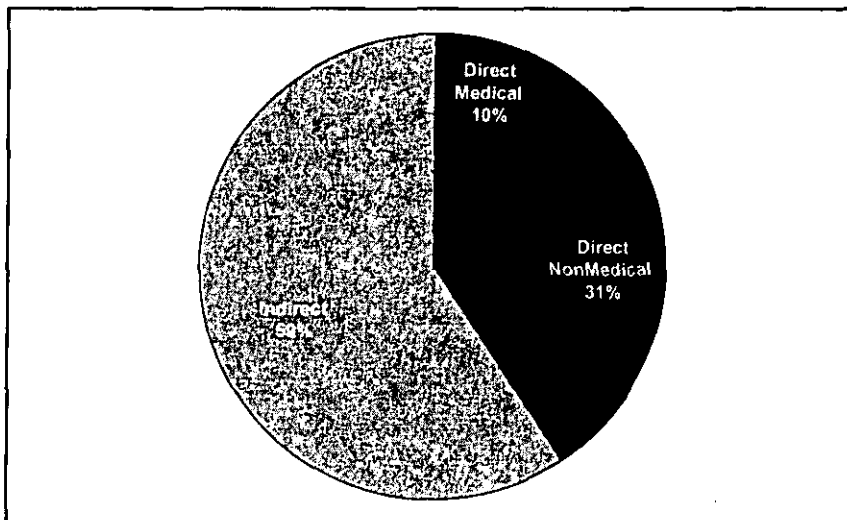
² Ganz, Michael L. (2007). “The Lifetime Incremental Societal Costs of Autism.” *Archives of Pediatric and Adolescent Medicine*. Vol. 161, Apr. 2007, pp. 343-349.

Direct Non-Medical:

- Childcare
- Adultcare
- Respite Care
- Home Improvement
- Special Education
- Supported Work
- Other

Indirect:

- Own lost productivity (wages)
- Caregiver/family lost productivity (wages)

Figure 1: Distribution of Lifetime Costs Associated With Autism

Source: Ganz, et al. and Hockenyos, et al.

The results from Chasson, et al. can be used to identify four cohorts within the overall autism designation: 1) those who recover to "Typical" status; 2) those who recover to "Improved" status; 3) those who see "Little Change" as a result of intervention; and 4) those who receive "No Intervention." The data from Ganz can be compared to the lifetime costs for each of these cohorts in turn. In essence, the cost of the direct medical interventions is the same for cohorts 1-3, although several interventions (such as behavioral) have been removed for cohort 4. The figure below shows the specific assumptions for each variable. A percent figure is shown in relation to the data outlined from Ganz in the Appendix; a figure of "<22" indicates 100% of Ganz until the age that precedes that figure (in this case, age 21). The impact is most pronounced in the timing, duration, and level of nonmedical and productivity (i.e., earnings) estimates, both for the child and his/her parents.

Table 1: Variable Adjustment Factors

	<i>Typical</i>	<i>Improved</i>	<i>Little Change</i>	<i>No Intervention</i>
	Cohort 1	Cohort 2	Cohort 3	Cohort 4
Direct Medical				
Physician/Dental	<22	<22	100%	100%
Drugs	<22	<22	100%	100%
Alt Therapies	<22	<22	100%	0%
Behavioral Therapies	100%	100%	100%	0%
Emergency/Hospital	<22	<22	100%	100%
Home Health	<22	<22	100%	0%
Travel	<22	<22	100%	0%
Direct Non-Medical				
Childcare	<8	<13	100%	100%
Adultcare	0%	0%	100%	100%
Respite Care	<8	<13	100%	100%
Home Improvement	<8	<13	100%	100%
Special Ed	<8	<13	100%	100%
Supported Work	0%	0%	100%	100%
Other	<8	<13	100%	100%
Indirect				
Own lost productivity	0%	at 50%	100%	100%
Other lost productivity	<8	at 75%	100%	100%

The results of this analysis are compelling. Cohort #1 had lifetime costs of \$603,448 (\$2008); Cohort #2 \$1,926,790; Cohort #3 \$3,697,979, and Cohort #4, the control group, \$3,439,065. Using the incidence percentages from Chasson, et al., the blended cost of Cohorts #1, #2, and #3 is \$1,535,074, creating a benefit-cost ratio of 2.24 as compared to Cohort #4, the control (No Intervention) group.

Table 2: Variation in Lifetime Costs by Cohort

	<i>Typical</i>	<i>Improved</i>	<i>Little Change</i>	<i>No Intervention</i>
	Cohort 1	Cohort 2	Cohort 3	Cohort 4
Lifetime Costs	\$603,448	\$1,926,790	\$3,697,979	\$3,439,065
Incidence	47%	40%	13%	
Blended Figure	\$283,621	\$770,716	\$480,737	\$1,545,074
Net Gain				\$1,903,991
Benefit-Cost Ratio				2.24

Application to Alaska

Selected information from the Boudier analysis is provided below. As shown, the midpoint estimates indicated that prevalence will vary by age band from 0.20 percent to 0.45 percent. Using these ranges in combination with an assumption of 55.9 percent Alaskan children being covered by group insurance and a specific estimate for state employees results in a mid-point figure of 351 total individuals who will receive coverage under H.B. 187. This yields a net benefit to society of \$667,708,307 (351 multiplied by the per capita net gain figure of \$1,903,991 above).

Table 3: Treated Prevalence Assumptions Under H.B. 187

Low Estimate				
Age Band	Treated Prevalence Rate	Group Plans	State & Union Plans	Total Children Treated
2 to 4	0.25%	42	1	43
5 to 9	0.35%	93	5	98
10 to 14	0.25%	67	4	71
15 to 19	0.20%	58	4	62
20 years	0.20%	9	1	10
TOTAL		269	15	284
Mid-Point Estimate				
Age Band	Treated Prevalence Rate	Group Plans	State & Union Plans	Total Children Treated
2 to 4	0.30%	50	2	52
5 to 9	0.45%	120	6	126
10 to 14	0.30%	80	5	85
15 to 19	0.25%	72	5	77
20 years	0.20%	9	1	10
TOTAL		332	19	351
High Estimate				
Age Band	Treated Prevalence Rate	Group Plans	State & Union Plans	Total Children Treated
2 to 4	0.45%	76	3	78
5 to 9	0.67%	178	9	187
10 to 14	0.35%	94	6	100
15 to 19	0.30%	86	7	93
20 years	0.25%	12	1	13
TOTAL		446	25	470

Source: Boulder analysis

Focus on Education

Regarding the cost-benefit of intensive ABA services, two analyses, one completed in Pennsylvania and the other in Texas, examined the future cost savings to government units resulting from investment in intensive behavioral interventions for people with autism.

The first such work, completed by John W. Jacobson, James A. Mulick, and Gina Green in 1998, notes that an abundance of research demonstrates the efficacy of early, intensive behaviorally-based interventions to enable substantial numbers of children with autism to "attain intellectual, academic, communication, social, and daily living skills within the normal range" (p. 201).³ Using representative costs from Pennsylvania, including costs for special educational and adult special

³ Jacobson, John W., James A. Mulick, and Gina Green (1998). "Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case." *Behavioral Interventions* 13, 201-226.

needs services, they found that, "At varying rates of effectiveness and in constant dollars, this model estimates that cost savings range from \$187,000 to \$203,000 per child for ages 3-22 years, and from \$656,000 to \$1,082,000 per child for ages 3-55 years" (Jacobson, et al., p. 201).

More recently, Chasson, et al. compared the costs of early intensive behavioral intervention ("EIBI") and special education for children with autism.⁴ Alluding to recent comparison studies that strongly suggest that "eclectic" special education programs are materially ineffective for many children with autism, the authors note that the human cost of failing to provide EIBI services is considerable. Consistent with Jacobson's et al.'s findings, Chasson et al. found that "the state of Texas would save \$208,500 per child across eighteen years of education with EIBI" (p. 401). It is important to note that, without treatment, persons with autism will grow to become adults dependent on publicly-funded services for their lifespan. As Chasson et al. put it, "By implementing EIBI with all children with autism, as a way to prevent the need for special education, the investment not only produces a sizeable savings after 18 years, but it maximizes the likelihood that most of these children will return a profit long after maturation" (p. 410). "The bottom line," they write, "is that a simple change in policy could drastically improve functioning and quality of life for thousands of children with autism in Texas."

Conclusion

Appropriate interventions with autistic children create measurable results. Based on our analysis of the impact of Alaska H.B. 187, we anticipate that its passage and implementation would contribute to the creation of net social benefits to Alaska of approximately \$667.7 million.⁵ Separate analysis suggests that these benefits can be supported by an increase in insurance premiums of about 0.92 percent, a rate well in line with other states that will yield cost increases per member of \$3.60 monthly. Furthermore, given the abundance of evidence concerning the efficacy of Applied Behavior Analysis in treating the varied symptoms of autism, the State of Alaska can expect significant future savings in avoided special education and human services costs. Lastly, expected premium and cost impacts relating to H.B. 187 are consistent with similar legislation enacted or pending in at least 10 other states.

⁴ Chasson, Gregory S., Harris, Gerald E., & Neely, Wendy J. (2007). "Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism." *Journal of Child and Family Studies*, 16, 401-413.

⁵ It should be noted that the expenditures outlined to create the benefits described extend beyond that which likely will be covered entirely by insurance. However, the costs associated with many interventions, especially behavioral interventions, are large enough to be beyond the means of all but the most affluent families absent insurance coverage.

Exhibit A: Expenditures by Cohort

Cohort 1 - "Typical"

Direct Annual Medical Expenditures (\$2008)

AGE	Physicians/ Dentists	Drugs	Alternative Therapy	Behavioral Interventions	ER/Hosp	Home Health	Travel	Total
3-7	\$1,342	\$172	\$232	\$38,030	\$969	\$546	\$95	\$41,386
8-12	\$675	\$179	\$128	\$4,719	\$899	\$355	\$82	\$7,036
13-17	\$509	\$153	\$59	\$4,071	\$692	\$312	\$70	\$5,866
18-22	\$498	\$151	\$39	\$1,467	\$997	\$154	\$61	\$3,368

Direct Annual Non-Medical Expenditures (\$2008)

AGE	Childcare	Adultcare	Respite Care	Home Improvement	Special Education	Supported Work	Other	Total
3-7	\$5,425	\$0	\$1,287	\$188	\$5,365	\$0	\$378	\$12,643

Indirect Annual Losses Due to Reduced/Foregone Income (\$2008)

AGE	Own	Parents/Caregiver	Totals
3-7	\$0	\$50,392	\$50,392

Total Costs: \$603,448

Cohort 2 - "Improvement"

Direct Annual Medical Expenditures (\$2008)

AGE	Physicians/ Dentists	Drugs	Alternative Therapy	Behavioral Interventions	ER/Hosp	Home Health	Travel	Total
3-7	\$1,342	\$172	\$232	\$38,030	\$969	\$546	\$95	\$41,386
8-12	\$675	\$179	\$128	\$4,719	\$899	\$355	\$82	\$7,036
13-17	\$509	\$153	\$59	\$4,071	\$692	\$312	\$70	\$5,866
18-22	\$498	\$151	\$39	\$1,467	\$997	\$154	\$61	\$3,368
23-27	\$580	\$145	\$33	\$0	\$908	\$124	\$53	\$1,841
28-32	\$593	\$133	\$29	\$0	\$798	\$102	\$46	\$1,701
33-37	\$640	\$115	\$25	\$0	\$700	\$109	\$39	\$1,628
38-42	\$632	\$98	\$21	\$0	\$611	\$105	\$34	\$1,501
43-47	\$882	\$84	\$19	\$0	\$498	\$160	\$29	\$1,683
48-52	\$989	\$71	\$16	\$0	\$412	\$180	\$25	\$1,693
53-57	\$996	\$61	\$14	\$0	\$342	\$76	\$21	\$1,509
58-62	\$948	\$51	\$12	\$0	\$378	\$16	\$19	\$1,424
63-66	\$740	\$40	\$11	\$0	\$352	\$46	\$16	\$1,204

Direct Annual Non-Medical Expenditures (\$2008)

AGE	Childcare	Adultcare	Respite Care	Home Improvement	Special Education	Supported Work	Other	Total
3-7	\$5,425	\$0	\$1,287	\$188	\$5,365	\$0	\$378	\$12,643
8-12	\$4,679	\$0	\$1,109	\$163	\$12,102	\$0	\$325	\$18,379

Indirect Annual Losses Due to Reduced/Foregone Income (\$2008)

AGE	Own	Parents/Caregiver	Totals
3-7	\$0	\$50,392	\$50,392
8-12	\$0	\$48,136	\$48,136
13-17	\$0	\$33,748	\$33,748
18-22	\$0	\$31,672	\$31,672
23-27	\$19,133	\$16,706	\$35,839
28-32	\$19,084	\$2,752	\$21,837
33-37	\$18,050	\$0	\$18,050
38-42	\$17,044	\$0	\$17,044
43-47	\$15,562	\$0	\$15,562
48-52	\$14,352	\$0	\$14,352
53-57	\$10,400	\$0	\$10,400

Total Costs: \$1,926,790

Cohort 3 – “No Improvement”

Direct Annual Medical Expenditures (\$2008)

AGE	Physicians/ Dentists	Drugs	Alternative Therapy	Behavioral Interventions	ER/Hosp	Home Health	Travel	Total
3-7	\$1,342	\$172	\$232	\$38,030	\$969	\$546	\$95	\$41,386
8-12	\$675	\$179	\$128	\$4,719	\$899	\$355	\$82	\$7,036
13-17	\$509	\$153	\$59	\$4,071	\$692	\$312	\$70	\$5,866
18-22	\$498	\$151	\$39	\$1,467	\$997	\$154	\$61	\$3,368
23-27	\$580	\$145	\$33	\$0	\$906	\$124	\$53	\$1,841
28-32	\$593	\$133	\$29	\$0	\$798	\$102	\$46	\$1,701
33-37	\$640	\$115	\$25	\$0	\$700	\$109	\$39	\$1,626
38-42	\$632	\$98	\$21	\$0	\$611	\$105	\$34	\$1,501
43-47	\$892	\$84	\$19	\$0	\$498	\$160	\$29	\$1,683
48-52	\$989	\$71	\$16	\$0	\$412	\$180	\$25	\$1,693
53-57	\$996	\$61	\$14	\$0	\$342	\$76	\$21	\$1,509
58-62	\$948	\$51	\$12	\$0	\$378	\$16	\$19	\$1,424
63-66	\$740	\$40	\$11	\$0	\$352	\$46	\$16	\$1,204

Direct Annual Non-Medical Expenditures (\$2008)

AGE	Childcare	Adultcare	Respite Care	Home Improvement	Special Education	Supported Work	Other	Total
3-7	\$5,425	\$0	\$1,287	\$188	\$5,365	\$0	\$378	\$12,643
8-12	\$4,679	\$0	\$1,109	\$163	\$12,102	\$0	\$325	\$18,379
13-17	\$4,037	\$0	\$957	\$140	\$10,440	\$0	\$281	\$15,855
18-22	\$3,402	\$0	\$826	\$12	\$7,310	\$0	\$996	\$12,545
23-27	\$0	\$29,328	\$0	\$11	\$0	\$978	\$1,907	\$32,224
28-32	\$0	\$25,298	\$0	\$9	\$0	\$844	\$1,645	\$27,796
33-37	\$0	\$21,823	\$0	\$8	\$0	\$728	\$1,419	\$23,978
38-42	\$0	\$18,824	\$0	\$7	\$0	\$628	\$1,224	\$20,683
43-47	\$0	\$16,238	\$0	\$6	\$0	\$542	\$1,057	\$17,842
48-52	\$0	\$14,006	\$0	\$5	\$0	\$467	\$910	\$15,388
53-57	\$0	\$12,083	\$0	\$5	\$0	\$341	\$786	\$13,214
58-62	\$0	\$10,422	\$0	\$4	\$0	\$0	\$677	\$11,103
63-66	\$0	\$8,688	\$0	\$4	\$0	\$0	\$565	\$9,254

Indirect Annual Losses Due to Reduced/Foregone Income (\$2008)

AGE	Own	Parents/Caregiver	Totals
3-7	\$0	\$50,392	\$50,392
8-12	\$0	\$48,136	\$48,136
13-17	\$0	\$44,994	\$44,994
18-22	\$0	\$42,229	\$42,229
23-27	\$38,268	\$22,274	\$60,540
28-32	\$38,169	\$3,669	\$41,838
33-37	\$36,100	\$0	\$36,100
38-42	\$34,088	\$0	\$34,088
43-47	\$31,125	\$0	\$31,125
48-52	\$28,704	\$0	\$28,704
53-57	\$20,800	\$0	\$20,800

Total Costs: \$3,697,979

11 Benefit-Cost Analysis of Alaska Autism Legislation – H.B. 187

Cohort 4 – “No Intervention”

Direct Annual Medical Expenditures (\$2008)

AGE	Physicians/ Dentists	Drugs	Alternative Therapy	Behavioral Interventions	ER/Hosp	Home Health	Travel	Total
3-7	\$1,342	\$172	\$0	\$0	\$969	\$546	\$0	\$2,483
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13-17	\$508	\$153	\$0	\$0	\$892	\$312	\$0	\$1,354
18-22	\$498	\$151	\$0	\$0	\$997	\$154	\$0	\$1,646
23-27	\$580	\$145	\$0	\$0	\$906	\$124	\$0	\$1,631
28-32	\$593	\$133	\$0	\$0	\$798	\$102	\$0	\$1,525
33-37	\$640	\$115	\$0	\$0	\$700	\$109	\$0	\$1,454
38-42	\$632	\$98	\$0	\$0	\$611	\$105	\$0	\$1,341
43-47	\$892	\$84	\$0	\$0	\$498	\$180	\$0	\$1,474
48-52	\$989	\$71	\$0	\$0	\$412	\$180	\$0	\$1,472
53-57	\$996	\$61	\$0	\$0	\$342	\$76	\$0	\$1,398
58-62	\$948	\$51	\$0	\$0	\$378	\$16	\$0	\$1,377
63-66	\$740	\$40	\$0	\$0	\$352	\$46	\$0	\$1,131

Direct Annual Non-Medical Expenditures (\$2008)

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3-7	\$5,425	\$0	\$1,287	\$188	\$5,365	\$0	\$378	\$12,643
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Indirect Annual Losses Due to Reduced/Foregone Income (\$2008)

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23-27	\$38,266	\$22,274	\$60,540
28-32	\$38,169	\$3,669	\$41,838
33-37	\$36,100	\$0	\$36,100
38-42	\$34,088	\$0	\$34,088
43-47	\$31,125	\$0	\$31,125
48-52	\$28,704	\$0	\$28,704
53-57	\$20,800	\$0	\$20,800

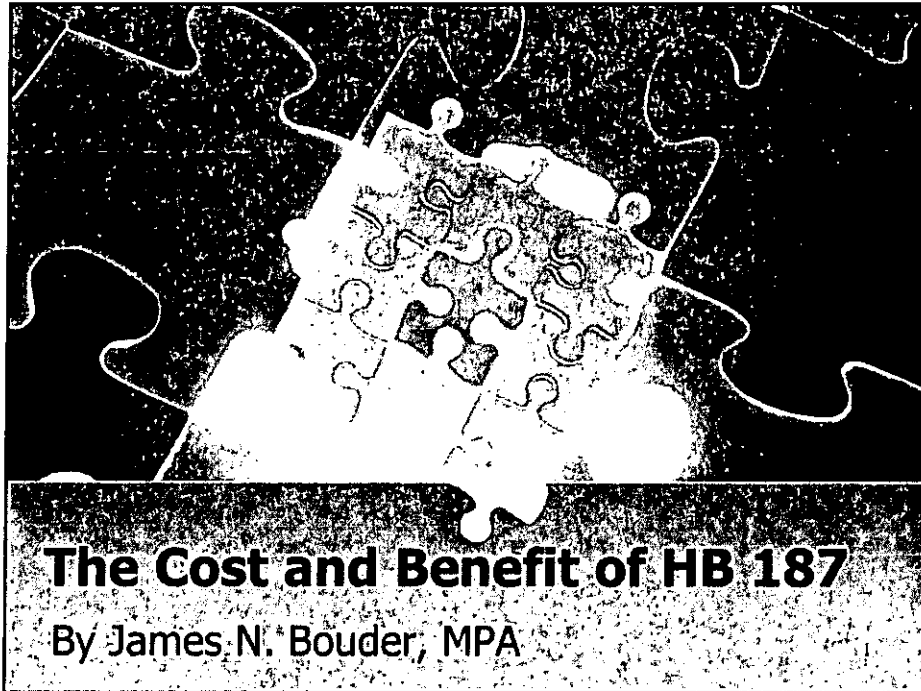
Total Costs: \$3,439,065

Biosketch of Author

Jon Hockenyos has had a life-long interest in economics and public policy. Following stints as an aide to a member of the British Parliament and work on a Senatorial campaign in his home state of Illinois, Mr. Hockenyos founded TXP while attending the LBJ School of Public Affairs at the University of Texas at Austin in 1987. Since then, TXP has successfully completed hundreds of projects for a wide variety of clients, with a strong record of on-time, on-budget delivery.

Along with serving as President of the firm, Mr. Hockenyos makes numerous public presentations and speeches, has served as a resource witness on a variety of issues for a large number of city councils, state legislatures, and the U.S. Congress, and is widely quoted by both print and electronic media.

Mr. Hockenyos received a Bachelor of Arts in Philosophy from the University of Illinois and Masters of Public Affairs from the LBJ School of Public Affairs, where he has taught as an Adjunct Professor. He also served on Board of Directors for Capital Metro (the Austin area transit authority), is the current President of the Board of Directors of Hyde Park Theatre in Austin, and is a member of the Advisory Board of American Bank of Commerce. *Resources for Hope* is the recently founded not-for-profit created by Jon Hockenyos and Rebecca Yerly to provide analytical support to autism insurance reform.



Cost Benefit Analysis

Contents:

- Effect on Commercial Insurance Rates
- Effect on State Employee Claims if Legislature Extends Benefits to Dependents of State Workers
- Long-Term Considerations
- Other State Estimates

Summary of HB 187

Bill Summary:

- Requires private insurance coverage for diagnosis and treatment of autism, up to \$36,000 annually
- Provides for coverage of medically necessary, evidence-based services
 - Speech, Occupational, and Physical Therapy
 - Psychological and Psychiatric Care
 - Pharmacy Care
 - Rehabilitative Care, including Applied Behavior Analysis

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Commercial Insurance Cost Estimate

Assumptions:

- Approximately 48,425 Alaskans between the ages of 2 and 20 are insured under plans subject to HB 187, based on census estimates, adjustments for uninsured, and for ERISA preemption
- A treated prevalence rate between 1 in 250 to 1 in 400, to reflect the number of children satisfying the diagnostic criteria for autism who will require and seek treatment once coverage is available
- Highest expenditures experienced during early childhood years, tapering downward as child approaches adulthood

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Commercial Insurance Cost Estimate

Assumptions (cont'd):

- 85% Medical Loss Ratio (Industry Standard) to convert claims increase to premium revenue requirement
- Estimated premium base of \$345,975,000 for 2009, based on 2008 Report of the Alaska Division of Insurance
- Average Annual Individual Policy cost of \$4,683 and Family Policy cost of \$12,351 (Kaiser Family Foundation)
- An adequate provider network will be in place on the legislation's effective date

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How Many?

Eligible Beneficiaries

Total Aged 2-20 Yrs (Census '06 Est.)	190,947
% with Group Health Insurance	55.9%
Total Group Insured Aged 2-20	106,664
% Non-ERISA Plans (MEPS)	45.4%
Total Non-ERISA Aged 2-20	48,425

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How Many?

Treated Prevalence Assumptions

- Prevalence children w/ autism seeking and requiring significant levels of treatment
 - Shimabukuru et al. (2008): 1 in 526
 - Leslie et al. (2007): 1 in 520
 - Liptak et al. (2006): 1 in 476
 - Mandell et al. (2006): 1 in 500
- Based on literature, 1 in 500 (0.20%) of children with autism seek and require significant levels of treatment
 - This statistic has remained stable since 1999
- For purposes of this cost analysis, I have assumed a treated prevalence ranging from 1 in 250 to 1 in 400

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How Much?

Low Estimate (Treated Prevalence 1 in 400):

Age Band	# Children	Treated Prevalence	Cost per Person	Total \$ Cost
2 to 4	7,573	0.25%	\$30,000	\$567,999
5 to 9	11,962	0.35%	\$19,660	\$823,127
10 to 14	12,861	0.25%	\$6,758	\$217,292
15 to 19	13,346	0.20%	\$2,525	\$67,400
20 years	2,682	0.20%	\$2,525	\$13,543
Total	48,425			\$1,689,361
% PMPM (w/ 85% MLR)				0.57%
\$ PMPM (w/ 85% MLR)				\$2.24

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How Much?

Mid Estimate (Treated Prevalence 1 in 325):

Age Band	# Children	Treated Prevalence	Cost per Person	Total \$ Claims
2 to 4	7,573	0.30%	\$36,000	\$817,918
5 to 9	11,962	0.45%	\$26,200	\$1,410,357
10 to 14	12,861	0.30%	\$9,000	\$347,256
15 to 19	13,346	0.25%	\$3,500	\$116,782
20 years	2,682	0.20%	\$3,500	\$18,773
Total	48,425			\$2,711,085
% PMPM (w/ 85% MLR)				0.92%
\$ PMPM (w/ 85% MLR)				\$3.60

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How Much?

High Estimate (Treated Prevalence 1 in 250):

Age Band	# Children	Treated Prevalence	Cost per Person	Total \$ Claims
2 to 4	7,573	0.45%	\$36,000	\$1,226,877
5 to 9	11,962	0.67%	\$30,500	\$2,444,498
10 to 14	12,861	0.35%	\$9,000	\$540,176
15 to 19	13,346	0.30%	\$3,500	\$140,138
20 years	2,682	0.25%	\$3,500	\$23,466
Total	48,425			\$4,375,156
% PMPM (w/ 85% MLR)				1.49%
\$ PMPM (w/ 85% MLR)				\$5.81

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Short-Term Cost Estimates

Estimated % and \$ PMPM Increase by Year:

Estimated % Increase in Premiums by Year				
Scenario	Year 1	Year 2	Year 3	Year 4 and Beyond
Low	0.14%	0.29%	0.43%	0.57%
Mid	0.23%	0.46%	0.69%	0.92%
High	0.37%	0.75%	1.02%	1.49%

Estimated \$ Increase PMPM by Year				
Scenario	Year 1	Year 2	Year 3	Year 4 and Beyond
Low	\$0.55	\$1.13	\$1.67	\$2.24
Mid	\$0.90	\$1.79	\$2.69	\$3.60
High	\$1.44	\$2.92	\$3.97	\$5.81

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State Fiscal Impact

(Hypothetical)

Fiscal Impact if State Plans Included in HB 187:

Scenario	Annual \$ Total	\$ Cost Per Employee Per Month
Low	\$334,990	\$1.86
Mid	\$543,384	\$3.02
High	\$875,452	\$4.86

- Assumed same prevalence rates and costs per age band as with Commercial Insurance Estimate
- Based on census and claims data provided by the Division of Retirement and Benefits

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Future Savings

Access to Treatment Reduces Future Costs

- Avoided human service system costs very high
 - Jacobson et al. (1999) – \$2 million per person over lifespan
 - Chasson et al. (2007) – \$208,500 per capita savings during school years alone
- Ganz (2007) – Incremental societal cost for not treating autism approximately \$3.2 million per person
 - Adult care and lost productivity comprise the largest component of this cost
 - Also, lost productivity for primary caregivers a significant contributor to the societal cost

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Other State Findings

Cost Analyses in Other States

SEE ATTACHMENT "A"

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Conclusion

HB 187 Will Cost Little, But Save Much

- After an adequate provider network is in place, Alaskan insurance ratepayers can expect premium increases ranging from 0.57% to 1.49%
- Alaska can save approx. \$208,500 per child in avoided special education costs during the school years alone
- Alaska can save approx. \$2.0 million in avoided, lifetime human service costs per child who receives treatment
- **Conclusion:** Based on my review of the data and extant literature, the cost of providing effective treatment to children with autism is low, but the future savings from providing such treatment is significant

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Questions?

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ATTACHMENT "A"

State/Party	Eligibility/Disposition	Annual Cap	Lifetime Limit	Estimated % Premium Increase
Arizona	Birth to 16 yrs	\$50,000 to age 9, \$25,000 ages 10-16	None	
Key HealthCare Concepts, LLC ¹	Independent			0.33%-0.69%
Florida	< 18 yrs or 18 yrs & older if in HS & have a DD dx by age 8	\$36,000	\$200,000	
Bouder, James N. ²	Proponent			0.37%-0.75%
Louisiana	< 17 yrs	\$36,000	\$144,000	
Bouder, James N. ³	Proponent			0.27%-0.56%
Louisiana Office of Group Benefits ⁴	Independent			0.29%
Pennsylvania	< 21 yrs	\$36,000	None	
Abt Associates ⁵	Independent			+/- 1%
Blue Cross of Northeastern PA ⁶	Opponent			+/- 0.50%
Bouder, JN et al. ⁷	Proponent			+/- 1%
Highmark Blue Shield ⁸	Opponent			+/- 0.50%
PA Department of Insurance ⁹	Independent			+/- 1%
South Carolina	< 16 yrs & Dx w/ ASD at age 8 or younger	\$50,000	None	
Governor Sanford (Veto Letter)	Opponent			+/- 1%

¹ Key HealthCare Concepts, LLC (2008), *Actuarial Report Regarding Financial Impacts* [Regarding private insurance coverage for autism treatment], p. 4.

² Bouder, JN for Autism Speaks (2008) [Financial Impact Section Only], *Report Under § 624.215(2), Fla. Stat. (2007), Assessing the Social and Financial Impacts of House Bill 1291 and Senate Bill 2654*, retrieved from <<http://www.autismvotes.org>>

³ Bouder, JN (2008), *Cost Analysis - HB 958 of 2008 (As Amended 4/30/08)* (2008), pp. 2-7, retrieved from <<http://www.autismvotes.org>>

⁴ *Ibid*, pp. 7-9 and Exhibit "C-2"

⁵ Abt Associates, Inc. (2008), *Autism Spectrum Disorders Mandated Benefits Review Panel Report: Evidence Submitted Concerning Pennsylvania HB 1150*, Prepared for the Pennsylvania Health Care Cost Containment Council, retrieved from <<http://www.phc4.org>>

⁶ See Mercer (2008), *Annual Mandated Health Insurance Services Evaluation, Section 1, Coverage for Autism Spectrum Disorders*, prepared for the Maryland Health Care Commission, p. 23, evaluating Highmark Blue Shield's cost estimate submitted to the Pennsylvania Health Care Cost Containment Council.

⁷ Bouder, JN, Stuart Spielman, David S. Mandell (2009). *Brief Report: Quantifying the Impact of Autism Coverage on Private Insurance Premiums*, *Journal of Autism and Developmental Disorders*.

⁸ See Mercer (2008), *Annual Mandated Health Insurance Services Evaluation, Section 1, Coverage for Autism Spectrum Disorders*, prepared for the Maryland Health Care Commission, p. 23, evaluating Blue Cross of Northeastern Pennsylvania's cost estimate submitted to the Pennsylvania Health Care Cost Containment Council.

⁹ Commonwealth of Pennsylvania Insurance Department (2008), regarding the effect of Pennsylvania House Bill 1150 on commercial insurance rates, p. 8.

ATTACHMENT "A" (Cont'd)

State/Party	Eligibility/ Disposition	Annual Cap	Lifetime Limit	Estimated % Premium Increase
Connecticut	< 13 yrs	\$50,000 < 9 yrs, \$35,000 9 to 12 yrs	None	
Oliver Wyman ¹⁰	Proponent			0.19%-0.49%
Georgia	Not Specified	\$55,000	None	
Oliver Wyman ¹¹	Proponent			0.63%
Maryland	< 21 yrs	\$50,000	None	
Mercer/Oliver Wyman ¹²	Independent			0.52%-1.22%
New Jersey	Not Specified	None	None	
Mandated Benefits Advisory Comm. ¹³	Independent			1%
Oklahoma	< 21 yrs	\$75,000	None	
Aon (for OSEEGIB) ¹⁴	Independent			0.34%-1.00%
Virginia	< 21 yrs	\$36,000	None	
Oliver Wyman ¹⁵	Proponent			0.60%
West Virginia	< 24 yrs	\$75,000	None	
Bouder, James N. ¹⁶	Proponent			0.82%
Public Employees Insurance Agency ¹⁷	Independent			1.54%
Council for Affordable Health Insurance¹⁸	Not Specified	Not Specified	None	
	Opponent			+/- 1.00%

¹⁰ Oliver Wyman (2009), *Actuarial Cost Estimate: Connecticut Senate Bill 301 - An Act Related to Insurance for Coverage for Autism*, p. 14.

¹¹ Oliver Wyman (2009), *Actuarial Cost Estimate: Georgia Senate Bill 161 - An Act Related to Insurance Coverage for Autism*, p. 13.

¹² Mercer (2008), *Annual Mandated Health Insurance Services Evaluation, Section 1, Coverage for Autism Spectrum Disorders*, prepared for the Maryland Health Care Commission, pp. 30-31.

¹³ New Jersey Mandated Benefits Advisory Commission (2006), *Evaluation of the Impact of Autism Mandated Benefits contained in Assembly Bill A-999*.

¹⁴ Aon (2009), *Memorandum Regarding the Cost Impact of Oklahoma SB 1 on the Office of State Education Employees Group Insurance Board's Health Plans*.

¹⁵ Oliver Wyman (2009), *Actuarial Cost Estimate: Virginia House Bill 1588 - Coverage for the Diagnosis and Treatment of Autism Spectrum Disorder*, p. 12.

¹⁶ Bouder, JN (2009), *Cost Analysis - House Bill 4091 Pertaining to Private Insurance Coverage for Autism Diagnosis and Treatment*.

¹⁷ West Virginia Public Employee Insurance Agency (2008), *Fiscal Note Summary on Effect HB 4091 will have on Costs and Revenues of State Government*.

¹⁸ The Council for Affordable Health Insurance (March 2009), "The Growing Trend Toward Mandating Autism Coverage", *Issues and Answers*, p. 2.



Centers for Disease Control and Prevention
Your Online Source for Credible Health Information

Diagnostic Criteria

The American Psychiatric Association's Diagnostic and Statistical Manual-IV, Text Revision (DSM-IV-TR) 1 provides standardized criteria to help diagnose ASDs.

Diagnostic Criteria for 299.00 Autistic Disorder

- Six or more items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
 - qualitative impairment in social interaction, as manifested by at least two of the following:
 - marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - lack of social or emotional reciprocity
 - qualitative impairments in communication as manifested by at least one of the following:
 - delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - stereotyped and repetitive use of language or idiosyncratic language
 - lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
 - restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - apparently inflexible adherence to specific, nonfunctional routines or rituals
 - stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - persistent preoccupation with parts of objects
- Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.



Diagnostic Criteria for 299.80 Asperger's Disorder

- Qualitative impairment in social interaction, as manifested by at least two of the following:
 - marked impairment in the use of multiple nonverbal behaviors such as eye-to eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
 - lack of social or emotional reciprocity
- Restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:
 - encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity of focus
 - apparently inflexible adherence to specific, nonfunctional routines or rituals
 - stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - persistent preoccupation with parts of objects
- The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.
- There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).
- There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.
- Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

299.80 Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism" - presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

Diagnostic Criteria for 299.80 Rett's Disorder

- All of the following:
 - apparently normal prenatal and perinatal development
 - apparently normal psychomotor development through the first 5 months after birth
 - normal head circumference at birth
- Onset of all of the following after the period of normal development:
 - deceleration of head growth between ages 5 and 48 months
 - loss of previously acquired purposeful hand skills between 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand-wringing or hand washing)
 - loss of social engagement early in the course (although often social interaction develops later)
 - appearance of poorly coordinated gait or trunk movements
 - severely impaired expressive and receptive language development with severe psychomotor retardation

Diagnostic Criteria for 299.10 Childhood Disintegrative Disorder

- Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.
- Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:
 - expressive or receptive language
 - social skills or adaptive behavior
 - bowel or bladder control
 - play
 - motor skills
- Abnormalities of functioning in at least two of the following areas:
 - qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)
 - qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)
 - restricted, repetitive, and stereotyped patterns of behavior, interest, and activities, including motor stereotypes and mannerisms
- The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia

HB 187 – Autism Insurance Reform

WHAT:

- **HB 187 will require insurance coverage for autism spectrum disorders.**
- **Autism is a disorder affecting at least 1 in 150 children with approximately 1 in 500 requiring significant clinical treatment.** Alaska currently has 1,512 children and youth under the age of 21 who have autism; approximately 454 need significant clinical treatment.

WHY:

- **Because Alaska law does not require insurance coverage for autism services, families that do not qualify for DHSS services pay out of pocket, often as much as \$50,000 per year or more; in some instances, bearing this burden results in divorce or bankruptcy.** Families that cannot afford to do so, go without crucial intervention.
- **Autism is treatable.** 30 years of research shows that with treatment, many children overcome the severe symptoms of their disorder.
 - ✓ About half the children who receive intensive early intervention achieve normal functioning after 2-3 years of treatment.
 - ✓ There is an average gain of 22 IQ points.
 - ✓ 1/3 gained 45 IQ points.
 - ✓ Nearly 50% of those receiving intensive early intervention do not require lifelong services and supports.
- **The earlier the diagnosis, the more effective treatment is.** The diagnostic process involves a comprehensive assessment (neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, ophthalmology, audiology) by a multidisciplinary team. Only those children who meet specific medical criteria are diagnosed with autism.
- **Treatment equals savings.** With treatment, Alaska will see savings of \$208,500 per capita in avoided special education costs and lifetime savings of \$1.08 million per capita. Treatment may include the following medically necessary services.
 - ✓ Pharmacy, psychiatric, psychological, rehabilitative and therapeutic care.
 - ✓ Rehabilitative care includes applied behavior analysis (the design, implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

(Continued on back side)

HB 187 – Autism Insurance Reform

- **Without treatment it is estimated that it will cost the state \$3.2 million per capita. (Michael Ganz, Harvard economist)**
- **Coverage of medically necessary autism treatment in Alaska will enable many children to access the services they need and live more productive lives.**
- **Most private insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan.**
- **HB 187 requires private insurance policies (approximately 23% of all insurance plans) to provide a maximum coverage of \$36,000 a year for the diagnosis and treatment of autism spectrum disorders, including but not limited to applied behavior analysis.**
 - ✓ **Must be prescribed by a licensed physician, psychologist or advanced nurse practitioner.**
 - ✓ **Must be provided by an autism service provider as identified in a treatment plan developed following a comprehensive evaluation.**
 - ✓ **Must identify the medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care and therapeutic care.**
- **The maximum likely cost of such coverage to the private insurance ratepayer is approximately 0.92% or \$3.60 per policyholder per month.**

Diagnosis of Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) covers a wide range of symptoms from very mild to severe. ASD affects social skills, communication and cognitive development. ASD affects the individual's ability to convey or interpret others' emotions. Children may engage in restricted and/or repetitive play and have unusual attachments to objects. People with ASD might not seem interested in other people and prefer to be alone. People with ASD might not seem interested in other people and prefer to be alone. Some children with ASD do not like to be held or cuddled, and many do not make eye contact with others. Individuals with ASD also show varied degrees in impairment in their verbal and nonverbal communication. Some individuals with ASD may be nonverbal, while others may not have any difficulty speaking. Some repeat something previously heard or use stock phrases or learned scripts to communicate. Cognitively, individuals with ASD develop differently from others. Many people with ASD have difficulty processing sensory stimuli and verbal input, and this affects their understanding of the world around them.

It is important to note that some people without an ASD might also have some of these symptoms. But for people with an ASD, the impairment is bad enough to make life very challenging in terms of interacting with others, communicating, learning or holding down a job.

The Governor's Council on Disabilities recommended that the state establish universal screening for ASD during well-child exams to identify children who have behaviors that could indicate a disorder. The American Academy of Neurology recommends immediate referral for a diagnostic evaluation for any of the following:

- No babbling by 12 months
- No gesturing by 12 months
- No single words by 16 months
- No 2 word spontaneous phrases by 24 months
- Any loss of any language or social skills at any age

ASD screenings identify those children who require a comprehensive assessment across developmental and physical domains. Professionals from multiple disciplines then conduct a complete assessment (i.e. neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, ophthalmology, audiology). For young children, it is especially critical to conduct a differential diagnosis to rule out any other possible genetic or medical disorders.

The diagnosis focuses on determining to what extent the child has:

- Irregularities and impairments in communication
- Engagement in repetitive activities and stereotyped movements
- Resistance to environmental change or change in daily routines

Provided By: Millie Ryan 5 April 2009
The Governor's Council on Disabilities and Special Education

- Unusual responses to sensory experiences

In order to receive a diagnosis of ASD, the child must show qualitative impairment in reciprocal social interaction, qualitative impairment in communication and repetitive, stereotypical behaviors that interfere with his or her ability to develop, communicate and learn compared to typically developing peers.

In order to qualify for special education with an ASD, a child must

- exhibit a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age three, that adversely affects educational performance; and
- require special facilities, equipment, or methods to make the child's educational programs effective; and
- be diagnosed as having an autism spectrum disorder by a psychiatrist, physician, licensed psychologist or advanced nurse practitioner; and
- be certified by a group consisting of qualified professional and a parent of the child as qualifying for and needing special education services

HB

188

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 188
 () Publish Date: _____

Identifier (File Name): HB188-REV-TAX-02-22-10 Dept. Affected: Revenue
 Title: Tax on Moist Snuff RDU: Taxation and Treasury
 Component: Taxation and Treasury
 Sponsor: Representative Herron
 Requester: (H) Health & Social Services Component No.: 2476

Expenditures/Revenues (Thousands of Dollars)
 Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Personal Services	24.2	0.0	24.2	24.2	24.2	24.2	24.2
Travel	0.5	0.0	0.5	0.5	0.5	0.5	0.5
Contractual	186.2	0.0	1.2	1.2	1.2	1.2	1.2
Supplies	0.2	0.0	0.2	0.2	0.2	0.2	0.2
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	211.1	0.0	26.1	26.1	26.1	26.1	26.1

CAPITAL EXPENDITURES	0	0.0	0.0	0.0	0.0	0.0	0.0
-----------------------------	----------	------------	------------	------------	------------	------------	------------

CHANGE IN REVENUES ()	*	0.0	*	*	*	*	*
-------------------------------	----------	------------	----------	----------	----------	----------	----------

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	211.1	0.0	26.1	26.1	26.1	26.1	26.1
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	211.1	0.0	26.1	26.1	26.1	26.1	26.1

Estimate of any current year (FY2010) cost: 0

POSITIONS

Full-time	0.25	0	0.25	0.25	0.25	0.25	0.25
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

See Attached.

Prepared by: Johanna Bales Phone 907-269-6628
 Division: Tax Division Date/Time 3-20-09; 4:01 p.m.
 Approved by: Ginger Blaisdell, Director Date _____
 Agency: Administrative Services Division

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. HB 188

ANALYSIS CONTINUATION

Bill Language:

Alaska levies a tax on other tobacco products (OTP) at the rate of 75% of the wholesale cost. OTP includes any product containing tobacco that is not a cigarette. Moist snuff is one of many tobacco products upon which the OTP tax is currently levied. This bill will change the tax on moist snuff from an ad valorem tax (tax based on value) to a tax based on weight. All other tobacco products will continue to be taxed at the rate of 75% of the wholesale cost. Moist snuff will be taxed at the rate of \$1.88 per ounce. Moist snuff is defined as any finely cut, ground, or powdered tobacco that is not intended to be smoked or placed in the nasal cavity.

Revenues:

If Alaska had levied a tax on moist snuff at the rate of \$1.88 during fiscal year 2008 and consumption was not affected by the tax increase, total tobacco products tax revenue would have been approximately \$1.1 million more than what was collected. Historically, Alaska and other states have seen a drop in consumption of taxable cigarettes and other tobacco products when the tax rate is increased. This drop is due to a decrease in consumption as product price increases (price elasticity) and a decrease in taxable consumption as consumers turn to the Internet, mail order, or other means to purchase non-taxed product. The OTP tax is not levied on tobacco products, including moist snuff, that is imported into the state for personal consumption. It is legal for an individual to purchase other tobacco products off the Internet or through the mail without paying the tobacco products tax.

Based on an analysis of tax returns, the wholesale price of the most popular lower-priced brands in FY 2008 averaged \$1.03 per ounce. The average tax under the current tax structure in FY 2008 was \$.77 per ounce for a total average cost of \$1.80. Under the proposed weight-based tax, the total average cost would be \$2.91 per ounce, a 61% increase. Lower cost moist snuff products have an approximate 35% market share in Alaska. This market share has been increasing over the last few years as consumers continually look for cheaper products. It is expected that many of these consumers will turn to the Internet for moist snuff once the price of the product increases due to the increase in tax. This will, in turn, reduce the amount of revenue expected from this tax increase. Due to price elasticity and the unknown number of consumers who will turn to tax free Internet product, it is difficult to determine the change in revenues as a result of this legislation.

Expenditures:

This bill would require the Department of Revenue to add an additional tax program requiring a new tax return and license for other tobacco products. Collections, examination and compliance can be handled using existing staff. We anticipate requiring one-quarter of an Analyst Programmer IV (Range 20) for reprogramming and maintenance of the related aspects of our tax database system. There will also be \$185,000 in one-time startup expenses: \$175,000 for adding the new program to our tax examination and licensing system, and \$10,000 for education and communication with stakeholders as we implement the new tax program.

Adopted

26-LS0714\N.5
Bullock
2/23/10

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 188(HSS), Draft Version "N"

1 Page 1, line 7, following "products;":

2 Insert "**relating to the offense of selling tobacco to a minor;**"

3

4 Page 6, following line 18:

5 Insert a new bill section to read:

6 "*** Sec. 18. AS 11.76.100(e) is repealed.**"

7

8 Renumber the following bill sections accordingly.

9

10 Page 6, line 27:

11 Delete "sec. 19"

12 Insert "sec. 20"

Adopted

26-LS0714\N.3
Bullock
2/23/10

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 188(HSS), Draft Version "N"

1 Page 3, line 16:

2 Delete "sold"

3

4 Page 3, line 17, following "(1)":

5 Insert "sold"

6

7 Page 3, line 19, following the second occurrence of "in":

8 Insert "packages of not less than 10 units and in"

Adopted

26-LS0714N.2
Bullock
2/23/10

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 188(HSS), Draft Version "N"

1 Page 1, line 7, following "products;":

2 Insert "relating to the offense of selling tobacco to a minor;"

3

4 Page 1, line 9:

5 Insert a new bill section to read:

6 **"* Section 1.** AS 11.76.100(a) is amended to read:

7 (a) A person commits the offense of selling or giving tobacco **or nicotine** to a
8 minor if the person

9 (1) negligently sells a cigarette, a cigar, tobacco, or a product
10 containing tobacco **or nicotine** to a person under 19 years of age;

11 (2) is 19 years of age or older and negligently exchanges or gives a
12 cigarette, a cigar, tobacco, or a product containing tobacco **or nicotine** to a person
13 under 19 years of age;

14 (3) maintains a vending machine that dispenses cigarettes, cigars,
15 tobacco, or products containing tobacco **or nicotine**; or

16 (4) holds a business license endorsement under AS 43.70.075 and
17 allows a person under 19 years of age to sell a cigarette, a cigar, tobacco, or a product
18 containing tobacco **or nicotine**."

19

20 Page 1, line 10:

21 Delete "Section 1"

22 Insert "Sec. 2"

23

1 Renumber the following bill sections accordingly.

2

3 Page 3, line 3:

4 Delete "sec. 4"

5 Insert "sec. 5"

6

7 Page 6, line 21:

8 Delete "Sections 1 - 4 and 6 - 17"

9 Insert "Sections 2 - 5 and 7 - 18"

10

11 Page 6, line 23:

12 Delete "Section 5"

13 Insert "Section 6"

14

15 Page 6, line 24:

16 Delete "sec. 5"

17 Insert "sec. 6"

18

19 Page 6, line 25:

20 Delete "Section 5"

21 Insert "Section 6"

22 Delete "sec. 4"

23 Insert "sec. 5"

24

25 Page 6, line 27:

26 Delete "sec. 19"

27 Insert "sec. 20"

Failed

26-LS0714\N.4
Bullock
2/23/10

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE HOLMES

TO: CSHB 188(HSS), Draft Version "N"

1 Page 1, lines 1 - 2:

2 Delete ", including spitless moist snuff tobacco"

3

4 Page 2, line 14:

5 Delete "at the rate in (b) of this section [RATE"

6 Insert "in the amounts described in (b) of this section [AT THE RATE"

7

8 Page 2, line 26:

9 Delete "rate"

10

11 Page 2, line 27:

12 Delete ", other than spitless moist snuff tobacco, is"

13 Insert "is an amount equal to the wholesale price, but may not be less than"

14

15 Page 2, line 30:

16 Delete all material.

17

18 Renumber the following paragraph accordingly.

19

20 Page 2, line 31, through page 3, line 1:

21 Delete "subject to the tax rates in (1) and (2) of this subsection is 75 percent of"

22 Insert "is an amount equal to"

23

1 Page 3, lines 3 - 11:

2 Delete all material.

3

4 Renumber the following bill sections accordingly.

5

6 Page 4, line 16, following "tobacco":

7 Insert "and"

8

9 Page 4, lines 17 - 18:

10 Delete "other than spitless moist snuff tobacco; and

11 (3) spitless moist snuff tobacco"

12

13 Page 6, line 12:

14 Delete "(I), and (9)"

15 Insert "and (I)"

16

17 Page 6, lines 12 - 16:

18 Delete ";

19 (9) "spitless moist snuff tobacco" means moist snuff tobacco that is
20 typically steam-pasteurized smokeless tobacco in a tea-bag-like pouch designed to be
21 placed between the cheek and gum and is manufactured to obviate the need for
22 spitting"

23

24 Page 6, line 21:

25 Delete "(a) Sections 1 - 4 and 6 - 17"

26 Insert "Sections 1 - 16"

27

28 Page 6, lines 23 - 26:

29 Delete all material.

30

31 Renumber the following bill section accordingly.

1

2 Page 6, line 27:

3 Delete "Except as provided in sec. 19 of this Act, this"

4 Insert "This"

Sponsor Statement

House Bill 188: Taxation on Moist Snuff Tobacco (CS HB 188 (HSS) version 0714\N)

It is the Sponsor's intention that this bill will have two results:

- Provides a disincentive for Alaskans (particularly young Alaskans) to start using moist snuff tobacco products; and
- Increases the amount of tax on such products collected by the State.

Currently in state law, cigarettes are taxed at 10 cents per cigarette (\$2 a pack) and all other tobacco products (OTP) are taxed *ad valorem* at 75% of their wholesale price. Moist snuff tobacco (more commonly called "dipping tobacco") presently falls under the OTP tax regime.

HB 188 distinguishes between two types of moist snuff tobacco (MST): spitless MST and all other MST. The former are light-weight products that come in teabag-like pouches and obviate the need for expectoration. HB 188 taxes these dangerous new light-weight products that are being targeted towards youth at 100% *ad valorem*. All other MST will be taxed on a weight-based system of \$1.88 per ounce. All other OTPs remain taxed at an *ad valorem* rate of 75%.

Taxing MST (excluding spitless MST) at a \$1.88 per ounce is designed to reduce the price disparity between discount and premium MST products. \$1.88 per ounce is currently roughly equal to what the premium brands pay under the *ad valorem* system. The tax on discount brands will increase dramatically – the tax on premium brands will remain about the same; however, if the wholesale prices on these premium products increase over time (inflation), then the tax would not rise commensurately since it is by weight. The bill does include a sunset provision, whereby the \$1.88 per ounce tax on non-spitless MST products, barring further legislative action, would revert back to a 75% *ad valorem* rate after 3 years.

There is a nation-wide movement afoot to move to weight-based taxation systems for smokeless products (15 states currently use such a method, with 13 of those having changed to weight-based in the last 9 years).

This new taxation system will produce additional state revenue, by raising the taxes paid by discount MST brands. The Dept. of Revenue has estimated tax revenue would increase by \$1.1 million, although that's assuming the same amount of product is purchased as before the tax increase. Also, some popular MST companies lowered prices recently, having the net effect that this bill might result in as much as \$1.8 million in additional revenue.

According to the American Lung Association, "Increasing excise taxes on tobacco products is a proven way to reduce use, particularly among kids."

This bill also increases funding for the education and cessation fund by sending 25% of the annual tax revenue collected on MST to this fund, which may be used for tobacco education and cessation programs.

Currently, if you order cigarettes for personal use over the Internet, you must pay state taxes on those purchases. But in current state law, you do not have to pay taxes on any OTP products imported for personal use. This bill closes that loophole.

The bill also requires that cigars be sold in packages of at least five; that loose tobacco be sold in packages weighing at least one ounce; and that single dose units be sold in the original manufacturer's packaging.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

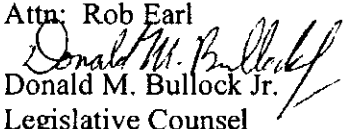
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

April 9, 2009

SUBJECT: Sectional Summary for CSHB 188(HSS), Draft Version "N"
(Work Order No. 26-LS0714\N)

TO: Representative Bob Herron
Co-Chair of the House Health and Social Services Committee
Attn: Rob Earl

FROM: 
Donald M. Bullock Jr.
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends AS 37.05.580(a) to authorize the deposit of 25 percent of the annual revenue from the tax on moist snuff tobacco into the tobacco use education and cessation fund.

Section 2. Amends AS 43.50.070(b) to exclude a buyer required to be licensed under AS 43.50.320(a) (amended in sec. 7 of the bill) from the definition of "licensee."

Section 3. Amends AS 43.50.300 by adding additional situations in which the excise tax on tobacco products is levied. In addition to the situations in current law, the tax would be levied when a person ships a tobacco product to an individual in the state for personal consumption and when a person brings a tobacco a product into the state for personal consumption.

Section 4. Amends AS 43.50.300 by adding a new subsection that lists the tax rates for the excise tax on tobacco products. The rates are \$1.88 an ounce for moist snuff tobacco other than spitless moist snuff tobacco; 100 percent of the wholesale price on spitless moist snuff tobacco, and 75 percent of the wholesale price on other tobacco products.

Section 5. Amends AS 43.50.300(b), which would be enacted by sec. 4 of the bill, to tax moist snuff tobacco at the same rate as tobacco products other than spitless moist snuff

tobacco. Under sec. 19 of the bill, this section takes effect three years after the effective date of sec. 4 of the bill.

Section 6. Adds a new section, AS 43.50.305, that describes how certain tobacco products must be packaged for sale.

Section 7. Repeals and reenacts AS 43.50.320(a) to add the requirement that a person that brings tobacco products into the state for personal consumption must be licensed as a buyer. The section continues to require distributors to be licensed.

Section 8. Amends AS 43.50.320(b) to require the Department of Revenue to issue a license to a buyer after receiving an application and the payment of a fee of \$25.

Section 9. Amends AS 43.50.320(d) to require certain information to be stated on a distributor license.

Section 10. Amends AS 43.50.320(e) to provide for the renewal of a buyer license.

Section 11. Amends AS 43.50.330(a) to add additional reporting requirements. The new requirements require the disclosure of the wholesale or purchase price of the tobacco products, the tax imposed on moist snuff tobacco other than spitless moist snuff tobacco, and the tax imposed on spitless moist snuff tobacco. (After the effective date of sec. 5, a report of the tax on moist snuff tobacco, other than spitless moist snuff tobacco, would still be needed for the purpose of determining the amount of revenue to be deposited into the tobacco use education and cessation fund; a portion of all revenue from the tax on all moist snuff tobacco is to be deposited into that fund regardless of the tax rate applicable to the different categories of moist snuff tobacco.)

Section 12. Repeals and reenacts AS 43.50.350 to designate the allocation of the tax collected on moist snuff tobacco between the tobacco use education and cessation fund (25%) and the general fund (75%). The tax on other tobacco products continues to be deposited in the general fund.

Section 13. Amends AS 43.50.390(1) by amending the definition of "distributor" to include a person that ships a tobacco product into the state for personal consumption.

Section 14. Amends AS 43.50.390(2) to include a "buyer" in the definition of "licensee."

Section 15. Amends the definition for "tobacco product" in AS 43.50.390(4) by stating that snuff tobacco includes moist snuff tobacco, and by adding other products that contain tobacco or nicotine. Excludes from the definition certain approved products used as a tobacco use cessation or harm reduction product or for other medical purposes, so long as the product is being marketed and used solely for the approved purposes.

Representative Bob Herron
April 9, 2009
Page 3

Section 16. Amends AS 43.50.390 by adding definitions for "buyer," "moist snuff tobacco," "smokeless tobacco," and "spitless moist snuff tobacco."

Section 17. Amends AS 43.70.110 by adding a definition of "cigarette" for the purposes of the business license endorsement.

Section 18. Provides that secs. 1 - 4 and 6 - 17 of the Act are applicable on the first day of the month immediately following the effective date of the section. Provides that sec. 5 of the Act is applicable on the first day of the month immediately following the effective date of sec. 5. (Tobacco taxes are reported on a monthly basis.)

Section 19. Makes sec. 5 take effect three years after the effective date of sec. 4 of the Act.

Section 20. Except for sec. 19 of the Act, provides that the Act take effect immediately.

DMB:ljw
09-230.ljw

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 188(HSS), Draft Version "N"

1 Page 1, line 7, following "products;":

2 Insert "relating to the offense of selling tobacco to a minor;"

3

4 Page 1, line 9:

5 Insert a new bill section to read:

6 **** Section 1.** AS 11.76.100(a) is amended to read:

7 (a) A person commits the offense of selling or giving tobacco or nicotine to a
8 minor if the person

9 (1) negligently sells a cigarette, a cigar, tobacco, or a product
10 containing tobacco or nicotine to a person under 19 years of age;

11 (2) is 19 years of age or older and negligently exchanges or gives a
12 cigarette, a cigar, tobacco, or a product containing tobacco or nicotine to a person
13 under 19 years of age;

14 (3) maintains a vending machine that dispenses cigarettes, cigars,
15 tobacco, or products containing tobacco or nicotine; or

16 (4) holds a business license endorsement under AS 43.70.075 and
17 allows a person under 19 years of age to sell a cigarette, a cigar, tobacco, or a product
18 containing tobacco or nicotine."

19

20 Page 1, line 10:

21 Delete "Section 1"

22 Insert "Sec. 2"

23

1 Renumber the following bill sections accordingly.

2

3 Page 3, line 3:

4 Delete "sec. 4"

5 Insert "sec. 5"

6

7 Page 6, line 21:

8 Delete "Sections 1 - 4 and 6 - 17"

9 Insert "Sections 2 - 5 and 7 - 18"

10

11 Page 6, line 23:

12 Delete "Section 5"

13 Insert "Section 6"

14

15 Page 6, line 24:

16 Delete "sec. 5"

17 Insert "sec. 6"

18

19 Page 6, line 25:

20 Delete "Section 5"

21 Insert "Section 6"

22 Delete "sec. 4"

23 Insert "sec. 5"

24

25 Page 6, line 27:

26 Delete "sec. 19"

27 Insert "sec. 20"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 188(HSS), Draft Version "N"

1 Page 3, line 16:

2 Delete "sold"

3

4 Page 3, line 17, following "(1)":

5 Insert "sold"

6

7 Page 3, line 19, following the second occurrence of "in":

8 Insert "packages of not less than 10 units and in"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE HOLMES

TO: CSHB 188(HSS), Draft Version "N"

1 Page 1, lines 1 - 2:

2 Delete ", including spitless moist snuff tobacco"

3

4 Page 2, line 14:

5 Delete "at the rate in (b) of this section [RATE"

6 Insert "in the amounts described in (b) of this section [AT THE RATE"

7

8 Page 2, line 26:

9 Delete "rate"

10

11 Page 2, line 27:

12 Delete ", other than spitless moist snuff tobacco, is"

13 Insert "is an amount equal to the wholesale price, but may not be less than"

14

15 Page 2, line 30:

16 Delete all material.

17

18 Renumber the following paragraph accordingly.

19

20 Page 2, line 31, through page 3, line 1:

21 Delete "subject to the tax rates in (1) and (2) of this subsection is 75 percent of"

22 Insert "is an amount equal to"

23

1 Page 3, lines 3 - 11:

2 Delete all material.

3

4 Renumber the following bill sections accordingly.

5

6 Page 4, line 16, following "tobacco":

7 Insert "and"

8

9 Page 4, lines 17 - 18:

10 Delete "other than spitless moist snuff tobacco; and

11 (3) spitless moist snuff tobacco"

12

13 Page 6, line 12:

14 Delete "(I), and (9)"

15 Insert "and (I)"

16

17 Page 6, lines 12 - 16:

18 Delete ";

19 (9) "spitless moist snuff tobacco" means moist snuff tobacco that is
20 typically steam-pasteurized smokeless tobacco in a tea-bag-like pouch designed to be
21 placed between the cheek and gum and is manufactured to obviate the need for
22 spitting"

23

24 Page 6, line 21:

25 Delete "(a) Sections 1 - 4 and 6 - 17"

26 Insert "Sections 1 - 16"

27

28 Page 6, lines 23 - 26:

29 Delete all material.

30

31 Renumber the following bill section accordingly.

1

2 Page 6, line 27:

3 Delete "Except as provided in sec. 19 of this Act, this"

4 Insert "This"

26-LS0714\N
Bullock
4/9/09

CS FOR HOUSE BILL NO. 188(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): REPRESENTATIVE HERRON

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the taxation of moist snuff tobacco, including spitless moist snuff**
 2 **tobacco; including different types of moist snuff tobacco in the definition of 'tobacco**
 3 **product' in provisions levying an excise tax on those products; relating to licensing for**
 4 **and taxation of tobacco products, including tobacco products imported for personal use**
 5 **and consumption; relating to the deposit of revenue from the taxation of moist snuff**
 6 **tobacco into the tobacco use education and cessation fund; defining 'moist snuff**
 7 **tobacco'; relating to the business license endorsement for the sale of tobacco products;**
 8 **and providing for an effective date."**

9 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

10 *** Section 1. AS 37.05.580(a) is amended to read:**

11 (a) There is created as a special account in the general fund the tobacco use
 12 education and cessation fund into which shall be deposited 20 percent annually of the

1 revenue derived from the settlement of State of Alaska v. Philip Morris, Incorporated,
2 et al, No. 1JU-97-915 CI (Alaska Super. 1997) and 25 percent of the annual
3 revenue collected from the tax on moist snuff tobacco under AS 43.50.300 -
4 43.50.390. The purpose of the tobacco use education and cessation fund is to provide a
5 source to finance the comprehensive smoking education, tobacco use prevention, and
6 tobacco control program authorized by AS 44.29.020(a)(14). In this subsection,
7 "moist snuff tobacco" has the meaning given in AS 43.50.390.

8 * Sec. 2. AS 43.50.070(b) is amended to read:

9 (b) In this section, "licensee" means a person licensed under AS 43.50.010 -
10 43.50.180 or 43.50.300 - 43.50.390, except for a buyer required to be licensed
11 under AS 43.50.320(a)(2).

12 * Sec. 3. AS 43.50.300 is amended to read:

13 Sec. 43.50.300. Excise tax levied. (a) An excise tax is levied on tobacco
14 products in the state at the rate in (b) of this section [RATE OF 75 PERCENT OF
15 THE WHOLESALE PRICE OF THE TOBACCO PRODUCTS]. The tax is levied
16 when a person

17 (1) brings, or causes to be brought, a tobacco product into the state
18 from outside the state for sale;

19 (2) makes, manufactures, or fabricates a tobacco product in the state
20 for sale in the state; [OR]

21 (3) ships or transports a tobacco product to a retailer in the state for
22 sale by the retailer or to an individual for personal consumption; or

23 (4) brings or causes to be brought a tobacco product into the state
24 from outside the state for personal consumption.

25 * Sec. 4. AS 43.50.300 is amended by adding a new subsection to read:

26 (b) The excise tax rate on

27 (1) moist snuff tobacco, other than spitless moist snuff tobacco, is
28 \$1.88 multiplied by the number of ounces of moist snuff tobacco, including fractions
29 of an ounce;

30 (2) spitless moist snuff tobacco is 100 percent of the wholesale price;

31 (3) tobacco products other than moist snuff tobacco products subject to

1 the tax rates in (1) and (2) of this subsection is 75 percent of the wholesale price of the
2 tobacco product.

3 * Sec. 5. AS 43.50.300, as amended by sec. 4 of this Act, is amended to read:

4 (b) The excise tax rate on

5 (1) [MOIST SNUFF TOBACCO, OTHER THAN SPITLESS MOIST
6 SNUFF TOBACCO, IS \$1.88 MULTIPLIED BY THE NUMBER OF OUNCES OF
7 MOIST SNUFF TOBACCO, INCLUDING FRACTIONS OF AN OUNCE;

8 (2)] spitless moist snuff tobacco is 100 percent of the wholesale price;

9 (2) [(3)] tobacco products other than spitless moist snuff tobacco
10 products subject to the tax rate [RATES] in (1) [AND (2)] of this subsection is 75
11 percent of the wholesale price of the tobacco product.

12 * Sec. 6. AS 43.50 is amended by adding a new section to read:

13 **Sec. 43.50.305. Packaging of certain tobacco products for sale.** (a) Cigars,
14 except for cigars that are hand-rolled and wrapped in whole tobacco leaf, shall be sold
15 in packages containing at least five cigars.

16 (b) Smokeless tobacco sold

17 (1) as loose tobacco shall be sold in packages containing at least one
18 ounce;

19 (2) in single-dose units shall be sold only in original unaltered
20 manufacturer's packaging.

21 * Sec. 7. AS 43.50.320(a) is repealed and reenacted to read:

22 (a) Except as provided in (g) of this section, a person engaged in an activity
23 described in

24 (1) AS 43.50.300(a)(1) or (3) must be licensed by the department as a
25 distributor;

26 (2) AS 43.50.300(a)(4) must be licensed as a buyer.

27 * Sec. 8. AS 43.50.320(b) is amended to read:

28 (b) The department, upon application and payment of a fee of

29 (1) \$50, shall issue a license for one year to a person who applies for a
30 license as a distributor under (a)(1) of this section;

31 (2) \$25, shall issue a license for one year to a person who applies

1 **for a license as a buyer under (a)(2) of this section.**

2 * **Sec. 9.** AS 43.50.320(d) is amended to read:

3 (d) A license issued under **(b)(1) of** this section must include the name and
4 address of the licensee, the type of business to be conducted, and the year for which
5 the license is issued.

6 * **Sec. 10.** AS 43.50.320(e) is amended to read:

7 (e) The department may renew a license issued under

8 **(1) (b)(1) of** this section for a fee of \$50;

9 **(2) (b)(2) of this section for a fee of \$25.**

10 * **Sec. 11.** AS 43.50.330(a) is amended to read:

11 (a) On or before the last day of each calendar month, a licensee shall file a
12 return with the department. The return must state the number or amount of tobacco
13 products sold by the licensee during the preceding calendar month, the **wholesale**
14 **price or purchase** [SELLING] price of the tobacco products, and the amount of tax
15 imposed on

16 **(1) [THE] tobacco products other than moist snuff tobacco;**

17 **(2) moist snuff tobacco other than spitless moist snuff tobacco; and**

18 **(3) spitless moist snuff tobacco.**

19 * **Sec. 12.** AS 43.50.350 is repealed and reenacted to read:

20 **Sec. 43.50.350. Disposition of proceeds.** (a) The tax collected by the
21 department, other than the tax collected on moist snuff tobacco, shall be deposited in
22 the general fund.

23 (b) Of the tax collected by the department on moist snuff tobacco,

24 (1) 25 percent shall be deposited in the tobacco use education and
25 cessation fund established in AS 37.05.580; and

26 (2) 75 percent shall be deposited in the general fund.

27 (c) The annual estimated balance in the account maintained by the
28 commissioner of administration under AS 37.05.142 may be used by the legislature to
29 make appropriations for health care, health research, health promotion, and health
30 education programs.

31 * **Sec. 13.** AS 43.50.390(1) is amended to read:

- 1 (1) "distributor" means a person who
2 (A) brings, or causes to be brought, a tobacco product into the
3 state from outside the state for sale;
4 (B) makes, manufactures, or fabricates a tobacco product in the
5 state for sale in the state; or
6 (C) ships or transports a tobacco product to a retailer in the
7 state for sale by the retailer or to an individual for personal consumption;

8 * Sec. 14. AS 43.50.390(2) is amended to read:

- 9 (2) "licensee" means a distributor or buyer who is
10 (A) licensed under AS 43.50.320; or
11 (B) exempted by AS 43.50.320(g) from licensing under
12 AS 43.50.320;

13 * Sec. 15. AS 43.50.390(4) is amended to read:

- 14 (4) "tobacco product" means
15 (A) a cigar, including any roll of tobacco wrapped in leaf
16 tobacco;
17 (B) a cheroot;
18 (C) a stogie;
19 (D) a perique;
20 (E) snuff tobacco, including moist snuff tobacco, and snuff
21 flour;
22 (F) smoking tobacco, including granulated, plug-cut, crimp-cut,
23 ready-rubbed, and any form of tobacco suitable for smoking in a pipe or
24 cigarette;
25 (G) chewing tobacco, including cavendish, twist, plug, scrap,
26 and tobacco suitable for chewing; [OR]
27 (H) an article or product made of tobacco or a tobacco
28 substitute, but not including a cigarette as defined in AS 43.50.170; or
29 (I) any other product containing tobacco or nicotine that is
30 intended or expected to be consumed without being combusted unless it
31 has been approved by the United States Food and Drug Administration

1 **for sale as a tobacco use cessation or harm reduction product or for other**
2 **medical purposes and is being marketed and sold solely for the approved**
3 **purposes;**

4 * **Sec. 16.** AS 43.50.390 is amended by adding new paragraphs to read:

5 (6) "buyer" means a person who imports tobacco products for the
6 person's own consumption from any source other than licensee;

7 (7) "moist snuff tobacco" includes spitless moist snuff tobacco and
8 means any finely cut, ground, or powdered tobacco that is not intended to be

9 (A) smoked; or

10 (B) placed in the nasal cavity;

11 (8) "smokeless tobacco" means a tobacco product defined in (4)(E),
12 (G), (H), (I), and (9) of this section;

13 (9) "spitless moist snuff tobacco" means moist snuff tobacco that is
14 typically steam-pasteurized smokeless tobacco in a tea-bag-like pouch designed to be
15 placed between the cheek and gum and is manufactured to obviate the need for
16 spitting.

17 * **Sec. 17.** AS 43.70.110 is amended by adding a new paragraph to read:

18 (5) "cigarette" has the meaning given in AS 43.50.170.

19 * **Sec. 18.** The uncodified law of the State of Alaska is amended by adding a new section to
20 read:

21 **APPLICABILITY.** (a) Sections 1 - 4 and 6 - 17 of this Act are applicable starting on
22 the first day of the month immediately following the effective date of this section.

23 (b) Section 5 of this Act is applicable starting on the first day of the month
24 immediately following the effective date of sec. 5.

25 * **Sec. 19.** Section 5 of this Act takes effect three years after the effective date of sec. 4 of
26 this Act.

27 * **Sec. 20.** Except as provided in sec. 19 of this Act, this Act takes effect immediately under
28 AS 01.10.070(c).

HB 188, Smokeless Tobacco – Rep. Bob Herron

Tax Table

<u>Tobacco Product</u>	<u>Tax Currently</u>	<u>Tax under HB 188 Version N</u>	<u>Change in Tax</u>
Cigarettes	10 cents per cigarette	10 cents per cigarette	No change
Moist Snuff (except Spitless)*	75% ad valorem	\$1.88 per ounce	Higher for most brands
Spitless Moist Snuff*	75% ad valorem	100% ad valorem	33% increase
Everything Else*	75% ad valorem	75% ad valorem	No change

*Note: These products currently all fall under Other Tobacco Products (OTP) and are taxed at 75% ad valorem

Tax Per Dose Calculation Sheet

Cigarettes

\$2.00 tax per pack / 20 = 10 cents tax per dose.

Spitless MST (For this example, Camel Snus specifically)

15 bags – total weight .32 ounces -- \$2.46 wholesale

- At 75%: Tax is \$1.85 / 15 doses = 12.3 cents per dose.
- **At 100%: \$2.46 / 15 doses = 16.4 cents per dose.**
- At \$1.88 per ounce tax x .32 oz = \$.60 / 15 doses = 4 cents per dose.

Moist Snuff Dipping Tobacco (excluding spitless):

Wholesale price about \$2.00 (ranges from \$1.45 – \$2.39)

- At 75%: \$1.50 tax / 20 doses = 7.5 cents per dose
- At 100%: \$2.00 tax / 20 doses = 10 cents per dose
- **At 1.88 per ounce x 1.2 oz = \$2.25 tax / 20 = 11.3 cents per dose.**

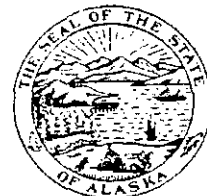
HB 188 does not affect the cigarette tax. All moist snuff tobacco (MST) is currently taxed at 75% of the wholesale price. As currently written, HB 188 would tax spitless MST at 100% of the wholesale price and all other MST at \$1.88 per ounce (in bold above). All Other Tobacco Products (except for the two types of MST) will remain taxed at 75% ad valorem.

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182

Phone: (907) 465-4942 • Fax: (907) 465-4589



House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

Sponsor Statement

House Bill 188: Taxation on Moist Snuff Tobacco

Akiachak

Akiak

Atmautluak

Bethel

Chefornak

Eek

Goodnews Bay

Kasigluk

Kipnuk

Kongiganak

Kwethluk

Kwigillingok

Lower Kalskag

Mekoryuk

Mertarvik

Napakiak

Napaskiak

Newtok

Nightmute

Nunapitchuk

Oscarville

Platinum

Quinhagak

Toksook Bay

Tuluksak

Tununak

Tuntutuliak

Upper Kalskag

"An Act relating to the taxation of moist snuff tobacco, and amending the definition of 'tobacco product' in provisions levying an excise tax on those products."

HB 188 changes the state tax methodology used for smokeless tobacco products to one that is more stable for state revenues and equal across similar weighted products regardless of price. The current ad valorem tax on smokeless products has the effect of increasing the price disparity between premium and discount brands. It can be argued, therefore, that discount products gain an unfair price advantage over premium products under an ad valorem tax regime. Already the federal government and 15 states now use the weight-based method for smokeless product taxation – 13 of those states have changed to weight-based in the last 9 years.

A weight-based taxation system will produce additional state revenue. Taxing all smokeless products at the equivalent that premium products are currently assessed will result in greater tax revenue for the state government. According to the National Association of Convenience Stores, "Evidence from a 2007 analysis documented that states that had converted to a weight-based method (New Jersey, Rhode Island, and Vermont) realized immediate gains averaging nearly 32 percent."

HB 188 levels the tax playing field. Under the current ad valorem rate, discount brands pay less in taxes for each unit, which is one of the reasons discount brands have grown their share from 4% to 36% of the market in the last four years. Under HB 188, these products would be taxed at the same rate as higher priced premium products.

Additionally, according to the American Lung Association, "Increasing excise taxes on tobacco products is a proven way to reduce use, particularly among kids."

Other consumer products are already taxed by a per unit method in the state, such as gasoline, alcohol and cigarettes. HB 188 would make the taxation of smokeless products consistent with these other consumer products, and close the existing tax loophole the state provides to discount products.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 19, 2009

SUBJECT: Sectional summary for CSHB 188(HSS), Draft Version "S"
(Work Order No. 26-LS0714/S)

TO: Representative Bob Herron
Co-chair of the House Health & Social Services Committee
Attn: Rob Earl

FROM: 
Donald M. Bullock Jr.
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends AS 43.50.300 to acknowledge the rates of tax are moved to AS 43.50.300(b), a new subsection added by sec. 2 of the bill.

Section 2. Provides a tax rate on moist snuff tobacco of \$1.88 multiplied by the number of ounces, including fractions of an ounce. Continues the tax rate of 75 percent of the wholesale price on other tobacco products.

Section 3. Requires the monthly reporting of the number of ounces of moist snuff sold, the amount of tax imposed on moist snuff tobacco, and the amount of tax imposed on tobacco products other than moist snuff tobacco.

Section 4. Amends the definition of "tobacco product" in AS 43.50.390(4) to specifically include moist snuff tobacco.

Section 5. Adds a definition for "moist snuff tobacco" to AS 43.50.390.

Section 6. Makes secs. 1 - 5 of the Act applicable starting on the first day of the month immediately following the effective date of the Act.

DMB:ljw
09-170.ljw

26-LS0714\S
Bullock
3/18/09

CS FOR HOUSE BILL NO. 188(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE HERRON

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the taxation of moist snuff tobacco by weight; including moist snuff**
2 **tobacco in the definition of 'tobacco product' in provisions levying an excise tax on those**
3 **products; and defining 'moist snuff tobacco.'"**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1. AS 43.50.300 is amended to read:**

6 **Sec. 43.50.300. Excise tax levied.** An excise tax is levied on tobacco products
7 in the state at the rate in (b) of this section [RATE OF 75 PERCENT OF THE
8 WHOLESALE PRICE OF THE TOBACCO PRODUCTS]. The tax is levied when a
9 person

10 (1) brings, or causes to be brought, a tobacco product into the state
11 from outside the state for sale;

12 (2) makes, manufactures, or fabricates a tobacco product in the state
13 for sale in the state; or

14 (3) ships or transports a tobacco product to a retailer in the state for

1 sale by the retailer.

2 * Sec. 2. AS 43.50.300 is amended by adding a new subsection to read:

3 (b) The excise tax rate on

4 (1) moist snuff tobacco is \$1.88 multiplied by the number of ounces of
5 moist snuff tobacco, including fractions of an ounce;

6 (2) tobacco products other than moist snuff tobacco is 75 percent of the
7 wholesale price of the tobacco product.

8 * Sec. 3. AS 43.50.330(a) is amended to read:

9 (a) On or before the last day of each calendar month, a licensee shall file a
10 return with the department. The return must state the number or amount of tobacco
11 products including the number of ounces of moist snuff tobacco sold by the
12 licensee during the preceding calendar month, the selling price of the tobacco
13 products, [AND] the amount of tax imposed on [THE] tobacco products other than
14 moist snuff tobacco, and the amount of tax imposed on moist snuff tobacco.

15 * Sec. 4. AS 43.50.390(4) is amended to read:

16 (4) "tobacco product" means

17 (A) a cigar;

18 (B) a cheroot;

19 (C) a stogie;

20 (D) a perique;

21 (E) snuff tobacco, including moist snuff tobacco, and snuff
22 flour;

23 (F) smoking tobacco, including granulated, plug-cut, crimp-cut,
24 ready-rubbed, and any form of tobacco suitable for smoking in a pipe or
25 cigarette;

26 (G) chewing tobacco, including cavendish, twist, plug, scrap,
27 and tobacco suitable for chewing; or

28 (H) an article or product made of tobacco or a tobacco
29 substitute, but not including a cigarette as defined in AS 43.50.170;

30 * Sec. 5. AS 43.50.390 is amended by adding a new paragraph to read:

31 (6) "moist snuff tobacco" means any finely cut, ground, or powdered

1 tobacco that is not intended to be

2 (A) smoked; or

3 (B) placed in the nasal cavity.

4 * Sec. 6. The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 APPLICABILITY. Sections 1 - 5 of this Act are applicable starting on the first day of
7 the month immediately following the effective date of this Act.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 188
 () Publish Date: _____

Identifier (File Name): HB188-DOR-TAX-03-23-09 Dept. Affected: Revenue 04
 Title Tax on Moist Snuff RDU Taxation and Treasury
 Component Taxation and Treasury
 Sponsor Representative Herron
 Requester (H) Health & Social Services Component No. 2476

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personal Services	24.2	0.0	24.2	24.2	24.2	24.2	24.2
Travel	0.5	0.0	0.5	0.5	0.5	0.5	0.5
Contractual	186.2	0.0	1.2	1.2	1.2	1.2	1.2
Supplies	0.2	0.0	0.2	0.2	0.2	0.2	0.2
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	211.1	0.0	26.1	26.1	26.1	26.1	26.1

CAPITAL EXPENDITURES	0	0.0	0.0	0.0	0.0	0.0	0.0
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CHANGE IN REVENUES ()	*	0.0	*	*	*	*	*
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	211.1	0.0	26.1	26.1	26.1	26.1	26.1
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	211.1	0.0	26.1	26.1	26.1	26.1	26.1

Estimate of any current year (FY2009) cost: 0

POSITIONS

Full-time	0.25	0	0.25	0.25	0.25	0.25	0.25
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

See Attached.

Prepared by: Johanna Bales/Dan Stickel Phone 907-269-6628
 Division Tax Date/Time 3/20/09 4:01 p.m.
 Approved by: _____ Date _____
 Agency _____

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. HB 188

ANALYSIS CONTINUATION

Bill Language:

Alaska levies a tax on other tobacco products (OTP) at the rate of 75% of the wholesale cost. OTP includes any product containing tobacco that is not a cigarette. Moist snuff is one of many tobacco products upon which the OTP tax is currently levied. This bill will change the tax on moist snuff from an ad valorem tax (tax based on value) to a tax based on weight. All other tobacco products will continue to be taxed at the rate of 75% of the wholesale cost. Moist snuff will be taxed at the rate of \$1.88 per ounce. Moist snuff is defined as any finely cut, ground, or powdered tobacco that is not intended to be smoked or placed in the nasal cavity.

Revenues:

If Alaska had levied a tax on moist snuff at the rate of \$1.88 during fiscal year 2008 and consumption was not affected by the tax increase, total tobacco products tax revenue would have been approximately \$1.1 million more than what was collected. Historically, Alaska and other states have seen a drop in consumption of taxable cigarettes and other tobacco products when the tax rate is increased. This drop is due to a decrease in consumption as product price increases (price elasticity) and a decrease in taxable consumption as consumers turn to the Internet, mail order, or other means to purchase non-taxed product. The OTP tax is not levied on tobacco products, including moist snuff, that is imported into the state for personal consumption. It is legal for an individual to purchase other tobacco products off the Internet or through the mail without paying the tobacco products tax.

Based on an analysis of tax returns, the wholesale price of the most popular lower-priced brands in FY 2008 averaged \$1.03 per ounce. The average tax under the current tax structure in FY 2008 was \$.77 per ounce for a total average cost of \$1.80. Under the proposed weight-based tax, the total average cost would be \$2.91 per ounce, a 61% increase. Lower cost moist snuff products have an approximate 35% market share in Alaska. This market share has been increasing over the last few years as consumers continually look for cheaper products. It is expected that many of these consumers will turn to the Internet for moist snuff once the price of the product increases due to the increase in tax. This will, in turn, reduce the amount of revenue expected from this tax increase. Due to price elasticity and the unknown number of consumers who will turn to tax free Internet product, it is difficult to determine the change in revenues as a result of this legislation.

Expenditures:

This bill would require the Department of Revenue to add an additional tax program requiring a new tax return and license for other tobacco products. Collections, examination and compliance can be handled using existing staff. We anticipate requiring one-quarter of an Analyst Programmer IV (Range 20) for reprogramming and maintenance of the related aspects of our tax database system. There will also be \$185,000 in one-time startup expenses: \$175,000 for adding the new program to our tax examination and licensing system, and \$10,000 for education and communication with stakeholders as we implement the new tax program.

Alaska Tobacco Facts

January 2007 Update

Sarah Palin, Governor
Karleen Jackson, PhD, Commissioner
Deborah Erickson, Acting Director
Tammy Green, MPH, Section Chief

Suggested Citation:

http://www.hss.state.ak.us/dph/chronic/tobacco/pdf/tobacco_facts.pdf

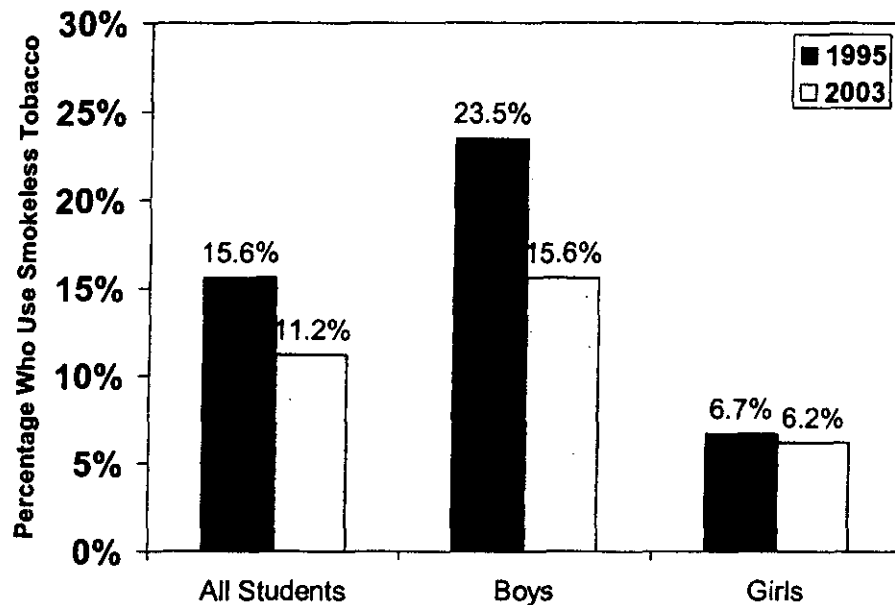
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Alaska Tobacco Facts, January 2007 Update

8. Youth Smokeless Tobacco Use

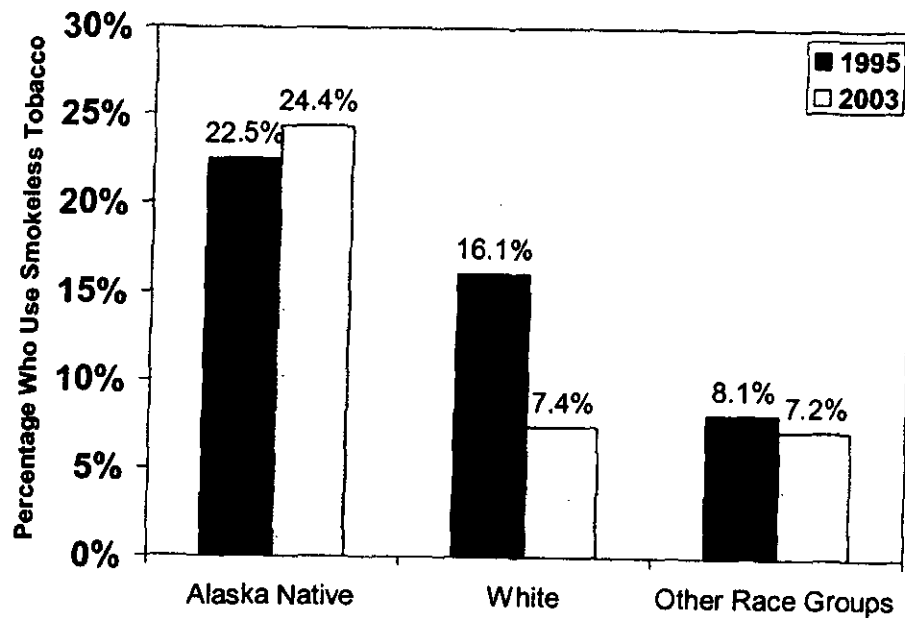
Percentage of High School Students Who Use Smokeless Tobacco,
by Sex and Year
Alaska, 1995 & 2003



Source: Alaska Youth Risk Behavior Survey

- Overall, use of smokeless tobacco among high school students dropped from 15.6% in 1995 to 11.2% in 2003; this was largely due to the decline in boys' use of smokeless tobacco during this time.
- In 2003, nearly 4,400 high school students used smokeless tobacco.

**Percentage of High School Students Who Use Smokeless Tobacco,
by Race and Year
Alaska, 1995 & 2003**



Source: Alaska Youth Risk Behavior Survey

- The largest drop in youth smokeless tobacco rates between 1995 and 2003 was seen among White students.

The Effect of Federal Tobacco Tax Increases on Alaska's Tobacco Taxes

Prepared by: Johanna Bales

Alaska levies an excise tax on cigarettes and on other tobacco products (OTP). The tax rates, tax calculation, and how the tax is levied differ between cigarettes and OTP. The following outlines those differences and the effect of recent federal tobacco tax increases on Alaska tobacco taxes:

Cigarette Tax

Alaska's cigarette tax is levied on each cigarette. The tax is currently 10 cents per cigarette or \$2.00 per pack of twenty cigarettes. The tax is levied when cigarettes are brought into the state for sale or personal consumption. What this means is that if an individual buys cigarettes over the Internet or has friends or family ship cigarettes to them through the mail, they are liable to pay the Alaska tax. The federal tax was 39 cents per pack, but is now \$1.01 per pack of twenty. The increase in the federal tax does not affect Alaska's tax rate. However, it can and probably will affect revenue as people either quit smoking or cut back due to the higher cost of cigarettes that will result from the federal increase. We also expect smuggling to increase in all states, including Alaska, which will also cut into Alaska's cigarette tax revenue.

Other Tobacco Products (OTP)

Alaska's OTP tax is levied at the rate of 75% of the wholesale price of the tobacco product. OTP includes little cigars, cigars, pipe tobacco, chewing tobacco, snuff, roll-your-own tobacco, etc. Basically, anything other than a cigarette that has tobacco in it. The tax is levied when OTP is brought into the state for sale. It is important to note, the OTP tax is not levied when OTP is brought into the state for personal consumption. The wholesale price is defined in statute as the "established price for which a manufacturer sells a tobacco product to a distributor . . ." This is basically the manufacturer's list price.

The federal law increased many OTP products significantly. For example, the tax on little cigars increased from 4 cents per pack to \$1.01 per pack of twenty. Chewing tobacco increased from 19.5 cents to 50.33 cents per pound and roll-your-own tobacco increased from \$1.0969 to \$24.78 per pound. The federal tax is paid by the manufacturer. Therefore, the manufacturer's list price will increase to reflect the increases in the federal tax. Even though our tax rate of 75% of the wholesale cost remains the same, the amount upon which the 75% is multiplied will be significantly higher. As such, Alaska's tax on OTP will also increase.

Will people start buying roll-your-own and other OTP from states without a tax? Most states have a tax, but if the product is exported from the state that state's tax doesn't apply. The question should be, "will people start buying roll-your-own and other OTP from Internet sellers?" The answer is, "yes." When Alaska increased the tax on OTP in 1997 from 25% to 75% of the wholesale cost, we did see an increase in people buying OTP through the mail. It is perfectly legal for them to do so since the OTP tax is only levied when OTP is imported or brought into the state for sale. With the increase in the federal tax and resultant increase in the Alaska tax, we will definitely see individuals and possibly even businesses purchasing OTP from Internet sites and through the mail. This will result in lost revenue to the state.

When Alaska increased its cigarette tax during a special legislative session in the summer of 2004, a couple of legislators tried to insert language that made it so the OTP tax was levied on individuals who imported OTP for personal consumption. Their concern was that local businesses which sell OTP were unable to compete with Internet sellers because it was legal for individuals to buy through the mail and

Internet without paying Alaska's tax, but the local retailer had to pay the tax. I think this will be even more of an issue now that the federal tax has significantly increased and the Alaska tax will be even more.

Alaska's cigarette and OTP tax rates are set in statute. The Department of Revenue has no authority to change the tax rates.

One other thing to note is that the federal law provides for a floor stock tax. What this means is that every distributor and retailer in the state must identify their inventory as of April 1, 2009 and pay the difference between the new and old federal tax rates to the federal government by August 1, 2009. Alaska does not have a floor stock tax. Even though distributors and retailers must remit the higher tax on their inventory to the federal government, the Alaska tax on OTP will be based on the manufacturer's list price at the time the product was imported into the state for sale.

Attached is the new federal language with a chart showing the changes in the federal tax rates by product.



**THE BEST WAY TO TAX SMOKELESS TOBACCO
IS WITH A PERCENTAGE-OF-PRICE TAX
[Weight-Based Taxes Hurt State Revenues and Increase Youth Use]**

The most common practice among the states is to tax smokeless tobacco, cigars, pipe tobacco, and the various other tobacco products besides cigarettes at a percentage of their wholesale price (sometimes referred to as the manufactures price). These state flat taxes on other tobacco products (OTPs) range as high as 90 percent of wholesale price (in Massachusetts), with 26 states having non-cigarette tobacco tax rates of 20 percent of wholesale price or more.

A few states tax smokeless or moist snuff tobacco products on a per-weight basis. This approach has been pushed aggressively by UST, the largest U.S. smokeless tobacco manufacture, primarily to reduce the effective tax rates on the higher-priced premium products it sells – while raising the effective tax rates on the lower-priced smokeless products primarily sold by UST's competitors.¹ But UST's best-selling premium products (Copenhagen, Skoal) are also smokeless tobacco products most popular with youth; so reducing their taxes and prices would directly increase youth smokeless tobacco initiation and use, dooming even more kids to a lifetime of tobacco addiction, related harms, and premature death.²

Beyond the fact that establishing a per-weight tax for smokeless tobacco would favor UST, harm its competitors, and increase youth use, taxing all OTPs or all smokeless at a percentage of price is not only easier to administer but also better for state revenues.

- A single percentage-of-price tax rate treats all OTPs the same. In sharp contrast, it is impossible to have a single weight-based tax rate that could equitably apply to all OTPs or even just to all smokeless tobacco or moist snuff because of all of the different types, sub-types, styles, and weights per dose of the products and brands in each category. Consequently, establishing a per-weight system just for smokeless tobacco or just for moist snuff smokeless still entails figuring out different tax rates by weight for each different sub-type or style – and such new rates would have to be established whenever another new type, sub-type or style of tobacco product entered the smokeless or moist snuff market.
- Failing to have different weight-based tax rates for each different type or style of product within the smokeless or moist snuff categories would end up grossly under taxing lighter-weight products. Most importantly, the newest trend in smokeless moist snuff products is toward spit-less pre-packed single-dose tablets or pouches, such as Ariva and Stonewall lozenges, RJR's Camel Snus, Philip Morris's Marlboro Snus and UST's Skoal Dry. This new generation of smokeless moist snuff tobacco products weigh as little as one-tenth per dose compared to the standard moist snuff that comes in a can. Any switch to a weight-based tax would allow these emerging products to pay to almost nothing as they gain increasingly larger shares of the smokeless moist snuff market, thereby sharply reducing state revenues.
- Weighing each product to apply a weight-based tax accurately and equitably would also entail significant new costs. Alternatively, relying on the stated weights provided by manufacturers would open the door to potential abuses – and require periodic checks to confirm the accuracy of the stated weights. In contrast, the prices used by a percentage-of-price tax are clear, publicly available, and easy to confirm quickly.

¹ See American Lung Association, *Taxation of Smokeless Tobacco: Percentage of Price vs. Net Weight*, April 20, 2001, <http://tobaccofreekids.org/research/factsheets/pdf/0175.pdf>.

² Substance Abuse & Mental Health Services Admin., *Results from the 2005 National Survey on Drug use and Health*, Table 7.67B, <http://oas.samhsa.gov/NSDUH/2k5nsduh/tabs/Sect7peTabs58to67.pdf>.

- Unlike weight-based taxes, percentage-of-price tax rates automatically increase with inflation and other tobacco product price increases, thereby protecting the state's tax rate and revenues from being eroded over time. UST often packages its weight-based proposals so that they will purportedly bring in more revenues in the next couple of years. But the fixed monetary tax rate in a weight-based system will inevitably erode over time as inflation and product prices increase, producing substantially less state revenues than a parallel percentage-of-price tax. Accordingly, if a state wants more revenue from its smokeless or OTP taxes – over both the short and long term – it should simply raise its percentage-of-price rate or establish a reasonable minimum tax to reach those tobacco products with bargain-basement or predatory prices.
- Since most states tax non-cigarette tobacco products by percentage-of-price, having such a tax system for all OTPs allows a state to make quick and accurate comparisons against other states' OTP tax rates and related revenues. In addition, a single percentage-of-price tax for all OTPs establishes and maintains tax equity by ensuring that all OTPs pay the same flat tax rate. If smokeless moist snuff pays taxes by weight while other OTPs pay by price, tax inequities are certain to develop over time if not immediately.
- The percentage-of-price tax is a flat tax that applies the exact same percentage tax rate to each and every tobacco product and brand of tobacco product other than cigarettes. Just like with sales taxes, the actual tax amount paid on higher priced products will be larger than the amount for lower priced products. But the percentage tax rate on each product will stay exactly the same. In other words, those products priced to bring in the most revenues and profits will pay more per product than cheaper versions that bring in less revenue and profits. But each will pay the same flat percentage-of-price rate.

UST argues that a change to a weigh-based system is necessary to raise the effective tax rates on cut-rate smokeless tobacco products sold by their competitors. But predatory pricing and other below-market pricing practices could be addressed more effectively and appropriately through adding a minimum tax to a percentage-of-price tax and establishing smokeless tobacco product minimum price laws.³

UST's only legitimate claim about operating under a competitive disadvantage comes from UST currently being the only smokeless tobacco company that has signed onto the smokeless tobacco Master Settlement Agreement (STMSA). That competitive disadvantage could be eliminated, to the benefit of the states, by new state laws that penalize non-participating smokeless tobacco manufacturers that do not sign onto the STMSA, paralleling the state laws that do the same thing regarding nonparticipating manufacturers (NPMs) and the cigarette MSA. Such laws would level the playing field and either produce new payments to the states or get more smokeless manufacturers to sign onto the STMSA and comply with its various payment requirements and other requirements designed to reduce tobacco use by kids.⁴

Campaign for Tobacco-Free Kids, February 19, 2008 / Eric Lindblom

For more information, see the Campaign factsheets at <http://tobaccofreekids.org/research/factsheets/pdf/0180.pdf> and <http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=18>.

³ The Campaign for Tobacco-Free Kids has model legislative language, available upon request, to establish a minimum tax in existing state percentage-of-price tobacco tax systems – or to modify existing or proposed weight-based tax systems for smokeless or moist snuff so that (like a percentage-of-price system) they keep up with inflation and product price increases, do not fail to tax low-weight products adequately, and better protect the public health. To get any of this model legislative text, please email elindblom@tobaccofreekids.org.

⁴ Model legislation to establish such a STMSA NPM fee is also available from the Campaign for Tobacco-Free Kids. To get a copy of this model legislative text, please email elindblom@tobaccofreekids.org.

From: Jack Crow [Jack_Crow@ykhc.org]
Sent: Monday, March 09, 2009 4:27 PM
To: Rep. Bob Herron
Cc: Wole Fadahunsi
Subject: YKHC's Tobacco tax review
Attachments: Smokeless Tobacco Tax Policy.doc

Hi Bob. Attached is a brief write up that our Director of Community Health and Wellness, Wole Fadahunsi draft about the potential change to the smokeless tobacco tax. Good luck.

Jack Robert

Smokeless Tobacco Tax Policy

There is a current debate as to how best to tax smokeless tobacco products and currently two policies are practiced by the different states in the US. The majority tax these tobacco products by a system referred to as ad valorem while the rest tax by a per unit basis inline with what obtains at the Federal level. Alaska as a state currently taxes Moist Snuff Tobacco (MSF) products at a rate of 75% of wholesale price -- a ad valorem tax policy.

In order to answer the question about what the appropriate practice should be regarding the tax policy to be adopted it would be better to do this within a framework. There are a couple questions to be answered to arrive at a reasonable answer and these are:

1. Should smokeless tobacco be taxed at all,
2. What method should be adopted in taxing this product,
3. What is the appropriate level of taxation?

Should Smokeless Tobacco be Taxed?

The use of tobacco products has been shown to cause harm to the individual and other people around. This is quite evident with the issue of second hand smoke (SHS). But working from the framework that government is there to protect individuals from harming one another, and not necessarily to protect an individual from harming him/herself it can be argued that government has no business taxing MSF.

However, there are other costs that tobacco use imposes on the society as a whole and the most commonly cited are: increased healthcare burden to other taxpayers, the unattractiveness of witnessing someone use chew tobacco, and message children receive viewing adults use tobacco. Therefore, to the extent that tobacco use has a burden on the society as a whole these products should be taxed.

What method should be adopted in taxing MSF?

As earlier mentioned there are two methods of taxation for MSF currently in use. The ad valorem tax system places a tax on these products based on the sale price of these products. The per unit tax system places a tax on these products based on the standard unit of the product.

Those who have worked in the area of setting tax policy for smoke tobacco products understand that a unit of cigarette (one stick) does the same amount of damage (to the individual and society) notwithstanding the cost (premium or regular) of this stick of cigarette. As a result, smoked tobacco products are taxed on a per unit basis. As with MSF, the same is true- a unit weight of this product will do the same amount of damage to the individual and society without regard to its 'premium or regular status'.

Another argument in favor of taxation on a per unit basis is: when you tax ad valorem what obtains is that premium brands get more expensive relative to the cheaper products and this can be seen as government giving undue advantage to the cheaper products because what simply happens is that consumers of the product simply shift to using the cheaper products. But with a per unit taxation all tobacco products, without regards to

their premium or regular class, are taxed evenly since they will cause the same amount of damage to individual and society. True to Jefferson's core principles, states should not be in the business of picking winners and losers, but should let the market decide free of discriminatory government intervention.

What is the appropriate level of taxation?

As a tax on MSF is designed to equalize the cost differential between the societal cost of use of the product and the individual cost a per unit basis of taxation should be adopted. The appropriate tax level should balance up these costs if the societal cost is greater than the individual cost. The problem policy makers have to solve before they can set the appropriate level of taxation is figuring out what these costs are (i.e. the societal and individual cost).

Relevant articles to consult:

- What Is Proper Tax Policy for Smokeless Tobacco Products? by Gerald Prante, as downloaded from <http://www.taxfoundation.org/news/show/23045.html> on 03/09/09
- Tax Policy: A Fair Deal for Smokeless Tobacco by Michael Keegan, as downloaded from <http://www.alec.org/am/pdf/apf/apfmst.pdf> on 03/09/09
- Economics of Tobacco Control and Tobacco Tax Policy by Hana Ross, PhD. as downloaded from http://www.tobaccoevidence.net/pdf/sea_activities/Laos_WB_evidence.pdf on 03/09/09

**A Weight-Based Tax
on Moist Smokeless
Tobacco (MST)**

Alaska

\$1.88/ounce

March 2009



Altria

Altria Client Services Inc. (ALCS) Supports a Weight-Based Method of Taxation for MST

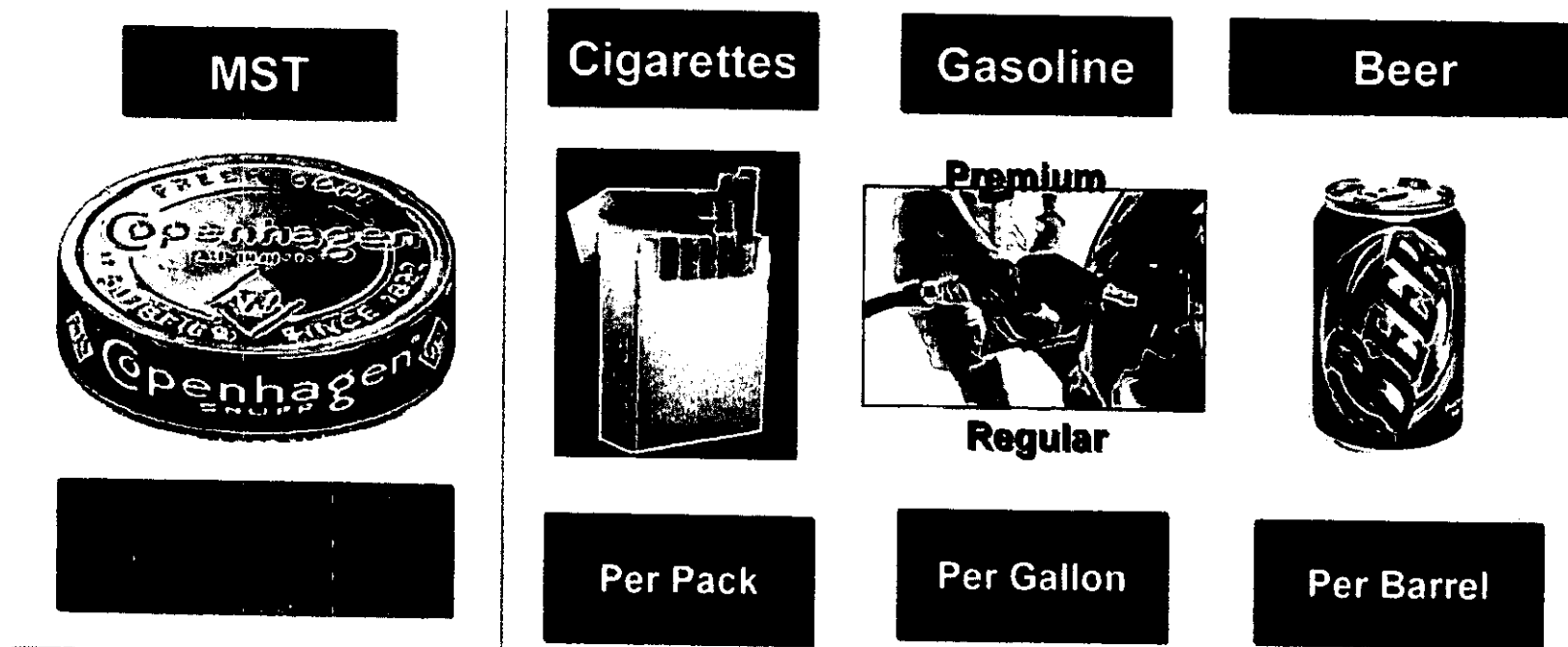
This legislation will:

- **Tax MST consistently with other consumer products.**
- **Align Alaska's tax methodology with that of the federal government and 16 other states.**
- **Establish tax equity for MST products.**
- **Generate additional state MST tax revenues.**
- **Create a stable and predictable stream of MST tax revenue for the state.**
- **Reduce complexity and administrative burden on the state, wholesalers and retailers.**



Information provided by Altria Client Services Inc. on behalf of
Philip Morris USA Inc. and US Smokeless Tobacco Company

A Weight-Based Tax is Consistent with State Excise Taxes on Other Products



An ad valorem tax method on consumer products is unusual. Unlike a sales tax, which is applied to the price of the product, an excise tax is a consumption tax. Its intent is to tax all like products uniformly. Product categories such as cigarettes, beer, wine and gasoline are taxed based upon unit, weight or volume. When taxing under a weight-based system, a state does not consider price points – the weight of the product determines the excise tax liability.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

A Weight-Based Tax Methodology Establishes Tax Equity for MST Products

An ad valorem system of taxation results in large variations in excise taxes:

- The current ad valorem excise tax rate in Alaska is 75%.
- MST products of equal tobacco weight are priced differently throughout the smokeless tobacco category leading to large differences in taxes paid per unit.
- The current system, in effect, creates a tax break for lower-priced brands, resulting in an unfair advantage.

A weight-based method of taxation does not favor one brand over another.



	Premium	Discount
Current Tax/1.2 oz. can	\$2.39 * 75% = \$1.79	\$0.98 * 75% = \$0.74
Weight-Based Tax/1.2 oz. can	\$1.88/oz. * 1.2 oz. = \$2.26	\$1.88/oz. * 1.2 oz. = \$2.26

Source: Copenhagen was used as the premium brand and Longhorn was used as the discount brand. Effective March 29, 2009, the price of Copenhagen will be \$2.39. As of March 11, 2009, the wholesale price of Longhorn was \$0.98.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

Effect of an Ad Valorem System

Equivalent products carry different tax burdens...



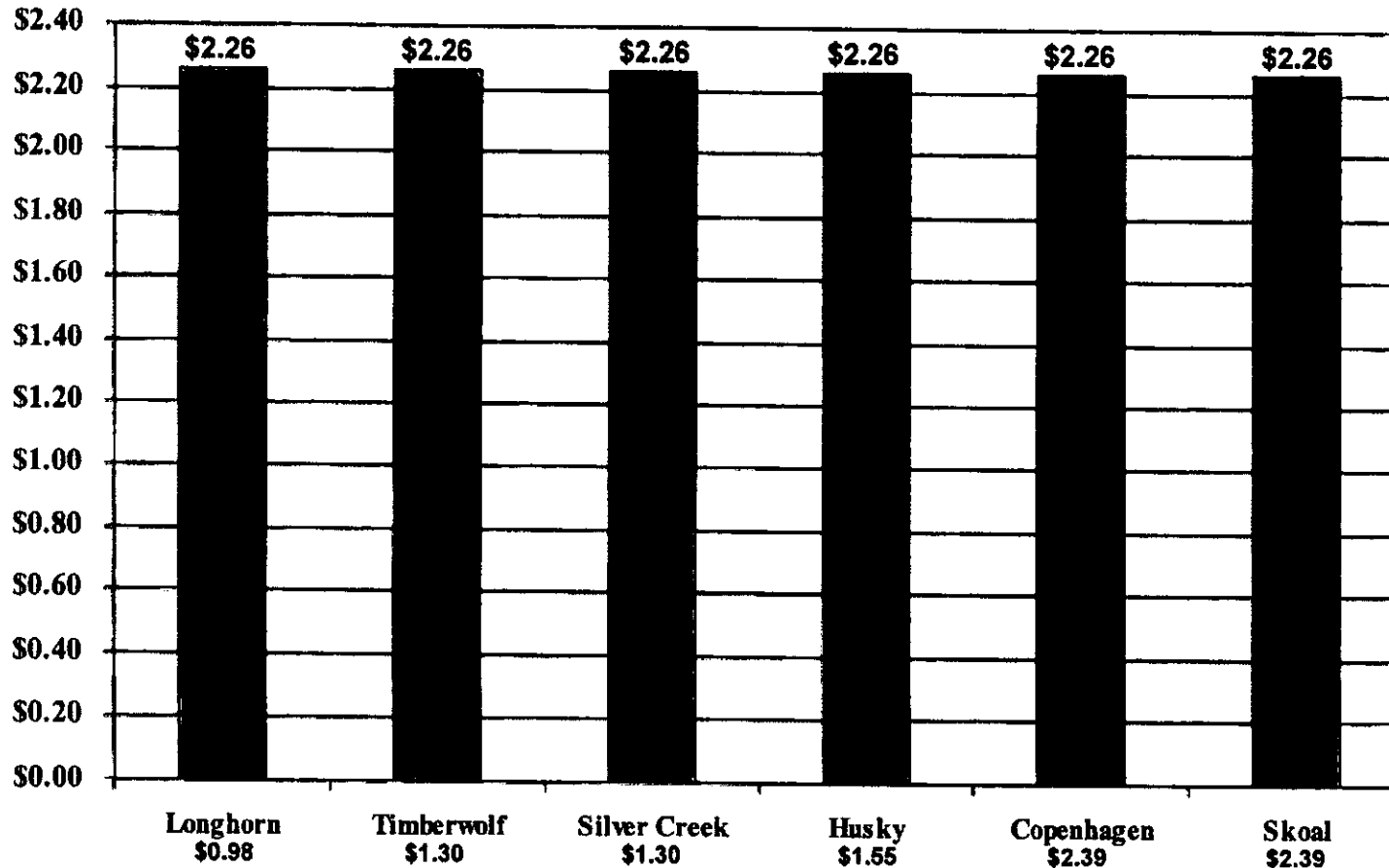
Source: Longhorn and Timberwolf pricing as of February 1, 2009 based on USSTC RAD SVT sales database; these prices are estimates and may vary. As of March 8, 2009 the price of Husky is \$1.55. Effective March 29, 2009 the price of Red Seal is \$1.75 and the price of Copenhagen and Skoal is \$2.39.



Information provided by Altria Client Services Inc. on behalf of
Philip Morris USA Inc. and US Smokeless Tobacco Company

Under a Weight-Based System

Equivalent products carry the same tax burden...



Source: Longhorn, Grizzly, Silver Creek and Timberwolf pricing as of February 1, 2009 based on USSTC RAD SVT sales database; these prices are estimates and may vary. As of March 8, 2009 the price of Husky is \$1.55. Effective March 29, 2009 the price of Copenhagen and Skoal is \$2.39.

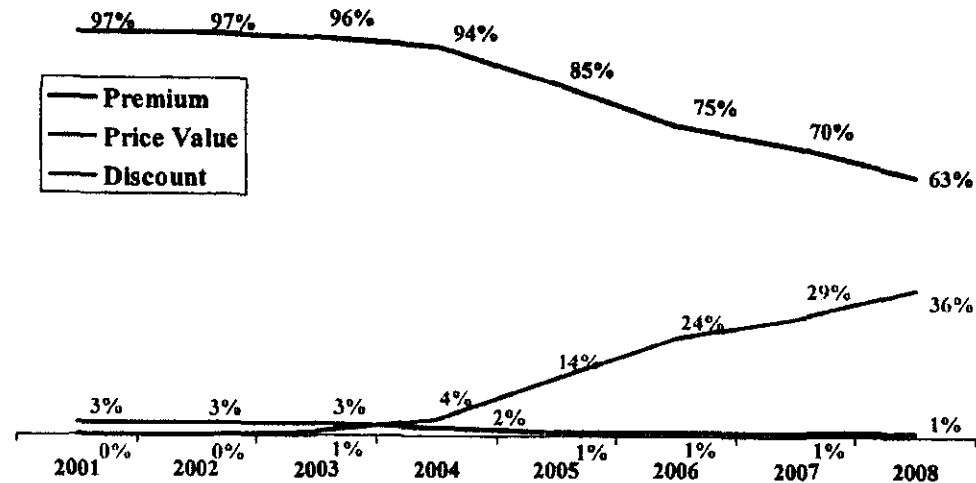


Information provided by Altria Client Services Inc. on behalf of
Philip Morris USA Inc. and US Smokeless Tobacco Company

Under an Ad Valorem Methodology, Down Trading Means Less Revenue for the State

In 2008 Tier 3 share of market continued to grow. The state receives as much as \$1.05 less revenue per can every time an adult consumer down-trades from a Tier 1 MST product to a Tier 3 product under the current ad valorem system.

Alaska left an estimated \$1.16 million on the table in 2008 due to down-trading.

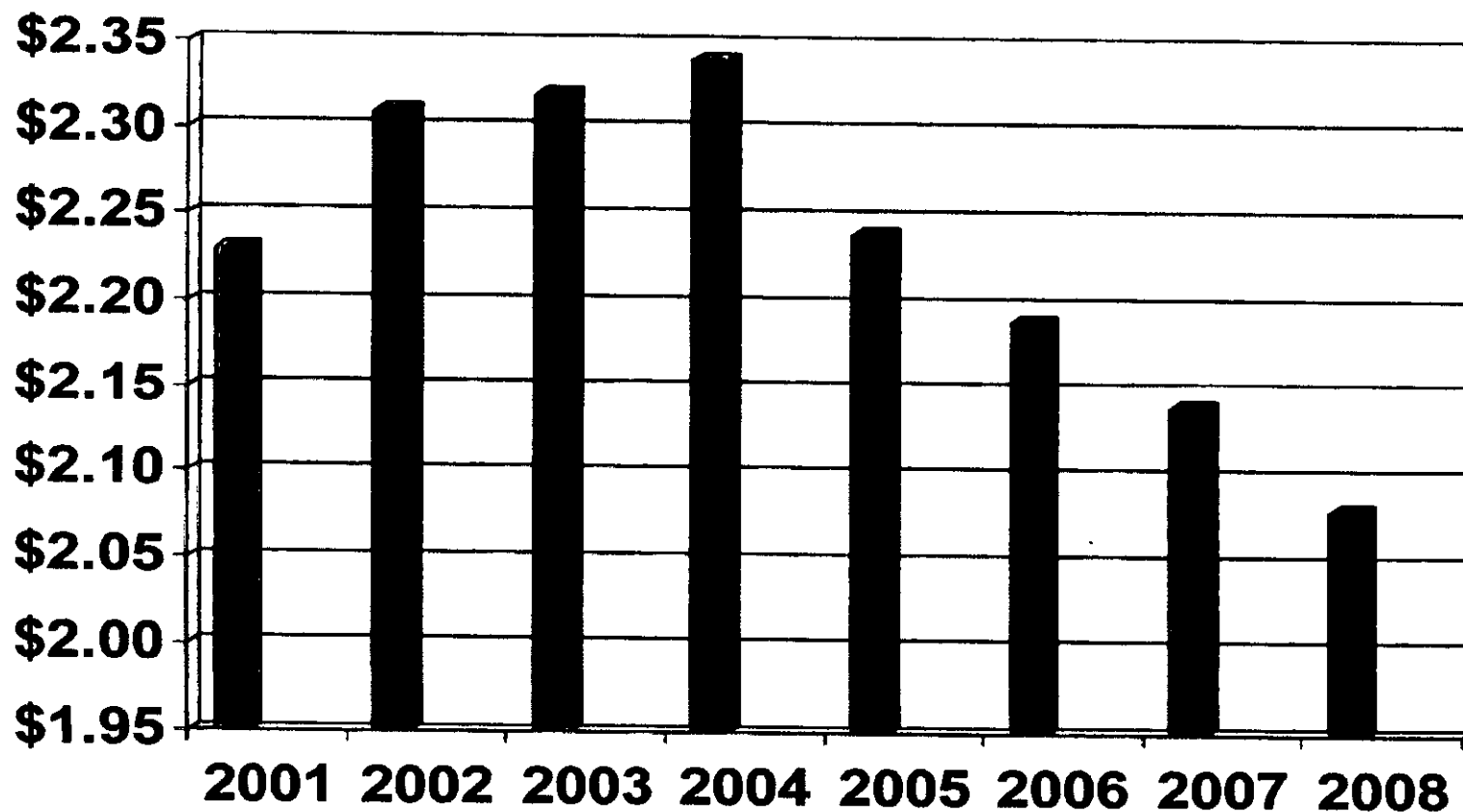


Note: \$1.16 million MST excise tax revenue gain based on estimated sales from USSTC RAD database and share trends in 2008. The revenue model was run on a rate of \$1.88 per oz.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

MST National Average Wholesale Price 2001- 2008*

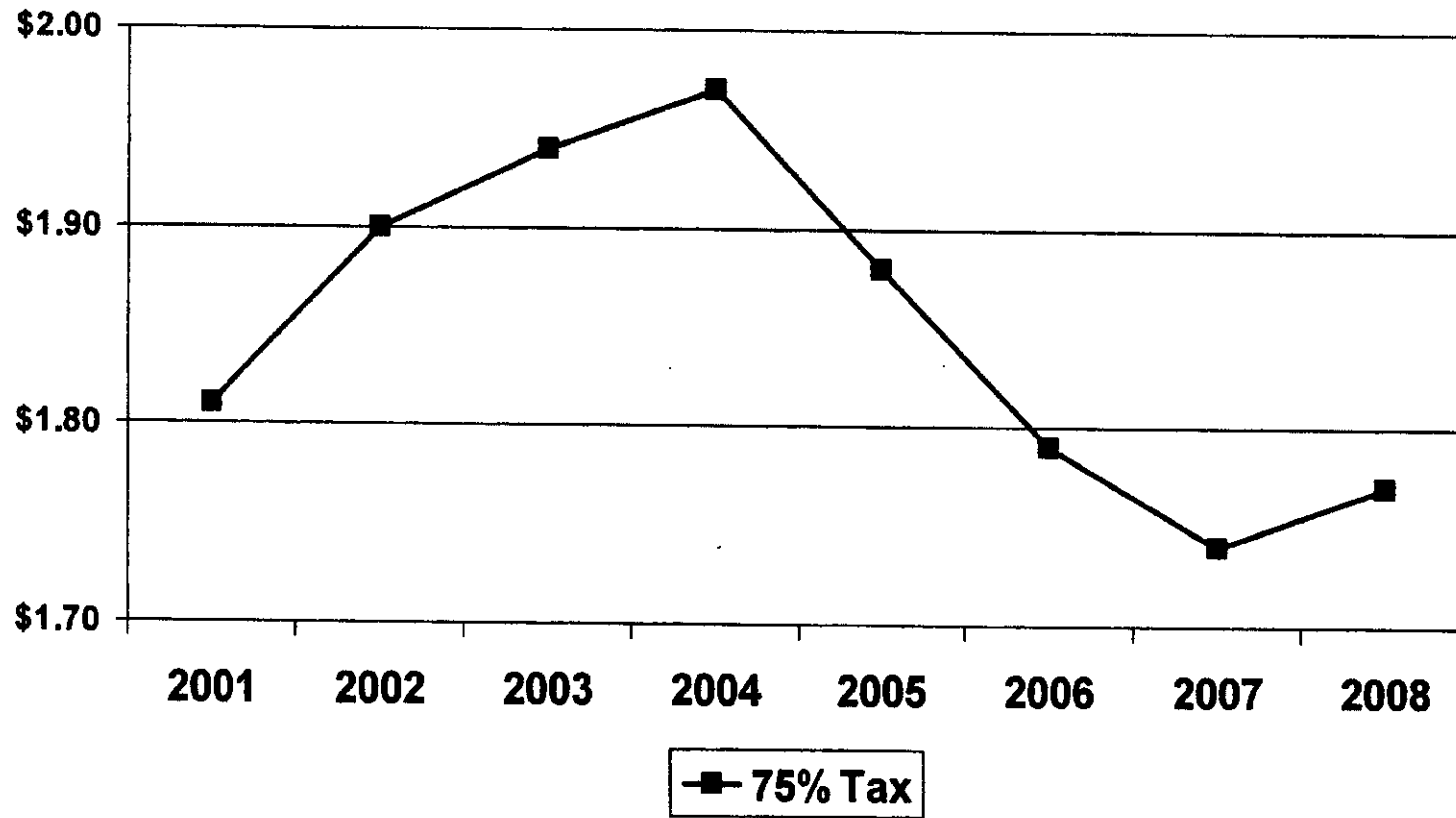


Source: Based on USSTC RAD SVT
sales database as of October 31, 2008.



Information provided by Altria Client Services Inc. on behalf of
Philip Morris USA Inc. and US Smokeless Tobacco Company

Alaska Weighted Average Tax Per MST Can 2006-2008

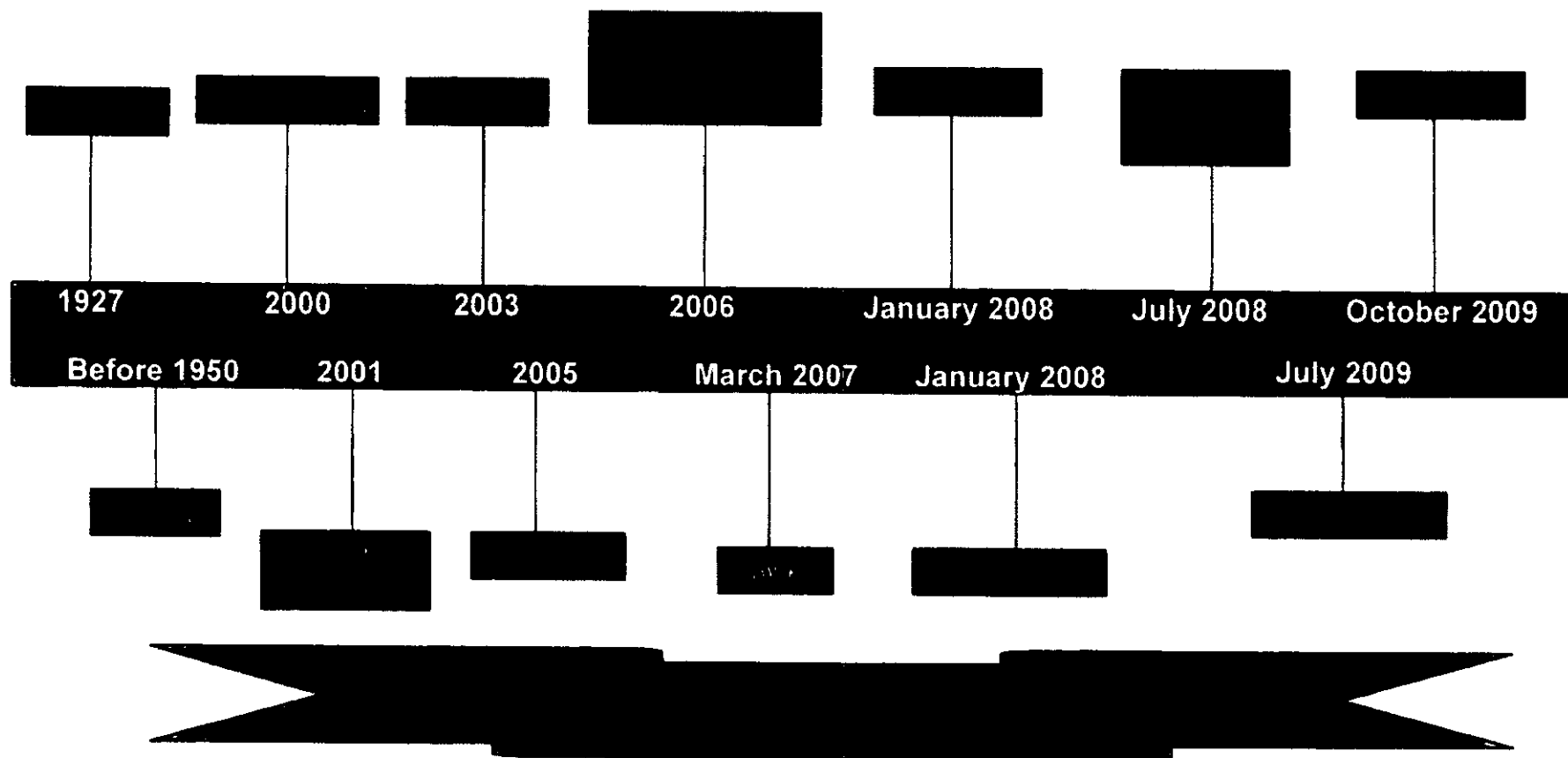


Source: USSTC RAD SVT sales database.



Information provided by Altria Client Services Inc. on behalf of
Philip Morris USA Inc. and US Smokeless Tobacco Company

Weight-Based Conversion Timeline

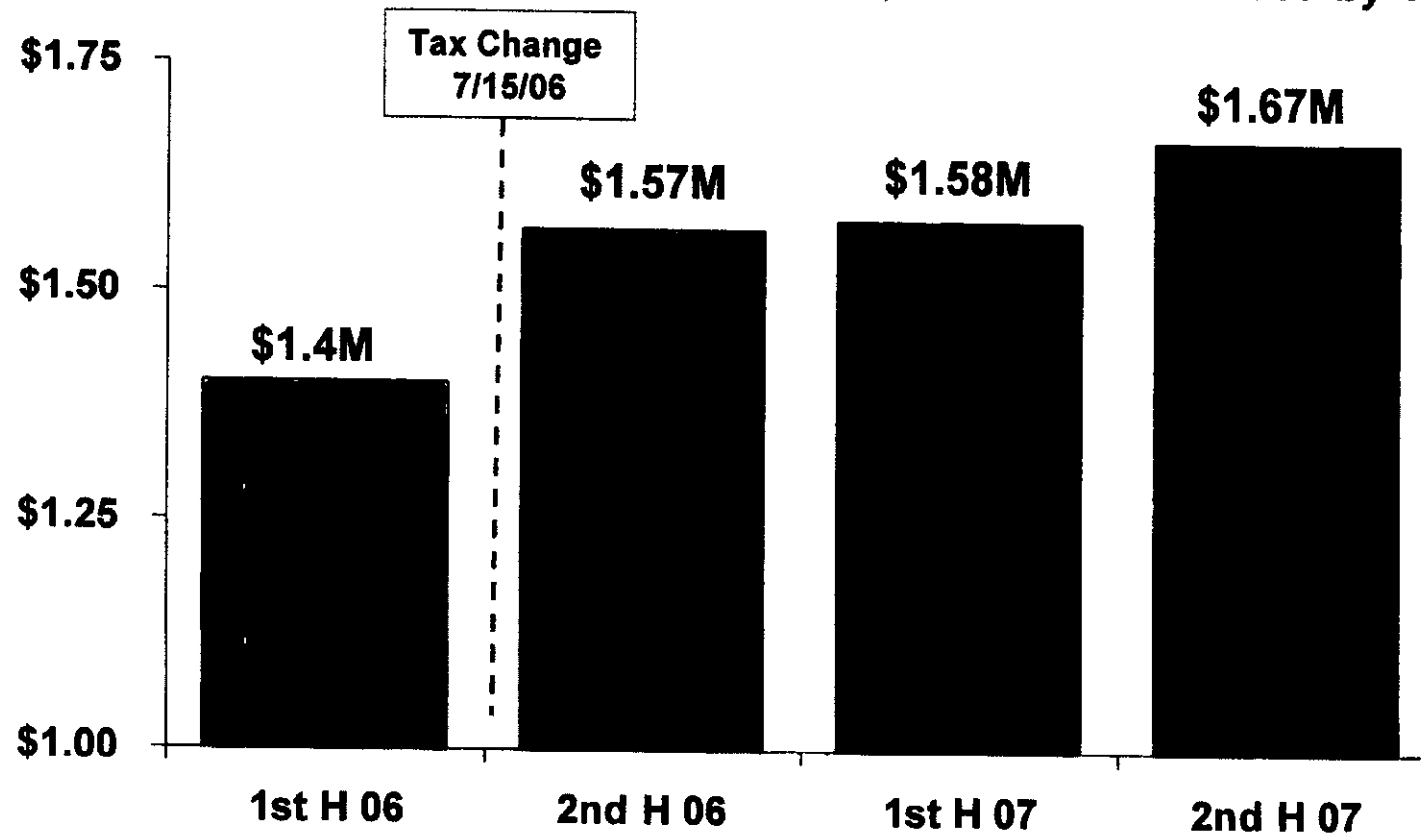


Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

New Jersey Weight-Based Conversion Case Study

In July 2006, New Jersey converted its MST tax from a 30% ad valorem rate to a 75¢/oz. weight-based Rate.

In the 18 months following the conversion, revenues increased by 19%.



Source: Based on USSTC RAD SVT System

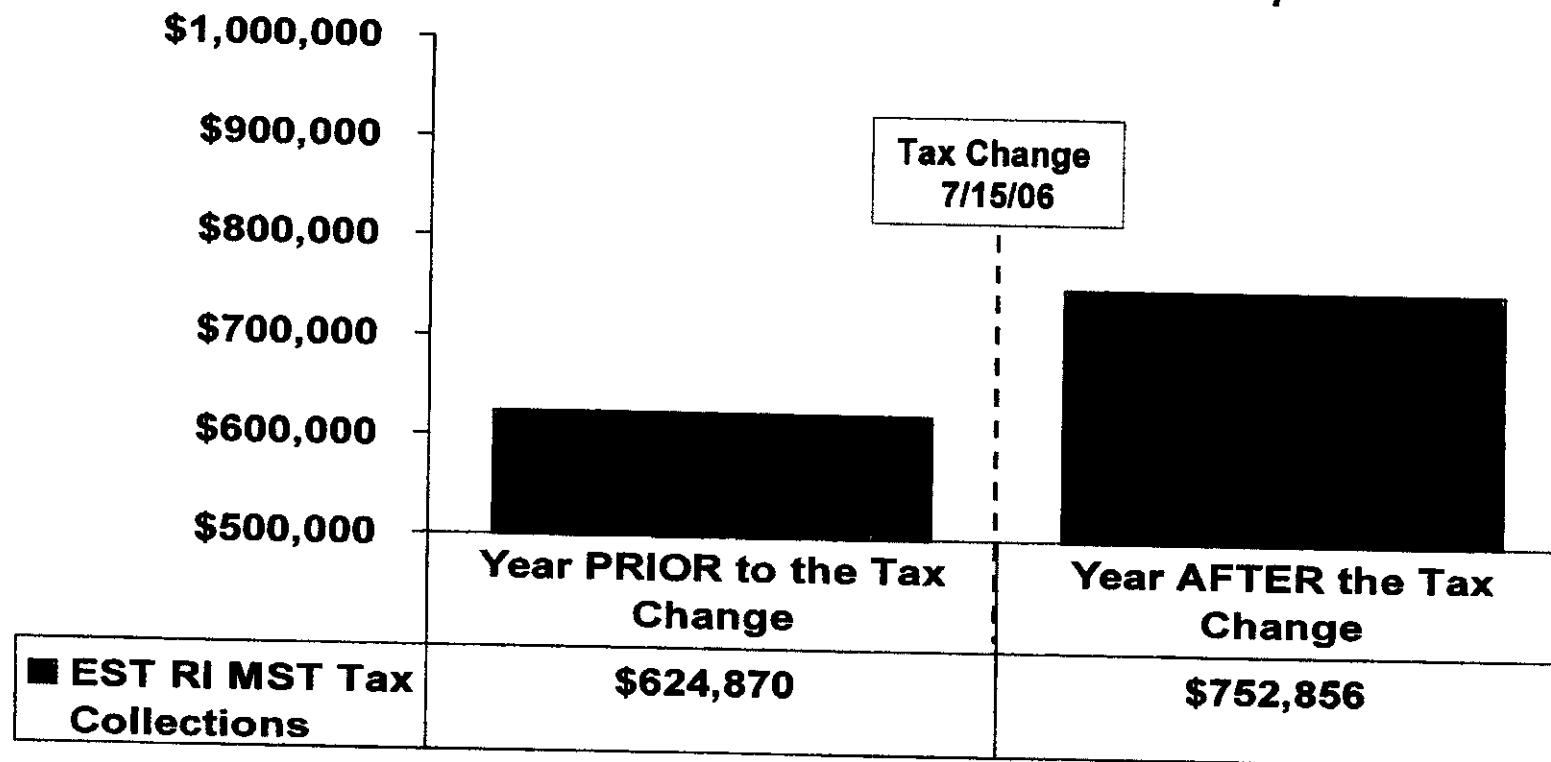


Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

Rhode Island Weight-Based Conversion Case Study

In July 2006, Rhode Island converted its MST tax from a 40% ad valorem rate to a \$1.00/oz. weight-based rate.

One year following the conversion revenues were up 20.5%.



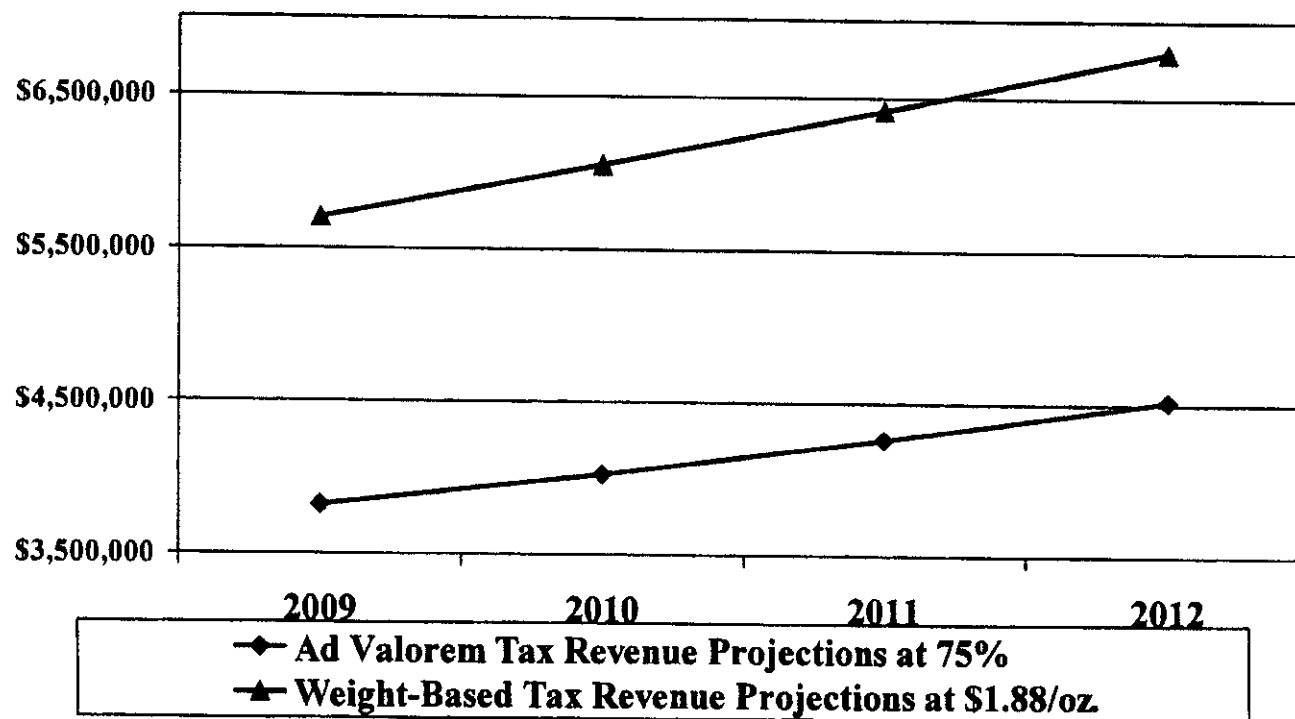
Source: RAD SVT compares time period 52 weeks prior to 7/1/06 and 52 weeks after 7/1/06



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

Future MST Tax Revenue Projections

Revenues are projected to increase under a weight-based method of taxation.



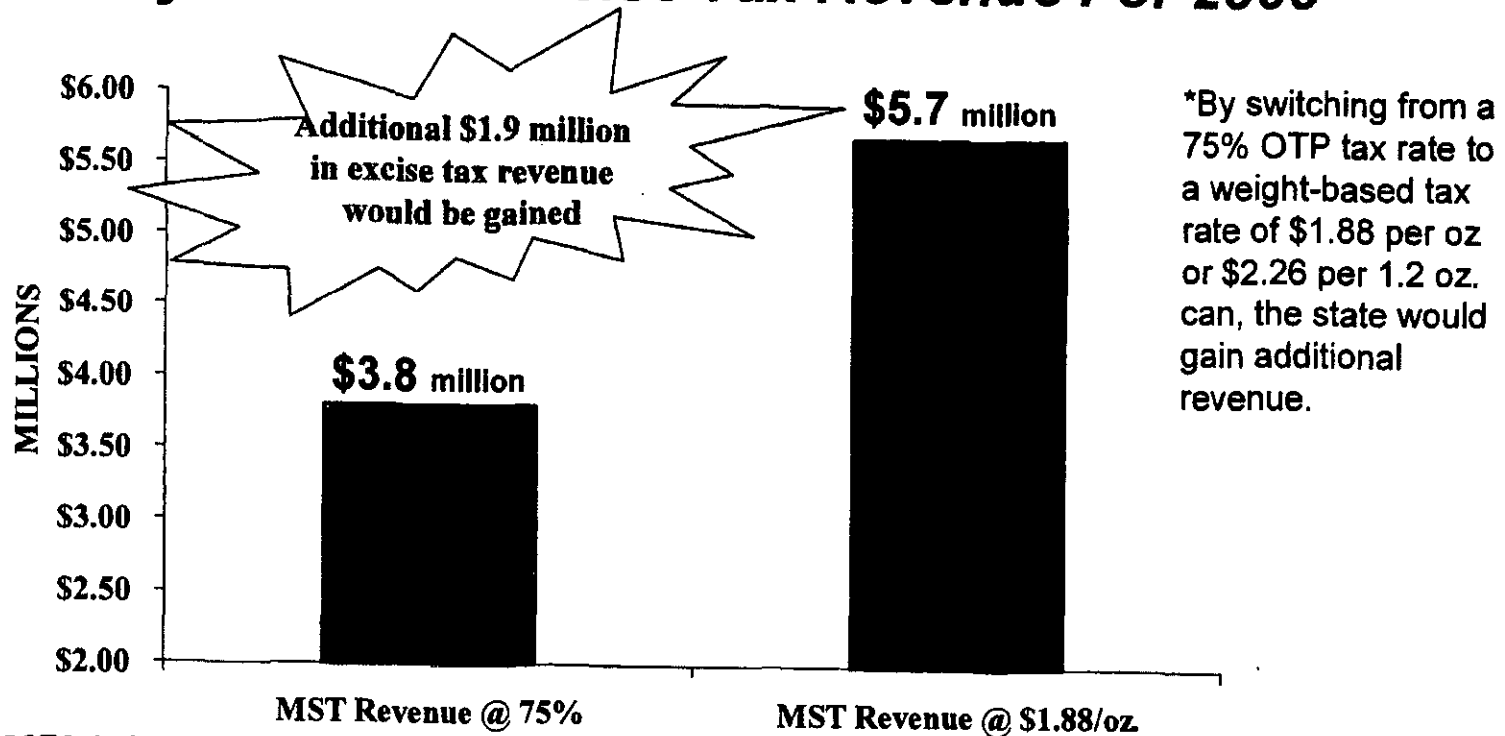
Note: Based on estimated sales from USSTC RAD database and share trends in 2008. The revenue model was run on a rate of \$1.88 per oz.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

A Weight-Based Tax Methodology Will Generate Additional Alaska MST Tax Revenues

Projected MST Excise Tax Revenue For 2009



Source: USSTC RAD SVT sales database.

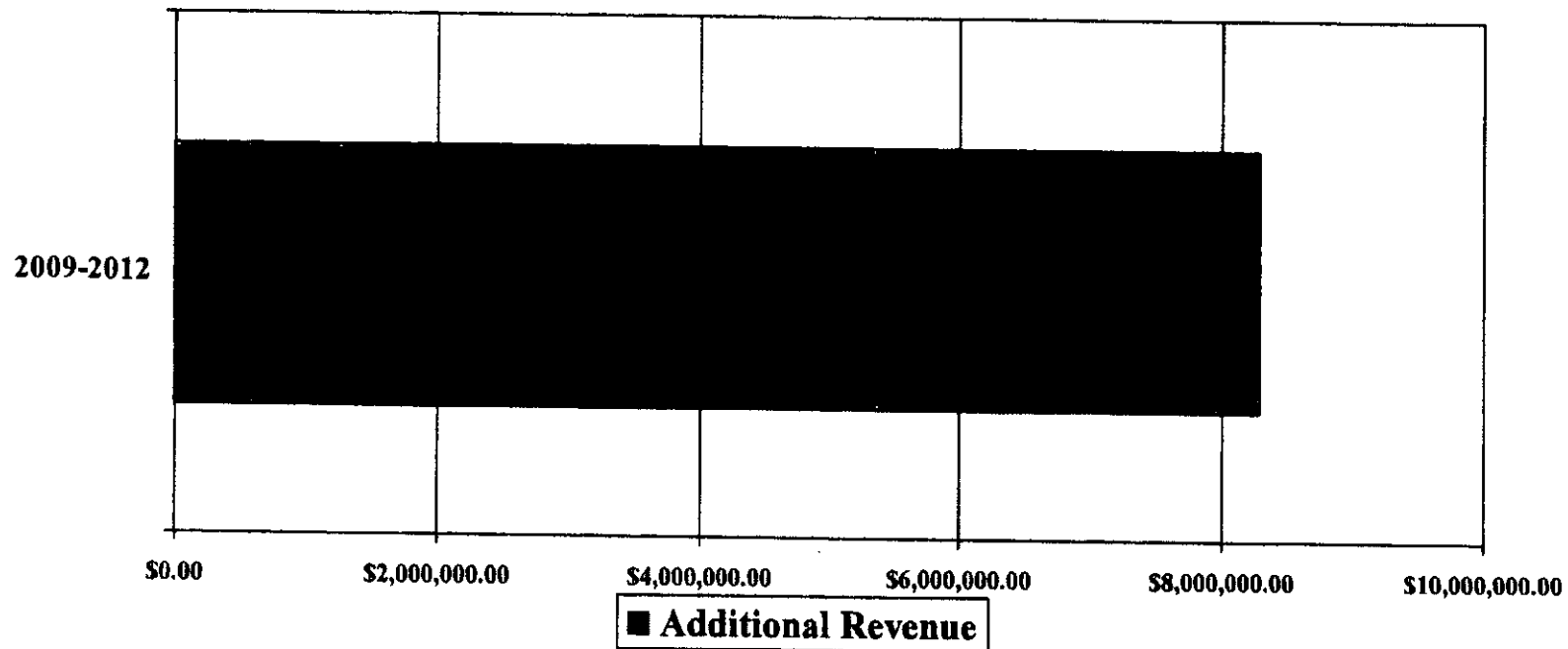
Note: Based on estimated sales from USSTC RAD database and share trends in 2008. The revenue model was run on a premium equivalent rate of \$1.88 per oz.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

Additional Weight Based Tax Revenue 2009 - 2012

By switching to a weight-based tax, Alaska could receive over
\$8.3 million in additional revenue over 4 years.



Note: Based on estimated sales from USSTC RAD database and share trends in 2008. The revenue model was run on a premium equivalent rate of \$1.88 per oz.



Information provided by Altria Client Services Inc. on behalf of
Philip Morris USA Inc. and US Smokeless Tobacco Company

Wholesalers: Weight-Based Taxes Are Easier To Administer



“A weight based system would allow us to reduce the tax administration burden that will in turn benefit our customers.”

March 7, 2008 letter from Neftali Garcia, Director, Governmental Relations to the Honorable Margarita Prentice, Washington State Senate Ways and Means Committee Chair.



“Taxing moist snuff at a flat rate amount per ounce is straight forward and a lot easier to implement and report to the state.”

February 7, 2008 letter to Whom It May Concern from Kelly Kaiser, Vice President, O.K. Distributing Co., Inc.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

ALCS Supports a Weight-Based Method of Taxation for MST

This legislation will:

- **Tax MST consistently with other consumer products.**
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- **Create a stable and predictable stream of MST tax revenue for the state.**
- **Reduce complexity and administrative burden on the state, wholesalers and retailers.**



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company

Taxing Moist Smokeless Tobacco

State excise taxes levied on Moist Smokeless Tobacco (MST) is unique amongst excise taxes levied across the United States. For most products, excise taxes are levied based on the number of units sold or quantity. Gasoline excise taxes are levied in cents per gallon. Beer, wine, and spirits excise taxes are levied in cents per gallon. Cigarette excise taxes are levied on a per pack basis. Even the federal government taxes MST based on the product's weight.

Many states (39 in all), on the other hand, tax MST based on the price of the product, see Table 1. This divergence from the standard method of levying excise taxes is inefficient and creates problems for states that tax MST on the basis of price. Consequently, MST taxation can be improved by switching MST taxation from a price-based system to a quantity-based tax system. There are two methods for taxing MST by quantity: levying the tax based on the weight of the product and levying the tax based on the number of units sold. Most states that use a quantity excise tax choose a tax on the weight of the product.

Table 1
State Tax Rate on Moist Smokeless Tobacco (MST) DIFFERENTIATE WEIGHT VERSUS UNIT BASE 2008¹

<u>State</u>	<u>Rate</u>	<u>Type of Tax</u>
Alabama	\$0.02 per ounce	Weight-based
Alaska	75% of wholesale price	Ad Valorem
Arizona	\$0.123 per ounce	Weight-Based
Arkansas	32% of manufacturers price	Ad Valorem
California	46.76% of wholesale price	Ad Valorem
Colorado	40% of manufacturers price	Ad Valorem
Connecticut	\$0.40 per ounce	Weight-based
Delaware	\$0.54 per ounce	Weight-based
Florida	25% of wholesale price	Ad Valorem
Georgia	10% of wholesale price	Ad Valorem
Hawaii	40% of wholesale price	Ad Valorem
Idaho	40% of wholesale price	Ad Valorem
Illinois	18% of wholesale price	Ad Valorem
Indiana	24% of wholesale price	Ad Valorem
Iowa	\$1.19 per ounce	Weight-based
Kansas	10% of wholesale price	Ad Valorem
Kentucky	\$0.095 per unit	Per Can
Louisiana	20% of manufacturers price	Ad Valorem
Maine	78% of wholesale price	Ad Valorem
Maryland	15% of wholesale price	Ad Valorem
Massachusetts	90% of wholesale price	Ad Valorem
Michigan	32% of wholesale price	Ad Valorem
Minnesota	70% of wholesale price	Ad Valorem

¹ Based on: Prante Gerald (2008) "What Is Proper Tax Policy for Smokeless Tobacco Products?" *Tax Foundation Fiscal Fact* No. 120, March 26; including changes in MST taxes since publication.

Mississippi	15% of manufacturers price	Ad Valorem
Missouri	10% of manufacturers price	Ad Valorem
Montana	\$0.85 per ounce	Weight-based
Nebraska	20% of wholesale price	Ad Valorem
Nevada	30% of wholesale price	Ad Valorem
New Hampshire	19% of wholesale price	Ad Valorem
New Jersey	\$0.75 per ounce	Weight-based
New Mexico	25% of product value	Ad Valorem
New York	\$0.96 per ounce	Weight-based
North Carolina	10% of wholesale price	Ad Valorem
North Dakota	\$0.60 per ounce	Weight-based
Ohio	17% of wholesale price	Ad Valorem
Oklahoma	60% of wholesale price	Ad Valorem
Oregon	65% of wholesale price	Ad Valorem
Pennsylvania	No	-----
Rhode Island	\$1.00 per ounce	Weight-based
South Carolina	5% of manufacturers price	Ad Valorem
South Dakota	35% of wholesale price	Ad Valorem
Tennessee	6.6% of wholesale price	Ad Valorem
Texas	40% of manufacturers price	Ad Valorem
Utah	\$0.75 per ounce	Weight-based
Vermont	\$1.49 per ounce	Weight-based
Virginia	10% of wholesale price	Ad Valorem
Washington	75% of wholesale price	Ad Valorem
West Virginia	7% of wholesale price	Ad Valorem
Wisconsin	\$1.31 per ounce	Weight-based
Wyoming	20% of wholesale price	Ad Valorem

Issues of Tax Equivalency

Price-based taxes, or ad valorem taxes, are levied as a percentage of the product's price. With respect to MST, these taxes are typically levied as a percentage of the wholesale price. For instance, in Idaho the tax on MST is 40% of the wholesaler's price. Consequently, for MST products that wholesale for \$3 per can, the 40% tax would impose an excise tax of \$1.20. For MST products that wholesale for \$1 per can, the 40% tax would impose an excise tax of \$0.40.

From an equivalency perspective, any ad valorem tax can be set at a level such that it imposes the same burden on MST as a weight-based or unit-based tax. In other words, any ad valorem tax can be converted into a unit-based or weight-based tax with the same equivalent tax burden.

Table 2 illustrates this principle based on Florida's current ad valorem MST excise tax. Looking at the premium category, currently, the state levies a tax that is 25% of the wholesale price. Based on a wholesale price of \$3.00 per 1.2 ounce can, the state could switch their ad valorem tax to a quantity tax of \$0.75 per unit or \$0.63 per ounce. In either scenario, the effective tax burden would be the same under all three scenarios – a 75-cent per can tax. Rows 3 & 4 illustrate the impact of the equivalency calculation on the Price Value and Deep Discount categories. While an ad-valorem tax provides a tax

Page 2 This document was prepared by Arduin, Laffer & Moore Econometrics on behalf of Altria Client Services Inc. It is intended for ALCS employees and consultants for educational purposes. It is not intended for third party distribution.

break for the lower-priced categories, both the unit-based and weight-based taxes levy the same dollar tax – the same dynamic that occurs when states (and the federal government) levies excise taxes on every other product subject to excise taxes.

Table 2
Premium Equivalency
Ad valorem, Per Can, and Per Ounce MST Taxes
for 1.2 ounce MST Products
In Florida
 (Based on 2008 Ad valorem Tax)

Wholesale Price	Ad Valorem	Unit-Based	Weight-Based (per ounce)
Premium (\$3.00/can)	\$0.75	\$0.75	\$0.75
Price Value (\$2.00/can)	\$0.50	\$0.75	\$0.75
Deep Discount (\$1.00/can)	\$0.25	\$0.75	\$0.75

The example in Table 2 is often referred to as a “pure” weight-based method. Below is language from the 2008 Utah House Bill 356, a “pure” weight-based bill.

- (4) The rate of the tax under this section is:
 - (a) for tobacco products except for moist snuff, 35% of the manufacturer’s sales price;
 - (b) subject to Subsection (5), for moist snuff, \$.75 per ounce.
- (5) (a) The tax under this section on moist snuff shall be imposed on the basis of the net weight of the moist snuff as listed by the manufacturer.
 - (b) If the net weight of moist snuff is in a quantity that is a fractional part of one ounce, a proportionate amount of the tax described in Subsection (4)(b) is imposed on that fractional part of one ounce.

The equivalency rates in Table 2 assume a constant can size – 1.2 ounces. However, MST products are sold in different sized cans (e.g., low-weight MST products). As the name implies, a weight-based tax method would result in a lower tax for lower-weight products of the same price. Unit-based taxes would not.

Currently, only Kentucky imposes a MST excise tax per unit, although Washington State considered replacing its current ad valorem tax with a per unit tax. Because MST products come in different size cans (i.e., 1.5 oz, 1.2 oz, and 0.12 oz), per unit tax proposals will typically include a “band” where the smaller-sized containers are taxed at the same rate as the standard containers.

A per unit tax with this feature is often referred to as a “banded” tax. Tax bands establish a tax floor such that the tax on lower-weight products is the same as the tax on standard-weight products. And proportionally larger per unit taxes are levied on larger sized cans such that the tax burden is not

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minimized by marketing larger products. Below is language from the 2008 Washington House Bill 2288, a "banded" bill.

Two dollars and thirty-five cents per ounce of moist snuff with a proportionate tax at the like rate on all fractional parts of an ounce thereof, provided that cans or packages of moist snuff with a net weight of less than one and two-tenths ounces shall be taxed at the equivalent rate of packages or cans weighing one and two-tenths ounces. Such tax on moist snuff shall be computed based on the net weight as listed by the manufacturer.

Table 3 illustrates the tax equivalency calculation based on Tier 1 products that are *banded* up to cans of 1.2 ounces.

Table 3
Equivalent Ad valorem, Per Can, and Per Ounce MST Taxes
By MST Product Size, for Tier 1 MST Products
In Florida
(Based on 2008 Ad valorem Tax, All products cost \$3.00)

Wholesale Price	Ad Valorem	Unit-Based	Weight-Based (per ounce)
1.5 ounces	\$0.75	\$0.94	\$0.94
1.2 ounces	\$0.75	\$0.75	\$0.75
0.12 ounces	\$0.75	\$0.75	\$0.08

The tax rates in Table 3 show that a unit-based (or banded) tax creates a tax floor of \$0.75 per can for all products, including those of a lower weight. Therefore, even though there is tax equivalency for products with a weight of 1.2 ounces and above, similar products with less weight will have a higher tax burden than under ad valorem or weight-based tax methods.

What MST Wholesale Price?

An important difficulty arises for ad valorem taxation: How does the ad valorem excise tax statute define *wholesale price*? The retail chain varies depending upon many factors. In some instances, MST is distributed from the manufacturer, to a wholesaler, then to a retailer and finally the customer. In this case, defining the wholesale price is straightforward.

Oftentimes the retail chain is longer than this example. In circumstances where there are two (or more) wholesalers, defining the wholesale price becomes more complex. This complexity creates problems. For instance,

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A company that distributes smokeless tobacco products to retailers in Florida filed a lawsuit against the Department of Business & Professional Regulation (DBPR), claiming a refund of more than \$14 million dollars in Other Tobacco Products Taxes over a five-year period. The core of the argument was what constitutes the "wholesale sales price."

The distributor contended the taxable wholesale sales price was the lower price a smokeless tobacco company's sales and marketing subsidiary paid to its manufacturing subsidiary for the product the distributor later purchased. The distributor had been taxed on the price it paid to the sales and marketing subsidiary.

In March 2005, the Court approved a settlement under which DBPR gave the distributor a \$6.2 million credit against future taxes. The Court retained jurisdiction for one year. The potential for other such claims exists.²

Standard industry discounting actions also impact tax revenues from ad valorem taxes. Oftentimes, manufacturers promote their products by offering "buy 1, get 1 free" or "buy 2, get 1 free" specials. Because the price is \$0 for a product that is given away, ad valorem taxes do not levy a tax on promotional products under an ad valorem tax system.

Quantity-based taxes avoid both of the problems discussed above. Under a quantity-based tax system the definition of the tax base is straightforward and not subject to differences in interpretation. The same logic applies to the promotional problem. With per unit or weight-based taxes, the manner in which products are promoted are irrelevant. Quantity taxes include both purchased products and promotional products as part of the tax base. These features create significant advantages for state governments that levy per unit or weight-based MST excise taxes instead of an ad valorem MST excise taxes.

Weight-based or Unit-based Taxes Are More Stable and Easier to Forecast

Related to the issue of price variability is the added difficulty state revenue forecasters face forecasting ad valorem MST taxes compared to quantity-based MST taxes.

Forecasting a quantity-based MST tax only requires the forecaster to track overall volume trends. Any changes in expected prices will impact consumption, and consequently tax revenues. However, the price impacts affect tax revenues only through their impact on the quantity sold – the changes in price do not directly increase or decrease the total tax revenues. Furthermore, price differentials across different

² Wenner Kurt R. and Turcotte John (2006) "Legislature Should Consider a Unit-Based Tobacco Products Tax" *Florida TaxWatch Briefings*, April.

types of products do not matter for tax revenue forecasts for quantity-based MST taxes, only the overall price trends. These features lead to a more stable, and consequently easier to forecast, tax revenue source from per unit or weight-based taxes.

Forecasting an ad valorem excise tax requires forecasters to track both price and volume trends. In addition, it is not just the overall price and volume trends that matter. Total MST ad valorem excise tax revenues will vary depending upon the price and volume trends by price category. Consequently, in states that impose MST ad valorem excise taxes, forecasters must predict the average MST price for all three MST price tiers, the changes in price differentials across the price tiers, and then predict how these changes in absolute and relative prices will impact expected volumes for each price tier. These complexities make accurately forecasting MST tax revenues from ad valorem excise taxes much more difficult than forecast MST tax revenues from per-unit excise taxes – it also can create a more variable excise tax revenue source.

Prices That Go Up Can Also Come Down

Proponents of ad valorem taxes on MST claim ad valorem taxes provide automatic protection against inflation. As the argument goes, when inflation increases, MST prices will increase in step, therefore tax revenues will be protected against inflation. Such arguments overlook the complexity of actual pricing decisions made by consumers and manufacturers.

Manufacturers often engage in price discounts in order to gain/protect market share. When the MST excise tax is based on the wholesale price of the product, then state government revenues are directly impacted by manufacturer's competitive actions. These impacts are compounded when one manufacturer's price discounts turn into an all out pricing war. The lower prices on all products lower the state excise tax revenues from the entire category. Such pricing actions may or may not occur during periods of high inflation.

Consequently, there is no guarantee that MST prices will increase in line with inflation. In fact, between 2000 and 2007, total OTP tax revenues in those states that impose a per unit tax on MST (either weight-based or based on the number of cans) grew more than total OTP tax revenues in those states that impose an ad valorem tax on MST, see Figure 1.

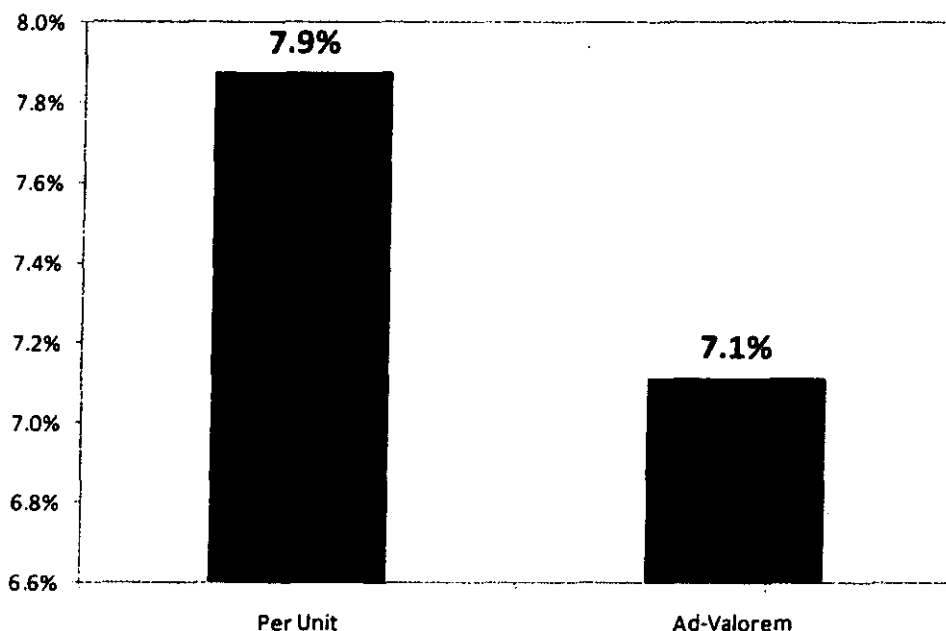
Consumers can also impact government revenues by their purchasing decision. Because most excise taxes are imposed on a quantity-basis, the type of product a consumer chooses is irrelevant to the government. For instance, gasoline excise taxes are levied on cents per gallon. Consequently, whether gasoline consumers choose regular or premium gasoline does not matter from the state government's perspective. State gasoline tax revenues are precisely the same. This is not the case for states that

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impose ad valorem MST taxes. State revenues change depending upon which product category a consumer chooses when states impose ad valorem MST taxes. This dynamic creates unexpected revenue declines if consumers change their product choice. In fact, this dynamic is taking place:

Data from Citigroup shows that sales of MST grew 6.4% nationwide in 2005 and that while Tier 3 grew by 28.8%, sales of Tier 1 products fell by 2.8%.³

Figure 1
Compound Annual Growth Rate in Per Unit and Ad Valorem OTP Taxes
2000 - 2007⁴



More troubling for state governments, consumer price sensitivity increases during more difficult economic times. Consumers will be looking toward economizing on their costs and may be more willing to purchase lower priced products. Manufacturers, aware of this dynamic, will be more sensitive to consumers' price consciousness and will be more willing to forgo price increases and perhaps even cut prices. As a result, both consumer and manufacturer actions will work toward limiting price increases during difficult economic times, and may even push actual average prices down.

Not surprisingly, state tax revenues are generally under pressure during the same tough economic times, see Figure 2. The gray shaded areas in Figure 2 represent recessions. The gray dotted line represents

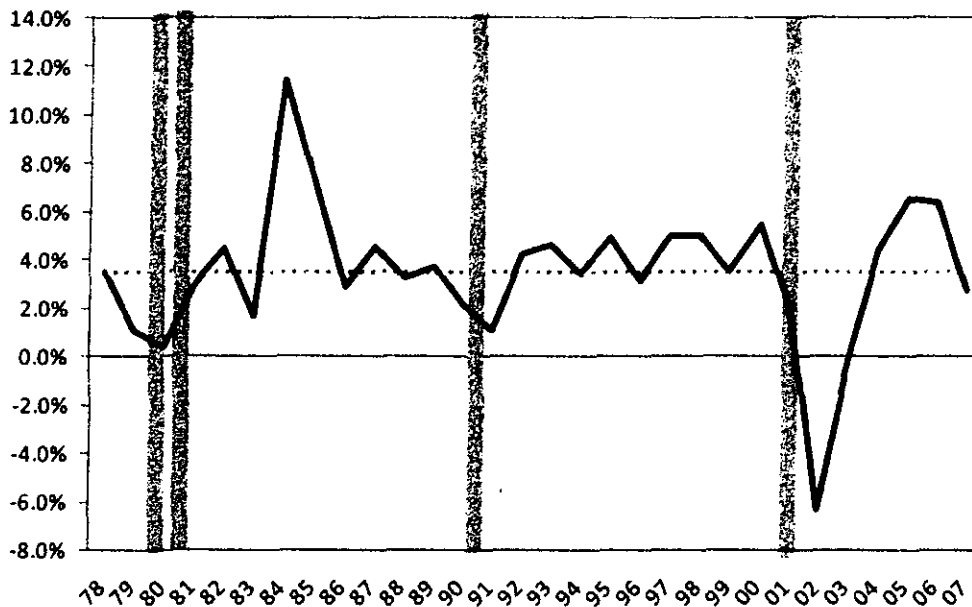
³ Wenner Kurt R. and Turcotte John (2006) "Legislature Should Consider a Unit-Based Tobacco Products Tax" *Florida TaxWatch Briefings*, April.

⁴ Source: Orzechowski Bill and Walker Rob (2008) *The Tax Burden on Tobacco* vol. 42. In order to ensure comparability across time, only those states that levied an MST tax throughout the entire period were included in the analysis.

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the average growth in real state tax revenues, which has been 3.5% between 1978 and 2007. State tax revenue growth was well below the average state tax revenue growth rate during and following all four official recessions since 1978. Recently, 2007 state tax revenues have fallen below average, and the quarterly data from the U.S. Census shows that tax revenues will likely fall even further in 2008 – consistent with the declining economy.

Figure 2
Percent Change in Inflation Adjusted Total State Tax Revenues
1978 - 2007⁵



Ad valorem MST taxes are determined by both the price of the product and the quantity sold. Due to pressure on MST prices (driven either by manufacturers or consumers) during a slowing economy, ad valorem MST taxes will under-perform state tax revenue needs at the precise time when states need revenues the most. Quantity based MST taxes avoid this problem by being determined by the quantity sold alone.

Equity Considerations

According to the National Conference of State Legislatures, tax equity "has two primary components – horizontal equity and vertical equity. Horizontal equity means that taxpayers with similar economic

⁵ Source: U.S. Census, www.census.gov.

circumstances have similar tax burdens. Vertical equity refers to the distribution of tax burdens among taxpayers with different economic circumstances.⁶

The issue of horizontal equity is the most relevant with respect to ad valorem MST taxation. Ad valorem excise taxes create an artificial market advantage for the lower-priced MST products. As illustrated in the example above, in a state with a 40% ad valorem tax on the wholesale price of the product (and assuming that the wholesale price can be clearly defined), the actual dollar tax paid on a product that wholesales for \$3 per can (\$1.20) will be 300% more than the actual dollar tax paid on a product that wholesales for \$1 per can (\$0.40).

Because the tax burden is levied on the product not the individual, ad valorem MST taxes vary the tax burden on individuals that is not based on the individual's ability to pay. The ad valorem system, consequently, violates the horizontal equity consideration defined by the National Conference of State Legislatures.

Conclusion

Most states levy an ad valorem tax on MST products. Not only is this atypical for excise taxation in the U.S., but it is also less efficient. The evidence shows that tax revenues in those states that rely on ad valorem taxes do not necessarily grow faster than those states that levy a per unit MST tax. In fact, between 2000 and 2007, revenues in the states that levied a per unit tax grew at a faster rate than revenues in the states that levied an ad valorem tax.

Ad valorem taxation also creates unnecessary complexity in the tax code, which makes it more difficult to forecast tax revenues and exposes the state's tax revenues to unnecessary volatility. For all of these reasons, taxing Moist Smokeless Tobacco on a per unit basis is more efficient than an ad valorem tax.

⁶ Fiscal Affairs Program (2003) "Tax Policy Handbook for State Legislators" *National Conference of State Legislators*, April.

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Recent MST Price Reductions Will Result in Revenue Loss in Ad Valorem States

On Tuesday, March 10, 2009, Conwood Company LLC announced a price reduction on Kodiak and Hawken. On Wednesday, March 4, 2009, US Smokeless Tobacco Company announced a price reduction on Copenhagen, Skoal and Red Seal and a price increase on Husky. The table below shows these price changes.

	Current Wholesale Price	New Wholesale Price	Price Change
Kodiak	\$3.11	\$2.39	(\$0.72)
Hawken	\$3.11	\$2.39	(\$0.72)
Copenhagen	\$3.01	\$2.39	(\$0.62)
Skoal	\$3.01	\$2.39	(\$0.62)
Red Seal	\$2.02	\$1.75	(\$0.27)
Husky	\$1.35	\$1.55	\$0.20

In states that use an ad valorem excise tax methodology for MST, price reductions will result in an immediate reduction in MST excise tax revenues. The Alaska ad valorem rate is 75%. The annual revenue reduction is estimated in the chart below.¹

	Price Change Per Can	Cans Sold	Revenue Change
Kodiak and Hawken	(\$0.72)	183,000	(\$99,000)
Copenhagen and Skoal	(\$0.62)	1.45 million	(\$676,000)
Red Seal	(\$0.27)	12,000	(\$2,000)
Husky	\$0.20	100,000	\$15,000
Total			(\$762,000)

If Alaska converted to a weight-based taxation methodology, state revenues would not be dependent on the pricing decisions in the marketplace, including manufacturer discounts or promotions. However, because Alaska taxes MST based on price, rather than on weight, the state will lose an estimated \$762,000 in excise tax revenue per year.

Weight-based taxes protect states from loss of revenue that can follow price reductions or promotional activity in ad valorem states. With an ad valorem tax, the state's revenues depend not only on the volume of sales, but also on pricing decisions of the manufacturers – which leads to less stability in tax revenue collections. Under a weight-based methodology, every 1.2 ounce can pays the same excise tax to the state, regardless of pricing.

A weight-based MST tax methodology creates a stable and predictable stream of MST tax revenue for the state.

¹ USSTC RAD sales database. Cans sold is an estimate based on wholesaler reporting. It covers 2008. The revenue loss was estimated by multiplying the price reduction per can, the volume of cans for the affected brands and the ad valorem tax rate. We assume no changes in volume for 2009 for purposes of this estimate.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company
For more information, please visit www.philmsa.com

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ISSUE ALERT

To: Alaska ALEC House Member
From: Michael Hough, Task Force Director
Re: House Bill 188
Date: March 24, 2009

The Alaska House is considering **HB 188**, which would change the current tax on moist smokeless tobacco (MST) from an ad valorem basis (percentage tax based on price) to a weight-based system. **The American Legislative Exchange Council (ALEC) fully supports this concept.** Changing the current tax on moist smokeless tobacco to weight-based system is sound tax policy that provides tax fairness and fits squarely within the Jeffersonian Principles of free market enterprise and fair commerce.

In fact, ALEC recently passed a model resolution and statement of principles explaining the importance of implementing this needed change in tax law. We have attached the resolution, *Resolution on the Enhancement of Economic Neutrality, Commercial Efficiency, and Fairness in the Taxation of Moist Smokeless Tobacco Products* to this Issue Alert.

ALEC believes that all like products would be taxed the same and there should be no tax preference for inexpensive products that could harm state revenues. Additionally, such a tax change would simplify and ease compliance for retailers and state tax administrators and would erase the tax-conferred market advantage that some products have enjoyed in recent years, while restoring the principles of sound tax policy.

Proponents' claim that taxes based upon price discourages consumption, especially among teenagers. To the contrary, an ad valorem tax merely shifts demand from one product to the next. Proponents also suggest that this is no different than a consumer who pays higher taxes for a more expensive car than a cheaper alternative. This confuses an excise tax with a sales tax rate; sales taxes are solely intended to tax the price or value of a product while excise taxes are intended to tax actual consumption. Automobiles are not consumable items and therefore this argument is without merit.

Regardless of the politics or perceived social benefits, sound tax policy should still apply to excise taxes. ALEC does not believe any state should support a tax policy which creates a preference for one product over another, nor should the state interfere with the invisible hand of the free market by encouraging the use of one product over another. True to Jefferson's core principles, states should not be in the business of picking winners and losers, but rather let the market decide free of discriminatory government intervention.

Finally, ALEC does not believe this legislation should be used for a revenue enhancer and do not support the idea of raising taxes during these tough economic times. While we fully support the concept of **replacing the ad valorem tax with a weight-based tax, we do not support the overall tax increase that results from this legislation.**

If you should have any questions please contact ALEC's Commerce, Insurance and Economic Development Task Force Director, Michael Hough at 202-742-8530 or mhough@alec.org.

Tax Policy: A Fair Deal for Smokeless Tobacco

ALEC resolution calls on 40 states to change tax structure and adopt fair excise tax policy for smokeless tobacco products.

By Michael Keegan

In December 2006, ALEC fully approved a resolution and statement of principles calling for states to change their tax treatment of smokeless tobacco products — and any other consumer products taxed in a similar way — from an ad valorem basis (percentage tax based upon price) to a weight- or unit-based system. This change would ensure that all like products would be taxed at the same rate, it would eliminate a tax preference for inexpensive products that could harm state revenues and it would align smokeless tobacco products with all other consumer products subject to an excise tax. Additionally, such a tax change would simplify and ease compliance for retailers and state tax administrators, and it would erase the tax-conferred market advantage that some products have enjoyed in recent years, while restoring the principle of sound tax policy.

The cornerstone of excise tax policy is simply to tax the consumption of a product. The federal and state governments impose excise taxes on a range of products, including gasoline, beer, alcohol and tobacco products. In all instances, state excise taxes are based upon the unit or weight of a product (i.e., a gallon of gasoline, a liter of alcohol, a pack of cigarettes).

The beneficial result of an excise tax based upon unit or weight is that like products are taxed equally regardless of price, and the tax is spread evenly. For example, a gallon of 87-octane gasoline is taxed at the same rate

as a gallon of 93 octane, a pack of premium cigarettes is taxed at the same rate as a pack of generic cigarettes and the same holds true across the line for many other products.

In 40 states, however, moist smokeless tobacco (MST) is taxed as a percentage of its price, not its weight. A tax based upon price not only creates the effect of a double sales tax (as these products are also subject to a sales tax based upon price) but worse, it distorts consumer behavior by taxing similar products in a very dissimilar

manner. The result of ad valorem taxation is that certain products are subject to a much higher tax than similar less expensive products.

This policy creates a glaring market distortion as the tax treatment of the more expensive products artificially shifts demand toward lower priced products by

exacerbating the price difference between the two. As highlighted by Americans for Tax Reform, “Excise taxes based upon price are taxes on autopilot, which creates a double and triple taxation effect and hides the real tax burden.”

Although proponents claim that taxes based upon price discourage consumption — especially among teenagers — the reality is that an ad valorem tax merely shifts demand from one product to the next. Supporters of this disparate tax system also suggest that it is no different than when consumers pay higher taxes for a more expensive car than for a cheaper alternative. This argument confuses an excise tax with a sales tax.



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The difference is that sales taxes are solely based on the price or value of a product while excise taxes are generally fixed-fee and can be imposed at the point of production, importation or sale. They are intended to both raise revenue and to discourage particular behavior.

Regardless of the politics or perceived social benefits, sound tax policy should still apply to excise taxes. ALEC does not believe any state should support a tax policy that creates a preference for one product over another, nor should the state interfere with the invisible hand of the free market by encouraging the use of one product over another. True to Jefferson's core principles, states should not be in the business of picking winners and losers, but should let the market decide free of discriminatory government intervention.

It is with these guiding principles relating to tax equity, tax fairness, free market economy and commerce without discriminatory interference by government that ALEC encourages all policymakers in states that currently tax smokeless tobacco on price (ad valorem) to support and adopt legislation that taxes all consumer products — including smokeless tobacco products — fairly, based upon the weight of a can.

This chart indicates states that currently tax smokeless tobacco products on an ad valorem basis and shows the wide discrepancies in the state excise tax rates on smokeless tobacco products.

*Adjusted annually by the California Board of Equalization.
Source: Tax Foundation and Federation of Tax Administrators.

State	Tax Rate on Smokeless Tobacco	Type of Tax
Alaska	75% of wholesale price	ad valorem
Arkansas	32% of manufacturer's price	ad valorem
California	46.76% of wholesale price*	ad valorem
Colorado	40% of manufacturer's price	ad valorem
Delaware	15% of wholesale price	ad valorem
Florida	25% of wholesale price	ad valorem
Georgia	10% of wholesale price	ad valorem
Hawaii	40% of wholesale price	ad valorem
Idaho	40% of wholesale price	ad valorem
Illinois	18% of wholesale price	ad valorem
Indiana	18% of wholesale price	ad valorem
Iowa	22% of wholesale price	ad valorem
Kansas	10% of wholesale price	ad valorem
Louisiana	20% of manufacturer's price	ad valorem
Maine	78% of wholesale price	ad valorem
Maryland	15% of wholesale price	ad valorem
Massachusetts	90% of wholesale price	ad valorem
Michigan	32% of wholesale price	ad valorem
Minnesota	70% of wholesale price	ad valorem
Mississippi	15% of manufacturer's price	ad valorem
Missouri	10% of manufacturer's price	ad valorem
Nebraska	20% of wholesale price	ad valorem
Nevada	30% of wholesale price	ad valorem
New Hampshire	19% of wholesale price	ad valorem
New Mexico	25% of product value	ad valorem
New York	37% of wholesale price	ad valorem
North Carolina	3% of wholesale price	ad valorem
Ohio	17% of wholesale price	ad valorem
Oklahoma	60% of wholesale price	ad valorem
Oregon	65% of wholesale price	ad valorem
South Carolina	5% of manufacturer's price	ad valorem
South Dakota	35% of wholesale price	ad valorem
Tennessee	6.6% of wholesale price	ad valorem
Texas	40% of manufacturer's price	ad valorem
Utah	35% of manufacturer's price	ad valorem
Virginia	10% of wholesale price	ad valorem
Washington	75% of wholesale price	ad valorem
West Virginia	7% of wholesale price	ad valorem
Wisconsin	25% of manufacturer's price	ad valorem
Wyoming	20% of wholesale price (or 10% of retail)	ad valorem

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Resolution on the Enhancement of Economic Neutrality, Commercial Efficiency and Fairness in the Taxation of Moist Smokeless Tobacco (MST) Products

WHEREAS, excise taxes are levied by individual states on the distribution of a variety of consumer products in the United States.

WHEREAS, excise taxes are levied at various points or transactions during the distribution of these consumer products having a compounding effect on all other taxes levied further along the distribution chain, including sales taxes.

WHEREAS, levy of excise taxes should be equally applied to all products of a like nature or category, as to not create a tax policy that benefits one product and penalizes another of the same nature or category.

WHEREAS, state tax policy should not create preferences among products of a like nature or category.

WHEREAS, taxes that create a consumer preference within a product category impede free market commerce.

WHEREAS, excise taxes levied on the basis of value or price "ad valorem" at any point during the distribution of any products greatly aggravate the compounding effect on taxes and prices between products and distort consumer preference between similar products.

WHEREAS, MST products are all of a like nature and category, and packaging is distinguishable only by volume, weight or labeling.

WHEREAS, ad valorem excise taxes on MST creates a tax preference for inexpensive MST products, thereby artificially disrupting free market consumer dynamics.

WHEREAS, ad valorem excise taxes on MST result in automatic tax increases or decreases **without** legislative oversight or action, and negatively impact consumers and producers while denying them any legislative recourse.

WHEREAS, ad valorem excise tax statutes are subject to differing interpretations as to the appropriate point or transaction to apply the tax, creating compliance problems for producers and state tax administrators.

WHEREAS, excise taxes on MST based on volume or weight eliminate the possibility of market distortions and manipulations, tax preferences for lower priced products and aggravation of the compounding nature of an excise tax levied during distribution.

WHEREAS, virtually all other products on which excise taxes are levied carry a tax based on volume or weight, ensuring that manufacturers and consumers face a level marketplace based on freedom of consumer choice.

NOW, THEREFORE BE IT RESOLVED, THAT the American Legislative Exchange Council (ALEC) will support efforts to change or convert state excise taxes levied on MST from ad valorem or price based to weight or volume based.

NOW, THEREFORE BE IT FURTHER RESOLVED THAT ALEC shall support the following statement of principles.

Statement of Principles Regarding State Ad Valorem Taxes on Consumer Products

The Problem: Ad Valorem Excise Taxes on Consumer Products

- Ad valorem taxes give less expensive products a tax preference, which encourages consumers to switch to those products, thus artificially distorting the market and influencing consumer behavior.
- Market distortions created by ad valorem taxes erode and destabilize state revenues over time.
- Ad valorem excise taxes lack neutrality. Products with identical weights and packaging can have widely different tax burdens, harming commercial activity and artificially distorting the dynamics of the marketplace.
- Ad valorem excise taxes are not consistent with virtually all other consumer product excise taxes that tax solely on the basis of the amount of the product purchased and consumed, and do not discriminate on price.
- Ad valorem state excise taxes amount to a tax on top of a tax because a portion of the price basis for applying the excise tax is attributable to any existing federal excise tax.
- Ad valorem excise taxes result in automatic tax increases and decreases **without** legislative oversight or action.

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- Ad valorem excise tax statutes are subject to differing interpretations regarding the appropriate tax base and payer; this increases complexity and compliance problems for manufacturers, distributors and state tax administrators.

The Solution: Weight-Based Excise Taxes

- Under a weight-based tax structure, not a state tax system that arbitrarily gives a preference to one product over another, consumer products compete fairly in the marketplace on the basis of product attributes and price.
- Weight-based excise taxes eliminate the market distortions and revenue erosion caused by ad valorem excise taxes.
- Like products should carry identical taxes. All products and taxpayers are treated fairly and equally under a weight-based tax system.
- A weight-based excise tax would equalize the tax treatment of all like consumer products in the states and eliminate an economic disincentive that hinders commercial activity.
- A weight-based excise tax on MST eliminates the possibility of a tax on tax.
- A weight-based excise tax eliminates automatic tax increases, and requires specific legislative action to increase or decrease taxes.
- Weight-based taxes are easy for taxpayers to understand and for tax administrators to support and enforce.

Conclusion

Adherence to the principles of sound tax policy, economic neutrality, fairness, simplicity, efficiency and fiscal stability should lead state legislators in states that currently tax consumer products on an ad valorem basis to replace that method of taxation with one that taxes products on a per unit, weight or volume basis.

Adopted by the Commerce, Insurance and Economic Development Task Force on July 21, 2006, and approved by the ALEC Board of Directors in December 2006.

Michael Keegan is the former director of the ALEC Commerce, Insurance and Economic Development Task Force. For additional information please view the resolution and Statement of Principles on the ALEC Web site or contact Jonathan Shore at jshore@alec.org

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The Effect of Federal Tobacco Tax Increases on Alaska's Tobacco Taxes

Prepared by: Johanna Bales

Alaska levies an excise tax on cigarettes and on other tobacco products (OTP). The tax rates, tax calculation, and how the tax is levied differ between cigarettes and OTP. The following outlines those differences and the effect of recent federal tobacco tax increases on Alaska tobacco taxes:

Cigarette Tax

Alaska's cigarette tax is levied on each cigarette. The tax is currently 10 cents per cigarette or \$2.00 per pack of twenty cigarettes. The tax is levied when cigarettes are brought into the state for sale or personal consumption. What this means is that if an individual buys cigarettes over the Internet or has friends or family ship cigarettes to them through the mail, they are liable to pay the Alaska tax. The federal tax was 39 cents per pack, but is now \$1.01 per pack of twenty. The increase in the federal tax does not affect Alaska's tax rate. However, it can and probably will affect revenue as people either quit smoking or cut back due to the higher cost of cigarettes that will result from the federal increase. We also expect smuggling to increase in all states, including Alaska, which will also cut into Alaska's cigarette tax revenue.

Other Tobacco Products (OTP)

Alaska's OTP tax is levied at the rate of 75% of the wholesale price of the tobacco product. OTP includes little cigars, cigars, pipe tobacco, chewing tobacco, snuff, roll-your-own tobacco, etc. Basically, anything other than a cigarette that has tobacco in it. The tax is levied when OTP is brought into the state for sale. It is important to note, the OTP tax is not levied when OTP is brought into the state for personal consumption. The wholesale price is defined in statute as the "established price for which a manufacturer sells a tobacco product to a distributor . . ." This is basically the manufacturer's list price.

The federal law increased many OTP products significantly. For example, the tax on little cigars increased from 4 cents per pack to \$1.01 per pack of twenty. Chewing tobacco increased from 19.5 cents to 50.33 cents per pound and roll-your-own tobacco increased from \$1.0969 to \$24.78 per pound. The federal tax is paid by the manufacturer. Therefore, the manufacturer's list price will increase to reflect the increases in the federal tax. Even though our tax rate of 75% of the wholesale cost remains the same, the amount upon which the 75% is multiplied will be significantly higher. As such, Alaska's tax on OTP will also increase.

Will people start buying roll-your-own and other OTP from states without a tax? Most states have a tax, but if the product is exported from the state that state's tax doesn't apply. The question should be, "will people start buying roll-your-own and other OTP from Internet sellers?" The answer is, "yes." When Alaska increased the tax on OTP in 1997 from 25% to 75% of the wholesale cost, we did see an increase in people buying OTP through the mail. It is perfectly legal for them to do so since the OTP tax is only levied when OTP is imported or brought into the state for sale. With the increase in the federal tax and resultant increase in the Alaska tax, we will definitely see individuals and possibly even businesses purchasing OTP from Internet sites and through the mail. This will result in lost revenue to the state.

When Alaska increased its cigarette tax during a special legislative session in the summer of 2004, a couple of legislators tried to insert language that made it so the OTP tax was levied on individuals who imported OTP for personal consumption. Their concern was that local businesses which sell OTP were unable to compete with Internet sellers because it was legal for individuals to buy through the mail and

Internet without paying Alaska's tax, but the local retailer had to pay the tax. I think this will be even more of an issue now that the federal tax has significantly increased and the Alaska tax will be even more.

Alaska's cigarette and OTP tax rates are set in statute. The Department of Revenue has no authority to change the tax rates.

One other thing to note is that the federal law provides for a floor stock tax. What this means is that every distributor and retailer in the state must identify their inventory as of April 1, 2009 and pay the difference between the new and old federal tax rates to the federal government by August 1, 2009. Alaska does not have a floor stock tax. Even though distributors and retailers must remit the higher tax on their inventory to the federal government, the Alaska tax on OTP will be based on the manufacturer's list price at the time the product was imported into the state for sale.

Attached is the new federal language with a chart showing the changes in the federal tax rates by product.

Product	Current Tax Rates	Senate SCHIP Tax Rates
Cigarettes	39¢ per pack	\$1.01 per pack
Large Cigars	20.719% of manufacturer's price; cap of 4.875¢/cigar	52.75% of manufacturer's price; cap of 40.26 cents per cigar
Little Cigars	4¢ per pack	\$1.01 per pack:
Pipe Tobacco	\$1.0969 per pound	\$2.8311 per pound
Chewing Tobacco	19.5¢ per pound	50.33¢ per pound
Snuff	58.5¢ per pound	\$1.51 per pound
RYO; Cigar Wrappers	\$1.0969 per pound	\$24.78 per pound
Cigarette Paper	1.22¢ per 50 papers	3.15¢ per 50 papers
Cigarette Tubes	2.44¢ per 50 tubes	6.30¢ per 50 tubes

H.R.2

Children's Health Insurance Program Reauthorization Act of 2009 (Engrossed Amendment as Agreed to by Senate)

SEC. 701. INCREASE IN EXCISE TAX RATE ON TOBACCO PRODUCTS.

(a) *Cigars-* Section 5701(a) of the Internal Revenue Code of 1986 is amended--

(1) by striking '\$1.828 cents per thousand (\$1.594 cents per thousand on cigars removed during 2000 or 2001)' in paragraph (1) and inserting '\$50.33 per thousand',

(2) by striking '20.719 percent (18.063 percent on cigars removed during 2000 or 2001)' in paragraph (2) and inserting '52.75 percent', and

(3) by striking '\$48.75 per thousand (\$42.50 per thousand on cigars removed during 2000 or 2001)' in paragraph (2) and inserting '40.26 cents per cigar'.

(b) *Cigarettes-* Section 5701(b) of such Code is amended--

(1) by striking '\$19.50 per thousand (\$17 per thousand on cigarettes removed during 2000 or 2001)' in paragraph (1) and inserting '\$50.33 per thousand', and

(2) by striking '\$40.95 per thousand (\$35.70 per thousand on cigarettes removed during 2000 or 2001)' in paragraph (2) and inserting '\$105.69 per thousand'.

(c) *Cigarette Papers-* Section 5701(c) of such Code is amended by striking '1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)' and inserting '3.15 cents'.

(d) Cigarette Tubes- Section 5701(d) of such Code is amended by striking `2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)' and inserting `6.30 cents'.

(e) Smokeless Tobacco- Section 5701(e) of such Code is amended--

(1) by striking `58.5 cents (51 cents on snuff removed during 2000 or 2001)' in paragraph (1) and inserting `\$1.51', and

(2) by striking `19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)' in paragraph (2) and inserting `50.33 cents'.

(f) Pipe Tobacco- Section 5701(f) of such Code is amended by striking `\$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)' and inserting `\$2.8311 cents'.

(g) Roll-Your-Own Tobacco- Section 5701(g) of such Code is amended by striking `\$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)' and inserting `\$24.78'.

(h) Floor Stocks Taxes-

(1) IMPOSITION OF TAX- On tobacco products (other than cigars described in section 5701(a)(2) of the Internal Revenue Code of 1986) and cigarette papers and tubes manufactured in or imported into the United States which are removed before April 1, 2009, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of--

(A) the tax which would be imposed under section 5701 of such Code on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) CREDIT AGAINST TAX- Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to \$500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on April 1, 2009, for which such person is liable.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT-

(A) LIABILITY FOR TAX- A person holding tobacco products, cigarette papers, or cigarette tubes on April 1, 2009, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT- The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT- The tax imposed by paragraph (1) shall be paid on or before August 1, 2009.

Recent MST Price Reductions Will Result in Revenue Loss in Ad Valorem States

On Tuesday, March 10, 2009, Conwood Company LLC announced a price reduction on Kodiak and Hawken. On Wednesday, March 4, 2009, US Smokeless Tobacco Company announced a price reduction on Copenhagen, Skoal and Red Seal and a price increase on Husky. The table below shows these price changes.

	Current Wholesale Price	New Wholesale Price	Price Change
Kodiak	\$3.11	\$2.39	(\$0.72)
Hawken	\$3.11	\$2.39	(\$0.72)
Copenhagen	\$3.01	\$2.39	(\$0.62)
Skoal	\$3.01	\$2.39	(\$0.62)
Red Seal	\$2.02	\$1.75	(\$0.27)
Husky	\$1.35	\$1.55	\$0.20

In states that use an ad valorem excise tax methodology for MST, price reductions will result in an immediate reduction in MST excise tax revenues. The Alaska ad valorem rate is 75%. The annual revenue reduction is estimated in the chart below.¹

Estimated Ad Valorem MST Tax Revenue Reduction for 2009			
	Price Change Per Can	Cans Sold	Revenue Change
Kodiak and Hawken	(\$0.72)	.183,000	(\$99,000)
Copenhagen and Skoal	(\$0.62)	1.45 million	(\$676,000)
Red Seal	(\$0.27)	12,000	(\$2,000)
Husky	\$0.20	100,000	\$15,000
Total			(\$762,000)

If Alaska converted to a weight-based taxation methodology, state revenues would not be dependent on the pricing decisions in the marketplace, including manufacturer discounts or promotions. However, because Alaska taxes MST based on price, rather than on weight, the state will lose an estimated \$762,000 in excise tax revenue per year.

Weight-based taxes protect states from loss of revenue that can follow price reductions or promotional activity in ad valorem states. With an ad valorem tax, the state's revenues depend not only on the volume of sales, but also on pricing decisions of the manufacturers – which leads to less stability in tax revenue collections. Under a weight-based methodology, every 1.2 ounce can pays the same excise tax to the state, regardless of pricing.

A weight-based MST tax methodology creates a stable and predictable stream of MST tax revenue for the state.

¹ USSTC RAD sales database. Cans sold is an estimate based on wholesaler reporting. It covers 2008. The revenue loss was estimated by multiplying the price reduction per can, the volume of cans for the affected brands and the ad valorem tax rate. We assume no changes in volume for 2009 for purposes of this estimate.



Information provided by Altria Client Services Inc. on behalf of Philip Morris USA Inc. and US Smokeless Tobacco Company
For more information, please visit www.philipmorris.com

Alaskans for Tobacco-Free Kids



March 24, 2009

Statement for House Bill 188: Taxation on Moist Snuff Tobacco

Alaskans for Tobacco-Free Kids is a coalition of organizations committed to reducing tobacco's effects on youth. Our coalition membership includes AARP, the American Cancer Society Cancer Action Network, the American Heart Association, and the American Lung Association of Alaska. We support efforts and strategies to reduce tobacco use, especially among our youth.

Smokeless tobacco use causes serious harm, including gum disease, and a substantially increased risk of oral cancer. Even more tragic, use during youth can lead to a lifetime of addiction to smokeless tobacco, or, frequently, to cigarettes, as nicotine addiction created by smokeless use can ultimately lead to habitual smoking.

We applaud efforts to keep tobacco products away from youth and know that tobacco taxes are one of the most effective ways to reduce the number of youth who ever start using tobacco. That said, our coalition has serious concerns with the specific provisions of House Bill 188. Primarily, weight-based taxes have been shown to increase youth use and over time, will hurt state revenues.

Weight-based taxation has been promoted by manufacturers of premium moist snuff products as a strategy to reduce the effective tax on their products, particularly the new generation of ultra low-weight products. At the same time, weight-based taxation systems increase the effective tax on lower-priced brands. This is particularly harmful to Alaskans as the vast majority of youth who use smokeless tobacco use the higher-priced premium brands. By lowering the price on the smokeless tobacco products most popular with youth, shifting to a weight-based tax could increase smokeless tobacco use among youth.

Taxing by weight also provides a massive tax break to the new generation of smokeless tobacco products that can weigh as little as one-tenth as much as the standard smokeless products.

Over time, shifts to a weight-based tax dramatically reduce the portion of state revenues gained from the smokeless tax. Fixing the monetary tax rate in a weight-based system will erode over time as inflation and product prices increase.

Unlike weight-based taxes, our current ad valorem tax rate automatically increases with inflation and other tobacco products price increases which protect the state's tax rate and revenue from eroding over time.

Alaskans for Tobacco-Free Kids supports and advocates the best way to tax smokeless tobacco is with our current ad valorem system. If Alaska wants more revenue from its smokeless tobacco products, we should simply raise our percentage-of-price rate.

Emily Nenon
Alaska Government Relations Director
American Cancer Society Cancer Action Network

Chris Sherwin
Director of Advocacy, Pacific Mountain Affiliate
American Heart Association

Kay Ashton
Director of Tobacco Prevention and Control
American Lung Association of Alaska

Pat Luby
State Director, Advocacy
AARP

Alaskans for Tobacco-Free Kids

American Cancer Society Cancer Action Network, American Heart Association, American Lung Association of Alaska, AARP

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Emily Nenon
Alaska Government Relations Director
American Cancer Society Cancer Action Network

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Director of Advocacy, Pacific Mountain Affiliate
American Heart Association

Carrie Nyssen
Senior Director of Advocacy
American Lung Association of the Northwest

Pat Luby
State Director, Advocacy
AARP

26-LS0714K
Bullock
2/24/10

CS FOR HOUSE BILL NO. 188(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE HERRON

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the taxation of moist snuff tobacco, including spitless moist snuff
 2 tobacco; including different types of moist snuff tobacco in the definition of 'tobacco
 3 product' in provisions levying an excise tax on those products; relating to licensing for
 4 and taxation of tobacco products, including tobacco products imported for personal use
 5 and consumption; relating to the deposit of revenue from the taxation of moist snuff
 6 tobacco into the tobacco use education and cessation fund; defining 'moist snuff
 7 tobacco'; relating to the business license endorsement for the sale of tobacco products;
 8 relating to the offense of selling tobacco to a minor; and providing for an effective date."

9 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

10 * Section 1. AS 11.76.100(a) is amended to read:

11 (a) A person commits the offense of selling or giving tobacco or nicotine to a
 12 minor if the person

1 (1) negligently sells a cigarette, a cigar, tobacco, or a product
2 containing tobacco or nicotine to a person under 19 years of age;

3 (2) is 19 years of age or older and negligently exchanges or gives a
4 cigarette, a cigar, tobacco, or a product containing tobacco or nicotine to a person
5 under 19 years of age;

6 (3) maintains a vending machine that dispenses cigarettes, cigars,
7 tobacco, or products containing tobacco or nicotine; or

8 (4) holds a business license endorsement under AS 43.70.075 and
9 allows a person under 19 years of age to sell a cigarette, a cigar, tobacco, or a product
10 containing tobacco or nicotine.

11 * Sec. 2. AS 37.05.580(a) is amended to read:

12 (a) There is created as a special account in the general fund the tobacco use
13 education and cessation fund into which shall be deposited 20 percent annually of the
14 revenue derived from the settlement of State of Alaska v. Philip Morris, Incorporated,
15 et al, No. 1JU-97-915 CI (Alaska Super. 1997) and 25 percent of the annual
16 revenue collected from the tax on moist snuff tobacco under AS 43.50.300 -
17 43.50.390. The purpose of the tobacco use education and cessation fund is to provide a
18 source to finance the comprehensive smoking education, tobacco use prevention, and
19 tobacco control program authorized by AS 44.29.020(a)(14). In this subsection,
20 "moist snuff tobacco" has the meaning given in AS 43.50.390.

21 * Sec. 3. AS 43.50.070(b) is amended to read:

22 (b) In this section, "licensee" means a person licensed under AS 43.50.010 -
23 43.50.180 or 43.50.300 - 43.50.390, except for a buyer required to be licensed
24 under AS 43.50.320(a)(2).

25 * Sec. 4. AS 43.50.300 is amended to read:

26 **Sec. 43.50.300. Excise tax levied.** (a) An excise tax is levied on tobacco
27 products in the state at the rate in (b) of this section [RATE OF 75 PERCENT OF
28 THE WHOLESALE PRICE OF THE TOBACCO PRODUCTS]. The tax is levied
29 when a person

30 (1) brings, or causes to be brought, a tobacco product into the state
31 from outside the state for sale;

1 (2) makes, manufactures, or fabricates a tobacco product in the state
2 for sale in the state; [OR]

3 (3) ships or transports a tobacco product to a retailer in the state for
4 sale by the retailer or to an individual for personal consumption; or

5 (4) brings or causes to be brought a tobacco product into the state
6 from outside the state for personal consumption.

7 * Sec. 5. AS 43.50.300 is amended by adding a new subsection to read:

8 (b) The excise tax rate on

9 (1) moist snuff tobacco, other than spitless moist snuff tobacco, is
10 \$1.88 multiplied by the number of ounces of moist snuff tobacco, including fractions
11 of an ounce;

12 (2) spitless moist snuff tobacco is 100 percent of the wholesale price;

13 (3) tobacco products other than moist snuff tobacco products subject to
14 the tax rates in (1) and (2) of this subsection is 75 percent of the wholesale price of the
15 tobacco product.

16 * Sec. 6. AS 43.50.300, as amended by sec. 5 of this Act, is amended to read:

17 (b) The excise tax rate on

18 (1) [MOIST SNUFF TOBACCO, OTHER THAN SPITLESS MOIST
19 SNUFF TOBACCO, IS \$1.88 MULTIPLIED BY THE NUMBER OF OUNCES OF
20 MOIST SNUFF TOBACCO, INCLUDING FRACTIONS OF AN OUNCE;

21 (2)] spitless moist snuff tobacco is 100 percent of the wholesale price;

22 (2) [(3)] tobacco products other than spitless moist snuff tobacco
23 products subject to the tax rate [RATES] in (1) [AND (2)] of this subsection is 75
24 percent of the wholesale price of the tobacco product.

25 * Sec. 7. AS 43.50 is amended by adding a new section to read:

26 **Sec. 43.50.305. Packaging of certain tobacco products for sale.** (a) Cigars,
27 except for cigars that are hand-rolled and wrapped in whole tobacco leaf, shall be sold
28 in packages containing at least five cigars.

29 (b) Smokeless tobacco

30 (1) sold as loose tobacco shall be sold in packages containing at least
31 one ounce;

1 (2) in single-dose units shall be sold only in packages of not less than
2 10 units and in original unaltered manufacturer's packaging.

3 * **Sec. 8.** AS 43.50.320(a) is repealed and reenacted to read:

4 (a) Except as provided in (g) of this section, a person engaged in an activity
5 described in

6 (1) AS 43.50.300(a)(1) or (3) must be licensed by the department as a
7 distributor;

8 (2) AS 43.50.300(a)(4) must be licensed as a buyer.

9 * **Sec. 9.** AS 43.50.320(b) is amended to read:

10 (b) The department, upon application and payment of a fee of

11 (1) \$50, shall issue a license for one year to a person who applies for a
12 license **as a distributor** under (a)(1) of this section;

13 (2) \$25, shall issue a license for one year to a person who applies
14 for a license as a buyer under (a)(2) of this section.

15 * **Sec. 10.** AS 43.50.320(d) is amended to read:

16 (d) A license issued under (b)(1) of this section must include the name and
17 address of the licensee, the type of business to be conducted, and the year for which
18 the license is issued.

19 * **Sec. 11.** AS 43.50.320(e) is amended to read:

20 (e) The department may renew a license issued under

21 (1) (b)(1) of this section for a fee of \$50;

22 (2) (b)(2) of this section for a fee of \$25.

23 * **Sec. 12.** AS 43.50.330(a) is amended to read:

24 (a) On or before the last day of each calendar month, a licensee shall file a
25 return with the department. The return must state the number or amount of tobacco
26 products sold by the licensee during the preceding calendar month, the wholesale
27 price or purchase [SELLING] price of the tobacco products, and the amount of tax
28 imposed on

29 (1) [THE] tobacco products **other than moist snuff tobacco;**

30 (2) **moist snuff tobacco other than spitless moist snuff tobacco; and**

31 (3) **spitless moist snuff tobacco.**

1 * **Sec. 13.** AS 43.50.350 is repealed and reenacted to read:

2 **Sec. 43.50.350. Disposition of proceeds.** (a) The tax collected by the
3 department, other than the tax collected on moist snuff tobacco, shall be deposited in
4 the general fund.

5 (b) Of the tax collected by the department on moist snuff tobacco,

6 (1) 25 percent shall be deposited in the tobacco use education and
7 cessation fund established in AS 37.05.580; and

8 (2) 75 percent shall be deposited in the general fund.

9 (c) The annual estimated balance in the account maintained by the
10 commissioner of administration under AS 37.05.142 may be used by the legislature to
11 make appropriations for health care, health research, health promotion, and health
12 education programs.

13 * **Sec. 14.** AS 43.50.390(1) is amended to read:

14 (1) "distributor" means a person who

15 (A) brings, or causes to be brought, a tobacco product into the
16 state from outside the state for sale;

17 (B) makes, manufactures, or fabricates a tobacco product in the
18 state for sale in the state; or

19 (C) ships or transports a tobacco product to a retailer in the
20 state for sale by the retailer or to an individual for personal consumption;

21 * **Sec. 15.** AS 43.50.390(2) is amended to read:

22 (2) "licensee" means a distributor or buyer who is

23 (A) licensed under AS 43.50.320; or

24 (B) exempted by AS 43.50.320(g) from licensing under
25 AS 43.50.320;

26 * **Sec. 16.** AS 43.50.390(4) is amended to read:

27 (4) "tobacco product" means

28 (A) a cigar, including any roll of tobacco wrapped in leaf
29 tobacco;

30 (B) a cheroot;

31 (C) a stogie;

- 1 (D) a perique;
- 2 (E) snuff tobacco, including moist snuff tobacco, and snuff
- 3 flour;
- 4 (F) smoking tobacco, including granulated, plug-cut, crimp-cut,
- 5 ready-rubbed, and any form of tobacco suitable for smoking in a pipe or
- 6 cigarette;
- 7 (G) chewing tobacco, including cavendish, twist, plug, scrap,
- 8 and tobacco suitable for chewing; [OR]
- 9 (H) an article or product made of tobacco or a tobacco
- 10 substitute, but not including a cigarette as defined in AS 43.50.170; or
- 11 (I) any other product containing tobacco or nicotine that is
- 12 intended or expected to be consumed without being combusted unless it
- 13 has been approved by the United States Food and Drug Administration
- 14 for sale as a tobacco use cessation or harm reduction product or for other
- 15 medical purposes and is being marketed and sold solely for the approved
- 16 purposes;

17 * Sec. 17. AS 43.50.390 is amended by adding new paragraphs to read:

18 (6) "buyer" means a person who imports tobacco products for the

19 person's own consumption from any source other than licensee;

20 (7) "moist snuff tobacco" includes spitless moist snuff tobacco and

21 means any finely cut, ground, or powdered tobacco that is not intended to be

22 (A) smoked; or

23 (B) placed in the nasal cavity;

24 (8) "smokeless tobacco" means a tobacco product defined in (4)(E),

25 (G), (H), (I), and (9) of this section;

26 (9) "spitless moist snuff tobacco" means moist snuff tobacco that is

27 typically steam-pasteurized smokeless tobacco in a tea-bag-like pouch designed to be

28 placed between the cheek and gum and is manufactured to obviate the need for

29 spitting.

30 * Sec. 18. AS 43.70.110 is amended by adding a new paragraph to read:

31 (5) "cigarette" has the meaning given in AS 43.50.170.

1 * **Sec. 19.** AS 11.76.100(e) is repealed.

2 * **Sec. 20.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 **APPLICABILITY.** (a) Sections 2 - 5 and 7 - 18 of this Act are applicable starting on
5 the first day of the month immediately following the effective date of this section.

6 (b) Section 6 of this Act is applicable starting on the first day of the month
7 immediately following the effective date of sec. 6.

8 * **Sec. 21.** Section 6 of this Act takes effect three years after the effective date of sec. 5 of
9 this Act.

10 * **Sec. 22.** Except as provided in sec. 21 of this Act, this Act takes effect immediately under
11 AS 01.10.070(c).

Rep. Keller
3/23/2010
HB 188

March 22, 2010

Re: HB 188 - Taxation on Moist Snuff

To Whom It May Concern:

I am working with a group people to educate the public about strategies used by tobacco companies to lure young people to use their products and the dangers of tobacco use. Many of the teens admit they have used smokeless tobacco. One of the reasons they gave for not using more was because it costs too much. HB 188 could potentially prevent snuff from being purchased by young people.

Research shows that snuff is often a "gateway" product that leads to smoking cigarettes. It also shows a correlation between snuff and an increased likelihood of also using alcohol or other drugs according to *Other Substance Use Among High School Students Who Use Tobacco*, Journal of Adolescent Health, November 1998.

Needless to say, HB 188 has my full support!

REGINA ANGRAK



Student
Bethel Alternative Boarding School

March 22, 2010

To Whom It May Concern:

I am a 16-year-old student and know many people who use tobacco. Many of these people are my peers. I, too, have used it in the past and it continues to be a struggle to leave behind. For many young people, the biggest obstacle to using tobacco is finding someone to buy it for you. The second biggest obstacle is paying for it. Most kids have very limited incomes because they don't work yet. If the cost for tobacco were increased, it would definitely make it harder for young people to buy it. I support any efforts to keep tobacco out of peoples' hands.

STACI M. ALOROLREA

Student
Bethel Alternative Boarding School

Staci M Alorolrea

March 22, 2010

Dear Representative Herron,

I appreciate that you are sponsoring a bill to increase taxes on chewing tobacco. While researching the effects of various types of tobacco for a community service project, I found that having 8 – 10 chews per day is equal to smoking 30 – 40 cigarettes per day. Anything that can be done to keep people from chewing must be done! If chew costs more, kids are less likely to be able to afford it, or at least not be able to buy as much because they don't have that much money.

THOMAS KILANAK

A handwritten signature in cursive script that reads "Thomas Kilanak".

Student
Bethel Alternative Boarding School

March 22, 2010

To Whom It May Concern:

According to an article published in *Nicotine & Tobacco Research*, August 2003, "... evidence shows that adolescent boys who use smokeless tobacco products have a higher risk of becoming cigarette smokers within four years." A report released by the US Department of Health & Human Services, *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*, 1994, found that, "Among all high school seniors who have ever used spit tobacco," in their study, "almost three-fourths began by the ninth grade."

Higher taxes on smokeless tobacco products would make it more difficult for adolescents to buy these products, thus decreasing the numbers who eventually start smoking cigarettes. I urge you to put measures in place to increase the cost of tobacco.

KEANE GUEST

Student
Bethel Alternative Boarding School



From: Kerri Fox [mailto:Kerri_Fox@lksd.org]
Sent: Monday, March 22, 2010 9:38 PM
To: Rep. Bob Herron
Cc: Liz Clement
Subject: Re: House Bill 188 "Tax on Moist Snuff"

Rep. Herron,

Attached are the letters of support from BABS students you requested. We are excited to be involved! Thank you for your support with Kick Butts Day, too. We plan to have a place at our carnival where others can write letters to support for HB 188. They won't be available for Tuesday, but you might need them in the future. Thanks for all you do for our youth!

Kind Regards,
Kerri Fox
Site Coordinator
Communities In Schools of Bethel
Youth Court/EUDL Program
Bethel MCA Community Diversion Panel
Phone: (907) 543-0622
Fax: (907) 543-5603 ATTN: Kerri
CISBethel@alaska.net
Kerri_Fox@lksd.org

Communities In Schools ... the nation's leading community-based organization helping kids stay in school and prepare for life.

Find out more: www.cisnet.org
In Alaska: www.cisalaska.org

HB

190

26-LS0502\c
Mischel
4/10/09

CS FOR HOUSE BILL NO. 190()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES FAIRCLOUGH, Hawker, Holmes, V. 2008

A BILL
FOR AN ACT ENTITLED

1 **"An Act amending the Alaska children's trust."**

2 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 *** Section 1.** AS 37.14.200 is amended by adding a new subsection to read:

4 (d) The legislature may appropriate annually an amount that is equivalent to
5 five percent of the market value of the unencumbered balance of the trust income and
6 principal, taking into account administrative expenses, as a grant to a named recipient
7 under AS 37.05.316 subject to terms and conditions set by the board under
8 AS 37.14.250.

9 *** Sec. 2.** AS 37.14.225 is amended to read:

10 **Sec. 37.14.225. Trust board established.** The Alaska Children's Trust Board
11 is established in the Office of the Governor. The board is composed of

- 12 (1) the governor or a designee of the governor;
- 13 (2) the commissioner of health and social services or the
14 commissioner's designee;
- 15 (3) the commissioner of education and early development or the

1 commissioner's designee; [AND]

2 (4) four public members appointed by the governor [; IN
3 APPOINTING THE PUBLIC MEMBERS, THE GOVERNOR SHALL GIVE A
4 PREFERENCE TO PERSONS] who have experience and expertise in

5 (A) children's or prevention programs; [OR]

6 (B) private sector finance;

7 (C) sexual assault; or

8 (D) domestic violence.

9 * Sec. 3. AS 37.14.230 is amended to read:

10 **Sec. 37.14.230. Powers and duties of the board.** The [WHEN ACTING AS
11 ADMINISTRATOR OF THE TRUST, THE] board shall

12 (1) hold regular and special meetings it considers necessary; the board
13 may hold meetings by teleconference;

14 (2) award a grant to a named recipient in an amount that is
15 appropriated under AS 37.14.200(d) under conditions [GRANTS FROM THE
16 NET INCOME OF THE TRUST TO COMMUNITY-BASED PROGRAMS AND
17 PROJECTS] that the board finds will aid in the prevention of child abuse and neglect;

18 (3) monitor approved subgrants made by the named recipient
19 [PROGRAMS AND PROJECTS] for compliance with AS 37.14.200 - 37.14.270 and
20 specified grant conditions;

21 (4) [BEFORE PROVIDING ASSISTANCE TO A PROGRAM OR
22 PROJECT,] approve written findings of the named recipient on the subgrant
23 program or project that include a consideration of the means of measuring the
24 effectiveness of the program or project;

25 (5) apply for, and use net income from the trust to obtain, private and
26 federal grants for the prevention of child abuse and neglect;

27 (6) solicit contributions, gifts, and bequests to the trust;

28 (7) keep audio tape recordings of each meeting of the board to be made
29 available on request; and

30 (8) submit to the governor and make available to the legislature by
31 February 1 each year a report describing

1 (A) the child abuse and neglect prevention services that were
2 provided by the programs and projects to which the named recipient
3 [BOARD] awarded grants; and

4 (B) the annual level of contributions, income, and expenses of
5 the trust.

6 * Sec. 4. AS 37.14.240 is repealed and reenacted to read:

7 **Sec. 37.14.240. Fund utilization.** (a) Five percent of the market value of the
8 unencumbered balance of the trust income and principal may be appropriated for
9 awarding a named recipient grant by the board under AS 37.14.250.

10 (b) Up to \$150,000 a year may be appropriated from the unencumbered
11 balance of the trust income and principal for the administrative expenses of the board
12 relating to AS 37.14.200 - 37.14.270, including obtaining private and federal grants
13 for the trust and soliciting contributions, gifts, and bequests for the trust.

14 * Sec. 5. AS 37.14.250 is repealed and reenacted to read:

15 **Sec. 37.14.250. Named recipient grant.** (a) A named recipient grant may only
16 be awarded to a nonprofit entity that is established for the purpose of enhancing the
17 mission of the Alaska Children's Trust and raising funds for the prevention of child
18 abuse and neglect.

19 (b) Before a grant to a named recipient is awarded or renewed by the board,
20 the Department of Commerce, Community, and Economic Development shall prepare
21 and execute an agreement under AS 37.05.316(a) with the named recipient that
22 describes grant conditions that include the following:

23 (1) a portion of the Alaska children's trust grant may be held in and
24 managed as a permanent endowment fund;

25 (2) the grantee may maintain a reserve to finance grants and grant
26 administration operations at a consistent level from year to year;

27 (3) the grantee may provide for the distribution of amounts from the
28 interest on an endowment fund established under (1) of this subsection for the
29 charitable purpose of preventing child abuse and neglect; and

30 (4) the grantee shall annually report the investment performance of an
31 endowment established under (1) of this subsection to the board.

AMENDMENT

OFFERED IN THE HOUSE

TO: CSHB 190(), Draft Version "C"

1 Page 2, line 8:

2 Delete "."

3 Insert "**; and**"

4

5 Page 2, following line 8:

6 Insert new paragraphs to read:

7 "**(5) one nonvoting member appointed by the speaker of the house**
8 **of representatives;**

9 **(6) one nonvoting member appointed by the president of the**
10 **senate.**"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE FAIRCLOUGH

TO: CSHB 190(), Draft Version "C"

1 Page 1, line 5:

2 Delete "market value of the unencumbered balance"

3 Insert "average of the market values"

4

5 Page 1, line 6, following "principal":

6 Insert "on June 30 for the first five of the six fiscal years immediately preceding that

7 fiscal year"



Alaska State Legislature

Representative Anna Fairclough – House District 17

House Bill 190

"An Act privatizing the Alaska children's trust as a separate endowment fund; providing for an administrator for the assets of the former trust; establishing conditions for a grant of the balance of the former Alaska children's trust; designating certain receipts as available for grants to the trust's successor; and providing for an effective date."

House Bill 190 would re-create the Alaska Children's Trust (ACT) as a 501(c)(3) non-profit entity, managed by a board of directors, including the Commissioners of the Departments of Health and Social Services and Education and Early Development, four (4) additional members appointed by the Governor, and three (3) members appointed by the Commissioners and the Governor's appointees. The nine (9) member board would have many of the same duties and obligations required by current statute.

It would preserve the present revenue sources of license plates and birth and marriage certificates for a grant to a named recipient to hold in trust for child abuse and neglect prevention activities and programs.

HB 190 would transfer the balance of the Alaska Children's Trust to a named recipient organized for charitable purposes to hold in trust as a permanent endowment fund for child abuse and neglect prevention programs. The ACT board has entered into an agreement with the Alaska Community Foundation to serve as this trustee, while the ACT board (re-created as a non-profit entity) would direct the Foundation on grant-making.

In summary, HB 190 would allow the legislature to use the estimated balance of the account maintained by the Commissioner of Revenue to make a named recipient grant to the Alaska Community Foundation to be governed by the non-profit ACT board, the majority of whom will be appointed by the Governor. With the Alaska Community Foundation as trustee, the ACT board will have greater flexibility to create a more stable, streamlined and simplified administrative structure that would greatly enhance the Trust's ability to pursue its mission efficiently and effectively.

The Trustees of the Alaska Children's Trust, with the support of the Friends of the Alaska Children's Trust, have recommended to the Governor and the Alaska Legislature that the Alaska Children's Trust be privatized.

I urge your support on this piece of legislation.

Session: Alaska State Capitol • Juneau, AK 99801 • 907-465-3777 • Fax 907-465-2819

Interim: 10928 Eagle River Road, Suite 238 • Eagle River, AK 99577 • 907-694-8944 • Fax 907-694-8945

Representative_Anna_Fairclough@legis.state.ak.us



Alaska State Legislature

Representative Anna Fairclough – House District 17

House Bill 190

"An Act privatizing the Alaska children's trust as a separate endowment fund; providing for an administrator for the assets of the former trust; establishing conditions for a grant of the balance of the former Alaska children's trust; designating certain receipts as available for grants to the trust's successor; and providing for an effective date."

Sectional Analysis

Section 1. Amends AS 18.50.225(d)

Allows the legislature to annually appropriate funds generated from birth certificates suitable for display to the endowment fund held by the charitable named recipient grantee.

Section 2. Amends AS 18.50.272(e)

Allows the legislature to annually appropriate funds generated from heirloom marriage certificates suitable for display to the endowment fund held by the charitable named recipient grantee.

Section 3. Amends AS 28.10.181(t)

Renames the Alaska Children's Trust license plates to call them Alaska children's endowment fund plates.

Section 4. Amends AS 28.10.421(d)(14)

Allows legislature to appropriate the fee for the children's fund special license plates to the endowment fund held by the charitable named recipient grantee.

Section 5. Amends AS 37.05.146(c)(20)

Allows the birth certificates suitable for display, the heirloom marriage certificates and special request children's fund license plates to be accounted for separately, and appropriations from these program receipts are not made from the unrestricted general fund.

Section 6. Amends AS 37.14 by adding a new section 37.14.205

Allows the legislature to transfer the balance of the Alaska Children's Trust to a charitable named recipient grantee to be held as a permanent endowment fund for child abuse and neglect prevention activities and programs.

The transfer of assets is subject to the terms of an agreement between the Department of Commerce, Community and Economic Development and the named recipient grantee.

The grantee shall provide the interest on the endowment fund to the corporate grant administrator for the purpose of prevention of child abuse and neglect.

Should the grantee ceases to exist or become unable to fulfill the purposes of the grant agreement, the balance of the grant is to revert to the state to be used for child abuse and neglect prevention programs.

Section 7. Amends AS 37.14 by adding a new section 37.14.215

Creates a corporate grant administrator independent from the named grant recipient.

The grant administrator solicits and evaluates grant proposals from organizations working to prevent child abuse and neglect, and awards grants from the interest on the endowment fund obtained from the named recipient grantee.

The board of the grant administrator is made up of nine members, six of which are appointed by the governor.

The grant administrator is also responsible for soliciting contributions, gifts and bequests to the endowment fund.

Section 8. Clean up language

Repeals current Alaska Children's Trust statutes.

Section 9. Amends the Uncodified law of the State of Alaska

Explains that this Act is contingent on the appropriation of the Alaska Children's Trust funds to a named recipient grantee.

Section 10. Effective date clause

Explains that the effective date of the act is the date of appropriation of the funds to the named recipient grantee.

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 190

Page 2, Line 8, 10 & 15

Delete "**children endowment fund**"

Insert "**ALASKA'S CHILDREN TRUST**"

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

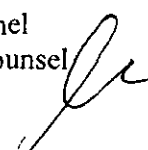
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 30, 2009

SUBJECT: Alaska Children's Trust Reference After Repeal of the Trust
(Amendment E.1 to HB 190 (Work Order No. 26-LS0502\E.1))

TO: Representative Anna Fairclough
Attn: Crystal Koeneman

FROM: Jean M. Mischel
Legislative Counsel 

I have made the changes you requested that retain the references to the Alaska Children's Trust in the provisions for special request license plates and fees. As previously discussed, referencing a repealed trust, particularly for purposes of fee collection, creates an unenforceable provision in codified law. While the nonprofit grantee may intend to use the former trust's name, such references must exist and be defined in codified law. In the meantime, if the amendment and the bill pass, the fees will be paid and collected under a false impression that the trust continues to exist as a state fund.

JMM:lmb
09-016.lmb

Enclosure

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 190

1 Page 2, line 8:

2 Delete "[ALASKA] children's endowment fund [TRUST]"

3 Insert "Alaska children's trust"

4

5 Page 2, lines 10 - 11:

6 Delete "[ALASKA] children's endowment fund [TRUST]"

7 Insert "Alaska children's trust ["

8

9 Page 2, line 15:

10 Delete "[ALASKA] children's endowment fund [TRUST]"

11 Insert "Alaska children's trust"

12

13 Page 2, line 30:

14 Delete "endowment fund"

15 Insert "trust"

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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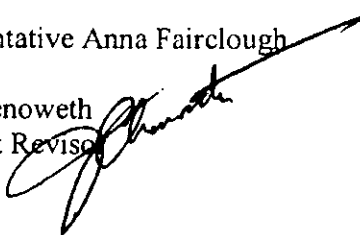
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 9, 2009

SUBJECT: Draft bill for an Act to substitute private management of the Alaska Children's Trust for the state's governmentally-administered endowment trust fund (Work Order No. 26-LS0502\A)

TO: Representative Anna Fairclough

FROM: Jack Chenoweth
Assistant Revisor 

This memo accompanies the draft of a bill proposing to substitute private management of the Alaska Children's Trust for the state's governmentally-administered endowment trust fund. The draft draws upon text that your office submitted with the work order request.¹

DRAFTING CONSIDERATIONS:

The text of the material submitted did not suggest a bill title, so we prepared one based on the apparent content of the proposal.

In the accompanying draft, the material in bill sections 1 - 5 draws on substantially similar amendments set out in the material submitted with the work order. These are conforming changes made so as to alter references to the current trust where they appear in certain of sources authorized for appropriation into the fund: AS 18.50.255(d) [certain birth certificate receipts], AS 18.50.272(e) [certain heirloom certificates of marriage], and AS 28.10.181 [special request license plates].² Bill section 8 repeals the various sections

¹ Under AS 37.14.200 - 37.14.270, proposed to be repealed in the bill, the Alaska Children's Trust Fund was established as a separate endowment trust of the state, consisting of legislative appropriations and private contributions. In addition, proceeds from specialized birth and marriage certificates, as well as license plate sales, are deposited into the general fund for the purpose of contributing to the trust fund or for any other public purpose.

² Each of these provisions adds reference to "a grant to a named recipient under AS 37.05.316." That section, functionally the state appropriation process's equivalent of a federal "carmark" -- the term was defined by recent federal legislation as "a provision or report language included primarily at the request of a Member [of Congress] . . . providing, authorizing, or recommending a specific amount of discretionary budget

that comprise the current Alaska Children's Trust, AS 37.14.200 - 37.14.270 inclusive. Again, the repeal provisions follow direction provided in the suggested text.

The critical substantive provisions of the bill appear in proposed AS 37.14.205, added by bill section 6, and AS 37.14.215, added by bill section 7. I have drawn from the language that was supplied, reversing the suggested subject matter order (reference to the corporate grant administrator in the draft follows the provisions for the trust management mechanism, rather than preceding it).

authority, credit authority, or other spending authority for a contract, loan, loan guarantee, grant, loan authority, or other expenditure with or to an entity, or targeted to a specific State, locality or Congressional district, other than through a statutory or administrative formula-driven or competitive award process." -- authorizes the legislature to identify by operation of law grantees that are not public entities:

(a) When an amount is appropriated or allocated to a department as a grant under this section for a named recipient that is not a municipality, the department to which the appropriation or allocation is made shall promptly notify the named recipient of the availability of the grant and request the named recipient to submit a proposal to provide the goods or services specified in the appropriation act for which the appropriation or allocation is made. A grant agreement must be executed within 60 days after the effective date of the appropriation or allocation unless the department determines that an award of the grant would not be in the public interest.

Significantly, while AS 37.05.316 establishes a mechanism by which the legislature may identify the recipient of what the section surely contemplates to be a single or one-time-only grant, in the draft accompanying this memo, amendments proposed to AS 18.50.225(d) [certain birth certificate receipts], to AS 18.50.272(e) [certain heirloom certificates of marriage], and to AS 28.10.421(d)(14) [special request license plates] operate so that these sources continue to be available to support annual grants to the named recipient. In other words, these may be considered permanent sources for the support of the revised trust fund subject to the likelihood of annual legislative appropriation.

Reliance on the artifice that the transfer will be handled as a grant is open to challenge. The legislation's proponents may regard the transfer as a grant -- because the transfers would occur annually, they are probably better viewed in context as an unlimited or open ended series of grants -- but, in fact, the form of the product that is transferred is a trust corpus or permanent endowment. No court would mistake the legislature's attempts to disguise the transfer of a trust corpus by calling it something that it is not in order to take advantage of the "grant to a named beneficiary" statute, AS 37.05.316.

These two sections identify two different entities.

The first, taken from AS 37.14.229 in the material provided and proposed to be codified in AS 37.14.205 in the accompanying draft, identifies a prospective trust manager, referred to in the material transmitted with the work order as the "charitable trustee" [page 4, line 7]. In the language of the material supplied, the "charitable trustee" has the status of a grantee, responsible for management of the transferred trust assets, transferred in the form of a grant. Subsection (b) of this section sets important sidebars on use of the grant of the transferred trust assets through use of an agreement,³ while subsection (c) -- as I have opted to redraft it -- directs a reversion to the state of "the balance of the grant" in the event the charitable trustee breaches the agreement. I have more to say about this entity and its operations below.

The other -- derived from AS 37.14.227 in the material provided and reworked as AS 37.14.215 in the accompanying draft -- is identified as the corporate grant administrator, comprising a board composed of state commissioners serving ex officio, other appointees of the governor, and persons collectively appointed by these other board members. As to the corporate grant administrator set out in AS 37.14.215, there are some omissions that deserve your attention before a new draft is prepared for introduction:

-- the terms of the seven board members serving other than ex officio are not specified or set;

³ Notably, the sidebar or standards provisions proposed do not carry forward specific direction concerning the manner of trust administration. As a public trust, AS 37.14.210(4) directs the commissioner of revenue to "invest and reinvest the assets of the trust as provided in this section and as provided for the investment of funds under AS 37.14.170." Under the latter provision, that public official is charged to "invest the money in the fund on the basis of probable total rate of return to promote the long-term generation of income," and, as well, that

In managing the trust fund, the commissioner shall

- (1) consider the status of the fund's capital and the income generated on both a current and a probable future basis;
- (2) determine the appropriate investment objectives;
- (3) establish investment policies to achieve the objectives;

and

- (4) act only in regard to the financial interests of the fund's beneficiaries.

By contrast, the draft bill omits specific standards and does not propose any alternative standards; it directs that the private manager -- the charitable trustee -- shall hold the transferred former trust assets in and manage them "as a permanent endowment trust fund." See proposed AS 37.14.205(b)(2).

-- there is no provision for organization, for convening and holding meetings (chair; support services), or for coverage or reimbursement for travel or per diem;

-- since this appears to be or to function as, at least in my judgment, an executive branch board or commission, the selection of the three members not serving ex officio or at the behest or pleasure of the governor is constitutionally questionable as a violation of the governor's appointing authority spelled out in article III of the state constitution.

POTENTIALLY SIGNIFICANT CONSTITUTIONAL CONSIDERATIONS:

This draft constitutes a reworking of an idea from the 25th Legislature, introduced as SB 206, "An Act repealing the Alaska children's trust; and providing for an effective date." In that bill, as in this draft, the legislation proposed to transfer management of the trust assets of the former Alaska Children's Trust to a specific named recipient. Section 3 of SB 206 provided:

CONTINGENT EFFECT. This Act is contingent on passage by the Second Regular Session of the Twenty-Fifth Alaska State Legislature and enactment into law of a bill appropriating an amount equal to the unencumbered balance of the funds described in sec. 2 of this Act as a grant to The Alaska Community Foundation, a nonprofit organization, for community activities and programs.

In short, the proposal offered during the 25th Legislature would have eliminated the Alaska Children's Trust as a public trust and provided for transfer of its money assets to a specified nonprofit organization. It was not at all clear whether the designated recipient would have been required to maintain and manage the transferred money assets in accordance with trust principles.

At the time, we were concerned that the legislature's ability to "privatize" management of a "former" public fund might encounter significant obstacles under state constitutional provisions applicable to the prohibition against dedicated funds⁴; the requirement of spending the money only for a public purpose⁵; and the risk of an equal protection

⁴ The prohibition appears in article IX, sec. 7:

Dedicated Funds. The proceeds of any state tax or license shall not be dedicated to any special purpose, except as provided in section 15 of this article or when required by the federal government for state participation in federal programs. This provision shall not prohibit the continuance of any dedication for special purposes existing upon the date of ratification of this section by the people of Alaska.

⁵ The so-called public purpose clause is set out in article IX, sec. 6:

violation by directing public funds to a private entity or pursuit.⁶ Moreover, the corpus of the Alaska children's trust, then, as now, included both money derived from public revenue sources and private contributions.⁷ Given that mix, in the event of a challenge brought to the proposal, it was not clear to us how a court would view the transfer of the responsibility for the trust's management from public oversight to a private entity.

We have considered those concerns as they might arise in the context of the accompanying draft.

Does the transfer of responsibility for trust management implicate a dedicated funds violation? While the possibility that the Alaska children's trust fund as originally constituted might be found invalid as a dedicated fund,⁸ the transfer of trust management responsibility into private hands probably does not significantly change that likelihood.

Public Purpose. No tax shall be levied, or appropriation of public money made, or public property transferred, nor shall the public credit be used, except for a public purpose.

⁶ State equal protection considerations derive from a clause of article I, sec. 1:

Inherent Rights. This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; *that all persons are equal and entitled to equal rights, opportunities, and protection under the law;* and that all persons have corresponding obligations to the people and to the State.

⁷ See AS 37.14.200(b):

(b) The principal of the [Alaska children's] trust consists of
(1) legislative appropriations to the trust; and
(2) *gifts, bequests, and contributions of cash or other assets from a person.*

⁸ See, Inf. Op. Atty. Gen'l (April 12, 1988):

... [T]he section on "fund utilization" ... provides that capital gains from investment of the fund become part of the principal. That provision raises a question of validity under art. IX, sec. 7, of the Alaska Constitution, which prohibits dedicated funds. As mentioned in 1982 A. G. Opinion No. 13 (J66-785-81 and J66-649-80; Nov. 30), at page 17, we will defend such a provision in court, but the issue is not free from doubt. Related to this issue is proposed AS 37.14.240(b)'s attempt to limit[] appropriations of fund income to certain purposes. An attempt to so limit a future legislature is invalid.

Does the transfer to private management implicate the public purpose clause? Again, probably not. Article IX, sec. 6 of the state constitution allows the legislature to appropriate funds for any public purpose. The Alaska Supreme Court has held that "where the legislature has found that a public purpose will be served by the expenditure or transfer of public funds or the use of the public credit, this court will not set aside the finding of the legislature unless it clearly appears that such finding is arbitrary and without any reasonable basis in fact." *DeArmond v. Alaska State Development Corp.*, 376 P.2d 717, 721 (Alaska 1962) citing *In re Opinion of the Justices*, 177 A.2d 205 (Del. 1962). The test of whether a public purpose is being served does not depend on the entity that will operate the use, but upon the character of the use to which the property will be put.⁹ The attorney general's office appears to be of the view that the public purpose clause permits use of public money "to pay state debts, support current services, or protect state assets," further subject to the caution that

... expenditure of [an] appropriation generally ... has to be done in accordance with an underlying statutory authority for [an agency] to provide the services which the [grantee or contractor] will provide or to otherwise assist the [grantee or contractor] for a public benefit. A mere authorization to provide for the public welfare will not suffice.

Inf. Op. Att'y Gen'l., September 22, 1980. If private management of the trust assets will assist the state in providing a public benefit, then the assignment of management responsibility to a private entity subject to appropriate standards and sidebars should survive a public purpose-based challenge.¹⁰

⁹ See *Weber v. Kenai Peninsula Borough*, 990 P.2d 611, 614 (Alaska 1999), citing *Milheim v. Moffat Tunnel Improvement District*, 67 L.Ed. 1994 (1923), and *Lien v. City of Ketchikan*, 383 P.2d 721 (Alaska 1963).

¹⁰ Looking to other jurisdictions, the courts of South Carolina have developed a fairly comprehensive jurisprudence on whether contractual arrangements that yield a perceived private benefit are constitutionally suspect, and have concluded that, in general, they are not. Summarized, the courts have reached the conclusion:

[T]he public character of an agency's purpose is not diminished or altered by the nature of the transaction used to accomplish it. Were that the case, no leasing transaction could ever be used to accomplish a legitimate public goal. Private benefit to the lessee is always present. Where the purpose is clearly public in nature, we have consistently held this "incidental" private benefit does not convert the public purpose to a private purpose.

South Carolina Public Service Authority v. Summers, 282 S.C. 148, 152-153 (S.C. 1984). I think this is a fair statement of the view held by the courts of this state on this issue.

Would the management transfer of the trust corpus raise a question under the equal protection principle? Legislative designation of a named recipient grantee under AS 37.05.316, while surely providing the designee an unfair advantage to the exclusion of any other private party that might have wished to have bid for the management agreement, is an arrangement presumably to be entered into for reasons of administrative efficiency. In and of itself, the designation does not implicate any suspect classification, nor does it present any obstacle to interstate migration, deny to anyone the necessities of life, penalize a person for having migrated to Alaska, or interfere with any other fundamental right that would require examination of the proposal under the standards of strict scrutiny. The compelling state interest test does not apply; the courts should apply a more deferential test, one that would consider whether the legislation bears a 'fair and substantial relationship' to legitimate purposes." *State v. Lewis*, 559 P.2d 630, 642 (Alaska 1977). The equal protection clause should not impose an obstacle.

Does the bill impermissibly violate the principle against nondelegation of a power exercisable by one branch of the government to another? In identifying a "named recipient under AS 37.05.316," the legislature may be substituting its authority for that of executive branch officials, who traditionally have had responsibility for selection of successful vendors and oversight of contract management in programs that significantly affect the public.

Let me explain.

The doctrine of nondelegation is at least implicit in constitutions that provide for or impose a separation of powers.¹¹ Delegation questions most often arise when legislative or law-making powers are assigned to executive branch agencies or officials. However, the doctrine operates universally and may apply as well to questions of improper delegations of legislative powers to judicial officials, improper delegations of judicial powers to legislative or executive officials, improper delegations of executive powers to legislative or judicial officials, improper delegations of legislative or judicial powers to subordinates within their branches, improper delegations of legislative, judicial, or executive powers to private parties, or improper delegations of private powers to public officials.

In this instance, the question appears to me to be one involving the delegation of an executive function to the legislature. To be sure, AS 37.05.316 is part of the statutory process applicable to appropriations, part of the state's Fiscal Procedures Act, AS 37.05.

¹¹ The Alaska Supreme Court has determined that the doctrine of the separation of powers is implicit in the Alaska constitution. *Public Defender Agency v. Superior Court, Third Judicial Dist.*, 534 P.2d 947 (Alaska 1975); *Bradner v. Hammond*, 553 P.2d 1, 5 (Alaska 1976).

There can be no doubt that the making of appropriations, including the designation of a party or entity to receive and expend the appropriation, is properly a matter for the legislature. But, except as to appropriations specifically made to the legislative and judicial branches, the executive, subject to applicable law, determines the specifics of how the direction given by the legislature is to be executed or implemented -- in other words, how the amount that is made in the appropriation is to be expended.

The management and investment of surplus state revenue is fundamentally a responsibility of the executive branch of government, assigned by law to the appropriate commissioner, board, or commission to make relevant decisions. Often, the party charged with responsibility for management and investment will enter into contracts with third parties to discharge those responsibilities. In this draft, the legislature anticipates substituting its judgment by identifying, in law, through the mechanism of the "grant to a named recipient under AS 37.05.316," the third party who would make those investment decisions. The legislature may, as part of its law-making function, conclude that certain services that are routinely the responsibility of the executive branch should be privatized and may also determine how the management of money appropriated for a purpose that is clearly an executive function ("child abuse and neglect treatment and prevention activities and programs," clearly an executive obligation under article VII, secs. 4 and 5, directing that the state "provide for the promotion and protection of public health" and "provide for public welfare") is to be managed -- for example, internally by a state agency or externally by contract with a private management service. While the legislature may generally prescribe the manner of money or fund management, the legislature may not at the same time also identify the entity that is to do that without at least raising the argument that it has intruded on a power reserved to the executive branch.¹²

¹² In addition, because the draft relies on AS 37.05.316, giving direction for an appropriation, an appropriation made subject to that section is subject to the confinement clause, the second sentence of art. II, sec. 13 of the Alaska Constitution (emphasis added):

Form of Bills. Every bill shall be confined to one subject unless it is an appropriation bill or one codifying, revising, or rearranging existing laws. *Bills for appropriations shall be confined to appropriations.* The subject of each bill shall be expressed in the title. The enacting clause shall be: "Be it enacted by the Legislature of the State of Alaska."

With respect to a measure subject to the confinement clause, the court has determined:

The superior court wrote that to satisfy the confinement clause, the qualifying language must be the minimum necessary to explain the Legislature's intent regarding how the money appropriated is to be spent. *It must not administer the program of expenditures.* It must not enact law or amend existing law. It must not extend beyond the life of the

Two federal decisions lend support for my concern.

Bowsher v. Synar, 478 U.S. 714, 106 S.Ct. 3181, 92 L.Ed.2d 583 (U.S. 1986), presented the question of Congressional control of matters committed to the executive branch, and more specifically whether the assignment by Congress to the Comptroller General of the United States of certain functions under the Balanced Budget and Emergency Deficit Control Act of 1985 violates the doctrine of separation of powers.. Under the Act, popularly known as the Gramm-Rudman-Hollings Act, Congress authorized the Comptroller General, an officer of the legislative branch, based upon economic forecasts proposed by the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO), to specify the spending reductions necessary to keep the budget deficit within the limits set by Congress. The Act provided that the Comptroller General was to use independent judgment in making the determination, showing "due regard" for the OMB-CBO forecasts. The Act directed the President then to issue a sequestration order "provid[ing] for reductions in [a] manner . . . consistent with [the Comptroller General's] report in all respects."

The United States Supreme Court rejected Congress's attempt through its agent to implement or execute the law and determined that there was a violation. Within "execution of the laws," it included the Comptroller General's administrative duties under the Act because those duties involved determining "precisely what budgetary calculations are required." The majority made it clear that "once Congress makes its choice in enacting legislation, its participation [and those of its agents] ends. Congress can thereafter control the execution of its enactments only indirectly -- by passing new legislation."

Congress of course initially determined the content of the Balanced Budget and Emergency Deficit Control Act; and undoubtedly the content of the Act determines the nature of the executive duty. However, as [*Immigration and Naturalization Service v. Chadha* [, 462 U.S. 919, 103 S. Ct. 2764, 77 L. Ed. 2d 317 (U.S. 1982) (striking down a one house "legislative veto" provision by which each house of Congress retained the power to reverse a decision Congress had expressly authorized the Attorney General to make)] makes clear, once Congress makes its choice

appropriation. Finally, the language must be germane, that is appropriate, to an appropriations bill.

We find the authority the superior court . . . persuasive, and we approve the . . . formulation as a non-exclusive test for deciding whether an appropriation violates the confinement clause.

Alaska Legislative Council v. Knowles, 21 P.3d 367, 377 (Alaska 2001) (emphasis added).

Representative Anna Fairclough
February 9, 2009
Page 10

in enacting legislation, its participation ends. Congress can thereafter control the execution of its enactment only indirectly -- by passing new legislation. *Chadha*, 462 U.S., at 958. By placing the responsibility for execution of the Balanced Budget and Emergency Deficit Control Act in the hands of an officer who is subject to removal only by itself, Congress in effect has retained control over the execution of the Act and has intruded into the executive function. The Constitution does not permit such intrusion.

Bowsher v. Synar, 478 U.S. 714, 733-734 (U.S. 1986).

Lear Siegler, Energy Prods. Div. v. Lehman, 842 F.2d 1102, 1111 (9th Cir. Cal. 1988), rev'd on other grounds, 893 F.2d 205 (9th Cir. 1989) (en banc), involved a claim by a bid contractor after it had made an unsuccessful bid for a contract with the defendant, the Secretary of the Navy. The Navy exercised its discretion and waived a penalty provision of the Buy American Act; the plaintiff then filed a bid protest with the Government Accounting Office. Although the bid award was stayed during the protest under the Competition in Contracting Act of 1984 (CICA), the Navy disregarded the stay. Plaintiff filed an action to compel the Navy to comply with the provisions of the Act requiring the stay and sought review of the bid award. The United States Senate, United States House of Representatives, and Government Accounting Office intervened, seeking injunctive and declaratory relief to uphold the constitutionality of CICA. The district court upheld the constitutionality of CICA.

On appeal, the court affirmed, holding that the Act's stay provisions were constitutional. The court reached the conclusion on the basis of this formulation:

The appropriate formal test must instead be derived from reading the principles of *Chadha* and *Bowsher* in light of the facts of those cases. Such a reading suggests improper congressional action to be the exercise of ultimate authority over an executive official, or a final disposition of the rights of persons outside the legislative branch. Put another way, the critical issue is whether Congress or its agent seeks to control (not merely to "affect") the execution of its enactments without respect to the Article I legislative process. See *Bowsher*, 106 S. Ct. at 3192. If Congress "in effect has retained control," its action and the statutory provision on which it is based is unconstitutional.

Lear Siegler, Inc. v. Lehman, 842 F.2d 1102, at 1108 (9th Cir. 1988). In the case of the draft, it is clear that the legislature, by making a choice of fund manager, seeks to control, not just to "affect," the manner of execution of the remainder of the proposed enactment.

JBC:ljw:plm
09-072.ljw

Enclosure

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

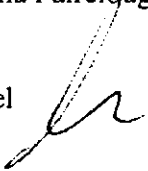
MEMORANDUM

February 9, 2009

SUBJECT: Legislative Delegation of Spending Authority to a Quasi-public Corporation (Work Order No. 26-LS0502\A)

TO: Representative Anna Fairclough

FROM: Jean M. Mischel
Legislative Counsel



In addition to the considerations raised in a memorandum from Jack Chenoweth that accompanies the above referenced work draft, the draft raises the question of whether the attempt to privatize an existing state trust fund and to appropriate state money for use by a private non-profit entity under a named recipient grant while retaining a "corporate administrator" that is comprised of public officials is an improper delegation of legislative authority. Art. II, sec. 1 of the state constitution vests the legislative power, including the appropriation power, in the legislature, and art. IX, sec. 13 of the state constitution requires an appropriation before money can be withdrawn from the state treasury and an authorization for any obligation for the payment of money. In this draft, a public asset (the Children's Trust Fund) is to be transferred out of the state treasury and given to a private entity with little direction on how and when the money is to be withdrawn and spent.

Alaska's Supreme Court has taken a fairly strict view of the legislature's appropriation power. In State v. Fairbanks North Star Borough, 736 P.2d 1140 (Alaska 1987), the court held that a statute allowing the governor to withhold or reduce appropriations when anticipated revenues would not cover appropriations was an unconstitutional delegation of the legislature's appropriation power. In McAlpine v. University of Alaska, 762 P.2d 81 (Alaska 1988), the court held that a provision of an initiative requiring the university to transfer property to the community college system established by the initiative, was an appropriation that could not constitutionally be accomplished by initiative. The court noted that the reason for prohibiting appropriation by initiative was "to ensure that the legislature, and only the legislature, retains control over the allocation of state assets among competing needs." McAlpine v. University of Alaska, 762 P.2d 81 at 88 (Alaska 1988) (emphasis in original).

In the context of legislative delegation of its powers to a state agency, the Alaska Supreme Court has set some ground rules. In Alaska Public Interest Research Group v. State of Alaska, 167 P.3d 27 (Alaska 2007), the court held that delegation of power to an administrative agency is more likely to be found constitutional if the grant of power

minimizes agency discretion. In Alaska Legislative Council v. Knowles, 21 P.3d 367 (Alaska 2001), the court limited item vetoes by the governor to those that included a specified sum of money for a defined purpose, holding that the governor's power over the state budget was limited to the power to reduce or strike sums of money. The court summarized the distinction between the executive function and the legislative powers over state assets in this way: "[t]he governor can delete and take away, but the constitution does not give the governor power to add to or divert for other purposes the appropriations enacted by the legislature." Id. at 368.

In my opinion, allowing private trustees to spend money recovered from the Children's Trust without express authorization for each expenditure may violate art. II, sec. 1, art. VII, secs. 4 and 5, or art. IX, sec. 13, of the state constitution. This conclusion is based on the following considerations.

First, the Alaska cases in this area are based on the premise that control over state assets and finances is vested in the legislature and only the legislature. The court was unwilling to "bend" that principle, even in the face of the fiscal emergency in the Fairbanks North Star Borough case. It has also refused, in the McAlpine case, to limit the appropriation power to cover only money.

Second, the possibility that other parts of the state budget would be affected by spending the money may well apply here. If trust fund money is to be spent on certain child protection programs, that fact may affect other programs of the state Department of Health and Social Services. If trust fund money is spent on programs that use state employees, that may also affect the state budget. The constitution -- art. VII, secs. 4 and 5 -- requires the legislature to provide for the public health and welfare, but this bill would delegate a portion of that duty to a private entity. Finally, if the trustees are themselves public employees acting as a "corporate administrator," that may also affect the long-term fiscal obligations of the state.

Some of the cases outside of Alaska holding that money is not subject to appropriation have been based on the fact that the money was being held by the state in trust for another political entity authorized to spend it. E.g. Navajo Tribe v. Arizona Dept. of Admin., 528 P.2d 623 (Ariz. 1974) (Tribe and cities); State ex rel Sego v. Kirkpatrick, 524 P.2d 975 (N.M. 1974) (University). On the other hand, in cases in which money was held not to be subject to appropriation, the money was coming to the state as a gift or grant from either the federal government or a third party not as here from the state treasury.

For all of the reasons discussed above, it may be that the state constitution requires legislative appropriation before the trust money can be spent. The bill draft provides no guidelines on how and when it is to be spent by the named recipient grantee.

The use of a "corporate administrator" to advise on the expenditure of the trust funds held by a private entity, it seems to me, does not settle the issue. It is unclear from this draft whether the administrator is subject to state laws that govern public bodies such as the

Representative Anna Fairclough
February 9, 2009
Page 3

open meetings and public records laws or whether the administrator enjoys state immunity for its actions.

If I may be of further assistance, please advise.

JMM:ljw:plm
09-071.ljw

Enclosure

To: Rep. Fairclough

Re: The Children's Trust Bill

Date: February 23, 2009

The week before last, you shared with us the draft bill that you received from legal services, and two memos outlining some concerns about the bill. We believe that the constitutional and technical concerns outlined in the two memos are not significant, and can be addressed. We do, however, believe that the bill draft needs to be altered in several ways that will, among other things, help ensure that the bill is in line with IRS rules. Those proposed edits are attached as "2-9-09Work Draft Revision FINAL 2-23-09", and we would request that the work draft dated 2/9/09 be amended to include these proposed changes.

As for the drafters' concerns, both memos are based on theoretical constitutional issues that have not been directly decided by the Alaska Supreme Court (this is, of course, the job of legislative counsel – to warn clients about any possible issue that may affect the validity of the bill).

The memo by Jack Chenoweth raises a series of potential constitutional issues, and largely concludes that the constitutional problems are likely inconsequential. Chenoweth considers and rejects the ideas that the transfer of funds is a violation of dedicated funds, that the transfer implicates the public purpose clause, or that the bill raises equal protection issues. Chenoweth is concerned about a possible impermissible delegation of powers, and also asks several largely technical questions unrelated to the delegation issue. For clarity, we call the memo by Mr. Chenoweth "Memo #1". The memo by Ms. Jean Mischel, called here "Memo #2", raises a different problem with the delegation of powers issue: essentially that the legislature must retain control over state assets. We consider each of these issues below.

Does the bill impermissibly direct the delegation of a nondelegable power from one branch of the government to another?

Memo #1 argues that it appears that the legislature is delegating the executive's power to invest and administer state funds. Our intent is very

different. We consider the legislature to represent the settlor and trustee of the Alaska Children's Trust (ACT) and as settlor and trustee it has the ability to select a new custodian. Under established trust law a trustee is permitted to invade an existing trust and appoint assets to another trust. AS 13.36.157. According to AS 13.36.157(d) the appointed trust must hold the assets of the invaded trust under "substantially identical terms." The Department of Revenue (DOR) was designated to act on behalf of the state by statute, and now, by statute, the legislature would be setting up a process to establish a private trustee and "trust" in the form of a permanent endowment fund. If the governor does not agree with the transfer to a private nonprofit, she can veto the bill and strike the designated grant appropriation.

The bill sets up a process to grant, or give away, the ACT on the condition that it continue to be used for existing purposes and administered in way that is consistent with public purposes. The bill gives substantial power to DOR in making the grant agreement with the grantee and then gives substantial oversight power over the grantee's endowment fund administration to avoid a nondelegation doctrine problem. The fact that the governor's appointees control a majority of the grant administration entity is also a factor that rebuts any delegation problem.

Do we need to specify the terms of board members?

No, we presume that the articles of incorporation of the non-profit corporate grant administrator would set these terms, as is usual for articles of incorporation.

Do we need trust administration standards?

These could be added to the bill, but the plan is to let the Alaska Community Foundation apply its own fiduciary standards, subject to review by DOR. If we apply the standards cited by Mr. Chenoweth (which are in existing law), then ACT possibly could not adopt a POMV concept, which allows spending a percentage of market value. As the goal is to get more money flowing into worthy child abuse prevention programs, while at the same time preserving the endowment fund, we want to maintain the greatest level of flexibility.

Can the board itself appoint additional members?

We believe that the board can appoint additional members. The impetus of this question arises from the fact that Memo #1 considers the non-profit to be functionally a state agency. This was not intended. Our intent is to create a private charity that will attract private donors who are willing to give to private causes. To achieve this environment it was intended that the grant administrator would be a private nonprofit corporation that would be carrying out a public purpose. We do not believe that there can be any infringement on the governor's executive power of appointment if the board is private.

Does the bill violate the confinement rule?

Memo #1 raises the issue that appropriation bills must be confined to appropriations. Unlike in Congress, the legislature cannot log roll substantive legislation into appropriation bills. Memo #1 argues that the designation of the grantee in the accompanying appropriation bill, (which we have not yet submitted) adds something to the bill beyond mere appropriation matter. He believes that the bill could be interpreted to be executing the law by directing the management of state money. This issue has never been decided by the Alaska Supreme Court, although when Justice Carpeneti was on the Superior Court, he decided that the designation of a grantee was nothing more than specifying the purpose for an appropriation and that the executive was free to go through the notification and solicitation process to determine if the named recipient would in fact become the grantee. This issue has not been decided by the Alaska Supreme Court and therefore, the statutes authorizing designated grants remain valid and enforceable.

Additionally, we chose the designated grant approach so that the legislature would have a hand in suggesting the grantee.

Does the bill impermissibly allow the legislature to delegate control over a state asset?

Memo #2 raises a different concern about delegation. It argues that the legislature cannot transfer the trust out of the state treasury "with little direction on how and when the money is to be withdrawn and spent." We do not agree with the premise of this argument: that the state constitution may require additional, specific legislative appropriations before the trust money can be spent.

First, the requirements of the ACT board in the bill are carefully modeled on existing law, and specify how and when the board is to make grants. Second, each year the legislature currently appropriates money from the trust to be used at the discretion of the existing ACT board – the only change in the bill is that the appropriation is for the trust *res* and thereafter the legislature would have nothing available to appropriate, other than the license revenues that annually become available – and that is, of course, purely discretionary. Finally, it is important to note the safeguards built into the bill, including the duties to maintain the funds as a permanent endowment fund, the duty to report on investment performance, the duty of the ACT board to annually report to the legislature the prevention services that were funded and the annual level of contribution, income and expenses of the fund, and – significantly – the section that allows the endowment fund to revert back to the state should the grantee cease to exist or is unable to fulfill the purposes of the grant agreement between the grantee and the Department of Commerce, Community, and Economic Development. For these reasons, we do not believe that the legislature appropriating the trust causes an impermissible delegation of legislative power.

ALASKA CHILDREN'S TRUST



Kids. You gotta love 'em!

March 26, 2009

Representative Anna Fairclough
Alaska State Legislature
State Capitol, Room 421
Juneau, AK 99801-1182

Dear Representative Fairclough:

Please accept this letter as an indication of the ACT board's support of **HB 190, CHILDREN'S TRUST GRANT FOR ENDOWMENT**. As Trustees for the Alaska Children's Trust (ACT), it is our belief that transitioning management of the ACT fund into an endowment model capitalizes on the best practices in the endowment world, and will result in greater performance and growth of the ACT fund over time. Additionally, privatization of the ACT will allow for ethical fundraising and for private sector funds to be used for dedicated purposes.

There are two small changes that we would like to request in HB 190 as follows:

In Sec.3. AS 28.10.181(t) and Sec. 4. AS 28.20431(d)(14), the Trustees would like to retain the name, **Alaska Children's Trust** plates;

In Sec. 7.37.14.215: The Trustees would like to retain the name, the **Alaska Children's Trust**.

We have been known as the Alaska Children's Trust since 1988 and keeping our name would allow us to maintain our established identity across the state as the only entity solely dedicated to the prevention of child abuse and neglect.

We truly appreciate your support of our ongoing efforts to eliminate child abuse and neglect in the State of Alaska. Please feel free to contact the ACT's executive director, Panu Lucier if you have any questions about the Alaska Children's Trust. She can be reached at 907-248-7676.

Sincerely,

A handwritten signature in cursive script that reads "Kaye M. Saxon".

Kaye Saxon, Chair

ALASKA CHILDREN'S TRUST
BOARD OF TRUSTEES

- ◇ Kaye M. Saxon, Chair
- ◇ William Hogan,
Commissioner, Health &
Social Services
- ◇ Larry LeDoux,
Commissioner,
Education & Early
Development
- ◇ Diane Kaplan
- ◇ Michael Lesmann
- ◇ Judy Patrick
- ◇ Marg Volz

EXECUTIVE DIRECTOR

- ◇ Panu Lucier

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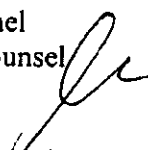
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 30, 2009

SUBJECT: Alaska Children's Trust Reference After Repeal of the Trust
(Amendment E.1 to HB 190 (Work Order No. 26-LS0502\E.1))

TO: Representative Anna Fairclough
Attn: Crystal Koeneman

FROM: Jean M. Mischel
Legislative Counsel 

I have made the changes you requested that retain the references to the Alaska Children's Trust in the provisions for special request license plates and fees. As previously discussed, referencing a repealed trust, particularly for purposes of fee collection, creates an unenforceable provision in codified law. While the nonprofit grantee may intend to use the former trust's name, such references must exist and be defined in codified law. In the meantime, if the amendment and the bill pass, the fees will be paid and collected under a false impression that the trust continues to exist as a state fund.

JMM:Imb
09-016.lmb

Enclosure

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 190

1 Page 2, line 8:

2 Delete "[ALASKA] children's endowment fund [TRUST]"

3 Insert "Alaska children's trust"

4

5 Page 2, lines 10 - 11:

6 Delete "[ALASKA] children's endowment fund [TRUST]"

7 Insert "Alaska children's trust ["

8

9 Page 2, line 15:

10 Delete "[ALASKA] children's endowment fund [TRUST]"

11 Insert "Alaska children's trust"

12

13 Page 2, line 30:

14 Delete "endowment fund"

15 Insert "trust"

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 190

Page 2, Line 8, 10 & 15

Delete "**children endowment fund**"

Insert "**ALASKA'S CHILDREN TRUST**"

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB 190(HSS)
 () Publish Date: _____

Identifier (file name): CSHB190(HSS)-DOR-TRS-4-14-09 Dept. Affected: Revenue
 Title: Amendment to Alaska Children's Trust RDU: Taxation and Treasury
 Component: Treasury
 Sponsor: Rep Fairclough, Hawker, Holmes, Wilson
 Requester: House H&SS Component Number: 121

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES		0.0	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ()		0.0	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary	0.0	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

The Committee Substitute Bill is an amendment to the the Alaska Children's Trust statute which would divest funds from the existing ACT Income fund managed by Treasury and transfer them to a 501(c)3 entity. Treasury would continue to invest the assets of the ACT Principal fund and would calculate 5% of market valu of the Principal fund balance for appropriation to the new 501(c)3 entity. No operating appropriation is required as implementation will be carried out through existing personal services and custodial resources. The effect this bill will have on investment performance is unknown.

Prepared by: Pamela Green, Comptroller
 Division: Treasury Division
 Approved by: Jerry Burnett, Deputy Commissioner
Department of Revenue

Phone 465-2300
 Date/Time Monday, 4 pm
 Date 4/13/2009

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB190
 () Publish Date: _____

Identifier (file name): HB190-DHSS-CTP-3-18-09 Dept. Affected: Health & Social Services
 Title Children's Trust Grant for Endowment RDU Office of Children's Services
 Component Children's Trust Programs
 Sponsor Fairclough, Hawkers, Holmes, Wilson
 Requester House HSS Component Number 2251

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel	(13.2)		(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)
Contractual	(790.0)		(790.0)	(790.0)	(790.0)	(790.0)	(790.0)	(790.0)
Supplies	(1.5)		(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)
Equipment								
Land & Structures								
Grants & Claims	(415.0)		(415.0)	(415.0)	(415.0)	(415.0)	(415.0)	(415.0)
Miscellaneous								
TOTAL OPERATING	(1,219.7)	0.0	(1,219.7)	(1,219.7)	(1,219.7)	(1,219.7)	(1,219.7)	(1,219.7)

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(630.0)		(630.0)	(630.0)	(630.0)	(630.0)	(630.0)	(630.0)
1003 GF Match								
1004 GF								
1099 Children's Trust Principal	(150.0)		(150.0)	(150.0)	(150.0)	(150.0)	(150.0)	(150.0)
1098 Children's Trust Earnings	(399.7)		(399.7)	(399.7)	(399.7)	(399.7)	(399.7)	(399.7)
Other Interagency Receipts	(40.0)		(40.0)	(40.0)	(40.0)	(40.0)	(40.0)	(40.0)
TOTAL	(1,219.7)	0.0	(1,219.7)	(1,219.7)	(1,219.7)	(1,219.7)	(1,219.7)	(1,219.7)

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB 190 privatizes the Alaska children's trust as a separate endowment fund, provides for an administrator, and designates receipts as available for grants.

This fiscal note eliminates authority for the Alaska Children's Trust in the Office of Children's Services RDU. The component will be deleted if this bill is passed.

Prepared by: Tammy Sandoval, Director
 Division Office of Children's Services

Phone 465-3191
 Date/Time 3/17/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance and Management Services

Date 3/17/2009

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. _____

ANALYSIS CONTINUATION

Page _ of _

HB

192

26-LS0483P
Mischel
3/30/09

CS FOR HOUSE BILL NO. 192()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE COGHILL

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to nonpayment of child support; relating to certain judicial and**
2 **administrative orders for medical support of a child; relating to periodic review and**
3 **adjustment of child support orders; relating to relief from administrative child support**
4 **orders; relating to child support arrearages; relating to medical support of a child and**
5 **the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil**
6 **Procedure; and providing for an effective date."**

7 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

8 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
9 to read:

10 **DEFINITION OF "STATE"; LEGISLATIVE INTENT.** (a) It is the intent of the
11 legislature that in order to bring Alaska into conformity with the nationwide Uniform
12 Interstate Family Support Act (UIFSA), as approved by the American Bar Association on
13 February 9, 1993, and as in effect on August 22, 1996, including any amendments officially

1 adopted as of that date by the National Conference of Commissioners on Uniform State Laws,
2 it is necessary to amend AS 25.25.101 to include "an Indian tribe" and "the United States
3 Virgin Islands" in the definition of "state."

4 (b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are
5 conforming amendments that will result in procedural changes in Alaska for enforcement and
6 modification of child support orders from other jurisdictions. UIFSA does not determine the
7 authority of an Indian tribe to enter, modify, or enforce a child support order. In Alaska, the
8 scope of tribal authority to enter, modify, or enforce a child support order is an unsettled legal
9 question, due in part to the lack of Indian country in most of the state. In adopting UIFSA
10 conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction
11 to enter, modify, or enforce child support orders, and the amendments are not intended, either
12 directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction.

13 * Sec. 2. AS 11.51.122(a) is amended to read:

14 (a) A person commits the crime of aiding the nonpayment of child support in
15 the second degree if the person knows that an obligor has a duty under an
16 administrative or judicial order for periodic payment of child support, for cash
17 medical support, or for the provision of health care coverage for a child under a
18 medical support order or a cash medical support order, or both and

19 (1) being a person with a statutory duty to disclose information to a
20 child support enforcement agency intentionally withholds the information when it is
21 requested by a child support enforcement agency;

22 (2) being an employer of the obligor, intentionally withholds
23 information about the residence or employment of the obligor, the eligibility of the
24 obligor's children for coverage under the employer's health insurance plan, or the cost
25 of the coverage of the children under the plan, when that information is requested by a
26 child support enforcement agency or when the employer is required by state or federal
27 law to report the information without a request by a child support enforcement agency;
28 or

29 (3) intentionally participates in a commercial, business, employment,
30 or other arrangement with the obligor, knowing at the time that the arrangement is
31 made that it will allow the obligor to avoid paying all or some of the support when it is

1 due or to avoid having a lien placed on assets for the payment of delinquent support;
2 receipt of a substantial asset for less than fair market value from an obligor after the
3 obligor's support order has been established constitutes a rebuttable presumption that
4 the person receiving the asset knew that the transfer would allow the obligor to avoid
5 paying all or some of the support or to avoid having a lien placed on the asset.

6 * Sec. 3. AS 25.25.101(19) is amended to read:

7 (19) "state" means a state of the United States, the District of
8 Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, or
9 any territory or insular possession subject to the jurisdiction of the United States; the
10 term "state" includes an Indian tribe and a foreign jurisdiction that has enacted a law
11 or established procedures for issuance and enforcement of support orders that are
12 substantially similar to the procedures under this chapter or under the Uniform
13 Reciprocal Enforcement of Support Act or the Revised Uniform Reciprocal
14 Enforcement of Support Act;

15 * Sec. 4. AS 25.27.060(c) is amended to read:

16 (c) In a court or administrative proceeding where the support of a minor child
17 is at issue, the court or agency, as applicable, may order either parent or both parents
18 to pay the amount necessary for support, maintenance, nurture, and education of the
19 child. Regardless of whether a support order for periodic payments is issued, the court
20 or agency shall issue a medical support order, a cash medical support order, or
21 both. The medical support order shall require health care insurance coverage for the
22 child if health care insurance coverage is available to either parent or both parents for
23 the child at a reasonable cost. The court or agency shall consider whether the child is
24 eligible for services through the Indian Health Service or other insurance coverage
25 before ordering either parent or both parents to provide health care coverage through
26 insurance, cash medical support, or other means or a combination of insurance,
27 cash medical support, or other means. The court or agency shall allocate equally the
28 cost of health care insurance for the child between the parents unless there is good
29 cause to allocate the costs unequally. If the obligor has the duty to make periodic
30 payments for non-medical child support, the obligor's periodic payments shall be
31 decreased by the amount of the other parent's portion of payments for health insurance

1 ordered by the court or agency and actually paid by the obligor. If the obligor has a
2 duty to make periodic payments for non-medical child support, the periodic payments
3 shall be increased by the obligor's portion of payments for health insurance if the other
4 parent is ordered to and actually does obtain and pay for insurance. The court or
5 agency shall allocate equally between the parents the cost of reasonable health care
6 expenses not covered by private insurance unless there is good cause to allocate the
7 costs unequally. One parent shall reimburse the other parent for the first parent's share
8 of the uncovered expenses paid by the parent within 30 days after receipt by the first
9 parent of the bill for the health care, payment verification, and, if applicable, a health
10 insurance statement indicating what portion of the cost is uncovered. The medical
11 support order must meet the requirements of AS 25.27.063. Upon a showing of good
12 cause, the court may order the parents required to pay support to give reasonable
13 security for payments.

14 * Sec. 5. AS 25.27.160(c) is amended to read:

15 (c) If the agency is establishing only [A] medical support [ORDER], the
16 notice and finding of financial responsibility must state

17 (1) that health care insurance shall be provided for the child to whom
18 the duty of support is owed if health care insurance is available to the alleged obligor
19 at a reasonable cost and that the alleged obligor and the other parent shall share
20 equally the cost of the health care insurance and the costs of reasonable health care
21 expenses not covered by insurance;

22 (2) the sum of periodic payments of cash medical support for
23 which either parent or both parents are found to be responsible under this
24 chapter;

25 (3) the name of the alleged obligee and the obligee's custodian;

26 (4) [(3)] that the alleged obligor may appear and show cause in a
27 hearing held by the agency why the finding is incorrect, should not be finally ordered,
28 and should be modified or rescinded, because

29 (A) no duty of support is owed;

30 (B) health care insurance for the child is not available to the
31 alleged obligor at a reasonable cost;

1 (C) adequate health care is available to the child through the
2 Indian Health Service or other insurance coverage; or

3 (D) there is good cause to allocate the costs of health insurance,
4 cash medical support, or uninsured health care expenses unequally between
5 the parents;

6 (5) [(4)] that, if the person served with the notice under this subsection
7 does not request a hearing within 30 days, a copy of the medical support order will be
8 sent to the person's employer under AS 25.27.063(b) without further notice or hearing
9 for inclusion of the child in family health coverage if it is available through the
10 person's employer.

11 * Sec. 6. AS 25.27.193 is amended to read:

12 **Sec. 25.27.193. Periodic review or adjustment of support orders.** As
13 necessary to comply with 42 U.S.C. 666, the agency, by regulation, shall provide
14 procedures and standards for the modification, through a three-year cycle of
15 [PERIODIC] review or adjustment, of a support order. Regulations adopted under this
16 section must include procedures for periodic notice of the right to request review,
17 procedures for hearings, and standards for adjustments regarding future periodic
18 support payments. A modification under this section may be made without a showing
19 of a material change in circumstances.

20 * Sec. 7. AS 25.27.195(a) is amended to read:

21 (a) A clerical mistake in an administrative order issued by the agency or an
22 error arising from an oversight or omission by the agency may be corrected by the
23 agency at any time [ON THE MOTION OF AN OBLIGOR].

24 * Sec. 8. AS 25.27.195(b) is amended to read:

25 (b) The [UPON THE MOTION OF AN OBLIGOR, THE] agency may, at any
26 time, vacate an administrative support order issued by the agency under AS 25.27.160
27 that was based on a default amount rather than on the obligor's actual ability to pay.

28 * Sec. 9. AS 25.27.900(2) is repealed and reenacted to read:

29 (2) "arrearage" means a debt that is past due and equal to at least one
30 monthly obligation under the support order for one or more of the following:

31 (A) monetary support;

- 1 (B) cash medical support;
- 2 (C) payment of health care costs or maintenance of health
- 3 insurance;
- 4 (D) reimbursement of related costs;
- 5 (E) payment of attorney fees and legal costs and other fees;
- 6 (F) penalty, interest, and other relief as required by a support
- 7 order;

* Sec. 10. AS 25.27.900(12) is amended to read:

(12) "support order" means any judgment, decree, or order that is issued by a tribunal for the support and maintenance of a child or of a parent with whom the child is living; "support order" includes a judgment, decree, or order

(A) on behalf of a child who has reached the age of majority if the judgment, decree, or order was lawfully issued; and

(B) for any or all of the following:

(i) monetary support, including arrearages;

(ii) payment of health care costs or maintenance of health insurance;

(iii) payment of cash medical support;

(iv) [(iii)] reimbursement of related costs;

(v) [(iv)] payment of attorney fees and legal costs and other fees; or

(vi) [(v)] penalty, interest, and other relief as required by a tribunal;

* Sec. 11. AS 47.07.025(b) is amended to read:

(b) Through the child support services agency or on its own behalf, the department may garnish the wages, salary, or other employment income of a person who

(1) is required by a medical support order, **cash medical support order, or both,** under AS 25.27.060(c) to provide **insurance or cash** coverage of the costs of medical care to a child who is eligible for medical assistance under this chapter;

1 (2) has received payment from a third party for the costs of the
2 services; and

3 (3) has not used the payments to reimburse, as appropriate, the other
4 parent or custodian of the child, the provider of the services, or the department.

5 * **Sec. 12.** AS 47.27.200(o) is amended to read:

6 (o) The applicability of AS 25.27 in the case of a recipient under an Alaska
7 Native family assistance program includes the following:

8 (1) an obligor is liable to the Alaska Native family assistance program
9 in the amount of the family assistance provided by the program to a child to whom the
10 obligor owes a duty of support except that, if a support order has been entered, the
11 liability of the obligor for assistance provided by an Alaska Native family assistance
12 program may not exceed the amount of support provided for in the support order, and,
13 if a medical support order, cash medical support order, or both, [ORDER OF
14 SUPPORT] has been entered, the liability of the obligor for assistance granted under
15 AS 47.07 may not exceed the amount of support provided for in the medical support
16 order, cash medical support order, or both, [ORDER OF SUPPORT]; the child
17 support services agency shall send notice of accruing liability under this paragraph in
18 the same manner as required under AS 25.27.120(c), and, if the agency fails to comply
19 with the notice requirement of this paragraph, interest does not accrue on the liability
20 to the Alaska Native family assistance program unless a support order or medical
21 support order, or cash medical support order, as applicable, has been entered;

22 (2) the child support services agency may appear in an action
23 authorized under AS 25.27.045 at the agency's own discretion if an obligor under
24 AS 25.27 is liable to the Alaska Native family assistance program under (1) of this
25 subsection;

26 (3) an Alaska Native family assistance program to which the child
27 support services agency erroneously disburses an overpayment of child support under
28 an income withholding order is liable to the state for the amount disbursed, plus
29 interest at the rate imposed under AS 25.27.062(l)(1);

30 (4) when the right to receive child support has been assigned to an
31 Alaska Native family assistance program, an agreement under AS 25.27.065(a) that

1 has not been adopted as an administrative order of the child support services agency is
2 not effective during a period when the obligee is receiving assistance under an Alaska
3 Native family assistance program;

4 (5) the child support services agency, on behalf of an Alaska Native
5 family assistance program, shall take all necessary action permitted by law to enforce
6 child support orders entered under AS 25.27, including petitioning the court for orders
7 to aid in the enforcement of child support;

8 (6) if an obligor under AS 25.27 is liable to an Alaska Native family
9 assistance program under (1) of this subsection, the state is subrogated to the rights of
10 the obligee to take actions authorized under AS 25.27.130(a);

11 (7) notwithstanding AS 25.27.130(c), the recovery of an amount for
12 which an obligor under AS 25.27 is liable that exceeds the total assistance granted
13 under AS 47.07 and this chapter shall be paid to the obligee;

14 (8) except as provided in AS 25.27.130(f), if an obligee under
15 AS 25.27 is not receiving assistance under AS 47.07 or this chapter at the time the
16 state recovers money in an action under AS 25.27.130(d) or (1) of this subsection, the
17 recovery of any amount for which the obligor is liable shall be distributed to the
18 obligee for support payments, including medical support payments, that had become
19 due and unpaid since the termination of assistance under AS 47.07 or this chapter
20 under a support order in favor of the obligee;

21 (9) after payment to the obligee under (8) of this subsection, the state
22 may retain an amount not to exceed the total unreimbursed assistance paid on behalf
23 of the obligee under AS 47.07 or this chapter;

24 (10) if an alleged obligor is liable to an Alaska Native family
25 assistance program under (1) of this subsection, and a support order has not been
26 entered, the child support services agency may, at its own discretion, undertake an
27 action to establish paternity and a duty of support using the procedures prescribed in
28 AS 25.27 and may enforce a duty of support using the procedures prescribed in
29 AS 25.27; the agency may also institute administrative proceedings to determine the
30 paternity of a child born out of wedlock upon application of an Alaska Native family
31 assistance program; the agency may not recover costs of genetic tests required under

1 this paragraph from a person who is a recipient of assistance under an Alaska Native
2 family assistance program;

3 (11) when a hearing officer makes a determination under
4 AS 25.27.170(d), the hearing officer shall, in addition to the factors described in
5 AS 25.27.170(e), consider the amount of the alleged obligor's liability to an Alaska
6 Native family assistance program under (1) of this subsection;

7 (12) notwithstanding AS 25.27.255(a), the child support services
8 agency may not pay to an obligee any money that has been assigned to an Alaska
9 Native family assistance program.

10 * **Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to
11 read:

12 **INDIRECT COURT RULE AMENDMENT.** AS 25.27.060(c), amended by sec. 4 of
13 this Act, has the effect of changing Rule 90.3, Alaska Rules of Civil Procedure, by changing
14 standards for issuance of medical and other support orders by the court.

15 * **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to
16 read:

17 **APPLICABILITY.** This Act applies to actions filed on or after the effective date of
18 this section and to motions filed on or after the effective date in proceedings filed before, on,
19 or after the effective date of this section.

20 * **Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:

22 **TRANSITION: REGULATIONS.** The Department of Revenue may proceed to adopt
23 regulations necessary to implement this Act. The regulations take effect under AS 44.62
24 (Administrative Procedure Act), but not before July 1, 2009.

25 * **Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to
26 read:

27 **NO CONDITIONAL EFFECT.** Because Rule 90.3, Alaska Rules of Civil Procedure,
28 is a substantive rule, sec. 4 of this Act takes effect even if sec. 13 of this Act fails to receives a
29 two-thirds majority vote of each house.

30 * **Sec. 17.** Section 15 of this Act takes effect immediately under AS 01.10.070(c).

31 * **Sec. 18.** Except as provided in sec. 17 of this Act, this Act takes effect July 1, 2009.

26-LS0483\S
Mischel
3/25/09

CS FOR HOUSE BILL NO. 192()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE COGHILL

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to nonpayment of child support; relating to certain judicial and**
2 **administrative orders for medical support of a child; relating to periodic review and**
3 **adjustment of child support orders; relating to relief from administrative child support**
4 **orders; relating to child support arrearages; relating to medical support of a child and**
5 **the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil**
6 **Procedure; and providing for an effective date."**

7 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

8 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
9 to read:

10 DEFINITION OF "STATE"; LEGISLATIVE INTENT. The amendment made to the
11 definition of "state" in AS 25.25.101(19) under sec. 3 of this Act is intended to conform state
12 law to recent recommendations made for the Uniform Interstate Family Support Act. The
13 change is not intended to alter or expand in any way the governmental relationship between

1 federally recognized tribes and the state.

2 * Sec. 2. AS 11.51.122(a) is amended to read:

3 (a) A person commits the crime of aiding the nonpayment of child support in
4 the second degree if the person knows that an obligor has a duty under an
5 administrative or judicial order for periodic payment of child support, for cash
6 medical support, or for the provision of health care coverage for a child under a
7 medical support order or a cash medical support order, or both and

8 (1) being a person with a statutory duty to disclose information to a
9 child support enforcement agency intentionally withholds the information when it is
10 requested by a child support enforcement agency;

11 (2) being an employer of the obligor, intentionally withholds
12 information about the residence or employment of the obligor, the eligibility of the
13 obligor's children for coverage under the employer's health insurance plan, or the cost
14 of the coverage of the children under the plan, when that information is requested by a
15 child support enforcement agency or when the employer is required by state or federal
16 law to report the information without a request by a child support enforcement agency;
17 or

18 (3) intentionally participates in a commercial, business, employment,
19 or other arrangement with the obligor, knowing at the time that the arrangement is
20 made that it will allow the obligor to avoid paying all or some of the support when it is
21 due or to avoid having a lien placed on assets for the payment of delinquent support;
22 receipt of a substantial asset for less than fair market value from an obligor after the
23 obligor's support order has been established constitutes a rebuttable presumption that
24 the person receiving the asset knew that the transfer would allow the obligor to avoid
25 paying all or some of the support or to avoid having a lien placed on the asset.

26 * Sec. 3. AS 25.25.101(19) is amended to read:

27 (19) "state" means a state of the United States, the District of
28 Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, or
29 any territory or insular possession subject to the jurisdiction of the United States; the
30 term "state" includes an Indian tribe and a foreign jurisdiction that has enacted a law
31 or established procedures for issuance and enforcement of support orders that are

1 substantially similar to the procedures under this chapter or under the Uniform
2 Reciprocal Enforcement of Support Act or the Revised Uniform Reciprocal
3 Enforcement of Support Act;

4 * Sec. 4. AS 25.27.060(c) is amended to read:

5 (c) In a court or administrative proceeding where the support of a minor child
6 is at issue, the court or agency, as applicable, may order either parent or both parents
7 to pay the amount necessary for support, maintenance, nurture, and education of the
8 child. Regardless of whether a support order for periodic payments is issued, the court
9 or agency shall issue a medical support order, a cash medical support order, or
10 both. The medical support order shall require health care insurance coverage for the
11 child if health care insurance coverage is available to either parent or both parents for
12 the child at a reasonable cost. The court or agency shall consider whether the child is
13 eligible for services through the Indian Health Service or other insurance coverage
14 before ordering either parent or both parents to provide health care coverage through
15 insurance, cash medical support, or other means or a combination of insurance,
16 cash medical support, or other means. The court or agency shall allocate equally the
17 cost of health care insurance for the child between the parents unless there is good
18 cause to allocate the costs unequally. If the obligor has the duty to make periodic
19 payments for non-medical child support, the obligor's periodic payments shall be
20 decreased by the amount of the other parent's portion of payments for health insurance
21 ordered by the court or agency and actually paid by the obligor. If the obligor has a
22 duty to make periodic payments for non-medical child support, the periodic payments
23 shall be increased by the obligor's portion of payments for health insurance if the other
24 parent is ordered to and actually does obtain and pay for insurance. The court or
25 agency shall allocate equally between the parents the cost of reasonable health care
26 expenses not covered by private insurance unless there is good cause to allocate the
27 costs unequally. One parent shall reimburse the other parent for the first parent's share
28 of the uncovered expenses paid by the parent within 30 days after receipt by the first
29 parent of the bill for the health care, payment verification, and, if applicable, a health
30 insurance statement indicating what portion of the cost is uncovered. The medical
31 support order must meet the requirements of AS 25.27.063. Upon a showing of good

1 cause, the court may order the parents required to pay support to give reasonable
2 security for payments.

3 * Sec. 5. AS 25.27.160(c) is amended to read:

4 (c) If the agency is establishing only [A] medical support [ORDER], the
5 notice and finding of financial responsibility must state

6 (1) that health care insurance shall be provided for the child to whom
7 the duty of support is owed if health care insurance is available to the alleged obligor
8 at a reasonable cost and that the alleged obligor and the other parent shall share
9 equally the cost of the health care insurance and the costs of reasonable health care
10 expenses not covered by insurance;

11 (2) the sum of periodic payments of cash medical support for
12 which either parent or both parents are found to be responsible under this
13 chapter;

14 (3) the name of the alleged obligee and the obligee's custodian;

15 (4) [(3)] that the alleged obligor may appear and show cause in a
16 hearing held by the agency why the finding is incorrect, should not be finally ordered,
17 and should be modified or rescinded, because

18 (A) no duty of support is owed;

19 (B) health care insurance for the child is not available to the
20 alleged obligor at a reasonable cost;

21 (C) adequate health care is available to the child through the
22 Indian Health Service or other insurance coverage; or

23 (D) there is good cause to allocate the costs of health insurance,
24 cash medical support, or uninsured health care expenses unequally between
25 the parents;

26 (5) [(4)] that, if the person served with the notice under this subsection
27 does not request a hearing within 30 days, a copy of the medical support order will be
28 sent to the person's employer under AS 25.27.063(b) without further notice or hearing
29 for inclusion of the child in family health coverage if it is available through the
30 person's employer.

31 * Sec. 6. AS 25.27.193 is amended to read:

1 **Sec. 25.27.193. Periodic review or adjustment of support orders.** As
2 necessary to comply with 42 U.S.C. 666, the agency, by regulation, shall provide
3 procedures and standards for the modification, through a three-year cycle of
4 [PERIODIC] review or adjustment, of a support order. Regulations adopted under this
5 section must include procedures for periodic notice of the right to request review,
6 procedures for hearings, and standards for adjustments regarding future periodic
7 support payments. A modification under this section may be made without a showing
8 of a material change in circumstances.

9 * **Sec. 7.** AS 25.27.195(a) is amended to read:

10 (a) A clerical mistake in an administrative order issued by the agency or an
11 error arising from an oversight or omission by the agency may be corrected by the
12 agency at any time [ON THE MOTION OF AN OBLIGOR].

13 * **Sec. 8.** AS 25.27.195(b) is amended to read:

14 (b) The [UPON THE MOTION OF AN OBLIGOR, THE] agency may, at any
15 time, vacate an administrative support order issued by the agency under AS 25.27.160
16 that was based on a default amount rather than on the obligor's actual ability to pay.

17 * **Sec. 9.** AS 25.27.900(2) is repealed and reenacted to read:

18 (2) "arrearage" means a debt that is past due and equal to at least one
19 monthly obligation under the support order for one or more of the following:

20 (A) monetary support;

21 (B) cash medical support;

22 (C) payment of health care costs or maintenance of health
23 insurance;

24 (D) reimbursement of related costs;

25 (E) payment of attorney fees and legal costs and other fees;

26 (F) penalty, interest, and other relief as required by a support
27 order;

28 * **Sec. 10.** AS 25.27.900(12) is amended to read:

29 (12) "support order" means any judgment, decree, or order that is
30 issued by a tribunal for the support and maintenance of a child or of a parent with
31 whom the child is living; "support order" includes a judgment, decree, or order

1 (A) on behalf of a child who has reached the age of majority if
2 the judgment, decree, or order was lawfully issued; and

3 (B) for any or all of the following:

4 (i) monetary support, including arrearages;

5 (ii) payment of health care costs or maintenance of
6 health insurance;

7 (iii) payment of cash medical support;

8 (iv) [(iii)] reimbursement of related costs;

9 (v) [(iv)] payment of attorney fees and legal costs and
10 other fees; or

11 (vi) [(v)] penalty, interest, and other relief as required
12 by a tribunal;

13 * Sec. 11. AS 47.07.025(b) is amended to read:

14 (b) Through the child support services agency or on its own behalf, the
15 department may garnish the wages, salary, or other employment income of a person
16 who

17 (1) is required by a medical support order, cash medical support
18 order, or both, under AS 25.27.060(c) to provide insurance or cash coverage of the
19 costs of medical care to a child who is eligible for medical assistance under this
20 chapter;

21 (2) has received payment from a third party for the costs of the
22 services; and

23 (3) has not used the payments to reimburse, as appropriate, the other
24 parent or custodian of the child, the provider of the services, or the department.

25 * Sec. 12. AS 47.27.200(o) is amended to read:

26 (o) The applicability of AS 25.27 in the case of a recipient under an Alaska
27 Native family assistance program includes the following:

28 (1) an obligor is liable to the Alaska Native family assistance program
29 in the amount of the family assistance provided by the program to a child to whom the
30 obligor owes a duty of support except that, if a support order has been entered, the
31 liability of the obligor for assistance provided by an Alaska Native family assistance

1 program may not exceed the amount of support provided for in the support order, and,
 2 if a medical support order, cash medical support order, or both, [ORDER OF
 3 SUPPORT] has been entered, the liability of the obligor for assistance granted under
 4 AS 47.07 may not exceed the amount of support provided for in the medical support
 5 order, cash medical support order, or both, [ORDER OF SUPPORT]; the child
 6 support services agency shall send notice of accruing liability under this paragraph in
 7 the same manner as required under AS 25.27.120(c), and, if the agency fails to comply
 8 with the notice requirement of this paragraph, interest does not accrue on the liability
 9 to the Alaska Native family assistance program unless a support order or medical
 10 support order, or cash medical support order, as applicable, has been entered;

11 (2) the child support services agency may appear in an action
 12 authorized under AS 25.27.045 at the agency's own discretion if an obligor under
 13 AS 25.27 is liable to the Alaska Native family assistance program under (1) of this
 14 subsection;

15 (3) an Alaska Native family assistance program to which the child
 16 support services agency erroneously disburses an overpayment of child support under
 17 an income withholding order is liable to the state for the amount disbursed, plus
 18 interest at the rate imposed under AS 25.27.062(l)(1);

19 (4) when the right to receive child support has been assigned to an
 20 Alaska Native family assistance program, an agreement under AS 25.27.065(a) that
 21 has not been adopted as an administrative order of the child support services agency is
 22 not effective during a period when the obligee is receiving assistance under an Alaska
 23 Native family assistance program;

24 (5) the child support services agency, on behalf of an Alaska Native
 25 family assistance program, shall take all necessary action permitted by law to enforce
 26 child support orders entered under AS 25.27, including petitioning the court for orders
 27 to aid in the enforcement of child support;

28 (6) if an obligor under AS 25.27 is liable to an Alaska Native family
 29 assistance program under (1) of this subsection, the state is subrogated to the rights of
 30 the obligee to take actions authorized under AS 25.27.130(a);

31 (7) notwithstanding AS 25.27.130(c), the recovery of an amount for

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which an obligor under AS 25.27 is liable that exceeds the total assistance granted under AS 47.07 and this chapter shall be paid to the obligee;

(8) except as provided in AS 25.27.130(f), if an obligee under AS 25.27 is not receiving assistance under AS 47.07 or this chapter at the time the state recovers money in an action under AS 25.27.130(d) or (1) of this subsection, the recovery of any amount for which the obligor is liable shall be distributed to the obligee for support payments, including medical support payments, that had become due and unpaid since the termination of assistance under AS 47.07 or this chapter under a support order in favor of the obligee;

(9) after payment to the obligee under (8) of this subsection, the state may retain an amount not to exceed the total unreimbursed assistance paid on behalf of the obligee under AS 47.07 or this chapter;

(10) if an alleged obligor is liable to an Alaska Native family assistance program under (1) of this subsection, and a support order has not been entered, the child support services agency may, at its own discretion, undertake an action to establish paternity and a duty of support using the procedures prescribed in AS 25.27 and may enforce a duty of support using the procedures prescribed in AS 25.27; the agency may also institute administrative proceedings to determine the paternity of a child born out of wedlock upon application of an Alaska Native family assistance program; the agency may not recover costs of genetic tests required under this paragraph from a person who is a recipient of assistance under an Alaska Native family assistance program;

(11) when a hearing officer makes a determination under AS 25.27.170(d), the hearing officer shall, in addition to the factors described in AS 25.27.170(e), consider the amount of the alleged obligor's liability to an Alaska Native family assistance program under (1) of this subsection;

(12) notwithstanding AS 25.27.255(a), the child support services agency may not pay to an obligee any money that has been assigned to an Alaska Native family assistance program.

* Sec. 13. The uncodified law of the State of Alaska is amended by adding a new section to read:

1 INDIRECT COURT RULE AMENDMENT. AS 25.27.060(c), amended by sec. 4 of
 2 this Act, has the effect of changing Rule 90.3, Alaska Rules of Civil Procedure, by changing
 3 standards for issuance of medical and other support orders by the court.

4 * **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to
 5 read:

6 **APPLICABILITY.** This Act applies to actions filed on or after the effective date of
 7 this section and to motions filed on or after the effective date in proceedings filed before, on,
 8 or after the effective date of this section.

9 * **Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to
 10 read:

11 **TRANSITION: REGULATIONS.** The Department of Revenue may proceed to adopt
 12 regulations necessary to implement this Act. The regulations take effect under AS 44.62
 13 (Administrative Procedure Act), but not before July 1, 2009.

14 * **Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to
 15 read:

16 **NO CONDITIONAL EFFECT.** Because Rule 90.3, Alaska Rules of Civil Procedure,
 17 is a substantive rule, sec. 4 of this Act takes effect even if sec. 13 of this Act fails to receives a
 18 two-thirds majority vote of each house.

19 * **Sec. 17.** Section 15 of this Act takes effect immediately under AS 01.10.070(c).

20 * **Sec. 18.** Except as provided in sec. 17 of this Act, this Act takes effect July 1, 2009.



ALASKA STATE LEGISLATURE
HOUSE RULES COMMITTEE
REPRESENTATIVE JOHN COGHILL, CHAIRMAN

State Capitol Juneau, AK 99801-1182 (907) 465-3719
3340 Badger Road Suite #290, North Pole, AK 99705 (907) 488-5725

Sponsor Statement

HB192 – Child Support Enforcement Amendments

Civil Rule 90.3, the child support guidelines, was enacted by the Alaska Supreme Court in 1987. Civil Rule 90.3 is substantive law and should have been passed by the legislature. The courts decide individual cases and enact procedural rules. This bill will enact the current rule as a statute and correct a long-standing deficiency.

Additionally this bill amends existing statute to conform to the new medical support regulations set by the federal government in July 2008 that require how one or both parents will provide healthcare needs for their child.

It gives a tribunal the authority to order either or both parents to pay cash medical support. CSSD will now review support orders on a three-year cycle rather than periodically. The definition of arrearage and support now includes cash medical support.

Finally the bill removes language limiting who may request a clerical mistake correction on an administrative order or vacating an administrative order based upon a default income.

STATE OF ALASKA
DEPARTMENT OF REVENUE
CHILD SUPPORT SERVICES DIVISION

SARAH PALIN, GOVERNOR

Please Reply To:

CSSD, MS DIR
550 WEST 7th AVE., SUITE 310
ANCHORAGE, AK 99501-6699

March 26, 2009

Rynniva Moss
Representative John Coghill's Office
Juneau AK 99801

RE: HB 192

Dear Ms. Moss:

As per your request, following is a sectional analysis of HB 192:

Section 1. Adds reference to cash medical support to the crime of aiding the nonpayment of child support in the second degree.

Section 2. Amends order of support provision to include both parents, medical support, and insurance.

Section 3. Adds medical support to provision authorizing the initiation of administrative action to establish a duty of support.

Section 4. Amends periodic reviews of support orders to require a three year cycle of review.

Section 5. Deletes motion requirement for correcting an administrative mistake in a support order.

Section 6. Deletes motion requirement for vacating a support order that is based on a default amount.

Section 7. Redefines "arrearage" for child support purposes.

Section 8. Amends the definition of "support order" to include cash medical support.

Section 9. Amends garnishment provision to include insurance and cash medical support.

Section 10. Amends the Alaska Native family assistance program to include obligations for cash medical support.

Section 11. Provides for an indirect court rule amendment to Rule 90.3, Alaska Rules of Civil Procedure for changes made in the bill.

TOLL FREE (In-state, outside Anchorage): (800) 478-3300

SOUTHEAST: (907) 465-5887

MAT-SU: (907) 357-3550

ANCHORAGE: (907) 269-6900 FAX: (907) 269-6813 or 6914

FAIRBANKS: (907) 451-2830

TDD machine only: (907) 269-6894 / TDD machine only, toll free (In-state, outside Anchorage): (800) 370-6894

Page 2
HB 192
March 26, 2009

Section 12. Makes bill changes applicable to child support actions filed on or after the bill's effective date.

Section 13. Authorizes the Department of Revenue to proceed to adopt regulations needed under the bill.

Section 14. Provides for a conditional effect for the court rule amendment in sec. 11 only for two-thirds majority vote.

Section 15. Makes sec. 13 effective immediately.

Section 16. Provides for a July 1, 2009 effective date for all other bill sections.

Let me know if you have any questions concerning this analysis.

Thank you,

Sincerely,



John Mallonee
Director

LAT/JM

TOLL FREE (In-state, outside Anchorage): (800) 478-3300

ANCHORAGE: (907) 269-6900 FAX: (907) 269-6813 or 6914

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FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 192
 () Publish Date: _____

Identifier (file name): HB192-DOR-CSS-03-30-09 Dept. Affected: Revenue
 Title Cash Medical Support for Minor Children RDU Child Support Services Division
 Component Child Support Services Division
 Sponsor Representative Coghill
 Requester _____ Component Number 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Debt Service								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1092 MHTAAR								
Bond Proceeds								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time								
Part-time								
Temporary								

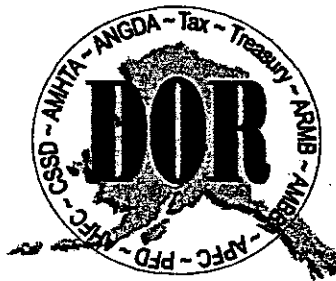
ANALYSIS: (Attach a separate page if necessary)

This legislation does not require any additional funding.

Prepared by: John Mallonee
 Division: Child Support Services Division
 Approved by: Ginger Blaisdell, Director
Administrative Services Division

Phone 269-6801
 Date/Time 3/30/2009 at 12:00 PM
 Date 3/30/2009

State of Alaska
Department of Revenue
Administrative Services Division



SARAH PALIN, GOVERNOR
333 Willoughby Avenue, 11th Floor
P.O. Box 110400
Juneau, Alaska 99811-0405
Phone: (907) 465-2300
Fax: (907) 465-2394

March 20, 2009

The Honorable John Coghill
Chair, House Rules Committee
Alaska State Legislature
State Capitol, Room 214
Juneau, AK 99801

Dear Representative Coghill;

The Department of Revenue, with support of the Governor asked you to introduce legislation regarding Child Support Services needs for legislative change to their statutes. Thank you for sponsoring this legislation and introducing HB 192 last week. This letter outlines the need for the legislation to pass during this legislative session both for content of the bill and fiscal impact to the citizens of the state.

The Alaska Child Support Services Division (CSSD) needs to amend state law on three issues.

1. The requirement for cash medical support
2. The three year review cycle
3. The change of the definition of state in UIFSA

The first two amendments are less controversial and only require that child support orders include a provision for obligors to pay cash medical assistance to the custodial parent to help with health costs when insurance is not provided for that child, and that the division performs regular reviews of its cases.

The third amendment could be considered more sensitive. The Uniform Interstate Family Support Act (UIFSA) contains a definition of "state." Under federal law, all states must adopt the uniform act's definition of "state" that includes "the United States Virgin Islands" and "an Indian tribe." For Alaska, the impact of adopting a definition that would include Indian tribes, means Indian tribes can issue and serve income-withholding orders on employers. The obligor would be entitled to contest the jurisdiction of the tribe to issue the order and the usual rights to contest the validity or enforcement of an order by an obligor would still apply. The change would also affect the process for state recognition of tribal orders. A tribal child support order would be registered in the Alaska state courts under the UIFSA procedures instead of a comity process. These changes are consistent with the purpose of UIFSA. The purpose of UIFSA is to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws.

One question raised by the changes required by UIFSA is whether the tribal amendment would result in an expansion of tribal authority. The Department of Law has examined this question and came to the

following conclusion:

“UIFSA’s underlying purpose is not to define jurisdiction. Nor does the state have the ability to define tribal jurisdiction. The overall purpose of UIFSA is simply to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws. These purposes do not trigger broader jurisdictional concerns.”

Intent language could be included in the introduced child support legislation (SB 96) to ease concerns of legislators who are not comfortable with issues related to Indian tribes. Or a letter of intent could be attached as a separate letter to the bill. I might suggest the following as an amendment:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that

(1) failure to bring AS 25.25.101 into compliance with the federal Social Security Act Title IV-D could result in the loss of approximately \$17,000,000 in administrative funding;

(2) of the 33 states that have federally recognized tribes, Alaska is the only state that has not yet passed conforming legislation; and

(3) to bring Alaska into conformity with UIFSA, the legislature finds that it is necessary to amend AS 25.25.101 to include “an Indian tribe” and “the United States Virgin Islands” in the definition of “state.”

(b) It is the intent of the legislature that this Act not alter or expand in any way the governmental relationship between federally recognized tribes and the state.

A zero fiscal note accompanies the legislation because passage of the bill would result in no additional impact to the Department of Revenue, Child Support Services Division. The fiscal impact to non-passage of SB96, or another like bill, could be detrimental to 62,000 Alaska’s children under age 19. If the state remains out of compliance after this legislative session, CSSD could lose nearly the entire operating budget required to operate the child support activities mandated by state and federal law and could jeopardize the entire TANF block grant received by the Department of Health and Social Services, Division of Public Assistance. (The division currently has a budget of \$174,000 General Funds.)

\$11,000,000	Federal receipts paid through Title IV-D of the Social Security Act for child support services.
\$12,708,403	Each year CSSD collects funds from families who also receive state benefits through the State’s TANF (Temporary Assistance for Needy Families) program. The collections received on behalf of the children receiving funding through TANF are retained by CSSD and used as match to obtain additional federal funding for child support, \$6,070,137 state match, and \$6,638,266 to be used as part of the total federal receipts to be paid to CSSD for its services. *FY08 totals

\$ 1,025,761	Annual collections from obligors whose children are in state foster care are sent to the Department of Health and Social Services to help pay for foster care costs. *FY08 totals
\$ 860,560	Annual collections from obligors whose children are institutionalized are sent to the Department of Health and Social Services to help pay for non-federal foster care. *FY08 totals
\$60,000,000	Federal TANF Block Grant is part of the Social Security Act. If any part of the Act is not in compliance, the State would risk losing the entire block grant. The majority of this funding is appropriated in the Department of Health and Social Services. Action Transmittal OCSE-AT-97-05 dated April 28, 1997 describes that CSSD funding would be lost and that non-compliance could also put at risk Title IV-A funding. The language from this Action Transmittal follows:

AUTHORITY:Section 455(a)(1)(A) of the Act specifies that funds appropriated under title IV-D shall be paid to States with approved State IV-D plans. There is no authority to expend Federal funds under title IV-D of the Act for the operation of a Child Support Enforcement program unless such State has an approved State IV-D plan.

Section 466 of the Act requires that all States, as a condition for approval of their State IV-D plan, must have in effect laws requiring the use of mandatory procedures to increase the effectiveness of their Child Support Enforcement programs. As a condition for State plan approval, section 454(20) of the Act provides that, to the extent required by section 466, States must have laws in effect and implement the procedures prescribed in or pursuant to such laws.

Section 454 of the Act sets the statutory requisites for the State IV-D plan. In addition, regulations at 45 CFR 301.10 define the State IV-D plan as a comprehensive statement submitted by the IV-D agency describing the nature and scope of its program. The State IV-D plan contains all the information necessary for the Office of Child Support Enforcement (OCSE) to determine whether the plan can be approved, as a basis for Federal financial participation in the State IV-D program.

Section 452(a)(3) of the Act requires that OCSE review and approve State plans for Child Support Enforcement programs under title IV-D of the Act. The authority to approve State plans is delegated to the Regional Office, but OCSE retains authority for determining that a State IV-D plan is not approvable.

As stated above, a determination that a State IV-D plan is disapproved will result in immediate suspension of all Federal payments for the State's child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE. If a State is dissatisfied with OCSE's decision, reconsideration may be requested pursuant to 45 CFR 301.14. Withholding of Federal payments cannot be stayed pending reconsideration.

Section 402(a)(2) of the Act (as amended by PRWORA) provides that the chief executive officer of a State must certify that it will operate a child support enforcement program under an approved IV-D plan as a condition of eligibility for a TANF block grant under title IV-A of the Act. Therefore, States should be aware that TANF funds may also be at risk.

CSSD Federal Compliance Impact Letter

March 20, 2009


Page 4 of 4

In conclusion:

1. Monthly distribution of child support payments to custodial parents averages \$9,350,000.
2. One out of six citizens (approximately 125,000 people) in Alaska are somehow involved in a child support case.
3. If this legislation does not pass in the next 30 days, Alaska risks losing its entire child support services program and could lose its state TANF block grant that serves low-income citizens in every community.

Thank you for working with us on this issue.

Sincerely,



Ginger Blaisdell
Director



DEPARTMENT OF HEALTH & HUMAN SERVICES

Administration for
Children and Families

2201 Sixth Avenue, RX-70
Seattle, WA 98121

MAR 27 2009

Mr. John Mallonee, Director
Child Support Services Division
550 West 7th Avenue, Suite 310
Anchorage, AK 99501

Dear Mr. Mallonee:

This is in response to your request for clarification of the potential Federal consequences if a State fails to enact laws to meet the State plan requirements with section 466(f) of the Social Security Act (the Act). The Act mandates that on and after January 1, 1998, each State must have in effect the Uniform Interstate Family Support Act (UIFSA), as approved by the American Bar Association on February 9, 1993, and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform States Laws. Specifically, Alaska State's UIFSA does not include Indian tribes in the definition of 'State'.

In order for a State to receive Federal funding for the operation of its child support enforcement program, it must have an approved State IV-D plan which meets the requirements of section 454 of the Social Security Act (the Act). One of those requirements, specified at section 454(20)(A), is that the State must have in effect all of the laws required by section 466.

When a State fails to comply with any statutory requirement, its plan is subject to disapproval by the Office of Child Support Enforcement (OCSE). In accordance with sections 452(a)(3) and 455(a)(1)(A) of the Act, there would then be no authority to expend Federal funds under Title IV-D to operate the State's child support enforcement program.

Therefore, a determination that a State IV-D plan is disapproved may result in immediate suspension of all Federal payments for the State's child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE. This suspension includes the Federal share of administrative expenditures as well as any performance based incentive payments to the State.

In addition, in order to be eligible for a block grant for Temporary Assistance to Needy Families (TANF), section 402(a)(2) of the Act requires a State to certify that it will operate a child support enforcement program under the State plan approved under part D. Therefore, Alaska should be aware that TANF funds may also be at risk if the State does not enact conforming child support legislation.

Page 2 - Mr. John Mallonee

In Federal Fiscal Year (FFY) 2008, the Federal share of Alaska's IV-D expenditures was \$14,657,800 and the State's TANF award amount was \$46,732,590. In addition, Alaska received \$1,794,516 in child support incentives for FFY 2007 (the latest year with available data).

We trust this statement of requirements and penalties clarifies our position. We are attaching our Action Transmittal 97-05 issued April 28, 1997 which outlines our procedures for determining that a State IV-D Plan is disapproved. Due to the gravity of the consequences that may result, we urge you to take all necessary steps to have the required UIFSA legislation enacted and implemented as soon as possible.

If you have any questions, please contact John Cheng at (206) 615-2566.

Sincerely,



Linda Gillett

Regional Program Manager, Region 10
Office of Child Support Enforcement

Enclosure: Action Transmittal 97-05

cc: Ms. Donna Bonar, Acting Commissioner, OCSE



U.S. Department of Health and Human Services

Administration for Children & Families

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THE OFFICE OF CHILD SUPPORT ENFORCEMENT

Giving Hope and Support to America's Children

PROGRAM INSTRUCTION

ACTION TRANSMITTAL

OCSE-AT-97-05

April 28, 1997

TO: STATE AGENCIES ADMINISTERING CHILD SUPPORT ENFORCEMENT PLANS APPROVED UNDER TITLE IV-D OF THE SOCIAL SECURITY ACT AND OTHER INTERESTED INDIVIDUALS

SUBJECT: Procedures for Determining That a State IV-D Plan is Disapproved

BACKGROUND: Title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P.L. 104-193, made a number of amendments to sections 454 and 466 of the Social Security Act (the Act), requiring States to either establish new, or modify existing, procedures effective either October 1, 1996, March 1, 1997 or October 1, 1997. For States which require legislation in order to conform their State IV-D plans to the revised statute, section 395(b)(2) of PRWORA provides a grace period until not later than the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that begins after the date of enactment of PRWORA (August 22, 1996). In cases which require that the State constitution be amended, section 395(c) of PRWORA provides a grace period until one year after the effective date of the State constitutional amendment, but no later than five years after the date of enactment of PRWORA.

CSE is tracking the progress of each of the States in enacting the new State plan requirements and mandatory laws, and is noting the date when each State's 1997 legislative session ends in order to ascertain when these laws are required to be in effect and when the State must submit new or amended State plan material for approval by OCSE in order to operate a Child Support Enforcement program according to the requirements of title IV-D of the Act. If a State fails to submit the necessary State plan amendments, OCSE will have to determine that the State does not have an approvable State plan. A determination that a State IV-D plan is disapproved will result in immediate suspension of all Federal payments for the State's child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE.

STATUTORY

AUTHORITY: Section 455(a)(1)(A) of the Act specifies that funds appropriated under title IV-D shall be paid to States with approved State IV-D plans. There is no authority to expend Federal funds under title IV-D of the Act for the operation of a Child Support Enforcement program unless such State has an approved State IV-D plan.

Section 466 of the Act requires that all States, as a condition for approval of their State IV-D plan, must have in effect laws requiring the use of mandatory procedures to increase the effectiveness of their Child Support Enforcement programs. As a condition for State plan approval, section 454(20) of the Act provides that, to the extent required by section 466, States must have laws in effect and implement the procedures prescribed in or pursuant to such laws.

Section 454 of the Act sets the statutory requisites for the State IV-D plan. In addition, regulations at 45 CFR 301.10 define the State IV-D plan as a comprehensive statement submitted by the IV-D agency describing the nature and scope of its program. The State IV-D plan contains all the information necessary for the Office of Child Support Enforcement (OCSE) to determine whether the plan can be approved, as a basis for Federal financial participation in the State IV-D program.

Section 452(a)(3) of the Act requires that OCSE review and approve State plans for Child Support Enforcement programs under title IV-D of the Act. The authority to approve State plans is delegated to the Regional Office, but OCSE retains authority for determining that a State IV-D plan is not approvable.

As stated above, a determination that a State IV-D plan is disapproved will result in immediate suspension of all Federal payments for the State's child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE. If a State is dissatisfied with OCSE's decision, reconsideration may be requested pursuant to 45 CFR 301.14. Withholding of Federal payments cannot be stayed pending reconsideration.

Section 402(a)(2) of the Act (as amended by PRWORA) provides that the chief executive officer of a State must certify that it will operate a child support enforcement program under an approved IV-D plan as a condition of eligibility for a TANF block grant under title IV-A of the Act. Therefore, States should be aware that TANF funds may also be at risk.

Although it is not required under Title IV-D of the Act, OCSE will give States an advance notice of "Intent to Disapprove" a previously approved State IV-D plan. The State will then be permitted the opportunity to waive reconsideration of the OCSE's final decision and to exercise, prior to the State plan approval/disapproval decision, the right to a hearing under the procedures set forth in 45 CFR Part 213. If the State elects to pursue its hearing rights prior to issuance of OCSE's decision, no further administrative appeal will be allowed.

ATTACHMENT: Instructions for State Plan Disapproval

Timetable of Effective Dates

1997 Legislative Calendar

SUPERSEDED

MATERIAL: OCSE-AT-86-21

INQUIRIES: ACF Regional Administrators

/ S /

Anne F. Donovan

Acting Deputy Director

Office of Child Support Enforcement

Instructions for State Plan Disapproval

I. Notice of Intent to Disapprove

OCSE will issue a Notice of Intent to Disapprove a State Plan to the State umbrella agency head when it has been determined that either of the following situations exist:

Pursuant to the requirements at 45 CFR 301.13(d) the State IV-D plan no longer meets the requirements for an approved State plan based on relevant Federal statutes and guidelines.

Pursuant to the requirements at 45 CFR 301.13(e) or (f) the State IV-D plan or amendment submitted for approval does not meet the requirements under title IV-D of

the Act and regulations issued pursuant to the Act.

II. Notice Of Opportunity For Hearing

The Notice of Intent to Disapprove will provide opportunity for the State to request a hearing prior to the issuance of the final decision if the State waives its right to a reconsideration of OCSE's decision under 45 CFR 301.14. The State must request a hearing within 60 days of the date of the Notice of Intent to Disapprove. If the State does not request a hearing, OCSE shall proceed according to the procedures set forth under Determination to Withhold outlined below.

Upon request of the State for a hearing, OCSE will issue a Notice of Hearing which will state the time and place of the hearing, the issues which will be considered, and shall be published in the Federal Register. The hearing procedures contained in regulations at 45 CFR Part 213 shall apply to these proceedings.

III. Negotiations

As provided in regulations at 45 CFR 213.1(b) the hearing process does not preclude or limit negotiations between OCSE and the State, whether before, during or after the hearing to resolve the issues which are, or otherwise would be, considered at the hearing. Such negotiations and resolution of the issues are not part of the hearing, and are not governed by the hearing procedures, except as expressly provided for in such procedures.

IV. Determination to Withhold

If OCSE concludes that the State does not have an approved State IV-D plan under section I of these instructions, it will notify the State that further Federal payments under title IV-D of the Act will not be made to the State until a State IV-D plan is submitted and approved. Until a State IV-D plan is approved, no further Federal payments under title IV-D will be made to the State for any child support enforcement activities. Pursuant to 45 CFR 213.33, the effective date for the withholding of Federal funds shall not be earlier than the date of OCSE's decision and shall not be later than the first day of the next calendar quarter following such decision.

V. Reconsideration

Any State which has not waived its right to reconsideration and is dissatisfied with OCSE's decision that the State does not have an approvable State plan may request reconsideration of the decision pursuant to regulations at 45 CFR 301.14. Funding, however, will be suspended and may not be restored unless OCSE subsequently determines that the original decision to withhold Federal IV-D funding was incorrect.

CHILD SUPPORT LEGISLATION IN 104TH CONGRESS

TIMETABLE OF EFFECTIVE DATES FOR STATE REQUIREMENTS

Based on Dates in Text of Title III of PL 104-193

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

Section 395 states that, except as specifically provided in the legislation, the effective date for provisions of PL 104-193 is 10/1/96 for provisions under "454 & 466 of the Act. Section 395 allows a grace period for State law changes and State constitutional amendments. For State law changes, the grace period is until the effective date of the State implementing provisions, but no later than the first day of the first quarter after the close of the first regular legislative session that begins after enactment of PL 104-193. For State constitutional amendments, the grace period is until one year after the effective date of the State constitutional amendment, but no later than five years after enactment of PL 104-193.

Requirements Effective 10/1/96

Income withholding ['314] -- '466(a)(1) and (b)

Locator networks; access to motor vehicle and law enforcement data ['315] -- '466(a)(12)

SSNs on applications for professional, commercial drivers, occupational and marriage licenses; on records of divorce decrees, support orders, and paternity determinations; and death records & certificates ['317] -- '466(a)(13)

Administrative enforcement in interstate cases ['323] -- '466(a)(14)

State laws providing expedited procedures, including:

Ordering genetic testing for paternity establishment; Issuing subpoenas for information and impose penalties for failure to respond; Requiring all entities in a State to promptly respond to inquiries by State agency and sanction failure to respond; Obtaining access to records of other State and local government agencies and records held by private entities including public utilities and financial institutions; Changing payee in cases subject to an assignment; Ordering income withholding; Securing assets to satisfy arrearages by intercepting or seizing periodic or lump-sum payments from a State or local agency and judgments, settlements, and lotteries; attach assets held by financial institutions; attach retirement funds; and impose liens; Increasing the amount of monthly support payments to include amounts for arrearages; Filing of information on location/identity of parties in State case registry upon entry of order; Statewide jurisdiction over orders and transfer of cases between local jurisdictions without additional filing; and Using of automated system to maximum extent feasible to implement expedited administrative procedures ['325] -- "466(c) & 454A(h)

State laws concerning paternity establishment, including:

Establish paternity before age 21 (retroactive to 8/16/84); Genetic tests in contested cases upon request w/sworn affidavits; Payment for genetic testing; Provide for a simple civil process for voluntarily acknowledging paternity with prior explanation/written notice to parents; Birth record agency must offer voluntary paternity establishment services, and other may; Name of father included on birth record only if both mother and father have signed an acknowledgment, or court or administrative authority has adjudicated paternity; Development of affidavit for voluntary acknowledgment of paternity which must be given full faith and credit in any other State; Procedures where voluntary acknowledgments and adjudication of paternity are filed with the State registry of birth records for comparison with State case registry; Admissibility of test results if performed by accredited laboratory; Rescission timeframe of 60 days for signed voluntary paternity acknowledgments; Elimination of judicial/administrative ratification proceedings on unchallenged paternity acknowledgments; Default orders; No right to jury trial in paternity cases; Issuance of temporary support orders in paternity cases; Evidentiary treatment of birth expenses/bills; and Opportunity for putative fathers to initiate paternity proceedings ['331(a)] -- '466(a)(5)

State plan requirements for paternity outreach activities ['332] -- '454(23)

Cooperation/good cause ['333] -- '454(29)

State use of definitions for collecting & reporting data ['343(b)] -- '454(30)

Simplified review & adjustment process ['351] -- '466(a)(10)

Voiding of fraudulent transfers ['364] -- '466(g)

Work requirement for persons owing child support ['365] -- '466(a)(15)

Reporting arrearages to credit bureaus ['367] -- '466(a)(7)

Liens on real/personal property by operation of law; full faith and credit to liens without registration of order ['368] -- '466(a)(4)

State law authorizing the suspension of licenses ['369] -- '466(a)(16)

International CSE -- State treatment of international requests ['371(b)] -- '454(32)

Financial Institution data matches ['372] -- '466(a)(17)

Enforcing orders against grandparents in cases of minors ['373] -- '466(a)(18)

State cooperative agreements with Indian Tribes ['375(a)] -- '454(33)

Enforcement of orders for health care coverage ['382] -- '466(a)(19)

Explicit statutory requirement that Title IV-D services be provided to nonresident applicants; enforce child support & support due on behalf of child's custodian ['301(a)] -- "454(4)&(6)

Continuation of IV-D services for former recipients of IV-A assistance [301(b)] -- '454(25)

Requirements Effective 3/1/97

Use of forms by States in interstate cases ['324(b)] -- '454(9)(E)

Requirements Effective 10/1/97

Annual State self-reviews & reports ['342(a)] -- '454(15)

Data submitted on compliance with Federal performance requirements ['342(a)] --'454(15)

State privacy safeguards ['303(a)] -- '454(26)

State procedures-notices & copies of orders ['304(b)] -- 454(12)

State directory of new hires ['313] -- 454 (28)

ADP systems meeting all IV-D requirements enacted on or before Family Support Act ['344] -- '454(24)

Denial/restriction/revocation of passport if arrears greater than \$5000 ['370] -- "452(k) & 454(31)

Requirements Effective 1/1/98

Adoption of UIFSA (with modifications) ['321] -- '466(f)

Requirements Effective 10/1/98

All support orders established or modified on or after 10/1/98 included in State central registry, which must be in place by 10/1/2000 ['311 and '344(a)(2)] -- '454A

Centralized automated unit for collections and disbursements ['312] -- '454(27)

Collection through State centralized collection unit of orders under wage withholding['312] -- '454B

State new hire reporting systems in existence prior to P.L. 104-193 must meet rest of new requirements ['313] -- '454(28)

Requirements Effective 10/1/99

End of optional exception period for local court collection of child support in lieu of State centralized collection unit ['312] -- '454B

Requirements Effective 10/1/2000

ADP systems must meet all IV-D requirements enacted on or before this law (with additional time tied to regulation issuance) ['344(A)(4)] -- '454(24)

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HB

223

House Health and Social Services Committee

Wes Keller, Co-Chair

State Capitol Building, Room 13
Juneau, AK 99801-1182
Phone (907) 465-2186
Fax (907) 465-3918
Rep_Wes_Keller@legis.state.ak.us



Bob Herron, Co-Chair

State Capitol Building, Room 415
Juneau, AK 99801-1182
Phone (907) 465-4942
Fax (907) 465-4589
Rep_Bob_Herron@legis.state.ak.us

Sponsor Statement

This bill has been filed in response to an urgent issue brought forward by four of Alaska's Residential Psychiatric Treatment Centers in Anchorage and Fairbanks. The Legislation intends to advance and accelerate the efforts to bring our most troubled Alaskan children home through the *Bring the Kids Home Project*. Existing DHSS regulations 7 AAC50.815 Qualifications of Caregiver Staff require that a majority of treatment staff in these facilities, namely the caregivers, be held to a higher qualification standard than Federal Medicaid laws and other states' currently housing Alaska's children. The current qualifications are as follows: 1) bachelors degree; 2) an associate degree and two years work experience in a RPTC; or 3) four years work experience in a RPTC. This proposed legislation remedies the current situation by requiring that each facility have at least one staff member with a bachelor degree on each shift to oversee caregivers. Additionally, caregivers will be required to meet strict training standards as authorized or approved by the Department as a condition of employment. The committee urges swift passage of this legislation.

SECTIONAL

CSHB 223(HSS)

“An Act relating to the qualifications for residential psychiatric treatment center caregiver staff; and providing for an effective date.”

Section 1: Title 47.32 Centralized Licensing and Related Administrative Procedures

Adds a new section AS 47.32.055 which expands the acceptable alternative qualifications for caregiver staff in a residential psychiatric treatment center under 7 AAC 50.815 by incorporating the existing standards and adding a fourth alternative. In the fourth alternative a person would be a qualified caregiver if he or she has at least a high school diploma or general educational development diploma, completes a training course provided or approved by the Department of Health and Social Services, and works only during hours when a person with a bachelor’s degree in a human services related field or who satisfies one of the other alternatives is also on duty.

Section 2: Providing that the new section will take effect immediately.



April 6, 2009

Representative Wes Keller, Co-Chair House HESS
Capitol Building
Juneau, Alaska 99811

Re: Qualifications for Caregivers in Residential Treatment Centers

Dear Representative Keller:

Thank you for your service to the State of Alaska and for your support of Alaska's families in need. Southcentral Foundation serves thousands of children and their families in our primary care center, residential treatment home for young men, therapeutic family group homes, and many other programs.

As you may know, Southcentral Foundation is partnering with the State of Alaska, the Denali Commission and the Alaska Mental Health Trust Authority to bring the kids home by building a culturally appropriate 44-bed Residential Psychiatric Treatment Center (RPTC). Our RPTC is a Level V and is in the design phase. We anticipate starting construction in June 2009, with an expected opening date in fall 2010. One of the challenges of this project is ensuring successful recruitment of the more than 80 FTEs necessary to provide quality treatment at this level of care. More specifically, it will be a challenge to recruit and train qualified staff with a bachelor's degree, associate degree with at least two years experience in residential treatment, or a high school diploma and four years experience in residential treatment.

Southcentral Foundation strives to employ Alaska Native and American Indian people as customer/owners of our health care system. We envision being able to train our own employees to work for and with our Alaska Native and American Indian customer/owners. Regulation 47 AAC 50.815 presents challenges to Southcentral Foundation's ability to "train our own" to provide the highest levels of quality and culturally appropriate care to those that need RPTC services. If the language is amended to allow for "department provided or approved training," our people will gain the experience they need to serve their community and Southcentral Foundation will be able to staff its RPTC.

Southcentral Foundation supports the proposed amendments to AS 47.32.030 regarding the qualifications for residential psychiatric treatment center caregiver staff and also supports the retroactive date. Again, thank you for your support.

Sincerely,

SOUTHCENTRAL FOUNDATION



Katherine Gottlieb, MBA
President/CEO



Board of Directors

Judy Binkley

Charlie Boddy, Chair

Cynthia Henry

Meg Nordale

Jeff Olson

David Paulsrud

Mary Sakakibara

Art Silva

Chris Simon

Richard C. Brown, Jr., M.D.
Medical Director

Robert P. Sheehan
President and CEO

MEMBER:
ALASKA BEHAVIORAL
HEALTH ASSOCIATION



A subsidiary of
Boys and Girls Home
and Family Services, Inc.

3101 Lathrop Street
Fairbanks, AK 99701
Telephone 907.459.4700
Facsimile 907.459.4796
www.boysandgirlshome.com

April 2, 2009

Dear Committee,

As Chairman of the Boys and Girls Home of Alaska Board of Directors, I've had firsthand knowledge of the fine work our agency is doing. The services we offer have been absent in our community and are a welcome relief. It is essential that these services continue.

Part of our struggle in Fairbanks is around folks having enough credentials to meet the present Medicaid standards. It is our hope that you will support the proposed Bill before you, in order for us to continue to deliver the services to children and their families while ensuring quality of care. We know that we are not alone in this process and that other Level V organizations around the state would also welcome this relief.

I look forward to meeting with you and I am hopeful that we can move this Bill forward.

Sincerely,

A handwritten signature in cursive script that reads "Boddy".

Charlie Boddy

April 3, 2009

The Honorable Johnny Ellis
Alaska State Senate
Juneau, AK

Re: Qualifications of Caregivers in Residential Treatment Centers

Dear Senator Ellis:

To begin, thank you for your support of mental health related issues that have allowed North Star Behavioral Health System to provide needed services for the children of our state. As a provider in a vast continuum of care, it is essential that we be able to continue to meet the needs of children and adolescents. Our ability to offer appropriate care that improves the lives of youth and families is often impacted by issues decided in the legislative arena.

One such issue is the Regulation 7AAC50.815, related to the qualifications of caregivers in Residential Psychiatric Treatment Centers. This regulation requires that a front line care giver (mental health aide) must either have a Bachelor's degree and/or an Associate's degree with at least two years experience in residential treatment, or a high school diploma and four years experience in residential treatment.

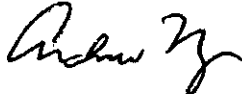
While the intent of the requirement is to ensure that front line caregivers are qualified and trained, this places an undue burden on providers. Clearly, one cannot gain experience without a degree, when the regulations require one have experience in order to be hired. Thus, only employees who could be "grand fathered" or come from state's that do not have such a requirement (out of state residents) would become eligible for hire. Given the rural nature of our state, this limits potential hires and thus can limit needed care in more rural communities. Given the state's push toward "Bringing our Children Home" for care, this appears conflicted with this purpose.

Currently, all facilities train and orient staff in addition to conducting back ground checks for safety. Annual training is required by the state, which acknowledges the need for continued training in addition to orientation curriculum. While I would understand and support reviewing this criteria every few years, until we reach a more qualified training pool, I would ask adjustments to be considered. Alternatives might include an increased amount of training required when hiring non-degreed candidates. In this way there is no

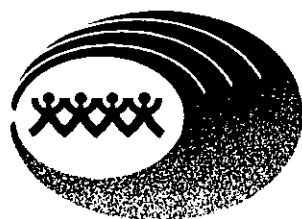
must invest at least that amount of dollars in additional training to meet new training requirements for hiring lesser trained employees. Certainly I would be willing to work with other providers in making such recommendations to the state or the state could decide such issues to ensure continued protection of our children. With that said, all residential facilities are reviewed for compliance by numerous agencies, and I see little danger in non-compliance with such changes.

In closing, I appreciate your consideration of this request and would be happy to answer any questions related to my comments.

Sincerely,



Dr. Andrew Mayo, CEO
North Star Behavioral Health System



Alaska Children's Services

March 31, 2009

The Honorable Johnny Ellis
Alaska State Senate
Juneau, AK

RE: Qualifications for Caregivers in Residential Treatment Centers

Dear Senator Ellis:

First, I want to thank you for your long-standing support of Alaska Children's Services and for Alaska's families in need. Thousands of Alaska children are enjoying a much more positive life because of your service to the state.

I want to call your attention to a serious issue that is impacting the ability of Alaska Children's Services and other intensive treatment programs to provide the quality of treatment that is necessary to assist children to become successful. Specifically, I am referring to Regulation 7AAC50.815 – "Qualifications of Caregivers in Residential Psychiatric Treatment Centers." This regulation requires that a caregiver in a program such as ACS must either have a Bachelor's degree, and Associate's degree with at least two years experience in residential treatment, or a high school diploma and four years experience in residential treatment.

While this regulation is intended to ensure that only the most qualified caregivers provide care and treatment to the most fragile and disturbed youth, it falls far short of that. First, the degree requirement is generic; therefore, a person with an accounting degree and no childcare experience is eligible for employment while a much more qualified person without a degree is not. Furthermore, the regulation establishes a classic "Catch 22" in that a non-degreed person with requisite experience can be hired, but the regulation does not allow any provision for a person to gain that experience.

For many years Alaska has been experiencing serious workforce issues and there are myriad workforce development projects currently sponsored by both state and private entities. Over five years ago, Alaska Children's Services, with the support of a federal Administration for Children and Families grant, developed a *Competency-Based Program for Training Childcare Workers*. It is both rural and urban appropriate and has been used by dozens of agencies. I am not advocating for our specific program; however, I am asking for support as the three Level 5 RTC's – ACS, North Star, and Boys and Girls Home of Alaska – work with the Department in efforts to change this regulation.

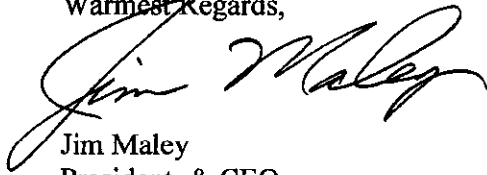


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email: akchild@ak.net • www.acs.ak.org

A Christian mission of American Baptist Churches USA, Evangelical Lutheran Church in America, and the United Methodist Church. A United Way agency, ACS is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Again, thanks so much for your support and please advise if there is any way we can assist you in your efforts.

Warmest Regards,

A handwritten signature in cursive script that reads "Jim Maley". The signature is written in black ink and is positioned above the printed name and title.

Jim Maley
President & CEO
Alaska Children's Services, Inc.

House H&SS Committee
Senate H&SS Committee
Sponsor Statement

This bill has been filed in response to an urgent issue brought forward by four of Alaska's Residential Psychiatric Treatment Centers in Anchorage and Fairbanks. The Legislation intends to advance and accelerate the efforts to bring our most troubled Alaskan children home through the *Bring the Kids Home Project*.

Existing DHSS regulations 7 AAC50.815 Qualifications of Caregiver Staff require that a majority of treatment staff in these facilities, namely the caregivers, be held to a higher qualification standard than Federal Medicaid laws and other states' currently housing Alaska's children.

The current qualifications are as follows: 1) bachelors degree; 2) an associates degree and two years work experience in a RPTC; or 3) four years work experience in a RPTC.

This proposed legislation remedies the current situation by requiring that each facility have at least one staff member with a bachelors degree on each shift to oversee caregivers. Additionally, caregivers will be required to meet strict training standards as authorized or approved by the Department as a condition of employment.

The committee urges swift passage of this legislation.

Matthew Johnson

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Tuesday, April 07, 2009 1:28 PM
To: Sen. Bettye Davis; Rep. Bob Herron; Rep. Wes Keller
Cc: Matthew Johnson; Marianna Carpeneti; Kim, Anna C (GOV); Hogan, William H (HSS); Hefley, Patrick B (HSS)
Subject: Boys & Girls Home follow up
Importance: High

I wanted to follow up on our meetings with you regarding the Alaska Boys & Girls Home with a few more points that have come to light since we met. The Department of Law has raised additional concerns because the legislation appears to be an attempt to alter existing law that is at the center of the on-going licensing investigation into practices at the Boys & Girls Home. As such, the legislation is an indirect attempt to resolve an adverse licensing action. We have also heard that it has been represented to you that the department plans to shut down the home. That is not our intent, we are actively working with the home to bring it into compliance and continue providing an important service to emotionally disturbed youth of Alaska.

We are available to meet with you at any time if you would like further explanation. Please do not hesitate to call.
w.

Wilda Laughlin, DHSS Legislative Liaison
Juneau: 907-465-1613
Cell: 907-723-3802

Matthew Johnson

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Thursday, April 02, 2009 5:08 PM
To: Matthew Johnson; Thomas Obermeyer
Cc: Kim, Anna C (GOV); Stone, Melissa W (HSS); Hogan, William H (HSS); Hefley, Patrick B (HSS); Sherwood, Jon (HSS)
Subject: FW: Boy's and Girls Home bill
Importance: High
Follow Up Flag: Follow up
Flag Status: Red

Tom and Matt, I believe the legislation that you are interested in introducing is identical to a bill that was provided to us this morning by Sen. Paskvan. Below see our very quick analysis of the legislation. We do not believe this is in the best interest of the children in residential care in the state. Please let me know if I can arrange a meeting with Rep. Keller or Sen. Davis to go over our concerns. Thank you very much for the heads up. We appreciate the chance to provide feedback.

Jake,

Commissioner Hogan sent me a copy of the bill that came from the Boy's and Girl's Home agency. We have not had time for the more appropriate comprehensive review of this bill by LAW and our Licensing section as well as by many of the affected Divisions. Given the limits of the timeframe however, I would like to offer you these constructs:

-We must comply with Federal requirements for Residential Psychiatric Facilities and we have not been able to review these proposed changes in light of those requirements. It is entirely possible that they would not meet these requirements

-We have questions as to why the bill is to be put into statutes. Specifically, AS 47.32.030 pertains to 16 entities (such as hospitals, ambulatory surgical centers) and I believe that placing it in this section of the statutes is not meant to affect all 16 entities. The more appropriate place to modify the qualifications of staff who work in residential psychiatric treatment centers would be in regulation or administrative code.

-the use of the words "caregiver staff", to which the proposed changes are meant to apply, is not definitive. Does this apply to medical, professional or paraprofessional staff?

-the training leading to certification reference in (d)(1) is problematic. We do not currently know if there is an adequate amount of this training available to provide all statewide staff who may need this training. This training and certification may also need to be expanded if it is meant to be the "ticket" that would allow a person to work in an RPTC. Again, we have not had time today to review this matter.

-Section (d) (2) (a) notes that a "caregiver staff" would be supervised by someone with a bachelors degree. There is no definition of the type of bachelors degree or the type of experience that this staff would need to have to oversee the "caregiver" staff. Clearly a person who has a bachelor's degree in public accounting would not be suitable for this responsibility. A degree in and of itself is not an adequate qualifying criteria for oversight of staff.

-Lines 15 and 16 which reference that DHSS would somehow review the education and experience of individuals for their "education or experience" of staff to be hired is problematic. We should not be reviewing each and every applicant for positions in these provider agencies who may not meet the bachelor's requirement as this would be an administrative burden that is inappropriate for DHSS.

Again, I regret that we have simply not had time to thoroughly review this bill. It would affect the Behavioral Health Division, The Office of Children's Services, and the Office of Juvenile. As noted above we have NOT had time for LAW, Licensing or our Medicaid office to review it for its' implications.

I can say that we do not support this proposed bill in its current form. We would also be willing to meet with you to discuss the bill. Thanks for the opportunity to provide you with a hurried review. Patrick Hefley, Deputy Commissioner, DHSS

HOUSE BILL NO.

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION**

BY REPRESENTATIVE KELLER

**Introduced:
Referred:**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the qualifications for residential psychiatric treatment center**
2 **caregiver staff; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.32 is amended by adding a new section to read:

5 **Sec. 47.32.055. Residential psychiatric treatment caregiver qualifications**
6 **and training.** (a) In addition to the other requirements of this chapter, an applicant for
7 a license or renewal of a license to operate a residential psychiatric treatment center
8 must comply with the standards set out in this section relating to training and
9 scheduling of caregivers.

10 (b) A caregiver employed by a residential psychiatric treatment center must
11 have

- 12 (1) a bachelor's degree;
13 (2) completed not less than two years of work experience in the
14 treatment of severely emotionally disturbed children and

1 (A) an associate's degree; or
 2 (B) not less than two years of full-time course work toward a
 3 bachelor's degree; or

4 (3) completed not less than four years of work experience as a
 5 caregiver of severely emotionally disturbed children and

6 (A) a high school diploma or general educational development
 7 diploma; and

8 (B) is assigned to work at the center only during hours in which
 9 an individual is on duty at the center who has a bachelor's degree in a human
 10 services-related field or who meets the requirement of (b)(1) or (2) of this
 11 section.

12 (c) The department shall provide or approve mandatory training for caregivers
 13 employed by a residential psychiatric treatment center in the state.

14 (d) In this section, "caregiver" means an individual employed by a residential
 15 psychiatric treatment center to provide direct care and supervision of children admitted
 16 to the center and who is not a physician, registered nurse, or mental health
 17 professional.

18 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
 19 read:

20 **TRANSITION.** Applications approved or renewed by the Department of Health and
 21 Social Services for licensing of a residential psychiatric treatment center before the effective
 22 date of this Act shall be reviewed for compliance with this Act, and a notice shall be mailed to
 23 licensees notifying the licensees of the requirements under AS 47.32.055.

24 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

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Mischel
4/6/09

HOUSE BILL NO.
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE KELLER

Introduced:
Referred:

A BILL
FOR AN ACT ENTITLED

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7 a license or renewal of a license to operate a residential psychiatric treatment center
8 must comply with the standards set forth in this section relating to training and
9 scheduling of caregivers.

10 (b) A caregiver employed by a residential psychiatric treatment center must
11 complete the training required under (c) of this section and be assigned to work at the
12 center only during hours in which an individual is on duty at the center who has

- 13 (1) a bachelor's degree in a mental health-related field; or
14 (2) education or experience that the department has determined is

1 equivalent to a bachelor's degree in a mental health-related field.

2 (c) The department shall provide or approve mandatory training for caregivers
3 employed by a residential psychiatric treatment center in the state.

4 (d) The department may not require a residential psychiatric caregiver to
5 obtain a postsecondary degree.

6 (e) In this section, "caregiver" means an individual employed by a residential
7 psychiatric treatment center who provides care to patients admitted to the center.

8 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
9 read:

10 TRANSITION. Applications approved or renewed by the Department of Health and
11 Social Services for licensing of a residential psychiatric treatment center before the effective
12 date of this Act shall be reviewed for compliance with this Act and a notice shall be mailed to
13 licensees notifying the licensees of the requirements under AS 47.32.055.

14 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

CS FOR HOUSE BILL NO. 223(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the qualifications for residential psychiatric treatment center**
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10 (b) A caregiver employed by a residential psychiatric treatment center must

11 (1) have a bachelor's degree;

12 (2) have

13 (A) completed not less than two years of work experience in
14 the treatment of

- 1 (i) severely emotionally disturbed children;
2 (ii) children in a residential child care facility; or
3 (iii) children in a long-term inpatient facility; and
4 (B) completed
5 (i) an associate degree; or
6 (ii) not less than two years of full-time course work
7 toward a bachelor's degree;
8 (3) have
9 (A) completed not less than four years of work experience as a
10 caregiver of
11 (i) severely emotionally disturbed children;
12 (ii) children in a residential child care facility; or
13 (iii) children in a long-term inpatient facility; and
14 (B) satisfied one of the following:
15 (i) earned a high school diploma or a general
16 educational development diploma; or
17 (ii) completed the training provided or approved under
18 (c) of this section; or
19 (4) satisfy or comply with all of the following:
20 (A) have earned a high school diploma or a general educational
21 development diploma;
22 (B) have completed the training provided or approved under (c)
23 of this section; and
24 (C) be assigned to work at the center only during hours in
25 which an individual is on duty at the center who has a bachelor's degree in a
26 human-services-related field or who meets the requirements of (1), (2), or (3)
27 of this subsection.
28 (c) The department shall provide or approve training for caregivers employed
29 by a residential psychiatric treatment center in the state.
30 (d) In this section, "caregiver" means an individual employed by a residential
31 psychiatric treatment center to provide direct care and supervision of children admitted

1 to the center and who is not a physician, registered nurse, or mental health
2 professional.

3 * **Sec. 2.** This Act takes effect immediately under AS 01.10.070(c).

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE CISSNA

TO: CSHB 223(HSS), Draft Version "C"

1 Page 2, line 28, following "shall":

2 Insert

3 "(1) adopt regulations that may include additional standards for a
4 caregiver employed by a residential psychiatric treatment center needed for the
5 safe care of children and security of employees at the center;

6 (2) work with interested persons in establishing the standards and
7 training for caregivers under this subsection; and

8 (3)"

9

10 Page 3, line 3:

11 Delete all material and insert:

12 "* Sec. 2. The uncodified law of the State of Alaska is amended by adding a new
13 section to read:

14 TRANSITIONAL PROVISIONS; REGULATIONS. The Department of Health
15 and Social Services may proceed to adopt regulations necessary to implement the
16 changes made by this Act. The regulations take effect under AS 44.62 (Administrative
17 Procedure Act), but not before the effective date of the law implemented by the
18 regulations.

19 * Sec. 3. This Act takes effect January 15, 2010."

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

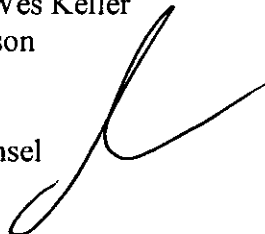
MEMORANDUM

April 14, 2009

SUBJECT: Drafting Issues (CSHB 223(HSS), Draft Version "T")
(Work Order No. 26-LS0842\T)

TO: Representative Wes Keller
Attn: Matt Johnson

FROM: Jean M. Mischel
Legislative Counsel



I have done what I can logically and structurally with the new changes suggested. This version, as requested, repeals all of the statutory changes within three years so that the entire bill is now in uncodified law. The assistant revisor correctly pointed out that since those changes take effect immediately, the transitional section allowing rulemaking to occur immediately, even if inconsistent with the temporary law, is unnecessary. The department has existing and very broad authority to adopt regulations. That authority has been relied upon in the past to adopt regulations in the area the bill covers. The proposed transition section does nothing to otherwise encourage a regulation change or to delay implementation of regulations that are either consistent or inconsistent with the temporary law as proposed. Regulations that are inconsistent with statutory authority cannot be adopted until the repeal of that authority. For these reasons, the transitional section is not included as requested in this version.

In addition, the rewrite requested two of the qualification categories to be restructured. The first of two subheadings cannot include three options in one subparagraph that must also accommodate another qualification requirement for that same category. Those have been organized as subparagraphs for structural reasons so that they make sense in the context used, as optional experience levels, added to required educational backgrounds. Lumping the options in one paragraph both confuses the structure and loses the ability to add another mandate. Instead, I have added the word "treatment" to two of the three optional experience levels which appeared to me to be the only substantive difference in the proposed draft and the bill draft. I do not know why the request otherwise includes a structural change since the problems related to that have been previously discussed. The change should, as previously advised, include definitions, rather than focus on non-substantive organizational issues. I do not know, for example, what "long-term inpatient treatment" means.

The addition of a ratio and supervision of mentorship under qualification category four also creates some confusion. I don't know how the ratio will be evaluated at the point of license application review or how it will be enforced. I also don't know from this request what "supervision or mentorship" means.

JMM:plm
09-278.plm
Enclosure

26-LS0842\T
Mischel
4/14/09

CS FOR HOUSE BILL NO. 223(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the qualifications for residential psychiatric treatment center**
2 **caregiver staff; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:

6 **RESIDENTIAL PSYCHIATRIC TREATMENT CAREGIVER QUALIFICATIONS**
7 **AND TRAINING.** (a) In addition to the other requirements of AS 47.32, an applicant for a
8 license or renewal of a license to operate a residential psychiatric treatment center must
9 comply with the standards set out in this section relating to training and scheduling of
10 caregivers.

11 (b) A caregiver employed by a residential psychiatric treatment center must
12 (1) have a bachelor's degree;
13 (2) have
14 (A) completed not less than two years of work experience in the

1 treatment of

- 2 (i) severely emotionally disturbed children;
3 (ii) children in a residential treatment facility; or
4 (iii) children in a long-term inpatient treatment facility; and

5 (B) completed

- 6 (i) an associate degree; or
7 (ii) not less than two years of full-time course work toward a
8 bachelor's degree;

9 (3) have

10 (A) completed not less than four years of work experience as a
11 caregiver of

- 12 (i) severely emotionally disturbed children;
13 (ii) children in a residential treatment facility; or
14 (iii) children in a long-term inpatient treatment facility; and

15 (B) satisfied one of the following:

- 16 (i) earned a high school diploma or a general educational
17 development diploma; or
18 (ii) completed the training provided or approved under (c) of
19 this section; or

20 (4) satisfy or comply with all of the following:

21 (A) have earned a high school diploma or a general educational
22 development diploma;

23 (B) have completed the training provided or approved under (c) of this
24 section; and

25 (C) be assigned to work at the center only during hours in which one
26 individual who has a bachelor's degree in a human-services-related field or who meets
27 the requirements of (2) or (3) of this subsection is on duty to provide supervision or
28 mentorship for not more than six caregivers at the center who are qualified only under
29 this paragraph.

30 (c) The department shall provide or approve training in residential child care for
31 caregivers employed by a residential psychiatric treatment center in the state.

1 (d) In this section, "caregiver" means an individual employed by a residential
2 psychiatric treatment center to provide direct care and supervision of children admitted to the
3 center and who is not a physician, registered nurse, or mental health professional.

4 * **Sec. 2.** Section 1 of this Act is repealed.

5 * **Sec. 3.** Section 1 of this Act takes effect immediately under AS 01.10.070(c).

6 * **Sec. 4.** Section 2 of this Act takes effect April 15, 2010.

ALASKA**AND FAMILY NETWORK**

P.O. Box 23-3142	Anchorage, Alaska 99523-3142
located in Anchorage at 401 E. Northern Lights Suite 100	

The National Alaska Chapter of the Federation of Families for Children's Mental Health
 (907) 770-4979 e-mail ayfn@ayfn.org www.ayfn.org fax (907) 770-4997

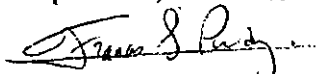
Members of the Health and Social Services Committee:

After reviewing HB 223 with 14 parents whose children have been admitted at least one time into residential treatment, these are their experiences:

1. There is a high turnover in staff in residential psychiatric treatment facilities and the better workers are not always those who have Bachelor degrees in the field.
2. Many workers with no degrees, no work experience but similar personal experience establish positive rehabilitative relationships with children and youth in the treatment setting.
3. The best workers are those individuals that are non-judgmental, able to not create "Power plays" with children and family members and able to facilitate positive dialogue. These workers would be more likely to remain in their jobs if they could earn more than a barely livable wage.

These are their recommendations:

1. This legislation allows more flexibility in the type and amount of formal education workers hold; however, it equates formal education and "approved training" with competence. Such pairing is not necessarily reasonable when professional competencies are a more viable measure for the outcomes needed.
2. This legislation does not set any standard about the level of knowledge or competence to positively engage with children and youth and their families. Among issues it does not address: understanding of resiliency or wellness, de-escalation or feeling management without restraint, positive communication, cultural competence, minimizing of stigma associated with mental illness, understanding of the interplay between physical and mental health and positive engagement of family members in a family/youth driven manner.
3. This bill is premature because there are workforce development committees working with the Alaska Mental Health Trust, the Department of Health and Social Services, the University of Alaska, behavioral health providers and family members currently developing standards of care and learning objectives for psychiatric treatment staff. It makes more sense to complete the committee work this year with the input of providers, consumers and educators before enacting a law that is likely to need different provisions.



Frances Purdy MEd JD and parent
 Executive Director of AYFN

Advocating for effective children's mental health through the use of Peer Navigators who teach and assist each family member to be an equal partner with professionals in a youth and family-driven educational, social and health system of care.

VARIANCE APPLICATION
AS 47.32 and 7AAC 10.9500

Facility Type:	
<input type="checkbox"/> Residential Child Care Facility	<input type="checkbox"/> Residential Psychiatric Treatment Center
<input type="checkbox"/> Maternity Home	
Specialization:	
<input type="checkbox"/> Emergency shelter care	<input type="checkbox"/> Emergency shelter care for runaway children
<input type="checkbox"/> Wilderness and Adventure experience	<input type="checkbox"/> Boarding school
<input type="checkbox"/> Supervised transition living	<input type="checkbox"/> Pregnant and parenting adolescents
<input type="checkbox"/> Substance use treatment	
Name of Facility: _____	Facility Phone: _____
License Age Range: _____ Capacity: _____ Current license dates: _____ License number: _____	
Administrator, Associate or Designee: _____	
Facility Physical Address: _____	
Facility Mailing Address: _____	
7 AAC 10.9510. Request for a general variance. A request must contain the following: (see page 2)	
(1) Regulation or Statute that cannot be met:	
(2) Description of why the entity is unable to meet the requirement:	
(3) Period of time variance requested:	
(4) Proposed alternative ways to meet the requirement:	
(5) Statement as to how the health, safety and welfare of the residents will be protected:	
(6) Plan to achieve compliance before variance expires:	
(7) Assurance that conditions don't present imminent danger:	
(8) Attached evidence of Fire safety or another state or municipal requirement has been reviewed:	
(9) Attached list of affected recipients and representatives names and addresses:	
(11) Additional information requested by the department:	
Please print name and title of person submitting request: _____ Signature: _____	Date: _____
Division of Public Health Licensing Only below this line:	
Variance Committee:	
1. _____	DATE: _____
2. _____	DATE: _____
3. _____	DATE: _____

APPROVED DISAPPROVED

Dates Variance Effective: _____ to _____.

COMMENTS OR CONDITIONS:

PURPOSE: 7 AAC 10.9500. Purpose and applicability

PROCEDURE:

7 AAC 10.9510. Request for a general variance. An entity seeking a general variance under 7 AAC 10.9500 – 7 AAC 10.9535 must submit to the department, on a form supplied by the department, a request for a general variance as required by this section. A request must contain the following:

- (1) the requirement from which the variance is sought;
- (2) the reasons why the entity is unable to comply with the requirement, a description of how the entity is not in compliance, and the extent to which compliance with the requirement will impose any substantial economic, technological, programmatic, legal, or medical hardship on the entity or recipients of services;
- (3) the period of time for which the variance is requested;
- (4) the proposed alternative means of satisfying the purpose of the requirement for which the variance is sought;
- (5) a statement as to how the health, safety, and welfare of recipients of services will be protected during the period of the variance;
- (6) the plan for achieving compliance before the variance expires;
- (7) assurance that the conditions at the entity do not present an imminent danger to the health, safety, or welfare of recipients of services;
- (8) if the request for a variance involves fire safety or another state or municipal requirement, evidence that the request has been reviewed by the appropriate authority;
- (9) for a licensed entity, the names of the recipients of services who would be affected by the variance, and the names and addresses of any representatives of those recipients of services; the requirements of this paragraph do not apply to a child care facility subject to 7 AAC 57 unless this information is requested by the department;
- (10) for an assisted living home, assurance that the notice requirements of 7 AAC 10.9515 will be met;
- (11) any additional information requested by the department to determine the effect of a variance on the health, safety, and welfare of recipients of services. (Eff. 6/23/2006, Register 178)

7 AAC 10.9520. Evaluation of a request for a general variance

7 AAC 10.9525. Grant or denial of a general variance. (a) The department's decision to grant or deny a request for a general variance will be issued in writing and will be delivered to the person who made the request.

7 AAC 10.9530. Posting of a general variance. (a) If the department grants a request for a general variance, the entity shall post a copy of the general variance decision in a conspicuous place, with the entity's license as required by AS 47.32.080, during the period the variance is in effect, and shall make it available to any person who wishes to review it. A general variance remains in effect for the duration stated, unless the department revokes the variance

STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

DIVISION OF BEHAVIORAL HEALTH

SARAH PALIN, GOVERNOR

3601 C Street, Suite 878
ANCHORAGE, ALASKA 99503

PHONE: (907) 269-3600
FAX: (907) 269-3623

March 31, 2009

Robert Sheehan, CEO
Boys and Girls Home of Alaska, Inc.
3101 Lathrop
Fairbanks, AK 99701-7426

Dear Mr. Sheehan,

The State of Alaska's Department of Health and Social Services conducted an integrated site review of the Boys and Girls Home of Alaska (BGHA) on the dates of January 12-14, 2009. As part of this review, Behavioral Health conducted a compliance review of Medicaid regulations governing Residential Psychiatric Treatment Centers. A copy of these regulations (7AAC 43.550 - 7 AAC 43.580) is attached for your review.

The January 12-14, 2009 site review identified the following deficiencies:

1. BGHA did not have the qualified staff required to participate as members of the Inpatient Interdisciplinary Team (IIT) (7AAC 43.552(f)) including a licensed psychological associate, a licensed occupational therapist, or a licensed clinical social worker. The resulting Plan of Improvement outlined in the Site Review Report directed BGHA to verify the employment status of the required staff no later than March 1, 2009. The department did not receive documented proof the BGHA had employed or contracted with the appropriate staff until March 25, 2009.
2. The medical necessity chart review conducted on Jan. 12-14, 2009, identified that the clinical documentation did not consistently meet the regulatory requirements specified in 7 AAC 43.552 and 7 AAC 43.555 or the criteria described in the State of Alaska's Inpatient Psychiatric Review Provider Manual.¹ The Medical Necessity Clinical Chart Review Plan of Improvement (POI) requires clinical documentation to be in compliance with regulatory and policy standards by May 1, 2009.

¹ <http://www.qualishealth.org/crm/alaska-medicareid/behavioral-health/upload/April-28-2008-Inpatient-Psychiatric-Alaska-Medicareid-Provid.pdf>

3/31/2009

Page 2

Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies from either the division of public assistance, the division of public health, or the division of mental health (7AAC 43.950 (18)) is a breach of the terms of the Medicaid provider agreement and provider certification on the Medicaid claims form (7AAC 43.950 (7)). As a result of the above deficiencies, the following sanction is invoked:

1. Attendance in provider education classes under 7 AAC 43.955(6). Behavioral Health staff will contact you to schedule the Education classes. Despite now having qualified staff, this training must be completed by May 15, 2009. Additionally, Behavioral Health staff will be conducting periodic follow-up reviews through December 2009. At that time the need for on-going reviews will be reassessed. Additionally, BGHA is required to inform Behavioral Health staff, no later than the next business day, if staffing levels fall below the minimum requirements set forth in 7 AAC 43.755.

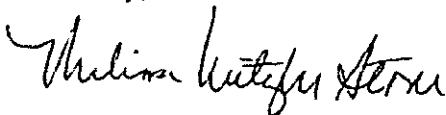
You should be fully aware that failure to comply with this sanction or to correct the documentation deficiencies noted in #2 above may result in further sanctions including but not limited to withholding of Medicaid payments, or suspension or termination from the Medicaid program.

The sanctions noted herein are effective 30 days after the date of this notice. If you choose to appeal these sanctions you may do so by submitting a notice within in 30 days of the date of this notice by submitting in writing a statement or statements that outline your appeal and all supporting documentation which shows you are in compliance with the Medicaid regulations to:

Commissioner Bill Hogan
Department of Health and Social Services
PO Box 110601
Juneau, AK 99811-1061

If you have questions or require further clarification in regards to this letter, please contact Teri Keklak or Pam Miller, Behavioral Health Program Administrators, at 269-3600.

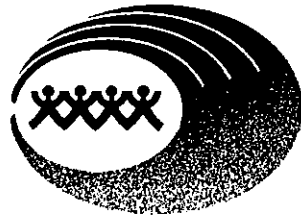
Sincerely,



Melissa Witzler-Stone
Director

Cc: Melissa Stone, Director
Pat Hefley, Deputy Commissioner, DHSS
Charlie Boddy, Chair - Board of Directors BGHA

Encl: Alaska Administrative Code Title 7 Health & Social Services Part 3 Chapter 43 Medical Assistance Title 10



Alaska Children's Services

March 31, 2009

The Honorable Johnny Ellis
Alaska State Senate
Juneau, AK

RE: Qualifications for Caregivers in Residential Treatment Centers

Dear Senator Ellis:

First, I want to thank you for your long-standing support of Alaska Children's Services and for Alaska's families in need. Thousands of Alaska children are enjoying a much more positive life because of your service to the state.

I want to call your attention to a serious issue that is impacting the ability of Alaska Children's Services and other intensive treatment programs to provide the quality of treatment that is necessary to assist children to become successful. Specifically, I am referring to Regulation 7AAC50.815 – "Qualifications of Caregivers in Residential Psychiatric Treatment Centers." This regulation requires that a caregiver in a program such as ACS must either have a Bachelor's degree, and Associate's degree with at least two years experience in residential treatment, or a high school diploma and four years experience in residential treatment.

While this regulation is intended to ensure that only the most qualified caregivers provide care and treatment to the most fragile and disturbed youth, it falls far short of that. First, the degree requirement is generic; therefore, a person with an accounting degree and no childcare experience is eligible for employment while a much more qualified person without a degree is not. Furthermore, the regulation establishes a classic "Catch 22" in that a non-degreed person with requisite experience can be hired, but the regulation does not allow any provision for a person to gain that experience.

For many years Alaska has been experiencing serious workforce issues and there are myriad workforce development projects currently sponsored by both state and private entities. Over five years ago, Alaska Children's Services, with the support of a federal Administration for Children and Families grant, developed a *Competency-Based Program for Training Childcare Workers*. It is both rural and urban appropriate and has been used by dozens of agencies. I am not advocating for our specific program; however, I am asking for support as the three Level 5 RTC's – ACS, North Star, and Boys and Girls Home of Alaska – work with the Department in efforts to change this regulation.

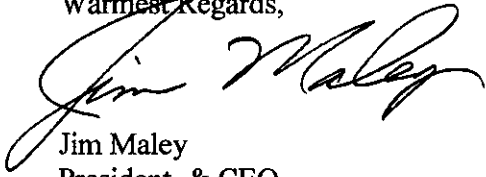
4600 Abbott Road, Anchorage, Alaska 99507-4314 • (907) 346-2101 • Fax (907) 348-9230
email: akchild@ak.net • www.acs.ak.org



A Christian mission of American Baptist Churches USA, Evangelical Lutheran Church in America, and the United Methodist Church. A United Way agency, ACS is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Again, thanks so much for your support and please advise if there is any way we can assist you in your efforts.

Warmest Regards,

A handwritten signature in black ink that reads "Jim Maley". The signature is written in a cursive style with a large, sweeping initial "J".

Jim Maley
President & CEO
Alaska Children's Services, Inc.

Justification for Rejecting the Fiscal Note to CSHB 223

The new section regarding qualifications of residential psychiatric treatment center caregivers will sunset in only one year. The Department already provides training so it would not need to develop a new training curriculum. The bill permits the Department to approve training, rather than provide it itself. The CEO of Alaska Children's Services, one of Alaska's oldest and most highly regarded providers of child residential care services, including RPTC services, testified before this Committee that it has developed comprehensive training for residential caregivers and will make that training available for free.

COMPARISON OF DIRECT CARE GIVER STANDARDS IN RESIDENTIAL PSYCHIATRIC TREATMENT CENTERS

Standard	ALASKA 7 AAC	COLORADO	OREGON	UTAH R501-	MONTANA 37.97
What Called	RPTC 50.800-890	PRTC 7.718.1	PRTF 309.032	-19 Resi. Tx Program -16 Interned Secure Tx Pr.	RTC 37.97.250-259
Qualifications	50.815. Caregiver must have completed: (1) bachelor's level college; (2) 2yr exp in residential or inpatient tx for children or other tx of SED children + 2 years college or AA; OR (3) 4yr increasing responsible caregiver experience in residential or inpatient tx of children or tx of SED children + high school, GED or certification of completion of DHSS-provided residential child care training	7.705.44 Child care worker must have completed: (1) 2 yrs of college; OR (2) high school or GED + 1 yr. exp in human services field Child care staff aides must work directly under supervision of child care worker (no reqts other than must be 18 yrs old and have approval of director)	309.032-1150(3)(c) & (7)(a). None specified.	-19-5.3.e. Reference to "other staff" requires only that they be trained to work w/ emotionally & behaviorally disturbed, or conduct disordered children & youth -16-4.F. Reference to "unlicensed staff" requires only that they be trained to work w/ youth who are chemically dependant or emotionally disturbed or behaviorally disturbed or conduct disorder. Both req. licensed clinical professional supervision	97.250. Child care staff: (1) bachelor's level degree; OR (2) 3 yrs experience in group child care; OR (3) any equivalent combination of education and experience
Orientation/ Initial Training	50.820: If exp working w/ emotionally disturbed persons in resid. setting is: < 6 mon, then 40 hrs + 40 hrs experience working under supervision; OR > 6 mon, then 20 hrs + 20 hrs supervised work	7.714.92. Req. intro training and orientation; no time requirement. (20 hrs/yr thereafter)		-19-5. <i>see above</i> -16-4.I. Unlicensed staff must receive 20 hrs of pre-service training and orientation.	97.501(4). gen trg reqt re: provider policies & status of residents. 97.206(4) in-svc trg: 15hr/yr
Direct Supervision	50.240. req. inexperienced caregiver to be monitored by experienced caregiver + monthly conferences re: needs of specific children		≥ 1 qualified mental health associate (QMHA), who must have completed: (1) BA in beh sci field OR (2) ≥ 3 yrs. work, educ, training or experience. 309.032.1110(71) 309.032.1150 No ratio for caregivers/kids. # prof'l staff per # kids: Awake: 1 of each 3 staff must be QMHA or 1 of Sleep: 1 of each 6 staff must be QMHA		
Staffing Ratio	50.865 staff/kids ≥ 2 [l awake] Awake: <10 kids: 1/3 Awake: ≥ 10 kids: 1/5 Sleep: 1/6 if kids <10 yrs old Sleep: 1/10 if kids >10 yrs + available on-call staff & on-call MH Professional	7.705.45 Awake 1/6 if kids 3-6 yrs Awake 1/8 if kids 7-12 Awake 1/10 if kids 13-16 Sleep: 1/12 if kids 3-6 Sleep: 1/16 if kids 7-12 Sleep: 1/20 if kids 13-16		-19-5.3.f. minimum of 2 staff (unspecified) w/ staff ratio of 1/4 awake; reduced at night (no minimum) -16-4G. ≥ 1/5 w/ > 2 on duty at all times Sleep: 2/25; 3/50; 4/75; 5/100; 6/>100	97.250(c): Awake: 1/6 + 1 on call Sleep: 1/12 + 1 on call

Standard	ALASKA 7 AAC	FLORIDA 65E-9			
What Called	RPTC 50.800-890	RTC 65E-9.001-014			
Qualifications	50.815. Caregiver must have completed: (1) bachelor's level college; (2) 2yr exp in residential or inpatient tx for children or other tx of SED children + 2 years college or AA; OR (3) 4yr increasing responsible caregiver experience in residential or inpatient tx of children or tx of SED children + high school, GED or certification of completion of DHSS-provided residential child care training	9.002(11) def. "direct care staff" 9:007(4)(f): direct care staff: (1) high school; OR (2) GED			
Orientation/ Initial Training	50.820. If exp working w/ emotionally disturbed persons in resid. setting is: < 6 mon, then 40 hrs + 40 hrs experience working under supervision; OR ≥ 6 mon, then 20 hrs + 20 hrs supervised work	9.007(5). req. orientation during first 2 mon + 40 hrs training annually for direct care staff			
Direct Supervision	50.240. req. inexperienced caregiver to be monitored by experienced caregiver + monthly conferences re: needs of specific children	9.007(c). An RN must be on duty at all times. See ratio below.			
Staffing Ratio	50.865. staff/kids Awake: <10 kids: 1/3 Awake:>10 kids: 1/5 Sleep: 1/6 if kids <10 yrs old Sleep: 1/10 if kids >10 yrs	9.007(e). direct care staff: min: ≥2 awake at all times; Awake: 1/4 Sleep: 1/6 (c) RN Awake: 1/30 Sleep: 1/40			

Matthew Johnson

From: Myra Munson [myra@sonoskyjuneau.com]
Sent: Thursday, April 09, 2009 7:26 AM
To: lindaa@pci.net; Matthew Johnson
Subject: FW: Caregiver standards in RCCF & Fed standards

FYI. Info sent to DHSS Deputy Commissioner Pat Hefley.

Myra M. Munson

Sonosky, Chambers, Sachse, Miller & Munson LLP
 302 Gold Street, Suite 201
 Juneau, AK 99801
 907-586-5880
 907-586-5883 (fax)
 907-250-4737 (mobile)
 Email: myra@sonoskyjuneau.com

From: Myra Munson
Sent: Thursday, April 09, 2009 7:25 AM
To: 'patrick.hefley@alaska.gov'
Subject: Caregiver standards in RCCF & Fed standards

Pat,

As I mentioned yesterday, I have researched both of these questions. Here are my findings. If you discover I have missed something or you think my conclusions are incorrect or misleading, please let me know.

What are the qualifications for caregiver staff in a RCCF?

7 AAC 50.210(i) A caregiver in a RCCF must have a high school diploma or GED.

7 AAC 50.230. An "associate administrator" must have 30 semester hours of college credit in a human services field.

7 AAC 50.240. Supervision requirements:

(a) A facility with one or more employees must ensure that an inexperienced caregiver is monitored by an experienced caregiver until the inexperienced caregiver is able to safeguard the health and safety of the children in care.

(b) An RCCF must have at least monthly conferences between supervisor and caregiver re: needs and treatment plans of specific children.

7 AAC 50.250. Orientation and training.

(a) Orientation: must begin at onset of employment, be completed within 8 weeks and include employer policies & procedures, including caregiver responsibilities; satisfying special needs of specific children, where appropriate; and emergency procedures and health and safety measures.

(d) Training. Each caregiver must receive a minimum of 15 hours of training a year exclusive of orientation.

7 AAC 50.410. Caregiver ratio. Awake: 1/6 and Sleep: 1/12

Is the newly proposed RPTC caregiver qualification lower than the standards for RCCF?

No.

Does the newly proposed caregiver qualification satisfy Federal requirements?

Yes. Psychiatric residential treatment facilities must satisfy the requirements of 42 C.F.R. Subpart D—Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. §§ 441.151 through 441.182) and Subpart G—Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21 (42 C.F.R. §§ 483.350 through 483.376). These set out no specific requirements for caregiver staff. With regard to staffing qualifications, they focus only on professional staff and training regarding restraints.

More on other matters later, perhaps.

Please call if talking will help us address the underlying issues driving this legislation and achieve better results for children.

Myra

Myra M. Munson

Sonosky, Chambers, Sachse, Miller & Munson LLP

302 Gold Street, Suite 201

Juneau, AK 99801

907-586-5880

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Email: myra@sonoskyjuneau.com

Deputy Director Pat Hefley: April 3, 2009

Response to Munson draft bill (citations will differ from introduced versions, however, issues raised by DHSS may remain)

Commissioner Hogan sent me a copy of the bill that came from the Boy's and Girl's Home agency. We have not had time for the more appropriate comprehensive review of this bill by LAW and our Licensing section as well as by many of the affected Divisions. Given the limits of the timeframe however, I would like to offer you these constructs:

-We must comply with Federal requirements for Residential Psychiatric Facilities and we have not been able to review these proposed changes in light of those requirements. It is entirely possible that they would not meet these requirements

Response: Attorney Myra Munson has researched this issue thoroughly. An RPTC must satisfy the requirements of 42 CFR Subpart D –Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. §§ 441.151 through 441.182) and Subpart G–Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21 (42 C.F.R. §§ 483.350 through 483.376). There are no specific requirements for caregiver staff. The requirements focus only on professional staff.

-We have questions as to why the bill is to be put into statutes. Specifically, AS 47.32.030 pertains to 16 entities (such as hospitals, ambulatory surgical centers) and I believe that placing it in this section of the statues is not meant to affect all 16 entities. The more appropriate place to modify the qualifications of staff who work in residential psychiatric treatment centers would be in regulation or administrative code.

Response: DHSS responded that they could pursue emergency regulations. It has been determined that legal limitations exist that will not allow justification for DHSS to pursue emergency regulations. Further, the standard regulation process will require months of non-compliance for those RPTC's who cannot now meet their standards. A Statutory remedy is the most expeditious and efficient way to keep the RPTC's in compliance and fully operational.

-the use of the words "caregiver staff", to which the proposed changes are meant to apply, is not definitive. Does this apply to medical, professional or paraprofessional staff?

Response: "Caregiver staff" is a term taken directly out of current regulations (7 AAC 50.990(4)). This legislation includes a definition of this term for clarification. This definition excludes professional staff.

-the training leading to certification reference in (d)(1) is problematic. We do not currently know if there is an adequate amount of this training available to provide all statewide staff who may need this training. This training and certification may also need to be expanded if it is meant to be the "ticket" that would allow a person to work in an RPTC. Again, we have not had time today to review this matter.

Response: Currently, RPTC's are required to implement the training. The legislation proposes that the DHSS MAY provide a training program or APPROVE a training program to be implemented by the provider. Currently, providers implement approved training programs for levels 1-3 as well as the more intensive Level 4 care. The legislation proposes the similar implementation for Level 5 care.

-Section (d) (2) (a) notes that a "caregiver staff" would be supervised by someone with a bachelors degree. There is no definition of the type of bachelors degree or the type of experience that this staff would need to have to oversee the "caregiver" staff. Clearly a person who has a bachelor's degree in public accounting would not be suitable for this responsibility. A degree in and of itself is not an adequate qualifying criteria for oversight of staff.

Response: Current DHSS regs do not define bachelors degree and therefore allow an individual with a public accounting degree to meet qualifications. The bill adds language to provide that an individual with a bachelor degree in human services related field be scheduled on every shift rather than require that all caregivers hold a bachelor degree in any field.

-Lines 15 and 16 which reference that DHSS would somehow review the education and experience of individuals for their "education or experience" of staff to be hired is problematic. We should not be reviewing each and every applicant for positions in these provider agencies who may not meet the bachelor's requirement as this would be an administrative burden that is inappropriate for DHSS.

Response: Again, current regulations and this legislation require the RPTC's to guarantee education and experience of individual staff, not the Department. DHSS retains the authority to review for compliance. There is no change from current practice and no additional burden to DHSS.

Again, I regret that we have simply not had time to thoroughly review this bill. It would affect the Behavioral Health Division, The Office of Children's Services, and the Office of Juvenile. As noted above we have NOT had time for LAW, Licensing or our Medicaid office to review it for its' implications.

I can say that we do not support this proposed bill in its current form. – DHSS Deputy Commissioner Pat Hefley

Since the April 3 communication, the Department has also raised other concerns, which are addressed below:

1) Is this bill being proposed to interfere with adverse licensing actions?

No. It will have prospective application only. It will provide a means for RPTCs to achieve full compliance with caregiver staffing.

2) Do the proposed caregiver qualifications for level V RPTC fall below those required for lower level residential child care facilities (RCCF).

No. The only educational requirement for a caregiver in an RCCF (other than in an RPTC) is a high school diploma or GED. 7 AAC 50.210(i). The supervision requirements for the caregivers are only that inexperienced caregivers must be monitored by an experienced caregiver until the inexperienced one is able to safeguard the health and safety of children in care and that there be at least monthly conferences between the supervisor and caregiver. 7 AAC 50.240(a) and (b). Orientation is allowed to occur within the first 8 weeks of employment and there are no specific hour requirements. Otherwise the caregiver is required to have only 15 hours of additional training a year. 7 AAC 50.250(a) and (d). The caregiver to child ratio is 1/6 during awake hours and 1/12 during sleep hours. 7 AAC 50.410. These are all lower than the requirements provided for in the bill.

AMENDMENT

OFFERED IN THE HOUSE

TO: CSHB 223(HSS)

Page 1, line 14 - page 2, line 3:

Delete all material and insert:

“residential treatment for children, inpatient long-term treatment for children, or other treatment of severely emotionally disturbed children; and”

Page 2, lines 9 -13:

Delete all material and insert:

“(A) at least four years of increasingly responsible caregiver experience in residential treatment for children, inpatient long-term treatment of children, or treatment of severely emotionally disturbed children; and”

Page 2, line 26:

Following “of”:

Delete “(1),”

Following “(2)”:

Delete “,”

Page 2, line 28

Following “training”

Insert “in residential child care

Explanation:

Page 1, line 14 - page 2, line 3:

This amendment will make the statute conform exactly to current standards under 7 AAC 50.815(2).

Page 2, lines 9 -13:

This amendment will make the statute conform exactly to current standards under 7 AAC 50.815(3).

Page 2, line 26:

This amendment will ensure that caregivers who are qualified under the new standard in subsection (c) can only work when someone is on-duty who has at least a bachelor's degree in a human-service-related field or has experience in treatment of children.

Page 2, line 28:

This amendment will ensure that the training described in the statute will be the equivalent of that currently provided for by regulation at 7 AAC 50.815(3)(C).

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CS HB 223 (HSS)
() Publish Date: _____

Identifier (file name): HB223CS(HSS)-DHSS-BHA-04-09-09 Dept. Affected: Health and Social Services
Title: Residential Psychiatric Treatment Centers RDU: Behavioral Health
Component: Behavioral Health Administration
Sponsor: House Health & Social Services
Requester: House HSS Component Number: 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation	Information					
	Required	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services	157.0		157.0	157.0	157.0	157.0	157.0
Travel							
Contractual	400.0		400.0	400.0	400.0	400.0	400.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	557.0	0.0	557.0	557.0	557.0	557.0	557.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health	557.0		557.0	557.0	557.0	557.0	557.0
Other Interagency Receipts							
TOTAL	557.0	0.0	557.0	557.0	557.0	557.0	557.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time	2		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The proposed legislation would amend AS 47.32 staff qualifications related to licensing and operation of residential psychiatric treatment centers (RPTC). Recommended changes would require a "department-provided training in residential child care" instead of the current regulation that provides this training in lieu of an academic diploma. This becomes a new state responsibility, requiring additional resources. Currently the division has a contract for behavioral rehabilitation certification within residential youth facilities that is a lower level of care. Based on the existing contract, the projected costs for certification of residential psychiatric treatment centers would be \$400,000 annually.

The proposed legislation would also require that Department of Health and Social Services (DHSS) provide

Prepared by: Melissa W. Stone Phone 269-3410
Division: Behavioral Health Date/Time 4/9/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 4/9/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

BILL NO. CS HB 233 (HSS)

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

and/or approve training for RPTC staff and review the "education or experience" of RPTC applications to be hired. To develop and conduct training, certify other training as approved, and review the applications of RPTC staff to assure that caregivers meet the education/experience and training requirements, a Mental Health Clinician III would be required as well as an Administrative Clerk III to coordinate the paperwork and track staff trainings.

HB

259

26-LS1126S
Mischel
2/22/10

CS FOR HOUSE BILL NO. 259()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered: *
Referred:

Sponsor(s): REPRESENTATIVES KELLER AND GATTO, Kelly

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to citizenship requirements and an alcohol impairment and drug**
2 **testing program for applicants for and recipients of specified cash assistance."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.05 is amended by adding new sections to read:

5 **Article 4. Alcohol and Drug Testing.**

6 **Sec. 47.05.400. Alcohol impairment and drug testing; legislative findings**
7 **and purpose.** The legislature finds that a statewide threat to public safety exists with
8 regard to the use of cash assistance for the purchase of alcohol and illegal drugs. The
9 purpose of the testing program established under AS 47.05.400 - 47.05.500 is to
10 reduce that risk and to protect the residents of the state.

11 **Sec. 47.05.410. Alcohol impairment and drug testing for eligibility;**
12 **regulations; immunity.** (a) The department shall implement a program consistent
13 with AS 47.05.400 - 47.05.500 that provides for random and suspicion-based testing
14 of recipients of cash assistance for use of alcohol that impairs a recipient's ability to

1 work or to seek work and of applicants for and recipients of cash assistance for the use
 2 of illegal drugs. In this paragraph, a "recipient of cash assistance" does not include a
 3 care provider or a third party recipient, as defined by the department in regulation.

4 (b) The department shall adopt regulations to implement this section. The
 5 regulations must include testing policies consistent with AS 47.05.430 and specify the
 6 type of testing to be conducted and the illegal drugs to be included in the testing
 7 program. The drug tested must have a cutoff level that yields a positive test result

8 (1) for initial testing of urine, as follows:

SUBSTANCE	CUTOFF CONCENTRATION (nanograms in each milliliter)
Marijuana metabolites	50
Cocaine metabolites	300
Opiate metabolites	2,000
Phencyclidine	1,000
Amphetamines	1,000

9
 10
 11
 12
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 14
 15
 16 (2) for confirmatory testing of urine, as follows:

SUBSTANCE	CUTOFF CONCENTRATION (nanograms in each milliliter)
Marijuana metabolite	15
(Delta-9-tetrahydrocannabinol-9-carboxylic acid)	
Cocaine metabolite (Benzoylcegonine)	150
Opiates	
Morphine	2,000
Codeine	2,000
6-Acetylmorphine	10
(when morphine concentration exceeds 2,000 nanograms in each milliliter)	
Phencyclidine	25
Amphetamines	
Amphetamine	500
Methamphetamine	500

1 (when amphetamine concentration is
2 greater than or equal to 200 nanograms
3 in each milliliter)

4 (3) for testing of alternative specimens that is consistent with the
5 mandatory guidelines for the federal workplace drug testing program adopted by the
6 United States Department of Health and Human Services.

7 (c) Unless the department or an agent or employee of the department knew or
8 should have known that the results of a test conducted under this section were false
9 and took action that affected a person's eligibility for cash assistance based on the false
10 test results, a person may not bring an action for damages against the department or an
11 agent or employee of the department for

12 (1) good faith actions taken to conduct, or as a result of, alcohol
13 impairment or drug testing under this section;

14 (2) failure to test for alcohol impairment or drugs or for a specific
15 drug;

16 (3) failure to test, or if the test was undetected, failure to detect a
17 specific drug or medical or psychological condition or disorder;

18 (4) termination or suspension of an alcohol or drug prevention or
19 testing program or policy.

20 (d) In a claim for damages based on false test results,

21 (1) a rebuttable presumption exists that the test results were valid if the
22 department complied with this section and the regulations adopted under this section;
23 and

24 (2) the department may not be held liable for monetary damages for
25 good faith reliance and reasonable actions taken as a result of false test results.

26 (e) A person may not bring an action against the department based on the
27 failure of the department to establish a program or policy on substance abuse
28 prevention or to implement alcohol impairment or drug testing.

29 **Sec. 47.05.420. Confidentiality; liability.** (a) The results of a test conducted
30 under AS 47.05.410 are confidential, except that the results may be revealed to the
31 recipient of cash assistance who was tested and to agents and employees of the

1 department as required to determine eligibility for cash assistance.

2 (b) A person may not bring an action for defamation of character or reputation
3 as a result of disclosure of the results of an alcohol impairment or drug test under the
4 alcohol impairment or drug testing program established under AS 47.05.410 unless

5 (1) the results were disclosed to a person, other than an agent or
6 employee of the department for the purpose of the testing program or under court or
7 administrative order;

8 (2) the information disclosed included false test results;

9 (3) the information was negligently or intentionally disclosed; and

10 (4) the elements of the tort claim are met.

11 **Sec. 47.05.430. Testing policies and procedures.** (a) The department shall
12 adopt testing policies that include

13 (1) a list of substances tested;

14 (2) a description of the testing methods and collection procedures,
15 including on-site testing;

16 (3) a right to confirmatory testing and the procedures for confirmatory
17 testing;

18 (4) the consequences for refusal to test or retest that are consistent with
19 the provisions in AS 47.05.450;

20 (5) the right of an applicant for or recipient of cash assistance to
21 receive test results within five working days after the department receives the test
22 results or the written request, whichever is later, if a written request is made by the
23 applicant or recipient within six months after the test;

24 (6) the right of an applicant and a recipient, on the applicant's or
25 recipient's request, to receive, within 72 hours or before an adverse action is taken,
26 whichever occurs first, a confidential explanation of the applicant's or recipient's test
27 results;

28 (7) providing the department's confidentiality and testing policies to
29 applicants for and recipients of cash assistance not less than 30 days before initiating
30 testing on the applicant or recipient.

31 (b) The department shall pay the cost of testing and, if the testing is performed

1 at a location other than a location of the department, the cost of transportation to and
2 from the testing center.

3 (c) Sample collection and testing must

4 (1) comply with scientifically accepted methods and procedures;

5 (2) be performed at a location identified by the department and
6 analyzed by a laboratory approved or certified by the Substance Abuse and Mental
7 Health Services Administration or by the College of American Pathologists;

8 (3) be conducted under reasonable, sanitary, and private conditions
9 that are consistent with reliability;

10 (4) be properly controlled and samples must be properly labeled; and

11 (5) include relevant medical information.

12 (d) A positive drug test must be confirmed using a different analytical process
13 than was used in initial testing. A positive drug test must be reported as a negative
14 result if a licensed physician verifies that the test was affected by medication
15 prescribed for the applicant or recipient tested.

16 (e) The department may not rely on a positive test result without confirmatory
17 testing.

18 **Sec. 47.05.440. Training of test administrators.** (a) The department shall
19 ensure that not less than one designated employee of the department receives not less
20 than one hour of training on alcohol abuse and an additional one hour of training on
21 the use of controlled substances for the purpose of finding reasonable suspicion for
22 testing under AS 47.05.400 - 47.05.500.

23 (b) If the department provides on-site testing for alcohol impairment or illegal
24 drug use under AS 47.05.410, the department shall employ on-site administrators who

25 (1) have received training in person and written certification of the
26 training by the test manufacturer's representative on the proper procedure for
27 administering the test and on accurate analysis of the on-site test results; the training
28 must include recognition of adulteration of a sample collected on-site;

29 (2) agree in writing to maintain confidentiality under the testing
30 policies adopted by the department.

31 **Sec. 47.05.450. Consequences of confirmatory positive testing.** (a) Except as

1 provided in (b) of this section, the department shall deny or suspend cash assistance to
2 an applicant for or recipient of the assistance who, under AS 47.05.400 - 47.05.500,
3 has

4 (1) been tested and received a confirmatory positive result for alcohol
5 impairment or use of illegal drugs and fails to comply with a treatment program
6 approved by the department; or

7 (2) refused alcohol impairment or drug testing required by the
8 department.

9 (b) The department may provide cash assistance on behalf of an eligible
10 recipient who is subject to denial or suspension under (a) of this section if the
11 department has in place an option for third-party receipt of the cash assistance for
12 which the recipient or the recipient's family is otherwise eligible and the third party
13 provides care, shelter, or food to the recipient or the recipient's dependent children.

14 **Sec. 47.05.500. Definitions.** In AS 47.05.400 - 47.05.500, "cash assistance"
15 means money received under Alaska Temporary Assistance under AS 47.27.010 -
16 47.27.085, Alaska Native Family Assistance under AS 47.27.200, and regional public
17 assistance programs under AS 47.27.300.

18 * **Sec. 2.** AS 47.25.120 is amended by adding a new subsection to read:

19 (b) A person must be a citizen of the United States or a legal alien as described
20 in 8 U.S.C. 1181 - 1186 and not otherwise precluded from eligibility under state or
21 federal law to be eligible for assistance under AS 47.25.120 - 47.25.300.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 22, 2010

SUBJECT: Sectional Summary of CSHB 259(),
(Work Order No. 26-LS1126S)

TO: Representative Wes Keller
Chair of the House Health and Social Services Committee
Attn: Jim Pound

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Establishes a program within the Department of Health and Social Services that provides for random and suspicion-based testing of recipients of cash assistance, as defined, for use of alcohol that impairs a recipient's ability to work or to seek work and of applicants for and recipients of cash assistance for the use of illegal drugs. Requires the adoption of regulations to carry out the program and provides cutoff concentrations for drug testing and for specified testing and retesting procedures. Provides for confidentiality of test results and for limits on state liability.

Section 2. Requires a person to be a citizen of the United States or a legal alien to be eligible for specified cash assistance.

JMM:med
10-024.med

ALASKA STATE LEGISLATURE

Interim:

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Phone (907) 373-1842
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Session:

State Capitol Building
Juneau, Alaska 99801-1182
Phone: (907) 465-2186
Fax: (907) 465-3818

REPRESENTATIVE WES KELLER DISTRICT 14

MEMO

To: Representative Wes Keller

Fm:  Jim Bond for Representative Wes Keller

Wes K

Cc: Representative Bob Herron

Date: January 19, 2010

Re: Request for hearing HB 259 (26-LS1126R)

Please consider this as a request for you to schedule HB 259- "Adult Public Assistance Eligibility" before the House Health and Social Services Committee. I have included a packet of information and will be glad to provide your committee staff a .pdf version if they so desire.

HB 259 will establish certain requirements for individuals receiving public assistance. The decisions on how to administer the requirements will be left to the experts in the Department. This bill will give the Department a valuable tool to work with public assistance recipients in returning to productive employed lives.

If you have any questions please feel free to contact my office.

The information contained in this memo is **CONFIDENTIAL** and/or privileged. This memo is intended to be reviewed initially by only the individual named above. If the reader of this page is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination, or copying of this memo or the information contained herein is prohibited. If you have received this memo in error, please immediately notify the sender by telephone and return this memo to the sender at the above address.

Thank you

E-Mail: [Representative Wes Keller@legis.state.ak.us](mailto:Representative_Wes_Keller@legis.state.ak.us)
Call Juneau Toll free: (800) 468-2186
Website: www.akrepublicans.org/keller/

ALASKA STATE LEGISLATURE

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Session:

State Capitol Building
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REPRESENTATIVE WES KELLER DISTRICT 14

Sponsor Statement House Bill 259

“An Act relating to citizenship requirements and an alcohol impairment and drug testing program for applicants for and recipients of adult public assistance.”

The cost of substance abuse in Alaska is staggering. Crime, child abuse, broken homes, domestic violence, cost of business, auto and industrial accidents, poor productivity, chronic health problems all have a causal relationship with substance abuse. It is irrational to expect the government to provide compassionate assistance without giving it the ability to identify substance abuse problems.

When we apply for a job we must provide proof of citizenship and in some cases we may also be required to submit to drug and alcohol testing. We comply because it is part of ensuring that we are qualified to work and because it is part of the package that returns a paycheck. Transportation, public safety, civil service, construction workers, and children who participate in sports are regularly asked to submit to drug and alcohol testing. Arguments in the public square against requirements for drug testing do not stand up to the arguments for the need to ensure safety.

Our Department of Health and Social Services is mandated to provide public assistance to those who need it. It is not appropriate to simply provide assistance without knowing whether the assistance will actually be fueling an addiction problem. HB 259 gives the department a tool they need to determine if substance or alcohol abuse is part of the equation. HB 259 leaves the initiative with the Department regarding how to specifically respond to a person requesting aid according to best practices to restore them to a productive life in their community.

E-Mail: [Representative Wes_Keller@legis.state.ak.us](mailto:Representative_Wes_Keller@legis.state.ak.us)
Call Juneau Toll free: (800) 468-2186
Website: www.akrepublicans.org/keller/

HOUSE BILL NO. 259

IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE KELLER

Introduced: 1/8/10
Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to citizenship requirements and an alcohol impairment and drug
2 testing program for applicants for and recipients of adult public assistance."

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 47.25.430(a) is amended to read:

5 (a) Financial assistance shall be given under AS 47.25.430 - 47.25.615, so far
6 as practicable under appropriations made by law, to every aged, blind, or disabled
7 needy resident who has not made a voluntary assignment or transfer of property to
8 qualify for assistance. In this subsection, "resident" means a person who is

9 (1) a citizen of the United States or a legal alien as described in 8
10 U.S.C. 1181 - 1186;

11 (2) living in the state voluntarily with the intention of making the state
12 the person's home; and

13 (3) [WHO IS] not living in the state for a temporary purpose.

14 * **Sec. 2.** AS 47.25.430(b) is amended to read:

1 (b) The department shall determine the amount of assistance with regard to the
 2 resources and needs of the person and the conditions existing in each case. Assistance
 3 shall be in an amount that will provide the applicant with reasonable subsistence
 4 compatible with decency and health in accordance with standards established by the
 5 department and with the standards established under 42 U.S.C. 1381 - 1383 (Title
 6 XVI, Social Security Act Supplemental Security Income Program). Direct payments
 7 for medical services and remedial care may not be considered in determining the
 8 maximum amount payable. When benefit amounts under 42 U.S.C. 1381 - 1383 are
 9 increased as a result of an increase in the cost of living, the state shall pass along the
 10 increase to recipients and, to the extent federal funds are provided for the federal
 11 benefit, shall increase the amount of the state contribution to recipients, other than
 12 those receiving a personal needs allowance, by a percentage of the state contribution
 13 equal to the percentage increase in the benefit amounts under 42 U.S.C. 1381 - 1383 if
 14 the legislature has appropriated money specifically for the purpose of increasing the
 15 state contribution because of an increase in federal benefit amounts under 42 U.S.C.
 16 1381 - 1383; this increase in the state contribution takes effect on the same day that
 17 the corresponding federal increase in benefits under 42 U.S.C. 1381 - 1383 takes
 18 effect.

19 * **Sec. 3.** AS 47.25 is amended by adding new sections to read:

20 **Sec. 47.25.461. Alcohol impairment and drug testing; legislative findings**
 21 **and purpose.** The legislature finds that a statewide threat to public safety exists with
 22 regard to the use of adult public assistance for the purchase of alcohol and illegal
 23 drugs. The purpose of the testing program established under AS 47.25.463 - 47.25.467
 24 is to reduce that risk and to protect the residents of the state.

25 **Sec. 47.25.463. Alcohol impairment and drug testing for eligibility;**
 26 **regulations; immunity.** (a) The department shall implement a program consistent
 27 with AS 47.25.463 - 47.25.467 that provides for random and suspicion-based testing
 28 of recipients of adult public assistance for use of alcohol that impairs a recipient's
 29 ability to work or to seek work and of applicants for and recipients of adult public
 30 assistance for the use of illegal drugs.

31 (b) The department shall adopt regulations to implement this section. The

1 regulations must include testing policies consistent with AS 47.25.465 and specify the
 2 type of testing to be conducted and the illegal drugs to be included in the testing
 3 program. The drug tested must have a cutoff level that yields a positive test result
 4 established, as of November 1, 2004, by the United States Department of Health and
 5 Human Services under 69 C.F.R. 19644.

6 (c) Unless the department or an agent or employee of the department knew or
 7 should have known that the results of a test conducted under this section were false
 8 and took action that affected a person's eligibility for adult public assistance based on
 9 the false test results, a person may not bring an action for damages against the
 10 department or an agent or employee of the department for

11 (1) good faith actions taken to conduct, or as a result of, alcohol
 12 impairment or drug testing under this section;

13 (2) failure to test for alcohol impairment or drugs or for a specific
 14 drug;

15 (3) failure to test, or if the test was undetected, failure to detect a
 16 specific drug or medical or psychological condition or disorder;

17 (4) termination or suspension of an alcohol or drug prevention or
 18 testing program or policy.

19 (d) In a claim for damages based on false test results,

20 (1) a rebuttable presumption exists that the test results were valid if the
 21 department complied with this section and the regulations adopted under this section;
 22 and

23 (2) the department may not be held liable for monetary damages for
 24 good faith reliance and reasonable actions taken as a result of false test results.

25 (e) A person may not bring an action against the department based on the
 26 failure of the department to establish a program or policy on substance abuse
 27 prevention or to implement alcohol impairment or drug testing.

28 **Sec. 47.25.464. Confidentiality; liability.** (a) The results of a test conducted
 29 under AS 47.25.463 are confidential, except that the results may be revealed to the
 30 recipient of adult public assistance who was tested and to agents and employees of the
 31 department as required to determine eligibility for adult public assistance.

1 (b) A person may not bring an action for defamation of character or reputation
 2 as a result of disclosure of the results of an alcohol impairment or drug test under the
 3 alcohol impairment or drug testing program established under AS 47.25.463 unless

4 (1) the results were disclosed to a person, other than an agent or
 5 employee of the department for the purpose of the testing program or under court or
 6 administrative order;

7 (2) the information disclosed included false test results;

8 (3) the information was negligently or intentionally disclosed; and

9 (4) the elements of the tort claim are met.

10 **Sec. 47.25.465. Testing policies and procedures.** (a) The department shall
 11 adopt testing policies that include

12 (1) a list of substances tested;

13 (2) a description of the testing methods and collection procedures,
 14 including on-site testing;

15 (3) a right to confirmatory testing and the procedures for confirmatory
 16 testing;

17 (4) the consequences for refusal to test or retest;

18 (5) the right of an applicant for or recipient of adult public assistance
 19 to receive test results within five working days after the department receives the test
 20 results or the written request, whichever is later, if a written request is made by the
 21 applicant or recipient within six months after the test;

22 (6) the right of an applicant and a recipient, on the applicant's or
 23 recipient's request, to receive, within 72 hours or before an adverse action is taken,
 24 whichever occurs first, a confidential explanation of the applicant's or recipient's test
 25 results;

26 (7) providing the department's confidentiality and testing policies to
 27 applicants for and recipients of adult public assistance not less than 30 days before
 28 initiating testing on the applicant or recipient.

29 (b) The department shall pay the cost of testing and, if the testing is performed
 30 at a location other than a location of the department, the cost of transportation to and
 31 from the testing center.

1 (c) Sample collection and testing must

2 (1) comply with scientifically accepted methods and procedures;

3 (2) be performed at a location identified by the department and
4 analyzed by a laboratory approved or certified by the Substance Abuse and Mental
5 Health Services Administration or by the College of American Pathologists;

6 (3) be conducted under reasonable, sanitary, and private conditions
7 that are consistent with reliability;

8 (4) be properly controlled and samples must be properly labeled; and

9 (5) include relevant medical information.

10 (d) A positive drug test must be confirmed using a different analytical process
11 than was used in initial testing. A positive drug test must be reported as a negative
12 result if a licensed physician verifies that the test was affected by medication
13 prescribed for the applicant or recipient tested.

14 (e) The department may not rely on a positive test result without confirmatory
15 testing.

16 **Sec. 47.25.466. Training of test administrators.** (a) The department shall
17 ensure that not less than one designated employee of the department receives not less
18 than one hour of training on alcohol abuse and an additional one hour of training on
19 the use of controlled substances for the purpose of finding reasonable suspicion for
20 testing under AS 47.25.463 - 47.25.466.

21 (b) If the department provides on-site testing for alcohol impairment or illegal
22 drug use under AS 47.25.463, the department shall employ on-site administrators who

23 (1) have received training in person and written certification of the
24 training by the test manufacturer's representative on the proper procedure for
25 administering the test and on accurate analysis of the on-site test results; the training
26 must include recognition of adulteration of a sample collected on-site;

27 (2) agree in writing to maintain confidentiality under the testing
28 policies adopted by the department.

29 **Sec. 47.25.467. Consequences of confirmatory positive testing.** The
30 department may deny or suspend adult public assistance to an applicant for or
31 recipient of the assistance who, under AS 47.25.463 - 47.25.467, has

- 1 (1) been tested and received a confirmatory positive result for alcohol
2 impairment or use of illegal drugs; or
3 (2) refused alcohol impairment or drug testing required by the
4 department.



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Researchers estimate that the direct healthcare cost of obesity for the state of Alaska is \$157 million. If current obesity levels are maintained, in 10 years Alaska could save \$388 million off a projected \$2.938 billion healthcare bill. That's \$735 for every adult in the state.

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Alaska (2009)

America's Health Rankings™

Ranking:

Alaska is 34th this year, it was 32nd in 2008.

Strengths:

Strengths include a low percentage of children in poverty at 9.8 percent of persons under age 18, low levels of air pollution at 6.9 micrograms of fine particulate per cubic meter, strong public health funding at \$171 per person and a low rate of deaths from cardiovascular disease at 235.8 deaths per 100,000 population.

Challenges:

Challenges include a high rate of uninsured population at 19.0 percent, a low high school graduation rate with 66.5 percent of incoming ninth graders who graduate within four years, high geographic disparity within the state at 19.4 percent, a high violent crime rate at 652 offenses per 100,000 population and a high occupational fatalities rate at 13.0 deaths per 100,000 workers. Alaska ranks lower for determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

↑ to 62.4 discharges per 1,000 Medicare enrollees ↓ In the past five years, the rate of deaths from cardiovascular disease declined from 279.5 to 235.8 deaths per 100,000 population. ↓ In the past five years, the prevalence of smoking decreased from 26.2 percent to 21.5 percent of the population. ↑ In the past ten years, immunization coverage increased from 54.3 percent to 76.2 percent of children ages 19 to 35 months receiving complete immunizations.

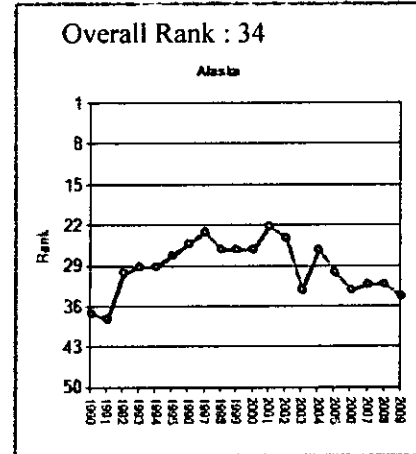
Health Disparities:

In Alaska, smoking is more prevalent among non-Hispanic American Indians and Alaskan Natives at 39.9 percent than non-Hispanic whites at 19.0 percent. Mortality rates vary considerably by race and ethnicity in Alaska, with 1,054.4 deaths per 100,000 population among American Indians and Alaskan Natives compared to whites, who experience 735.2 deaths per 100,000 population.

State Health Department Web Site:

health.hss.state.ak.us

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New! Supplemental Measures

America's Health Rankings™ have been expanded to include 15 more state-specific measures of health, from Daily Vegetable and Fruit intake to Incidence of High Blood Pressure and Diabetes. GO

Behaviors	2009		2008		No. 1 State
	Value	Rank	Value	Rank	
High School Graduation (Percent of incoming ninth graders)	66.5	43	64.1	45	87.5
Prevalence of Obesity (Percent of population)	27.0	29	28.2	35	19.1
Prevalence of Smoking (Percent of population)	21.5	40	22.2	38	9.3
Prevalence of Binge Drinking (Percent of population)	17.6	37	18.3	44	9.0
Community & Environment					
Occupational Fatalities (Deaths per 100,000 workers)	13.0	50	9.9	46	3.1
Infectious Disease (Cases per 100,000 population)	15.8	30	14.9	27	2.4
Air Pollution (Micrograms of fine particles per cubic meter)	6.9	5	7.2	5	4.8
Children in Poverty (Percent of persons under age 18)	9.6	3	8.5	2	8.6
Violent Crime (Offenses per 100,000 population)	651	44	661	43	117
Public & Health Policies					
Lack of Health Insurance (Percent of population)	19.0	46	17.4	39	5.4
Immunization Coverage (Percent of children ages 19 to 35 months)	76.2	32	78.6	35	85.0
Public Health Funding (Dollars per person)	\$170	3	\$175	2	\$220
Clinical Care					
Prenatal Care (Percent of pregnant women)	56.8	48	59.1	44	86.1

Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	62.4	14	58.2	8	29.3
Primary Care Physicians (Number per 100,000 population)	112.3	28	114.1	26	190.0
Health Outcomes					
Premature Death (Years lost per 100,000 population)	7898	32	7617	26	5595
Poor Physical Health Days (Days in the previous 30 days)	3.4	21	3.5	23	2.7
Infant Mortality (Deaths per 1,000 live births)	6.4	20	6.1	17	4.8
Poor Mental Health Days (Days in the previous 30 days)	3.2	19	3.2	16	2.2
Geographic Disparity (Relative standard deviation)	19.4	48	17.1	43	4.3
Cancer Deaths (Deaths per 100,000 population)	185.7	17	188.2	16	144.7
Cardiovascular Deaths (Deaths per 100,000 population)	235.8	5	248.5	6	212.6
Summation					
All Determinants	-0.130	34	-0.079	34	0.827
All Outcomes	0.039	28	0.074	26	0.348
Overall	-0.091	34	-0.005	32	1.064

Alaska - Supplemental Measures					
Behaviors	2009		2008		No. 1
	Value	Rank	Value	Rank	State
Cholesterol Check (Percent of adult population)	71.2	43	71.2	43	84.6
Recent Dental Visit (Percent of adult population)	66.3	39	66.9	37	80.2
Daily Vegetables and Fruit (Percent of population)	24.2	26	24.2	26	30.0
Physical Activity (Percent of adult population)	75.9	21	80.0	13	81.9
Chronic Disease					
Stroke (Percent of adult population)	2.0	3	1.9	5	1.8
High Cholesterol (Percent of adult population)	37.6	24	37.6	24	32.4
High Blood Pressure (Percent of adult population)	24.9	7	24.9	7	19.7
Heart Attack (Percent of adult population)	3.0	2	2.3	1	2.9
Cardiac Heart Disease (Percent of adult population)	3.0	2	2.5	2	2.7
Diabetes (Percent of adult population)	6.6	7	6.1	4	5.9
Economic					
Per Capita Personal Income (Dollars per person)	\$43321	7	\$40042	15	\$56248
Underemployment Rate (Percent)	12.0	45	11.2	49	5.7
Annual Unemployment Rate (Percent)	6.7	44	6.2	48	3.0
Median Household Income (Dollars per household)	\$63989	4	\$65413	5	\$66176
August 2009 Unemployment Rate (Percent)	8.3	23	6.7	41	4.3
Health Outcomes					
Health Status (Percent report fair or poor health)	14.3	24	13.8	19	10.7

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Influences on Substance Use in Alaska

Significant Risk and Protective Factors Influencing
adolescent substance use and their Indicators

Submitted to

Alaska Division of Behavioral Health

by

State Behavioral Health Epidemiology Workgroup

November 30, 2007

Special thanks to the "Epi- Influences" subcommittee

Becky Judd - Chair, Association of Alaska School Boards

James Gallanos, Alaska Division of Behavioral Health

Carol Greenough, Advisory Board on Alcoholism and Drug Abuse

Bill Herman, Mental Health Trust Authority

Marilyn Irwin, Advisory Board on Alcoholism and Drug Abuse

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Cristy Willer, Cook Inlet Tribal Council Inc.

Report may be download at <http://hss.state.ak.us/dbh/prevention/publications/>
For more information contact: becky.judd@alaska.gov

Influences on Substance Use in Alaska

Extensive national research spanning over fifty years¹⁻³⁰ has demonstrated a strong association between specific social conditions, personal experiences and the use of tobacco, alcohol and other drugs in adolescence. Most states track substance use by monitoring data on tobacco, alcohol and other drug consumption (e.g. 30 day use, binge use, ever use) or the consequences of use (e.g. drinking driving crashes, hospital visits, school suspensions.) Instead of tracking *consumption* and *consequence* data exclusively, Alaska must monitor research-based *influences that impact* substance use, as well. The more protective factors are increased (and risk factors reduced) the more likely substance abuse and suicide can be prevented. The priority influences on *adolescent* substance use are as follows (definitions and citations may be found on pages 4-6.)

Priority Factors	Alaska Data
Protective Factor Indicators	Protective Indicators with Baseline Data
Connection to Family	<i>Developmental Indicator Stage I</i>
Connection to School	33.4% of students agree that their school has a positive climate 9.5% of students are connected to their school <small>SCCS 2007</small>
Positive Connection to <i>Other</i> Adults	87% of students have a positive connection with at least <i>one other</i> adult outside of their home. <small>YRBS 2007</small>
Engagement in Meaningful Activities	51% of students are involved in volunteer and helping activities one or more times per week. <small>YRBS 2007</small>
Social, Emotional and Employability Skills	28.3% of students report they have social, emotional and employability skills. <small>SCCS 2007</small>
Cultural Identity	<i>Developmental Indicator Stage I</i> (<i>Loss of cultural identity can be a risk factor, see below</i>)
Risk Factor Indicators	Risk Indicators with Baseline Data
Experienced child abuse (neglect, physical, sexual abuse)	Alaska children are abused or neglected at a substantiated rate of 24.5 cases per 1,000 children, ages 0-17. <small>OCS new database 2007</small> Family violence rate: <i>Developmental Indicator Stage II</i>
Early initiation of substances	20.4% of students have used alcohol before the age of 13. <small>YRBS 2007</small>
Death by suicide of a family member	20.6 suicides were completed per 100,000 Alaskans <small>BVS 2007</small> Death rate of family members by suicide: <i>Developmental Stage II</i>
Availability of alcohol and other drugs	<i>Developmental Indicator Stage II</i>
Community norms and laws related to alcohol, drug use	<i>Developmental Indicator Stage II</i>
Loss of Cultural Identity	<i>Developmental Indicator Stage I</i>
<i>Developmental stage I: Indicator needs to be defined and measurement system put into place</i>	
<i>Developmental stage II: Potential indicator in place, existing data system needs further support and refinement</i>	
Note: The risk and protective factor indicators are state and population-based; the data may not be available for individual communities. Indicators may be modified for prevention programs and services, as performance measures.	

Influences of Substance Abuse in Alaska

Scope of project

In 2006 a State Epidemiological Outcomes Workgroup (SEOW) was created to collect, analyze, and report substance use incidence, prevalence and other related data. An "influences subcommittee" was created to: 1) identify and prioritize the factors that influence substance use and abuse, and 2) identify existing and recommend new indicators to monitor over time.

Process: The "influences subcommittee" began with the adolescent population while recognizing the significant need to look at younger and older populations as well. The risk and protective factor national research for adolescent substance use (and other risk behaviors) provided the working foundation. Additional factors were considered that had a strong research base of support. The priority factors were selected based on: 1) strength of the research; 2) relevance to Alaska; and 3) ability of a community /state partnerships to change that factor. To assure a comprehensive review, we examined factors across the social domains (family, community, school, and individual.) The availability of the data did not exclude a factor if it was considered to be of major significance to the Alaska population. For example, poverty is highly correlated with substance abuse, but not easily amenable to change.

Through this process five protective factors and five risk factors were prioritized. In addition, cultural identity or loss of culture was selected as factor that has tremendous influence on one's sense of self and subsequent behavior. Next the group turned to identifying population-based indicators for each of the selected factors. This process was divided into 1) factors with existing indicators and data; 2) factors with *some* indicators, but not reliable data at this point data; 3) factors that remain of high significance without indicators or data, at this time.

The *Influences on Substance Abuse in Alaska* was further reviewed by the data analyst for the Division of Behavioral Health as well as the full State Epidemiological Outcomes Workgroup.

This report is comprised of baseline data for the priority factors and their indicators. Three factors (family violence, availability of alcohol, community norms and laws) have indicators needing further refinement and/or support for data collection. Two factors (connection to family, cultural identity) do not have indicators at this time. The subcommittee urges the state to partner with interested organizations to further define indicators and develop accurate measurement tools for both of these factors.

Although the indicators are population-based Alaska measures, they are not meant to take precedent over community or program-based measures. This is important to note so that community planning efforts to deliver programs and services continue to be community-driven. The identified indicators reflect the need for a consistent source of population-based data that can be monitored over time across Alaska. Other community and program-based indicators continue to be developed and provide further support for advancing our efforts for data collection and evaluation in Alaska.

As noted previously, while the risk and protective factors identified in this report are based on research for adolescent substance use, many of the factors have implications for adult and older populations as well. A review of the literature was not conducted specifically for adults and may need additional scrutiny and peer review to determine both the availability and reliability of the research. Research on loss of culture and cultural identity was more thoroughly reviewed to apply across the lifespan, to children, youth and adults, and is cited here. Unfortunately, indicators in this area were difficult to locate, although promising as new measures are being developed.

In closing, two studies^{7, 30} found the presence of both protective factors: family support and school support in adolescents who have been physically abused, will reduce the likelihood of suicide attempts more than the mere removal of the risk factor of substance use (e.g. alcohol, drugs) regardless of gender. While communities must continue to reduce the factors that put children at risk, these studies point to the powerful impact protective factors can play in helping children cope with life experiences, they have no control over.

Risk and Protective Factor Definitions and their Indicators

The definition for each factor is derived from its research. Indicators are based on existing Alaska data sources that best match the definition. Some indicators are in a "developmental" stage, they have yet to be formalized. A brief summary of the developmental stage is offered.

Indicators of Protection

Connection to Family (bonding) - Family connectedness has several components. Connectedness refers to the feelings of warmth, love and caring children get from their parents. Children who feel support and connection report a high degree of closeness, feelings of being understood, loved, and wanted. A parental presence is related to connection; it refers to a parent being present during key times: before school, after school, dinner, bedtime and doing activities together. A "positive parenting style" involves high expectations, clear family rules, fair and consistent discipline practices and age appropriate supervision and monitoring of behavior, friends and whereabouts. The Add-Health study found this to be one of the strongest protective factors against all risk behaviors. ^{1,4,6,8,7,8,11,15, 21, 25}

Indicator Developmental Stage I: Indicator needs to be defined and measurement system put into place.

Status: Alaska does not collect population-based data related to parent/family connectedness. Indicators for this protective factor include: percent of families that - engage in regular routines (i.e. eating dinner together); participate in activities together; discuss current events/activities; or monitor children's behavior and set rules. **Recommendation:** The subcommittee urges the state to partner with interested organizations to further define family connectedness and develop indicators and measurement tools.

Connection to School - Students feel "connected" (attached or bonded) to their school based on their feelings about the people at school, both staff and other students. School connectedness is closely related to a caring positive school climate. School connectedness protects adolescents against many health risks, including smoking, alcohol, drug use, and early sexual initiation. Positive school climate and connectedness have been shown to contribute positively to academic achievement. ^{1,6,8,9,10,15,22 26}

Two Indicators: Percent of students agreeing that their school has a positive climate and percent of students that report being connected to their school. **Data source:** School Climate and Connectedness Survey 2007. (AASB)

Positive Connection to Other Adults - This factor refers to the student's perception that they receive support and caring in relationships with adults, other than family members i.e. neighbors, coaches, teachers, mentors or ministers. As children grow, they become involved in an expanded network of significant relationships. This enlarged network includes many adults who can provide regular contact, mentoring, support, and guidance. ^{1,3,4,5,9,10,11,13,14, 21,25}

Indicator: Percent of students who have a positive connection with at least one other adult outside of their home.

Data source: Youth Risk Behavior Survey 2007 (DEED/DHSS)

Engagement in Meaningful Activities - This refers to activities involving volunteering and helping others in community or peer-based programs, or service-learning projects. This protective factor is associated with the reduction of several risk-taking behaviors (alcohol, tobacco or drug use, delinquency, anti-social behaviors, teen pregnancy, school suspensions or school drop-out. Programs increase skills and positive development when youth are involved in all phases: planning, organizing, implementation and evaluation. ^{2,3,4,6,7,6,8,9,11,15, 25, 28, 27,29}

Indicator: Percentage of students are involved in volunteer and helping activities one or more times per week.

Data source: Alaska Youth Risk Behavior Survey 2007 (DEED/DHSS)

Social, Emotional and Employability Skills - This refers to the abilities that equip young people to make positive choices, maintain healthy relationships and succeed in life; the skills include: communication, conflict resolution, empathy, resistance, problem solving/decision making and cultural competence. ^{3,4,5,8,9,11}

Indicator: Percent of students who report they have social, emotional and employability skills.

Data source: School Climate and Connectedness Survey 2007 (AASB)

Indicators of Risk

Experienced Child Abuse (neglect, physical, sexual) or other family violence - Research suggests that children or youth who have been physically abused or neglected are more likely than others to commit violent crimes and/or become pregnant. Exposure to high levels of marital and family discord or conflict also appears to increase risk, as does antisocial or delinquent behavior by siblings and peers. ^{1,6,11,17,20}

Child Abuse Indicator Rate of substantiated child abuse and neglect per 1,000 children ages 0-17.

Definitions (continued)

Experienced Child Abuse (neglect, physical, sexual) or other family violence (continued)

Family Violence Indicator Developmental Stage II: Existing measurement system needs further support and refinement.

Status: The reporting of interpersonal violence remains incomplete. Victim services data, from the Council on Domestic Violence and Sexual Assault (CDVSA), is not representative of all incidents of family violence--only those who seek services. The CDVSA 2006 Annual Report identifies victim services data by total number, type of services (including age, gender and incident types) and by region. **Recommendation:** This indicator may become more representative if data collected from women's shelters and crisis centers are aggregated along with domestic violence reports from police and law enforcement records. This would not account for many rural and remote areas where there is no law enforcement or no reporting methods designed to collect this information. Furthermore, the addition of standardized questions about interpersonal violence to existing population-based surveys (e.g. PRAMS, YRBS, BHRFS) will enhance the development of a reliable indicator.

Early Initiation of Substances - The earlier young people begin using drugs, committing crimes, engaging in violent activity, dropping out of school and becoming sexually active, the greater the likelihood that they will have problems with these behaviors later on. For example, research shows that young people who initiate drug use before the age of 15 are at twice the risk of having drug problems as those who wait until after the age of 19. ^{6,8,18}

Indicator: Percent of students that have used alcohol before the age of 13. Data Source: Youth Risk Behavior Survey 2007(DHSS)

Availability of Alcohol and other Drugs - The more available alcohol and other drugs are in a community, the higher the risk that young people will use and abuse these substances. The perceived availability of drugs is also associated with greater risk of use. In schools where students believe drugs are more available, a higher rate of drug use occurs. ^{8,12,18}

Indicator Developmental Stage II: Existing measurement system needs further support and refinement.

Status: The Office of Public Safety, Alcoholic Beverage Control Board (ABC) conducts ongoing compliance checks (of sales to minors) of package stores, bars, lounges and restaurants across Alaska. The ABC board also collects data related to failure rates, but it has not consistently tracked this information until 2007. **Recommendation:** The data needs further analysis and the system of compliance checks needs additional support. *Other indicators related to access may need to be considered as well.*

Family History of Suicide or Attempts - Youth who have a suicide among any family member in the past 12 months are at greater risk for attempting suicide. ^{1,7,11}

Indicator: Completed suicide rate per 100,000 Alaskans (all ages) based on 2000-2004 data.

Data Source: Alaska Bureau of Vital Statistics, February 2007

Death rate of family members by suicide Indicator: Developmental Stage II. Vital Statistics is beginning to analyze mortality data and familial relationships.

Community Norms and Laws related to Alcohol and Drug Use - Community norms (the attitudes and policies a community holds about alcohol/drug use) are communicated in a variety of ways: through laws and written policies, informal social practices, and through the expectations parents and community members have of young people. (e.g. alcohol taxes, local option or drunk driving laws, perceptions of disapproval) ^{8,11,12,18}

Indicator Developmental Stage II: Existing measurement system needs further support and refinement.

Status: The Office of Public Safety, Alcoholic Beverage Control Board (ABC) has information on local alcohol laws and controls (e.g. licenses, sales and local option restrictions). The current and available data on social norms and attitudes of drug and alcohol use in Alaska, is collected through the *National Surveys on Drug Use and Health*. **Recommendation:** The statistics from the ABC board needs to be reviewed to identify if there is enough data to compile a statewide indicator related to alcohol control laws. The data from the *National Surveys on Drug Use & Health* need to be reviewed for its strength as a population-based Alaska indicator.

Loss of Cultural Identity (Protective Factor: Cultural Identity) - Alaska Native and American Indian people may face additional risks associated with alcohol and other drug use. The increased vulnerability may be due to marginalization, stigmatization, and loss or devaluation of language, culture, spiritual and traditional healing practices, and subsistence living. Another problem may be lack of access to culturally appropriate health care. Alaska Native and American Indian communities also experience higher levels of stress due to historical trauma and rapid cultural change. Other ethnic persons or groups may experience similar risk factors. ^{14,16,19,21}

Indicator: Developmental Stage I: Indicator needs to be defined and measurement system put into place.

Status: Information related to cultural identity such as percentage of Native language speakers and the number of rural households practicing subsistence lifestyles, exists primarily at the regional or local level. There are several ongoing research projects exploring the factors related to loss or preservation of cultural identity in Alaska. This research can assist in the development of stronger measures that may form the basis for future population-based and program-based indicators. **Recommendation:** The current indicators will require further analysis and represent only two elements of preservation or loss of cultural identity. The subcommittee urges the state to partner with interested organizations to further define cultural identity and develop indicators

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Alaska Influence Indicator Data Sources

- ◆ Child Abuse Rate 2007 – Calculated by the Office of Children's Services, ORCA investigation for SFY07.
- ◆ School Climate and Connectedness Survey 2007. Association of Alaska School Boards (AASB).
- ◆ Suicide Rate (2000-2004) - Calculated by the Alaska Bureau of Vital Statistics (BVS), February 2007.
- ◆ Youth Risk Behavior Survey 2007. Department of Education and Early Childhood and Development (DEED) and Department of Health and Social Services (DHSS).

Press Release

State of Alaska > Health & Social Services > Press



PRESS RELEASE - For Immediate Release
November 29, 2001

SUBSTANCE ABUSE COSTS ALASKA \$614 MILLION A YEAR

New Study from McDowell Group Shows Economic Impacts

The negative economic impacts of alcohol and other drug abuse amount to about \$614 million a year in Alaska, according to a new study completed by the McDowell Group for the Governor's Advisory Board on Alcoholism and Drug Abuse (ABADA).

"This is a staggering blow to Alaska's economy, communities and families," said Advisory Board chair Eric Tomasino of Palmer. "Year after year, substance abuse and chemical dependency drain our human and economic resources."

The study looked at five basic ways in which alcohol and other drug abuse cost money: productivity losses, traffic crashes, criminal justice system and protective services, health care and public assistance. Alcohol abuse costs accounted for \$453 million per year, while other drug abuse costs were estimated at \$161 million annually.

"We have always known that alcohol and other drug abuse exacts a high human toll in Alaska," said Pam Watts, Executive Director of ABADA. "But until now, we had to rely on national studies to estimate the economic costs to our state. This report gives us strong, Alaska-specific data to use."

According to the study, lost worker productivity accounts for more than half of the annual economic impact, \$319 million per year. These losses occur when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for a criminal offenses, or inpatient treatment or hospitalization. Of the productivity losses, nearly half were due to premature death from alcohol and other drug abuse. The economic loss for 1999 for this cause alone was \$172 million, based on an annual average number of deaths related to alcohol and other drug abuse. Between 1994 and 1998, this was an average 224 deaths a year.

The Economic Costs of Alcohol and Other Drug Abuse in Alaska, Phase Two report was prepared for ABADA by McDowell Group, a research-based consulting firm in Juneau and Anchorage, with a grant from the Alaska Mental Health Trust Authority. The ABADA is appointed by the Governor to advise the Administration and Legislature on substance abuse issues.

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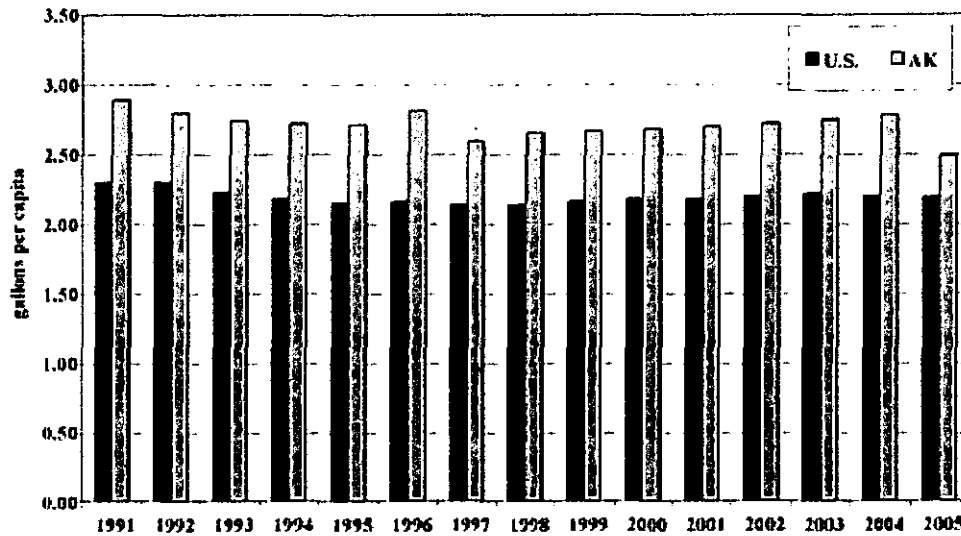
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Moving Forward

Comprehensive Integrated Mental Health Plan: 2006-2011

Figure 2
U.S. and Alaska Alcohol Consumption Comparisons



Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. The alcohol consumption rate in Alaska has been higher than the rate in the rest of the nation during each of the last 14 years, and is well above the *Healthy Alaskans 2010* goal of 2.2 gallons or less per person per year. Data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicates that Alaska remains in the highest group for alcohol consumption in the nation (per capita ethanol consumption per 10,000 people aged 14 and over). Consumption rates are calculated with in-state sales of alcoholic beverages and the state population of persons 14 years and older.

Source: Alaska Department of Revenue; Alaska DHSS Division of Behavioral Health; compiled by NCADD

Alaska receives \$10.7 million for substance abuse prevention infrastructure

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a five-year, \$10.7 million grant to DHSS, Division of Behavioral Health. The grant will focus on Alaska's ability to de-velop and promote community health and wellness by building regional and community prevention infra-structure and capacity, with a specific emphasis on prevention of substance use and abuse.

The state is required to utilize the five steps of the Strategic Prevention Framework – assessment, capacity building, planning, implementation and evaluation. The goal is to have the first three steps com-pleted by June 2010. Once the state's implementation plan has been approved by SAMHSA's Center for Substance Abuse Prevention, the state will solicit proposals from regional and/or community coalitions to develop a prevention infrastructure and capacity at the local level. These grant awards will not be for di-rect services, but for building sustainable infrastructure and capacity to prevent the consequences of alco-hol and other drug use at the community and regional level. Each sub-recipient will be required to also use the five steps of the SPF, and to develop strategies based on what the assessment data tells them—a true data driven process. Proposals will be accepted from regional/community coalitions with the ability to con-duct a thorough needs and capacity assessment; drawing on the input and commitment of the region/community at-large.

While direct program services will not be funded through these grant awards, we will encourage the utiliza-tion of environmental strategies that promote changing social and community norms, practices and policies.

We are very excited about the SPF SIG and the prevention opportunities these funds will provide to Alaska. Focusing on coalition building, community assessments, data-driven decision making, infrastruc-ture, capacity and sustainable systems change will enhance our overall prevention efforts and assist us in changing the trends of alcohol and drug use in Alaska and the devastating consequences that occur.

Working through and with coalitions is how we envision the fu-ture for community-driven prevention activities. The old way of doing business isn't getting us where we want to go—human and dollar re-sources are not abundant enough to allow individual agencies to work in isolation on a single issue. We know that social issues are intertwined, yet we continue to approach these problems as independent silos of activity.... By putting our energy and emphasis on building and sustaining community coalitions, the ability to promote healthy communities; to build strong protective factors; and to reduce risk factors will be greatly increased and the outcomes more positive and hopeful. We thank everyone who attended the training and look forward to following up with future training to continue building a strong coalition framework for

Family Risk Factors

Family history of the problem behavior - If children are raised in a family with a history of alcohol/ drug addiction, it increases the likelihood that children will also have alcohol and other drug problems. If children are raised in a family with a history of criminal activity, the risk of juvenile delinquency increases. Similarly, children who are raised by a teenage mother are more likely to become teen parents, and children of dropouts are more likely to drop out of school themselves.^{2,4,8,11,18}

Family management problems - Poor family management practices include lack of clear expectations for behavior, failure of parents to monitor their children – knowing where they are and whom they are with, and excessively severe or inconsistent punishment.^{8,18}

Family violence and conflict - Persistent, serious conflict between primary caregivers or between caregivers and children appears to increase children's risk for all of the problem behaviors. Whether the family consists of two biological parents, a single parent, or some other primary caregiver appears to matter less than whether the children experience much conflict in their families. For example, domestic violence in a family increases the likelihood that young people will engage in delinquent behaviors and substance abuse, as well as become pregnant or drop out of school.^{8,18}

Parental attitudes favorable to substance use and other problem behavior - Parental attitudes and behaviors toward drugs, crime, and violence influence the attitudes and behaviors of their children. Parental approval of young people's moderate drinking, even under parental supervision, increases the risk that the young person will use marijuana. Similarly, children of parents who excuse them for breaking the law are more likely to develop problems with juvenile delinquency. In families where parents display violent behavior, children are at greater risk of becoming violent.^{8,18}

The Advisory Board on Alcoholism and Drug Abuse, through the Alaska Department of Health and Social Services, contracted with McDowell Group in April 2005 to update a prior study on the economic costs of alcohol and other drug abuse in Alaska.

Alcohol and other drug abuse impacts the economy in many ways. Public safety, health care, and public assistance are among the areas impacted by alcohol and other drug abuse. The extent of these impacts is evident in the level of alcohol and other drug dependency and its associated cost on the Alaska economy. According to a 1998 study, 9.7 percent of Alaska's population is dependent upon or abuses alcohol (39,596 residents), while 1.5 percent is other drug dependent (14,238 residents). The total cost of this dependence to the Alaska economy is estimated to be \$738 million during 2003. Alcohol abuse costs accounted for \$525.5 million (71 percent). Other drug abuse costs were estimated at \$212.5 million (29 percent). Costs by category include:

- \$367 million from productivity losses.
- \$154 million from criminal justice and protective services.
- \$178 million from health care.
- \$35 million from traffic crashes.
- \$4 million from public assistance.

Public Assistance and Social Services

A portion of public assistance expenditures can be attributed to alcohol and other drug abuse. Alcohol and other drug-dependent persons may qualify for public assistance because of reduced income, inability to hold a job, or disability caused by substance abuse. Costs attributed to abuse (program administration costs only) were an estimated \$4.1 million in 2003.

Iditarod to drug test on the trail *BY TODD L. DISHER Frontiersman*

WASILLA — In a rule change that directly affects the event's three-time reigning champion, the governing body of the Iditarod Trail International Sled Dog Race will impose a strict drug testing policy on mushers starting in 2010.

Rule 29 now allows race officials to test mushers with or without cause, individually or as a group, and on a fixed or random schedule for the presence of prohibited drugs or alcohol.

The Iditarod Trail Committee Executive Director Stan Hooley said the rule change comes in response to a request from mushers.

“(The Iditarod Official Finishers’ Club) said to us, ‘We want you to implement a drug testing program to make sure no unfair advantage is gained. We are interested in the safety and the integrity of everyone in the race,’” Hooley said.

But for Lance Mackey, the musher who has dominated the sport for the last three years, the rule change is purely political.

“Some of the people who are pushing the issue are the people who can't beat me on the trail, so they are trying to beat me off it,” Mackey said.

Mackey survived a battle with throat cancer in 2001 and openly admits to using marijuana for what he says are medicinal purposes and with a doctor's approval.

“I have no taste buds and no real appetite,” Mackey said, as one of the purported benefits of marijuana is to improve food consumption. “It also helps me pay attention and focus on what I'm doing.”

It's that last part that irks fellow musher Ken Anderson. Anderson said he understands if Mackey uses marijuana to maintain his health, but if it really does help him stay focused, then it offers an unfair advantage.

“I guess that is a little bit troubling, that he was getting a leg up,” Anderson said. “And, that was against race rules.”

Anderson is referring to the rule that has been in place banning substances like marijuana even before the rule was recently changed. However, what the past rule lacked, Hooley said, was enforcement.

“There wasn't a protocol in place for (drug testing) that would stand up,” Hooley said. “You need to have professionals in place to carry out a program like that.”

After the request from the IOFC, Hooley said the rule became formalized with an agreement with WorkSafe Inc., a company that does drug testing for companies around the state. By offering WorkSafe a race sponsorship, the committee was able to get a contract for the tests at a reduced rate, he said.

The urine samples can be taken anywhere along the trail and flown to the testing facility in the Lower 48. Hooley said the turnaround time from sample taken to results should be about 48 hours, and the results will indicate levels of both illegal drugs and performance-enhancing substances.

As to why marijuana was included on the list of substances prohibited, Hooley said the committee was following federal guidelines. Alaska state law allows possession of up to 1 ounce of marijuana, but "by federal standards, marijuana is still an illegal drug," Hooley said.

What's more, marijuana is not eligible for the therapeutic exemption clause in the new rule. Hooley said marijuana only requires a physician's recommendation, not necessarily a prescription. Also, there is no regulated dispensing system that controls the dose because the federal government does not recognize marijuana as a medicine, Hooley said.

"Is marijuana considered performance-enhancing? I think most scientific folks would say no. But, it is an illegal drug that is not dispensed by the FDA through a prescription," Hooley said.

For his part, Mackey said he would not seek the therapeutic exemption even if it was offered, saying he does not want to use his medical marijuana card as a crutch. However, he said he still does not understand the reasoning behind the ruling.

"It's a dog race. They are the ones performing to get us to Nome. It didn't jeopardize their performance last year," Mackey said. "I finished with 15 of my 16 dogs and with a 12-hour lead in the toughest conditions the Iditarod has ever seen. It didn't do anything to hinder my outcome."

Asked if this means he used marijuana on the Iditarod trail last year, Mackey hesitated, but said yes.

"I wasn't dependent on it everyday. There was a little bit here and there. But it is irrelevant," he said.

What people don't understand, he said, is the effect cancer and the following chemotherapy and radiation treatment had on his body, and how marijuana alleviates this pain.

"I do not condone kids using pot. This is something I have had to deal with because of my medical history," Mackey said. "I don't know how to explain this. It seems like it is one of the reasons I'm still breathing."

Looking forward, Mackey said he is going to run a clean race in 2010 and likes his chances of becoming the first musher to win four Iditarod races in a row.

"I'm pretty confident. If I come in 50th this year, of course people are going to start pointing fingers," Mackey said. "But if they think my success in the past has been based on my marijuana use, they have more problems than me."

Social effects

The social problems arising from alcoholism can be massive and are caused in part due to the serious pathological changes induced in the brain from prolonged alcohol misuse and partly because of the intoxicating effects of alcohol.^{[17][22]} Alcohol abuse is also associated with increased risks of committing criminal offences including child abuse, domestic violence, rapes, burglaries and assaults.^[36] Being drunk or hung over during work hours can result in loss of employment, which can lead to financial problems including the loss of living quarters. Drinking at inappropriate times, and behavior caused by reduced judgment, can lead to legal consequences, such as criminal charges for drunk driving or public disorder, or civil penalties for tortious behavior. An alcoholic's behavior and mental impairment while drunk can profoundly impact surrounding family and friends, possibly leading to marital conflict and divorce, or contributing to domestic violence. This can contribute to lasting damage to the emotional development of the alcoholic's children, even after they reach adulthood. The alcoholic could suffer from loss of respect from others who may see the problem as self-inflicted and easily avoided.

Within the medical and scientific communities, there is broad consensus regarding alcoholism as a disease state. For example, the American Medical Association considers alcohol a drug and states that "drug addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use despite often devastating consequences. It results from a complex interplay of biological vulnerability, environmental exposure, and developmental factors (e.g., stage of brain maturity)."

Drug abuse

Further information: Drug abuse

Unemployment, underemployment, and distance from rural areas are where most drug abuse occurs. Some results of drug abuse are stealing, killing, theft, assault, prostitution, poor grades in school, and poor conduct at work. Some poverty is caused by people who have abused drugs and have spent all of their money buying them. When they have no other way to support their addiction, they resort to other measures to obtain them. The urge for the drugs began to take over their lives. People lose their families, friends and homes leaving them alone and in poverty.

Neurobehavior Disinhibition in Childhood Predicts Substance Use Disorder in Young Adulthood

The development of substance use disorder (SUD) was prospectively investigated in 66 boys having fathers with SUD and 104 boys having fathers with no adult psychiatric disorder. Evaluations were conducted to determine the context in which neurobehavior disinhibition in relation to parental SUD, parental neglect of the child and child's social maladjustment culminated in a DSM-III-R diagnosis of SUD. A neurobehavior disinhibition latent trait

reflecting prefrontal cortex disturbance was derived using indicators of behavior undercontrol, affect dysregulation and executive cognitive functioning in the boys when they were 10-12 and again at 16 years of age. The data were analyzed to determine whether the score on the neurobehavior disinhibition construct mediates the association between father's and mother's SUD and son's SUD. Several key results emerged. First, SUD in the mother and father predicted neurobehavior disinhibition in the son. Second, the neurobehavior disinhibition score of the sons at ages 10-12 predicted SUD at age 19. Third, neurobehavior disinhibition, in conjunction with social maladjustment and drug use frequency, mediated the association between paternal and maternal SUD and son's SUD. Fourth, neurobehavior disinhibition was unrelated to neglect of the child by either the father or mother; however, paternal but not maternal neglect at age 10-12 predicted SUD at age 19. These findings suggest that prefrontal cortex dysfunction contributes to SUD liability. Tarter R.E., Kirisci L., Habeych M., Reynolds M. and Vanyukov M. Neurobehavior Disinhibition in Childhood Predisposes Boys to Substance Use Disorder by Young Adulthood: Direct and Mediated Etiologic Pathways. *Drug and Alcohol Dependence*, 73, pp. 121-132, 2004.

Testing the Effectiveness of a Public Health Approach to Treating Substance-Abusing Women on Welfare

Jonathan Morgenstern, Ph.D.

Substance abuse (SA) among disadvantaged, parenting women has long been identified as a major public health problem. However, as States move to implement welfare reform, efforts to effectively address this problem take on greater urgency. This report describes preliminary findings from a study currently in progress to test the effectiveness of a public health approach to intervening with this population. The report will (1) describe the study rationale, design, and interventions, (2) compare baseline characteristics of substance-abusing women on welfare with a nonaffected comparison group, and (3) report on SA treatment entry and retention data for an initial cohort of participants. A standardized battery was administered to women (N=220) recruited in a welfare setting who either met current DSM-IV substance-dependence criteria or did not meet criteria for a substance use disorder in the prior 5 years. Substance-dependent women had significantly greater employment, mental health, family, medical, and housing problems, suggesting they would experience substantially greater barriers to employability. Substance-dependent women were then randomly assigned to receive a referral either to SA treatment or to an intensive case management intervention (ICM). Women assigned to ICM had significantly higher rates of SA treatment entry and attendance. Overall, women who received a referral only to SA treatment had low rates of treatment attendance. Findings are discussed in the context of the current interface between substance abuse and welfare-to-work services.

National Institute on Drug Abuse



Science of Addiction

Nora Volkow, M.D.
Director of the National Institute on Drug Abuse (NIDA)
National Institutes of Health

When scientists first started to study drug abuse, people addicted to drugs were thought to be morally flawed and lacking in willpower. This view has shaped society's response to drug abuse, treating it as a moral failing rather than a health problem, resulting in punitive rather than preventative and therapeutic actions. Due to groundbreaking scientific discoveries, we now recognize drug addiction as a brain disease that can be successfully prevented and treated.

What is Drug Addiction?

Drug addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use despite often devastating consequences. It results from a complex interplay of biological vulnerability, environmental exposure, and developmental factors (e.g., stage of brain maturity).

As with many other diseases, vulnerability to addiction stems partly from a person's genetic makeup. Scientists estimate that genetic factors account for 40–60 % of an individual's vulnerability to addiction, with environmental and developmental variables influencing whether and how particular genes are expressed. Additional factors, such as conditions at home, at school, or in the neighborhood, can heighten addiction vulnerability. Research also shows that early drug use increases the likelihood of addiction and that people with psychiatric disorders have a higher risk of drug abuse and addiction than the general population.

Research has improved our understanding of the biological mechanisms underlying drug abuse and addiction. All drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine—the neurotransmitter that regulates feelings of pleasure, as well as movement, emotion, cognition, and motivation. Overstimulation of this system produces the euphoric effects sought by people who abuse drugs and teaches them to repeat the behavior. Our brains are wired to repeat activities that bring us pleasure or reward (e.g., eating or having sex) as a way of ensuring our survival. Because taking drugs of abuse stimulates the same circuit, our brains urge repetition of the behavior, and thus people "learn" to abuse drugs without thinking about it. These intense impulses can overcome a person's willful intent not to take drugs, despite catastrophic consequences—which is really the essence of drug addiction.

Therefore, even though the initial decision to take drugs is mostly voluntary, once drugs take over, they cause brain changes that acutely impair a person's ability to exert self-control. Brain imaging studies of drug-addicted individuals have revealed physical changes in brain areas critical to judgment, decision-making, learning, memory, and behavior control, which may help explain the compulsive and destructive behaviors associated with drug addiction.

Preventing Drug Abuse

The National Survey on Drug Use and Health (NSDUH) estimated that 22.6 million persons (9.2 % of the U.S. population aged 12 or older) were classified with substance abuse or dependence in 2006 (based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition). Of these:

- 3.2 million abused or were dependent on both alcohol and illicit drugs;

- 3.8 million abused or were dependent on illicit drugs but not alcohol; and
- 15.6 million abused or were dependent on alcohol but not illicit drugs.

Data on teen drug use reflect both encouraging and troubling trends. Although statistics show a 23 % decline from 2001–2006 in past-month use of any illicit drug by students in 8th, 10th, and 12th grades, abuse of marijuana continues to be a problem with approximately 12 % of 8th graders, 25 % of 10th graders, and 32 % of 12th graders reporting use in the past year. Prescription painkillers also continue to be abused at unacceptably high levels, with 1 in 10 high school seniors reporting abuse in the past year. In addition, while past-year abuse of OxyContin was down among 12th graders, the rate nearly doubled among 8th graders between 2002 and 2006—going from 1.3 % to 2.6 %. Prescription drugs are easily accessible and are often obtained from a friend or relative for free. Moreover, there is a common misperception that, because they are prescribed by a doctor, prescription medications are safe, even when used in ways not intended.

Because early use of drugs increases a person's chance of more serious abuse and addiction, prevention is crucial. NIDA studies have shown that prevention programs backed by science (rationally designed and rigorously tested) can be effective in youth. Such programs work to boost protective factors, reduce risk factors for drug use, and help shape youths' perceptions about drug abuse risk.

Medical Consequences of Addiction

Illicit drug abuse causes 17,000 deaths annually in the United States and more than \$180 billion in annual economic costs. Abuse of nicotine, alcohol, and/or prescription drugs causes additional morbidity and mortality. Although some medical consequences of drug abuse and addiction are temporary and can be essentially reversed with treatment, others may be more persistent, diminishing the quality of individuals' health long after drug use has stopped. Whether short-lived or chronic, the many potential health effects from drug abuse and addiction underscore the fact that drug abuse does not exist in medical isolation—it causes a broad array of medical consequences throughout the body (<http://www.nida.nih.gov/consequences/>). A few examples follow:

- **Cardiovascular effects.** Researchers have found a connection between the abuse of most drugs and adverse cardiovascular effects, ranging from abnormal heart rate to heart attacks. Injection drug use can also lead to cardiovascular problems such as collapsed veins and bacterial infections of the blood vessels and heart valves. Use of marijuana, cocaine, methamphetamine, and inhalants can result in cardiovascular effects.
- **Neurological effects.** All drugs of abuse act in the brain to produce euphoric effects; however, some drugs also cause severe negative consequences in the brain such as seizures, stroke, and widespread brain damage that can impact all aspects of daily life. Drug use can also cause brain changes that lead to problems with memory, attention, and decision-making. Examples of drugs with neurological effects include cocaine, methamphetamine, inhalants, and ecstasy.
- **HIV, hepatitis, and other infectious diseases.** Drug abuse increases the spread of infectious diseases. Injection of heroin, cocaine, and methamphetamine causes more than a third of new AIDS cases and is a major contributor to the spread of hepatitis C. In addition, all drugs of abuse interfere with judgment and increase the likelihood of risky behaviors, which also contribute to the spread of HIV/AIDS and other sexually transmitted diseases.
- **Other health effects.** In addition to the effects various drugs of abuse may have on specific organs of the body, many drugs produce global body changes such as dramatic changes in appetite and increases in body temperature, which may impact a variety of health conditions. Withdrawal from drug use also may lead to numerous adverse health effects, including restlessness, mood swings, fatigue, muscle and bone pain, insomnia, cold flashes, diarrhea, and vomiting.

In addition to harmful effects for the addicted individual, drug abuse can result in serious health consequences for others. For example, while the full extent of the effects of prenatal drug exposure on a child is not known, studies show that various drugs of abuse may result in premature birth, miscarriage, low birth weight, and a variety of behavioral and cognitive problems in infants and children. Secondhand exposure to tobacco smoke is another example. According to the 2006 Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, exposure to environmental tobacco smoke increases the risk of heart disease and lung cancer in persons who have never smoked by 25–30% and 20–30%, respectively. Exposure to tobacco smoke in the home increases severity of childhood asthma and has been associated with sudden infant death syndrome.

Treatment and Recovery

Discoveries about the science of addiction have led to advances in drug abuse treatments that enable people to counteract addiction's powerful effects on the brain and behavior and regain control of their lives. Despite the availability of many forms of effective treatment for addiction, the problem of relapse remains the major challenge to achieving sustained recovery. However, relapse rates for addiction are similar to those for other well characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves changing deeply embedded behaviors, and relapse does not mean treatment failure. For the addicted patient, lapses back to drug abuse indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed. For most individuals, combining medications with behavioral therapies is the most successful approach.

Different types of medications may be useful at different stages of treatment—during withdrawal to ease symptoms; during treatment to help people stay engaged; and following treatment to prevent relapse. Medications currently available include those used to treat:

- **Tobacco addiction.** Nicotine replacement therapies (patch, inhaler, gum), bupropion, varenicline.
- **Opioid addiction.** Methadone, buprenorphine.
- **Alcohol and drug addiction.** Naltrexone (helps prevent relapse to alcohol and heroin abuse), disulfiram (helps prevent relapse to alcohol abuse and is currently being tested for treating cocaine abuse), acamprosate (helps prevent relapse to alcohol abuse).

Behavioral treatments help people modify attitudes and behaviors related to drug abuse and increase their ability to handle stressful situations and environmental cues that may trigger intense craving for drugs and prompt relapse. For example,

- **Cognitive behavior therapy** helps people recognize, avoid, and cope with situations in which they are most likely to abuse drugs.
- **Motivational incentives treatment** uses positive reinforcements (i.e., rewards or privileges) to help people remain drug free.
- **Motivational interviewing** is conducted at treatment entry to stoke an individual's desire to fully participate in treatment and change his or her behaviors.
- **Group therapy** helps people face their drug abuse realistically, acknowledge the harm it can cause, and increase motivation to not use drugs.

Behavioral therapies can also enhance the effectiveness of medications and help people remain in treatment.

The process of recovery from drug abuse or addiction can be long and complex. When people enter treatment, addiction has often taken over their lives. The compulsion to find and use drugs may have disrupted their families, their professional lives, and their standing in the community. It also may have

made them vulnerable to other serious illnesses. Because the effects of drug abuse are far reaching, treatment must address the needs of the whole person to have the best chance for success. The most effective programs incorporate a variety of rehabilitation services to address a person's medical, psychological, social, vocational, and legal needs to enhance their recovery process.

At NIDA, we believe that a fuller understanding of the science of addiction will encourage adoption of research-based policies and programs to reduce drug addiction and will increase support for scientific research to improve the health of our citizens. Please visit our recently created Web site to access a wealth of resources designed to help physicians recognize, diagnose, and treat drug abuse and addiction: <http://www.nida.nih.gov/medstaff.html>. Together, we can continue to leverage the power of science against this devastating disease that causes so much suffering for individuals, communities, and society at large.

August 30, 1987

Rich vs. Poor: Drug Patterns Are Diverging

By **PETER KERR**

Americans generally appear to be turning away from the use of illegal drugs, but, at the same time, the poor face mounting deaths and an ever bleaker future because of drug abuse, according to Government statistics and interviews with drug experts.

What may be emerging, some experts believe, is a tale of two drug problems: one in middle-class America, which may be past the worst of a 20-year mass experiment with illegal drugs; the other in the America of the poor, where, amid hopelessness and lack of education, people will suffer the worst consequences of cocaine, heroin and AIDS.

"We are dealing with two different worlds here," said Dr. David F. Musto, a professor of psychiatry and history of medicine at Yale University who has written extensively on the history of drug-use epidemics. Incentives to Stop

"The question we must be asking now is not why people take drugs, but why do people stop," Dr. Musto said. "In the inner city, the factors that counterbalance drug use - family, employment, status within the community - often are not there. It is harder for people with nothing to say no to drugs."

In recent years, the focus of greatest concern among drug experts has been cocaine, for while the use of other drugs was dropping or remaining stable, cocaine grew widely in popularity throughout the nation in the late 1970's and early 1980's.

Findings from two major Federal studies on drug use in America show that in the last few years, better-educated young people have been reducing their use of cocaine and other drugs. Meanwhile, the least-educated have increasingly used cocaine.

Experts caution that their conclusions are tentative and that the rise of a new drug or the appearance of other unpredictable factors could easily upset current trends. And, whatever the trends, they say, drug use is so widespread that it will remain a problem in all sectors of society for years. A Mixed Message

However, they point to a newly emerging picture of drug use in America that, they say, carries a mixed message of hope for the well-off and despair for the poor. Among their major conclusions are these:

* With the exception of heroin and crack among the poor, the use of illegal drugs in the nation appears to have peaked, including the snorting of powdered cocaine.

* Federally financed studies show that the people turning away from drugs are the most educated and affluent. The poorest and least-educated have continued or increased their drug use.

* Crack, a smokable form of cocaine, has largely remained a poor people's drug. Its rise in the past two years has had devastating effects on poor neighborhoods, but it has failed to make the same inroads into the middle class.

* The most deadly impact of illegal drug use is probably yet to come, as tens of thousands of intravenous drug users, their sexual partners and their children contract acquired immune deficiency syndrome. Most of those people will be poor.

Several drug treatment experts voiced concern that as the casualties of drug abuse shift increasingly into the ghetto, the drug issue may become less visible to many Americans and receive less attention from government. Putting Pressure on Legislators

"In the heroin crisis of the late 1960's and again with crack in recent years it was the threat to the middle- and upper-middle-class kids that put pressure on legislatures and Congress," said Dr. Mitchell S. Rosenthal, the president of Phoenix House, the operator of drug treatment centers in New York and California. "There is a danger that if they feel less of a threat, the resources won't stay with the problem."

Some scholars say societies experience widespread drug use in historic cycles. From 1885 to 1920, the United States experienced an epidemic of narcotics and cocaine use. Dr. Musto argues that a similar epidemic began in about 1965, but that it took years for casualties to mount and for society to react against drugs.

Statistics indicate that outside of the poorest neighborhoods, the nation's 20-year affair with illegal drugs is on the decline.

According to the National Institute on Drug Abuse, marijuana use peaked in 1978, and by 1985, 7 out of 10 high school seniors believed marijuana use to be harmful. Young people's use of hallucinogens, like LSD and PCP, or "angel dust," has fallen since 1979. A Different Generation

In 1985, a national household survey conducted by the University of Kentucky for the National Institute on Drug Abuse asked 18-to-25-year-olds if they had smoked marijuana in the last month. It found that people who never graduated from high school were most likely to be using the drug. The better educated the young people were, the survey found, the less they were using marijuana.

Among an earlier generation of smokers - people 35 and over, who probably developed their attitudes toward marijuana in the late 60's and early 70's - the findings were just the reverse. It was the college-educated who were most likely to be smoking marijuana.

Another study found similar results. The survey, conducted for the National Institute on Drug Abuse by the University of Michigan Institute for Social Research, asked high school seniors whether they had used drugs other than marijuana in the previous year.

The survey found that in 1986, seniors of all economic backgrounds were using drugs less than seniors were in 1981. But the greatest change took place among students whose parents had some graduate education: a drop of 13 percentage points, to 23.7 percent, from 36.7 percent. The least change took place among students whose parents had never been to high school: a drop of 2.7 percentage points, to 22.7 percent, from 25.4 percent. Flooding Across the Border

What confused the situation last year was cocaine, which had been rising in use since the late 70's. By last year, the white powder was flooding across the nation's southern border and was suddenly appearing in urban areas in the new smokable form of crack; from 1982 to 1986, the number of deaths and emergency room reports involving cocaine quadrupled.

For a time, experts feared that the pellet form of cocaine, which is much more quickly addicting than cocaine powder, would spread to all segments of society, including the middle class and affluent, who were using powdered cocaine. But it now appears that the growth of crack has leveled off in New York and many other cities around the country, law-enforcement and treatment officials say.

"In general we believe that cocaine has reached its peak," said David L. LeRoy, the chief of domestic intelligence with the cocaine desk of the Federal Drug Administration. "It is going to take a few months to have the numbers to prove it, but we feel fairly optimistic about it." Tracing the Growth in Appetite

The amount of cocaine entering the country could still be rising, Mr. LeRoy said, but the number of users appears to have leveled off or may be dropping. In other words, he said, the most recent growth in America's cocaine appetite can be traced to its most severe addicts, many of them inner-city crack addicts.

According to the household survey of 18-to-25-year-olds, the people most likely to have used cocaine in the previous month in 1982 were those who graduated from college. The least likely to have used cocaine were those who never finished high school. Among college graduates, 13 percent said they had used cocaine in the past month, while among those without high school diplomas, only 4 percent had used cocaine.

But by 1985, the situation was just the opposite. Only 3 percent of college graduates said they used cocaine in the last month. But 10 percent of people who never finished high school said they used the drug. Since the survey did not include people without homes, it may have understated drug use among the poorest and least-educated, according to Prof. Harwin Voss of the University of Kentucky, who helped direct the study. Severe Consequences

There is still evidence of middle-class crack use with severe consequences for those who have become addicted. In addition, treatment experts say "freebasing," or smoking of powdered cocaine, which has the same effect as smoking crack, is popular in some circles of middle-class and affluent drug users.

Nonetheless, the New York State Division of Substance Abuse Services and the Los Angeles County office of Drug Abuse report that most crack users appearing at hospitals and treatment centers are poor members of minority groups.

Such observations about crack and the poor are echoed by other drug treatment experts around the nation.

"Crack seems to have become entrenched in the inner-city areas," said James Hall, the director of Up Front Drug Information Inc., a foundation based in Miami. "With cocaine we are going to see a shrinking number of users who are going to be at greater risk from the drug. They are the poorest, the least educated, who have the least access to information."

But perhaps the most dire vision of the future concerns the intravenous users of heroin, a drug that has remained predominantly the preserve of the inner-city poor. AIDS Through Shared Needles

While the number of addicts around the nation has remained relatively stable, there has been an alarming rise in the proportion of addicts exposed to the AIDS virus from the sharing of needles.

While only a comparatively small fraction of heroin addicts died from overdoses, each year between 20 and 100 percent of those exposed to AIDS are expected to die from the disease.

Among heroin addicts entering drug treatment in New York, more than 50 percent are now testing positive for exposure to the virus, said Dr. Beny J. Primm, the executive director of the Addiction Research and Treatment Corporation, a drug treatment program in New York.

Dr. Primm described his vision of the future for the poorest black neighborhoods in New York, where homelessness and family disintegration are already rife.

"Five years from now, those people who are alive then will find their ranks devastated by AIDS, and there will be a type of hopelessness that is hard to imagine now," Dr. Primm said. "I am hearing people already say, 'I am infected with the virus, I might just as well shoot up drugs.' People will be turning more and more to drugs for solace."

Graph of percentage of nationwide high school seniors who said they used a drug other than marijuana in the last year (University of Michigan) (Page 28); photo of Dr. David F. Musto (NYT/Rollin A. Riggs) (Page 28)

Frequently Asked Questions About Drug Testing in Schools

What is drug testing?

Some schools, hospitals, or places of employment conduct drug testing. There are a number of ways this can be done, including: pre-employment testing, random testing, reasonable suspicion/cause testing, post-accident testing, return to duty testing, and follow-up testing. This usually involves collecting urine samples to test for drugs such as marijuana, cocaine, amphetamines, PCP, and opiates.

Following models established in the workplace, some schools have initiated random drug testing and/or reasonable suspicion/cause testing. During random testing schools select, using a random process (like flipping a coin), one or more individuals from the student population to undergo drug testing. Currently, random drug testing can only be conducted among students who participate in competitive extracurricular activities. Reasonable suspicion/cause testing involves a school requiring a student to provide a urine specimen when there is sufficient evidence to suggest that the student may have used an illicit substance. Typically, this involves the direct observations made by school officials that a student has used or possesses illicit substances, exhibits physical symptoms of being under the influence, and has patterns of abnormal or erratic behavior.

Why do some schools want to conduct random drug tests?

Schools that have adopted random student drug testing are hoping to decrease drug abuse among students via two routes. First, schools that conduct testing hope that random testing will serve as a deterrent, and give students a reason to resist peer pressure to take drugs. Secondly, drug testing can identify adolescents who have started using drugs so that interventions can occur early, or identify adolescents who already have drug problems, so they can be referred for treatment. Drug abuse not only interferes with a student's ability to learn, but it can also disrupt the teaching environment, affecting other students as well.

Is student drug testing a stand-alone solution, or do schools need other programs to prevent and reduce drug use?

Drug testing should never be undertaken as a stand-alone response to a drug problem. If testing is done, it should be a component of broader prevention, intervention and treatment programs, with the common goal of reducing students' drug use.

If a student tests positive for drugs, should that student face disciplinary consequences?

The primary purpose of drug testing is not to punish students who use drugs but to prevent drug abuse and to help students already using become drug-free. The results of a positive drug test should be used to intervene with students who do not yet have drug problems, through counseling and follow-up testing. For students that are diagnosed with addiction, parents and a school administrator can refer them to effective drug treatment programs, to begin the recovery process.

Why test teenagers at all?

Teens are especially vulnerable to drug abuse, when the brain and body are still developing. Most teens do not use drugs, but for those who do, it can lead to a wide range of adverse effects on the brain, the body, behavior and health.

Short term: Even a single use of an intoxicating drug can affect a person's judgment and decisionmaking—resulting in accidents, poor performance in a school or sports activity, unplanned risky behavior, and the risk of overdosing.

Long term: Repeated drug abuse can lead to serious problems, such as poor academic outcomes, mood changes (depending on the drug: depression, anxiety, paranoia, psychosis), and social or family problems caused or worsened by drugs.

Repeated drug use can also lead to the disease of *addiction*. Studies show that the earlier a teen begins using drugs, the more likely he or she will develop a substance abuse problem or addiction. Conversely, if teens stay away from drugs while in high school, they are less likely to develop a substance abuse problem later in life.

How many students actually use drugs?

Drug use among high schools students has dropped significantly since 2001. In December, the 2007 Monitoring the Future study of 8th, 10th, and 12th graders showed that drug use had declined by 24 percent since 2001.

Despite this marked decline, much remains to be done. Almost 50 percent of 12th graders say that they've used drugs at least once in their lifetime, and 18 percent report using marijuana in the last month. Prescription drug abuse is high—with nearly 1 in 10 high school seniors reporting non-medical use of the prescription painkiller Vicodin in the past year.

What testing methods are available?

There are several testing methods available that use urine, hair, oral fluids, and sweat (patch). These methods vary in cost, reliability, drugs detected, and detection period. Schools can determine their needs and choose the method that best suits their requirements, as long as the testing kits are from a reliable source.

Which drugs can be tested for?

Various testing methods normally test for a "panel" of drugs. Typically, a drug panel tests for marijuana, cocaine, opioids, amphetamines, and PCP. If a school has a particular problem with other drugs, such as MDMA, GHB, or steroids, they can include testing for these drugs as well.

What about alcohol?

Alcohol is a drug, and its use is a serious problem among young people. However, alcohol does not remain in the blood long enough for most tests to detect recent use. Breathalyzers and oral fluid tests can detect current use. Adolescents with substance abuse problems are often polydrug users (they use more than one drug) so identifying a problem with an illicit or prescription drug may also suggest an alcohol problem.

How accurate are drug tests? Is there a possibility a test could give a false positive?

Tests are very accurate but not 100 percent accurate. Usually samples are divided so if an initial test is positive a confirmation test can be conducted. Federal guidelines are in place to ensure accuracy and fairness in drug testing programs.

Can students "beat" the tests?

Many drug-using students are aware of techniques that supposedly detoxify their systems or mask their drug use. Popular magazines and Internet sites give advice on how to dilute urine samples, and there are even companies that sell clean urine or products designed to distort test results. A number of techniques and products are focused on urine tests for marijuana, but masking products increasingly are becoming available for tests of hair, oral fluids, and multiple drugs.

Most of these products do not work, are very costly, are easily identified in the testing process and need to be on hand constantly, because of the very nature of random testing. Moreover, even if the specific drug is successfully masked, the product itself can be detected, in which case the student using it would become an obvious candidate for additional screening and attention. In fact, some testing programs label a test "positive" if a masking product is detected.

Is random drug testing of students legal?

In June 2002, the U.S. Supreme Court broadened the authority of public schools to test students for illegal drugs. Voting 5 to 4 in *Pottawatomie County v. Earls*, the court ruled to allow random drug tests for all middle and high school students participating in competitive extracurricular activities. The ruling greatly expanded the scope of school drug testing, which previously had been allowed only for student athletes.

Just because the U.S. Supreme Court said student drug testing for adolescents in competitive extracurricular activities is constitutional, does that mean it is legal in my city or state?

A school or school district that is interested in adopting a student drug testing program should seek legal expertise so that it complies with all federal, state, and local laws. Individual state constitutions may dictate different legal thresholds for allowing student drug testing. Communities interested in starting student drug testing programs should become familiar with the law in their respective states to ensure proper compliance.

What has research determined about the utility of random drug tests in schools?

There is not very much research in this area, and the early research shows mixed results. A study published in 2007 (Goldberg et al, *J. Adolesc Health*, 41: 421-29, 2007) found that student athletes who participated in randomized drug testing had overall rates of drug use similar to students who did not take part in the program, and in fact some indicators of future drug abuse increased among those participating in the drug testing program. Because of the limited number of studies on this topic more research is warranted.

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Explore Cost Benefits

Most interested parties agree that they seek to help patients become less destructive and more productive members of society. In our society, an individual's contribution often is measured in monetary terms -which is why transforming measures of effectiveness into measures of monetary benefits is so important, and why cost-benefit analysis can be so useful for decisionmakers.

According to research by Ball and Ross (1991) and Gerstein et al. (1994), substance abuse treatment can be expected to both save money and produce new income. In California, various drug treatments were estimated to save between \$245 million and \$1,284 million after subtracting the cost of treatment from cost savings and income generated in a single year in the early 1990s (Gerstein et al. 1994, p. 82). Of course, every treatment program differs in how much (and how quickly) this return on investment occurs, which is one reason to measure the benefits as well as the costs of individual programs.

Typical Benefits of Substance Abuse Treatment

New Income

Real income may be generated by substance abuse treatment due to increased productivity and employment of patients. This does not always occur, however. Researchers have found that employment prospects may not be as positive for former substance abusers as might be hoped (cf. Gerstein et al. 1994). This may be due to the stigma of being a former substance abuser as well as difficulties posed by criminal records. Also, the behavior patterns sometimes acquired in drug abuse lifestyles may need to change radically to meet expectations of potential employers (such as getting to work on time every day and following directives).

Cost Savings

Another benefit of substance abuse treatment is cost savings to society or taxpayers. These cost savings include -

- Funds that otherwise would have been spent in the illicit economy for drugs.
- Criminal justice services not required.
- Social and health services no longer required.

These cost-savings benefits are real and can be quite substantial. Substance abuse researchers (Langenbucher et al. 1993) have found profound reductions in a number of costly events after treatment, including the following decreases:

- Patients involved in driving while intoxicated/driving under the influence arrests decreased from 18 percent (pretreatment) to 3 percent (posttreatment).
- Patients involved in accidents decreased from 14 to 1 percent.
- Patients' families who sought counseling decreased from 31 to 5 percent.
- Patients' children who missed school decreased from 5 to 1 percent.
- Patients' spouses who missed work decreased from 10 to 1 percent.

Although different jurisdictions and different methods of assessment may provide different figures, the level of criminal activity patients exhibit can be expected to decrease by roughly two-thirds (Gerstein et al. 1994). Not every program produces a two-thirds reduction, however, so it is essential to measure how much criminal activity changes for each patient.

The reduction in criminal activity following substance abuse treatment may not produce a corresponding reduction in actual costs to society. Although costs to citizens drop in direct proportion to reductions in criminal acts perpetrated on those citizens, public expenses for criminal justice services may not decline in a similar manner. Typically, police, courts, and other components of the criminal justice system are on limited and fixed budgets, while the need for criminal justice services greatly surpasses the ability to deliver those services. For this reason, the impact of substance abuse treatment on criminal behaviors may not result in an actual reduction in criminal justice expenditures. Instead, criminal justice resources saved because of a reduction in crimes committed by former substance abusers may be diverted to other criminal justice services. The entire budget for criminal services probably will still be spent.

Similar problems may occur when cost savings benefits are measured for reduced health, mental health, and future drug treatment services. Because resources in these services typically are very limited, the actual reduction in expenditures may not be as much as might be expected from the reduction in patient use of services.

Nevertheless, transforming effectiveness findings into estimated cost savings still may have considerable value for a program evaluation. In particular, cost savings estimates can show the magnitude of criminal justice and treatment resources that are now available to help other drug abusers who previously could not be helped because of budget restrictions.

Crime-Related Cost Savings

Other research provides evidence for numerous cost savings that result from drug abuse treatment. For example, Rajkumar and French (1996) found that although total costs of crime averaged \$47,971 per patient in the year prior to treatment, that figure dropped to an average of \$28,657 per patient in the year following treatment. That drop of \$19,314 was far more than the cost of treatment, making cost savings in terms of crime alone worth the cost of treatment: \$2,828 for methadone maintenance, \$8,920 for residential treatment, and \$2,908 for outpatient treatment (Rajkumar and French 1996).

Employment- Related Cost Savings

French and associates (1990) found that drug treatment improved the employment and earning potential of drug abusers. Although only 31 percent of drug abusers were employed at the start of treatment, almost 45 percent were employed after treatment. There was a similar increase in the number of patients seeking work (from 9 to 13 percent). And, employed patients earned more after treatment. French and colleagues (1990) found that average personal earnings for employed patients rose from \$6,158 during the year before treatment to \$7,120 during the year after treatment.

The legality of employment and income also can be positively affected by drug treatment. French and Zarkin (1992) found that increasing time spent in methadone treatment by just 10 percent increases legal earnings by 1.5 percent and decreases illegal earnings by 3.2 percent. A 10-percent increase in time spent in residential programs increases legal earnings 2.4 percent and decreases illegal earnings 4.1 percent.

Health Service- Related Cost Savings

French and colleagues (1996) estimated the cost savings if one case of the following health problems could be avoided:

- \$1,100 for avoiding a case of severe venereal disease
- \$74,513 for avoiding a case of severe hypertension
- \$96,005 for avoiding a case of severe tuberculosis
- \$114,796 for avoiding a case of AIDS

Caveats on Benefit Assumptions and Calculations

Reductions in each of the above events are notable in their own right, as well as in terms of monetary savings to the individual and society. For your program, the average cost of each event can be requested from those providing criminal justice, health, or social services locally. It also may be possible to glean this cost information directly from records of expenditures of public funds. The cost savings benefit then can be calculated for each patient as the reduction directly experienced in these events.

Some important changes may be impossible to monetize. For example, patients who interrupted their education decreased from 12 to 4 percent. Although this is a substantial decrease, it is impossible to determine the monetary value of this reduction. Other changes may not occur during the time period used to collect outcome data. For example, patients' financial problems may continue to occur for years after treatment because of the length of time necessary to compensate victims and pay off accumulated debt.

Increased Expenditures From Outcomes

Substance abuse treatment can temporarily increase patients' use of social services, including welfare support, disability payments, and health services. Patients may become well enough to seek help for health problems and to seek financial support from licit as opposed to illicit sources.

According to the CALDATA study (Gerstein et al. 1994), enrollment and payments received from various social services (other than health services) increased 17 to 50 percent during treatment. Being in treatment also may increase eligibility to receive a variety of social support services.

These increases in expenditures need to be included in treatment outcome reports. They should not be excluded simply because they do not seem like benefits. They are monetary outcomes and must be considered. They will likely be canceled out by the cost savings and income generated after treatment.

A case in point: In the CALDATA study, the costs of health services decreased between 1-year periods prior and subsequent to treatment from a mean \$3,227 to a mean \$2,469 per person. Also, in a study reported by Holder and Hallan (1986), private health insurance costs dropped from approximately \$100 per month per patient in the 2 years preceding treatment to less than \$14 per month per patient in the fifth year following treatment (which is when most health sequelae of substance abuse should have subsided).

Cost savings and other benefits may vary considerably depending on the type of treatment. In the CALDATA study, residential treatment was associated with a 58-percent reduction in costs to taxpayers, whereas methadone discharge was associated with a 17-percent reduction in costs to taxpayers. Also, longer treatment generally corresponded to greater cost savings, although not for methadone maintenance.

Transform Effectiveness Findings Into Benefits

Effectiveness findings often can be transformed into benefit findings by multiplying effectiveness data by a cost value. For example, to estimate cost savings after treatment, the change in the number of thefts before versus after treatment can be multiplied by the average cost of drug-related thefts in terms of property loss, victim losses, and criminal justice expenses. Statistical analysis of data collected in an experimental design is the best way to determine whether these cost savings are significant and can be ascribed to treatment. Other research designs, including correlational methods, provide guidance and useful estimates. The transformation procedure for figuring benefits from effectiveness findings remains relatively straightforward.

The exact cost value used to transform effectiveness findings into benefit findings is ascertained by surveying local criminal justice and social and health service agencies. Ideally, you would find the cost of each criminal act, the cost of each health service used, and so on, for each patient individually. If you cannot get that information, you may be able to use estimates of average costs per patient for these effectiveness variables.

For example, suppose you know that the number of theft convictions for a patient dropped from three in the year preceding treatment to one in the year following treatment. Suppose, too, that the estimated cost of a theft totaled \$1,200 after adding costs of arrest, holding, and conviction to the cost to citizens of lost property and mental anguish. The total savings that could be attributed to treatment would be the cost of thefts during a period prior to treatment, minus the cost of thefts during a similar period following treatment. For this patient, that would be:

$$(3 \times \$1,200) - (1 \times \$1,200) = \$3,600 - \$1,200 = \$2,400 \text{ in cost savings.}$$

It would be more accurate to find the actual cost of each theft. It is conceivable that the one theft following treatment was quite minor compared to the thefts preceding treatment. On the other hand, that one theft after treatment could have cost more than all the thefts before treatment.

There also may be too much variation between jurisdictions (and over years) to allow a set cost for social services, health services, criminal justice services, and other cost items to be established for all drug treatment programs throughout the country for all time.

When cost savings and benefits involve health services, welfare, and other services for which cost data are available for individual patients, the cost for each patient needs to be contrasted for different periods of treatment. These services can vary greatly between patients; an estimate of the average health care cost per patient could result in over- or underestimation of cost-savings benefits.

Table 24 lists examples of the types of costs and potential cost savings that can be included in the survey. It is not meant to be complete. Note also that room for a range of estimates is provided, in recognition of the variability in costs of these services between patients and over time for the same patient. Costs of the specific criminal behaviors of individual patients then can be contrasted for the periods -

- Before versus after treatment.
- Before versus during treatment.
- During versus after treatment.

These costs can be examined separately for each category of potential cost savings or actual income produced and then summed across all categories to find the total benefit.

Table 24. Types of Costs and Potential Cost Savings

	Effectiveness measure	Effectiveness-benefit transformation	Benefit measures
Possible Cost Savings	Criminal acts not performed	Thefts at \$___ / misdemeanor \$___/ felony Assaults at \$___	Savings to potential victims due to income loss avoided, property not damaged or lost, and health and mental health services not needed
	Drugs not purchased	Opiates at \$___ to \$___/day Cocaine and crack at \$___ to \$___/day Other at \$___ to \$___/day	Money not spent on drug purchases
	Criminal justice services not used	Arrests at \$___/ arrest Jail at \$___/day Prosecution at \$___/ day	Expense of criminal justice services avoided
	Drug treatment no longer needed	\$__ per patient per day for the mixture of treatments provided	Cost of drug treatment no longer needed
	Welfare payments not provided	\$__ per patient per day in welfare payments	Amount of welfare payments not provided
	Disability payments not made	\$__ per patient per day in disability payments	Size of disability payments not made
	Health services not used	Sum health care cost use for 6 - 12 months before treatment and 6 - 12 months after treatment	Cost of health services not used
Possible Benefits Produced	Employment (licit)		Income earned from licit sources
	Entrepreneurship (licit)		New income (profit) from enterprise
	Income taxes paid on licit income		Amount of Federal, State, and local taxes paid on licit income
	Increased productivity in an existing job		Increased profit for employer, company, and sole proprietorship

Net Benefit

Cost-benefit analysis answers the question of whether the outcomes of a program are worth the costs by -

- Measuring outcomes in the same units -dollars, usually -as costs.
- Seeing whether the value of outcomes exceeds the value of costs (by subtracting total costs from total benefits, which is called the net benefit).

To calculate the total benefit per patient for a program, simply add up the benefit figures for each of the specific measures. Similarly, to calculate the total cost per patient for a program, add up the cost figures for each procedure. Then you can calculate the net benefit (total benefits minus total costs) for the patient. Add these up for all patients to find the net benefit for the treatment program.

To make cost-benefit analysis more specific, list the specific costs of achieving the benefits on each measure. Instead of adding up benefits for all measures for one patient, and then summing or averaging across patients, add up or average for all patients the benefits attained by a program for one measure.

Present-Value Benefits

Immediate positive outcomes are more valuable than delayed positive outcomes. Nonmonetary outcomes rarely are adjusted for the amount they are delayed, but monetary benefits often are. If costs and benefits are to be compared, monetary benefits delayed by more than a year from the time that costs occur can be adjusted for their delayed value.

The adjustment divides benefits by the sum of 1 plus a discount rate (often 0.08, 0.10, or 0.14). The discount rate closely resembles the interest rate that could be earned if the money spent on treatment were invested in another activity (such as a money market fund). Benefits delayed by 2 years are adjusted by dividing them by the result of multiplying the sum 1 + (discount rate) by itself once (squared). Benefits delayed by 3 years are adjusted by dividing them by the result of multiplying the sum 1 + (discount rate) by itself and then by itself again, and so on.

The result of applying net present value to delayed benefits can be striking. Consider, for example, a stream of cost-savings benefits of \$10,000 that occur at the end of the year for each of 3 years and a discount rate of 0.10. It is tempting simply to sum the benefits for a total of \$30,000. The net present value of the first end-of-the-year return is, however, $\$10,000 \div (1 + .10) = \$10,000 \div 1.10 = \$9,091$ following the calculation guidelines given above.

The net present value of the second year's cost-savings benefit is $\$10,000 \div [(1 + .10) \times (1 + .10)] = \$10,000 \div [1.10 \times 1.10] = \$10,000 \div 1.21 = \$8,264$. The net present value of the third year's cost-saving benefit is $\$10,000 \div [(1 + .10) \times (1 + .10) \times (1 + .10)] = \$10,000 \div [1.10 \times 1.10 \times 1.10] = \$10,000 \div 1.331 = \$7,513$. The total of these net-present-value benefits is far less than \$30,000. It is only \$24,868.

The resulting present-value benefits reflect the declining value of benefits that take longer to occur. The difficulties of making this adjustment are minor, although two to three discount rates (say, 0.08, 0.10, and 0.14) should be used. The resulting benefit adjustments provide a quantitative advantage of alternative procedures (and alternative treatment programs) that produce benefits more rapidly.

Time to Return on Investment

Net benefit is the result of subtracting costs from benefits. Present valuing benefits reduces the value of benefits. Using present-value benefits gives an appropriate advantage to programs that achieve their benefits sooner. Present valuing benefits still, however, gives an advantage (appropriately) to programs that take longer but achieve better benefits than programs that produce quick but small benefits.

Time to return on investment is the time at which investment equals monetary outcomes. The time it takes benefits to begin to exceed costs for substance abuse treatment is of concern to funders and other interest groups. Each patient can be monitored for the time actually elapsed before the monetary value of the outcomes achieved equals the monetary value of the resources used. The average time to return on investment then can be computed for all patients.

One way to do this is to keep each patient's figurative "bill" on a lined piece of paper or on a spreadsheet, such as the one shown in table 25. "Investment" is the cost of treatment services delivered. "Return on Investment" is the monetary or monetized benefit resulting from treatment services. "Cumulative Investment" is the running total of all treatment and other service costs. "Cumulative Return on Investment" is the continuous total of all benefits (monetary and monetized) resulting from treatment. "Net Benefit" is the result of subtracting the Cumulative Investment from the Cumulative Return on Investment. An advantage of keeping these data on a computer spreadsheet is that the cumulative total and the net benefit can be automatically updated by the computer each time you enter new cost (investment) or benefit data.

Table 25 could be completed just from the perspective of the present treatment program, or from the perspective of past as well as present treatments, or for society as a whole. In the "Return on Investment" column, one could add the patient's debt to society -restitution owed victims or the cost of criminal justice services. The balance unpaid from previous treatment programs also could be added here.

Table 25. Sample Cumulative Costs and Benefits and Net Benefit

Time	Investment	Return on investment	Cumulative investment	Cumulative return on investment	Net benefit
Date	Cost of treatment services delivered	Benefit to society, patient, or other individual	Running total of all treatment costs	Running total of all benefits of treatment	Cumulative return minus cumulative investment
1/3 start	\$376 (screening)		\$376	0	-\$376
1/5	\$145 (session)	\$21 (drug-free day)	\$521	\$21	-\$500
1/6		\$21 (drug-free day)	\$521	\$42	-\$479
1/8	\$95 (group)	\$21 (drug-free day)	\$616	\$63	-\$458
1/8	\$145 (session)		\$761	\$63	-\$698
1/9		\$124 (income for employed day)	\$761	\$187	-\$574
1/9		\$21 (drug-free day)	\$761	\$208	-\$553

Total investment in treatment expenses can be compared to the total monetary value of outcomes achieved for a cohort of patients (say, the first 100 patients entering the clinic following the first year of startup and operation).

Time to return on investment can be contrasted for different groups of patients, such as those receiving different procedures or exhibiting different processes. The cost-benefit of different procedures also can be compared by contrasting time to return on investment for patients treated by the different procedures.

Just as calculations of time to return on investment should include present-value benefits, more delayed costs also should be adjusted for present value. The latter procedure quantifies the judgment that programs that delay some costs are preferred over programs that require all expenditures up front.

Potential Problems With Cost-Benefit Analysis

Erroneous Assumptions of Linearity

The strength of cost-benefit analysis also is its weakness or, more accurately, its problem. Because ratios can be calculated very readily (since costs and outcomes are in the same monetary units in most cost-benefit analyses), funders may make all the erroneous assumptions noted earlier that are encouraged by cost-outcome ratios .

Net benefit and time to return on investment forms of cost-benefit analysis encourage similar, and similarly erroneous, assumptions. For example, funders may incorrectly assume that because the benefit for an investment of \$100,000 in a substance abuse treatment program is \$50,000, doubling the investment to \$200,000 will double the benefit to \$100,000.

The common pattern of diminishing returns on investment would diminish this anticipated benefit to less than double. It also is possible that increasing the initial investment so much would allow entirely different (and much more effective and beneficial) treatment procedures to be used.

Some funders also may believe that increasing the investment in treatment might yield a quicker return on investment, which might not occur given limitations on how rapidly current treatment technology can modify the behaviors, life skills, and lifestyles associated with substance abuse.

Overemphasis on Monetary and Monetized Outcomes

The major problem with all forms of cost-benefit analysis is that monetary outcomes are the only outcomes considered. Most service providers, many patients, and some other interested parties believe that the most important outcomes of substance abuse treatment can hardly be quantified, much less monetized (translated into monetary outcomes). To note that some nonmonetary outcomes, such as reduced crime, can be monetized does not eliminate, but only reduces, this problem. Many providers are unwilling to consider placing a monetary value on the outcomes of their services. These providers often resent attempts by persons outside the treatment program to monetize their outcomes.

Critics also note that cost-benefit analysis has been used to justify a number of decisions that proved to be not only erroneous but disastrously so. For example, cost-benefit analyses conducted by State mental health hospitals in the 1980s apparently were used to justify sudden deinstitutionalization without preparation of the patient or the community. This removal of many mental patients from hospitals and placement into communities that were not prepared to provide necessary services exacerbated homelessness and amounted to abandonment of some patients.

This unwise decision does not necessarily mean that cost-benefit analysis is itself unwise. Problems arise when only one perspective is considered; it is important to adopt multiple perspectives in cost-outcome analyses. For example, in the deinstitutionalization analysis, only the perspective of the State mental hospital was considered.

Resources for Cost-Benefit Analysis

Several good books discuss the value of using cost-benefit analysis to evaluate programs (Nas 1996; Thompson 1980). A classic cost-benefit analysis performed in mental health (deinstitutionalization of schizophrenic patients) is provided by Weisbrod (1983). The much-discussed CALDATA study (Gerstein et al. 1994) also deserves your attention, as it is directly related to substance abuse treatment.



States Consider Drug Tests for Welfare Recipients

Thursday , March 26, 2009

Associated Press

CHARLESTON, W.Va. —

Want government assistance? Just say no to drugs.

Lawmakers in at least eight states want recipients of food stamps, unemployment benefits or welfare to submit to random drug testing.

The effort comes as more Americans turn to these safety nets to ride out the recession. Poverty and civil liberties advocates fear the strategy could backfire, discouraging some people from seeking financial aid and making already desperate situations worse.

Those in favor of the drug tests say they are motivated out of a concern for their constituents' health and ability to put themselves on more solid financial footing once the economy rebounds. But proponents concede they also want to send a message: you don't get something for nothing.

"Nobody's being forced into these assistance programs," said Craig Blair, a Republican in the West Virginia Legislature who has created a Web site — notwithmytaxdollars.com — that bears a bobble-headed likeness of himself advocating this position. "If so many jobs require random drug tests these days, why not these benefits?"

Blair is proposing the most comprehensive measure in the country, as it would apply to anyone applying for food stamps, unemployment compensation or the federal programs usually known as "welfare": Temporary Assistance for Needy Families and Women, Infants and Children.

Lawmakers in other states are offering similar, but more modest proposals.

On Wednesday, the Kansas House of Representatives approved a measure mandating drug testing for the 14,000 or so people getting cash assistance from the state, which now goes before the state senate. In February, the Oklahoma Senate unanimously passed a measure that would require drug testing as a condition of receiving TANF benefits, and similar bills have been introduced in Missouri and Hawaii. A Florida senator has proposed a bill linking unemployment compensation to drug testing, and a member of Minnesota's House of Representatives has a bill requiring drug tests of people who get public assistance under a state program there.

A January attempt in the Arizona Senate to establish such a law failed.

In the past, such efforts have been stymied by legal and cost concerns, said Christine Nelson, a program manager with the National Conference of State Legislatures. But states' bigger fiscal crises, and the surging demand for public assistance, could change that.

"It's an example of where you could cut costs at the expense of a segment of society that's least able to defend themselves," said Frank Crabtree, executive director of the West Virginia chapter of the American Civil Liberties Union.

Drug testing is not the only restriction envisioned for people receiving public assistance: a bill in the Tennessee Legislature would cap lottery winnings for recipients at \$600.

There seems to be no coordinated move around the country to push these bills, and similar proposals have arisen periodically since federal welfare reform in the 1990s. But the appearance of a cluster of such proposals in the midst of the recession shows lawmakers are newly engaged about who is getting public assistance.

Particularly troubling to some policy analysts is the drive to drug test people collecting unemployment insurance, whose numbers nationwide now exceed 5.4 million, the highest total on records dating back to 1967.

"It doesn't seem like the kind of thing to bring up during a recession," said Ron Haskins, a senior fellow at the Brookings Institution. "People who are unemployed, who have lost their job, that's a sympathetic group. Americans are tuned into that, because they're worried they'll be next."

Indeed, these proposals are coming at a time when more Americans find themselves in need of public assistance.

Although the number of TANF recipients has stayed relatively stable at 3.8 million in the last year, claims for unemployment benefits and food stamps have soared.

In December, more than 31.7 million Americans were receiving food stamp benefits, compared with 27.5 million the year before.

The link between public assistance and drug testing stems from the Congressional overhaul of welfare in the 1990s, which allowed states to implement drug testing as a condition of receiving help.

But a federal court struck down a Michigan law that would have allowed for "random, suspicionless" testing, saying it violated the 4th Amendment's protections against unreasonable search and seizure, said Liz Schott, a senior fellow at the Center on Budget and Policy Priorities.

At least six states — Indiana, Massachusetts, Minnesota, New Jersey, Wisconsin and Virginia — tie eligibility for some public assistance to drug testing for convicted felons or parolees, according to the NCSL.

Nelson said programs that screen welfare applicants by assigning them to case workers for interviews have shown some success without the need for drug tests. These alternative measures offer treatment, but can also threaten future benefits if drug problems persist, she said.

They also cost less than the \$400 or so needed for tests that can catch a sufficient range of illegal drugs, and rule out false positive results with a follow-up test, she said.

26-LS1126\E
Mischel
1/21/10

CS FOR HOUSE BILL NO. 259()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES KELLER AND GATTO, Kelly

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to citizenship requirements and an alcohol impairment and drug**
2 **testing program for applicants for and recipients of specified cash assistance."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.05 is amended by adding new sections to read:

5 **Article 4. Alcohol and Drug Testing.**

6 **Sec. 47.05.400. Alcohol impairment and drug testing; legislative findings**
7 **and purpose.** The legislature finds that a statewide threat to public safety exists with
8 regard to the use of cash assistance for the purchase of alcohol and illegal drugs. The
9 purpose of the testing program established under AS 47.05.400 - 47.05.500 is to
10 reduce that risk and to protect the residents of the state.

11 **Sec. 47.05.410. Alcohol impairment and drug testing for eligibility;**
12 **regulations; immunity.** (a) The department shall implement a program consistent
13 with AS 47.05.400 - 47.05.500 that provides for random and suspicion-based testing
14 of recipients of cash assistance for use of alcohol that impairs a recipient's ability to

work or to seek work and of applicants for and recipients of cash assistance for the use of illegal drugs.

(b) The department shall adopt regulations to implement this section. The regulations must include testing policies consistent with AS 47.05.430 and specify the type of testing to be conducted and the illegal drugs to be included in the testing program. The drug tested must have a cutoff level that yields a positive test result

(1) for initial testing of urine, as follows:

SUBSTANCE	CUTOFF CONCENTRATION (nanograms in each milliliter)
Marijuana metabolites	50
Cocaine metabolites	300
Opiate metabolites	2,000
Phencyclidine	1,000
Amphetamines	1,000

(2) for confirmatory testing of urine, as follows:

SUBSTANCE	CUTOFF CONCENTRATION (nanograms in each milliliter)
Marijuana metabolite (Delta-9-tetrahydrocannabinol-9-carboxylic acid)	15
Cocaine metabolite (Benzoylecgonine)	150
Opiates	
Morphine	2,000
Codeine	2,000
6-Acetylmorphine	10
(when morphine concentration exceeds 2,000 nanograms in each milliliter)	
Phencyclidine	25
Amphetamines	
Amphetamine	500
Methamphetamine	500
(when amphetamine concentration is	

1 greater than or equal to 200 nanograms
2 in each milliliter)

3 (3) for testing of alternative specimens that is consistent with the
4 mandatory guidelines for the federal workplace drug testing program adopted by the
5 United States Department of Health and Human Services.

6 (c) Unless the department or an agent or employee of the department knew or
7 should have known that the results of a test conducted under this section were false
8 and took action that affected a person's eligibility for cash assistance based on the false
9 test results, a person may not bring an action for damages against the department or an
10 agent or employee of the department for

11 (1) good faith actions taken to conduct, or as a result of, alcohol
12 impairment or drug testing under this section;

13 (2) failure to test for alcohol impairment or drugs or for a specific
14 drug;

15 (3) failure to test, or if the test was undetected, failure to detect a
16 specific drug or medical or psychological condition or disorder;

17 (4) termination or suspension of an alcohol or drug prevention or
18 testing program or policy.

19 (d) In a claim for damages based on false test results,

20 (1) a rebuttable presumption exists that the test results were valid if the
21 department complied with this section and the regulations adopted under this section;
22 and

23 (2) the department may not be held liable for monetary damages for
24 good faith reliance and reasonable actions taken as a result of false test results.

25 (e) A person may not bring an action against the department based on the
26 failure of the department to establish a program or policy on substance abuse
27 prevention or to implement alcohol impairment or drug testing.

28 **Sec. 47.05.420. Confidentiality; liability.** (a) The results of a test conducted
29 under AS 47.05.410 are confidential, except that the results may be revealed to the
30 recipient of cash assistance who was tested and to agents and employees of the
31 department as required to determine eligibility for cash assistance.

1 (b) A person may not bring an action for defamation of character or reputation
2 as a result of disclosure of the results of an alcohol impairment or drug test under the
3 alcohol impairment or drug testing program established under AS 47.05.410 unless

4 (1) the results were disclosed to a person, other than an agent or
5 employee of the department for the purpose of the testing program or under court or
6 administrative order;

7 (2) the information disclosed included false test results;

8 (3) the information was negligently or intentionally disclosed; and

9 (4) the elements of the tort claim are met.

10 **Sec. 47.05.430. Testing policies and procedures.** (a) The department shall
11 adopt testing policies that include

12 (1) a list of substances tested;

13 (2) a description of the testing methods and collection procedures,
14 including on-site testing;

15 (3) a right to confirmatory testing and the procedures for confirmatory
16 testing;

17 (4) the consequences for refusal to test or retest that are consistent with
18 the provisions in AS 47.05.450;

19 (5) the right of an applicant for or recipient of cash assistance to
20 receive test results within five working days after the department receives the test
21 results or the written request, whichever is later, if a written request is made by the
22 applicant or recipient within six months after the test;

23 (6) the right of an applicant and a recipient, on the applicant's or
24 recipient's request, to receive, within 72 hours or before an adverse action is taken,
25 whichever occurs first, a confidential explanation of the applicant's or recipient's test
26 results;

27 (7) providing the department's confidentiality and testing policies to
28 applicants for and recipients of cash assistance not less than 30 days before initiating
29 testing on the applicant or recipient.

30 (b) The department shall pay the cost of testing and, if the testing is performed
31 at a location other than a location of the department, the cost of transportation to and

1 from the testing center.

2 (c) Sample collection and testing must

3 (1) comply with scientifically accepted methods and procedures;

4 (2) be performed at a location identified by the department and
5 analyzed by a laboratory approved or certified by the Substance Abuse and Mental
6 Health Services Administration or by the College of American Pathologists;

7 (3) be conducted under reasonable, sanitary, and private conditions
8 that are consistent with reliability;

9 (4) be properly controlled and samples must be properly labeled; and

10 (5) include relevant medical information.

11 (d) A positive drug test must be confirmed using a different analytical process
12 than was used in initial testing. A positive drug test must be reported as a negative
13 result if a licensed physician verifies that the test was affected by medication
14 prescribed for the applicant or recipient tested.

15 (e) The department may not rely on a positive test result without confirmatory
16 testing.

17 **Sec. 47.05.440. Training of test administrators.** (a) The department shall
18 ensure that not less than one designated employee of the department receives not less
19 than one hour of training on alcohol abuse and an additional one hour of training on
20 the use of controlled substances for the purpose of finding reasonable suspicion for
21 testing under AS 47.05.400 - 47.05.500.

22 (b) If the department provides on-site testing for alcohol impairment or illegal
23 drug use under AS 47.05.410, the department shall employ on-site administrators who

24 (1) have received training in person and written certification of the
25 training by the test manufacturer's representative on the proper procedure for
26 administering the test and on accurate analysis of the on-site test results; the training
27 must include recognition of adulteration of a sample collected on-site;

28 (2) agree in writing to maintain confidentiality under the testing
29 policies adopted by the department.

30 **Sec. 47.05.450. Consequences of confirmatory positive testing.** (a) Except as
31 provided in (b) of this section, the department shall deny or suspend cash assistance to

1 an applicant for or recipient of the assistance who, under AS 47.05.400 - 47.05.500,
2 has

3 (1) been tested and received a confirmatory positive result for alcohol
4 impairment or use of illegal drugs and fails to comply with a treatment program
5 approved by the department; or

6 (2) refused alcohol impairment or drug testing required by the
7 department.

8 (b) The department may provide cash assistance on behalf of an eligible
9 recipient who is subject to denial or suspension under (a) of this section if the
10 department has in place an option for third-party receipt of the cash assistance for
11 which the recipient or the recipient's family is otherwise eligible and the third party is
12 a legal guardian, public institution, or licensed health care facility that provides care,
13 shelter, or food to the recipient or the recipient's dependent children.

14 **Sec. 47.05.500. Definitions.** In AS 47.05.400 - 47.05.500, "cash assistance"
15 means general relief under AS 47.25.120 - 47.25.300 and Alaska Temporary
16 Assistance under AS 47.27.

17 * **Sec. 2.** AS 47.25.120 is amended by adding a new subsection to read:

18 (b) A person must be a citizen of the United States or a legal alien as described
19 in 8 U.S.C. 1181 - 1186 and not otherwise precluded from eligibility under state or
20 federal law to be eligible for assistance under AS 47.25.120 - 47.25.300.

HB

260

26-LS1128R
Mischel
2/4/10

CS FOR HOUSE BILL NO. 260(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE KELLER

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to preventive care services for medical assistance recipients; and**
2 **providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.07 is amended by adding a new section to read:

5 **Sec. 47.07.047. Preventive care services.** (a) The department shall provide
6 services and opportunities to enable eligible medical assistance recipients to receive a
7 full range of preventive care services that are coordinated and that are provided in the
8 least restrictive and most home-like environment. The services must include

- 9 (1) coordination by a primary care provider;
- 10 (2) use of evidence-based practice guidelines;
- 11 (3) patient education;
- 12 (4) specialty referral and provider collaboration;
- 13 (5) routine health assessments;
- 14 (6) outcome assessment and measurement;

1 (7) other preventive services identified by the department in regulation.

2 (b) To implement (a) of this section, the department may contract with
3 qualified entities or providers to provide preventive care services that include medical
4 home-based services and programs of alternative care for the elderly.

5 (c) The department may provide services required under (a) of this section
6 under a waiver, in accordance with 42 U.S.C. 1396 - 1396p (Title IX Social Security
7 Act), this chapter, and regulations adopted under this chapter, if the department

8 (1) finds that providing the services under a waiver is the most cost-
9 effective and cost-efficient method of providing the services;

10 (2) receives appropriations allocated for that purpose; and

11 (3) receives approval from the federal government for the waiver.

12 (d) The department shall evaluate the projected and actual savings resulting
13 from implementation of this section and provide an annual report to the legislature
14 describing the services provided, participant outcomes, and savings.

15 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
16 read:

17 **FEDERAL MEDICAL ASSISTANCE APPROVAL; NOTIFICATION.** (a) The
18 Department of Health and Social Services may apply for a waiver from the United States
19 Department of Health and Human Services to provide preventive services to medical
20 assistance recipients under AS 47.07.047, enacted by sec. 1 of this Act.

21 (b) On or before July 1, 2011, the commissioner of health and social services shall
22 notify the revisor of statutes of the approval or denial of a waiver applied for under this
23 section.

24 * **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to
25 read:

26 **PREVENTIVE CARE SERVICES; REGULATIONS.** The Department of Health and
27 Social Services may adopt regulations necessary to implement AS 47.07.047, enacted by sec.
28 1 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act) but
29 not before the effective date of sec. 1 of this Act.

30 * **Sec. 4.** Sections 2 and 3 of this Act take effect immediately under AS 01.10.070(c).

Adopted. 3/23/2010. -ling

26-LS1128\R.2
Mischel
3/18/10

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 260(HSS), Draft Version "R"

- 1 Page 2, line 14, following "outcomes,":
- 2 Insert "costs,"

Adopted 3/23/2010. - lig

26-LS1128\R.1
Mischel
3/18/10

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE SEATON

TO: CSHB 260(HSS), Draft Version "R"

1 Page 2, following line 14:

2 Insert a new subsection to read:

3 "(e) The department shall establish measures that include medical, social, and
4 economic components for the services provided under this section. The measures shall
5 be used in evaluating outcomes and savings for purposes of reporting under (d) of this
6 section."

ALASKA STATE LEGISLATURE

Interim:

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Session:

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Juneau, Alaska 99801-1182
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REPRESENTATIVE WES KELLER DISTRICT 14

Sponsor Statement House Bill 260

“An Act relating to preventive care and disease management services for medical assistance recipients; and providing for an effective date.”

“An ounce of prevention is worth a pound of cure.” Those were words most of us heard from our mothers or fathers when we were young. Today, we have an opportunity to apply those words in a practical and economical sense. House Bill 260 will open the door for those receiving Medicaid to participate in preventative care and disease management programs.

Under the proposal, providers will be reimbursed for giving patients the option of learning and pursuing good health based on their personal history and risk factors. Often if a condition is dealt with early on, a cure can be as simple as a life style change. This could eliminate the need for extensive medical intervention later and will save money.

Preventative medicine is the basis for so much of our life style today from smoking cessation to reducing alcohol consumption. Currently, the Medicaid system does not permit, nor will it pay for preventative types of activity. House Bill 260 will give those using Medicaid the same opportunity to learn how to make changes in their lives that will help them live healthier.

E-Mail: Representative_Wes_Keller@legis.state.ak.us
Call Juneau Toll free: (800) 468-2186
Website: www.akrepublicans.org/keller/

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB260
() Publish Date: _____

Identifier (file name): HB260-DHSS-MAA-2-8-10 Dept. Affected: Health & Social Services
Title: Medicaid: Preventive Care/ Disease RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Keller
Requester: House HSS Component Number: 242

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services	94.2		94.2	94.2	94.2	94.2	94.2	94.2
Travel								
Contractual	9.6		9.6	9.6	9.6	9.6	9.6	9.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Equipment	7.6							
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	112.4		104.8	104.8	104.8	104.8	104.8	104.8

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	56.2		52.4	52.4	52.4	52.4	52.4	52.4
1003 GF Match	56.2		52.4	52.4	52.4	52.4	52.4	52.4
1004 GF								
1005 GF/Program Receipt								
1037 GF/Mental Health								
Other Interagency Receipt								
TOTAL	112.4		104.8	104.8	104.8	104.8	104.8	104.8

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time	1		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

HB 260 would require DHSS to develop a program of preventive care and disease management for Medicaid recipients. The department anticipates complying with this requirement by establishing a Program of All-Inclusive Care for the Elderly (PACE) and/or medical home program. This bill would not affect the total number of Medicaid recipients served, but would alter the mix of services that some individuals receive and, in some instances, how they receive it.

DHSS anticipates that actual provision of the preventive care and disease management would occur through PACE and primary care providers. However, it would be necessary to hire one new staff to develop and oversee these programs.

(continued on Page 2)

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services

Phone 269-7827
Date/Time 2/5/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 2/8/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. HB260

ANALYSIS CONTINUATION

Administrative Costs:

1 Medical Assistance Administrator III, \$94,207 (Range 20) ; . All personal services costs include benefits. Assumes \$9.6 per FTE annually for office space, phones, and other contractual costs; \$2.6 one time costs per FTE for computers and software; \$5.0 one time costs per FTE for office equipment; \$1.0 per FTE annually for supplies.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB260
 () Publish Date: _____

Identifier (file name): HB260-DHSS-MS-2-8-10 Dept. Affected: Health & Social Services
 Title: Medicaid: Preventive Care/ Disease RDU: Health Care Services
 Component: Medicaid Services
 Sponsor: Keller
 Requester: House HSS Component Number: 2077

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	0.0		0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES								
---------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match	0.0		0.0	0.0	0.0	0.0	0.0	0.0
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB 260 would require DHSS to develop a program of preventive care and disease management for Medicaid recipients. The department anticipates complying with this requirement by establishing a Program of All-Inclusive Care for the Elderly (PACE) and/or medical home program. This bill would not affect the total number of Medicaid recipients served, but would alter the mix of services that some individuals receive and, in some instances, how they receive it.

PACE is an optional benefit under both the Medicare and Medicaid programs. It serves people over 55 years who meet the State's standards for nursing home care. PACE providers receive capitated payments from Medicare and Medicaid and assume the risk for all Medicare and Medicaid services. For most patients, a comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services, which are integrated into a complete health care plan. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner

Phone 269-7827

Division: Health Care Services

Date/Time 2/8/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 2/8/2010

FISCAL NOTE

STATE OF ALASKA

BILL NO. HB260

2010 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Starting a PACE program requires an agreement between the State Medicaid and the federal Medicare programs. It may take as long as 2 years to initiate a program including the possible need to obtain a Medicaid waiver, negotiating an agreement with Medicare to participate in a regional program, and securing the interest of a PACE organization. Initially, capitated Medicaid payments to the PACE provider would probably equal what the Medicaid program is currently paying for services for these clients. Eventually, with enough actuarial experience, capitated payments might be adjusted downward if the program successfully bends the cost curve.

Medicaid Medical home is a model of health care delivery in which a Medicaid recipient chooses a primary care provider (PCP) who is responsible for coordinating the participant's care. These plans provide participants a medical home and a relationship with a primary care provider to increase primary care and reduce the need for specialty and emergency department care. PCPs are paid a monthly fee for coordinating the participant's care on top of the payment for providing medical services reimbursed on a fee-for-service basis.

Considerable efforts on the part of HCS would be necessary in order to recruit primary care providers to participate in a medical program. One potential opportunity would be to enlist the participation and partnership of the Primary Care Association and a contracting relationship with specific Community Health Centers to develop medical home programs. Potential cost savings from the program would be depending on the level of fees necessary to attract adequate PCPs. Because of the uncertainty about the necessary level of the fee, DHSS does not project spending reductions by FY 2016. However, DHSS does believe that Primary Care case management would result in improved quality of care for Medicaid recipients.

Preventive Health Care: An Ounce of Prevention

by Eve B. Scheffenacker

When people talk about the dire state of health care in this country, fingers point in every direction. At hospitals and HMOs (health maintenance organizations) that make treatment decisions based on cost-benefit analysis. At drug companies whose profit margins have been described as obscene. At insurance companies that won't insure people who've been treated for depression or acid reflux.

Clearly, there's plenty of blame to go around. So let's not overlook another influential group--patients like you and me, especially the ones who have insurance. While thousands of Americans do without medical care that they need but can't afford, an even larger number of insured people ignore health services that will cost them a little and could save everyone a lot.

What's the story?

A recent study found that, of the people who have preventive care benefits available through their medical plans, only 10% actually use them. The other 90% don't get routine exams like mammograms and prostate screenings, don't get lab work to check their cholesterol and blood sugar, and don't get their children vaccinated. They don't enroll in an exercise class or a disease management program. Not even when their plans cover all or most of the costs.

A new MRI available in some areas can diagnose heart disease 10 years before the person is at risk for heart attack.

Some of these people may not know the benefits exist and don't think to ask. A lot of them, though, are in denial, believing that "it"--heart disease, cancer, diabetes, or stroke--won't happen to them. Some of them may be right, but the odds don't favor them. The U.S. spends \$240 billion a year treating diabetes, obesity, and tobacco-related diseases. That figure represents a lot of very sick people whose diseases could have been detected and managed by preventive care.

The pound of cure

These people may be making a risky and expensive mistake, because preventive care saves lives and money. So if you belong to the 90% majority that is choosing to go without preventive care, here are some reasons to consider joining the minority.

- *Preventive care is inexpensive long-term care* because it protects your future health. Medical and pharmaceutical advances have only a small effect on our overall health. In fact, 25 of the 30 years added to life expectancy in the past century are due to advances in preventive medicine and public health.

Only 10% of the people who have preventive care benefits through their medical plans use them.

Even when you're feeling well, the first signs of a critical disease may be present. Only blood tests, X-rays, and other procedures can detect those early signs. Doctors now are better educated about doing routine screening and knowing what to look for. In the meantime, advances in routine tests have made

them remarkably accurate. For example, a new type of MRI (magnetic resonance imaging; note that this test is not available everywhere) can diagnose heart disease as much as 10 years before the person is at risk for heart attack. Think how the death rate from heart attack might drop if more people took advantage of that one test.

Detecting a chronic or acute disease in its early stage puts you ahead of the curve. It also saves you a lot of money. Instead of working to combat an advanced disease and its complications, your doctor can focus on keeping a small symptom from becoming bigger. Usually, the earlier you start treating a condition, the better your chances of surviving. For example:

Detecting an acute disease in its early stages puts you ahead of the curve, medically and financially.

- When doctors can diagnose heart disease before symptoms occur, they can treat and even reverse the progress of most conditions with outpatient care--and patient compliance.
- Because colon polyps grow slowly, routine colonoscopies could prevent more than 90% of deaths from colon cancer.
- Several studies show that routine mammograms after age 40 lower a woman's risk of dying from breast cancer.
- *Regular preventive care means better overall care from your primary doctor.* When you receive regular preventive care, your doctor can track your health over a period of years. He or she then is more likely to notice small but telling changes in your weight or blood pressure, sleep patterns, or appetite. Your doctor also can help you manage behaviors that contribute to heart disease, diabetes, and cancer. Walking 20 minutes a day, cutting back on fat in your diet, or stopping smoking are manageable changes that literally can save your life.
- *Routine immunizations give you and your children immediate protection.* Pediatric vaccinations protect children from serious infections including polio, chicken pox, and meningitis. And among older Americans, the annual flu shot can prevent the flu and other, more serious complications including heart attack, pneumonia, and stroke.

Take care of yourself now and protect the health you hope to enjoy 10 years from now.

Bottom line--preventive care could lead the way to health-care reform

Everyone, including you, saves money when more people make an effort to stay well. And we could be talking about a lot of money. According to the National Congress on Pre-Symptom Medicine, regular use of preventive care by Americans could cut projected health-care costs by 50% over the next 10 years.

Think about what that means. If there's any truth in that statistic, a large part of the solution to the health-care crisis is in our control. The financial impact of the preventive care that you and your family members receive in the coming years can reach far beyond your paycheck. It can have a strong and salutary effect on the health-care industry and even the economy. With rising health-care costs undermining the profitability of businesses and the health of millions of people, that possibility is worth exploring and acting on.

A large part of the solution to the health-care crisis is in our control.

So find out what coverage your medical plan has for wellness and preventive care. Make an appointment now for a routine physical or a bone density test. Take your children in for their vaccinations, or get a flu shot at a health fair. Grit your teeth and schedule a mammogram, colonoscopy, or prostate exam. Take care of yourself now and protect the health you hope to enjoy 10 years from now. You'll save money that you can spend on more pleasant pastimes. You'll also be doing your part to resolve the health-care crisis.

It can only do you good!



Does Preventive Care Save Money? Health Economics and the Presidential Candidates

Joshua T. Cohen, Ph.D., Peter J. Neumann, Sc.D., and Milton C. Weinstein, Ph.D.

With health care once again a leading issue in a presidential race, candidates have offered plans for controlling spiraling costs while enhancing the quality of care. A popular component of

such plans involves greater promotion of preventive health measures. The first element in Hillary Clinton's plan is to "focus on prevention: wellness not sickness." John Edwards has stated that "study after study shows that primary and preventive care greatly reduces future health care costs, as well as increasing patients' health." Mike Huckabee has said that a focus on prevention "would save countless lives, pain and suffering by the victims of chronic conditions, and billions of dollars." Barack Obama has argued that "too little is spent on prevention and public health."

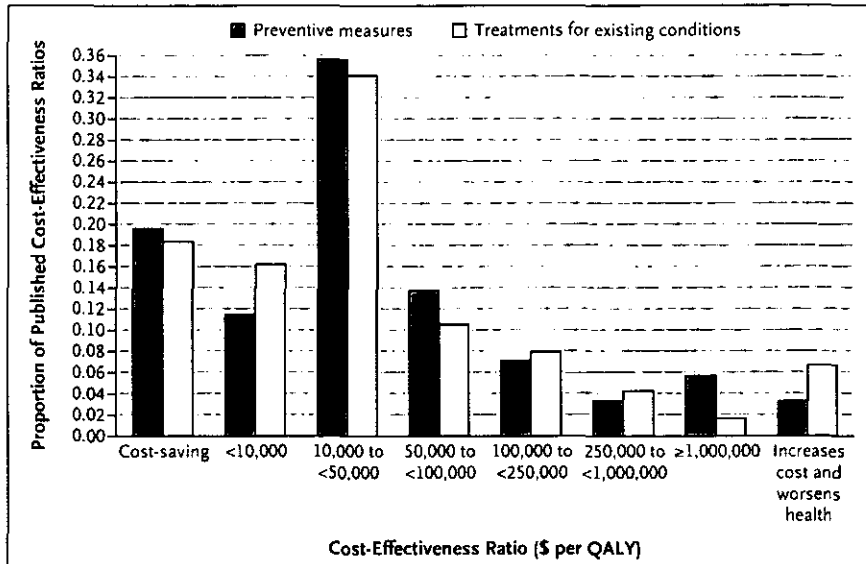
Indeed, some evidence does suggest that there are opportunities to save money and improve health through prevention. Preventable causes of death, such as to-

bacco smoking, poor diet and physical inactivity, and misuse of alcohol have been estimated to be responsible for 900,000 deaths annually — nearly 40% of total yearly mortality in the United States.¹ Moreover, some of the measures identified by the U.S. Preventive Services Task Force, such as counseling adults to quit smoking, screening for colorectal cancer, and providing influenza vaccination, reduce mortality either at low cost or at a cost savings.²

Sweeping statements about the cost-saving potential of prevention, however, are overreaching. Studies have concluded that preventing illness can in some cases save money but in other cases can add to health care costs.³ For example, screening costs will exceed the savings from

avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures. Preventive measures that do not save money may or may not represent cost-effective care (i.e., good value for the resources expended). Whether any preventive measure saves money or is a reasonable investment despite adding to costs depends entirely on the particular intervention and the specific population in question. For example, drugs used to treat high cholesterol yield much greater value for the money if the targeted population is at high risk for coronary heart disease, and the efficiency of cancer screening can depend heavily on both the frequency of the screening and the level of cancer risk in the screened population.⁴

The focus on prevention as a key source of cost savings in health care also sidesteps the question of whether such measures are generally more promising and efficient



Distribution of Cost-Effectiveness Ratios for Preventive Measures and Treatments for Existing Conditions.

Data are from the Tufts–New England Medical Center Cost-Effectiveness Registry. QALY denotes quality-adjusted life-year.

than the treatment of existing conditions. Researchers have found that although high-technology treatments for existing conditions can be expensive, such measures may, in certain circumstances, also represent an efficient use of resources.⁵ It is important to analyze the costs and benefits of specific interventions.

A systematic review of the cost-effectiveness literature sheds light on these issues. We analyzed the contents of the Tufts–New England Medical Center Cost-Effectiveness Analysis Registry (www.tufts-nemc.org/cearegistry), which consists of detailed abstracted information on published cost-effectiveness studies through 2005. Each registry article estimates the cost-effectiveness of one or more interventions as the incremental costs (converted here to 2006 U.S. dollars) divided by the incremental health benefits quantified in terms of quality-adjusted life-years (QALYs). Low cost-effectiveness ratios are “favorable” because they indicate that incremental QALYs can be accrued inexpensively. An intervention is

“cost-saving” if it reduces costs while improving health. Poorly performing interventions can both increase costs and worsen health.

Our analysis was restricted to the 599 articles (and 1500 ratios) published between 2000 and 2005 that properly discounted future costs and benefits. We classified 279 ratios as preventive because they refer to interventions designed to avert disease or injury; all 1221 other ratios pertain to treatments, a category that includes both “tertiary” measures (designed to ameliorate the effects of a disease or condition) and “secondary prevention” measures (designed to reverse or retard progression of an existing condition), such as the use of implantable cardioverter-defibrillators in patients with myocardial disease.

The bar graph shows that the distributions of cost-effectiveness ratios for preventive measures and treatments are very similar — in other words, opportunities for efficient investment in health care programs are roughly equal for prevention and treatment, at least

as reflected in the literature we reviewed. Moreover, both distributions span the full range of cost-effectiveness. The table shows the cost-effectiveness ratios for selected interventions of various types.

These results are consistent with earlier reviews but cover a larger sample of studies and quantify benefits in terms of QALYs. Some preventive measures save money, while others do not, although they may still be worthwhile because they confer substantial health benefits relative to their cost. In contrast, some preventive measures are expensive given the health benefits they confer. In general, whether a particular preventive measure represents good value or poor value depends on factors such as the population targeted, with measures targeting higher-risk populations typically being the most efficient. In the case of screening, efficiency also depends on frequency (more frequent screening confers greater benefits but is less efficient). Third, as is the case for preventive measures, treatments can be relatively efficient or inefficient.

Of course, our review reflects a selected sample of studies in the peer-reviewed literature and does not cover all possible opportunities to spend resources to improve health. In addition, there may be inconsistency among the studies in terms of the methods used. Still, our analysis is based on a large and diverse set of studies that used recommended metrics for cost-effectiveness analysis, and we believe that it offers important lessons.

Our findings suggest that the broad generalizations made by many presidential candidates can be misleading. These statements convey the message that substantial resources can be saved through prevention. Although some preventive measures do save money, the vast majority reviewed in the health

Cost-Effectiveness of Selected Preventive Measures and Treatments for Existing Conditions (2006 Dollars). ^{*c}	
Intervention	Cost-Effectiveness Ratio
Preventive measures	
<i>Haemophilus influenzae</i> type b vaccination of toddlers	Cost-saving
One-time colonoscopy screening for colorectal cancer in men 60–64 years old	Cost-saving
Newborn screening for medium-chain acyl-coenzyme A dehydrogenase deficiency	\$160/QALY
High-intensity smoking-relapse prevention program, as compared with a low-intensity program	\$190/QALY
Intensive tobacco-use prevention program for seventh- and eighth-graders	\$23,000/QALY
Screening all 65-year-olds for diabetes as compared with screening 65-year-olds with hypertension for diabetes	\$590,000/QALY
Antibiotic prophylaxis (amoxicillin) for children with moderate cardiac lesions who are undergoing urinary catheterization	Increases cost and worsens health
Treatments for existing conditions	
Cognitive-behavioral family intervention for patients with Alzheimer's disease	Cost-saving
Cochlear implants in profoundly deaf children	Cost-saving
Combination antiretroviral therapy for HIV-infected patients	\$29,000/QALY
Liver transplantation in patients with primary sclerosing cholangitis	\$41,000/QALY
Implantation of cardioverter-defibrillators in appropriate populations, as compared with medical management alone	\$52,000/QALY
Left ventricular assist device, as compared with optimal medical management, in patients with heart failure who are not candidates for transplantation	\$900,000/QALY
Surgery in 70-year-old men with a new diagnosis of prostate cancer, as compared with watchful waiting	Increases cost and worsens health

* The cost-effectiveness ratio is the incremental costs divided by the incremental benefits, relative to a comparator. The comparator is omitted from the intervention's description if it was no treatment or current treatment or if the intervention was added to, rather than substituted for, another treatment. The cost-effectiveness estimates listed are point-estimate values from the original articles (a more detailed table appears in the Supplementary Appendix, available with the full text of this article at www.nejm.org). Preventive measures are those designed to avert the development of a condition. Treatments for existing conditions include both those designed to prevent the progression of a condition and those designed to ameliorate the effects of a disease or condition. QALY denotes quality-adjusted life-year. For more information see www.tufts-nemc.org/cearegistry.

economics literature do not. Careful analysis of the costs and benefits of specific interventions, rather than broad generalizations, is critical. Such analysis could identify not only cost-saving preventive measures but also preventive measures that deliver substantial health benefits relative to their net costs; this analysis could also identify treatments that are cost-saving or highly efficient (i.e., cost-effective).

In addition to determining which preventive measures and treatments are most efficient, it will be necessary to identify those that are not yet fully deployed and those that could serve a large population and bring about substantial aggregate improvements in health at an acceptable cost. Findings that some cost-saving or highly efficient measures are underused would in-

dicate that current practice is inconsistent with the efficient delivery of health care. Other services might be identified as overused, and such findings would underscore the importance of fashioning policies that provide incentives to shift practice toward more cost-effective delivery of health care. In the face of increasingly constrained resources, there is a realistic way of achieving better health results: conduct careful analysis to identify evidence-based opportunities for more efficient delivery of health care — whether prevention or treatment — and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions.

No potential conflict of interest relevant to this article was reported.

Dr. Cohen is a research associate professor of medicine and Dr. Neumann a professor of medicine and the director at the Center for the Evaluation of Value and Risk in Health, Institute for Clinical Research and Health Policy Studies, Tufts–New England Medical Center, Boston; Dr. Weinstein is a professor of health policy and management at the Harvard School of Public Health, Boston.

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HB

265

ALASKA STATE LEGISLATURE

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Representative Berta Gardner *House District 24*

Sponsor Statement- House Bill 265

HB 265 – An Act relating to a two year funding cycle for medical assistance coverage for dentures.

HB 265 makes a simple change to the Adult Medicaid Dental program that would allow patients who are approved for dentures to receive both the uppers and lowers in a single fiscal year. The bill would let patients access two years of funding in a single year, thereby allowing them and their dentists to schedule treatment around the oral health of the patient, rather than the bureaucratic ease of the state fiscal year.

Current law places a limit on expenditures per eligible client at \$1,150 per year. This number was designed to pay for ½ of a set of dentures, either uppers or lowers, in a single fiscal year. When the program was created, the idea was that a client who needed dentures could receive one set on June 30th, and the second on July 1st. Unfortunately, this has proven to be impractical. Dentists who are forced to pull teeth can't always do so on the state's fiscal calendar, and Alaskans shouldn't suffer needlessly because their medical emergency occurred in the fall rather than the summer.

Adult Medicaid Dental has been recognized across the political spectrum as a successful government health care program. Over the past three years, the state has saved substantial amounts of money – and poorer Alaskans have been saved immense pain and hardship – by allowing Medicaid to pay for exams, cleanings, fillings, root canals, and dentures before painful and expensive surgery became necessary. HB 265 will fix a small flaw in the cost-containment portion of the program and help protect this important state investment.

HOUSE BILL NO. 265

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVES GARDNER, PETERSEN, AND GARA

Introduced: 1/8/10

Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

1 "An Act providing for a two-year funding cycle for medical assistance coverage for
2 dentures."

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 47.07.067(a) is amended to read:

5 (a) Subject to appropriation, the department shall pay for minimum treatment
6 and for preventative and restorative adult dental services provided under
7 AS 47.07.030(b) and under regulations adopted by the commissioner in conformity
8 with applicable federal requirements and this chapter. Regulations adopted under this
9 section must include the following:

10 (1) except as provided in (e) of this section, a maximum amount of
11 benefits for preventative and restorative adult dental services of \$1,150 for each
12 eligible recipient in a fiscal year; and

13 (2) specification of the scope of coverage for preventative and
14 restorative adult dental services.

1 * **Sec. 2.** AS 47.07.067 is amended by adding a new subsection to read:

2 (e) If the department authorizes or approves payment for complete or partial
3 dentures for an eligible recipient, the department may authorize the payment in one
4 fiscal year of the maximum payment amount for not more than two fiscal years. A
5 recipient is not eligible for additional benefits under this section for a two-year period.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB265
 () Publish Date: _____

Identifier (file name): HB265-DHSS-MAA-2-9-10 Dept. Affected: Health & Social Services
 Title: Medicaid Coverage for Dentures RDU: Health Care Services
 Component: Medical Assistance Administration
 Sponsor: Gardner, Peterson, Gara
 Requester: House HSS Component Number: 242

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services	84.5							
Travel								
Contractual	54.8							
Supplies	1.0							
Equipment	7.6							
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	147.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES								
---------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	86.4							
1003 GF Match	61.5							
1004 GF								
1005 GF/Program Receipt								
1037 GF/Mental Health								
Other Interagency Receipt								
TOTAL	147.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) c: _____

POSITIONS

Full-time	1.0							
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if nece:

HB 265 is meant to address limitations of coverage for upper and lower dentures within a given state fiscal year under the \$1,150 annual limit. The annual limit provides for expenditures that would typically cover only an upper or lower denture, thus requiring Medicaid recipients to wait until the subsequent fiscal year to obtain the opposing denture under the Medicaid program.

The bill would authorize the department to allow for provision of both an upper and lower denture within the same state fiscal year, however when these services are provided the adult recipient would not be eligible for additional services under Medicaid preventative and restorative dental for a two-year period.

Prepared by: William J. Streur, Deputy Commissioner
 Division: DHSS Health Care Services

Phone: (907) 334-2520
 Date/Time: 2/9/10 9:20 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date: 2/9/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. HB265

ANALYSIS CONTINUATION

The Division of Health Care Services estimates that it will need a total of 1 FTE to fully track expenditures and to authorize procedures up to the limit of the proposed legislation in the first year of the program, prior to modification of the claims payment system (MMIS) to permit automated tracking of expenditures.

Administrative Costs:

1 Medical Assistance Administrator II (Range 18), \$84,510; All personal services costs include benefits. Assumes \$9.6 per FTE annually for office space, phones, and other contractual costs; \$2.6 one time costs per FTE for computers and software; \$5.0 one time costs per FTE for office equipment; \$2.0 per FTE annually for supplies. GF portion of these expenses is 50%.

Medical Assistance Administrator II Duties

If legislation is passed and implemented to allow recipients the ability to utilize two fiscal year's annual cap for dentures (full sets and partials) during SFY2011, it will create a labor intensive process of tracking the service limits manually. Our current Medicaid Management Information System has the capability of applying service exceptions on an annual basis only. Combining two years' limits will initially require a manual work-around for tracking the 11 denture and partial procedure codes being utilized by approximately 4,400 recipients, and follow-up to ensure limits are not exceeded nor services duplicated at any point in the two year period. To authorize payment of individual dental claims, staff will have to research, review, and evaluate the recipients' claims and treatment history for the two year period in question. The division estimates the need for a Medical Assistance Administrator II to handle the increased workload until modifications can be made to the MMIS.

Modification of MMIS

DHSS estimates that it will cost \$50.0 in contractual to modify the present MMIS or enhance the new MMIS currently in development. Part of the development process involves ceasing all modifications to the current MMIS prior to conversion, to ensure that the new system can replicate the functionality of the present system. DHSS assumes that it will not be able to make the necessary modifications prior to the "freeze" of the current system, likely to occur early in the summer of 2010. If DHSS is able to make the modifications before the freeze, it will not fill the position requested. GF portion of the system modification is 25%.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: **HB265**
 () Publish Date: _____

Identifier (file name): HB265-DHSS-APDMS-2-9-10 Dept. Affected: **Health & Social Services**
 Title **Medicaid Coverage for Dentures** RDU **Health Care Services**
 Component **Adult Preventive Dental**
 Sponsor **Gardner, Peterson, Gara**
 Requester **House HSS** Component Number **2839**

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	935.0		467.5	0.0	0.0	0.0	0.0	0.0
Miscellaneous								
TOTAL OPERATING	935.0	0.0	467.5	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES								
---------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	626.5		266.5					
1003 GF Match	308.6		201.0	0.0	0.0	0.0	0.0	
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	935.0	0.0	467.5	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) c _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if nece:

This bill addresses limitations of coverage for upper and lower dentures within a given state fiscal year with the current \$1,150 annual limit. The annual limit provides for expenditures that would typically cover only an upper or lower denture, thus requiring Medicaid recipients to wait until the subsequent fiscal year to obtain the opposing denture under the Adult Preventive Dental (APD) program. The bill would authorize the department to allow for provision of both an upper and lower denture within the same state fiscal year, however when these services are provided the adult recipient would not be eligible for additional services under the APD program for a 2-year period.

In SFY 2009, the total cost of complete, partial and immediate denture claims was approximately \$1,620.0.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
 Division **Health Care Services**

Phone 269-7827
 Date/Time 1/25/10 9:34 AM

Approved by: Alison Elgee, Assistant Commissioner
 DHSS Finance & Management Services

Date 2/9/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. HB265

ANALYSIS CONTINUATION

We estimate that the cost of denture services in the APD has grown at the same rate as all Health Care Services Medicaid Services costs (forecasted to be 6%) from FY 2009 to 2010. Medicaid growth for APD alone is forecasted to be 8.9% from FY 2010 to 2011 to reach a baseline cost of \$1,868.0 for denture services in FY 2011 with no changes to the program.

With the changes proposed in this bill and an expected effective date of July 1, 2010, we estimate the baseline costs noted above for denture services in FY 2011 will increase by 50%, assuming half of denture services recipients would be completing the denture process from FY2010 and the other half would be getting both their upper and lower dentures in FY 2011 for a total cost of \$2,803.0 (a difference of \$935.0 from baseline). We would still expect some increased costs over baseline in FY2012 as the number of people getting denture services has been growing each year as adults continue to learn about the APD program and this bill allows for them to be paid in one year. For FY2012, we estimate the need for increased funds to be half of the amount needed in FY 2011.

For subsequent years, we would expect the cost of denture services to level out to approximately what we would expect without the changes in this bill, the shift being not in cost but in how many recipients are receiving services.

For FY2011, we estimate 67% of APD services to be federally reimbursable, assuming ARRA FMAP increases are valid through all 4 quarters of FY 2011. For FY2012 we expect a FMAP of 50%. As some ADP services are IHS and reimbursed at 100%, we expect 57% of ADP costs to be federally reimbursable.



Alaska Dental Society, Inc.

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info@akdental.org

The Honorable Johnny Ellis
State Capitol, Rm 103
Juneau, AK 99801 + 1182

5 November 2009

Dear Senator Ellis:

Thank you for sponsoring the legislation to allow Medicaid recipients to utilize two years of benefits to receive a full set of dentures. This will provide a valuable service for Medicaid recipients and will improve the delivery of care for providers. In a true win-win solution this should lessen the overall costs for the Medicaid division when the additional travel costs for delivering the same service twice and the associated medical and dental costs for trying to retain non salvageable teeth during that interim year are factored in.

Respectfully yours

Gary A. Moeller, DDS
President

L O G A N
D E N T A L

November 10, 2009

Senator Ellis
716 W. 4th Ave. Suite 500
Anchorage AK, 99501-2133

Dear Senator Ellis:

Thank you for sponsoring a bill to allow Medicaid recipients to use two consecutive years of supplemental benefits in the same year to receive upper and lower dentures at the same time. This will greatly help recipients as a single denture when you have no teeth to oppose it is of limited value. I believe it will ultimately lower costs for the Medicaid division, also, when travel benefits are factored in for this multi step procedure that must be repeated twice under the current system.

A case I did earlier this year may illustrate the problem providers' face. Due to HIPAA concerns I am not using names for this story.

I have a dental office in Juneau. Unfortunately, for a variety of reasons, dental offices in other Southeast communities do not usually accept new Medicaid patients. This patient had to travel over from Sitka and needed dentures, both upper and lower. He currently did not have either upper and lowers having lost both sets. The supplemental system for adult Medicaid benefits would cover a single denture, either the upper or lower. The patient, 78 years old and on fixed income, was unable to afford the second set even at reduced Medicaid fees. I wrote a letter Medicaid division, enclosed, outlining the problem and pointing out that travel costs associated with constructing the second set at a later date (when the new year's benefits kicked in) would ultimately cost more than the Medicaid fee for a denture. I received a reply from the division basically saying their hands were tied given the current statutes in place.

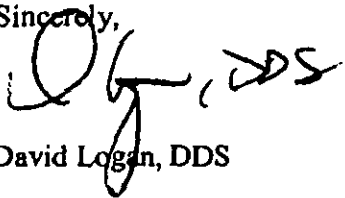
In the case of this patient I did a full set of dentures for the patient and absorbed the cost of construction of the second set. As I write this letter I saw two patients today in the same situation, one who lives here in Juneau that we are constructing an upper denture alone although he has no lower teeth. Currently are plan is construct the lowers after July

2237 N. Jordan Avenue, Juneau, AK 99801
Phone: (907) 780-6066 Fax: (907) 780-4274 info@juneausmiles.com

www.juneausmiles.com

1, 2010. The second patient traveled here from Angoon and lost both his upper and lower dentures 2 weeks ago. His treatment will be further complicated as his old set was apparently ill fitting and led to a large tissue mass on the lower that will have to be removed prior to denture construction.

Sincerely,

A handwritten signature in black ink, appearing to read "D Logan, DDS". The signature is stylized and includes the letters "DDS" at the end.

David Logan, DDS

2237 N. Jordan Avenue, Juneau, AK 99801

Phone: (907) 780-6066 Fax: (907) 780-4274 info@juneausmiles.com

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L O G A N
D E N T A L

December 17, 2008

ACS
Preauthorizations
POB 240808
Anchorage, AK 99524-0808

Re: [REDACTED]
Medicaid #: [REDACTED]


Dear Sirs:

Mr. [REDACTED] is currently edentulous (without teeth) upper and lower. We have previously preauthorized Mr. [REDACTED] for a lower denture (preauth [REDACTED]) - working with a Sitka Clinic we had not previously seen Mr. [REDACTED].

Mr. [REDACTED] has been without teeth for 6 years. One denture, the maximum allowed under the MEDS system, will provide little improvement for him. Mr. [REDACTED] will be traveling to our office from Sitka for completion of the denture. The travel costs will ultimately cost more than the fee for the denture given the number of appointments required to properly construct a denture.

I am requesting preauthorization for upper and lower dentures (included) for Mr. [REDACTED]. This is a case where everyone will benefit: the state will have less overall costs than a second round of travel costs to construct the other denture after July 1, Mr. [REDACTED] will have opposing dentures to eat with, and my overall costs will be less than repeating the same appointments come July 1.

Sincerely,


David Logan DDS

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Phone: (907) 780-8066 Fax: (907) 780-4274 info@juneausmiles.com

www.juneausmiles.com

The TRUST

The Alaska Mental Health
Trust Authority

Alaskan Seniors
Living Longer Growing Stronger
from the Alaska Commission on Aging



**Governor's Council on Disabilities
and Special Education**

**Advisory Board on Alcoholism
and Drug Abuse**



Alaska Mental Health Board

Adjust Cap on Adult Dental Services Reimbursed by Medicaid

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority and the Alaska Brain Injury Network, jointly support the developing a solution that will allow for the adjustment of the current cap on adult dental services reimbursed by Medicaid.

- Currently, the annual cap for dental services – such as cleanings, exams, crowns, root canals and dentures – is \$1,150 per individual. With the rising cost of dental care, this cap is proving not adequate yet the cap is set in statute and has not been increased in over three years.
- The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs, and as former U.S. Surgeon General C. Everett Koop stated, "You're not healthy without good oral health."
- Trust beneficiaries continue to list dental services as a priority unmet health needs.
- The challenge this session is to find a current bill or to introduce a new bill that will create a method for adjusting the adult dental Medicaid cap on a regular basis or will at least increase the cap to cover the increase the cost of living increases over a 4 or five year period.

Therefore, we support a legislative solution that will allow for the adjustment of the current cap on adult dental services reimbursed by Medicaid.

SENIOR VOICE

Serving Older Alaskans and Their Families Since 1978

A publication of *Older Persons Action Group, Inc.* 325 E. Third Ave., Suite 300, Anchorage, Alaska 99501

Vol. 32 No. 11 November, 2009

Desperate senior prompts denture legislation

By SEN. JOHNNY ELLIS

Late last summer, an elderly man walked into my office and threatened to commit suicide. Needless to say, it was a very tense and upsetting situation for me and my staff. This gentleman had come from the Medicaid Adult Dental office, where he had been told that he had a choice – he could receive either the upper half or the lower half of the dentures that he needed, but not both, at least not in the same year. Of course, this set of options was really no choice at all, seeing as how he had no teeth at all. The state's wholly inadequate response to this constituent's unfortunate situation set my office in motion, and I am prepared to introduce legislation this session with bipartisan support that will provide a common-sense fix to an otherwise successful and needed program.

Medicaid Adult Dental was created three years ago. Until that time, Medicaid only covered emergency dental services for low income Alaskans. By expanding the program to cover preventative care – exams, cleanings, root canals, fillings and dentures – the state has saved millions of dollars and patients have avoided painful surgeries as the need for emergency care declines. In addition, good dental health

I have worked with the Dept. of Health and Social Services to allow patients who qualify for dentures under the Medicaid Adult Dental program to receive their full set of dentures in one sitting.

is closely linked with decreased risk for diabetes, heart disease, cancer and other serious diseases. Last year, the legislature unanimously made this successful program permanent.

The program limits the care that can be paid for in a single year, which is intended as a cost-control measure, an important feature in these uncertain budgetary times. Unfortunately, these measures go beyond cost control and have impacted the function of the program by limiting patients to half of a set of dentures per year. In public testimony on these limits, it was suggested that a patient could receive the upper dentures on June 30, the final day of the state fiscal year, and the lower dentures on July 1. I don't believe that we should be punishing citizens who happen to require dental care in the fall or winter, and I don't believe that dentists should be forced to schedule the care their patients need to make things more convenient for bureaucrats. This is the kind of frustrating flaw in our

system that drives people crazy and gives government a bad name.

That's why I have worked with the Department of Health and Social Services to develop a way to allow patients who qualify for dentures under the Medicaid Adult Dental program to receive their full set of dentures in one sitting, without destroying the cost-control mechanisms currently in place. The bill will be introduced when the legislature goes back into session in January, and I am pleased to have received bi-partisan support from my colleagues in the Senate.

In fact, as I have continued to work on this issue, I have heard more and more about how much sense this small change makes. A dentist in Juneau told me about the patients he sees from all around Southeast Alaska. The state pays for them to fly to Juneau, pays for their lodging, and pays for one half of their dentures. Then, a little while later, public money is spent to do it all over again for the other half. Allowing him and other

dentists to consolidate the care they are giving into one session will make the program a more efficient use of public money and improve the quality of care received by patients.

State government can be a large and unwieldy bureaucracy, and change is hard to do and often happens slowly. Most of the attention goes to the big issues that attract press coverage or help generate campaign slogans. But sometimes, there are issues that require us to place people over politics and give a direct benefit to the neighbors and constituents we are privileged to serve. It's too late for the gentleman who threatened to kill himself in my office – we worked with him to get his dentures through the existing two-year process – but it's not too late for others in his situation. This may be a small bill, and it won't change the world, but it will improve the lives of a few senior citizens in need – and that's a job I'm glad to do.

Senator Johnny Ellis represents downtown and midtown Anchorage in the Alaska State Senate and serves as the Majority Leader of the Senate Bi-Partisan Working Group.

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 29, 2010

Representative Berta Gardner
Representative Pete Petersen
Representative Les Gara
House Health and Social Services Committee
Alaska State Capitol - Rooms 424,422, 434
Juneau, AK 99801-1182

Subject: Support Letter for HB 265

Dear Representatives Gardner, Petersen and Gara:

The Alaska Commission on Aging (ACoA) is pleased to offer support for HB 265, a bill to provide access to Medicaid patients who are approved for dentures using a two-year funding cycle for medical assistance benefits to cover the costs for complete and partial dentures in a single fiscal year. Thank you for sponsoring this important legislation.

The Commission believes HB 265 provides a common sense solution that allows patients and their dentists the flexibility to schedule treatment around the oral health needs of the patient, which will improve the quality of care for older Alaskans and other qualifying recipients. Moreover, this legislation enhances the cost-effectiveness of the current Medicaid Adult Dental program by reducing the number of oral surgery visits, medical procedures, and related travel costs required for individuals who need a complete set of dentures but are limited to half of a set of dentures per fiscal year under the existing program. Anecdotally, we have learned that some individuals may even refuse partial extractions in one arch knowing that they could be without teeth for a prolonged period waiting for Medicaid to cover the cost of the other complete denture in the next fiscal year.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain and missing or decaying teeth can affect dietary choices for seniors that may impact overall health and wellness. Vulnerable older Alaskans are at risk of developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease. Restorative dental care can help to prevent the progression of serious dental disease and discomfort which can result in more costly emergency care.

Older Alaskans utilize the Medicaid Adult Dental program. According to data based on Medicaid claims information for persons age 60 years and older for the period April 1, 2007 thru December 31, 2009, there were a total of 3,104 (unduplicated) seniors served by the Medicaid Adult Dental Program. The average cost for partial dentures for seniors ranges between \$1,085 (for a complete maxillary denture) to \$1,125 (for a complete mandibular denture). The approximate cost for a complete set of dentures is \$2,225. The current program cap is \$1,150 per year.

As we move forward, the Commission respectfully asks for your consideration of our recommendations below to enhance HB 265 and the Adult Dental Medicaid program for qualifying older Alaskans and other Medicaid recipients:

- Allow eligible patients access to two years of total funding as determined by the cost cap of the Medicaid Adult Dental program to permit individuals receiving partial dentures through the program the ability to access remaining benefits under the cost cap should they need additional denture services during the two-year period.
- Pending approval of HB 265, begin work with the Department of Health and Social Services to expand the two-year access of services to phase in other preventative and restorative services allowed under the Medicaid Adult Dental program in FY 2012.
- Adjust the annual cost cap for dental services (currently in statute for the last three years) to address the rising costs of dental care and encourage more participation of Medicaid dental providers.

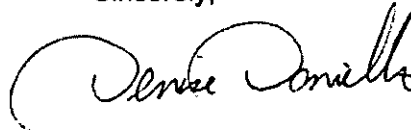
Please accept our sincere appreciation for your efforts to improve the Medicaid Adult Dental program by allowing patients who qualify for dentures under the program to receive their full set of dentures according to a treatment schedule determined by the patient with their dentist. We believe that HB 265 will help to improve health and wellness for many older Alaskans who need dentures and we support passage of this legislation. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information. Thank you.

Sincerely,



Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

November 19, 2009

Honorable Johnny Ellis
Majority Leader
Alaska Senate
716 W. 4th Avenue
Anchorage, AK 99501

Dear Majority Leader Ellis:

On behalf of the 97,000 members of AARP in Alaska, we would like to pledge our support for your bill to establish a two year funding cycle for the adult dental benefit in Medicaid.

We understand you are particularly interested in changing the benefit for dentures so that an adult Medicaid beneficiary would be able to use the funds available for two years to pay for dentures. This makes sense for both the client and the provider.

Older persons in need of dentures often have accompanying nutrition problems. These nutrition problems can cause other health issues and create an overall deterioration in health status. For those who need them, dentures are essential to quality health care. Two-year funding for dentures should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent on more serious health care problems resulting from poor oral health status.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)



November 6, 2009

Senator Johnny Ellis
Senate Majority Leader
Alaska State Legislature
716 W. 4th Ave
Anchorage, AK 99501
Fax: (907) 269-017

Dear Senator Ellis;

I am writing on behalf of the Alaska Public Health Association (ALPHA) to extend our support for and thank you for introducing a Bill that will allow Alaska's adult Medicaid recipients to receive a set of dentures within one fiscal year. This Act will meet the needs of patients and dental providers by providing two-years worth of dental benefits for dentures in a single year.

The ALPHA represents over 150 health professionals in Alaska; the primary mission of ALPHA is the enhancement of the public's health. In fulfilling our mission, we support systems that support patient-oriented health service delivery. ALPHA believes that the "Act providing for a two-year funding cycle for medical assistance coverage for dentures" establishes a system enabling patients to receive patient-oriented care.

Thank you for consulting ALPHA in developing this Bill. Please feel free to contact me if you have further questions.

Sincerely,

Karol Fink, MS, RD
ALPHA Health Policy Chair
Karolfink@yahoo.com
907.227.8178



AARP Alaska
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Anchorage, AK 99503

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February 10, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 411
Juneau, AK 99801-1182

RE: HB 265 (Gardner, Peterson, Gara)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support HB 265, to establish a two-year funding cycle in Medicaid for a very specific limited purpose. The bill is authored by Representatives Berta Gardner, Pete Peterson, and Les Gara.

HB 265 basically changes the benefit for dentures so that an adult Medicaid beneficiary would be able to use the funds available for two years to pay for dentures. This makes sense for both the client and the provider.

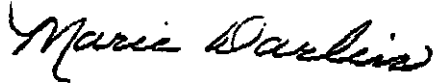
Older persons in need of dentures often have accompanying nutrition problems. These nutrition problems can cause other health issues and create an overall deterioration in health status. For those who need them, dentures are essential to quality health care. Two-year funding for dentures should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent on more serious health care problems resulting from poor oral health status.

AARP recommends an "AYE" vote on HB 265.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Representative Tammie Wilson
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes
Representative Berta Gardner
Representative Pete Peterson
Representative Les Gara



ALASKA NATIVE MEDICAL CENTER



Dr. Thomas J. Kovaleski DDS
Dental Director
Southcentral Foundation
Anchorage, Alaska

To whom it may concern:

As Director of the Southcentral Foundation (SCF) Dental Program I am writing in support of HB265 (Medicaid Coverage for Dentures). This bill would address a flaw in the current system and allow Alaska's adult Medicaid recipients to receive a set of dentures within one fiscal year. This is a practical solution to a situation that has been difficult for patients and providers. SCF provides denture services for Medicaid recipients in our clinics at the Alaska Native Medical Center and the Fireweed Clinic in Anchorage. I thank you for your efforts on behalf of the adult Medicaid recipients.

Sincerely,

Dr. Thomas J Kovaleski DDS.

Senate & House HSS Committees

Senators and Representatives,

RE: SB199 & HB265 "An Act providing for a two-year funding cycle for medical assistance coverage for dentures."
I have an opportunity to travel way south to visit family that I haven't seen for a long time and will not be in contact to send a message when these bill(s) are heard. Please accept my advance testimony for this important legislation.

I had occasion to visit my dentist here in Fairbanks today and asked him what he thought of this legislation. This is a very experienced former military dentist who has seen everything. He, like so many of our local medical providers, is retirement age but sticking around to help his patients.

Dr. James A. Cerney DDS
4001 Geist Rd. Suite 5B
Fairbanks AK 99709
Ph: (907) 479-3326

Dr. Cerney's response to my question about this legislation was that it has been his experience that dentures fit better when both upper and lower plates are made at the same time, approximately anyway. He told me that he is willing to speak with any legislators that may want to contact him.

He has some days or part days that he may be out of the office, but has an answering service. Since he is willing to have me call after hours if I have a problem I know he would take your call anytime if at all possible. I believe he has been involved in issues through the state dental society, but I don't know who head's that organization to tell you.

I know how touchy dental issues are with me, only it is crowns instead of plates. I suspect there are those who have no other way to get dentures that have an experience of having to have repeat visits to the dentist because of fit problems with the current 1 plate/yr. set-up. I say "no other way" because I don't know anyone who would want the feeling of having to grovel to get one plate at a time and keeping the plate in a box someplace for a year as they wait for the time to pass before work can begin on the second plate.

I wonder if people choose the bottoms or the tops the first year now? I wonder how they make that decision? It is a curious situation that better efforts were not made to avoid this in the beginning.

Please do your best, and remember that the income has to be quite low, and the need quite great for anyone to jump through the hoops to get dentures through Medicaid.

Sincerely,

Doris Robbins
1281 Overhill Dr.
Fairbanks AK 99709
(907) 374-0597

Dear Representative Gardner,

I am writing this brief note to to urge you to support HB265 Medicaid Coverage for Dentures. As a practicing dentist with SEARHC in Juneau, AK, I see on a day to day basis the struggle many of our Alaskan Natives have with their dental care. For many of these patients, Medicaid funds are their only hope for dental care. In many cases, a patient that requires two dental appliances (upper and lower complete dentures), does not have enough funding to allow the patient to receive both denture plates in the same fiscal year under the current guidelines. This leaves many edentulous patients without one of their denture plates, making eating difficult for patients who in many cases are elderly.

Currently, SEARHC is looking into the possibility of fabricating dentures on site at smaller villages such as Hoonah and Angoon in Southeast Alaska. Many elderly patients find it difficult or impossible to come to Juneau for denture treatment, this bill would make this program economically feasible.

This is an important bill that would help many people in Alaska. I therefore hope that you will give your approval to this worthy legislation.

Mitch Wilkinson DDS, MS



Alaska Dental Society

9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
info@akdental.org

SB199/HB265 Medicaid Adult Dental Coverage

The Alaska Dental Society urges passage of SB199/HB265.

SB199 and its companion bill HB265 remedy an unintended consequence of the adult dental supplemental Medicaid coverage. Currently, under the maximum allowable benefit, a Medicaid recipient may receive either an upper or lower denture. Unfortunately many Medicaid recipients need dentures for both the upper and lower jaws or dental arches. SB199/HB265 would allow a Medicaid recipient to combine two years worth of coverage so they could receive a full denture of both upper and lower dentures at the same time.

SB199/HB265 provides a benefit for everyone involved – the patient, the doctor and the Medicaid program:

- Medicaid recipients benefit from receiving both dentures at once, restoring their appearance, their ability to talk and chew, and most importantly their dignity.
- Providers benefit as they are no longer placed in the uncomfortable position of deciding which arch is in the worst condition. They can also work in a more efficient fashion constructing both sets of dentures simultaneously.
- The state benefits economically. The cost for both dentures, which would normally be borne over 2 years are now in one year but Medicaid recipients would still be limited to the same benefit total for 2 years. Denture patients frequently have to use travel benefits to reach a provider and for dentures this can be especially costly as dentures require multiple appointments. Providing both dentures at the same time would reduce the states travel expenses in half. Removing diseased and abscessed teeth would also save on costly ER and oral surgery visits.



February 8, 2010

Representative Gardner
Alaska State Legislature

Dear Representative Gardner;

I am writing on behalf of the Alaska Public Health Association (ALPHA) to extend our support for and thank you for introducing a Bill that will allow Alaska's adult Medicaid recipients to receive dentures. This Act will meet the needs of patients and dental providers by providing two-years worth of dental benefits for dentures in a single year.

The ALPHA represents over 200 health professionals in Alaska; the primary mission of ALPHA is the enhancement of the public's health. In fulfilling our mission, we support systems that support patient-oriented health service delivery. ALPHA believes that the "Act providing for a two-year funding cycle for medical assistance coverage for dentures" helps establish a patient-oriented care system.

Please feel free to contact me if you have further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Karol Fink". The signature is fluid and cursive, written in a dark ink on a white background.

Karol Fink, MS, RD
ALPHA Health Policy Chair
Karolfink@yahoo.com
907.227.8178

HB

270

Alaska State House of Representatives

Session:

State Capitol, Room 409
Juneau, AK 99801-1182
Phone: (907) 465-3744
Fax: (907) 465-2273



Session:

State Capitol, Room 102
Juneau, AK 99801-1182
Phone: (907) 465-2689
Fax: (907) 465-3472

Sponsor Statement:

Representative Cathy Munoz (R-4)
Representative Paul Seaton (R-35)
Representative Bob Herron (D-38)
Representative Max Gruenberg (D-20)

HB270 - Medicaid For Medical & Intermediate Care

"An Act amending the eligibility threshold for medical assistance for persons in a medical or intermediate care facility."

Status: PREFILE RELEASED >> (H) HSS : 2010-01-19

In 2003, the Legislature modified Alaska Statute to freeze the Medicaid long-term services income eligibility limit at that year's level (\$1,656). This change created a ceiling for waiver eligibility, rather than allowing the eligibility limit to adjust annually in tandem with the Supplemental Security Income maximum benefit amount. This meant that from 2003 on, a small Social Security cost of living adjustment could put a person over the \$1,656 limit, and in effect disqualify many people from the program.

The Supplemental Security Income (SSI) is a federal needs-based disability program for adults and children. For an adult, the SSI disability requirement is based on the ability to work. An adult is considered disabled if the person cannot do the work that they performed before the disability occurred or cannot do alternate work because of a severe physical or mental condition. For a child to be eligible, they must suffer from serious physical and/or mental problems. For both adults and children, the disability must last, or be expected to last for at least one year.

House Bill 270 will change the current income eligibility rate which is frozen at \$1,656 a month, or 300% of the 2003 SSI benefit rate, to 300% of the current SSI rate.

Near the end of 2008 many individuals received notices that they would no longer be eligible for the waiver after the 2009 Social Security COLA went into effect. Because the waiver eligibility limits no longer adjust with changes in the cost of living, it placed some people slightly over the \$1,656 monthly limit. While there are options available for preserving eligibility, such as with the creation of a Medicaid qualifying income trust, also known as a Miller trust, these options have drawbacks. To qualify for a Miller trust the individual must seek the assistance of an attorney and find a trusted individual to manage

their trust assets. In addition, the Miller trust has a number of responsibilities and restrictions that must be followed.

Medicaid services are critical to the well-being of Alaska's most vulnerable citizens. Lending support to this legislation will ensure that eligible Alaskans can continue to receive nursing home care and in-home services.

###

House Majority Press: <http://housemajority.org/spon.php?id=26HB270>

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 30, 2010

Representative Cathy Muñoz
Alaska State Capitol, Room 409
Juneau, AK 99801-1182

Subject: Support Letter for HB 270

Dear Representative Muñoz:

The Alaska Commission on Aging (ACoA) is pleased to offer our support of HB 270, a bill to amend the income eligibility threshold for persons requiring nursing home level of care stated in AS 47.07.020(b)(6). This bill is authored by you and co-sponsored by Representatives Paul Seaton, Bob Herron, Max Gruenberg, and Les Gara.

ACoA supports returning the statutory income limit for this benefit from the current fixed dollar amount of \$1,656 per month to 300% of Supplemental Security Income (SSI), the previous statutory limit, in order to allow the eligibility limit to adjust annually with the Supplemental Security Income maximum benefit amount. This change will ensure that eligible Alaskans can continue to receive nursing home care and in-home services provided by the State's Medicaid program when they receive cost-of-living adjustments to their Social Security and other benefit amounts.

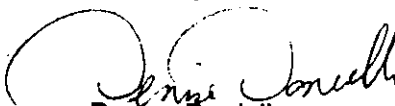
In 2003, the Alaska Legislature changed AS 47.07.020 (b) (6) to freeze the Medicaid long-term services income eligibility limit at that year's level (\$1,656). This change created a fixed ceiling for waiver eligibility, rather than allowing the eligibility limit to adjust annually in tandem with the SSI maximum benefit amount, which is tied to changes in the Consumer Price Index (CPI). The downstream impact of this freeze has been that from 2003 and into the future, a small Social Security cost-of-living adjustment could put a person over the \$1,656 limit, and in effect disqualify many people from the program. Most public assistance programs in Alaska are indexed to the Alaska poverty level or other guidelines which provide flexibility as incomes rise along with living costs.

We thank you for sponsoring HB 270 to ensure that eligible Alaska seniors and other vulnerable Alaskans can maintain their income eligibility and continue to receive home- and community-based services, despite small COLA increases to their Social Security and other benefit payments. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information. Thank you.

Sincerely,


Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,


Denise Daniello
ACoA Executive Director

Cc: Representative Paul Seaton
Representative Bob Herron

Representative Max Gruenberg
Representative Les Gara

AGENET

Alaska Geriatric Exchange Network

Alaska's Association of Senior Service Providers

c/o 419 Sixth Street, Juneau, Alaska 99801

February 18, 2010

Representative Cathy Munoz
State Capitol, Room 409
Juneau, Alaska 99801-1182

Dear Representative Munoz:

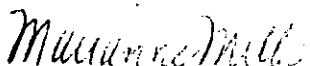
On behalf of the members of AGENET (the Alaska Geriatric Exchange Network), I am pleased to offer this letter of support for House Bill 270, "an act amending the eligibility threshold for medical assistance for persons in a medical or intermediate care facility". This bill will help older Alaskans continue their access to cost-effective home and community-based services which help them maintain their health and independent living in their own home and community.

Most seniors who receive Social Security benefits or retirement pensions receive a small annual cost of living adjustment (COLA) to their benefit amounts. Because the program income eligibility limits do not adjust with changes in the cost of living, each year some people receiving home and community-based (HCB) waiver services find that their adjusted incomes place them slightly over the \$1,656 monthly limit. They receive notice that they are no longer eligible for HCB waiver services, their services are suddenly cut off, and their health and independent living is threatened as a result.

House Bill (HB) 270 would correct the situation by changing income eligibility as the cost of living changes, instead of the current fixed amount of \$1,656 per month. The proposed change makes sense, especially since older Alaskans prefer remaining in their own homes for as long as possible rather than having to go to costly nursing homes when their health declines prematurely.

Thank you for introducing this bill and for your consistent support of services for older Alaskans. Feel free to contact me at 463-6154 if I may provide further assistance to promote passage of HB 270.

Sincerely,



Marianne Mills
AGENET President

QUESTIONS AND ANSWERS ON AS 47.07.020 (b)(6) PROPOSED CHANGE

❖ What is SSI?

SSI, or Supplemental Security Income, is a federal needs-based disability program for adults and children which provides cash benefits and automatic Medicaid eligibility.

❖ What are the eligibility requirements for SSI?

The person must:

- (1) Have limited income and resources;
- (2) Be an adult or a child who is blind or disabled, or an adult who is age 65 or older;
- (3) Live in the United States;
- (4) Be a U.S. citizen or an eligible non-citizen (including lawful permanent residents and some other categories...)

❖ What are the income and resource requirements for SSI eligibility?

Monthly benefits are calculated by subtracting certain excluded amounts from the individual's monthly income, and then subtracting the remainder from the maximum SSI benefit amount (currently \$674). The resulting amount will be the individual's monthly SSI benefit. In other words, an individual's income must be substantially below the poverty level (which is currently \$1,127.50 per month in Alaska).

Individuals may have up to \$2,000 in resources, or up to \$3,000 in resources for a couple.

❖ What is the SSI definition of disability?

For an adult, the SSI disability requirement is based on the ability to work. An adult is considered disabled if the person cannot do the work they did before and cannot do a different kind of work because of a severe physical or mental condition.

To be eligible for SSI, a child must suffer from serious physical and/or mental problems that prevent the child from living a normal life.

For both adults and children, the disability must last, or be expected to last, for at least a year, or to result in death.

❖ Is SSI different from Social Security Disability Insurance?

Yes. Both programs provide assistance for people with disabilities who meet certain medical criteria, and both are administered by the Social Security Administration. However, Social Security Disability Insurance is a program for individuals (and certain family members) who are "insured," that is, they have worked long enough in jobs where they paid Social Security taxes. SSI, on the other hand, is based solely on the financial need of the disabled individual, even if that person has little or no work history.

❖ **What is the current maximum monthly benefit amount for SSI?**

In both 2009 and 2010, the maximum monthly cash benefit amount for an individual on SSI is \$674 (or \$1,011 for a couple). This amount normally increases from year to year based on an automatic annual cost of living adjustment (COLA) which is calculated from changes in the Consumer Price Index (CPI). However, there were no increases in any of the Social Security programs' benefits this past year due to the very low rate of inflation.

❖ **Why did AS 47.07.020 originally key Medicaid waiver eligibility to an income level three times the maximum monthly SSI benefit rate? When did this statutory limit change?**

In most states, Medicaid financial eligibility rules are more liberal for people who require long-term services. Under federal law, a state may grant Medicaid eligibility to persons who have incomes as high as three times the basic benefit standard for the SSI program. In operating a HCBS waiver program, a state may employ the same financial eligibility rules to determine eligibility as it does for institutional services. Accordingly, before 2003, AS 47.07.020 set Alaska's Medicaid long-term care (including waiver services) financial eligibility at three times the maximum SSI amount. In 2003, that amount was \$552, so the income limit that year was \$1,656 (three times \$552).

In 2003, the Alaska Legislature changed AS 47.07.020 (b) (6) to freeze the Medicaid long-term services income eligibility limit at that year's level (\$1,656). This change created a ceiling for waiver eligibility, rather than allowing the eligibility limit to adjust annually in tandem with the SSI maximum benefit amount, which is tied to changes in the Consumer Price Index (CPI). This meant that from 2003 on, a small Social Security COLA could put a person over the \$1,656 limit, which no longer adjusted with the SSI rate.

Most public assistance benefits in Alaska are keyed to federal poverty guidelines or other income standards that are automatically adjusted annually.

❖ **If Alaska returns to the prior version of AS 47.07.020, what will the Medicaid waiver income eligibility limit be?**

The Medicaid waiver income eligibility limit for 2010 would be \$2,022 monthly, or three times the current maximum SSI monthly benefit (\$674). This would be an increase of slightly over 22 percent in the income limit, and would return waiver coverage to those earning slightly more than 175% of the federal poverty limit (FPL) for Alaska, versus the current 147% FPL.

Year	Waiver Limit	% of AK FPL	(AK FPL)
2003	\$1,656	177%	\$11,210
2009	\$1,656	147%	\$13,530
2010	\$2,022*	179%	\$13,530

*Result of proposed legislation

❖ **What problems have been created by the 2003 change to AS 47.07.020?**

Most individuals receiving Social Security retirement or disability benefits, or retiree pensions, receive a small annual cost of living adjustment (COLA) to their benefit amounts. Because the waiver eligibility limits no longer adjust with changes in the cost of living, each year some people receiving waiver services find that their adjusted incomes place them slightly over the \$1,656 monthly limit, thus ending their eligibility for the Medicaid waiver. People in this position have had to pay privately for nursing home care (thousands of dollars per month) or try to set up a Medicaid qualifying income trust, also known as a Miller trust.

Near the end of 2008, a panic ensued when dozens of individuals received notices that they would no longer be eligible for the waiver after the 2009 Social Security COLA went into effect. While they were told that they may be able to preserve their eligibility by implementing a Miller trust, this was not a workable solution for some recipients. [A Miller trust (or Medicaid qualifying income trust) makes Social Security and other income exempt from calculations of income and resources if the state is reimbursed from the trust for Medicaid expenses upon the recipient's death.]

New waiver applicants who are medically qualified for Medicaid long term services are disqualified for income reasons when they apply, even though their monthly incomes may be very modest, say, 150% of the federal poverty level.

❖ **What are the problems with obtaining a Miller trust to shelter excess income in order to continue Medicaid waiver eligibility?**

First, the disabled individual must locate an attorney who can assist them in creating a Miller trust (or qualified income trust). While free legal services are available, they are not readily accessible in every community in Alaska. The individual or their family must spend their time (generally around the end-of-year holidays) frantically trying to find affordable legal help. If the person is too disabled to be able to take the steps to create such a trust, and has not granted anyone else the financial power to do so, it will be necessary to go to court to obtain a conservatorship in order to create the Miller trust.

In order to create a Miller trust, the individual must have a trustworthy friend or family member whom they feel will manage the trust responsibly. Sadly, in today's world, attorneys tell us that this can be an issue – many Medicaid recipients do not know anyone they wish to put in charge of their finances. These people must either trust a stranger to manage their money or forego benefits. Other recipients risk their money by having less-than-trustworthy relatives serve as trustee. We are aware of a current case of an elder whose granddaughter has left the state with the individual's trust account funds.

Managing one's own finances is a matter of personal dignity for many older Alaskans. Being forced to give up this right can be stressful and humiliating, as well as financially risky.

Initial responsibilities of a trustee include obtaining a lawyer to draft the trust – sometimes within a 30-day window, registering the trust with the court system, obtaining an identification number from the IRS, setting up a special trust account with a bank (which not all banks will do), arranging direct deposits to that account through Social Security and other income sources, and securing approval for the trust from the Division of Public Assistance (DPA).

There are many additional details specific to management of the Miller trust, such as the requirement for the money to be placed in a non-interest-bearing account.

Once the account is set up, it is the trustee's responsibility to ensure that the trust distributes a monthly allowance to the Medicaid recipient equal to the monthly Medicaid income limit. The trustee must keep the remainder of the monthly income in the account, or purchase items on the recipient's behalf in accordance with certain restrictions. These restrictions are not always clearly spelled out under federal or state law, and are a large source of confusion for trustees. Diligent trustees often fear personal liability for spending trust money on items that turn out to be disapproved. Less-than-diligent trustees can jeopardize a recipient's Medicaid benefits by spending money without regard for the rules. Trustees also have to pass annual audits with DPA to ensure that the trusts are being managed correctly.

Money in the Miller trust can be used only for "allowable expenses," which do not include food or housing expenses. Generally, the individual has received a COLA on their Social Security or pension for the express purpose of keeping up with increased costs of food and housing. Being forbidden to use this extra money for its intended benefit places them at a disadvantage in meeting their basic needs.

Finally, a Miller trust is irrevocable. In the rare event that an individual's health improves to the degree that they are no longer medically eligible for long term services, they will not have access to the funds in the trust for their daily expenses.

Creation of a Miller trust should normally be considered a last resort when there are no other options available.

ALASKA STATUTES 1962

Volume 10

TITLE 45 TO TITLE 47

NOVEMBER 2002

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Under the Supervision of
JANICE COFFIELD, THOMAS D. CRANFIELD, JR.,
AND BRIAN YOST

Effective Date of Statutes
See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5589. For complete
scope of annotations, see preface. For detailed in-
formation on the use of the Alaska Statutes,
see User's Guide in Volume 1.



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... (b) ... (c) ... (d) ... (e) ... (f) ... (g) ... (h) ... (i) ... (j) ... (k) ... (l) ... (m) ... (n) ... (o) ... (p) ... (q) ... (r) ... (s) ... (t) ... (u) ... (v) ... (w) ... (x) ... (y) ... (z) ...

Sec. 25.23.020. Eligible persons. (a) Persons residing in the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396a — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, if they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resources requirements of the federal program designated as the successor to the aid to families with dependent children program.

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

ALASKA STATUTES 1962

2003 SUPPLEMENT

NOVEMBER 2003

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Under the Supervision of

TERESA BUCHHOLZ, ANN GRADY, THOMAS D. CRANFIELD, JR., AND BRIAN M. YOST

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5704. For complete scope of annotations, see preface. For detailed information on the use of the Alaska Statutes, see User's Guide in Volume 1 of the 2002 main set.



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- (14) "medical assistance record" means records required to be kept by state or federal law or regulation regarding claims to a medical assistance agency;
- (15) "organization" has the meaning given in AS 11.81.900;
- (16) "person" has the meaning given in AS 11.81.900;
- (17) "properly" has the meaning given in AS 11.81.900;
- (18) "reckless disregard" means acting recklessly, as that term is defined in AS 11.81.900;
- (19) "services" or "medical assistance services" means a health care benefit that may qualify for reimbursement under AS 47.07 or AS 47.08, including health care benefits provided, attempted to be provided, or claimed to have been provided to another, by a medical assistance provider, or "services" as defined in AS 11.81.900;
- (20) "unconditional discharge" has the meaning given in AS 12.55.185. (§ 3 ch 66 SLA 2003)

Chapter 07. Medical Assistance for Needy Persons.

Section

10. Purpose
20. Eligible persons
30. Medical services to be provided
32. Inpatient psychiatric services for persons under 21 years of age
35. [Repealed]
36. Cost containment measures authorized

Section

42. Recipient cost-sharing
70. Payment rates for health facilities
73. Uniform accounting, budgeting, and reporting
74. Audits and inspections
- 110 — 190. [Repealed]
900. Definitions

Sec. 47.07.010. Purpose. It is declared by the legislature as a matter of public concern that the needy persons of this state who are eligible for medical care at public expense under this chapter should seek only uniform and high quality care that is appropriate to their condition and cost-effective to the state and receive that care, regardless of race, age, national origin, or economic standing. It is equally a matter of public concern that providers of services under this chapter should operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients. Accordingly, this chapter authorizes the department to pay for participation in the national medical assistance program as provided for under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 66 SLA 2003)

Effect of amendments. The 2003 amendment, effective September 9, 2003, amended the first sentence to read: "The department shall administer the medical assistance program and in the last sentence substituted "department" for "Department of Health and Social Services."

NOTES TO DECISIONS

quoting *Garner v. State*, 63 P.3d 264 (Alaska 2003).

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1396a (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resource requirements, do not receive supplemental security income under 42 U.S.C. 1381 -- 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed \$1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are ward-to-place children eligible for subsidy under AS 25.23.190 -- 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 -- 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

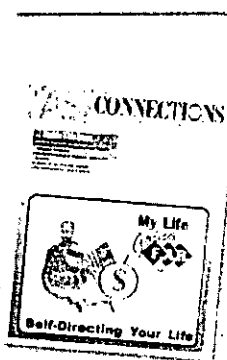
(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and



Supporting Individuals and Families to Self Direct Their Lives Through the Maryland New Directions Medicaid Waiver

- [About the Project](#)
- [MD New Directions Waiver](#)
- [New Directions Fact Sheets](#)
- [Person-Centered Planning](#)
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- [What is Self-Direction?](#)
- [Regional Workshops](#)
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- [Glossary of Acronyms & Terms](#)
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Inside the March - April 2005 Issue of TASH Connections: [Self-Directing Your Life \(.pdf file\)](#)

My Life: Going FAR is a project of [TASH](#).

This project is funded by the [Maryland Developmental Disabilities Council](#), in cooperation with the [Maryland Developmental Disabilities Administration](#).

What is a Medicaid Waiver?

The Medicaid program is an enormously important source of money to pay for services and supports for people with developmental disabilities. About \$3 of every \$4 that states spend for developmental disabilities services comes by way of Medicaid. Once, Medicaid dollars only paid for institutional services. Today, Medicaid allows more diverse services and supports for individuals in the community, by "waiving" the need to get those same services in an institution.

This information is based on a Policy Brief of the National Center for Family Support. The entire brief can be found at www.familysupport-HSRI.org

Why is it important to learn all about Medicaid?

Advocates need to keep in mind that states have the ability to decide who gets funded for what services (criteria for eligibility and coverage). To realize many of the opportunities afforded by federal policy, a state must elect to include an "option" or change its current policies. Medicaid policy change at the state level means convincing policy makers (governors and legislators) to take advantage of key options if they have not done so already. This is why it is important for individuals, families and other stakeholders to be "at the table" when Medicaid policy is discussed.

The Way Medicaid Works

Federal law (Title XIX of the Social Security Act) and regulations spell out the requirements that a state must meet in operating its Medicaid program. If a state meets these requirements, then the federal government pays a percentage of money (called the Federal Medical Assistance Percentage (FMAP)) of the amount of money that the state spends for services to people who are eligible for Medicaid. The FMAP rate varies, depending on income levels in each state. The lowest FMAP for high-income states is 50%; the maximum rate allowed is 83%. The highest rate currently being paid is about 77% (Mississippi).

States must use their own or local tax dollars (called "matching dollars") to meet their share of Medicaid costs. In order to expand Medicaid services, a state must provide more of their own tax dollars to get more money from the federal government. In the federal budget, Medicaid is an "open-ended entitlement" program. This means that the federal government is required by law to pay its share of state Medicaid costs regardless of the total amount. Each state spells out what is available under its Medicaid program in a document called the "state plan." The state plan describes the groups of individuals who can receive Medicaid services and the services that the state will make available to them. A state can amend its plan to change its program. State plan amendments are subject to federal review and approval. Each state must designate one of its agencies (called the "single state Medicaid agency") to administer its Medicaid program. The Medicaid



Sign up for the My Life: Going FAR email discussion group. This group is for sharing questions, ideas, and success stories related to self-directing support services and for supporting people to self-direct and use the Maryland New Directions Medicaid Waiver.

Individuals with developmental disabilities, families, and interested advocates or supporters are welcome and encouraged to participate.

If you or someone you know is interested in the information, but does not have regular access to email or the internet, please call us at 410-828-8274 x109 and we will add you to our regular mailing list.

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agency may enter into agreements with other state agencies (e.g., the state developmental disabilities agency) to administer specific services.

The federal agency responsible for the Medicaid program is the Center for Medicaid and State Operations (CMSO), a branch of the Health Care Financing Administration (HCFA) in the Federal Department of Health and Human Services. HCFA issues regulations and other policy guidance concerning Medicaid. It also oversees state Medicaid program operations. There are ten HCFA Regional Offices located around the country that work with individual states concerning the operation of their Medicaid programs.

Key Requirements For States

There are key requirements with which a state's Medicaid program must comply. These basic requirements govern Medicaid programs nationwide. They include:

- A state must make services available to individuals on a *comparable* basis. With some exceptions, a state may not provide services that differ in amount or type to one group of beneficiaries than others.
- A state must guarantee that recipients have *free choice* in selecting from among qualified service providers when obtaining Medicaid services. That is, a state cannot require a person to obtain services from a specific provider to the exclusion of others.
- A state must make Medicaid services available *statewide* and provide that individuals have *ready access* to them.
- A state must accept and make a *prompt decision* concerning a person's application for Medicaid services.
- A state may not limit or ration services due to a funding shortfall. A state is obligated to provide services in its state plan to all eligible persons. If a state cannot afford to provide the services, it must change its state plan.
- A state also must permit individuals to appeal adverse decisions concerning their eligibility or the authorization of services. This is called the Fair Hearing process.

In some cases, a state may request *waivers* of some of these requirements. Medicaid home and community-based service waiver programs operate under such waivers. The HCBS waiver program will be discussed in more detail below. When a state decides to use a managed care arrangement to obtain services for individuals (thereby limit their freedom of choice), there are federal laws and regulations concerning how such arrangements must be set up in order to safeguard their interests. Medicaid services must be obtained from "qualified providers." A state must spell out the qualifications that an individual or agency must meet in order to furnish services. States have considerable latitude in specifying these qualifications. At a minimum, providers must meet requirements spelled out in state law. In addition, each provider must enter into a contract (called a "provider agreement") with the state in order to be paid for services it provides to beneficiaries.

Medicaid is a "vendor payment" program. Typically, states pay providers directly on a fee-for-service basis once the provider has furnished a service. Subject to federal requirements, a state may pay for Medicaid services through prepayment ("capitation") arrangements when services are provided by health maintenance organizations (HMOs) or similar organizations. States have broad discretion in determining the amount of payments for services. Federal law requires that payment rates must be

sufficient to attract enough providers so that recipients can access needed services.

Eligibility: The Portal to Medicaid Services

Medicaid services are available only to individuals determined eligible for a state's program. Eligibility is the "portal" through which people must pass in order to obtain Medicaid services. On the other side of this portal lie services that people can obtain.



There are two parts to Medicaid eligibility. One is *financial eligibility*. Medicaid is a *means-tested* program. To qualify for Medicaid, a person cannot have income or assets that exceed the amounts that the state has specified. *The second leg of eligibility is whether a person is a member of a "group" that recognized in federal law* (e.g., people with disabilities who receive federal Supplemental Security Income (SSI) benefits). In order to receive Medicaid services, a person has to meet both tests. "Mandatory" groups (e.g., individuals that all states must serve) essentially include SSI recipients and children who live in very low-income households. But, there are many options or "doors" available to states to widen Medicaid eligibility beyond the mandatory groups. People with developmental disabilities qualify for Medicaid by meeting financial eligibility tests and being members of recognized but broader groups (e.g., individuals with disabilities). It is important to understand that over the past fifteen years, federal Medicaid policy has changed to permit states to offer Medicaid services to more groups of individuals who do not actually receive public assistance payments. Medicaid no longer is closely tied to "welfare." Even though the program is still means-tested, new mandates and options have been added so that individuals and families who have income above the poverty line can pass through the portal.

There are certain eligibility options that can play an important role in enabling people with developmental disabilities to qualify for Medicaid services, even though these options are not reserved exclusively for such individuals. These options revolve around children and adults who do not qualify as members of a mandatory group, generally because their or the family's income prevents them from being eligible to receive an SSI or other public assistance payment. It is helpful to discuss these options in terms of those that are relevant to children, adults and those that cut across all ages.

- **Children.** Not all children and youth with severe disabilities can qualify for an SSI payment and, thus, Medicaid. In the case of children with severe disabilities who live with their families, SSI rules require that a portion of the family's income be counted as available ("deemed") to the child. Even in the case of low-to-moderate income families, this requirement can result in the child's not qualifying for an SSI payment and, thus, make the child ineligible for Medicaid. However, if the child were placed permanently out of the family home in an institutional setting, the family's income would not be counted and the child would qualify for Medicaid. In order to correct this problem, in 1982 Congress enacted the "Katie Beckett option" (also known as "TEFRA 134"). Under this option, a state can decide not to count the family's income when the child meets SSI disability criteria and would be eligible for Medicaid if s/he were in an institutional setting. Several states have adopted this option. One state where this option is used extensively is Wisconsin. See the _ for how to obtain more information about Wisconsin's Katie Beckett program.

- Children who do not receive SSI also can qualify for Medicaid in a variety of other ways. They can qualify as members of low and moderate income households (needy families). There can be other avenues available, depending on the state. The Vermont Parent-to-Parent Network has identified six ways (including the Katie Beckett option) that children with disabilities can obtain Medicaid eligibility in Vermont. See the _ for how to access this information.
- Congress is considering a bill (the Family Opportunity Act) that would give states still another option for extending Medicaid eligibility to children with disabilities who live in higher income households eligible for Medicaid services. We discuss this bill more in the final section.
- **Adults.** Family income does not play a role in Medicaid eligibility for adults with disabilities, including when the person lives with his/her family. Only the adult individual's own income and resources are considered. As noted previously, states must extend Medicaid eligibility to individuals who receive SSI payments. SSI program rules permit individuals to earn income up to a certain level and still qualify for SSI. Recently, these earning limits were raised to \$740/month. There also are special rules that continue SSI and Medicaid benefits for a period of time after a person exceeds the earned income ceiling. It is not true that having a job automatically disqualifies a person for Medicaid. But, problems can arise once the person's income climbs above levels that SSI permits.
- Not all adults with severe disabilities qualify for an SSI payment. People who receive "adult disabled child" Social Security benefits or who have other income (including employment income) that exceed SSI maximums can qualify for Medicaid under other options. A state can set higher income thresholds that permit more of these individuals to qualify even though they do not receive SSI. Many states also permit individuals to qualify as "medically needy." In a medically needy program, people who have income above the state's maximum qualify for Medicaid by "spending down" their income on health services until it reaches the state's maximum (e.g., if a state's maximum is \$600 per month and a person has income of \$800, the person will qualify once he or she spends \$200 on health services). Recently, HCFA issued new rules that give states more options to make it easier for people to qualify as medically needy and thus obtain Medicaid eligibility. In addition, starting in 1997, Congress has added more eligibility options that permit states to extend or continue Medicaid eligibility for adults with disabilities whose employment earnings would otherwise disqualify them for Medicaid. See the _ for how to obtain information on this new options (which some states already have adopted). The rules concerning Medicaid eligibility for adults with disabilities differ considerably from state to state with the exception of the requirement that states include SSI recipients. As with children, it is important to have solid information concerning the rules in your state.
- **Long-term Services Eligibility.** In most states, Medicaid financial eligibility rules are more liberal for people who require long-term services. For example, a state may grant Medicaid eligibility to such persons who have incomes as high as three-times the basic grant standard for the SSI program (i.e., as high as \$1,590 per month). In operating an HCBS waiver program, a state may employ the same financial rules to determine eligibility as it does for institutional services. For children, this yields the same result as the Katie Beckett option. However, the Katie Beckett option is broader since it

does not hinge on whether the child participates in a waiver program. In the case of adults, using institutional financial eligibility rules can make a big difference in enabling individuals to obtain Medicaid eligibility. But, again, these special provisions apply to people who qualify for long-term services.

Medicaid operates under a simple rule: no Medicaid card, no services. States have many options for widening the eligibility portal for both children and adults with disabilities beyond those who receive an SSI payment. Advocacy with respect to Medicaid eligibility centers on urging states broaden eligibility options to more children with severe disabilities who live with their families and adults who do not qualify for SSI.

Once a person successfully navigates through a Medicaid portal, the next question is what services they can obtain that would be valuable in meeting his or her needs? Answering this question revolves around "coverage" -- the collection of "services" or "benefits" a state offers to Medicaid beneficiaries.

Medicaid coverage also has two parts. Every state must provide all Medicaid recipients with a core set of *mandatory services* (e.g., hospital, physician, nursing facility, home health services). A state also may elect to provide additional *optional services* (e.g., personal assistance, home and community-based waiver services). See the _ for how to locate information about the all the services that a state must or may offer. States can operate Medicaid programs that have either wide or narrow benefits. Usually you can find out about all the services your state offers at the Medicaid agency's website (_). Like other health insurance programs, whether a person requires a service is based on "necessity" (medical or otherwise) criteria (e.g., does a person's condition require a treatment or service that is covered under the state plan?).

State-to-state, the basic services that are available depend on whether the person is a child or adult as well as the decisions that a state has made with respect to the services it offers. Everyone who has a Medicaid card can access the services that a state offers through its Medicaid state plan. Here, we describe some key "regular" Medicaid services (e.g., services that a state can provide without seeking special waivers). In the next section, we will discuss services that a state can offer through an HCBS waiver program.

There are differences in the services that a state must or may offer children and adults. In particular:

- **Children.** For more than a decade, Congress has focused on strengthening the role that the Medicaid program plays in ensuring that children (with or without disabilities) have access to health care. In 1989, Congress extensively revamped federal Medicaid law what are labeled "Early and Periodic Screening, Diagnosis and Treatment" (EPSDT) services. States must provide EPSDT services to all children who are eligible for the Medicaid program. It is one of the mandates that states must meet in operating a Medicaid program. Through EPSDT, children must be seen periodically by health care professionals. If the child is identified as having a medical condition, further diagnoses must be performed and a state must follow through to provide all necessary treatment services. However, needed services can be identified at any time by professionals other than the child's own physician. The 1989 law

changes required states to step up their performance in operating EPSDT programs. It also mandated that states furnish any necessary Medicaid service (including dental care) that a child requires – regardless of whether the state specifically covers the service as part of its regular Medicaid program or not. The EPSDT mandate, for example, means that Medicaid eligible children with severe disabilities who require therapeutic services must be provided them. A state cannot restrict the services that it provides under the EPSDT mandate; it must make all types of services available, including the services that children with severe disabilities or special health care needs require. Such services can include home health services and personal assistance. However, EPSDT services do not include services (like respite) that only can be furnished through an HCBS waiver program. It is this EPSDT mandate that potentially makes obtaining Medicaid eligibility so valuable for children with disabilities.

- **Adults.** Except for the mandatory services that all states must include in their Medicaid programs, states have latitude in terms of the types of services that they make available to adults with disabilities. With respect to adults, there is no equivalent to the EPSDT mandate. States vary considerably with respect to the optional services that they make available to adults. For example, states frequently make available only very limited dental services or restrict the provision of therapeutic services only to people who need such services to "restore function," a restriction that frequently results in persons with developmental disabilities not being able to obtain such services. In addition, often states impose restrictions on optional services that can narrow their scope considerably.

There are three "regular" Medicaid services that are especially relevant to meeting the needs of people with developmental disabilities:

- One is home health, which all states must offer in their Medicaid programs. Home health services are provided to individuals at their place of residence. Home health services must include part-time or intermittent nursing services, home health aide services, and certain medical supplies and equipment. Physical, occupational therapy and speech pathology and audiology services also may be provided on an optional basis. In some states, access to home health services has been restricted to "homebound" individuals. But in July 2000, HCFA issued a policy clarification that states cannot restrict the availability of these services to people whose condition prevents them from leaving the home. This is expected to increase access to home health services by individuals who live in the community.
- The second important "regular" Medicaid service coverage is personal care (a.k.a., "personal assistance" or "attendant care"). When this service is offered, workers can provide assistance to people with disabilities in a wide variety of ways (helping with activities of daily living, grocery shopping, or getting about in the community). Once, federal rules limited the provision of these services to the person's home and described them in "medical model" terms. In 1993, Congress changed federal law so that personal assistance could be provided out in the community and "demedicalized" them. In 1999, HCFA issued new guidelines that gave states increased flexibility in providing these services, including sanctioning the use of consumer-directed personal care services (____). A state may provide personal care/assistance services without obtaining a waiver from HCFA and people do not have a

demonstrate a "need for institutional services" in order to obtain these services. Personal care is a potentially very flexible benefit that states can make available to all beneficiaries. However, fewer than 30 states offer personal care under their regular Medicaid programs and many have imposed more stringent restrictions on them than federal policy requires. A few states (e.g., Washington) make personal assistance available relatively widely.

- Another service is "targeted case management." The service is labeled "targeted" because it is one of the few regular Medicaid services that a state can cover but limit to specific groups of individuals. Many states use this coverage to fund their service coordination systems for people with developmental disabilities. States can offer these services to one or many groups of beneficiaries. Targeted case management is designed to help Medicaid beneficiaries access any of a wide range of services -- including social and educational services -- not just health care services.

The "regular" services that a state offers through its Medicaid state plan make up a "core" benefit package available to all Medicaid beneficiaries. Federal policy is very liberal with respect to the range of benefits that states may offer. But, many states are reluctant to add more services to their Medicaid programs or loosen up the restrictions that apply to the services that they presently offer. It is not surprising that concerns about increased spending lie behind this reluctance. Once a service is included in the core benefit package, it becomes an entitled service that might be very costly to provide. Nonetheless, advocates should be vigilant for opportunities to urge states to take advantage of opportunities to add services that are important to people with disabilities or remove overly stringent restrictions.

This information is based on a Policy Brief of the National Center for Family Support. The entire brief can be found at www.familysupport-HSRI.org

My Life: Going FAR is a project of **TASH**.

This project is funded by the Maryland Developmental Disabilities Council, in cooperation with the Maryland Developmental Disabilities Administration.



01/24/05



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[HEALTHCHOICE](#)

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[EMPLOYED INDIVIDUALS WITH DISABILITIES PROGRAM \(EID\) INFORMATION](#)

[MESSAGE TO COMMUNITYCHOICE ADVISORY GROUP](#)

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Waiver Programs

The Medicaid Program is responsible for the implementation and ongoing administration of home and community-based services waivers and targeted case management programs for special population groups. The Program studies, plans, and implement services relating to the needs of special populations such as the elderly, the mentally ill, and the physically and mentally disabled.

- [Waiver Programs Overview](#)
- [Reportable Event Information](#)
- [Provider Billing Forms and Instructions](#)
- [Registry Policy for Closed Waivers](#)
- [Older Adults Fact Sheet](#) Updated
- [Autism Waiver Fact Sheet](#)
- [Model Waiver Fact Sheet](#)
- [TBI Waiver Fact Sheet](#)
- [Living at Home Waiver Program](#)
- [Frequently Asked Questions List](#)
- [Estate Fact Sheet](#)
- [Estate Fact Sheet - Spanish Version](#)
- [Medical Day Care Waiver Fact Sheet](#) NEW!
- [Medical Day Care Waiver Application](#) NEW!
- [Medical Day Care Services Waiver](#) NEW!
- [Residential Treatment Center \(RTC\) Waiver](#) NEW!
- [Waiver Program Updates](#)
 - [Autism Waiver Application](#)
 - [Approved Living at Home Waiver Application](#)
 - [1915 \(b\)\(4\) waiver application for Living at Home Case Management, Submitted July 2009](#)

What is a waiver?

Under Section 1915(c) of the Social Security Act, Medicaid law authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. These waivers enable States to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization. Waiver services may be optional State Plan services which either are not covered by a particular State or which enhance the State's coverage. Waivers may also include services not covered through the State Plan such as respite care, environmental modifications, or family training.

The four basic types of 1915(c) HCBS waivers available for states based on the target population's level of alternative long-term institutional care are:

- intermediate care facility-mental retardation (ICF-MR) level of care for mentally retarded and/or developmentally disabled individuals;
- chronic or rehabilitative hospital level of care for individuals who are medically fragile, chronically ill, or severely disabled;
- psychiatric hospital level of care for individuals who are severely or chronically mentally ill; and
- nursing facility level of care for individuals who are elderly, physically disabled, and/or cognitively impaired.

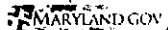
To be a waiver participant, an individual must be medically qualified, certified for the waiver's institutional level of care, choose to enroll in the waiver as an alternative to institutionalization, cost Medicaid no more in the community under the waiver than he or she would have cost Medicaid in an institution, and be financially eligible based on their income and assets.

Updated
July 16, 2009

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MD Relay Number: 1-800-735-2258

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FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB270
 () Publish Date: _____

Identifier (file name): HB270-DHSS-SDMS-03-18-10 Dept. Affected: Health & Social Services
 Title: Medicaid for Medical and Intermediate Care RDU: Senior and Disability Services
 Component: Senior and Disability Medicaid Services
 Sponsor: Munoz
 Requester: House HSS Component Number: 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURE								
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CHANGE IN REVENUES								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipt								
1037 GF/Mental Health								
Other Interagency Receipt								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill would increase the Medicaid income eligibility standard for individuals who reside in medical institutions, typically nursing facilities. This standard is also used for people who receive home and community-based waiver services. Currently, this standard is fixed at \$1,656 per month. The bill would increase the amount to 300 percent of the federal Supplemental Security Income (SSI) monthly benefit, which is currently \$674, adjusted for cost of living each year. Initially, the new standard for Medicaid nursing facility residents and waiver recipients would be \$2,022 per month.

DHSS does not anticipate that increasing the monthly standard for this eligibility category will increase the number of Medicaid recipients receiving services. While this is contrary to DHSS expectations when the Legislature fixed the standard at a set dollar amount in 2003, experience shows that as individuals receive cost of living increases in pensions or Social Security payments that raise their incomes over \$1,656 per month, they use Medicaid qualifying income trusts to reduce their countable income below that amount and continue to qualify for Medicaid.

(Continued on Page 2).

Prepared by: William J. Streur, Deputy Commissioner
 Division: DHSS Health Care Services

Phone: 269-7827
 Date/Time: 2/3/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date: 3/18/2010

ANALYSIS CONTINUATION

Another consideration is that Medicaid recipients who qualify under this institutional income standard are required to make a contribution toward the cost of the Medicaid institutional or waiver services they receive if their countable income exceeds the personal needs allowance established for their living arrangement. The personal needs allowance for people on waivers has historically been set in regulation and the amount varies depending on the person's living situation, and is not linked to the institutional income standard. DHSS has not assumed an increase to the personal needs allowance. Therefore, DHSS does not anticipate an increase in Medicaid spending as a result of this legislation. If DHSS increased the personal needs allowance in conjunction with increasing the income eligibility standard, it would increase Medicaid expenditures.

HB

277

26-LS0951\S
Bullard
3/26/10

CS FOR HOUSE BILL NO. 277()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES PEGGY WILSON AND LYNN

A BILL

FOR AN ACT ENTITLED

1 **"An Act requiring the Department of Health and Social Services to adopt standards for**
2 **the approval of and to approve certain training programs relating to the possession of**
3 **epinephrine and the administration of epinephrine in emergency situations; and**
4 **authorizing certain individuals to obtain a prescription for epinephrine, purchase**
5 **epinephrine, and administer epinephrine in emergency situations."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1. AS 17 is amended by adding a new chapter to read:**

8 **Chapter 22. Use of Epinephrine in Emergency Situations.**

9 **Sec. 17.22.010. Prescription, purchase, and administration of epinephrine**
10 **by a trained individual. An individual who is 18 years of age or older may obtain a**
11 **prescription for and purchase, and may, in an emergency situation, administer**
12 **epinephrine using**

13 **(1) an auto-injector, if the individual has successfully completed a**

1 training program approved by the department under AS 17.22.020(b); or

2 (2) an ampule, if the individual has successfully completed a training
3 program approved by the department under AS 17.22.020(c).

4 **Sec. 17.22.020. Approval of training programs.** (a) The department shall
5 adopt standards for the approval of training programs for the use of

6 (1) epinephrine auto-injectors; and

7 (2) epinephrine ampules.

8 (b) The department shall approve an auto-injector training program that meets
9 standards adopted under (a)(1) of this section. The standards must require an
10 epinephrine auto-injector program to provide training in

11 (1) techniques on how to recognize symptoms of severe asthmatic or
12 allergic reactions, including anaphylaxis;

13 (2) standards and procedures for the storage of epinephrine auto-
14 injectors and administration of epinephrine using auto-injectors; and

15 (3) emergency follow-up procedures.

16 (c) The department shall approve an epinephrine ampule training program that
17 meets standards adopted under (a)(2) of this section. The standards must require an
18 epinephrine ampule program to provide training in

19 (1) techniques on how to recognize symptoms of severe asthmatic or
20 allergic reactions, including anaphylaxis;

21 (2) standards and procedures for the storage of epinephrine ampules
22 and administration of epinephrine using ampules; and

23 (3) emergency follow-up procedures.

24 **Sec. 17.22.030. Applicability.** This chapter does not apply to a person who is
25 authorized under another law to administer epinephrine or to a person who is
26 prescribed epinephrine for personal use.

27 **Sec. 17.22.040. Liability of certified individual.** A claim for relief may not be
28 brought against an individual who has successfully completed a training program
29 approved by the department under AS 17.22.020 for an act or omission relating to the
30 administration of epinephrine to another individual in an emergency situation if the
31 individual who completed the training program acted in good faith under the authority

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granted by this chapter.

Sec. 17.22.090. Definitions. In this chapter,

- (1) "department" means the Department of Health and Social Services;
- (2) "emergency situation" means a circumstance where an individual experiences a severe asthmatic or allergic reaction, including anaphylaxis, that requires the administration of epinephrine to avoid severe injury or death and where a certified or licensed health care provider authorized to administer epinephrine is not available.

26-LS0951\S
Bullard
3/26/10

CS FOR HOUSE BILL NO. 277()

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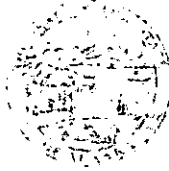
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reasonably

(2.)

ALASKA STATE LEGISLATURE

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P.O. Box 109
Wrangell, AK 99929
Phone: (907) 874-3088
Fax: (907) 874-3055



Session:
State Capitol, Room 406
Juneau, AK 99801-1182
Phone: (907) 465-3824
1-800-686-3824
Fax: (907) 465-3175

REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

SPONSOR STATEMENT

House Bill 277

“An Act establishing a program in the Department of Health and Social Services to certify certain individuals to be issued a prescription to administer epinephrine and to possess and administer epinephrine in certain situations.”

House Bill 277 allows individuals who have passed a departmentally-approved program to purchase and administer epinephrine.

Epinephrine (adrenalin) is used in emergency situations to combat severe allergic reactions, anaphylactic shock and heart attacks.

It is difficult to foresee the possibility of an allergic reaction when an individual has no known allergies. A victim of an allergic reaction can go into anaphylactic shock and medical attention may not be readily available. During these situations, the administration of epinephrine could be necessary to save a victim's life. Under current statute, the administrator can be held personally liable.

The passage of this bill would increase access to this life-saving medication, maintain and increase available safety measures, and reduce personal liability for acts of good faith.

ALASKA STATE LEGISLATURE

Interim:
P.O. Box 109
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Fax: (907) 465-3175

**REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2**

Sectional

Committee Substitute for House Bill 277

“An Act requiring the Department of Health and Social Services to approve training programs to certify individuals to possess epinephrine and to administer epinephrine in emergency situations; and authorizing certified individuals to obtain a prescription for, purchase, and possess epinephrine, and to administer epinephrine in emergency situations.”

Section 1:

- An individual who successfully completes training requirements may obtain a prescription for epinephrine, purchase it, and may in an emergency situation administer epinephrine either through epinephrine auto-injectors or ampules.
- Department of Health and Social Services shall approve a set of standards for the training of both epinephrine auto-injectors and ampules.
- Applicability does not apply to an authorized administrator or to someone already prescribed epinephrine.
- Outlines liability of the certified individual.
- Defines “certified individual,” “department,” and “emergency situations.”

26-LS0951AE
Bullard
3/22/10

CS FOR HOUSE BILL NO. 277()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

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Referred:

Sponsor(s): REPRESENTATIVES PEGGY WILSON AND LYNN

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11 (2) standards and procedures for the storage of epinephrine auto-
12 injectors and administration of epinephrine using auto-injectors; and

13 (3) emergency follow-up procedures.

14 (c) The department shall approve an epinephrine ampule training and
15 certification program that meets standards adopted under (a)(2) of this section. The
16 standards must require an epinephrine ampule program to provide training and
17 certification in

18 (1) techniques on how to recognize symptoms of severe asthmatic or
19 allergic reactions, including anaphylaxis;

20 (2) standards and procedures for the storage of epinephrine ampules
21 and administration of epinephrine using ampules; and

22 (3) emergency follow-up procedures.

23 **Sec. 17.22.030. Applicability.** This chapter does not apply to a person who is
24 authorized under another law to administer epinephrine or to a person who is
25 prescribed epinephrine for personal use.

26 **Sec. 17.22.040. Liability of certified individual.** A claim for relief may not be
27 brought against a certified individual for an act or omission relating to the
28 administration of epinephrine to another individual in an emergency situation if the
29 individual acted in good faith under the authority granted by this chapter.

30 **Sec. 17.22.090. Definitions.** In this chapter,

31 (1) "certified individual" means an individual certified by a training

- 1 program approved by the department under AS 17.20.020;
- 2 (2) "department" means the Department of Health and Social Services;
- 3 (3) "emergency situation" means a circumstance where an individual
- 4 experiences a severe asthmatic or allergic reaction, including anaphylaxis, that
- 5 requires the administration of epinephrine to avoid severe injury or death and where a
- 6 licensed health care provider authorized to administer epinephrine is not available.



EXECUTIVE SUMMARY

Introduction

In 1999 the Washington State Legislature passed the "Kristine Kastner Act" (SHB 1992) requiring the Department of Health, with the respective House and Senate Health Care Committees, to prepare a report on the statewide incidence of anaphylaxis (severe allergic reactions) and the training and care necessary to allow Emergency Medical Technicians (EMTs) to carry and administer epinephrine. This legislation was driven by the concern that EMTs are not currently trained to diagnose the need for epinephrine by emergency patients they encounter. Epinephrine, when appropriately administered to the patient experiencing anaphylaxis or severe allergic reaction, may be required to save the patient's life.

This report includes data on the incidence of anaphylaxis statewide, and information on a pilot training program to determine the training and care standards necessary for EMTs to carry and administer epinephrine. Also included is an estimate of costs to provide that training. Recommendations are provided on the identification of any mitigating circumstances such as age, patient care protocols and specific signs and symptoms required to determine whether to administer epinephrine.

Recommendations



Education and Training -

- Training EMTs to safely administer epinephrine to anaphylaxis patients less than 30 years old must:
 - include no less than two hours didactic time;
 - include department-approved educational objectives; and
 - include a written and practical assessment of each EMT by the instructor.
- Instructors of new epinephrine material must be recommended by the county EMS Medical Program Director (Physician responsible for oversight of EMS personnel in each county) and approved by DOH.
- To maintain effective quality assurance of EMT performance, medical program directors must evaluate and report to DOH every use of epinephrine by EMTs and any anaphylaxis death in their monthly report.
- To retain knowledge and skill competency, each EMT's required Continuing Medical Education must include the use of epinephrine for anaphylaxis during each certification period (3 years).

Supplies -

All licensed basic life support vehicles must carry at least one adult and one pediatric auto-injector of 1:1000 epinephrine for anaphylaxis.

Mitigating Factors -

Age Factors:

- Based upon the limits of the pilot program, for patients who do not have a prescription or parental request, we recommend epinephrine be administered to persons under the age of 30.

Signs & Symptoms:

- To ensure safe administration of epinephrine to persons, EMTs may only administer epinephrine when signs and/or symptoms of anaphylaxis include respiratory distress or hypoperfusion.

Medical Control

- Usual medical program director specific methods of on-line/offline medical control will be followed.

From: Mike Motti [mailto:mikemotti@mac.com]
Sent: Friday, January 22, 2010 9:06 AM
To: Rep. Peggy Wilson
Subject: HB 277

Rep Wilson: I fully support this bill. I have been involved in EMS in Alaska since 1973 and have been teaching wilderness medicine for 20 years. However, as currently written, the Department is going to attach a huge fiscal note to the bill. I respectfully suggest that the wording be changed to direct the Section of EMS and Emergency Preparedness to approve the TRAINING COURSES, and that anyone showing a current certification card for one of these courses be allowed to purchase epinephrine without a prescription.

Right now the State EMS Training Committee approves CPR courses. They meet 3 times a year, and could approve epi training courses during their meetings without any significant expense to the State.

Respectfully,

Mike Motti
Sitka, Alaska

From: messa@mtaonline.net

I am writing to ask that you have HB277 CERTIFY EMERGENCY USE OF EPINEPHRINE heard and voted on this session. I recently received my Wilderness First Responder (WFR) Certification. The reason I took the course is that I work in wilderness settings, for many years, as an outdoor educator with youth. I have been very fortunate to not have a trip go bad from an emergency stand point. I have come close a few times. A big worry I have is the need to treat Anaphylaxis or Severe Asthma in the field. Many of my clients have Epinephrine (Epi)prescribed to them and they carry it. There are other clients that may not know they have the predisposition to Anaphylaxis. The way the law is now I cannot administer Epi to this person because it is not prescribed to them. If I had a physicians order on hand I could, but in todays litigious society most physicians won't stick their neck out. I also subject my clients to stress, new environments and new natural vegetation (nature). These things can exacerbate Asthma to severe levels. Epi would give my Asthmatic clients a fighting chance if a severe attack occurs. I dread the day when, under the current law, I have to make a chance at life with the use of Epi or death because I am not allowed, by law, to administer the drug to my client. Please support HB277 and the many people who enjoy the wilds of Alaska. Thank You. Roger Gossett (907)746-3181.

~ Roger Gossett
Zip Code: 99645
Voter ID: I have one

The curriculum for training of people to deliver epi via epi pen has been developed by the American Heart Association, Wilderness Medical Society and the Red Cross. These plans are geared to the general public, are included with CPR instruction and would suit the requirements for training for the proposed bill.

I think that the Department should be able to review and endorse any or all of these nationally approved training modules to do the job.

If there are any other questions I can help with, let me know.

Bobbi Leichty, Director
SEREMS
907-747-8005

Here are summaries of enacted New Jersey and Utah laws from 2007 and 2008. These are specific to epinephrine administration. There are some bills specific to peanut allergies that have not been included in this list.

New Jersey

School allergy - Student Epinephrine Administration

(2006) NJ S **SPONSOR:** Kean
79 **COSPONSOR(S):** Turner, Coniglio, Sarlo, Martin, Asselta N, McNamara, Sweeney
TITLE: Student Epinephrine Administration
INTRODUCED: 01/10/2006
ENACTED: 03/16/2007
DISPOSITION: Enacted
LOCATION: Chaptered
CHAPTER: 2007-57
SUMMARY:
Clarifies law concerning the emergency administration of epinephrine to students for anaphylaxis, increases number of delegates trained to administer epinephrine; requires a plan to reduce student exposure to allergens.
STATUS:
03/16/2007 Signed by GOVERNOR.
03/16/2007 Chapter No. 2007-57

Utah - epi-pen use for Anaphylactic Reaction

(2007) UT H **AUTHOR:** Kiser
56 **TITLE:** Emergency Injection for Anaphylactic Reaction Act
INTRODUCED: 01/15/2007
ENACTED: 03/07/2007
DISPOSITION: Enacted
LOCATION: Chaptered
CHAPTER: 037
SUMMARY:
Amends the Emergency Injection for Anaphylactic Reaction Act; authorizes the Department of Health to approve training programs for the use and storage of epinephrine auto-injectors in an emergency; authorizes the department to conduct educational programs to train people in the use and storage of EPI pens; establishes a standard for when a person has a need for training in the use of epinephrine auto-injectors; authorizes a trained person to obtain a prescription for the auto-injector.
STATUS:
04/02/2007 Chaptered. Chapter No. 037

(2008) UT H **AUTHOR:** Kiser
101 **TITLE:** Anaphylactic Emergency Injections
INTRODUCED: 01/21/2008
ENACTED: 03/14/2008
DISPOSITION: Enacted
LOCATION: Chaptered
CHAPTER: 064
SUMMARY:
Provides that a school, school board, or school official may not prohibit or dissuade a teacher or other school employee from possessing, storing, administering, or receiving training to administer an epinephrine auto-injector; requires schools to make an emergency epinephrine auto-injector available to any qualified employee; requires primary and secondary school training regarding the storage and use of an epinephrine auto-injector to a teacher or school employee who volunteers to take the training.
STATUS:
04/02/2008 Chaptered. Chapter No. 064

The following are recently enacted laws:

New York - school allergy

New York AB 4051 (Enacted 8/15/2007)

The law enacts the Food Allergy and Anaphylaxis Management Act. The law requires that an anaphylactic policy is established for school districts for the prevention and treatment of anaphylaxis.

(2007) NY A **SPONSOR:** Rivera J
4051 **TITLE:** Food Allergy and Anaphylaxis Management Act
INTRODUCED: 01/31/2007
ENACTED: 08/15/2007
DISPOSITION: Enacted
LOCATION: Chaptered
CHAPTER: 579

SUMMARY:

Enacts Food Allergy and Anaphylaxis Management Act; provides for the establishment of an anaphylactic policy for school districts for the prevention of anaphylaxis and during a medical emergency resulting from anaphylaxis.

STATUS:

08/15/2007 Signed by GOVERNOR.
08/15/2007 Chapter No. 579

Nevada – School based administration of anaphylaxis medications – enacted

NV AB 182 **Requires principals and school nurses to allow pupils to self-administer prescribed medications for asthma and anaphylaxis under certain circumstances**

Relating to pupils; requiring a principal or a school nurse of a public school to allow pupils to self-administer prescribed medications for asthma and anaphylaxis under certain circumstances; and providing other matters properly relating thereto. (9.6 KB)

Matches:
allergen,
allergic, allergy,
food

05/09/2005 Approved by the Governor. Chapter 43.

Below is some additional information on the web site of the food allergy and anaphylaxis network, including training materials about how to use an epi-pen and permission/planning forms for who may administer in an emergency:

<http://www.foodallergy.org/section/schoolchildcare>

<http://www.foodallergy.org/page/food-allergy-action-plan1>

<http://www.foodallergy.org/files/FAAP.pdf>

Also, there was federal legislation proposed in 2009:

At the federal level, the Food Allergy and Anaphylaxis Management Act (FAAMA), which calls for voluntary national guidelines to help schools manage students affected by food allergy and anaphylaxis is pending:

S.456 and HR.1378.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 29, 2010

SUBJECT: Epinephrine: Immunity for responding to an emergency
(CSHB 277() ; Work Order No. 26-LS0951\5)

TO: Representative Peggy Wilson
Attn: Michael Dunning

FROM: Tamara Brandt Cook
Director *TBC*

You ask how the provision in CSHB 277() addressing immunity from suit differs from the general Good Samaritan statute.

Sec. 17.22.040 of the bill draft prevents a claim from being brought for an act or omission against a person who (1) has completed an approved training program for the use of epinephrine auto-injectors or epinephrine ampules; (2) administers epinephrine to another; (3) does so in an emergency situation; and (4) acts in good faith under the authority granted in AS 17.22. For purposes of (3) an "emergency situation" is defined in sec. 17.22.090 to mean:

a circumstance where an individual experiences a severe asthmatic or allergic reaction, including anaphylaxis, that requires the administration of epinephrine to avoid severe injury or death and where a certified or licensed health care provider authorized to administer epinephrine is not available.

This is a narrow grant of immunity that will not apply in some situations that involve the use of epinephrine to aid another person. For example, if the epinephrine is administered but the situation does not meet the definition of "emergency situation" because the victim's reaction is due to heart attack, stroke, diabetes, or some other cause, or the epinephrine turns out not to be required to avoid injury or death, the immunity provided in sec. 17.22.040 will not apply.

Some of those situations might still be covered by the general Good Samaritan statute that broadly applies to emergency aid found at AS 09.65.090. It provides:

(a) A person at a hospital or any other location who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid

Representative Peggy Wilson

March 29, 2010

Page 2

to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

.....
(d) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

Since cases involving liability or immunity for negligence are often fact specific, there may be some situations when a trained individual administers epinephrine but does not enjoy immunity under AS 17.22.040. In those situations, the individual might be granted immunity under AS 09.65.090. It does not appear that either statute precludes potential application of the other.

Note that Alaska statutes contain other provisions granting immunity or limited immunity in particular situations. AS 08.64.366 (liability for services rendered by a mobile intensive care paramedic) uses language somewhat similar to that in sec. 17.22.040. In addition to other specific grants of immunity in AS 09.65, examples are AS 18.08.086 (liability for services rendered by certain medical professionals); AS 14.30.325(b) (surrogate parents); AS 44.21.450 (volunteer guardians).

TBC:med
10-063.med

HB

282

26-LS1208\W
Bullard
3/30/10

CS FOR HOUSE BILL NO. 282()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES MUÑOZ, Austerman

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to naturopaths and to the practice of naturopathy; establishing an**
2 **Alaska Naturopathic Medical Board; authorizing medical assistance program coverage**
3 **of naturopathic services; amending the definition of 'practice of medicine'; and**
4 **providing for an effective date."**

5 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

6 *** Section 1.** AS 08.01.010(26) is amended to read:

7 (26) Alaska Naturopathic Medical Board (AS 08.45.003)
8 [REGULATION OF THE PRACTICE OF NATUROPATHY UNDER AS 08.45];

9 *** Sec. 2.** AS 08.01.050(d) is amended to read:

10 (d) At the request of one of the following boards, the department may contract
11 with public agencies and private professional organizations to provide assistance and
12 treatment to persons licensed by the board who abuse alcohol, other drugs, or other
13 substances:

14 (1) Board of Social Work Examiners;

- 1 (2) Board of Dental Examiners;
- 2 (3) [REPEALED
- 3 (4)] State Medical Board;
- 4 (4) [(5)] Board of Nursing;
- 5 (5) [(6)] Board of Examiners in Optometry;
- 6 (6) [(7)] Board of Pharmacy;
- 7 (7) [(8)] State Physical Therapy and Occupational Therapy Board;
- 8 (8) [(9)] Board of Professional Counselors;
- 9 (9) [(10)] Board of Psychologist and Psychological Associate
- 10 Examiners;
- 11 (10) [(11)] Board of Veterinary Examiners;
- 12 (11) [AND (12)] Board of Marital and Family Therapy; and
- 13 (12) Alaska Naturopathic Medical Board.

14 * **Sec. 3.** AS 08.03.010(c) is amended by adding a new paragraph to read:

- 15 (23) Alaska Naturopathic Medical Board (AS 08.45.003) - June 30,
- 16 2015.

17 * **Sec. 4.** AS 08.45 is amended by adding new sections to read:

18 **Sec. 08.45.003. Board created; organization.** (a) There is created the Alaska
 19 Naturopathic Medical Board. The board consists of seven members appointed by the
 20 governor as follows:

- 21 (1) three members shall be naturopaths licensed under this chapter who
- 22 have been engaged in the practice of naturopathic medicine in the state for at least five
- 23 years immediately preceding appointment, at least one of whom lives outside the third
- 24 judicial district;
- 25 (2) one member shall be a licensed pharmacist;
- 26 (3) one member shall be a licensed physician;
- 27 (4) one member shall be a hospital administrator; and
- 28 (5) one member shall be a public member who may be a licensed
- 29 physician.

30 (b) The board shall select from among its members a chair and a secretary.
 31 The board shall meet at least twice a year, and additional meetings shall be held on

1 request of the chair or on request of the department.

2 (c) Notwithstanding AS 08.01.035, members of the board serve staggered
3 terms of three years unless removed by the governor for neglect of duty or other just
4 cause.

5 (d) Four members of the board constitute a quorum for the transaction of all
6 business properly before the board.

7 (e) When appointing naturopaths under (a) of this section, the governor may
8 consider licensed naturopaths who have been nominated by the Alaska Association of
9 Naturopathic Physicians.

10 (f) In the event of the death, resignation, or removal of a member, the vacancy
11 shall be filled for the unexpired portion of the term in the same manner as the original
12 appointment.

13 **Sec. 08.45.005. Duties of the board.** The board shall

14 (1) approve naturopathic medical programs;

15 (2) implement the continuing education requirements of AS 08.45.058;

16 and

17 (3) adopt regulations necessary to implement this chapter in a manner
18 that protects public health, including regulations that define a physician-patient
19 relationship for purposes of AS 08.45.045(6).

20 * **Sec. 5.** AS 08.45.030 is amended to read:

21 **Sec. 08.45.030. Issuance of license.** The board shall request that the
22 department [SHALL] issue, and the department may issue, a license to practice
23 naturopathy to an applicant who provides proof satisfactory to the board
24 [DEPARTMENT] that the applicant has received a degree from an accredited four-
25 year college or university, has paid the applicable fees, and

26 (1) on or before December 31, 1987, has graduated from a school of
27 naturopathy that required four years of attendance at the school and after graduation
28 has received a license in another state after passing an examination for licensure in
29 that state and is licensed by a state at the time of application; or

30 (2) after December 31, 1987, has

31 (A) graduated from a school of naturopathy that required four

1 years of attendance at the school and at the time of graduation the school was
2 accredited or a candidate for accreditation by the Council on Naturopathic
3 Medical Education or a successor organization recognized by the United States
4 Department of Education; and

5 (B) passed the Naturopathic Physicians Licensing Examination.

6 * Sec. 6. AS 08.45.035(a) is amended to read:

7 (a) The board shall request that the department [SHALL] issue, and the
8 department may issue, a temporary license to practice naturopathy to an applicant
9 who has applied for and is qualified to take the next Naturopathic Physicians
10 Licensing Examination offered after the date of application and provides proof
11 satisfactory to the board [DEPARTMENT] that the applicant

12 (1) has paid the applicable fees;

13 (2) meets the requirements of AS 08.45.030(2)(A); and

14 (3) [(2)] has not previously failed the Naturopathic Physicians
15 Licensing Examination.

16 * Sec. 7. AS 08.45 is amended by adding a new section to read:

17 **Sec. 08.45.045. Scope of practice as a naturopath.** A naturopath may

18 (1) use physical examinations consistent with naturopathic medical
19 education and training for diagnostic purposes;

20 (2) perform and administer therapies consistent with naturopathic
21 medical education and training, including intravenous delivery of dietetic substances;

22 (3) order or conduct medical imaging and laboratory examinations
23 consistent with naturopathic medical education and training;

24 (4) perform preemployment, school, and workplace health
25 examinations;

26 (5) perform minor surgery; in this paragraph, "minor surgery"

27 (A) means the use of

28 (i) operative, electrical, or other methods for surgical
29 repair and care incidental to superficial lacerations and abrasions or
30 superficial lesions and the removal of foreign bodies located in
31 superficial tissues; and

1 (ii) antiseptics and local anesthetics in connection with
2 methods authorized under (i) of this subparagraph;

3 (B) does not include use of general or spinal anesthetics,
4 surgery of the body cavities, or specialized surgery, such as plastic surgery,
5 surgery involving the eyes, or surgery involving tendons, ligaments, nerves, or
6 blood vessels; and

7 (6) subject to AS 08.45.050, administer and prescribe prescription
8 drugs, vaccines, hormones, and medical devices for a person with whom the
9 naturopath has a physician-patient relationship as defined by the board in regulations,
10 except a naturopath may not administer or prescribe a schedule IA, IIA, IIIA, IVA,
11 VA, or VIA controlled substance under state law or a schedule I, II, III, IV, or V
12 controlled substance under federal law.

13 * **Sec. 8.** AS 08.45.050 is amended to read:

14 **Sec. 08.45.050. Restrictions on practice of naturopathy.** A person who
15 practices naturopathy may not

16 (1) give, prescribe, or recommend in the practice

17 (A) a prescription drug, vaccine, or hormone, except as
18 authorized under AS 08.45.045(6);

19 (B) a controlled substance;

20 (C) a poison;

21 (2) engage in surgery, except minor surgery as authorized under
22 AS 08.45.045;

23 (3) use general or spinal anesthetics; or

24 (4) administer ionizing radioactive substances for therapeutic
25 purposes [USE THE WORD "PHYSICIAN" IN THE PERSON'S TITLE].

26 * **Sec. 9.** AS 08.45 is amended by adding a new section to read:

27 **Sec. 08.45.058. Continuing education requirements.** (a) For each biennial
28 license period, a person licensed to practice naturopathy under AS 08.45.030 shall
29 complete and submit to the board evidence of at least 35 hours of continuing
30 education, at least 15 of which are in pharmaceutical education. The 35 hours of
31 continuing education must be in training programs approved by the board.

1 (b) The department shall publish, on a regular basis, a listing of training
2 programs that may be used to satisfy the continuing education requirements of this
3 section.

4 * **Sec. 10.** AS 08.45.100 is amended to read:

5 **Sec. 08.45.100. Regulations.** The board and the department
6 [DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC
7 DEVELOPMENT] shall adopt regulations to implement this chapter.

8 * **Sec. 11.** AS 08.45 is amended by adding a new section to read:

9 **Sec. 08.45.110. Fees.** The department shall set fees under AS 08.01.065 for
10 each of the following:

- 11 (1) a license issued under this chapter;
- 12 (2) a temporary license issued under this chapter;
- 13 (3) renewal of a license issued under this chapter.

14 * **Sec. 12.** AS 08.45.200 is amended by adding, a new paragraph to read:

15 (4) "board" means the Alaska Naturopathic Medical Board established
16 under this chapter.

17 * **Sec. 13.** AS 08.64.380(6) is amended to read:

18 (6) "practice of medicine" or "practice of osteopathy" means:

19 (A) for a fee, donation or other consideration, to diagnose,
20 treat, operate on, prescribe for, or administer to, any human ailment, blemish,
21 deformity, disease, disfigurement, disorder, injury, or other mental or physical
22 condition; or to attempt to perform or represent that a person is authorized to
23 perform any of the acts set out in this subparagraph;

24 (B) to use or publicly display a title in connection with a
25 person's name, including "doctor of medicine," "physician," "M.D.," or "doctor
26 of osteopathic medicine" or "D.O.," unless the designation additionally
27 contains the word "naturopathy" or "naturopathic" in the title, or to use
28 or publicly display a specialist designation, such as [INCLUDING]
29 "surgeon," "dermatologist," or a similar title, in such a manner as to show that
30 the person is willing or qualified to diagnose or treat the sick or injured;

31 * **Sec. 14.** AS 08.80.400 is amended to read:

1 **Sec. 08.80.400. Other licensees not affected.** This chapter does not affect the
2 practice of medicine by a licensed medical doctor and does not limit a licensed
3 medical doctor, osteopath, podiatrist, physician assistant, advanced nurse practitioner,
4 dentist, veterinarian, dispensing optician, naturopath, or optometrist in supplying a
5 patient with any medicinal preparation or article within the scope of the person's
6 license.

7 * **Sec. 15.** AS 47.07.030(b) is amended to read:

8 (b) In addition to the mandatory services specified in (a) of this section and the
9 services provided under (d) of this section, the department may offer only the
10 following optional services: case management and nutrition services for pregnant
11 women; personal care services in a recipient's home; emergency hospital services;
12 long-term care noninstitutional services; medical supplies and equipment; advanced
13 nurse practitioner services; naturopathic services; clinic services; rehabilitative
14 services for children eligible for services under AS 47.07.063, substance abusers, and
15 emotionally disturbed or chronically mentally ill adults; targeted case management
16 services; inpatient psychiatric facility services for individuals age 65 or older and
17 individuals under age 21; psychologists' services; clinical social workers' services;
18 midwife services; prescribed drugs; physical therapy; occupational therapy;
19 chiropractic services; low-dose mammography screening, as defined in
20 AS 21.42.375(e); hospice care; treatment of speech, hearing, and language disorders;
21 adult dental services; prosthetic devices and eyeglasses; optometrists' services;
22 intermediate care facility services, including intermediate care facility services for the
23 mentally retarded; skilled nursing facility services for individuals under age 21; and
24 reasonable transportation to and from the point of medical care.

25 * **Sec. 16.** AS 47.07.900 is amended by adding a new paragraph to read:

26 (20) "naturopathic services" means services that are furnished by a
27 person who is licensed to practice naturopathy under AS 08.45.030 or 08.45.035 and
28 that are within the person's scope of practice under AS 08.45.045.

29 * **Sec. 17.** The uncodified law of the State of Alaska is amended by adding a new section to
30 read:

31 **TRANSITION: REGULATIONS.** The Department of Commerce, Community, and

1 Economic Development may proceed to adopt regulations necessary to implement the
2 changes made by this Act. The regulations take effect under AS 44.62 (Administrative
3 Procedure Act), but not before the effective date under sec. 21 of this Act.

4 * Sec. 18. The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 TRANSITIONAL PROVISIONS APPLICABLE TO ALASKA NATUROPATHIC
7 MEDICAL BOARD. Notwithstanding AS 08.45.003, as enacted in sec. 4 of this Act, the
8 terms of the first members of the Alaska Naturopathic Medical Board appointed by the
9 governor are as follows: (1) one licensed naturopath member, the licensed pharmacist
10 member, and the physician member shall be appointed for three-year terms; (2) one licensed
11 naturopath member and the public member shall be appointed for two-year terms; and (3) one
12 licensed naturopath member and the hospital administrator member shall be appointed for a
13 one-year term. The governor shall specify the term of office of each licensed naturopath
14 member appointed subject to this section.

15 * Sec. 19. The uncodified law of the State of Alaska is amended by adding a new section to
16 read:

17 TRANSITIONAL PROVISIONS AFFECTING EXISTING LICENSEES.
18 Notwithstanding AS 08.45.030, as amended by sec. 5 of this Act, and AS 08.45.035(a), as
19 amended by sec. 6 of this Act,

20 (1) a license issued under those provisions by the Department of Commerce,
21 Community, and Economic Development before the effective date of this section is valid for
22 the period issued until renewal under the provisions of this Act; and

23 (2) the Department of Commerce, Community, and Economic Development,
24 without prior approval of the Alaska Naturopathic Medical Board, may issue a license or
25 renew a license to practice naturopathy on or after the effective date of this section and until
26 the day before the effective date of the regulations initially adopted by the board setting out
27 procedures under which license applications and renewals are submitted for board review and
28 approval.

29 * Sec. 20. Section 17 of this Act takes effect immediately under AS 01.10.070(c).

30 * Sec. 21. Except as provided in sec. 20 of this Act, this Act takes effect July 1, 2010.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB 282 (L&C)
 () Publish Date: _____

Identifier (file name): HB282CS(L&C)-CED-CBPL-3-31-10 Dept. Affected: DCCED
 Title: Naturopaths RDU: Corp, Bus, & Prof Licensing (117)
 Component: Corp, Bus, & Prof Licensing
 Sponsor: Representative Munoz
 Requester: House Labor and Commerce Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services	28.3	0.0	28.3	28.3	28.3	28.3	28.3	28.3
Travel	7.6	0.0	7.6	7.6	7.6	7.6	7.6	7.6
Contractual	2.0	0.0	2.0	2.0	2.0	2.0	2.0	2.0
Supplies	0.5	0.0	0.5	0.5	0.5	0.5	0.5	0.5
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	38.4	0.0	38.4	38.4	38.4	38.4	38.4	38.4

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (1156)	38.4	0.0	0.0	76.8	0.0	76.8	0.0
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other: RSS (1156)	38.4	0.0	38.4	38.4	38.4	38.4	38.4	38.4
TOTAL	38.4	0.0	38.4	38.4	38.4	38.4	38.4	38.4

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time								
Part-time	1	0	1	1	1	1	1	1
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This legislation amends AS 08.45 to establish the Alaska Naturopathic Medical Board and expands the scope of practice of naturopaths.

The program is required to cover its costs with licensing fees under AS 08.01.065, and revenue generated from program fees must cover its full operating costs.

A detailed analysis of costs is attached.

Prepared by: Jennifer Strickler, Division Operations Manager
 Division: Corporations, Business & Professional Licensing
 Approved by: Emil Notti, Commissioner
Commerce, Community and Economic Development

Phone (907) 465-2144
 Date/Time 03/22/2010 1:00PM
 Date 3/31/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. CSHB 282 (L&C)

ANALYSIS CONTINUATION

Total PERSONAL SERVICES: \$28.3

- One (1) part-time Occupational Licensing Examiner position, Range 13, to staff the Board. A position is needed to support Board activities by keeping the official records and providing administrative support to the Board and the licensing program. The current licensing program is supported by a position that is assigned ten of the non-board licensing programs. Adding requirements to that position in support of a Board is not realistic.

Total TRAVEL: \$7.6

- The legislation establishes the Alaska Naturopathic Medical Board consisting of 7 members. In accordance with Section 4 of the bill, AS 08.45.003(b) requires the Board to meet at least twice a year. The estimated travel costs for 7 members and 1 staff will cover two meetings, assuming one is held in Anchorage and one is held in Juneau.

Total CONTRACTUAL: \$2.0

- Contractual costs include public notices of meetings, regulations, legal review of regulations, communications, and printing expenses.

Total SUPPLIES: \$0.5

- Supplies consists of standard operating desk top supplies (paper, etc.)

REVENUE: Revenue will be generated from license fees. A majority of the fees will be collected biennially during the biennial licensing renewal period. The bill is set to take effect immediately upon passage and current naturopath licenses are due to expire on March 31, 2010. Therefore, fees for existing licensees will be adjusted prior to the March 31, 2012 license renewal period.

Program costs average \$5.9 annually; \$11.8 biennially (representing the two-year licensing cycle). CSHB 282 (L&C) is expected to increase costs by \$38.4 annually, for a total annual program cost of \$44.3 (\$5.9 + \$38.4); \$88.6 over the biennial licensing cycle. Since fees are adjusted prior to the biennial license renewal, fees will need to cover the biennial licensing costs every other year.

At the end of FY09, there were 40 current licensees. For projection purposes, the 40 licensees can expect to pay license fees totaling \$2,215 for the biennium (\$88.6 divided by 40 = \$2,215), in comparison to the present biennial fee of \$470; an increase of \$1,745. Since the next renewal period will not occur until March 31, 2012, the fee analysis will be based on actual expenditure and revenue information.

Alaska State House of Representatives

Interim:

Phone: (907)
Fax: (907)



Session:

State Capitol, Room 409
Juneau, AK 99801-1182
Phone: (907) 465-3744
Fax: (907) 465-2273

Sponsor Statement from:

Representative Cathy Munoz R - District 4

RELEASED: February 3, 2010

CONTACT: Kendra Kloster, 465-4712

HB282 - Naturopaths

"An Act relating to naturopaths and to the practice of naturopathy; establishing an Alaska Naturopathic Medical Board; authorizing medical assistance program coverage of naturopathic services; amending the definition of 'practice of medicine'; and providing for an effective date."

Status: PREFILE RELEASED >> (H) L&C : 2010-01-19

House Bill 282 creates a Naturopathic Medical Board for the purpose of expanding allowed practices and procedures of Naturopathic Doctors (NDs) and regulates the practice of naturopathic medicine. The board will consist of three naturopaths, one licensed pharmacist, and one public member. The board will work with the Division of Occupational Licensing to issue licenses, and will have authority to investigate and discipline as required. In addition, the state will authorize prescription endorsement which will be offered for the first time for NDs who have practiced for five years; participated in 60 hours of pharmacology education from an approved program; and met all the requirements relating to administration and prescription of drugs, vaccinations, hormones, and medical devices. The prescription endorsement must be renewed every two years. The bill mandates continuing medical education of 35 hours bi-annually, 15 of which must be in pharmacy education.

Prescribing authority will give flexibility to NDs to provide necessary medical treatment to patients. Prescription rights, which are already permitted for advanced nurse practitioners, will allow access to a range of commonly prescribed medicines that can be used in correlation with naturopathic treatment to improve patient care.

HB 282 will align the definition of a naturopathic physician with the U.S. Department of Labor which released a new definition of naturopathic physician to include job titles of "Naturopathic Doctor, Physician, and Doctor of Naturopathic Medicine." This is an important step in recognizing NDs as qualified doctors and primary care physicians.

Naturopathic doctors are highly trained medical professionals. NDs attend a four-year post-graduate professional naturopathic medical program and are educated in the same basic sciences as conventional medical students. Studies concentrate on holistic and traditional approaches to therapy with a strong emphasis on disease prevention and optimization of wellness. Naturopathic doctors take similar rigorous professional board exams for licensure and continue educational training each year.

As Alaska continues to face shortages in the healthcare professions, HB 282 provides an avenue to help fill the gap of primary care physicians. This bill will reasonably expand the services of naturopaths and follow the responsibilities set forth by the board while providing the important services for keeping Alaskans healthy.

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House Majority Press: <http://housemajority.org/spon.php?id=26HB282>

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: CSHB 282(L&C)
 (H) Publish Date: 3/22/10

Identifier (file name): HB282-CED-CBPL-2-26-10 Dept. Affected: DCCED
 Title NATUROPATHS RDU Corp, Bus, & Prof Licensing (117)
 Component Corp, Bus, & Prof Licensing
 Sponsor Representative Munoz
 Requester House Labor and Commerce Component Number 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services	28.3		28.3	28.3	28.3	28.3	28.3	28.3
Travel	5.6		5.6	5.6	5.6	5.6	5.6	5.6
Contractual	2.0		2.0	2.0	2.0	2.0	2.0	2.0
Supplies	0.5		0.5	0.5	0.5	0.5	0.5	0.5
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	36.4		36.4	36.4	36.4	36.4	36.4	36.4

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (1156)	36.4		0.0	72.8	0.0	72.8	0.0
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other: RSS (1156)	36.4		36.4	36.4	36.4	36.4	36.4
TOTAL	36.4		36.4	36.4	36.4	36.4	36.4

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time	1		1	1	1	1	1
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This legislation amends AS 08.45 to establish the Alaska Naturopathic Medical Board and expands the scope of practice of naturopaths.

The program is required to cover its costs with licensing fees under AS 08.01.065, and revenue generated from program fees must cover its full operating costs.

A detailed analysis of costs is attached.

Prepared by: Jennifer Strickler, Division Operations Manager
 Division Corporations, Business & Professional Licensing
 Approved by: Emil Notti, Commissioner
Commerce, Community and Economic Development

Phone (907) 465-2144
 Date/Time 02/25/2010 10:45AM
 Date 2/26/2010

FISCAL NOTE #1

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. CSHB 282(L&C)

ANALYSIS CONTINUATION

Total PERSONAL SERVICES: \$28.3

- One (1) part-time Occupational Licensing Examiner position, Range 13, to staff the Board. A position is needed to support Board activities by keeping the official records and providing administrative support to the Board and the licensing program. The current licensing program is supported by a position that is assigned ten of the non-board licensing programs. Adding requirements to that position in support of a Board is not realistic.

Total TRAVEL: \$5.6

- The legislation establishes the Alaska Naturopathic Medical Board consisting of 5 members. In accordance with Section 3 of the bill, AS 08.45.003(b) requires the Board to meet at least twice a year. The estimated travel costs for 5 members and 1 staff will cover two meetings, assuming one is held in Anchorage and one is held in Juneau.

Total CONTRACTUAL: \$2.0

- Contractual costs include public notices of meetings, regulations, legal review of regulations, communications, and printing expenses.

Total SUPPLIES: \$0.5

- Supplies consists of standard operating desk top supplies (paper, etc.)

REVENUE: Revenue will be generated from license and endorsement fees. A majority of the fees will be collected biennially during the biennial licensing renewal period. The bill is set to take effect immediately upon passage and current naturopath licenses are due to expire on March 31, 2010. Therefore, fees for existing licensees will be adjusted prior to the March 31, 2012 license renewal period.

Program costs average \$5.9 annually; \$11.8 biennially (representing the two-year licensing cycle). HB 282 is expected to increase costs by \$36.4 annually, for a total annual program cost of \$42.3 (\$5.9 + \$36.4); \$84.6 over the biennial licensing cycle. Since fees are adjusted prior to the biennial license renewal, fees will need to cover the biennial licensing costs every other year.

At the end of FY09, there were 40 current licensees. For projection purposes, the 40 licensees can expect to pay license fees totaling \$2,115 for the biennium (\$84.6 divided by 40 = \$2,115), in comparison to the present biennial fee of \$470; an increase of \$1,645. Since the next renewal period will not occur until March 31, 2012, the fee analysis will be based on actual expenditure and revenue information.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 2
 Bill Version: CSHB 282(L&C)
 (H) Publish Date: 3/22/10

Identifier (file name): HB 282-DHSS-MAA-2-25-10 Dept. Affected: Health & Social Services
 Title: Naturopaths RDU: Health Care Services
 Component: Medical Assistance Administration
 Sponsor: Munoz
 Requester: House L&C Component Number: 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual	150.0							
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	150.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1002 Federal Receipts							
1003 GF Match							
1004 GF	150.0						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	150.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This legislation would require the Medicaid program to cover naturopathy services. The Department does not anticipate increased expenditures of Medicaid services because naturopathy services would largely replace other covered services, and any increase in total covered services would be offset by payment of naturopaths at a lower rate than physicians. However, there would be a one-time cost to make system changes to the MMIS, the Department's Medicaid claims processing system. The Department is in the process of replacing its existing MMIS with a new system. Because this change would be made to the old system prior to replacement, it would not be eligible for matching federal reimbursement.

Prepared by: William J. Streur, Deputy Commissioner Phone 279-7827
 Division: Health Care Services Date/Time 1/28/10 12:22 PM

Approved by: Alison Elgee, Assistant Commissioner Date 2/25/2010
DHSS Finance & Management Services

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 22, 2010

SUBJECT: Sectional Summary of CSHB 282()
(Work Order No. 26-LS1208\C)

TO: Representative Cathy Muñoz
Attn: Kendra Kloster

FROM: Alpheus Bullard *AB*
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds the Alaska Naturopathic Board to the list of boards and professions to which AS 08.01 applies.

Section 2. Adds the Alaska Naturopathic Board (board) to a list of boards that may request that the Department of Commerce, Community, and Economic Development (department) provide assistance and treatment to the boards' licensees who abuse alcohol, drugs, or other substances.

Section 3. Provides that the board will terminate June 30, 2015.

Section 4. Adds new sections to AS 08.45 (Naturopaths).

Sec. 08.45.003. Provides for the establishment and organization of the Alaska Naturopathic Board.

Sec. 08.45.005. Provides the duties and powers of the board.

Section 5. Amends AS 08.45.030 to provide that the board shall request the department to issue a license to practice naturopathy to an applicant who has provided satisfactory proof of the applicant's educational qualifications and paid the applicable fees.

Section 6. Amends AS 08.45.035(a) to provide that the board shall request that the department, and that the department may, issue a temporary license to practice naturopathy to an applicant who has provided satisfactory proof to the board of the applicant's qualifications and paid the applicable fees.

Section 7. Adds a new section to AS 08.45 defining the scope of practice of naturopaths.

Section 8. Amends AS 08.45.050 (restrictions on the practice of naturopathy) to (1) allow a naturopath authorized under AS 08.45.056(6) to be able to prescribe and recommend certain substances, engage in minor surgery authorized under AS 08.45.045, and use the word "physician" in the person's title and (2) prohibit a naturopath from prescribing or recommending a vaccine or hormone (except as may be authorized under AS 08.45.045(6)), using general or spinal anesthetics, or administering ionizing radioactive substances for therapeutic purposes.

Section 9. Establishes continuing education requirements for naturopaths.

Section 10. Amends AS 08.45.100 to provide that both the department and the board shall adopt regulations to implement AS 08.45.

Section 11. Adds a new section that provides what fees may be charged by the department under AS 08.45.

Section 12. Adds a definition for "board" to AS 08.45.

Section 13. Amends the statutory definition of the "'practice of medicine' or 'practice of osteopathy'" in AS 08.64 to permit a practitioner of naturopathy to use or publically display a title in connection with that person's name that includes the words "doctor of medicine" or "physician," if the designation additionally contains the word "naturopathy" or "naturopathic" in the title.

Section 14. Adds naturopaths to the list of licensees whose practices are not limited by the statutes applicable to pharmacists in AS 08.80, as long as the naturopath is acting within the scope of the license or endorsement under AS 08.45.

Section 15. Adds naturopathic services to the list of services that are eligible for Medicaid reimbursement under state law.

Section 16. Provides a definition of naturopathic services for AS 47.07 (Medical Assistance for Needy Persons).

Section 17. Adds a provision to uncodified law allowing the department to adopt regulations necessary to implement the Act.

Section 18. Adds a provision to uncodified law that provides transitional provisions governing the terms of the first members of the Alaska Naturopathic Board.

Section 19. Adds a provision to uncodified law that provides for treatment of naturopathic licensees licensed before the effective date of the Act.

Section 20. Gives an immediate effective date to sec. 17 so that the regulations process can start before the rest of the bill takes effect (90 days after becoming law).

Section 21. Provides that the Act, except as provided in sec. 20, will take effect July 1, 2010.

TLAB:ljw
10-200.ljw

The Future of Naturopathic Medicine: A Message from Karen E. Howard, Executive Director of the American Association of Naturopathic Physicians

Throughout 2010, the American Association of Naturopathic Physicians (AANP) celebrates its 25th Anniversary. Looking forward in this New Year, one must wonder what future the US Congress is divining as it struggles to reform our current healthcare system. It is likely that the Senate and House of Representatives will successfully complete a conference on healthcare reform legislation and send President Obama a bill to sign into law. Will this bill be good for patients, or has compromise forced decisions that will do little to effect change?

If you have a glass half-full mentality, you understand that the virtue of patience can yield amazing opportunities. This can be the first step on the road to reform. Perhaps forcing millions more into a failing system will accomplish two things. First, people will not be at risk for losing life savings, they will no longer avoid going to the doctor for life-threatening conditions, nor will they be forced to rely on their local emergency room for healthcare. Second, in the matter of a few short years, the experts who continue to assert that our system is unsustainable might be proven correct. It is likely we will witness a collapse that will force legislators into implementing true change. Regardless, the public is demanding ownership of their health and a return to wellness. A final vote in the House and Senate is not likely to quell their voice, nor will it fulfill the objectives of the American Association of Naturopathic Physicians (AANP).

The AANP's vision is to transform the healthcare system from disease management to health promotion by incorporating the principles of naturopathic medicine. The mission of the AANP is to serve our members by advancing the profession of naturopathic medicine and preserving its integrity. The question of how the AANP shows up in the world, with our long-term commitment to creating sustainable healthcare, lies at the heart of each naturopathic physician's practice and the work of the association itself.

While the number of licensed naturopathic physicians continues to grow, the AANP is working to further empower our public policy efforts by developing strong collaborative relationships with like-minded organizations representing practitioners, patients, products, and environmental interests. Our external partnerships are diverse in nature and universal in intent.

The power of the AANP's relationships enables pursuit of a broader agenda, one more fitting to the naturopathic philosophy. Working with likeminded groups adds voice to a larger, less parochial agenda. By teaming with this larger audience, we seek to establish a voice in the larger reform effort and the reengineering of healthcare reform proposals to embody a wellness model. In partnership with the associations in the natural products realm, the AANP actively advocates for passage of food stamp legislation and other public health initiatives aimed at significantly impacting health status for at-risk populations. As a leader in the Coalition for Patient Rights, whose membership of 35 organizations represents more than 3.3 million providers, the AANP is advancing a unified message to expand consumer choice and access to qualified providers.

Our purpose for engaging in partnership is to support the rights of consumers to access highly qualified practitioners of their choice. The AANP honors the credentials of each of our partners, and we are strong advocates for practitioners' rights to practice to the full extent of their abilities, education, qualifications, and legal authority. Our commitment to establishing standards for naturopathic medicine is evidenced by our work to gain licensure in all 50 states and our efforts to establish recognition at the federal level. This fall, the US Department of Labor released a new definition of "naturopathic physician" in its Occupational Information Network System (the replacement for the old Department of Labor Dictionary of Occupational Titles). The 2009 Department of Labor custom report for naturopathic physicians now defines members of our profession as people who:

"Diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals. May use physiological, psychological or mechanical methods. May also use natural medicines, prescription or legend drugs, foods, herbs, or other natural remedies.

Sample job titles include Naturopathic Physician, Naturopathic Doctor, Physician, and Doctor of Naturopathic Medicine." (Occupational Information Network, 2009)

This is a monumental success for the naturopathic profession. The federal government now officially recognizes naturopathic medicine as one of 965 recognized occupations and defines the key features of this "occupation" by using a standardized, measurable set of variables. The outdated Department of Labor definition of "Naturopathic Doctor" is now null and void. This independent data will be updated on a regular basis for employers, prospective students, and educators. The new definition will stand as a cornerstone for our work to advance the profession in the following ways.

- Advocating for inclusion in all federal loan repayment programs, on par with graduates of conventional medical programs, to support naturopathic medical graduates as they pursue opportunities to support underserved populations. Legislation enumerating inclusion in the Indian Health Service loan repayment program is now moving forward in Congress.
- Advancement of state licensing efforts. Efforts in Pennsylvania, New York, Massachusetts, and a host of other states will continue in 2010 and beyond as we aggressively seek regulation in all 50 states.
- Expansion of Scope of Practice. In the past 2 years several licensed jurisdictions have been successful in expanding the naturopathic scope of practice, and these efforts will continue.
- Inclusion in employer-funded, state-sponsored, and federal healthcare programs. The expansion of Medicaid, creation of

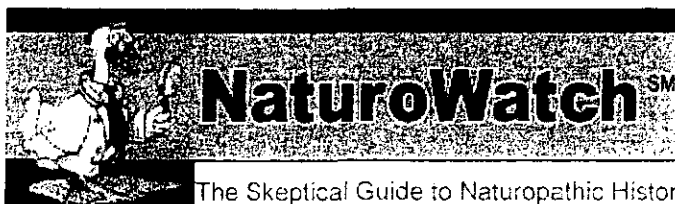
state-based insurance programs with the pending insurance reform legislation, and the expansion of wellness programs by self-insured employers will create enormous demand for the skills of naturopathic physicians who are perfectly qualified to provide primary care and address the needs of people suffering from chronic disease.

Each of the individual professions in the field of integrative medicine has similarly worthy and essential legislative and regulatory agendas. And we now have a unique opportunity to pursue a parallel intention that reflects our interconnectedness and vision. If you see the glass as half empty on the eve of passage of "insurance reform" legislation, you might fear we've lost our chance for real reform where everyone has uniform, cost-effective coverage for services that will improve their health. While very far from perfect, this legislation sets the stage for creating the new paradigm we seek—over the long term. And while we have virtually no control over the result of this effort, one thing is absolutely certain: Each of us as individuals, our professional associations, and indeed the collective commitment of our united collaborations have an obligation to be the voice of sustainable healthcare and personal empowerment—for the sake of generations to come.

Karen E. Howard serves as the Executive Director for the American Association of Naturopathic Physicians (AANP). Howard is responsible for overseeing the AANP, the nation's only national professional organization representing licensed naturopathic physicians, and ensuring that it fulfills its mission. The AANP is committed to changing the current healthcare system from one that treats disease to one that promotes health.



In addition, the organization is actively engaged in state and national discussions with policy makers and industry experts to affect change. Howard has spent almost 25 years working with Congress, state legislatures and healthcare provider organizations to develop innovative healthcare policy and programs for public and private organizations. She has also served in a variety of executive positions and worked as a national lobbyist on Capitol Hill. Her policy experience is in mental health, managed care, integrative medicine, and natural medicine.



The Skeptical Guide to Naturopathic History, Theories, and Practices

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Overview of Naturopathic Regulation

Colorado Department of Regulatory Agencies
October 14, 2005

The legal status of naturopathy varies from state to state. In some states, the practice of naturopathy, though not regulated, is protected through court rulings or attorney general opinions. In most states, naturopathic physician status is unprotected or unclear. Two states, Florida and Nevada, have repealed regulation of this profession. Nevada ceased licensing naturopathic physicians in 1987 (in Nevada naturopathic physicians were required to be supervised by medical doctors). Although naturopathic licensing in Florida was discontinued in 1959, there are still laws and a board regulating those naturopaths still practicing. Florida allows naturopathic physicians licensed prior to program termination dates to continue to practice. In Tennessee and in South Carolina, the practice of naturopathy is illegal. Tennessee law, for example, provides that the practice of naturopathy is a Class B misdemeanor, but renders this prohibition inapplicable to "persons who comply with the regulatory laws of the state with respect to the practice of the various healing arts." Without a similar textual qualification, however, a South Carolina statute prohibits the practice of naturopathy and subjects offenders to a fine not to exceed \$500 or imprisonment for a period not exceeding one year, or both.

The multiplicity of therapies and techniques that typically comprise the statutory definition of naturopathy may often fall within the scope of practice for other professions. The Montana Naturopathic Practice Act expressly acknowledges this fact by recognizing that many of the therapies used by naturopathic physicians, such as the use of nutritional supplements, herbs, foods, homeopathic preparations, and such physical forces as heat, cold, water, touch, and light, are not the exclusive privilege of naturopathic physicians, and their use, practice, prescription, or administration by persons not licensed to practice naturopathic medicine is not prohibited by this practice act.

Currently, 15 states and the District of Columbia license naturopathic physicians: Alaska, Arizona, California, Connecticut, Florida, Hawaii, Idaho, Kansas, Maine, Montana, New Hampshire, Oregon, Utah, Vermont, and Washington. In several states, licensed naturopathic physicians must also qualify for a certificate to practice natural childbirth, acupuncture, or to dispense a natural substance or device. The following highlights the regulatory programs found in the 15 states.

Alaska

Alaska's law places several restrictions on the practice of naturopathy. A person who practices naturopathy may not prescribe a prescription drug, perform surgery, or use the word "physician" as a title. There are currently 36 licensed naturopathic doctors in Alaska.

Arizona

Arizona's Naturopathic Physicians Board of Medical Examiners (Arizona Board) was established in 1935. Arizona remains the state with the third highest number of licensed naturopathic physicians (400). The Arizona Board has the statutory authority to adopt rules for recognizing naturopathic specialties. The Arizona Board has approved training programs in four specialty areas and has issued certificates to at least 16 naturopaths in the specialty of family medicine. Additionally, the Arizona Board has assembled a formulary of more than 460 items that naturopathic physicians may dispense including both prescription drugs and some controlled substances. In 2000, the Arizona Board underwent a performance audit. The review concluded that terminating the Arizona Board would not significantly harm the public's health and safety since the practice of medicine would continue to be regulated by the Allopathic Board of Medical Examiners. Naturopaths could continue to perform many traditional activities, but would no longer be allowed to act as primary medical care providers. However, the review further stated that terminating the Arizona Board could harm the public's welfare by potentially limiting access to alternative medical care. Subsequently, there was no action taken by the Arizona legislature to repeal the Arizona Board.

California

California's Bureau of Naturopathic Medicine (Bureau) within the Department of Consumer Affairs was established to administer the Naturopathic Doctor's Act and was authorized to collect fees and receive license applications beginning January 1, 2004. This act authorizes the creation of an advisory committee comprised of three licensed naturopathic doctors, three licensed physicians, and three public members. The committee's first meeting was convened on December 13, 2004. Additionally, a naturopathic formulary advisory committee was formed and a naturopathic childbirth attendance advisory committee was created to issue recommendations concerning the practice of naturopathic childbirth attendance. The scope of practice for licensed naturopathic doctors includes diagnosis and treatment of patients, including the authority to order lab tests and prescribe most drugs subject to supervision of a medical or osteopathic physician. Licensed naturopathic doctors may perform minor procedures, such as treating lacerations and removing moles and growths. The program began accepting license applications in January 2005. Currently there are 129 licensed naturopathic doctors in California.

Connecticut

Connecticut's law, which was enacted in 1920, does not allow licensed naturopathic physicians to perform minor surgery, prescribe drugs, or practice obstetrics and gynecology. The statute requires that naturopathic physicians maintain professional liability insurance. There are currently 196 licensed naturopaths in Connecticut.

District of Columbia

In May 2004, final approval was given to the Naturopathic Medicine Licensing Amendment Act of 2004 to license naturopathic physicians as primary care providers. The act recognized naturopathic physicians who have completed four-years of naturopathic medical college training and successfully passed the NPLEX. Prior to the passage of this act, the District of Columbia had a registration program for naturopaths. A person registered to practice naturopathy was entitled to use the title "Doctor of Naturopathy." The only requirements for registration were that applicants must be at least 18 years of age and not have been convicted

of a crime of moral turpitude that bears directly on the applicant's fitness to be registered. The practice specifically excluded the use of x-rays, performing any surgical procedure, injecting any substance into a person by needle, or performing any invasive procedure. As of September 2005, the District of Columbia had not promulgated any rules or issued any licenses.

Florida

Florida's licensing authority for naturopathic physicians was abolished in 1959 and licensees who were licensed at that time were allowed to continue practicing naturopathic medicine. Draft legislation proposed by the Florida Naturopathic Physician Association was introduced in 2004 to reestablish regulation of naturopathic medicine through licensure and to create the Board of Naturopathic Medicine within the Department of Health. A 2004 Sunrise Report on Proposed Licensure of Naturopathic Physicians, by the Florida House of Representatives, Committee on Health Care, concluded that while there is evidence for support of licensure based on the existence of accredited training programs and licensure examinations, there is no documented evidence of substantial risk from not licensing naturopathic physicians. Moreover, there is potential risk from licensing naturopathic physicians and allowing them to provide a broad range of primary care services.

Hawaii

Hawaii has regulated naturopathic physicians since 1925. There are currently 81 licensed naturopaths. Originally, the Board of Health was responsible for conducting examinations and issuing licenses. In 1969, the regulation was transferred to the Department of Regulatory Agencies, now the Department of Commerce and Consumer Affairs. The regulation of naturopathy was reviewed in 1978 and 1985, with continued regulation recommended in both instances.

Idaho

Idaho became the 15th state in 2005 to create a licensure program for naturopathic physicians. The legislation is a full scope and title protection act. The law requires the creation of a formulary council to determine pharmaceutical privileges for naturopathic physicians.

Kansas

Kansas passed legislation during the 2002 legislative session to regulate the practice of naturopathic medicine. The bill, signed into law in May 2003, provides registration for naturopathic doctors, rather than licensing, yet requires educational and testing requirements. Naturopathic medicine is defined to include such procedures as venipuncture, naturopathic acupuncture, and minor office procedures. Naturopathic doctors may not perform surgery, practice obstetrics, administer ionizing radiation or prescribe, dispense or administer any controlled substances or any prescription-only drugs except those listed on the naturopathic formulary adopted by the Kansas board.

Maine

Maine's Board of Complimentary Health Care Providers regulates 19 naturopathic doctors. Naturopathic doctors have the exclusive right to the use of the terms "naturopathic doctors," "naturopathic," "naturopath," "doctor of naturopathic medicine," "Doctor of Naturopathy,"

"naturopathic medicine," "naturopathic health care," "naturopathy," and "N.D." Use of the term "physician" by a licensee is prohibited. Naturopathic Doctors have a limited scope of prescriptive authority.

Montana

Montana's Naturopathic Health Care Practice Act was enacted in 1991 to regulate lay midwives and naturopathic physicians. Naturopathic physicians are authorized to perform minor surgery, attend a natural childbirth if in possession of a certificate of specialty practice, and prescribe certain drugs as established by the natural substance formulary list. When the program first began there were only five licensed naturopathic physicians in the state, however, as of August 2005, there were 66.

New Hampshire

New Hampshire's Naturopathic Health Care Practice Act was enacted in 1994. Specialty certificates in naturopathic childbirth and acupuncture are offered. Doctors of naturopathic medicine with specialty certification in naturopathic childbirth are authorized to use oxytocin and pitocin. There are currently 36 licensed naturopathic physicians in New Hampshire.

Oregon

Oregon first began licensing naturopathic physicians in 1927, although they were able to practice before then under an exemption in the Osteopathic Practice Act. The total number of licensed naturopathic physicians in Oregon equals 636, ranking second for licensees in a state. Oregon also has the most encompassing law as practitioners are allowed to prescribe drugs, perform minor surgery, and practice natural childbirth with a certificate of special competency.

Utah

Utah's Naturopathic Physicians Licensing Board was created in 1996. The board currently issues five different categories of licenses: naturopath, naturopath including surgery/obstetrics, naturopathic physician, temporary naturopathic physician, and naturopathic controlled substance. In order to perform naturopathic childbirth, a licensee must satisfy the standards of the American College of Naturopathic Obstetricians or its successor.

Vermont

Vermont's licensed naturopathic physicians may order, prescribe, dispense, and administer certain medications of mineral, animal, or botanic origin and must adhere to the Naturopathic Physician Formulary Rules promulgated by the Vermont Department of Health. Licensees may not practice naturopathic childbirth unless they have obtained a special endorsement that requires specific education; training; passage of an examination; and actual childbirth assistance, participation, and observation.

Washington

Washington has regulated naturopathic physicians since 1919, as part of its law created to regulate professions engaged in "drugless healing." The law was substantially amended in 1988 to reflect the current practice of naturopathic physicians. The total number of licensed

naturopathic physicians in Washington is 650, ranking first for licensees in a state.

This article was extracted from the [Sunrise Review of Naturopathic Physicians](#), published by the Colorado Department of Regulatory Agencies' Office of Policy, Research and Regulatory Reform in October 2005.

This article was posted on November 20, 2005.

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Links to Recommended Companies

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- [Believe](#): A hilarious movie about multilevel marketing.
- [ConsumerLab.com](#): Evaluates the quality of dietary supplement and herbal products.
- [Healthgrades](#): Check your doctors' training, board certifications, and disciplinary actions.
- [Outdoor lighting by Arcadian](#): Best prices and services on outdoor lighting fixtures.
- [OnlyMyEmail](#): Award-winning anti-spam services.
- [Herbal Medicine, 3rd edition](#): Excellent reference book, discount-priced.
- [10 Types](#): Website design, development, and hosting with superb technical support.

ref HB 282

Emily A. Kane, ND LAc

Naturopathic Doctor

Alaska License No 22

Licensed Acupuncturist

Alaska License No 18

March 3, 2010

The Honorable Kurt Olson
Chair, House Labor and Commerce
State Capitol Building, Room 24
Juneau AK 99801

Dear Representative Olson,

Thank you for your consideration in hearing HB 282, an act relating to naturopaths, with intent to promote improved access for all Alaskans to safe, effective, health promoting therapies. Naturopathic Medicine is continuously evolving, deeply wedded to evidence based practices, and built on a foundation of thoroughly trained health scientists.

I enclose for your review a document comparing MD/DO education and that of naturopathic doctors in the 21st century. Also attached is a book list for students enrolled in US DOE-accredited institutions of higher learning which offer the doctorate degree in Naturopathic Medicine.

As you may know, in 2006 the American Medical Association (AMA) undertook a massive, well funded, effort to restrict the scope of practice of 10 "ancillary" healthcare professionals, including PAs and ANPs. The SOPP document is especially vitriolic, and inaccurate, in discussing Naturopathic Medicine. I would like the opportunity to offer referenced corrections to many of the gross mischaracterizations of Naturopathic Medicine in the SOPP document which you recently received from Dr. Brion Beerle.

I mention Physician Assistants and Advanced Nurse Practitioners because both of these mid-level medical professionals have enjoyed expanded scope in Alaska, to no detriment to the wellbeing of Alaskans. Please note, moreover, that PAs capture their degree with 2 years of post-college training, and that ANPs also hold master's level degrees. This is in contrast to Naturopathic Doctors, who have doctorate level training (at least 4 years, plus a year of preceptorship - our word for residency) after achieving a bachelor's degree from an accredited 4-year undergraduate college. My intention is not to undermine the usefulness or training of my mid-level professional colleagues. It is to point out that Naturopathic Doctors are highly trained, and there already exist strict standards for our practice in Alaska. Further, there exists precedent for Naturopathic Physicians being registered with the federal Drug Enforcement Agency, and also for NDs to serve Medicaid patients.

418 Harris Street, Suite 329 Juneau, AK 99801

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In Alaska, however, we are underutilized. Properly trained and licensed NDs (Alaskan law does not permit any of the ANMA-variety "traditional" naturopaths to practice here) are indeed part of the answer to our failing healthcare delivery system. We have deep and broad training in pharmacology not so much because we turn to drugs primarily for therapy – we have very effective and generally much safer, less expensive treatment modalities – but because we see patients taking multiple prescriptive medications daily. Many of these patients are unwell, and we are uniquely positioned to help them transition to less dependence on pharmaceuticals which may be undermining, not always supporting, their health. We employ the most effective and least harmful therapy to our patients at every encounter. Sometimes that means choosing legend drugs, and sometimes it means modifying drug use. Naturopathic physicians specialize not only in comprehensive and holistic approaches to medicine, but in individualized protocols for each and every patient. There is no "one size fits all" fix; each patient is considered in their entirety, with all their personal physical and psycho-social history.

Most of the licensed NDs in Alaska have been serving the constituents for at least a decade. I personally have been in practice in Juneau for over 15 years, with over 12 years of professional affiliation with our regional hospital. Integrated models of healthcare are burgeoning all over the country. The consumers are demanding it and in response many MD/DOs are actually practicing elements of naturopathic medicine with much less training than we receive! Just to be clear – at a national policy level, naturopathic physicians welcome integrative care. We share patients with MDs, DOs, ANPs, and chiropractors, acupuncturists, massage therapists, etc. One of the most important aspects of my job is to "case manage" or help integrate the care of my patients with their many providers.

Thank you for your attention. I look forward to further explaining my training and commitment to providing safe, effective, patient-centered, health-promoting protocols for all Alaskans.

Best wishes,



Dr. Emily A. Kane
Naturopathic Doctor
Licensed Acupuncturist

Attachments:

- 1) comparison of medical education MD/DO and ND
- 2) representative textbook list for the contemporary ND curriculum
- 3) US Department of Labor definition of Naturopathic Physician 2009

cc Rep Cathy Mmcoz



Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix E: Comparison of Naturopathic and Major Medical Schools

	National	Bastyr	Southwest	John Hopkins	Yale	Stanford
Basic and Clinical Sciences:						
Anatomy, Cell Biology, Physiology, Pathology, Neuroscience, Clinical/Physical Diagnosis, Histology, Genetics, Biochemistry, Pharmacology, Lab Diagnosis, Pharmacognosy, Public Health, History, Philosophy, Ethics, Research and other coursework.	1548	1639	1419	1771	1420	1383
Clerkships (1) and Allopathic Therapeutics:						
Lecture and clinical instruction in Dermatology, Family Medicine, Psychiatry, Internal Medicine, Radiology, Pediatrics, Obstetrics, Gynecology, Neurology, Surgery (2), Ophthalmology and Clinical Electives.	2244	1925	1920	3391	2891	3897
Naturopathic Medicine:						
Advanced Naturopathic Therapeutics	-	44	20	-	-	-
Ayurvedic Medicine	-	22	20	-	-	-
Botanical Medicine	96	110	120	-	-	-
Therapeutic Nutrition (3)	144	132	130	-	-	-
Counseling (4)	144	143	100	-	-	-
Homeopathy	144	88	140	-	-	-
Hydrotherapy	48	39	40	-	-	-
Naturopathic Case Analysis/Management (5)	-	66	120	-	-	-
Naturopathic Manipulative Therapy	156	176	180	-	-	-
Naturopathic Philosophy	72	55	60	-	-	-
Oriental Medicine	72	33	200	-	-	-
Subtotals:	876	908	1130	0	0	0
Total Reported Hours:	4668	4472	4469	5162	(+Thesis) 4311	5280

- 1) Clerkships are estimated to be 40 hours of mixed lecture and clinical training.
- 2) Naturopathic physicians study minor surgery only.
- 3) No dedicated coursework in therapeutic nutrition appears in the college catalogs of Hopkins, Yale or Stanford; although they indicate that the subject is addressed in other courses.
- 4) Totals for Hopkins, Yale and Stanford included in psychiatry coursework.
- 5) Hours which also could be allocated to this category may be included elsewhere for some institutions because of terminology differences in the course.

Sources: 1996-97 *Curriculum Directory of the American Association of American Medical Colleges*
 1995-96 Catalog of National College of Naturopathic Medicine
 1996-98 Catalog of Bastyr University
 1996-97 Catalog of Southwestern College of Naturopathic Medicine and Health Sciences

- Data Collection Program
- O*NET Academy
- U.S. Department of Labor
- Related Sites

Updated 2009

Summary Report for: 29-1199.04 - Naturopathic Physicians

Diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals. May use physiological, psychological or mechanical methods. May also use natural medicines, prescription or legend drugs, foods, herbs, or other natural remedies.

Sample of reported job titles: Naturopathic Physician, Naturopathic Doctor, Physician, Doctor of Naturopathic Medicine

View report: **Summary** Details Custom

[Tasks](#) | [Tools & Technology](#) | [Knowledge](#) | [Abilities](#) | [Work Activities](#) | [Work Context](#) | [Job Zone](#) | [Interests](#) | [Work Styles](#) | [Work Values](#) | [Wages & Employment](#)

Tasks

- Interview patients to document symptoms and health histories.
- Advise patients about therapeutic exercise and nutritional medicine regimens.
- Administer, dispense, or prescribe natural medicines such as food or botanical extracts, herbs, dietary supplements, vitamins, nutraceuticals, and amino acids.
- Document patients' histories, including identifying data, chief complaints, illnesses, previous medical or family histories, or psychosocial characteristics.
- Educate patients about health care management.
- Diagnose health conditions based on patients' symptoms and health histories, laboratory and diagnostic radiology test results, or other physiological measurements, such as electrocardiograms and electroencephalographs.
- Conduct physical examinations and physiological function tests for diagnostic purposes.

- Maintain professional development through activities such as post-graduate education, continuing education, preceptorships, and residency programs.
- Order diagnostic imaging procedures such as radiographs (x-rays), ultrasounds, mammograms, and bone densitometry tests, or refer patients to other health professionals for these procedures.
- Administer treatments or therapies, such as homeopathy, hydrotherapy, Oriental or Ayurvedic medicine, electrotherapy and diathermy, using physical agents including air, heat, cold, water, sound, or ultraviolet light to catalyze the body to heal itself.

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Tools & Technology

Tools used in this occupation:

Electrotherapy combination units — Electrical stimulation equipment; Interferential electrical stimulation machines

Galvanic or faradic stimulators — High-voltage galvanic stimulation machines; Low-voltage galvanic stimulation machines

Microcentrifuges

Ophthalmoscopes or otoscopes or scope sets — Ophthalmoscopes; Otoscopes

Therapeutic heating or cooling pads or compresses or packs — Therapeutic cold packs; Therapeutic hot packs

Technology used in this occupation:

Accounting software — EZ-Zone Software Alternative Medical Billing

Information retrieval or search software — Online medical databases

Medical software — Enova eNatro; NaturaeMed OfficePro; Trigram Software AcuBase Pro; ZYTO LSA Pro

Point of sale POS software

Spreadsheet software — Microsoft Excel

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Knowledge

Medicine and Dentistry — Knowledge of the information and techniques needed to diagnose and treat human injuries, diseases, and deformities. This includes symptoms, treatment alternatives, drug properties and interactions, and preventive health-care measures.

Biology — Knowledge of plant and animal organisms, their tissues, cells, functions, interdependencies, and interactions with each other and the environment.

Psychology — Knowledge of human behavior and performance; individual differences in ability, personality, and interests; learning and motivation; psychological research methods; and the assessment and treatment of behavioral and affective disorders.

Therapy and Counseling — Knowledge of principles, methods, and procedures for diagnosis, treatment, and rehabilitation of physical and mental dysfunctions, and for career counseling and guidance.

Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.

English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.

Chemistry — Knowledge of the chemical composition, structure, and properties of substances and of the chemical processes and transformations that they undergo. This includes uses of chemicals and their interactions, danger signs, production techniques, and disposal methods.

Education and Training — Knowledge of principles and methods for curriculum and training design, teaching and instruction for individuals and groups, and the measurement of training effects.

Administration and Management — Knowledge of business and management principles involved in strategic planning, resource allocation, human resources modeling, leadership technique, production methods, and coordination of people and resources.

Sales and Marketing — Knowledge of principles and methods for showing, promoting, and selling products or services. This includes marketing strategy and tactics, product demonstration, sales techniques, and sales control systems.

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Abilities

Problem Sensitivity — The ability to tell when something is wrong or is likely to

go wrong. It does not involve solving the problem, only recognizing there is a problem.

Oral Comprehension — The ability to listen to and understand information and ideas presented through spoken words and sentences.

Inductive Reasoning — The ability to combine pieces of information to form general rules or conclusions (includes finding a relationship among seemingly unrelated events).

Oral Expression — The ability to communicate information and ideas in speaking so others will understand.

Deductive Reasoning — The ability to apply general rules to specific problems to produce answers that make sense.

Speech Clarity — The ability to speak clearly so others can understand you.

Written Comprehension — The ability to read and understand information and ideas presented in writing.

Information Ordering — The ability to arrange things or actions in a certain order or pattern according to a specific rule or set of rules (e.g., patterns of numbers, letters, words, pictures, mathematical operations).

Speech Recognition — The ability to identify and understand the speech of another person.

Category Flexibility — The ability to generate or use different sets of rules for combining or grouping things in different ways.

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Work Activities

Getting Information — Observing, receiving, and otherwise obtaining information from all relevant sources.

Assisting and Caring for Others — Providing personal assistance, medical attention, emotional support, or other personal care to others such as coworkers, customers, or patients.

Making Decisions and Solving Problems — Analyzing information and evaluating results to choose the best solution and solve problems.

Documenting/Recording Information — Entering, transcribing, recording, storing, or maintaining information in written or electronic/magnetic form.

Updating and Using Relevant Knowledge — Keeping up-to-date technically and applying new knowledge to your job.

Identifying Objects, Actions, and Events — Identifying information by

categorizing, estimating, recognizing differences or similarities, and detecting changes in circumstances or events.

Establishing and Maintaining Interpersonal Relationships — Developing constructive and cooperative working relationships with others, and maintaining them over time.

Interpreting the Meaning of Information for Others — Translating or explaining what information means and how it can be used.

Performing for or Working Directly with the Public — Performing for people or dealing directly with the public. This includes serving customers in restaurants and stores, and receiving clients or guests.

Thinking Creatively — Developing, designing, or creating new applications, ideas, relationships, systems, or products, including artistic contributions.

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Work Context

Telephone — How often do you have telephone conversations in this job?

Face-to-Face Discussions — How often do you have to have face-to-face discussions with individuals or teams in this job?

Freedom to Make Decisions — How much decision making freedom, without supervision, does the job offer?

Structured versus Unstructured Work — To what extent is this job structured for the worker, rather than allowing the worker to determine tasks, priorities, and goals?

Contact With Others — How much does this job require the worker to be in contact with others (face-to-face, by telephone, or otherwise) in order to perform it?

Indoors, Environmentally Controlled — How often does this job require working indoors in environmentally controlled conditions?

Deal With External Customers — How important is it to work with external customers or the public in this job?

Electronic Mail — How often do you use electronic mail in this job?

Frequency of Decision Making — How frequently is the worker required to make decisions that affect other people, the financial resources, and/or the image and reputation of the organization?

Physical Proximity — To what extent does this job require the worker to perform job tasks in close physical proximity to other people?

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Job Zone

Title Job Zone Five: Extensive Preparation Needed

Education Most of these occupations require graduate school. For example, they may require a master's degree, and some require a Ph.D., M.D., or J.D. (law degree).

Related Experience Extensive skill, knowledge, and experience are needed for these occupations. Many require more than five years of experience. For example, surgeons must complete four years of college and an additional five to seven years of specialized medical training to be able to do their job.

Job Training Employees may need some on-the-job training, but most of these occupations assume that the person will already have the required skills, knowledge, work-related experience, and/or training.

Job Zone Examples These occupations often involve coordinating, training, supervising, or managing the activities of others to accomplish goals. Very advanced communication and organizational skills are required. Examples include librarians, lawyers, aerospace engineers, wildlife biologists, school psychologists, surgeons, treasurers, and controllers.

SVP Range (8.0 and above)

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Interests

Interest code: **IS**

Investigative — Investigative occupations frequently involve working with ideas, and require an extensive amount of thinking. These occupations can involve searching for facts and figuring out problems mentally.

Social — Social occupations frequently involve working with, communicating with, and teaching people. These occupations often involve helping or providing service to others.

Artistic — Artistic occupations frequently involve working with forms, designs and patterns. They often require self-expression and the work can be done without following a clear set of rules.

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Work Styles

Integrity — Job requires being honest and ethical.

Concern for Others — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.

Self Control — Job requires maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.

Dependability — Job requires being reliable, responsible, and dependable, and fulfilling obligations.

Initiative — Job requires a willingness to take on responsibilities and challenges.

Attention to Detail — Job requires being careful about detail and thorough in completing work tasks.

Analytical Thinking — Job requires analyzing information and using logic to address work-related issues and problems.

Independence — Job requires developing one's own ways of doing things, guiding oneself with little or no supervision, and depending on oneself to get things done.

Leadership — Job requires a willingness to lead, take charge, and offer opinions and direction.

Stress Tolerance — Job requires accepting criticism and dealing calmly and effectively with high stress situations.

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Work Values

Relationships — Occupations that satisfy this work value allow employees to provide service to others and work with co-workers in a friendly non-competitive environment. Corresponding needs are Co-workers, Moral Values and Social Service.

Achievement — Occupations that satisfy this work value are results oriented and allow employees to use their strongest abilities, giving them a feeling of accomplishment. Corresponding needs are Ability Utilization and Achievement.

Independence — Occupations that satisfy this work value allow employees to work on their own and make decisions. Corresponding needs are Creativity, Responsibility and Autonomy.

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Wages & Employment Trends

National

Median wages data collected from **Health Diagnosing and Treating Practitioners, All Other**.
Employment data collected from **Health Diagnosing and Treating Practitioners, All Other**.

Median wages (2008) \$31.67 hourly, \$65,880 annual

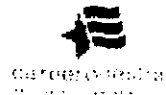
Employment (2006) 65,000 employees

Projected growth (2006-2016) .. Average (7% to 13%)

Projected need (2006-2016) 19,000 additional employees

State & National

Select a State



Source: Bureau of Labor Statistics [2008 wage data](#) and [2006-2016 employment projections](#).
"Projected growth" represents the estimated change in total employment over the projections period (2006-2016). "Projected need" represents job openings due to growth and net replacement.

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Appendix B

BASTYR UNIVERSITY
SCHOOL OF NATUROPATHIC MEDICINE
Booklist Academic Year 08-09 (FALL 2009)
Submitted by Jane Guiltinan, ND, Dean

FALL 2009

BC 5104 Biochemistry 1

Marks' Basic Medical Biochemistry 3rd edition– Lieberman

Required

Medical Biochemistry at a Glance 2nd edition – Salway

Recommended

BC 5107 Human Physiology 1 Lec/Lab

Human Physiology 4th edition – Rhoades

Required

Physiology Coloring Book, 2nd edition – Kapit

Recommended

BC 5110 Histology Lec/Lab

Netter's Essential Histology – Ovalle

Required

Photographic Atlas of Histology – Leboffe

Required

Histology Lab Manual – Frederickson/Love

Required

BC 5112 Embryology

Developing Human 8th ed – Moore

Required

BC 5122 Gross Human Anatomy 1 Lec

Clinically Oriented Anatomy 5th Edition – Moore

Required

Bates Guide to Physical Examination 9th Edition – Bickley

Required

Physical Examination of the Spine and Extremities 2nd Ed– Hoppenfield

Required

Atlas of Human Anatomy 4th Edition – Netter

Required

Gray's Atlas of Anatomy – Drake

Highly Recommended

Color Atlas of Anatomy 6th – Rothen

Recommended

Anatomy Coloring Book 3rd ed- Kapit

Recommended

Choose one:

Stedman's Medical Dictionary 28th ed

Highly recommended (*this or Dorland's – see below)

Dorland's Illustrated Medical Dictionary 31st ed

Highly recommended (*this or Stedman's – see above)

BC 5122L Gross Human Anatomy 1 Lab

Grant's Dissector 14th ed – Tank

Required

Atlas of Human Anatomy 4th Edition – Netter
Recommended
Color Atlas of Anatomy 6th – Rohen
Recommended

BC 6200 Human Pathology 1

Robbins and Cotrans Pathologic Basis of Disease 8th ed – Kumar
Required
Pocket Companion to Pathologic Basis of Disease 7th ed – Mitchell
Optional

BC 6204 A&B Immunology

Immune System 3rd edition – Parham
Required

BO 6301 Botanical Medicine 2

Medical Herbalism – Hoffman
Required
Principles and Practice of Phytotherapy – Mills
Required
Herbal Medicine from the Heart of the Earth – Tilgner
Recommended
Book of Herbal Wisdom – Wood
Recommended

BO 7300 Botanical Medicine 4

Herbal Medicine: Classic edition – Weiss
Required
Medical Herbalism – Hoffman
Recommended
Principles and Practice of Phytotherapy – Mills
Recommended
Medicinal Plants of the Pacific West – Moore
Recommended

BO 7300L Botanical Medicine 4 – Lab

See BO 7300 lecture for textbooks

HO 6300 Homeopathy 1

Pocket Manual of Homeopathic Materia Medica and Repertory – Boericke
Required
Lectures on Homeopathic Materia Medica – Kent
Required
Repertory of the Homoeopathic Materia Medica – Kent
Required
Leaders in Homoeopathic Therapeutics – Nash
Required
Homeopathic Treatment of Children – Herscu
Recommended
Lectures on Homoeopathic Philosophy – Kent
Recommended

MW 7320 Normal Maternity

Heart and Hands, Midwife's GT Pregnancy and Birth 4th Ed – Davis
Required
Holistic Midwifery, Volumes 1 & 2 – Frye

Recommended
Ina May's Guide to Childbirth – Gaskin
Recommended
Varney's Midwifery, 4th edition – Varney
Recommended
Williams Obstetrics, 23rd edition – Cunningham
Recommended (due 11/13/09)

NM 5113 Naturopathic Medicine in Historical Context

Vitalism: History of Herbalism, Homeopathy, Flower Essences – Wood
Required
Nature Doctors – Kirchfeld
Required
Nature Cure – Lindlahr
Required
Energy Medicine – Oschman
Recommended
Embracing Mind – Wallace
Recommended
Art of Possibility – Zander
Recommended

NM 5804 Clinic Entry

No Textbook

NM 6210 Clinical Lab Diagnosis

Clinical Hematology and Fundamentals of Hemostasis 5th ed – Harmening
Required
Manual of Laboratory & Diagnostic Tests, 8th ed – Fischbach
Required
Merck Manual, 18th edition – Beers
Required
Cecil Essentials of Medicine 7th edition – Andreoli
Recommended
5-Minute Clinical Consult 2010 – Domino
Recommended
Ferri's Clinical Advisor 2010 – Ferri
Recommended

NM 6210D Clinical Lab Diagnosis Discussion

Field Guide to Bedside Diagnosis 2nd edition – Smith
Required

NM 6210L Clinical Lab

Color Atlas of Hematology 3rd edition – Thiel
Required
Color Atlas & Instruction Manual of Peripheral Blood Cell Morphology – O'Connor
Recommended
Interpretation of Diagnostic Tests 8th ed - Wallach
Recommended

NM 6221 Physical/Clinical Diagnosis 1 Lecture

Bates Guide to Physical Examination and History 9th ed – Bates
Required
Harrisons Principles of Internal Medicine 17th ed – Fauci
Highly Recommended

Merck Manual
Recommended
Ferri's Clinical Advisor 2010 – Ferri
or
5-Minute Clinical Consult, 2010 -
Domino

NM 6221L Physical/Clinical Diagnosis 1 Lab

Bates Guide to Physical Examination and History 9th Edition – Bickley
Required
Orthopedic Physical Assessment 5th Edition – Magee
Recommended

NM 7302 Gastroenterology

Naturopathic Gastroenterology -Yarnell
Highly Recommended

NM 7307 Ear, Eye, Nose, and Throat

Natural Approach to Ophthalmology/Otolaryngology 6th ed – Conroy
Required
Basic Ophthalmology 8th Edition – Bradford
Recommended
Essentials of Otolaryngology 5th Edition – Lucente
Recommended

NM 7313 Gynecology

Berek & Novak's Gynecology 14th Edition – Berek
Recommended
Women's Encyclopedia of Natural Medicine 2nd ed– Hudson
Recommended
Contraceptive Technology 19th ed – Hatcher
Recommended
Glass' Office Gynecology 6th edition – Curtis
Recommended
Women's Gynecologic Health – Schulling
Recommended
Managing Contraception pocket version 2007/2009 edition – Hatcher
Optional

NM 8101 Ethics

Principles of Biomedical Ethics 6th ed – Beauchamp
Recommended
Clinical Ethics 6th ed – Jonsen
Recommended

NM 8206 Radiographic Interpretation 1 Lecture

No Textbook

NM 8207 Radiographic Interpretation 1 Lab

Pocket Atlas of Radiographic Anatomy 2nd ed – Moeller
Required
Merrill's Pocket Guide to Radiography 6th ed – Frank
Required
Normal Findings in Radiography – Moeller
Recommended

NM 8303 Geriatrics

Primary Care Geriatrics 5th ed – Ham
Required

Merck Manual of Geriatrics 3rd Ed – Merck
Recommended(out of print)

NM 8308 Endocrinology

Greenspan's Basic and Clinical Endocrinology 8th Edition – Greenspan
Required

Endocrinology and Naturopathic Therapies 8th Ed – Powell
Highly Recommended

NM 8312 Urology

Naturopathic Urology and Men's Health – Yarnell
Required

NM 8413 Advanced Naturopathic Therapeutics 1

Adrenal Fatigue: The 21st Century Syndrome - Wilson
Recommended

Hypothyroidism Type 2 – Starr
Recommended

PM 7301 Naturopathic Manipulation 2

Muscle Energy Techniques 3rd ed– Chaitow
Recommended

Photographic Manual of Regional Orthopaedic and Neurological Tests 4th ed – Cipriano
Recommended

PM 7302 Naturopathic Manipulation 3

Instructor: TBA

Chiropractic Technique – Peterson
Required

PM 7305 Orthopedics

Photographic Manual of Regional Orthopaedic and Neurological Tests 4th ed – Cipriano
Recommended

Physical Examination of the Spine – Hoppenfield
Recommended

Orthopedic Physical Assessment – Magee
Recommended

PS 6305 Naturopathic Counseling 1

Essentials of Intentional Interviewing – Ivey
Required

PS 6305L Naturopathic Counseling 1 Lab

No Textbook

PS 7200 Psychological Assessment

DSM IV TR – APA
Required

TR 6310 Food Dietary Systems & Assessment

Healing with Whole Foods – Pitchford
Recommended

Worlds Healthiest Foods – Mateljan
Recommended
Omnivore's Dilemma – Pollan
Recommended

TR 7411 A&B Diet & Nutrient Therapy 1

No Textbook

WINTER 2009

BC 5105 Biochemistry 2

Mark's Basic Medical Biochemistry: A Clinical Approach 2nd Ed – Smith
Required

Metabolism at A Glance 3rd ed – Salway
Recommended

BC 5108 Human Physiology 2 Lec/Lab

Medical Physiology 3rd edition – Rhoades
Required

Physiology Coloring Book 2nd edition – Kapit
Required

BC 5112 Embryology

Developing Human 8th ed – Moore
Required

BC 5123 Gross Anatomy 2

Gray's Atlas of Anatomy – Drake
Required

Clinically Oriented Anatomy 5th Edition – Moore
Required

Bates Guide to Physical Examination 9th Edition – Bickley
Required

Physical Examination of the Spine and Extremities – Hoppenfield
Required

Anatomy Coloring Book 2nd edition – Kapit
Recommended

Atlas of Human Anatomy 4th edition – Netter
Recommended

Choose one:

Stedman's Medical Dictionary 28th ed.
Highly recommended (*this or Dorland's – see below)

Dorland's Illustrated Medical Dictionary 31st ed.
Highly recommended (*this or Stedman's – see above)

BC 5123L Gross Human Anatomy 2 Lab

Grant's Dissector 14th ed – Sauerland
Required

Atlas of Human Anatomy 4rd ed – Netter
Recommended

Color Atlas of Anatomy 6th ed – Rothen
Recommended

BC 5142 Fundamentals of Research Design

Epidemiology 4th edition – Gordis
Required

Clinical Epidemiology & Evidence Based Med – Katz

Recommended

BC 6201 Human Pathology 2

Robbins and Cotran Pathologic Basis of Disease 7th Ed – Kumar
Required
Lecture Outlines in Human Pathology 2 - Frederickson
Recommended

BC 6209 Infectious Disease

Mim's Medical Microbiology 4th edition – Goering
Required
Sanford GT Antimicrobial Therapy 2008 – Gilbert
Required

BC 6305 Pharmacology

Principles of Pharmacology 2nd edition – Golan
Required
Sanford GT Antimicrobial Therapy 2008 – Gilbert
Recommended

BO 6302 Botanical Medicine 3

Women, Hormones & the Menstrual Cycle 2nd ed – Trickey
Required

HO 6301 Homeopathy 2

Leaders in Homeopathic Therapeutics – Nash
Required
Desktop Guide to Keynotes & Symptoms – Morrison
Required
Repertory of the Homoeopathic Materia Medica – Kent
Required
Pocket Manual of Homoeopathic Materia Medica & Repertory – Boericke
Required

NM 5114 Funds. of Naturopathic Clinical Theory

Nature Cure – Lindlahr
Required
Organon of the Medical Art (O'Reilly) – Hahnemann
Required
Nature Doctors – Kirchfeld
Recommended

NM 5804 Clinic Entry 1

No Required Textbook

NM 6211 Clinical Lab Diagnosis 2

Clinical Chemistry 6th Edition – Marshall
Required
Clinical Hematology and Fundamentals of Hemostasis 5th ed – Harmening
Required
Cecil's Essentials of Medicine 7th edition – Andreoli
Required
Color Atlas of Hematology 2nd edition – Thiel
Recommended
Clinical Hematology Atlas 3rd edition – Carr
Recommended

Manual of Laboratory & Diagnostic Tests, 8th ed – Fischbach
Recommended
Interpretation of Diagnostic Tests 8th edition – Wallach
Recommended

NM 6211D Clinical Lab Diagnosis 2 Disc

Field Guide to Bedside Diagnosis 2nd ed – Smith
Recommended

NM 6211L Clinical Lab Diagnosis 2 Lab

Manual of Laboratory and Diagnostic Tests 8th ed - Fischbach
Required
Interpretation of Diagnostic Tests 8th ed - Wallach
Required

NM 6222 Physical/Clinical Diagnosis 2

Bates Guide to Physical Examination 9th ed – Bickley
Required
Harrisons Principles of Internal Medicine 17th edition –Fauci/Kasper
Highly recommended
Merck Manual 18th edition – Merck
Recommended
5-Minute Clinical Consult 2009 - Domino
Recommended

NM 6223L Physical/Clinical Diagnosis 2 Lab

Bates Guide to Physical Examination 9th ed – Bickley
Required
Orthopedic Physical Assessment 4th ed – Magee
Recommended

NM7101 Environmental Medicine

Needed Books on reserve at library

NM7102 Public Health

Understanding Health Policy 5th ed – Bodenheimer
Required

NM 7115 Naturopathic Clinical Theory 2

Instructor did not respond to Bookstore

NM 7142 Critical Evaluation of Medical Literature

Evidence Based Medicine Toolkit 2nd ed. – Heneghan
Recommended

NM 7304 Dermatology

Fitzpatrick's Color Atlas/Synopsis Clinical Dermatology, 5th ed. – Wolff
Required

NM 7306 Oncology

Oncology 2nd edition - Watson
Required

NM 7314 Pediatrics I

Herbal Treatment of Children – McIntyre
Required

Choose one of these two:

Nelson's Essentials of Pediatrics 5th Ed – Behrman

Required or choose

Current Pediatric Diagnosis/Treatment 18th ed – Hay

Required

NM 8101 Ethics

Principles of Biomedical Ethics 5th ed – Beauchamp

Recommended

Clinical Ethics 6th edition – Jonsen

Recommended

NM 8212 Radiographic Interpretation 2

Chest X-Ray Made Easy 2nd edition – Corne

Optional

Essential Radiology – Gunderman

Optional

Essentials of Skeletal Radiology 2nd ed. – Yochum

Special order

NM 8213 Diagnostic Imaging

Essential Radiology 2nd – Gunderman

Required

Right Imaging Study – Eisenberg

Recommended

NM 8309 Rheumatology

Integrative Rheumatology – Vasquez

Required

Primer on the Rheumatic Diseases 13th ed – Klippel

Recommended

NM 8325 Nat Case Analysis

No Textbook

NM 8414 Adv. Naturopathic Therapeutics 2

Adrenal Fatigue: The 21st Century Syndrome – Wilson

Recommended

Hypothyroidism Type 2 – Starr

Recommended

PM 5301 Hydrotherapy/Physiotherapy Lecture

Evidence Based Guide To Therapeutic Physical Agents – Belanger

Required

Lectures in Naturopathic Hydrotherapy – Boyle

Recommended

Manual of Hydrotherapy and Massage – Moor

Recommended

PM 5305 Hydrotherapy/Physiotherapy Lab

No Textbooks

PM 7302 Naturopathic Manipulation 3

Chiropractic Technique – Bergmann

Required

PM 7303 Naturopathic Manipulation 4

Chiropractic Technique – Bergmann

Required

PM 7341 Sports Medicine/Therapeutic Exercise

Conditioning for Outdoor Fitness - Musnick

Highly Recommended

Clinical Sports Medicine, 3rd edition – Brukner

Required

PS 6306 Naturopathic Counseling 2

Cognitive Therapy: Basics and Beyond – Beck

Required

Clinical Handbook of Psychological Disorders 4th ed – Barlow

Recommended

Mindfulness and Psychotherapy – Germer

Recommended

Acceptance and Commitment Therapy – Hayes

Recommended

PS 7203 Addictions and Disorders

Uppers, Downers, All Arounders 6th ed– Inuba

Recommended

TR 6311 Macro & Micronutrients

Advanced Nutrition and Human Metabolism 5th ed– Groff

Required

Evidence-Based Approach to Vitamins and Minerals – Higdon

Required

Biochemical and Physiological Aspects of Human Nutrition 2nd ed – Stipanuk

Recommended

TR 7412 Diet & Nutrient Therapy 2

Instructor: Brignall

No Textbook

SPRING 2009

BC 5106 Biochemistry 3

Mark's Basic Medical Biochemistry 2nd edition – Smith

Required

Metabolism at a Glance 3rd edition – Salway

Recommended

BC 5109 Human Physiology 3 Lecture

Medical Physiology 3rd edition – Rhoades

Required

Physiology Coloring Book, 2nd edition – Kapit

Required

BC 5124 Gross Human Anatomy 3 Lecture

Gray's Atlas of Anatomy – Drake

Required

Clinically Oriented Anatomy 5th Edition – Moore

Required

Bates Guide to Physical Examination 9th Edition – Bickley

Required

Physical Examination of the Spine and Extremities – Hoppenfield

Required

Anatomy Coloring Book 2nd edition – Kapit

Recommended

Choose one:

Stedman's Medical Dictionary 28th ed.

Highly recommended (*this or Dorland's – see below)

Dorland's Illustrated Medical Dictionary 31st ed.

Highly recommended (*this or Stedman's – see above)

BC 5124L Gross Human Anatomy 3 Lab

Grant's Dissector 14th ed – Sauerland

Required

Atlas of Human Anatomy 4rd ed – Netter

Recommended

Color Atlas of Anatomy 6th ed – Rothen

Recommended

BC 5129 Neuroscience

The Human Brain, 6th edition – Nolte

Required

Neuroanatomy Atlas of Structures, Sections, Systems 7th – Haines

Required

BC 5142 Fundamentals of Research Design

Epidemiology 4th edition – Gordis

Required

BC 6202 Human Pathology 3

Robbins and Cotran Pathologic Basis of Disease 7th Ed – Kumar

Required

BC 6209 Infectious Diseases

Mim's Medical Microbiology 4th edition – Goering

Required

Sanford Guide to Antimicrobial Therapy 2009 ed – Gilbert

Required

BC 6305 Pharmacology

Principles of Pharmacology 2nd edition – Golan

Required

Sanford GT Antimicrobial Therapy 2009 ed – Gilbert

Recommended

BO 5301 Botanical Medicine 1

Medical Herbalism – Hoffman

Required

Herbal Medicine from the Heart of the Earth – Tilgner

Recommended

BO 6303 Bot Med Dispensary Lab

No Textbook

BO 7301 Botanical Medicine 5

Herbal Medicine classic edition – Weiss

Required

Principles and Practice of Phytotherapy – Mills
Recommended
Medical Herbalism – Hoffmann
Recommended
Herbal Vade Mecum – Skendari
Recommended

HO 6302 Homeopathy 3

Lectures on Homeopathic Philosophy – Kent
Required
Lectures on Homeopathic Materia Medica – Kent
Required
Pocket Manual of Homeopathic Materia Medica & Repertory - Boericke
Required

HO 9303 Homeopathy 6

Homeopathic Treatment of Children – Herscue
Required
Lectures on Homeopathic Materia Medica – Kent
Required
Kent's Repertory of the Homoeopathic Materia Medica – Kent
Required
Key Notes and Red Line Symptoms – Lippe
Recommended
Pocket Manual of Homeopathic Materia Medica & Repertory - Boericke
Recommended

NM 5115 Naturopathic Medicine in Global Context

In Search of the Medicine Buddha – Crow
Recommended

NM 5804 Clinic Entry 1

No Textbook

NM 6212 Clinical Lab Diagnosis 3

Clinical Chemistry 6th Edition – Marshall
Required
Cecil's Essentials of Medicine 7th ed – Andreoli
Required
Manual of Laboratory Diagnostic Tests 8th Edition – Fischbach
Recommended

NM 6212D Clinical Lab Diagnosis 3 Disc

Field Guide to Bedside Diagnosis 2nd ed – Smith
Recommended

NM 6212L Clinical Lab Diagnosis 3 Lab

Handbook of Routine Urinalysis – Graff
Recommended

NM 6223 Physical/Clinical Diagnosis 3 Lec

Bates' Guide to Physical Examination 9th ed – Bickley
Required
Differential Diagnosis in Primary Care 4th edition – Collins
Recommended

NM 6223L Physical/Clinical Diagnosis 3 Lab

Bates' Guide to Physical Examination 9th ed – Bickley
Required

Orthopedic Physical Assessment 5th edition – Magee
Recommended

NM 6804 Clinic Entry 2

No Textbook

NM 7109A Practice Management 1

Success Signals – Hiler
Recommended

NM 7109B Practice Management 1

12 Months to Your Ideal Practice: a workbook – Grodzki
Recommended

NM 7302 Gastroenterology

Naturopathic Gastroenterology – Yarnell
Required

NM 7305 Clinical Ecology

Food Allergies and Food Intolerance – Brostoff
Required

Coping with Food Intolerances 4th edition – Thom
Recommended

NM 7311 Neurology

Four-Minute Neurologic Exam – Goldberg
Required

Neurology for the Non-Neurologist 5th edition – Weiner
Recommended

NM 7315 Pediatrics 2

Herbal Treatment of Children – McIntyre
Required

Choose one of these two:

Nelson's Essentials of Pediatrics 5th Ed – Behrman
Required or choose

Current Diagnosis and Treatment in Pediatrics 19th ed – Hay
Required

NM 7320 Family Medicine

No Textbook

NM 7330 Healing Systems

No Textbook

NM 7341 Cardiology

Pathophysiology of Heart Disease 4th ed – Lilly
Required

Rapid Interpretation of EKGs 6th ed – Dubin
Required

NM 7416 Minor Office Procedures

No Textbook

NM 7417 Medical Procedures

Plumer's Principles and Practice of IV Therapy 8th ed – Weinstein
Recommended

NM 8102 Jurisprudence

Primary Care Provider's Guide to Compensation and Quality 2nd ed– Buppert
Recommended

Success Signals – Hiler
Recommended

NM 8109B Practice Management 2

12 Months to Your Ideal Practice: a workbook – Grodzki
Required

NM 8212 Radiographic Interpretation 2

Essential Radiology 2nd edition - Gunderman
Required

Clinical Radiology Made Ridiculously Simple 2nd ed – Ouellette
Recommended

Chest X-Ray Made Easy 2nd edition – Come
Recommended

NM 8213 Diagnostic Imaging

Essential Radiology 2nd edition – Gunderman
Optional

NM 8308 Endocrinology

Greenspan's Basic & Clinical Endocrinology 8th ed – Gardner
Required

Endocrinology & Naturopathic Therapies 8th ed – Powell
Highly Recommended

NM 8314 Pulmonary Medicine

No Textbook

NM 8325 Nat Case Analysis & Mgmt 2

No Textbook

NM 9562 IV Therapy

Plumer's Principles and Practice of Intravenous Therapy 8th ed – Weinstein
Recommended

OM 5120 Fundamental Principles of TCM (ND)

Web That Has No Weaver – Kaptchuk
Required

PM 5310 Myofascial Analysis

Anatomy Trains, 2nd edition – Myers
Recommended

Palpation and Assessment Skills 2nd edition – Chaitow
Recommended

Patient Gowns required for the class are located by the lab coats.

PM 6300 Naturopathic Manipulation 1
Physical Examination of the Spine – Hoppenfeld

Recommended
Anatomy Trains, 2nd edition – Myers
Recommended
Photographic Manual of Regional Orthopaedic/Neurological Tests 4th ed – Cipriano
Recommended

PM 7303 Naturopathic Manipulation 4

Chiropractic Technique 2nd edition – Peterson
Recommended

PS 7315 Naturopathic Counseling 3

Motivational Interviewing – Miller
Required
Learning ACT: Training Manual for Therapist – Luoma
Required
Cognitive Therapy: Basics and Beyond – Beck
Recommended

SUMMER 2009

AV 9110 Fundamentals of Ayurvedic Medicine

Textbook of Ayurveda – Lad
Recommended

BC 5110 Histology

Netter's Essential Histology – Ovalle
Required
Photographic Atlas of Histology – Leboffe
Required
Histology Laboratory Guide – Frederickson
Required

BC 5110L A Histology Lab

See BC 5110 lecture

BC 5110L B Histology Lab

See BC 5110 lecture

BC 5142 Fundamentals of Research Design

Epidemiology 4th ed –Gordis
Required

BC 6204 Immunology

Immune System 3rd edition – Parham
Required

BC 9505 Laboratory Research Methods

No Textbook

BO 6303 Bot Med Dispensary Lab

Herbal Medicine-Makers Handbook – Green
Required
Encyclopedia of Herbal Medicine 2nd edition – Chevallier
Recommended
Herbal Medicine from the Heart of the Earth – Tilgner
Recommended
Complex Herbs-Complete Medicines – Brinker

Recommended
Making Plant Medicine 3rd edition – Cech
Recommended
Phytochemistry and Pharmacy for Practitioners – Yarnell
Recommended
Medical Herbalism – Hoffman
Recommended
Herbal Recipes for Vibrant Health – Gladstar
Recommended

NM 7325 Nat Case Analysis & Mgmt 1
Clinicians Handbook of Natural Medicine 2nd ed – Pizzorno
Required

NM 7341 A&B Cardiology
Pathophysiology of Heart Disease 4rd ed – Lilly
Required
Rapid Interpretation of EKGs 6th ed – Dubin
Required

NM 7416 Minor Office Procedures
No Textbook

NM 7417 Medical Procedures
Plumer's Principles and Practice of IV Therapy – Weinstein
Recommended

NM 8206A Radiographic Interp 1 Lecture
No Textbook

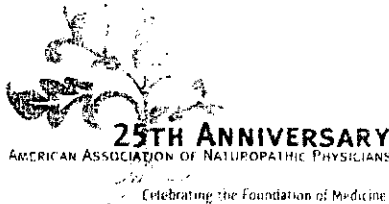
NM 8207 Radiographic Interp 1 Lab
Pocket Atlas of Radiographic Anatomy 2nd ed. – Moeller
Required
Pocket Guide to Radiography 6th ed. – Ballinger
Required
Normal Findings in Radiography – Moeller
Recommended

OM 5120 Fundamental Principles of TCM (ND)
Web That Has No Weaver – Kaptchuk
Required

PM 7301 Naturopathic Manipulation 2
Muscle Energy Techniques 3rd ed – Chaitow
Recommended
Photographic Manual of Regional Orthopaedic and Neurological Tests – Cipriano
Recommended

PS 7200 Psychological Assessment
DSM-IV-TR – APA
Required
DSM-IV Made Easy – Morrison
Recommended

TR 7412 Diet & Nutrient Therapy 2
No Textbook



AANP STATE LEGISLATIVE AFFAIRS
AMA Attempting to Restrict Access to Primary Care

March 10, 2010

Governor Sean Parnell
PO Box 110001
Juneau AK 99811-0001

The American Association of Naturopathic Physicians urges you to support **HB 282 and SB 70**, which would allow comprehensively trained medical professionals the ability to serve all Alaskans to the extent of their considerable training.

Access to quality healthcare is fundamental to the wants and needs of Americans. Patients are best served when they have a team of healthcare professionals who work together to ensure overall health and wellness. Currently there is a divisive and coordinated movement led by the American Medical Association to restrict valuable services provided by more than 3.3 million licensed healthcare professionals who are not DOs or MDs. Known as the Scope of Practice Partnership (SOPP), this campaign is designed to limit patient access to safe, high-quality and cost-effective healthcare.

What is a Naturopathic Physician? Naturopathic physicians are doctors trained to provide family healthcare and to emphasize the use of natural therapies to prevent and treat acute and chronic illnesses.

What training is required to become a Naturopathic Physician? Naturopathic physicians hold a doctorate in naturopathic medicine from a four-year, graduate-level, federally-recognized and accredited naturopathic medical school. These schools train physician-level practitioners in diagnosis and scientifically-based treatment with emphasis on natural therapies. There are currently five such schools in the United States and two in Canada.

The ND degree confers the title of Doctor of Naturopathic Medicine and provides a guarantee to the public that the doctor possesses the necessary training to practice naturopathic medicine. The doctorate degree prepares naturopathic doctors to offer qualified naturopathic medical care and to work together with other medical providers.

What therapies do Naturopathic Physicians employ for their patients? Naturopathic physicians use a variety of natural and non-invasive therapies, including clinical nutrition, herbal medicine, lifestyle counseling, homeopathy, physical medicine and hydrotherapy. Naturopathic physicians also have expertise in drug / herb / nutrient interactions. Many naturopathic physicians receive additional certification in disciplines such as midwifery, acupuncture and Oriental medicine.

Why are Naturopathic Physicians critical for so many patients in Alaska? Naturopathic physicians work in private practice or in integrated settings with other medical providers such as

conventional medical doctors and osteopathic physicians. The result is a patient-centered, comprehensive approach that provides the most appropriate treatment for an individual's needs. Naturopathic physicians educate patients about why they are unhealthy and provide them with the tools for achieving optimal health.

Naturopathic medicine affords a high degree of personalized care, a focus on disease prevention, lower costs and much lower incidences of harm or malpractice. We ask for your consideration in evaluating the outdated and inaccurate claims made by the Alaska branch of the American Medical Association. Please also consider that the large majority of MDs and DOs work effectively and cooperatively with all the mid-level healthcare professionals targeted by the AMA. It is only a few, politically motivated, physicians who insist on pulling outdated and inaccurate material to protect their "turf." If successful, the SOPP will place an enormous and unnecessary burden on the American healthcare system.

Naturopathic medicine is one of 10 professions selected for profiling by the AMA. The SOPP document, made available to legislators across the county, fails to appropriately define either the practice of naturopathic medicine or the training of naturopathic physicians. Following is the federal Department of Labor current definition of naturopathic medicine and the responsibilities of naturopathic physicians, based on their training.

DEFINITION NATUROPATHIC MEDICINE: U.S. DEPARTMENT OF LABOR 2009

Naturopathic Medicine: Diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals. May use physiological, psychological or mechanical methods. May also use natural medicines, prescription or legend drugs, foods, herbs, or other natural remedies.

Sample of reported job titles: Naturopathic Physician, Naturopathic Doctor, Physician, Doctor of Naturopathic Medicine¹

Department of Labor further defines naturopathic medical practice in 5 areas that follow:

1. Professional and Public Health Obligations

- Conduct periodic public health maintenance activities such as immunizations and screenings for diseases and disease risk factors.
- Monitor updates from public health agencies to keep abreast of health trends.
- Report patterns of patients' health conditions, such as disease status and births, to public health agencies.
- Maintain professional development through activities such as post-graduate education, continuing education, preceptorships, and residency programs.

¹ Occupational Information Network. (2009). 29-1199.04 - Naturopathic Physicians. Retrieved December 1, 2009, from the Occupational Information Network website: <http://online.onetcenter.org/link/details/29-1199.04#Education>

2. Patient Intake and Diagnosis

- Document patients' histories, including identifying data, chief complaints, illnesses, previous medical or family histories, or psychosocial characteristics.
- Interview patients to document symptoms and health histories.
- Conduct physical examinations and physiological function tests for diagnostic purposes.
- Diagnose health conditions based on patients' symptoms and health histories, laboratory and diagnostic radiology test results, or other physiological measurements, such as electrocardiograms and electroencephalographs.
- Order diagnostic imaging procedures such as radiographs (x-rays), ultrasounds, mammograms, and bone densitometry tests, or refer patients to other health professionals for these procedures.

3. Patient Education/Advocacy

- Educate patients about health care management.
- Advise patients about therapeutic exercise and nutritional medicine regimens.
- Administer, dispense, or prescribe natural medicines such as food or botanical extracts, herbs, dietary supplements, vitamins, nutraceuticals, and amino acids.

4. Naturopathic Medical Practice

- Administer treatments or therapies, such as homeopathy, hydrotherapy, Oriental or Ayurvedic medicine, electrotherapy and diathermy, using physical agents including air, heat, cold, water, sound, or ultraviolet light to catalyze the body to heal itself.
- Naturopathic physicians consistently consult with other health professionals to provide optimal patient care, referring patients to traditional health care professionals as necessary.
- Obtain medical records from previous physicians or other health care providers for the purpose of patient evaluation.
- Perform minor surgical procedures, such as removing warts, moles, or cysts, sampling tissues for skin cancer or lipomas, and applying or removing sutures.
- Prescribe synthetic drugs under the supervision of medical doctors or within the allowances of regulatory bodies.

5. Naturopathic Prescribing Practice

It is well known that overuse of pharmaceuticals has led to thousands of preventable deaths as well as antibiotic resistance. While naturopathic doctors preferentially choose natural therapies to treat disease, they are also trained to utilize pharmaceutical drugs when in the best interest of the patient. This practice is reflected in the Survey data from the Department of Labor.

"While no naturopathic physicians reported prescribing on an hourly basis, 32% prescribe on a daily or weekly basis, and 54% prescribe more than once a month."

According to the Institute for Medicine (IOM) an estimated 15 million adults take herbal remedies or high-dose vitamins along with prescription drugs. Naturopathic doctors are the **only** physicians trained in the contraindications of herbs and botanicals with pharmaceuticals.

PRIMARY CARE EDUCATION AND TRAINING

The U.S. Secretary of Education recognizes CNME as the national accrediting agency for programs leading to the Doctor of Naturopathic Medicine (ND or NMD) or Doctor of Naturopathy (ND) degree. The program is a resident course of at least 4 years and 4620 hours of study. Clinical education requirements for, as mandated by accreditation agencies, include a minimum of 1200 clock hours in direct patient contact. All licensed naturopathic physicians have matriculated from the CNME approved schools, and successfully passed a national exam administered by the North American Board of Naturopathic Examiners (NABNE).

Both the Department of Education and the Carnegie Institute classify the ND degree under "doctorate-professional" (clinical) on par with the MD and DO degrees.

State Legislatures Address Primary Care Shortage

Six state legislatures designate NDs as primary care givers: Alaska, California, Montana, New Hampshire, Utah, and Vermont. Across the country legislatures are expanding scope and access to naturopathic medicine.

- Arizona, Hawaii, Oregon and Washington allow NDs full prescriptive authority.
- Vermont utilizes NDs in its Medicaid program.
- Hawaii expanded naturopathic scope of practice to include IV Therapy and minor surgery, in addition to prescribing authority.

States are acting to improve health status of its citizens by accessing science and evidenced-based medicine of highly educated and trained (non-MD and DO) providers of primary care.

State of Oregon	Naturopathic Physicians	Family Nurse Practitioners
Scope of Practice	Can diagnose and treat any condition	Can diagnose and treat any condition
Drugs Controlled Drugs	Can prescribe "Legend" drugs Schedule II-V	Can prescribe "Legend" drugs Schedule II-V
Basic and Clinical Sciences	224.50 credits	64 credits
Supervised Clinical Practice	1548 hours	760 hours
Pharmacology	72 hours	45 hours

The doctor shortage in Alaska and nationwide is no secret; this problem will only increase as the population ages. Naturopathic physicians are highly skilled, rigorously trained, licensed health care professionals who stand ready to meet the unmet needs of consumers in urban, rural, and underserved areas.

Sincerely,

Karen Howard,
Executive Director, American Association of Naturopathic Physicians

Re: Support SB 70 and HB 282

Dear Legislator,

At the same time Alaska faces a healthcare crisis with a serious deficit in primary care physicians there are at least 40 competent doctors already in Alaska eagerly waiting to provide care to this underserved population. Naturopathic doctors are trained at 4 year accredited medical schools an in most other Northwest states are board certified primary care providers. They are proficient in all the basic sciences, conventional diagnostics, and management of disease in both Western allopathic treatments as well as naturopathic treatment modalities (botanicals, physical medicine, etc). This training includes 1 year of pharmacology, minor surgery, and complete physical exam and assessment.

A major challenge in delivering primary care to Alaska is that naturopathic doctors are not licensed to practice their full scope of training including prescriptive privileges and minor surgery - including mole removals, biopsies, and superficial laceration repairs. To be able to provide the most effective and efficient primary care to Alaska's diverse patient population, naturopathic doctors must be able to prescribe antibiotics if indicated and suture wounds when needed.

As more mid-levels, such as nurse practitioners, are licensed to prescribed medications in Alaska, access to healthcare as well as patient outcomes across the state have improved. Naturopathic doctors have been licensed to practice medicine in Alaska since 1986, but the legal scope of practice has not kept up with other Pacific Northwest states who regulate the same physicians. Granting naturopathic doctors the legal ability to practice their full scope will increase the number of practitioners able to travel to remote villages, increase availability to specialists when they are needed, decrease undue burden on emergency rooms, increase access to education, prevention and primary care, and a likely decrease overall statewide healthcare costs.

The majority of the Westerns states have already passed legislation allowing naturopathic doctors to practice their full scope including prescriptive privileges and minor surgery. Alaska must act now to pass SB 70 and HB 282 to increase the quality and accessibility to healthcare.

Thank you for your time and I hope you consider endorsing SB 70 and HB 282 to increase access to primary care for your constituents and for all Alaskans.

Sincerely,

Abby Laing NDC .

Homer Alaska
abbylaing@gmail.com

Tom Laing
35035 Lowbush St, Homer, AK
tac.laing@gmail.com

Re: Support for SB 70 and HB 282

Dear Legislator,

I am writing to ask for your support of SB70 or HB 282, which would expand the scope of practice of Naturopathic Doctors (ND's) in Alaska. As I'm sure you know, Alaska has a serious deficit in primary care physicians, which will continue to worsen in the foreseeable future. Allowing Naturopathic Doctors to practice their full scope of training would greatly help to alleviate this shortage of primary medical care. To me, it seems foolish, and a waste of good resources, to not allow any professional to do the work they were trained to do whether they be architects, lawyers or Naturopathic Doctors.

Naturopathic doctors have all completed a 4-year university degree plus 4 years of an accredited medical school, the same duration as their allopathic counterparts, and have passed rigorous board testing. In most Western states, ND's are board certified primary care providers. They are trained in, and proficient in all the basic sciences, conventional diagnostics, and management of disease in conventional allopathic methods as well as naturopathic treatment modalities. This training includes 1 year of pharmacology, minor surgery, and complete physical exam and assessment. All have clinical experience as part of their training.

ND's face a huge obstacle in delivering primary care within Alaska since they are not allowed to practice using their full scope of training, which including prescribing medications such as antibiotics, performing minor surgery (including mole removals, biopsies, and superficial laceration repairs). Even nurse practitioners who have much less training than ND's have these rights.

ND's have been licensed to practice medicine in Alaska since 1986, but the legal scope of practice does not recognize the full extent of their training. Granting Naturopathic Doctors the legal ability to practice to the full extent of their training will increase the number of practitioners able to travel to remote Alaska villages, increase availability to specialists when they are needed, decrease undue burden on emergency rooms, increase access to education, prevention and primary care, and likely slow the increase of statewide healthcare costs.

I urge you to support SB 70 and HB 282 I hope you consider endorsing to increase access to primary care for your constituents and for all Alaskans.

Sincerely,

Tom Laing

Homer, AK

Kendra Kloster

From: Rep. Cathy Munoz
Int: Tuesday, March 09, 2010 2:53 PM
To: Kendra Kloster
Subject: FW: In support of SB 70 and HB 282

For naturopathic bill

From: Jessica McCord [mailto:mccordjess@gmail.com]
Sent: Monday, March 08, 2010 6:07 PM
To: Sen. Dennis Egan; Sen. Bill Wielechowski; Rep. Kyle Johansen; Sen. Lesil McGuire; Rep. Cathy Munoz; Sen. Bettye Davis; Rep. Beth Kerttula; Rep. Peggy Wilson; Sen. Bert Stedman
Subject: In support of SB 70 and HB 282

March 8, 2010

In support of SB 70 and HB 282

Dear Legislators,

There is a severe doctor shortage in Alaska. Many Medicaid patients in the state today are unable to find a doctor who accepts Medicaid assignment. Naturopathic physicians, who graduate from federally accredited medical schools with doctorate-level training, would like to serve this population without legal barriers.

Some of the challenges in delivering more care for less cost can be met by expanding the scope of practice for naturopathic physicians, a highly trained group of mid-level health care professionals who currently operate under a restricted legal system.

Consider the benefits Alaskans have enjoyed by legislating increased scope for advanced nurse, dental hygienists and optometrists. Chronic, and non-emergency medical, dental and vision problems can now be resolved without costly referrals.

Nurse practitioners were granted prescription endorsement because they made the case that expanding their scope of practice would better serve. This has proven to be true. There are, at this time, fewer naturopathic physicians in Alaska than ANPs and therefore we have less lobbying power. Nevertheless, naturopathic physicians, who have been licensed to practice medicine in Alaska since 1986, have significantly more medical training than nurse practitioners (doctorate level natural medical training – whereas advanced nurse practitioners hold masters level degrees).

We would like to bring our laws into line with our training. We see no controversy in this proposal. We are the most highly trained experts in preventive medicine. We are critically important in helping to change the currently unsustainable model of health care, which is increasingly expensive disease management.

Naturopathic physicians offer an alternative to drugs as a first choice for medical intervention. We will always choose safer, effective therapies (such as diet changes, or plant remedies) before going to drugs or riskier interventions. However, it is inconvenient, inefficient and potentially dangerous (because of delay in service) to refer a patient needing minor surgery or a short-term legend drug remedy to another doctor when we are perfectly capable of effectively providing these services to our patients, usually for significantly less cost.

I have a personal interest in returning to Alaska, my home state, to practice medicine. I was in the top my class at Bartlett High School in Anchorage, graduated with a B.S. in Zoology with honors from Northern Michigan University, and I am now pursuing a doctorate degree in naturopathic medicine at the National College of Naturopathic Medicine (a federally accredited college) in Portland, OR. However, the restrictions placed on naturopathic doctors in Alaska have provided me with reservations about ever being able to return and practice as a physician. I hope that this will change, and that I will be able to consider practicing medicine in Alaska one day.

Thank you for your consideration to endorse SB 70 and HB 282, which will allow holistically oriented physicians, with deep and rigorous scientific training and an excellent safety record, to more fully serve your constituents.

Sincerely,

Jessica McCord
Naturopathic Medical Student
Born and raised in Alaska (Hope, Seward and Anchorage)

Kendra Kloster

From: Rep. Cathy Munoz
nt: Friday, January 22, 2010 3:21 PM
o: Kendra Kloster
Subject: FW: Thank you for HB 282

From: cidickess@gci.net [mailto:cidickess@gci.net]
Sent: Thursday, January 21, 2010 11:51 AM
To: Rep. Cathy Munoz
Cc: Daniel J. Young
Subject: Thank you for HB 282

Dear Representative Cathy Munoz,

I'm writing to thank you for your interest in natural medicine and for your belief in freedom of choice in health care and working creatively towards a solution to our national health care crisis. I want to share with you my personal experience with naturopathic medicine with the vested interest in seeing it expand its benefit to me and others.

I am fortunate to have access to a Naturopathic Physician, Dr. Daniel Young at the Center for Natural Medicine (CNM), as my primary care provider. Although I qualify for Indian Health Services through Southcentral Foundation and the Alaska Native Medical Center at no cost to me, I have chosen to change my primary care to CNM since August, 2009. The difference in the quality of care has been worth the \$6,000 out of my pocket that I paid to CNM for medical services in 2009.

In my experience, naturopathic physicians practice medicine the way it should be practiced—with the patient's needs as the driving force, rather than meeting system needs first. For example, as a patient at the Primary Care Center (PCC) run by Southcentral Foundation, I was allocated 15 minutes for an office visit, regardless of the presenting issue. I could request 30 minutes to be seen for more than one issue, but the visits rarely lasted longer than that. When I see Dr. Young, the visits are as long as they need to be to address the issue(s) at hand. At the PCC, for over a year, I never saw the same care provider twice and when I was seen, the provider didn't have my chart to reference. Since I started seeing Dr. Young in August, he has gotten to know me better than any other provider I've seen since I was a child. The care is clearly patient-centered.

Another positive difference in the quality of care I've received via ND vs. MD or traditional practitioner is that Dr. Young listens to what I tell him about my experience with my own body. ND's respect the patient's knowledge of his/her own body, whereas the traditional practitioner will follow the results of a lab test regardless of any evidence to the contrary provided by the patient.

There are so many other reasons that I'm supporting the cause of naturopathic physicians to expand their ability to practice as they have been trained to do through companion bills SB70 and HB 282, not the least of which is that the practice of ND's is ultimately sustainable. ND's promote wellness, which reduces our dependency on late-stage disease management. This standard of practice not only saves money and valuable resources, but it also improves the patient's quality of life.

Again, thank you for your forward thinking in expanding access to all qualified health care providers in Alaska.

Sincerely,
Clarice Stewart

January 31, 2010

RE: HB 282

Dear Representative Cathy Munoz:

Thank you so much for your support of naturopathic care! Over the years, I have had two naturopathic care doctors – Dr. Torrey Smith/Anchorage and Dr. Daniel Young/Eagle River. Both have provided excellent care. I actually prefer “alternative” care since I do not wish to be on prescription medications unless absolutely necessary, but most of all, Dr. Smith and Dr. Young actually listen to my concerns.

In March of 2008, I started going to Dr. Young. Since my husband and I are both retired teachers, he was able to accept my health insurance. Needless to say, I was thrilled! The most wonderful thing was the time he spent with *speaking* with me regarding my health concerns. No hurry-hurry, no rush-rush. Here was a doctor who fully listened to my questions and concerns. He asked me questions and had me fill out a survey so that he could see me as a “whole” patient.

At that point, I had two main concerns – an ear problem and what seemed to be something like irritable bowel syndrome. I had spent Christmas 2007 a nervous wreck taking Imodium AD to relieve symptoms, and I was particularly nervous about flying.

Before going to Dr. Young, I had gone to 3 different ear specialists. One doctor was extremely rude – so rude in fact, I wrote a letter to him to express my dismay with his personal comments during an appointment. I was so shocked at his comments that I didn’t even speak. By the way, his response to my letter consisted of six, hand-written, rambling pages assuring me that he got 1,500 new patients each year, and basically said I just didn’t understand his *sense of humor*. Really?

Dr. Young used acupuncture to treat my ear, but my insurance did not cover acupuncture, so he recommended an ear specialist that I now trust and go to regularly.

As for my other concern, Dr. Young was able to diagnose and help me almost immediately through office treatments and herbal formulas.

Currently I am on Medicare and since he does not accept Medicare, I have to pay Dr. Young out of pocket. Even with that, I prefer to go to him because of his excellent, personal care.

Please, please work to expand access to *all qualified health care providers in Alaska*. As Alaskans, we are so blessed to have their devoted care.

Thank you so much.

Sincerely,

Sharon Sellens/Wasilla
ssellens2008@gmail.com

 **WELLSPRING**
Integrative Medical Center

January 21, 2009

Dear Alaskan Legislators:

I write in support of establishment of a Naturopathic Medical Board consisting of three (3) Naturopathic Doctors (ND), one (1) pharmacist and one (1) member of the public. This board is needed to assure the Alaskan public of safe naturopathic care complying with the regulations of ND practice in Alaska.

Wellspring, an Integrative Medical Center, located in Juneau, Alaska, has employed a naturopathic doctor for nine years. Patients constantly acknowledge their gratefulness for this option. However, he has been unable to fully practice his profession in Alaska because there is no ND Board overseeing the totality of his practice for which he was educated for four years, post-baccalaureate degree.

Please support this ND bill to improve wellness and health care for Alaskans, to increase access to ND care and to provide cost-effective options for our communities.

Please contact me if you have further questions.

Sincerely,

C. Trollan, ANP
Advanced Nurse Practitioner
Owner

February 5, 2010

In support of SB 70 and HB 282

Dear Legislators,

There is a severe doctor shortage in Alaska. Many Medicaid patients in the state today are unable to find a doctor who accepts Medicaid assignment. Naturopathic physicians, who graduate from federally accredited medical schools with doctorate-level training, would like to serve this population without legal barriers.

Some of the challenges in delivering more care for less cost can be met by expanding the scope of practice for naturopathic physicians, a highly trained group of mid-level health care professionals who currently operate under a restricted legal system.

Consider the benefits Alaskans have enjoyed by legislating increased scope for advanced nurse, dental hygienists and optometrists. Chronic, and non-emergency medical, dental and vision problems can now be resolved without costly referrals.

Nurse practitioners were granted prescription endorsement because they made the case that expanding their scope of practice would better serve. This has proven to be true. There are, at this time, fewer naturopathic physicians in Alaska than ANPs and therefore we have less lobbying power. Nevertheless, naturopathic physicians, who have been licensed to practice medicine in Alaska since 1986, have significantly more medical training than nurse practitioners (doctorate level natural medical training – whereas advanced nurse practitioners hold masters level degrees).

We would like to bring our laws into line with our training. We see no controversy in this proposal. We are the most highly trained experts in preventive medicine. We are critically important in helping to change the currently unsustainable model of health care which is increasingly expensive disease management.

Naturopathic physicians offer an alternative to drugs as a first choice for medical intervention. We will always choose safer, effective therapies (such as diet changes, or plant remedies) before going to drugs or riskier interventions. However, it is inconvenient, inefficient and potentially dangerous (because of delay in service) to refer a patient needing minor surgery or a short-term legend drug remedy to another doctor when we are perfectly capable of effectively providing these services to our patients, usually for significantly less cost.

Thank you for your consideration to endorse SB 70 and HB 282, which will allow holistically oriented physicians, with deep and rigorous scientific training and an excellent safety record, to more fully serve your constituents.

Sincerely,



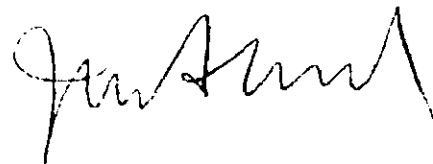
Dr. Emily A. Kane
serving Juneau since 1995

Wayne Aderhold
353 Grubstake Ave
Homer, AK 99603

RECEIVED
MAR 10 2010

Testimony to House L&C Committee
March 10, 2010
Re: HB 282

- I am 60 yrs old, resident of AK since '74 and utilize Naturopathic Physicians as my primary care providers since approx 1993. I see HB 282 as primarily a benefit to consumers like me.
- There are currently at least 2 practicing ND's on the Kenai Peninsula serving many residents of both Homer and Kenai/Soldotna with primary care by traveling between our communities on a weekly basis.
- There is currently a troubling shortage of primary care physicians both nationwide (ref Newsweek of March 8th) and statewide (ref current legislation by AK Senate to offer monetary incentives to lure primary care physicians to AK)
- Improvement of primary care is the documented solution to containing and even reducing overall healthcare cost to the community.
- HB 282 is the culmination of many year's effort by the ND community and others to both increase the services provided by ND's and improve their governance structure (via a Board) with NO ADDITIONAL COST to the State. It is as close to perfection as it can get now.
- Personally, I could have benefitted from both the prescriptive and minor surgical provisions of this bill between '02 and now, had it been enacted earlier. Sooner than I might like to admit, the Medicare provision will also apply to me.
- There is no logical reason not to move this bill forward immediately and assure it's passage during this session. Doing so, you will be **safely increasing the utilization** of these skilled and dedicated professionals who have already committed themselves to serving our community and the State of Alaska. Please move HB 282 forward now.



Plus 3 page backup.



A CRITICAL SHORTAGE OF PRIMARY-CARE PHYSICIANS IS YET ANOTHER SYMPTOM OF OUR AILING HEALTH-CARE SYSTEM.

BY MARY CARMICHAEL

AFTER TAKING A MONTH TO REGROUP, the White House has put health care back at the top of its agenda, asking Republicans for new ideas and trying to regain momentum for old ones. But last week's summit came down mostly to the same old talking points. And even if the president does manage to get some version of health-insurance reform passed

in the next few months, he and the country are still going to be dealing with the related crisis of America's doctor shortage. Primary-care physicians, family docs, general practitioners—whatever you call them, they're the country's first line of defense, the ones responsible for promoting preventive care, finding ways to keep people from getting sick in the

first place, and thus bringing down costs throughout the system. If every American went to one of these doctors regularly, health-care costs might come down as much as 5.6 percent a year, saving \$67 billion, according to one estimate. Yet we don't have nearly enough doctors to make that happen, and fewer are being produced every year.

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**IN SOME SURVEYS,
AS MANY AS HALF
OF PRIMARY-CARE
PROVIDERS HAVE
STOPPED TAKING
NEW PATIENTS.**

The annual number of American medical students who go into primary care has dropped by more than half since 1997. It's hard to get an appointment with the doctors who remain. In some surveys, as many as half of primary-care providers have stopped taking new patients. The other half are increasingly overworked and harried. Clearly we need to find a way to increase their ranks, and both the congressional health-care bills and President Obama's reform proposal make moves in that direction. But those efforts are somewhat limited, and a more comprehensive solution could be thwarted by the same thing that's stalled the rest of health-care reform so far: politics.

The reason behind America's doctor gap is a matter of money. The average income in primary care is somewhere in the mid-\$100,000s, which sounds like a lot but is less than half what specialists such as radiologists and dermatologists make. Given that doctors may graduate with as much as \$200,000 in med-school debt, it's easy to see why primary care started hemorrhaging recruits more than a decade ago and why radiology and other well-paid, high-tech specialties took off in popularity.

The field has since entered a vicious cycle. As fewer people have entered primary care, the doctors who are left have been forced by tight schedules to short-change some patients, forgoing the long, meandering chats that used to be a big part of checkups in favor of 15-minute, checklist-style appointments. The close relationships that general practitioners once had with patients drew many idealistic students into the field. Now recruiters face an extra-tough sell: they have to convince bright young would-be docs to pursue a career that won't pay very well and won't be as emotionally fulfilling as it once was.

How can schools entice more aspiring doctors into primary care? The Tufts University School of Medicine, to take one example, offers a \$25,000-per-year scholarship for med students who agree to work in primary-care practices in rural Maine for much of their training period. Students on this Maine Track start shadowing doctors on the third day of orientation. This year's program drew 257 applicants for just 36 slots.

The problem with the Maine Track is that it doesn't actually require med students to enter primary care after they graduate. It can't, says Peter Bates, chief medical officer at Maine Medical Center, which jointly administers the program with Tufts. "If you're a bright kid with a great future, being told you have to be a family physician in rural Maine—even if that's what you want to do [now]—might strike you as confining," Bates says. "Why would you close down your opportunities?"

There are dozens of training programs like Tufts's around the country, as well

as the National Health Service Corps, which pays back loans and hands out scholarships and stipends in exchange for a few years of service in rural areas, where the shortage of primary-care providers is most acute. Obama and the Senate have both called for an expansion of the program in their proposals for reform, which has already received \$200 million in stimulus funds. Several new medical schools, including some that focus on primary care, have also recently opened. But all those changes may not be enough to fill the gap. "We need more than half of doctors in this country doing primary care," says Harris Berman, interim dean of the medical school at Tufts. "It's a bigger problem than we can solve with programs like ours."

So what else can be done? Lately, some policymakers have argued that instead of having a primary-care doctor, more people—especially young, healthy patients with simple medical needs—should see a nurse or physician assistant who administers routine care and kicks more complex problems up to a doctor when they arise. "If you're just coming in to have your blood pressure checked and your pulse taken, you really don't need to see a doctor, and you might not need to see a nurse, either," says David Barrett, president and CEO of the Lahey Clinic in Burlington, Mass. "There are three-stripe military sergeants with two-year degrees who can provide excellent primary care. There's absolutely no reason to force all primary-care providers to have an M.D."

The Lahey Clinic is an "integrated group practice"—one of the teamwork-oriented organizations, like the Mayo Clinic and the Cleveland Clinic, that have been lauded for cutting costs and eliminating waste in the health system. In its primary-care service, a "team captain" physician supervises nurses,

SOUTH FLORIDA—BOB BENTLEY/ST. LAMBERT

PAs, and other health-care professionals who perform tasks like checking blood pressure but don't necessarily make formal diagnoses on their own. The problem with taking this approach nationwide is that nurses and PAs are subject to the same economic forces that drive medical students. Almost half of current nurse practitioners and physician assistants work in specialty practices, where the money is. Then there's the fact that the country already has a nursing shortage. How are nurses going to replace doctors if there aren't enough nurses to begin with?

There's one more group of people, foreign medical graduates, who could theoretically fill in for the missing primary-care providers. The trouble is, they're already doing that. More than a quarter of primary-care doctors currently practicing in the United States have gotten their diplomas abroad. Increasing their numbers would be problematic for both the left (which might object to poaching doctors from developing countries that need them) and the right (which would surely object to recruiting non-Americans to do a job that reliably pulls in six figures, especially when unemployment is high).

Inevitably, then, the solution to the primary-care crisis is going to have to involve something simpler: paying primary-care providers more, so as to draw more bright young physicians into the field. At least it sounds simpler. But even this turns out to be maddeningly complex.

Most primary-care doctors, like all other physicians, are paid bit by bit for each medical task they perform (unless they work somewhere like the Lahey or the Mayo, which pay set annual salaries). Private insurers decide how much they'll reimburse docs for each task partly by looking to Medicare's policies for guidance. Medicare, in turn, makes its decisions by committee. Here is the bad

news for primary-care docs: most of the physicians on the committee that sets the reimbursement rates are specialists. Medicare—and, consequently, private insurance—doesn't reimburse primary-care doctors as lavishly as it does their more specialized counterparts. That's why primary-care incomes are relatively low in the first place.

Changing anything about the way primary-care providers are paid will be immensely complicated. For one thing, rural doctors sometimes perform specialized procedures because no one else is available—would they still qualify for a raise? And then, what exactly constitutes a task that should be reimbursed? For a high-tech specialist, this is often clear-cut: each scan or chemical test counts. But what about all the things primary-care doctors do that don't involve technology? "You don't get paid to talk to people and tell them to stop smoking. Nobody values my time to do that," says Joe Gravel, a family physician and chief medical officer at the Greater Lawrence Family Health Center in Massachusetts. "They'll pay for the lung transplants, but they won't pay to prevent 50 people from needing them."

In January, Medicare raised reimbursement rates for some primary-care services by about 4 percent, and its payment committee will call for another small increase this week. That's a good start, says Lori Heim, president of the American Academy of Family Physicians, but "if you're talking about changing the way students view primary care, it needs to be more like 25 percent, and that's on the low side." Both the House and Senate reform bills also include a slight increase in primary-care payments—5 and 10 percent, respectively.

To fund such a pay raise, Congress would either have to spend more money on health care or pinch some from the specialists by lowering their pay rates. The first strategy is clearly controversial—no one wants to increase health-care costs further. The second, budget-neutral strategy is bound to tick off the specialists. Peter Mandell, a spokesman for the American Academy of Orthopaedic Surgeons, sent a clear message last year when the Medicare reimbursement committee suggested a 10 percent shift in payments toward primary-care docs and away from specialists. Telling *The New York Times* that his group had "a problem" with the idea,

Mandell added, "If there's less money for hip and knee replacements, fewer of them will be done for people who need them." It's a short step from his polite, reasonable statement to rallies over the specter of rationing.

So here is the fundamental dilemma of the primary-care crisis: One of the solutions with the best chance of working is politically unpalatable, and even those who support it admit it's a bureaucratic nightmare. But without it, we may be heading for an even bigger disaster that nobody wants. Does this sound familiar? The cure for primary care, it turns out, is ultimately going to be the same thing that's needed to fix the rest of the health-care system: political will.

ONE GROUP THAT COULD THEORETICALLY FILL IN FOR THE MISSING DOCS: FOREIGN MEDICAL GRADUATES.



Kendra Kloster

From: Rep. Cathy Munoz
nt: Friday, January 29, 2010 11:52 AM
o: Kendra Kloster
Subject: FW: HB 282

Please add to file on the bill.

From: jacqui yeagle [mailto:jacqui_yeagle@yahoo.com]
Sent: Friday, January 29, 2010 8:52 AM
To: Rep. Cathy Munoz
Subject: HB 282

Dear Rep. Munoz,

Alaska experiences a critical shortage of primary care physicians, yet excludes naturopathic physicians from providing care at the level of training and skill they have acquired. Expanding the scope of care provided by these licensed health care practitioners will increase the supply of primary care providers in Alaska. It will also ensure that Alaskans have the opportunity to receive medical care from their provider of choice, and possibly help reduce overall health care costs. I support HB 282 and SB 70.

Thank you,

Jacqui Yeagle

Kendra Kloster

From: Rep. Cathy Munoz
nt: Tuesday, January 26, 2010 1:01 PM
o: Kendra Kloster
Subject: FW: HB 282 - expand access to naturopathic medicine this session

Please add to file on naturopathic bill

From: Juneau Montessori School [mailto:montessori@acsalaska.net]
Sent: Tuesday, January 26, 2010 10:25 AM
To: Rep. Cathy Munoz
Cc: dremilykane@gmail.com
Subject: HB 282 - expand access to naturopathic medicine this session

Dear Cathy,

I am writing in support to expand access to naturopathic medicine in Alaska. Companion bills SB70 and HB282

Alaskans deserve to have access to the services of a variety of licensed health care practitioners. I believe that in the many areas of the State where primary care medical doctors are scarce or overextended, having access to other types of qualified and licensed primary care professionals, including naturopathic physicians will be of great service to those people.

It has been our family's experience that naturopathic care makes sense. After being diagnosed with arthritis by a medical doctor and prescribed expensive pharmaceuticals with a long list of side effects, that I was expected to take for the rest of my life, I decided to seek naturopathic care. The treatment included mainly changes on my diet and lifestyle; which, in a short period of time, reduced significantly the symptoms and improved my overall health. I did not need those pharmaceuticals any more. Other chronic illnesses I suffer since I was a teenager have been successfully managed by alternative medicine. So far I have avoided surgery my medical doctor anticipated 20 years ago. Since then, my two children, now 18 and 14, have mostly been cared by naturopathic and other alternative care professionals, who have worked with our family to promote wellness and prevent diseases that run genetically through our family, such as diabetes and heart disease.

Please ensure that the Alaskan people have freedom of choice in health care by allowing naturopathic physicians to be recognized as primary care physicians by the US Department of Labor and update outdated laws in the State of Alaska to allow them to create an Alaska Naturopathic Medical Board; allow Medicaid patients to access naturopathic care, and support continuing medical education.

By recognizing naturopathic physicians the State would also increase the supply of primary care providers and reduce overall health care costs.

Thank you for your continued support for children and families in our State,

Lupita

LUPITA ALVAREZ
401 F Street
Douglas, AK 99824
(907) 364-2334

Statement Supporting SB70 and HB282

I am testifying as a consumer of health care. For the last 25 years, the primary health care providers for my family have been naturopathic doctors. We have been successfully treated for numerous ailments, including sinus infections, earaches, urinary tract infections, and insomnia. I have worked with a number of naturopaths and have found them all to be extremely competent and highly professional.

As far as I am concerned, this legislation should be completely non-controversial. Every other state on the West Coast has a Naturopathic Board. Naturopaths are highly trained health care providers whose focus is on wellness, education and prevention. It seems to me that this is exactly the kind of health care that we need more of.

I have heard that some members of the medical community are concerned that ND's might practice outside of their area of competence. I think this is a red herring. There is no evidence this has been a problem in other states. And I am not aware that it has been a problem in Alaska either.

I can tell you from my own experience that the NDs I have worked with are well aware of their limitations, and have referred me to other providers when that was appropriate.

In fact, a few years ago, I came back from a trip to Africa with a bad case of what I thought was traveler's diarrhea. I had been staying in a place with notoriously bad water and had gotten the runs from drinking the water earlier in my trip.

After several days, I wasn't getting any better and was experiencing alternating fever and chills. It was a naturopathic doctor, Emily Kane, who recognized that I might have something more serious. So she came over to my house during her lunch hour and drew my blood and sent it away to be tested for malaria. It came back positive the next day.

I went to Bartlett hospital and ultimately ended up at the University of Washington Hospital in Seattle to be treated for a nasty case of cerebral malaria. It was because of Dr. Kane's alert intervention that I was diagnosed with a life threatening condition in time to be successfully treated.

Two things about this. Number one, it illustrates the highly personalized form of medical care that is typical of the naturopathic profession. How many doctors do you know who make house calls? Yet Dr. Kane is not the first naturopath to make a house call at my house.

Number two, it is an example of a naturopath making a correct diagnosis and referring a patient to appropriate care. Dr. Kane did not suggest that I treat my cerebral malaria with colloidal silver or wormwood. She urged me to go to the hospital and get treated. And when it turned out that Bartlett hospital did not have the appropriate drugs or expertise to treat my condition, I was transferred to the University of Washington, where I had the good fortune to be treated by one of the leading malaria experts in North America.

ND's clearly have a role to play in our health care system. They are primary care providers who can treat many if not most of the common conditions that people go to a doctor for. The care they provide is personalized, cost effective, and prevention oriented.

Perhaps most important, it is focused on individuals taking responsibility for their own wellness. I firmly believe that we will never get medical costs under control until we acknowledge that all of us need to start taking better care of ourselves. Helping people do this is one thing NDs do best.

I urge you to support this legislation.

David Ottoson
212 West Ninth Street
Juneau, AK 99801



Alaska Pharmacists Association

March 8, 2010

Re: HB 282

The Alaska Pharmacists Association represents Alaska Pharmacists, technicians, and others interested in improving medication use and advancing patient care. Alaska Pharmacists Association members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, community health centers, managed, care organizations, hospice settings, and the military.

The Alaska Pharmacists Association (AkPhA) would support the establishment of an Alaska Naturopathic Board with the purpose of regulation of the practice of the Naturopathic Doctors in the State of Alaska. We appreciate the inclusion of pharmacists in the development of the Naturopathic Board.

AkPhA appreciates the rigorous education and training many Naturopath Doctors have completed. We also understand that all Naturopath Doctors do not complete the same level or quality of training. Our hopes are that the development of a Naturopathic Board would develop standards for Naturopathic practitioners within the State of Alaska, including post graduate residency training and mandatory continuing education. AkPhA does not view naturopaths as an alternative to allopathic health care providers, but an addition to traditional practice. Naturopathic medicine is not meant as a replacement in areas where health care providers are of short supply or where there are not physicians accepting Medicare patients.

Finally, prescription endorsement regulations need to be developed in extensive detail beyond what is described in HB282. AkPhA, with the assistance of the Board of Pharmacy, is willing to open a dialog concerning prescriptive authority guidelines for Naturopathic Doctors.

Respectfully,

Barry Christensen, RPh

Co-Chair, Legislative Committee
Alaska Pharmacists Association

E-mail: akphrmcy@alaska.net

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FOUNDATION REPRESENTATIVES

March 5, 2010

Via Facsimile: (907) 465-2273

The Honorable Cathy Munoz
Alaska State Legislature
State Capitol, Room 409
Juneau, AK 99801-1182

RE: HB282 "An Act Relating to Naturopaths"

Dear Representative Munoz:

As Chief of Staff of Fairbanks Memorial Hospital, I appreciate the opportunity to present my concerns and the concerns of our medical staff regarding House Bill 282, which would give prescribing rights to naturopathic physicians. We are convinced that naturopaths do not have the training or the expertise to safely and effectively prescribe medications to the public.

Medical Doctors and Osteopathic Doctors spend a minimum of 7 years in an intense academic environment (including both Medical School and Residency) learning both the art and the science of medicine. This process includes, but is certainly not limited to, learning both when to use and when not to use medications in an appropriate manner. Though the use of medicines is just one piece of an enormous therapeutic armamentarium, it is not a piece that can easily be mastered without the rest of the fund of knowledge that is involved in the intense training that MDs and DOs currently undertake. Though medications have a tremendous ability to improve the lives of the patients that we care for, they also have equally profound ability to cause harm.

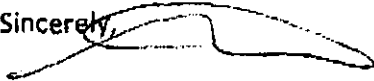
This letter is not meant to serve as an attack on the naturopathic profession. There are many health professionals in addition to naturopaths, such as chiropractors, physical therapists, acupuncturists, and others, who provide

benefit and care to the health of the public. However, we do not believe that naturopaths possess either the training or expertise to prescribe medications in a safe and effective manner for patients.

Thank you for your time.

Please feel free to contact me at any time.

Sincerely,



Michael R. Burton, MD
Chief of Staff
Fairbanks Memorial Hospital



Banner Health

Tanana Valley Clinic

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Fairbanks, AK 99701
Phone 907-459-3500
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Representative Olson,

We, the Board of Directors at Tanana Valley Clinic, are writing in opposition of House Bill 282. While we find the specific treatments that naturopathic doctors provide patients valuable, we do not support any expansion of a naturopath's scope of practice, specifically the designation as a 'primary care physician.'

HB282 proposes that naturopaths are allowed to write and administer prescriptions, perform minor surgeries, and enable full primary-care practices for naturopathic doctors. However, it does not take into account the distinct differences between the education and training of an MD or DO, and a naturopath. This new bill would allow naturopaths to practice well beyond the scope of their education. To earn his or her degree, an MD or DO must attend a rigorous four-year medical school, perform a *required* 3-5 year residency, oftentimes complete a 3-5 year fellowship, and pass multiple boards; a naturopath completes a four-year program at a naturopathic medical college – many of which are offered online – and passes a licensing exam, with an *optional* residency program for a specialty. The difference between these two educational backgrounds is distinct, in both quantifiable time requirements and practical experience. Allowing the recipients of both degrees to practice under the same title – 'primary care physician' – is not only inappropriate but erroneous.

This bill also puts forward a state-authorized prescription endorsement; it is our opinion that this is not in the best interest of patients. Sixty hours of pharmacology education is not a sufficient amount of training to earn prescribing rights, and will allow naturopaths to practice beyond their scope. Many states whose licensed naturopaths have prescriptive rights limit their abilities (see attachment). We believe that these limits are indicative of proactive checks and balances that recognize naturopaths' lack of prescription training, and prevent them from causing potential harm to patients. These limitations should be considered before granting Alaska's naturopaths prescribing rights under HB282.

Alaska may be facing a shortage of primary care physicians, but filling these positions with under-qualified naturopaths is not the answer. Patients in Alaska have a deserved expectation



Banner Health

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that when they visit a 'physician,' they are being seen by someone with extensive medical training and expertise. Ultimately, the training received by both bodies of providers is not the same; allowing naturopaths to have prescribing rights, perform minor surgeries, and be called 'primary care physicians' would allow them to practice beyond their scope, endangering patients and devaluing MDs and DOs. We strongly urge you to consider our concerns, and oppose HB282.

Sincerely,

Michelle Nace, MD

Chairman of the Board

Todd Capistrant, DO

Board Member

J. Timothy Foote, MD

Board Member

James Shill, MBA

CEO, Tanana Valley Clinic

Clay Triplehorn, DO

Board Member

Hunter Judkins, MD

CMO, Tanana Valley Clinic



Assuring Safe Naturopathic Medical Practices for Alaskans
Appendix D: States' Prescriptive Authority and Minor Surgery
Scope for Licensed Naturopathic Doctors

State	Rx Authority ¹	Controlled Substances Act Schedules ²					Minor Surgery
		I	II	III	IV	V	
Alaska	No						No
Arizona	Yes		x	x	x	x	Yes
California	Yes ³			x	x	x	Yes
Connecticut	No						Yes
Hawaii	No						No
Idaho	Yes						Yes
Kansas	Yes						No
Maine	Limited ⁴						Yes
Montana	Yes		x	x			Yes
New Hampshire	Limited						No
Oregon	Yes		x	x	x	x	Yes
Utah	Yes						Yes
Vermont	Limited ⁵			x	x		No
Washington DC	In Progress						In Progress
Washington State	Yes			x	x		Yes
Puerto Rico	No						No

¹ Prescriptive authority is the ability to prescribe controlled substances as identified in schedules I-IV of the Controlled Substance Act (21 USC, Sections 801-971). Maine's law refers to the "legend" and "non-legend" classifications of the official United States pharmacopoeia, rather than to the Controlled Substance Act. "Legend" drugs are those for which a prescription is required by federal law. In 2005, Washington State added some schedule 3-5 drugs to "legend" drugs that naturopathic doctors may prescribe.

² The schedules of the Controlled Substance Act are available on the US Drug Enforcement Agency's website at www.usdoj.gov/dea/pubs/scheduling.html.

³ Pursuant to California Code §3640.5, NDs may only prescribe controlled drugs under the supervision of a medical doctor.

⁴ In Maine, NDs are permitted to prescribe "non-controlled legend drugs" only after a twelve-month period of review by an allopathic physician. Such drugs may only be from the following categories: homeopathic remedies, vitamins and minerals, hormones, local anesthesia and immunizations that are designated by rule.

⁵ Vermont only allows NDs to prescribe only testosterone from schedule III and codeine from schedule IV.

Sources:

Burnham, *Legislative Research Report #05.074*, 1/6/2005, pg. 5

Hough, Dower & O'Neil, *Portrait of a Profession: Naturopathic Practice*, Center for the Health Professions, UCSF, 9/2001, pg. 27.

SB 1158, State of Idaho, 58th Legislature, 2005.

HB 1546, State of Washington, 59th Legislature, 2005.



STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sean Parnell, Governor
Emil Notti, Commissioner
Lynne Smith, Director

Division of Corporations, Business and Professional Licensing

1 March 2010

The Honorable Sean Parnell
Governor of Alaska
Post Office Box 110001
Juneau AK 99811-0001

Governor Parnell, the Alaska State Medical Board urges you and your colleagues in the legislature to defeat House Bill 282 that creates a "naturopathic medical board" and gives certain rights and recognitions to naturopaths in Alaska.

In a recent Alaska State Medical Board meeting, board members were unanimous in their strong opposition to the proposed legislation for a variety of reasons.

The principles of naturopathy are based on the belief that the body is self-healing, that the patient's "vital force" is restored by ridding the body of "toxins." As scientists, we find this simplistic approach to human ailments to be in direct conflict with the science-based knowledge of body physiology and pathology as taught to medical physicians (M.D.s) and osteopathic physicians (D.O.s). The danger of this approach is that patients with serious diseases will rely solely on the treatments provided by practitioners of naturopathy ignoring the treatments proven to be safe and effective by a science-based medical physician. All forms of naturopathic education include concepts incompatible with basic science, and do not necessarily prepare a practitioner to make appropriate diagnosis or referrals.

In 1968, in a report entitled "Independent Practitioners under Medicare," the United States Department of Health, Education, and Welfare concluded:

"Naturopathic theory and practice are not based on the body of basic knowledge related to health, disease, and health care which has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of naturopathic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."

Doctors of naturopathy, unlike medical and osteopathic physicians, are not required to obtain a minimum level of education that includes a bachelor's degree before entering into school to become a naturopath. There is little requirement for pharmaceutical education beyond the "natural" products typically used by naturopaths. There is little to no training to perform surgical procedures. And yet, naturopaths want to be allowed to perform surgical procedures and to prescribe medications for which they have received little or no education or training.

In a paper entitled "Naturopathy: A Monograph," Kimball C. Atwood, MD, Massachusetts Medical Society for the Massachusetts Special Commission on Complementary and Alternative Medical Practitioners, April, 2001, wrote:

"Licensure offers regulation to protect the public. Regulators must hold health professions to a very high standard, since considerable damage can occur as a result of treatment by incompetent practitioners. To be considered a *health* profession, an occupation must be able to demonstrate an objective, scientific, and ethical basis. Naturopathy fails to meet this standard."

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We are also very concerned with doctors of naturopathy being allowed to call themselves "physician." The title of physician has been historically reserved for medical doctors and osteopathic doctors. To permit others to use the title will serve only to confuse the public into thinking they are receiving care from someone whose education equals that of a medical or osteopathic doctor. We urge you to reject this attempt to grant greater recognition to the practitioner of naturopathy profession that it is due. The public will not be served.

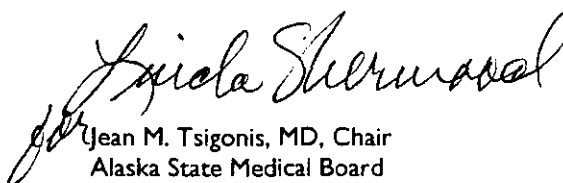
As the regulatory body entrusted with the responsibility for the licensure and discipline of physicians in our state, it is our opinion that the education and training attained by those who practice naturopathy does not prepare them adequately in modern pharmacology nor are they sufficiently trained and skilled to perform surgical procedures. Contrast the four-year education received by the naturopath consisting of two years of didactic training and two years of clinical training against the typically eight to twelve years of education and training received by allopathic and osteopathic physicians.

While some would give the impression that naturopathy is a widely accepted and approved form of health care, only 20 states license naturopaths in this country. Many of those 20 states do not permit naturopaths to prescribe controlled substances or perform surgeries.

Naturopaths are currently licensed in Alaska. They are regulated but there is no formal, appointed board that provides oversight. With the predominance of remote practice and the lack of on-site supervision or support, it would not serve the Alaskan public well to be in the lead for states to expand the scope of practice for other health care practitioners. In fact, the board believes that the safety of our patients would be at risk.

In the best interests of our patients, we urge you, Governor Parnell, and our legislators, to defeat these bills.

On behalf of the members of the Alaska State Medical Board, and all physicians in the state, thank you, sir, for your support.



Jean M. Tsigonis, MD, Chair
Alaska State Medical Board

xc: Members, Alaska State Senate
Members, Alaska State House of Representatives

1. Concerns over the unintended consequences of applying the term "Physician"
 - a. Quick internet search shows the term "physician" is used 238 times in current law. I would like to know what affect applying "physician" to naturopath's has on current laws?
 - b. Understanding is currently Medicare will not pay for naturopaths. We have a shortage of physicians that accept Medicare. This committee just passed a bill to provide incentives to "physicians" – will that bill now apply to naturopaths? Concern is that we may lose the impact on our Medicare problems. That is just an example. Believe a thorough examination of current law needs to be done so we know all effects.

2. Concerns over patient protections.
 - a. Is there a difference in the standard of care determination between a naturopath and physician? Standard of care being the threshold question for liability as to whether the physician acted negligently.
 - b. Is there a difference in liability insurances or are they exactly the same? Can we get someone to discuss the different insurance requirements for physicians and naturopaths and what that means for patients?
 - c. Do we have an attorney from legislative legal that can explain the standard of care that will be required under this bill? If a physician performs a minor surgery or a naturopath will it change the legal standard of care that a court will look at if something was done improperly? Same question on a miss-diagnosis that prescribes medication – are the standards of care the same? Are naturopath's ok with being judged under a "physician" standard of care? Why not?
 - d. Believe we should get a memo from legislative legal that fully outlines what differences there are for patient protections or recommend this go to Judiciary.

HB 282

April 1, 2009

Testimony by Patrick Neary, ND to the Alaska Legislature House of Representatives', Health and Social Services committee.

Honorable Representatives, thank you for making time in your busy schedules to hear from us on House Bill 282, a bill relating to Naturopathic Doctors.

This bill will increase choice and access to safe natural healthcare services for the Alaskan people.

I am Dr. Patrick Neary and I present today in support of passage of House Bill 282. I have lived in Juneau with my family for the past 15 years and make my livelihood in service as a Naturopathic Doctor. I work at the Wellspring Clinic in collaboration with three Advanced Nurse Practitioners.

As you know, NDs have been licensed to practice as independent primary care doctors in Alaska since 1986.

House bill 282 is a clarification of our Naturopathic licensing statutes. It brings Alaska up to the current standard of Naturopathic medical care offered in the other licensed States.

House bill 282 provides Alaskan families with increased access to care and increased freedom of choice in their health treatment while at the same time increasing safety and oversight of our profession.

The provisions of this bill allow for inclusion of Naturopathic Medical services in the Medicaid (Denali KidCare program), aligns the prescriptive authority of Naturopaths in Alaska with the national norms for licensed states in keeping with our medical training. This bill also creates a Naturopathic Medical board to protect public safety through regulatory and disciplinary powers.

Shortage of Primary Care Providers in Alaska

It is no secret that there is a shortage of primary healthcare providers nationally and particularly in Alaska. Primary care providers act as the medical home for patients. The provider patient relationship aims to improve patient health and avoid the life and financial costs of chronic disease and expensive unnecessary emergency room treatment.

There is a shortage of providers even here in Juneau. Currently in Juneau there is only one medical clinic accepting new adult patients and the wait is reportedly three weeks for a first appointment.

In Alaska, there are now approximately 40 Naturopathic Doctors licensed as primary care providers. The average length of practice of the NDs in Alaska is 10 years. We are seasoned care providers, who stand ready to assist with the current unmet need for primary health care.

Will this bill solve the primary care shortage? No. However for patients and families who chose a more natural or alternative approach to their health care, HB 282 provides Naturopaths with a safe and cost effective scope of practice to offer patients.

Although prescription medication will seldom be our first offering, HB282 allows Naturopaths to prescribe or adjust the dose of prescription medications without a patient having to wait and reschedule with a medical prescriber. This time savings will alleviate physical and financial suffering.

Our inclusion in the Denali Kid care program will allow low income parents of children with chronic health problems access to Naturopathic diet and lifestyle information which may improve the health of their child for a lifetime.

There is resistance to allowing complete scope of practice for all midlevel providers.

The passage of this bill is a free market solution to availability of healthcare in Alaska. In a capitalist society competition is a good thing. It provides freedom of choice, improved quality at lower costs.

However, professional medical trade unions oppose competition with their monopoly status. They are fighting legislative efforts to complete licensing of midlevel providers across the country.

The American Medical Association has sent this legislature, copies of its Scope of Practice Campaign document against Naturopathy. This document has out dated information and is part of a National campaign to thwart the free market competition from 15 classes of midlevel medical practioners.

The American Medical Association and its state medical associations in 2009 have fought to limit the scope of practice legislation of midlevel providers in more than 150 state legislative efforts.

As you can see on Attachment 1, across the country the AMA's Scope of Practice Campaign efforts sought to restrict or deny licensure to 15 classes of midlevel providers. Acupuncturists, Advance Nurse Practitioners(26), Audiologists, Chiropractors, Dentists, Midwives, Optometrists, Pharmacists, Physician assistants, Physical therapists, Podiatrists, Psychologists, Naturopaths (15), Speech pathologists, Surgical assistants These midlevel providers have moved for legislation that allows them to practice to the full extent of their training and expertise.

All of these providers have had their practice licensing efforts targeted by the AMA to fail because they are not in the interest of the AMA members.

Medical dissatisfaction with its own practice

During the same timeframe, in the Fall of 2008 a representative survey of 12,000 Medical Doctors by the Physicians Foundation painted a grim picture of primary healthcare. This survey was reported nationally and in the Fall 2008 Heartbeat, newsletter from the Alaska Medical Association.

This survey found that 78% of doctors believe there is a shortage of primary care doctors. 49% of Physicians (>150,000 doctors) said that they plan over the next three years on reducing the number of patients they see or stop work altogether. 33% have closed their practices to Medicaid. 45% would retire today if they had the resources. 60% of doctors would not recommend medicine as a career to young people.

According to this the primary care shortage is going to become a lot worse.

Maybe the service provided by the all of the trained midlevel providers mentioned above would reduce our growing shortfall in primary care if given a chance.

Naturopathic scientific medical education

Medical doctors claim that the education that Naturopaths receive is not scientifically and clinically adequate to allow competent clinical practice. This is patently wrong.

The current educational standard for a Naturopathic Physician is a 4 or 5 year doctoral program of basic and clinical medical sciences on top of a Bachelors degree. My Bachelors of Science degree is in Chemical Engineering from the oldest engineering school in the Nation, Rensselaer Polytechnic Institute.

I can personally attest to the rigor of the sciences required in the Bastyr Naturopathic Medical School from which I graduated in 1993. Many of our basic science and clinical instructors were PhDs and MDs who were also on the teaching staff of the University of Washington, Medical School or had taught at other regular medical schools. All of the modern Naturopathic Medical colleges are regionally and nationally accredited by appropriate governing agencies.

Attachment 2 is the curriculum of the Bastyr University. This represents the current National standard of the four year study of science based natural medical care leading to an ND degree. The first two years encompass approximately 1400 hours of modern basic and clinical diagnostic science. Of note is the 55 hours of class time in Pharmacology. Specific instruction in pharmacology and prescribing are also presented in each specialization course. Please note that none of the course hours of natural medical nature and none of the third and fourth year hours are included in the above total.

Attachment 3 is the two year Masters Degree curriculum from University of California, San Francisco. This degree qualifies Advanced Nurse Practitioners in Alaska to practice independently with full prescribing rights. The pharmacology class work for this degree is in the 40 hour range. Please note that the total graduate educational hour requirements of the Masters degree Advanced Nurse Practitioners are approximately half of those required for a Naturopathic degree.

Advanced Nurse Practitioners are independently licensed and provide safe, cost effective primary care in Alaska. Attachment 4 is an Executive Proclamation issued by our Governor Sean Parnell attesting to the excellent service Advanced Nurse Practitioners have provided Alaskans for over 35 years.

The prescribing abilities of both Naturopaths and Advanced Nurse Practitioners are not meant to be on the same par as Medical Doctors. Medical Doctors faster paced practice requires a higher degree of skill and experience. Their training prepares them for this.

Both Naturopaths and Nurse Practitioners and are aware of the limit of our knowledge and training. We see fewer patients and spend longer with them. Generally one to three patients an hour is the norm for either Naturopaths or Advanced Nurse Practitioners.

We strive to maintain appropriate, professional referral relationships with our respected Medical colleagues. We confer with and refer our patients to Medical Doctors often.

Naturopathic prescribing a remarkable record of safety

A committee comprised of three Medical doctors, three Naturopaths, and three Registered Pharmacists produced the document Findings and Recommendations Regarding the Prescribing and Furnishing Authority of a Naturopathic Doctor. This was presented to The California State Legislature in January 2007 by the California Bureau of Naturopathic Medicine. Attachment 5 is page 11 of this report.

This table shows that of the thirteen states that then licensed Naturopathic Doctors, Alaska was one of only three states that did not allow Prescriptive Authority.

Attachment 6 presents the pristine record of safety that this committee discovered. None of the state licensing agencies reported any patient harm or disciplinary action due to ND prescribing nor were any agencies aware of any civil actions against ND's.

The Medical malpractice insurance company NCMIC reported that "In the five years that they had been insuring Naturopathic Physicians and the Naturopathic Colleges they had never opened a claim against a Naturopathic Physician involving prescriptive medications." Additionally a search of the legal data bases of Oregon and Washington the states with the highest number of and years of service of Naturopaths (since 1919 and 1927 respectively) there were no legal cases against Naturopaths for prescription negligence or for anything at all!

Attachment 7 is a quote from my malpractice insurance company NCMIC for the \$1 million, \$3 million policy that I carry. This is the level required by Bartlett Hospital that allows me to order diagnostic and outpatient services there. Please note that the costs of this coverage in Alaska, Washington and Arizona are all very close. In Washington, Naturopaths have a large list of prescription drugs which they are licensed prescribe. Arizona allows NDs the almost complete prescribing authority available to Medical doctors. This parity of cost demonstrates that the insurance market does not recognize any increased risk with Naturopathic prescribing.

Closing

Naturopathic Doctors strive to provide freedom of medical choice and access to care for Alaskans. Yet the extent of our effort is hampered by our current legislation.

Naturopathic Doctors are trained in a rigorous 4 year long scientific clinical education to offer a broad spectrum of natural and medical primary care. Our training is on par with Advanced Nurse Practitioners who offer excellent medical care in Alaska. We strive to work collaboratively with our Medical colleagues for the best interest of our patients.

Naturopaths practicing to the completeness of our training offer safe primary medical service including medical prescription. The state agencies who regulate Naturopaths report no problems with Naturopaths prescribing medication. The malpractice insurance industry does not realize any increased risk of Naturopaths with prescribing authority.

House Bill 282 will allow Naturopathic Doctors to safely offer services to the full scope of our educational training as true primary care doctors. It will provide increased oversight and accountability through formation of a Naturopathic Board.

Alaskans, especially low income Alaskan families will benefit from more freedom of medical choice and access to care. Please support the passage of this important legislation.

Thank you



Scope of Practice Campaign
Trends for 2009 State Legislative/Regulatory Sessions
(By state)

State	Scope of Practice Issue
Alabama	Advance Practice Nurses: independent prescribing rights
Arizona	Optometrists: mandatory PreK vision screenings
Arkansas	Advance Practice Nurses: independent practice
California	Advance Practice Nurses: independent practice
California	Naturopaths: prescribing privileges
California	Physical Therapists: direct access (or expansion thereof)
California	Psychologists: independent prescribing rights
Colorado	Advance Practice Nurses: Certified Nurse Anesthetists: independent practice
Colorado	Advance Practice Nurses: independent prescribing rights
Colorado	Chiropractors: ability to refer to selves as "physicians"
Colorado	Naturopaths: licensure
Connecticut	Advance Practice Nurses: independent practice
Delaware	Midwives: Lay Midwives: licensure
Delaware	Pharmacists: collaborative management (similar to NPs)
Florida	Advance Practice Nurses: authority to prescribe controlled substances
Florida	Optometrists: authority to perform surgery
Florida	Optometrists: mandatory PreK vision screenings
Florida	Physical Therapists: direct access (or expansion thereof)
Florida	Podiatrists: authority to treat the ankle and all soft tissue structures below the knee governing the function of the foot and ankle
Florida	Psychologists: independent prescribing rights
Georgia	Nonphysician Providers (generally): use of lasers
Georgia	Psychologists: independent prescribing rights
Hawaii	Optometrists: mandatory PreK vision screenings
Hawaii	Psychologists: independent prescribing rights
Idaho	Midwives: Lay Midwives: licensure
Idaho	Naturopaths: licensure
Idaho	Optometrists: authority to perform surgery
Idaho	Optometrists: expansion of authority to perform injections
Illinois	Naturopaths: licensure
Illinois	Optometrists: mandatory PreK vision screenings
Illinois	Pharmacists: collaborative management (similar to NPs)
Illinois	Physical Therapists: direct access (or expansion thereof)
Illinois	Psychologists: independent prescribing rights
Illinois	Speech Language Pathologists: authority to perform treatment functions independently

State	Scope of Practice Issue
Indiana	Advance Practice Nurses: Certified Nurse Anesthetists: prescriptive authority
Indiana	Advance Practice Nurses: Certified Nurse Anesthetists: independent practice
Indiana	Midwives: Lay Midwives: licensure
Indiana	Surgical Assistants: licensure
Iowa	Advance Practice Nurses: authority to supervise the use of fluoroscopic x-ray systems by radiologic technologists and students
Iowa	Advance Practice Nurses: Certified Nurse Anesthetists: authority to perform any medical procedure, including but not limited to, interventional pain management
Iowa	Optometrists: mandatory PreK vision screenings
Iowa	Pharmacists: authority to administer immunizations
Iowa	Physician Assistants: independent practice
Kansas	Pharmacists: authority to administer immunizations
Kansas	Physical Therapists: direct access (or expansion thereof)
Kentucky	Audiologists: direct access
Kentucky	Physical Therapists: direct access (or expansion thereof)
Louisiana	Advance Practice Nurses: Certified Nurse Anesthetists: independent practice
Maine	Pharmacists: authority to administer immunizations
Maine	Pharmacists: collaborative management (similar to NPs)
Maryland	Anesthesia Assistants: licensure
Massachusetts	Nonphysician Providers (generally): use of lasers
Massachusetts	Nonphysician Providers (generally): administration of certain injectable materials including, but not limited to, flourescein dye, collagen or Botulinium toxin
Massachusetts	Optometrists: authority to prescribe certain therapeutic pharmaceutical agents
Michigan	Advance Practice Nurses: general scope expansions
Michigan	Chiropractors: authority to determine differential diagnosis; access to imagine technology
Michigan	Chiropractors: authority to treat the entire body, including joints and extremities not currently permitted
Michigan	Nonphysician Providers (generally): Physician employment by
Michigan	Pharmacists: collaborative management (similar to NPs)
Michigan	Physical Therapists: direct access (or expansion thereof)
Michigan	Physical Therapists: protection of POPTS (physician owned physical therapy services)
Michigan	Speech Language Pathologists: licensure
Minnesota	Advance Practice Nurses: independent prescribing rights

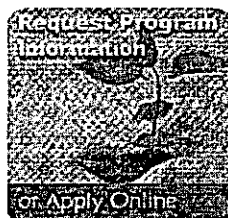
State	Scope of Practice Issue
Minnesota	Nonphysician Providers (generally): Physician employment by
Minnesota	Nonphysician Providers (generally): use of lasers
Minnesota	Psychologists: independent prescribing rights
Minnesota	Speech Language Pathologists: authority to perform treatment functions independently
Mississippi	Optometrists: authority to perform surgery
Mississippi	Psychologists: independent prescribing rights
Missouri	Midwives: Lay Midwives: licensure
Missouri	Naturopaths: licensure
Missouri	Psychologists: independent prescribing rights
Montana	Psychologists: independent prescribing rights
Nebraska	Advance Practice Nurses: independent practice
Nebraska	Optometrists: authority to perform surgery
Nebraska	Optometrists: authority to prescribe certain therapeutic pharmaceutical agents
Nebraska	Optometrists: expansion of authority to perform injections
Nebraska	Optometrists: authority to prescribe therapeutic contact lenses
Nebraska	Psychologists: independent prescribing rights
Nevada	Alternative Medicine Practitioners/CAM: general scope of practice expansions without registration/regulation/licensure
Nevada	Nonphysician Providers (generally): Physician employment by
Nevada	Physical Therapists: direct access (or expansion thereof)
Nevada	Physical Therapists: protection of POPTS (physician owned physical therapy services)
Nevada	Podiatrists: general scope of practice expansions
Nevada	Psychologists: independent prescribing rights
New Hampshire	Naturopaths: prescribing privileges
New Jersey	Physical Therapists: direct access (or expansion thereof)
New Mexico	Acupuncturists: expanded prescriptive authority
New Mexico	Optometrists: authority to perform surgery
New Mexico	Optometrists: expansion of authority to perform injections
New Mexico	Physician Assistants: independent practice (primary care and family medicine)
New Mexico	Psychologists: removal of Board of Medicine oversight of prescriptive authority/ability to prescribe off label
New York	Advance Practice Nurses: Certified Nurse Anesthetists: independent practice
New York	Chiropractors: scope of practice expansions within workers' compensation
New York	Dentists: authority to perform cosmetic surgery in oral maxillofacial region; unrelated to dental health

State	Scope of Practice Issue
New York	Naturopaths: licensure
New York	Optometrists: authority to prescribe certain therapeutic pharmaceutical agents
New York	Podiatrists: authority to treat the ankle
North Carolina	Audiologists: general scope expansions
North Carolina	Chiropractors: general scope expansions
North Carolina	Midwives: Lay Midwives: licensure
North Carolina	Naturopaths: licensure
North Dakota	Advance Practice Nurses: Nurse Practitioners: mandatory listing as primary care providers (PCPs) by Medicaid
Ohio	Advance Practice Nurses: prescriptive authority – Schedule II drugs
Ohio	Naturopaths: licensure
Ohio	Nonphysician Providers (generally): Physician employment
Ohio	Optometrists: prescription authority
Ohio	Pharmacists: collaborative management (similar to NPs)
Ohio	Physician Assistants: increasing Medicaid reimbursement rules (APRN parity)
Ohio	Psychologists: independent prescribing rights
Oklahoma	Advance Practice Nurses: Certified Nurse Anesthetists: authority to perform any medical procedure, including but not limited to, interventional pain management
Oklahoma	Naturopaths: licensure
Oklahoma	Nonphysician Providers (generally): Physician employment by
Oklahoma	Pharmacists: collaborative management (similar to NPs)
Oklahoma	Physical Therapists: direct access (or expansion thereof)
Oklahoma	Psychologists: independent prescribing rights
Oregon	Chiropractors: general scope expansions
Oregon	Naturopaths: prescribing privileges
Oregon	Psychologists: independent prescribing rights
Pennsylvania	Audiologists: expand scope to include diagnosis, treatment, and management of hearing and balance disorders
Pennsylvania	Nonphysician Providers (generally): administration of certain injectable materials including, but not limited to, flourescein dye, collagen or Botulinium toxin
Pennsylvania	Optometrists: authority to prescribe certain therapeutic pharmaceutical agents
Pennsylvania	Optometrists: mandatory PreK vision screenings
South Carolina	Advance Practice Nurses: general scope expansions

State	Scope of Practice Issue
South Carolina	Chiropractors: general scope expansions
South Carolina	Naturopaths: licensure
South Carolina	Optometrists: authority to perform surgery
South Carolina	Podiatrists: authority to treat the ankle and all soft tissue structures below the knee governing the function of the foot and ankle
Tennessee	Naturopaths: licensure
Tennessee	Nonphysician Providers (generally): administration of certain injectable materials including, but not limited to, fluorescein dye, collagen or Botulinium toxin
Tennessee	Psychologists: independent prescribing rights
Texas	Nonphysician Providers (generally): use of lasers
Texas	Optometrists: authority to perform surgery
Texas	Physician Assistants: lessening of supervision requirements by an MD and/or DO
Texas	Advance Practice Nurses: independent practice
Texas	Physical Therapists: direct access (or expansion thereof)
Texas	Acupuncturists: licensure
Utah	Midwives: Direct Entry Midwives: general scope expansions
Utah	Physical Therapists: direct access (or expansion thereof)
Utah	Psychologists: independent prescribing rights
Vermont	Advance Practice Nurses: Certified Nurse Anesthetists: independent practice
Virginia	Advance Practice Nurses: Nurse Practitioners: gives the state Nursing Board sole authority to interpret the practice of NPs
Virginia	Advance Practice Nurses: Nurse Practitioners: change supervision requirement to collaboration and consultation
Virginia	Naturopaths: licensure
Washington	Advance Practice Nurses: general scope expansions
Washington	Optometrists: mandatory PreK vision screenings
Washington D.C.	Optometrists: authority to perform surgery
West Virginia	Optometrists: authority to perform surgery
Wisconsin	Advance Practice Nurses: general scope expansions
Wisconsin	Audiologists: expand scope to include diagnosis, treatment, and management of hearing and balance disorders
Wisconsin	Chiropractors: general scope expansions
Wisconsin	Naturopaths: licensure
Wisconsin	Pharmacists: collaborative management (similar to NPs)
Wisconsin	Psychologists: independent prescribing rights



ACADEMIC DEGREE PROGRAMS



Attachment 2

Curriculum for Doctor of Naturopathic Medicine 2009-2010

Four-Year Track: Year I

Quarter	Cat. No.	Course Title	Credits	Lec.	L/C	Tot.
Fall	BC5104	Biochemistry 1	4	4	0	44
	BC5107	Human Physiology 1 Lec/Lab	5.5	4	3	77
	BC5110	Histology*	5	4	2	66
	BC5122	Gross Human Anatomy 1	4.5	4	1	55
	BC5122L	Gross Human Anatomy 1 Lab	1	0	2	22
	NM5113	Naturopathic Medicine in Historical Context	2	1	2	33
	NM5804	Clinic Entry 1	1	0	2	22
		<i>Quarterly Total:</i>	23	17	12	319
Winter	BC5105	Biochemistry 2	4	4	0	44
	BC5108	Human Physiology 2 Lec/Lab	5.5	4	3	77
	BC5112	Embryology	3	3	0	33
	BC5123	Gross Human Anatomy 2	4.5	4	1	55
	BC5123L	Gross Human Anatomy 2 Lab	1	0	2	22
	BC5142	Fundamentals of Research Design*	2	2	0	22
	NM5114	Fundamentals of Naturopathic Clinical Theory	2	1	2	33
	OM5120	Fundamental Principles of TCM*	3	3	0	33
	PM5301	Hydrotherapy/ Physiotherapy Lecture	2	2	0	22
	PM5305	Hydrotherapy/Physiotherapy Lab*	1	0	2	22
		<i>Quarterly Total:</i>	28	23	10	363
	Spring	BC5106	Biochemistry 3	4	4	0
BC5109		Human Physiology 3	3	3	0	33
BC5124		Gross Human Anatomy 3	4.5	4	1	55
BC5124L		Gross Human Anatomy 3 Lab	1	0	2	22
BC5129		Neuroscience	5.5	4	3	77
BO5301		Botanical Medicine 1 Lec/Lab	2	1.5	1**	26.5
NM5115		Naturopathic Medicine in Global Context	2	1	2	33
PM5310		Myofascial Analysis	1.5	0	3	33
		<i>Quarterly Total:</i>	23.5	17.5	12	323.5

*BC5110, BC5142, OM5120: Usually also offered in summer

**Two hours every other week times five weeks

Four-Year Track: Year II

Quarter	Cat. No.	Course Title	Credits	Lec.	L/C	Tot.
Fall	BC6200	Human Pathology 1	4	4	0	44
	BC6204	Immunology*	4	4	0	44
	BO6301	Botanical Medicine 2	2	2	0	22
	HO6300	Homeopathy 1	2	2	0	22
	NM6210	Clinical Lab Diagnosis 1	3.5	2	3	55
	NM6221	Physical/Clinical Diagnosis 1 Lecture	2	2	0	22
	NM6221L	Physical/Clinical Diagnosis 1 Lab	2	1	2	33
	PS6305	Naturopathic Counseling 1	3	3	0	33
	TR6310	Foods, Dietary Systems & Assessment	3	2	2	44
		<i>Quarterly Total:</i>	25.5	22	7	319
	Winter	BC6201	Human Pathology 2	4	4	0
BC6209		Infectious Diseases**	5	5	0	55

	BO6302	Botanical Medicine 3 Lec	2	2	0	22
	HO6301	Homeopathy 2	3	3	0	33
	NM6211	Clinical Lab Diagnosis 2	3.5	2	3	55
	NM6222	Physical/Clinical Diagnosis 2 Lecture	2	2	0	22
	NM6222L	Physical/Clinical Diagnosis 2 Lab	2	1	2	33
	PS6306	Naturopathic Counseling 2	3	3	0	33
	TR6311	Macro & Micronutrients	3	3	0	33
		<i>Quarterly Total:</i>	27.5	25	5	330
Spring	BC6202	Human Pathology 3	4	4	0	44
	NM6100	Successful Charting and Coding	1	1	0	11
	BC6305	Pharmacology **	5	5	0	55
	HO6302	Homeopathy 3	3	3	0	33
	NM6212	Clinical Lab Diagnosis 3	3.5	2	3	55
	NM6224	Physical/Clinical Diagnosis 3 Lecture	2.5	2.5	0	27.5
	NM6224L	Physical/Clinical Diagnosis 3 Lab	2	1	2	33
	NM8801	Preceptorship 1	1	0	4	44
	PM6300	Naturopathic Manipulation 1	2	2	0	22
		<i>Quarterly Total:</i>	24	20.5	9	324.5

*BC6204: Usually also offered in summer

** BC6209 and BC6305: Offered in winter and spring quarter

Eligible to take NPLEX basic science exams after the successful completion of the second year.

Four-Year Track: Year III

Quarter	Cat. No.	Course Title	Credits	Lec.	L/C	Tot.
Summer	BO6303	Botanical Medicine Dispensary Lab	1	0	2	22
	NM7325	Naturopathic Case Analysis & Mgmt 1	1.5	0	3	33
	NM7341	Cardiology	3	3	0	33
	NM7416	Minor Office Procedures*	3	3	0	33
	NM7417	Medical Procedures*	3	3	0	33
		<i>Quarterly Subtotal:</i>	11.5	9	5	154
		1-2 Clinic Shifts**	2-4	0	4-8	44-88
Fall	BO7300	Botanical Medicine 4 Lec/Lab	2	1.5	1	26.5
	MW7320	Normal Maternity	3	3	0	33
	NM 7302	Gastroenterology ****	2	2	0	22
	NM 7307	EENT	2	2	0	22
	NM7313	Gynecology	3	3	0	33
	PM7301	Naturopathic Manipulation 2*****	3	3	0	33
	PM7305	Orthopedics	2	2	0	22
	PS7200	Psychological Assessment	2	2	0	22
	TR7411	Diet & Nutrient Therapy 1	3	3	0	33
		<i>Quarterly Subtotal:</i>	22	21.5	1	246.5
		1-2 Clinic Shifts**	2-4	0	4-8	44-88
Winter	NM7101	Environmental Medicine	1.5	1.5	0	16.5
	NM7102	Public Health	1.5	1.5	0	16.5
	NM7116	Naturopathic Clinical Theory	1	1	0	11
	NM7304	Dermatology	2	2	0	22
	NM7306	Oncology	2	2	0	22
	NM7314	Pediatrics 1	2	2	0	22
	PM7302	Naturopathic Manipulation 3****	3	3	0	33
	PM 7341	Sports Medicine/Therapeutic Exercise	2	2	0	22
	PS7203	Addictions & Disorders	2	2	0	22
	TR7412	Diet & Nutrient Therapy 2	3	3	0	33
	NM7142	Critical Evaluation of the Medical Literature	2	2	0	22
		<i>Quarterly Subtotal:</i>	22	22	0	242
		1-2 Clinic Shifts**	2-4	0	4-8	44-88
Spring	BO7301	Botanical Medicine 5 Lec/Lab	2	1.5	1	26.5
	NM6105	Fundamentals of Business Operations	2	2	0	22
	NM7305	Clinical Ecology	2	2	0	22
	NM7311	Neurology	2	2	0	22
	NM7315	Pediatrics 2	2	2	0	22
	NM7320	Family Medicine	2	2	0	22

NM7330	The Healing Systems	1	1	0	11
PM7303	Natuopathic Manipulation 4*** *****	3	3	0	33
PS7315	Natuopathic Counseling 3	2	2	0	22
	<i>Quarterly Subtotal:</i>	18	17.5	1	202.5
	1-2 Clinic Shifts**	2-4	0	4-8	44-88

* NM7341, NM7416 and NM7417: May also be offered in spring
 ** Students are assigned 6 shifts during their first year (4 quarters) in clinic.
 *** Two hours every other week times five weeks
 **** NM7302: Offered fall and spring.
 ***** PM7301: One section usually offered in summer
 *** ** PM7302: One section usually offered in fall
 *** ***** PM7303: One section usually offered in winter

Four-Year Track: Year IV

Quarter	Cat. No.	Course Title	Credits	Lec.	L/C	Tot.
Summer	NM8201	Radiographic Interpretation 1 Lecture*	2	2	0	22
	NM6115	Goal Setting and Self Motivation OR	1	1	0	11
	NM6120	Professional Speaking and Writing	1	1	0	11
		<i>Quarterly Subtotal:</i> 3-4 Clinic Shifts	3 6-8	3 0	2	33 132-176
Fall	NM8303	Geriatrics	2	2	0	22
	NM8308	Endocrinology**	3	3	0	33
	NM8312	Urology	1.5	1.5	0	16.5
	NM8325	Nat. Case Analysis & Mgmt 2: Grand Rounds***	1	0	2	22
	NM8413	Adv'd Naturopathic Therapeutics 1	2	2	0	22
		<i>Quarterly Subtotal:</i> 3-4 Clinic Shifts	9.5 6-8	8.5 0	2	115.5 132-176
Winter	NM8101	Ethics****	1	1	0	11
	NM8214	Diagnostic Imaging*** **	3	3	0	33
	NM8309	Rheumatology	1.5	1.5	0	16.5
	NM8414	Adv'd Naturopathic Therapeutics 2	2	2	0	22
	NM8802	Preceptorship 2	1	0	4	44
		<i>Quarterly Subtotal:</i> 3-4 Clinic Shifts	8.5 6-8	7.5 0	4	126.5 132-176
Spring	NM8102	Jurisprudence	1	1	0	11
	NM8212	Radiographic Interpretation 2**** **	3	3	0	33
	NM8314	Pulmonary Medicine	1.5	1.5	0	16.5
	NM8803	Preceptorship 3	1	0	4	44
	NM8844	Interim Patient Care*** ****	2	0	4	44
		<i>Quarterly Subtotal:</i> 3-4 Clinic Shifts	8.5 6-8	5.5 0	8	148.5 132-176

*NM8201: Offered summer and fall
 **NM8308: Offered fall and spring
 ***NM8325: Offered in fall, winter and spring
 ****NM8101: Offered fall and winter
 *****NM8212 and NM8214: Both offered winter and spring
 *****NM8844: Students are required to complete a total of 44 interim clinic hours. (Usually students staff the shifts they are assigned to in the quarter just ended.) Students register for and pay for this shift in their last quarter of attendance.

Summary of Clinic Requirements: Naturopathic Medicine Program

Quarter*	Cat. No	Course Title	Credits	Lec.	L/C	Tot.
variable	NM7820-29	Patient Care 1-10	20	0	40	440
variable	NM8801-3	Preceptorship 1-3	3	0	12	132
variable	NM8830-36	Patient Care 11-17	14	0	28	308
variable	NM8844	Interim Patient Care	2	0	4	44
variable	PM7801-2	Physical Medicine 1-2	4	0	8	88
variable	PM8801-2	Physical Medicine 3-4	4	0	8	88
		<i>Clinic Total:</i>	47	0	100	1100

*Quarterly shift assignments are based on availability.

Elective Requirements: Naturopathic Medicine Program

Quarter	Cat. No.	Course Title	Credits	Lec.	L/C	Tot.
variable	variable	Elective and Special Topics	14	14	0	154
		Elective Total:	14	14	0	154

Curriculum and course changes in the 2009-2010 Bastyr University Catalog are applicable to students entering during the 2009-2010 academic year. Please refer to the appropriate catalog if interested in curriculum and courses required for any other entering year.

Total Requirements: Naturopathic Medicine Program

The following requirements apply to all naturopathic medicine program tracks.

	Credits	Lec.	L/C	Total
Total Core Course Credits and Hours	249.5	219.5	60	3071.5
Total Elective Credits and Hours	14	14	0	154
Total Clinic Credits and Hours	47	0	100	1100
Total Requirements	310.5	233.5	160	4325.5

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Attachment 3

University of California, San Francisco | [About UCSF](#) | [Search UCSF](#) | [UCSF Medical Ctr.](#) *advancing health world*[School of Nursing](#) | [about the school](#) | [prospective students](#) | [faculty / depts.](#) | [masters specialties](#)
[research](#) | [current students](#) | [news/events](#) | [alumni / friends](#) | [Search \(Nursing\)](#) | [Applications](#)**Adult Nurse Practitioner (ANP) Master's Specialty Area
ANP Sample Curriculum (2009-11)****Note:** Curriculum and course scheduling are **subject to change** without notice.**Caution: DO NOT** file your study list on-line until you speak to your adviser and/or clinical faculty during the first week of classes.

Number	Course	Units	Time	Faculty (FOR)
YEAR ONE, FALL QUARTER (2009)				
N253 or N221.01	Theories of the Policy Process OR Theories Rel. to Nrsng. Care of the Adult	3	Wed 8-10	Malone/Carrieri-Kolhman
N257	Asmt./Mgmt. of Common Psych. Symptoms	2	Wed 10-12	Phoenix
N270	Advanced Health Assessment	2	Wed 1-3	Hollinger
N301.01	Adv. Health Asmt. skills lab	1	Thu 8-10 or 10-12	ANP Faculty
N404.01*	ANP clinical practicum	1	Th 12-2 qowk	ANP Faculty
N236A	Complementary Healing	2	Wed. 3-5	Abercrombie
WINTER QTR. (2010)				
N262A	Research Methods	2	Wed 8-10	A. Alkon
N245	Health Protection/Promotion	2	Wed 10-12	Segovia-Bain
N232	Clinical Pharmacology	4	Wed 1-3 & web	Macera/Ford
N245.01	ANP Seminar: Health Protection/Promtn.	1	Wed 3-5 qowk even	Grundland
N414.01*	ANP Clinical Practicum	2	Wed 3-5 qowk odd	ANP Faculty
SPRING QTR. (2010)				
N246	Asmt./Mgmt. of Signs/Symptoms	3	Wed 8-11	Scarr
N246.01	ANP Urgent Care Residency + clin. confc.	1	Wed 11-1 qowk even	Dreier
N415.01A*	ANP Residency (8 hrs/wk + clinical confc.)	3	Wed 11-1 qowk odd	ANP Faculty
N262.05	Research in Primary/Complementary Care	2	Wed 1-3	Janson
YEAR TWO, FALL QUARTER (2010)				
N247	Complex Health Problems & Management	3	Mon 2-4 and web	Saxe
N241	Dimensions in Advanced Practice	2	Wed 1-3	Sparacino/Levi
N415.01B*	ANP Residency + clinical confc.	4	Wed. 3-5 qowk, or Wed 3-5 qowk Weds 3-5 qowk Wed 3-5 qowk	Burgel Collins-Bride Stringari Newlin
WINTER QTR. (2011)				
N415.01B*	ANP Residency plus clinical confc.	4	Wed 10-12 qowk odd Wed 5-6 q wk	Burgel, Saxe, Stringari Newlin
N247.01	Seminar- Adult Pri. Care: Complex Hlth.	2	Wed 1-4	Oka
S222	Probs. Health Care Economics + Policy	2	Wed 3-5	Chapman
SPRING QTR. (2011)				
N271.01	Decision-Making in Adult Primary Care	3	Wed 1-4 q wk	Newlin
N415.01B*	ANP Residency + clinical confc.	4	Wed. 11-1 qowk or Wed 4:30-5:30	Burgel, Saxe, Stringari TBD
Comprehensive Examination				Graduate Adviser

Table Revised: 2/19/2010, Subject to Change

* 1 unit N 400 coursework = 3 hours clinical per week. Clinical conference meets qowk (qowk = every other week).

Note: 2 units of Socio-Cultural content, Nutrition (Nu218, 2 units) in Fall or Winter Quarter (web-based), and microscope workshop (part of N415.01A) are required.

N259.04 Contraception (1 unit), which is offered in Fall and Winter Quarters as a web-based course and in-class meetings, is required for the ANP-generalist, ANP-HIV and ANP-ICH students.

Optional course includes X-Ray (N284, 1 unit), which will be offered in Spring Quarter (web-based).

This curriculum meets the requirements of the ANCC for *Adult Nurse Practitioner* certification.

Links/Related Web Pages at UCSF School of Nursing

- **Adult Nurse Practitioner** MS Specialty Area Page
- **Prospective Students**
 - **Master of Science (MS) Program**
 - **Information Sessions**
 - **Application Procedures**
- **Master's Specialty Areas**
 - **Adult Nurse Practitioner**
 - Acute Care Nurse Practitioner
 - Advanced Community Health and International Nursing (ACHIN)
 - Cardiovascular Nursing
 - Critical Care/Trauma Nursing
 - Family Nurse Practitioner
 - Gerontological Nursing
 - Health Policy Nursing
 - Leadership/Administration
 - Nurse Midwifery
 - Occupational & Environmental Health Nrsng.
 - Oncology Nursing
 - Pediatric Nursing, Advanced Practice
 - Perinatal Nursing, Advanced Practice
 - Psychiatric/Mental Health Nursing, Advc. Practice
- **Current/Incoming Students Information** page

More Information/Contact: info@nursing.ucsf.edu

Revised: Feb. 2010

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STATE OF ALASKA



Executive Proclamation by *Sean Parnell, Governor*

WHEREAS, there are more than 125,000 licensed Nurse Practitioners (NPs) in the United States with more than 650 licensed in Alaska, providing high-quality, cost-effective, personalized healthcare to Alaskans for more than 35 years; and

WHEREAS, Alaska has one of the highest numbers of NPs per capita of any state in the nation; and

WHEREAS, NPs work to achieve advanced education, most hold master's degrees, and many hold doctorates - including advanced clinical training beyond their initial registered nurse preparation; and 24 percent of practicing NPs in Alaska have received their graduate nursing education through the University of Alaska's Family Nurse Practitioner Program; and

WHEREAS, NPs are partners in the healthcare of their patients, so that, in addition to clinical services, NPs focus on health promotion, disease prevention, and health education and counseling, guiding patients to adopt smarter health and lifestyle choices; and

WHEREAS, NPs can provide excellent, skilled, cost-effective care; and

WHEREAS, NPs offer services in the areas of family practice, women's health, pediatrics, geriatrics, psychiatric mental health, midwifery services, and other specialties; and

WHEREAS, NPs provide healthcare to people of all ages throughout the State of Alaska, and in diverse healthcare settings which include community clinics, health department clinics, public health centers, schools, university student health centers, private practice, emergency departments, home health care, long-term care facilities, and hospitals; and

WHEREAS, about 40 percent of NPs in Alaska practice in rural settings, an estimated 35 percent practice in medically underserved areas of Alaska, and nearly ten percent are the sole licensed providers in their communities; and

WHEREAS, NPs bring a unique perspective to health care service delivery by emphasizing both nursing and medical care.

NOW, THEREFORE, I, Sean Parnell, Governor of the State of Alaska, do hereby proclaim November 8-14, 2009 as:

Alaska Nurse Practitioner Week

in Alaska, and encourage Alaskans to recognize the many contributions that this dedicated group of healthcare professionals makes to the health and well-being of the people in the communities they serve.

Dated: October 16, 2009



Sean Parnell

Sean Parnell, Governor
who has also authorized the
seal of the State of Alaska to
be affixed to this proclamation.

COMMITTEE FINDINGS

Formulary Laws from Other States

As the scope of practice for NDs varies from state to state, so do the laws and regulations regarding prescribing. Of the 13 other states that license NDs, 9 of those states allow NDs to prescribe independently, without any MD supervision or protocol. Only one state, Kansas, which instituted licensure in 2003, requires MD supervision, and Maine requires collaboration with a physician for one year prior to independent prescribing.

State	ND Licensure Enacted	# of Current Active NDs	Prescriptive Authority	MD Supervision Required
Alaska	1986	40	No	No
Arizona	1935	375	Yes	No
Connecticut	1920	210	No	No
Hawaii	1925	85	Yes	No
Idaho	2005	8	Yes	No
Kansas	2003	11	Yes	Yes
Maine	1995	27	Yes	1 year
Montana	1991	67	Yes	No
New Hampshire	1994	57	No	No
Oregon	1927	715	Yes	No
Utah	1997	18	Yes	No
Vermont	1995	117	Yes	No
Washington	1919	802	Yes	No

The formularies for each state vary greatly. A brief summary is given below. The actual formularies may be viewed in the Appendix.

Arizona has the broadest formulary in the nation. Arizona NDs are allowed to independently prescribe all classes of prescription drugs, with 4 exceptions:

- IV medications (except vitamins, chelation therapy, and drugs used in emergency resuscitation and stabilization, which are allowed).
- Controlled substances listed as Schedule I or II (except morphine is allowed).
- Cancer chemotherapeutics classified as legend drugs.
- Antipsychotics.

To support this broad prescribing authority, Arizona passed HR 2028 in 2002. This bill required, as of January 1, 2005, that all NDs complete a 60-hour series of pharmacy courses and pass an examination. After that date, only NDs who have completed the additional training and passed the test in

Safety Record of ND Prescribing

In preparation for this report, the Bureau contacted the licensing agencies for each of the states that allow NDs to prescribe. None of the states reported any patient harm or disciplinary action due to ND prescribing. In addition, the states were not aware of any civil actions against NDs for prescribing.

The Bureau also contacted NCMIC Insurance Company. NCMIC insures NDs in all of the licensing states and also insures the naturopathic medical schools. In a letter to the Bureau dated June 7, 2006, NCMIC stated: "In the five years that NCMIC has been insuring Naturopathic Physicians and the colleges, we have never opened a claim against a Naturopathic Physician involving prescription medications." [See Appendix.]

Additionally, the Committee contacted Jury Verdicts Northwest (JVN) to see if there were any civil actions filed against a licensed ND. JVN covers both Oregon and Washington, the two states with the greatest number of NDs and that have been licensing NDs for a considerable length of time (since 1919 and 1927, respectively). JVN responded "Upon reviewing cases contained in Jury Verdicts Northwest's database we found no cases against naturopaths for prescription negligence, or for that matter our database contained no cases against naturopaths at all." [See Appendix.]

Why Do NDs Need to Prescribe?

The NIH National Center for Complementary and Alternative Medicine considers naturopathy a "major Western whole medical system" that "involves complete systems of theory and practice that have evolved independently from or parallel to allopathic (conventional) medicine." In 1987, the American Association of Naturopathic Physicians (AANP) began work on a consensus definition of naturopathic medicine for the modern era. The definition, unanimously adopted by the AANP's House of Delegates in 1989, focused on the guiding naturopathic principles and philosophy rather than specific therapeutic modalities or treatments. The definition reads:

"Naturopathic medicine is a distinct system of primary health care - an art, science, philosophy and practice of diagnosis, treatment and prevention of illness. Naturopathic medicine is distinguished by the principles which underlie and determine its practice. These principles are based upon the objective observation of the nature of health and disease, and are continually reexamined in the light of scientific advances. Methods used are consistent with these principles and are chosen upon the basis of patient individuality. Naturopathic physicians are primary health care practitioners, whose diverse techniques include modern and traditional, scientific and empirical methods."

Attachment 7

FAX

14001 University Avenue, Clive, Iowa 50325-8258

Mailing Address: P.O. Box 9118
Des Moines, Iowa 50306-9118

To: Patrick Neary, ND
Company:
Fax: 907-789-7168

From: Erika Boone
Fax: 800-996-2642
Phone: 800-952-9935

RECEIVED

MAR 29 2010

Pages including cover: 01
Sent: Monday, March 29, 2010 12:33:42 PM.

WELLSPRING INC.
WELL HEALTH CENTER**NOTES:**

Dr. Neary,

Per your request, below are the malpractice insurance annual rates for each state you are considering to practice in:

AK: (Full Time) \$3,703.00 or (Part Time) \$1,666.00 (this currently includes a Claims Free discount)

AZ: (Full Time) \$4,293.00 or (Part Time) \$2,147.00

WA: (Full Time) \$3,595.00 or (Part Time) \$1,798.00

Please let me know if you have any questions or if there is anything else I can do for you.

Thank you for your business,

Erika Boone
NCMIC Client Representative

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HB

284

ALASKA STATE LEGISLATURE



REPRESENTATIVE NANCY DAHLSTROM
REPRESENTATIVE LES GARA
REPRESENTATIVE BOB HERRON

House Bill 284

"An Act requiring the Department of Health and Social Services to accept federal prescription drug benefits or to provide comparable benefits for residents of the Alaska Pioneers' Home, including residents eligible for discount or free benefits from the United States Department of Veterans Affairs or the Indian Health Service of the United States Department of Health and Human Services."

In April of this past year, Veterans residing at Pioneer Homes across Alaska were caught in the middle of a bureaucratic dispute. Officials at the Pioneer Homes could not accept prescription drugs from the Veterans Administration because of safety concerns with how those drugs were delivered. The VA refused to change how they sent drugs to the Pioneer Homes. Veterans who were unable to self-administer drugs had to pay the Pioneer Homes' pharmacy out-of-pocket for drugs they needed, prescriptions that they would otherwise receive for free from the VA.

A joint effort between the Department of Health and Social Services, the Department of Military and Veterans Affairs, local public veterans' advocates and legislative involvement appear to have fixed the problem at the policy level with the Dept. of HSS. State administrators found a solution to safely administer prescription drugs from the VA and veterans began to receive their free drugs once again.

House Bill 284 would stop this from happening again. Administrators could only prevent residents from receiving Federal prescription drug benefits if there was a safety concern. If they did prevent residents from receiving those drug benefits, the Pioneer Homes would step in to cover the value of the denied benefit.

This bill would protect not only Veteran residents, but all Pioneer Home residents receiving Federal prescription drug benefits, including benefits from Indian Health Services. The Pioneer Homes have always worked with residents eligible for IHS benefits to receive their prescription drugs. However, if something changes in the future with the distribution of IHS drugs, the Homes could stop accepting them but would need to cover the cost to affected residents.

With the passage of House Bill 284 veterans and other groups who have earned Federal drug benefits will no longer have to worry about not receiving their much needed prescription medications because bureaucrats are unable reach, what should be, a simple agreement.

ALASKA STATE LEGISLATURE



REPRESENTATIVE NANCY DAHLSTROM
REPRESENTATIVE LES GARA
REPRESENTATIVE BOB HERRON

HB 284

Sectional Analysis

Section 1: Amends AS 47.55.010(c), maintenance and operation of Alaska Pioneers' Home and Alaska Veterans' Home, to require the Department of Health and Social Services to accept Federal prescription drug benefits earned and due to Pioneers' Home residents.

Section 2: Adds a new subsection to AS 47.55.020, admission to home, to provide the Department of Health and Social Services the option of providing comparable prescription drug benefits to pioneers and veterans.

ALASKA STATE LEGISLATURE



REPRESENTATIVE NANCY DAHLSTROM
REPRESENTATIVE LES GARA
REPRESENTATIVE BOB HERRON

House Bill 284

Departments Effected

Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB284
 () Publish Date: _____

Identifier (file name): HB284-DHSS-PH-03-05-10 Dept. Affected: Health & Social Services
 Title Pioneers Home RX Drug Benefit RDU Alaska Pioneer Homes
 Component Pioneer Homes
 Sponsor Gara
 Requester House HSS Component Number 2671

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

HB 284 ensures that eligible Pioneer Home residents will continue to have access to federal prescription drug benefits available from the Veterans Administration or Indian Health Services. There is no fiscal impact to this bill as the Pioneer Homes are already allowing residents to access their federal prescription benefits.

Prepared by: Dave Cote, Director Phone 465-5737
 Division Alaska Pioneer Homes Date/Time 1/21/10 12:00 AM
 Approved by: Alison Elgee, Assistant Commissioner Date 3/5/2010
DHSS Finance & Management Services

David Theriault

From: Cote, David D (HSS) [david.cote@alaska.gov]
Sent: Saturday, October 17, 2009 9:37 PM
To: Hogan, William H (HSS); Rep. Les Gara
Cc: Sen. Bill Wielechowski; Rep. Nancy Dahlstrom; David Theriault; Laughlin, Wilda J (HSS); Hefley, Patrick B (HSS)
Subject: RE: Disabled Veterans Prescription Drug Benefit/Pioneer Home Problem - a heads up

Thank you all for your interest in this. I hope we can put our heads together to find a solution that works for everyone.

-----Original Message-----

From: Hogan, William H (HSS)
Sent: Sat 10/17/2009 7:42 AM
To: Gara, Les (LAA); Cote, David D (HSS)
Cc: Wielechowski, Bill (LAA); Dahlstrom, Nancy (LAA); Theriault, David C (LAA); Laughlin, Wilda J (HSS); Hefley, Patrick B (HSS)
Subject: Re: Disabled Veterans Prescription Drug Benefit/Pioneer Home Problem - a heads up

Thanks everyone. We have been trying to make this work, but with little success so far. We would be glad to problem solve with you. Can you work with Wilda Laughlin on our end to set up a meeting? Thanks, Bill

From: Rep. Les Gara
To: Hogan, William H (HSS); Cote, David D (HSS)
Cc: Wielechowski, Bill (LAA); Dahlstrom, Nancy (LAA); Theriault, David C (LAA)
Sent: Fri Oct 16 09:04:18 2009
Subject: Disabled Veterans Prescription Drug Benefit/Pioneer Home Problem - a heads up

Hi Bill and Dave. I hope all's well. I just want to give you a heads up on the attached letter you'll receive from me, Rep. Dahlstrom & Sen Wielechowski. A number of folks in that veterans community have also agreed that we should send the letter, as the prescription drug benefit issue we've tried to work on this summer for our disabled veteran constituents remains unresolved.

Rather than taking an unjustifiably acerbic approach that the Pioneer Homes are doing terrible things (we do understand your concerns, and have been trying to working around them), we have been careful and purposeful in keeping the letter (and a press release we've sent) conciliatory. Our point, and we perceive your point - is that there has to be a solution out there that addresses the Homes' safety and other concerns, the relative non-cooperation by the VA, and the interest in honoring the right of disabled veterans to their hard-earned free prescription medicine benefit.

We've proposed a few alternative solutions, which we'd like to work with you to settle upon. When you have had the time to analyze the approaches, we'd like to sit down with you soon to figure out a plan of action to solve the problem.

Thank you for all your work. I know we may presently disagree about some of the issues, but hope we can work towards a timely solution. We don't plan on taking an aggressive stance against the Pioneers Homes if the press follows up on the story - just that we believe there is a solution, and want to achieve it.

Thanks. I'll call. Les

From: David Theriault
Sent: Friday, October 16, 2009 9:02 AM
To: Rep. Les Gara
Subject:

ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA
SENATOR BILL WIELECHOWSKI
REPRESENTATIVE NANCY DAHLSTROM

October 16, 2009

David Cote, Director
Alaska Pioneer Homes
Central Office, P.O. 110690
Juneau, AK 99811-0690

Re: Veterans at the Pioneer Homes Who Cannot Receive Their Free VA Prescription Drug Benefit

Dear Mr. Cote:

We are writing to recommend a solution to the problem facing disabled Veterans at Alaska's Pioneer Homes. As you know from work with our offices, we are concerned that the Pioneer Homes will not administer prescription drugs veterans receive for free from the Veterans Administration. As a result, Veterans entitled to no-cost prescription medicine have to purchase it from the Pioneer Homes pharmacy. So far in correspondence, and work on the matter, we have not found a solution that is acceptable to the Pioneer Homes. However, we are writing because we do believe a solution can be achieved, and will present some recommendations. Our hope is that you will agree to support one or more of them, and we would like to work with you on what you determine is the best solution to this problem.

We've attached the correspondence, and legal memoranda between the Pioneer Homes and Rep. Gara's Office, as it may help you. And we do respect the difficulties the Homes face, including the lack of cooperation from physicians and staff in the VA system that Pioneer Homes staff have experienced (sometimes physicians do not accept concerns from Pioneer Homes Staff about the appropriateness of prescriptions; the VA won't send prescriptions in blister packages).

The basic problem is that the Pioneer Homes like to administer all a patient's medicines in a blister package, rather than from prescription bottles. The Pioneer Homes like to do this for safety reasons, and current law does not let the Pioneer Homes repackage bottled drugs into a blister package. Here are some proposed solutions. We will work with you to implement one, or accept a separate proposal from the Pioneer Homes. But the current status – that veterans who are entitled to free prescription medicine are not allowed to use that benefit – begs a solution.

1. Change in the law. We will write the Board of Pharmacy to change the regulations to allow the Pioneers Homes to repackage medicine into blister packages. If they decide not to allow this, we will write legislation to achieve this.
2. Alternatively, under current law, the Pioneer Homes may re-package medicine if it receives a "manufacturers license". We would ask that the Pioneer Homes look into determining whether achieving this license is feasible.
3. Alternatively, the Pioneer Homes could ask for the staff you have advised us you would need to safely administer prescription medicine in the form it comes in from the Veterans Administration. That is, the Homes have a safety concern about administering medicine from drug canisters. While nursing staff are certainly qualified to administer medicine from a bottle, you have advised us you may need additional staff to make sure this can be done safely, and that you are too short on staff to do this safely with current personnel. If this is the approach you would like to take, let us know.
4. Finally, it just might be less expensive, given the small number of affected patients, to adopt a policy as follows, that would require no change in staff or packaging: To provide free prescription medicines to any Pioneer Home resident who qualifies for free medicines that the Pioneers Home decides it cannot administer. That is, if you do not accept medicines from another institution that are provided to the resident for free, then the Pioneer Homes would have to supply that resident free medicine at cost to the Pioneer Home.
5. We will consider legislation that allows Pioneer Home repackaging, and that allows the Pioneer Homes to choose the most acceptable method for providing free prescription medicine to those who would otherwise qualify for it.

Thank you for working with us. So far we have not been able to find a solution that is acceptable to you. This letter expresses our intention that we continue to work to find one that will work as soon as practicable. We look forward to your response.

Best Regards,



Rep. Les Gara



Sen. Bill Wielechowski



Rep. Nancy Dahlstrom

Cc: Governor Parnell
Comm. Hogan
Alaska Board of Pharmacy
Alaska Veterans Advisory Council

Veterans in Pioneer Homes will get their medicines from VA FREE OR LOW COST: Issue of distribution safety resolved.

By ROSEMARY SHINOHARA

rshinohara@adn.com

(11/14/09 02:47:41)

The state announced Friday that it has found a solution that will allow veterans who live in state-run Alaska Pioneer Homes to get the free or low-cost medicines they are entitled to from the VA, but have been denied in recent months.

The state will also refund the money the affected veterans had to pay to fill prescriptions through the Pioneer Homes pharmacy, according to officials from the state Department of Health and Social Services.

The Pioneer Homes quit accepting medicine from the VA last April for veterans who need help from staff to take their pills. The decision affected about a dozen veterans in the Anchorage Pioneers' Home, and perhaps a couple of veterans at the Palmer home.

Pioneer Homes director Dave Cote said the VA medicine wasn't packaged in the right kind of packs to make sure staff could safely distribute it. The Pioneer Homes wanted the medicine to come in blister packs labeled with the patient's name, with foil on one side and plastic on the other and each pill ready to be popped out individually. That way it would be easy to tell if the pill had been administered.

But Cote said after a high-level meeting with Veterans Administration last week, it became clear "they could not be flexible. ... There was not anything they were going to do on their side of things."

Ken Strum, pharmacy chief for the Veterans Administration in Anchorage, said the VA doesn't have equipment needed to package medicine in blister packs as the Pioneer Homes wanted. And, Strum said, it would be against state regulation for the Pioneer Homes pharmacy to repackage in blister packs medicine it receives from the VA pharmacy.

So Cote and the Pioneer Homes nurses instead figured out the safest way to distribute VA medicine from the bottles it comes in, Cote said. Basically, they're going to be more careful.

The Pioneer Homes nursing staff will keep the pills in the original bottles, instead of transferring all of a veteran's pills into a pill box where all meds to be taken at a time would be mixed together. That's to prevent a problem in case certain prescriptions are discontinued, which happens often with older folks, Cote said.

Also, instead of allowing aides to dispense VA pills, nurses will do it, he said.

The dispute between the VA and the Pioneer Homes gained attention this fall after Bea Combs, stepdaughter of Pioneers Homes veteran Melvin Ertwine, went to a legislator's office seeking to get the free or low-cost medicines re-instated.

State Reps. Les Gara of Anchorage and Nancy Dahlstrom of Eagle River and Sen. Bill Wielechowski of Anchorage began sending letters and meeting with state administrators about it.

"I think it's a great solution," Wielechowski said Friday. "It was sort of two large bureaucracies clashing with each other. Somebody had to give."

The state was able to be "a little more nimble," he said. "One reason we were able to do it is it's a small number of people."

Find Rosemary Shinohara online at adn.com/contact/rshinohara or call her at 257-4340.

Print Page

Close Window

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In Service to America®

ALASKA STATE COUNCIL

February 5, 2010
Representative Gara
REF: HB284

Rep Gara:

As one of the Veteran Service Organizations that worked through a number of meetings last year with you and other Members of our State Legislature including Rep Les Gara and Rep Nancy Dahlstrom and staff, I wanted to ensure each of you know how appreciated for your efforts and your willingness to step up for our veterans is as they face ongoing issues in relation to their care both at our State Pioneer Homes and the Alaska Veterans Home.

Each of you became intimately aware of the knot veterans face with differing government agencies attempting to untie their regulatory webs to meet the real day-to-day needs of our veterans. It was difficult, complex, and troubling. The leadership of this team of Legislators and the Commissioner of Health and Social Services in finding a solution was most welcome and appreciated. It will be remembered.

We are delighted you have decided to formally codify this new understanding in state law by the introduction of HB284. We have read the bill and discussed it with your staff and others and wanted you to know that you have the full support and appreciation of the veterans of Alaska, and specifically those Vietnam Veterans we represent here in Alaska and nationally. We will be forwarding this bill to other states that also face similar challenges.

I hope to be able to testify in support of this bill when it is before the various committees, but travel and work may keep me away. Please advise the members of any committee this bill is heard before that HB284 has our strong support and is listed as one of our top state legislative priorities for 2010.

If there is anything we can do to assist in moving this bill through this session, just ask.

It is an honor,


Ric Davidge
President

3705 Arctic Blvd #415, Anchorage, Alaska 99503
907 222 6945 907 222 6933 fax 907 229 5328 Chairman's Cell 907 748 1722 Ex Dir

HB

309

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: January 19, 2010

FURTHER REFERRALS: Finance

Date of Committee Action: March 25, 2010

The HEALTH AND SOCIAL SERVICES Committee considered:

HB 309

HOUSE BILL NO. 309

"An Act prohibiting health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allowing those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibiting those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy."

HB 309 DENTAL CARE INSURANCE

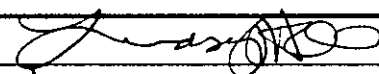
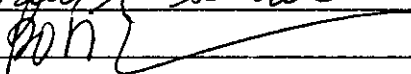
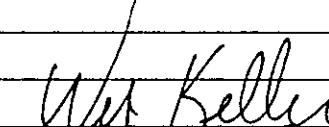
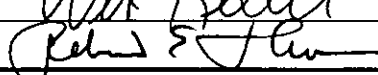
Recommends it be replaced with HCS or HCS for HB 309 (HSS)
 For Senate Bills with new title: Technical Title New Title: HCR _____ Same Title New Title

- attach amendments
- add new referral to _____ Committee
- Letter of Intent _____ Committee

List of Abbrev for Depts.:
 ADM
 CED
 COR
 CRT
 EED
 DEC
 DFG
 GOV
 DHS
 LWF
 LAW
 LEG
 MVA
 DNR
 DPS
 REV
 DOT
 UA

<u>NEW FISCAL NOTES</u>				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
<u>CED</u>				✓

<u>PREVIOUS FISCAL NOTES</u>				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

<u>Signing with recommendations</u>	Printed Last Name	DP	DNP	NR	AM
	Holmes			X	
Jammie Wilson	T Wilson			X	
Paul Seaton	SEATON			X	
	LYNN	X			
Chair: 	Keller			X	
Chair: 	HERRON			X	

Adopted

moved by Rep. Henon

AMENDMENT #1

Offered in : House Health & Social Services Committee

By:

To: HB 309 work draft 26-LS1315\C

Page 1, Line 14

After (2)

Insert "not"

26-LS1315C
Bailey
3/24/10

CS FOR HOUSE BILL NO. 309()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE THOMAS

A BILL
FOR AN ACT ENTITLED

1 **"An Act prohibiting health care insurers that provide dental care coverage from setting**
2 **fees that a dentist may charge under a preferred provider contract for dental services**
3 **not covered under the insurer's policy, and relating to preferred provider contracts**
4 **between insurers and dentists."**

5 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

6 *** Section 1. AS 21.42.392(c) is amended to read:**

7 (c) A health care insurer that provides coverage for dental care may
8 (1) reimburse a covered person at a different rate because of the
9 person's choice of a dentist if the dentist is not a part of the covered person's dental
10 network or preferred provider organization agreement; the [. THE] covered expense
11 for non-network providers may not be less than that allowed to a network provider,
12 although the covered expense may be reimbursed at a lower percentage or with higher
13 deductibles than if the service had been provided within the network;
14 (2) limit a fee set by a dentist for a service unless the service is
15 covered under the insurer's plan or contract, except as provided under (3) of this

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subsection; and

(3) offer a dentist the option of entering into a preferred provider contract with the insurer that provides a fee schedule for covered services only or a fee schedule for both covered and uncovered services; under this paragraph,

(A) the health care insurer may not

(i) take an action against the dentist based on the dentist's refusal to enter into a contract with an insurer;

(ii) fail to list a dentist who does not enter into a contract with an insurer in the insurer's marketing materials; or

(iii) take action against the dentist during the management or administration of a contract based on the dentist's choice of contract;

(B) the terms or provisions of the contract

(i) may not violate AS 45.50.562 - 45.50.566; and

(ii) ^{shall require both and the dentist} ~~may~~ authorize the insurer to provide information

to the insured describing the dentist's choice of contract and fee schedules;

(C) "covered service" means a health care service for which

a health care insurer pays a benefit for all or part of the service, including

a benefit that is available but limited by deductible, coinsurance, or

frequency terms under the contract between the insurer and the insured.

*Adopted
Meady Senter
Conceptual
#2*

CS HB 309 26LS1315\C

Bailey 3/24/10

Page 1, Line 2 and 3

DELETE ALL

Page 1, Line 4

DELETE "Insurers from setting"

Page 1, Line 4

after "for" INSERT "under preferred provider contract"

Page 1, Line 5

After "policy" INSERT ", and relating to preferred provider contracts between insurers and dentists"

Page 2

DELETE ALL

INSERT "; (2) limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract, except as provided under (3) of this subsection; and

(3) offer a dentist the option of entering into a preferred provider contract with the insurer that provides a fee schedule for covered services only or a fee schedule for both covered and uncovered services; under this paragraph,

(A) the health care insurer may not

(i) take an action against the dentist based on the dentist's refusal to enter into a contract with an insurer;

(ii) fail to list a dentist who does not enter into a contract with an insurer in the insurer's marketing materials; or

(iii) take action against the dentist during the management or administration of a contract based on the dentist's choice of contract;

(B) the terms or provisions of the contract

(i) may not violate AS 45.50.562 – 45.50566; and

(ii) may authorize the insurer to provide information to the insured describing the dentist's choice of contract and fee schedules;

(C) "covered service" means a health care service for which a health care insurer pays a benefit for all or part of the service, including a benefit that is available but limited by deductible, coinsurance, or frequency terms under the contract between the insurer and the insured."

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 9, 2010

SUBJECT: Does AS 21.42.345 cover dependents for dental care?
(HB 309, Work Order No. 26-LS1315\R)

TO: Representative Bill Thomas
Attn: Cecile Elliott

FROM: Dennis C. Bailey *DCB*
Legislative Counsel

You have asked whether AS 21.42.345, which requires an insurer to insure the children of an insured under a policy with dependent coverage, would override the proposed provision of HB 309, which would prohibit insurers from setting a minimum age under which a child would not receive coverage for dental care. This memorandum reviews the terms of AS 21.42.345 and the proposed change to AS 21.42.392 in HB 309 and concludes that the two provisions conflict.

AS 21.42.385.

AS 21.42.345 provides:

Sec. 21.42.345. Required provision for coverage of dependents.

(a) A health care insurance plan providing coverage for a dependent of a covered individual shall, as to the dependent's coverage, also provide that the health care insurance benefits applicable for dependents shall be payable with respect to

(1) a newly born child of a covered individual from the moment of birth;

(2) a child adopted by a covered individual from the date of adoption;

(3) a child placed with a covered individual for adoption from the date of placement for adoption; and

(4) a spouse from not later than the first day of the first month beginning after the date the request for enrollment is received, but the insurer may require that a request for enrollment be received within 31 days of the date of marriage.

(b) The coverage for a newly born child under this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

To paraphrase, AS 21.42.345 requires that a health care insurance plan that provides for dependent coverage must include coverage for newborn children, adopted children, and new spouses. This section only applies to policies that provide dependent coverage, and would not apply, for example, if a group plan sponsored by an employer either did not provide coverage for an employee's dependents or allowed the insured to elect coverage without dependent benefits.

AS 21.42.345, however, does not state whether dental care is included in the required coverage for dependent children. That question is answered by AS 21.12.050, which defines health care insurance as follows (emphasis added):

Sec. 21.12.050. Health and health care insurance defined.

(a) Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) including every insurance that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance and stop-loss insurance but does not include workers' compensation insurance. Health care insurance described in (b) of this section is a type of health insurance under this subsection.

(b) Health care insurance means that part of health insurance that provides benefits for medical care whether provided directly, through reimbursement, or other method.

...

Under subsection (a), the meaning of that health care insurance includes coverage for dental care. Also, under subsection (b), health care insurance includes coverage for "medical care." The definition of "medical care" includes amounts paid for "diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body." See, AS 21.90.900(30). Under these definitions, it is reasonable to conclude that health care insurance would include dental services.

In summary, one may conclude that AS 21.42.345 requires coverage, including dental coverage, for newborn and adopted children under a health care insurance plan that covers dependents.¹

¹ AS 21.42.385 requires a health care insurer to offer a plan sponsor or individual minimum dental coverage "not less than the dental . . . coverage provided on January 1, 2009, to an individual entitled to medical benefits under AS 39.35.535 (public employees retirement system of Alaska)." AS 39.35.535 identifies who is eligible for the coverage but does not describe the coverage provided as of that date.

Representative Bill Thomas
March 9, 2010
Page 3

AS 21.42.392.

HB 309 proposes amendments to AS 21.42.392 to prohibit a health care insurer who provides coverage for dental care from setting a minimum age for receiving dental care coverage in a health care insurance plan. Under this prohibition, a health care insurer presumably would not be allowed to limit coverage based on an age set by an insurer and could not restrict coverage for newborn children, the lowest age limit possible. Therefore, the proposed amendment prohibiting a health care insurer from setting a minimum age for dental care coverage conflicts with AS 21.42.345.

Keep in mind, though, that AS 21.42.345 only applies to a plan that includes dependent coverage. Conversely, if the plan did not provide dependent coverage, an insurer is not obligated to provide coverage for newborn children, adopted children, and new spouses and the conflict would not longer exist.

The last question presented is whether the date of coverage for dependents begins at birth or at the time of adoption. Coverage for a newly born child is required from the moment of birth and, for an adoption, from the date of adoption under AS 21.42.345(a).

If I may be of further assistance, please advise.

DCB:ljw
10-142.ljw

NFIB

The Voice of Small Business®

ALASKA

March 25, 2010

The Honorable Bill Thomas
State Capitol Building
Juneau, Alaska 99801-1182

Dear Representative Thomas:

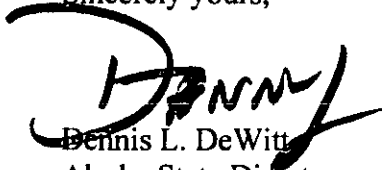
RE: HB 309 Proposed Committee Substitute

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully remove our opposition to House Bill 309. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

We want to express our appreciation of your willingness to address our previous concerns and to propose a committee substitute that eliminates the portion of the bill that we opposed.

Thus, the NFIB/AK no longer has any concerns with House Bill 309.

Sincerely yours,


Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council
House Health & Social Services Committee

CS FOR HOUSE BILL NO. 309(HSS)

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE THOMAS

A BILL

FOR AN ACT ENTITLED

1 **"An Act prohibiting health care insurers that provide dental care coverage from setting**
2 **fees that a dentist may charge under a preferred provider contract for dental services**
3 **not covered under the insurer's policy, and relating to preferred provider contracts**
4 **between insurers and dentists."**

5 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

6 *** Section 1. AS 21.42.392(c) is amended to read:**

7 (c) A health care insurer that provides coverage for dental care

8 (1) may reimburse a covered person at a different rate because of the
9 person's choice of a dentist if the dentist is not a part of the covered person's dental
10 network or preferred provider organization agreement; the [. THE] covered expense
11 for non-network providers may not be less than that allowed to a network provider,
12 although the covered expense may be reimbursed at a lower percentage or with higher
13 deductibles than if the service had been provided within the network;

14 (2) may not limit a fee set by a dentist for a service unless the
15 service is covered under the insurer's plan or contract, except as provided under

1 (3) of this subsection; and

2 (3) may offer a dentist the option of entering into a preferred
3 provider contract with the insurer that provides a fee schedule for covered
4 services only or a fee schedule for both covered and uncovered services; under
5 this paragraph,

6 (A) the health care insurer may not

7 (i) take an action against the dentist based on the
8 dentist's refusal to enter into a contract with an insurer;

9 (ii) fail to list a dentist who does not enter into a
10 contract with an insurer in the insurer's marketing materials; or

11 (iii) take action against the dentist during the
12 management or administration of a contract based on the dentist's
13 choice of contract;

14 (B) the terms or provisions of the contract

15 (i) may not violate AS 45.50.562 - 45.50.566; and

16 (ii) must require both the insurer and the dentist to
17 provide information to the insured describing the dentist's choice
18 of contract and fee schedules;

19 (C) "covered service" means a health care service for which
20 a health care insurer pays a benefit for all or part of the service, including
21 a benefit that is available but limited by deductible, coinsurance, or
22 frequency terms under the contract between the insurer and the insured.

AMENDMENT

OFFERED IN THE HOUSE
TO: HB 309

BY REPRESENTATIVE KELLER

1 Page 1, lines 1 - 5:

2 Delete all material and insert:

3 **""An Act prohibiting health care insurers who provide dental care coverage from**
4 **setting fees that a dentist may charge for dental services not covered under the insurer's**
5 **policy and allowing those insurers to set a maximum age for receiving dental care**
6 **coverage as a dependent.""**

7

8 Page 2, line 1, following "i":

9 Insert "or"

10

11 Page 2, line 2:

12 Delete all material.

13

14 Renumber the following paragraph accordingly.

26-LS1315\S
Bailey
2/16/10

CS FOR HOUSE BILL NO. 309()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE THOMAS

A BILL
FOR AN ACT ENTITLED

1 **"An Act prohibiting health care insurers that provide dental care coverage from setting**
2 **a minimum age for receiving dental care coverage, allowing those insurers to set a**
3 **maximum age for receiving dental care coverage as a dependent child, and prohibiting**
4 **those insurers from setting fees that a dentist may charge for dental services not covered**
5 **under the insurer's policy."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1.** AS 21.42.392(a) is amended to read:

8 (a) A health care insurer who provides coverage for dental care may not
9 include in the health care insurance plan or contract a provision that

10 (1) prohibits a covered person from obtaining dental care services from
11 a dentist of the person's choice, including a specialist;

12 (2) restricts a covered person's right to receive full information from
13 the person's dentist regarding the care or treatment options that the dentist believes are

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in the best interests of the person;

(3) sets a minimum age for receiving dental care coverage; or

(4) permits an insurer to limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract.

* Sec. 2. AS 21.42.392(c) is amended to read:

(c) A health care insurer that provides coverage for dental care may

(1) reimburse a covered person at a different rate because of the person's choice of a dentist if the dentist is not a part of the covered person's dental network or preferred provider organization agreement; the [. THE] covered expense for non-network providers may not be less than that allowed to a network provider, although the covered expense may be reimbursed at a lower percentage or with higher deductibles than if the service had been provided within the network; and

(2) set the maximum age for a person to receive coverage for dental care as a dependent child.



REPRESENTATIVE BILL THOMAS

ALASKA STATE LEGISLATURE DISTRICT 5

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webpage: www.akrepublicans.org/thomas/

State Capitol

Juneau AK, 99801-1182

907-465-3732

888-461-3732

FAX 907-465-2652

HB 309 prohibits insurance companies from setting fee limits on noncovered procedures and also prevents them from setting age limitations for covered services.

A national trend has developed where dental managed care insurance plans are setting caps on dentist's fees for services that are not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates. The insurance company sets a fee limit for a service and the consumer knows upfront how much will be covered and how much he or she will have to pay out of pocket. The problem arises when an insurance carrier tries to set fee limits on services that are *not* covered. Insurance companies have begun setting fee limits for certain noncovered services, forcing dentists to reevaluate their decision to participate in the insurance plan thus decreasing the number of dentists participating in the managed care plan. This leaves consumers with fewer dental care options, which usually ends up costing the consumer financially as well as in quality of care.

A second, more recent trend in dental managed care plans is minimum age restrictions. Before benefits are allowed, some insurance companies require that a child be at least four years old. This presents a huge problem in young children obtaining necessary dental care. Dental cavities in very young children continue to be a problem in Alaska and arbitrarily setting minimum age requirements will handicap efforts to restore dental health to this vulnerable population. Tooth decay is highly preventable through early and sustained home care and regular professional preventive services. In May 2003, the American Academy of Pediatrics issued a policy statement urging dental exams for very young children. The policy recommends that infants receive an oral health assessment from a health care professional by six months and be referred to a dental health professional by one year. This important statement recognizes that oral health problems can begin long before a child reaches the age of three.

HB 309 goes a long way towards preventing the above mentioned problems and will ensure that Alaskans continue to receive the dental care that they need. I strongly urge your support of HB 309.



REPRESENTATIVE BILL THOMAS

ALASKA STATE LEGISLATURE DISTRICT 5

e-mail: Representative.Bill.Thomas@legis.state.ak.us

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888-461-3732

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List of Departments Affected by HB 309

- 1.) Department of Commerce, Community, and Economic Development -- Division of Insurance
- 2.) Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB 309
() Publish Date: _____

Identifier (file name): HB309-CED-INS-2-5-10
Title: Dental Care Insurance
Dept. Affected: DCCED
RDU: Insurance
Component: Insurance
Sponsor: Representative Thomas
Requester: House Health and Social Services Committee
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: None

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill would prohibit health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allow those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibit those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy.

The department does not expect additional operating expenses as a result of this legislation.

Prepared by: Linda Hall, Director
Division: Insurance
Approved by: Emil Notti, Commissioner
Department of Commerce, Community and Economic Development

Phone 907-269-7900
Date/Time 2/5/10 2:22 PM
Date 2/5/2010



Alaska Dental Society, Inc.

9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

HB309

HB309 will prohibit dental managed care insurance plans from setting fee limits on noncovered procedures and setting minimum age limitations for covered services. A national trend has developed where dental managed care insurance plans are setting caps on dentists' fees for services not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates in exchange for limitations on the numbers of dentists who participate and services that are covered. The insurance companies' actions are causing dentists to reevaluate their decision to participate in plans due to philosophical opposition to insurance companies dictating fee levels for services not covered and the economic impact on their practices. The result is increasing numbers of dentists stopping their participation in managed care plans leaving the consumers with fewer choices for participating providers. Patients could then lose the benefit provided and either have to pay more to stay with their dental home, or seek care from another practitioner causing disruption to treatment.

A second, more recent, trend is dental managed care plans setting minimum age restrictions before benefits are allowed. Dental cavities in very young children continue to be a problem in Alaska and arbitrarily limiting the age dependants receive covered benefits will handicap efforts to restore dental health to this vulnerable population.

The insurance companies are requiring state plans to amend provider contracts in a way that allows the managed care plans to control what dentist's charge, even for services they DO NOT cover. The contract amendment says that dentists serving covered patients will not be able to charge the patient a fee in excess of the managed care plans prescribed fee for the non-covered service. It should be noted the two services that fee caps have been set for are orthodontics and veneers, services that are generally discretionary and rarely covered under any insurance plan.

The managed care plans decision to set fee limitations for noncovered services raises questions about the sincerity of their most recent approach to lowering costs. Managed care plans artificially capping a dentist's fee without providing a concurrent benefit for the patient amounts to a subsidy from participating dentists for the insurance companies marketing. At the outset, the reduced fees help the insurer attract customers and, therefore improves the insurer's bottom line. Dentists front the costs of this marketing approach and have a tough decision to make when faced with a contract amendment that caps the non-covered fees



Alaska Dental Society, Inc.

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HB309

- Encourages increased access to dental care
- Prevents insurance companies from intruding on patient-dentist relationship
- Ensures at risk children will continue to receive dental benefits
- Prohibits insurance companies from setting fees on services they do not provide dental benefits for
- Insures dental plans work for the patients best interest not the insurance companies best interest



Alaska Dental Society

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info@akdental.org

20 January 2010

To whom it may concern:

On behalf of the members of the Alaska Dental Society I urge the swift passage of HB309

HB309 will prohibit dental managed care insurance plans from setting fee limits on noncovered procedures and setting minimum age limitations for covered services. A national trend has developed where dental managed care insurance plans are setting caps on dentists' fees for services not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates in exchange for limitations on the numbers of dentists who participate and services that are covered. The insurance companies' actions are causing dentists to reevaluate their decision to participate in plans due to philosophical opposition to insurance companies dictating fee levels for services not covered and the economic impact on their practices. The result is increasing numbers of dentists stopping their participation in managed care plans leaving the consumers with fewer choices for participating providers. Patients could then lose the benefit provided and either have to pay more to stay with their dental home, or seek care from another practitioner causing disruption to treatment.

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Sincerely,

Gary A. Moeller, DDS
President, Alaska Dental Society

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You &
Your Practice

Noncovered services: House supports legislative action to counter trend

Posted Nov. 12, 2009

By Arlene Furlong

Honolulu—Seeking legislative action to prevent dental plans from capping the amount dentists can charge for services a plan doesn't cover, the 2009 House of Delegates adopted Resolution 59H-2009.

Dental plans began implementing contract provisions holding dentists to maximum allowed fees for services for which no benefit is available with increasing frequency last year.

Many dentists fear such provisions limit access.

"Why should insurance companies be able to charge for things that aren't even in their benefit packages?" asked Dr. Robert Plage, chair of the ADA Dental Benefit Information Service. "If dentists aren't reimbursed for services, the insurance companies won't suffer but the public may. Exercising this contract provision doesn't cost insurers a dime."

ADA News has heard from insurers on the issue. Insurers say including a maximum allowable fee as part of the benefit or plan design allows patients access to services that otherwise would not be covered. They also say the competition is doing it—a reason for employing the provision.

In its first provision, Res. 59H-2009—Maximum Fees for Noncovered Services—establishes ADA policy supporting legislative action to stop the capping of fees for nonscheduled dental services. It resolves that:

- as a matter of policy, the American Dental Association opposes any third-party contract provisions that establish fee limits for nonscheduled dental services.

"The importance of having ADA policy calling for legislative action on this is to let the insurance companies and our members know exactly where we stand on this," said Dr. Plage.

The second resolving clause says the ADA will continue to actively pursue federal legislation to prohibit ERISA covered plans from applying such provisions (ERISA supercedes state plans) and the third directs the ADA to encourage individual states to pursue legislation to prohibit insurance plans from applying noncovered services provisions. (In June, Rhode Island passed a bill preventing dental plans there from capping the amount dentists can charge for services the plan doesn't cover.)

The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for retirement and health benefit plans in private industry.

The second and third clauses of Res. 59H-2009—Maximum Fees for Noncovered Services—resolves as follows:

- that the American Dental Association continue to actively pursue passage of federal legislation to prohibit ERISA covered plans from applying such provisions;
- that the American Dental Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.



The Council on Dental Benefit Programs prioritizes the noncovered services issue as one of dentists' top concerns and is working with the Council on Government Affairs to introduce federal legislation that would get directly at the issue for ERISA plans (federally regulated plans). State legislatures cannot effect changes to ERISA.

"This resolution accomplishes a lot," commented Dr. Plage. "It formally establishes our policy, while giving our members and our respective state dental societies direction on what to do."

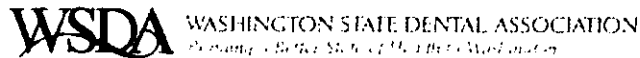


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Non-Covered Services

Non-Covered Services Talking Points

WSDA has proposed legislation for the 2010 session which would prohibit dental insurers from limiting fees for services not included in dental benefit plans.

Why is legislation necessary?

In July 2009 Washington Dental Services, the state's largest dental insurer, announced new provider contract provisions, allowing it to limit fees charged by its contracted dentists for services that are not covered by the insurer's dental plans. WDS said it was doing so to stay competitive with other insurers implementing similar provisions, however WDS also indicated it disagreed with this policy and was forced to implement it due to its alliance nationally with the Delta Dental system.

- Unless prohibited by insurance law, these provisions constitute an unjust interference in the financial affairs of dental practices.
- Some dental insurers have also added contract provisions to force dental practices to reduce charges when patients reach annual benefit maximum limits.
- Non-covered services vary by insurer and include such items as use of nitrous oxide to control dental fear and anxiety, implants, and posterior composite restorations. While a complete list from WDS is not yet available, WSDA understands these will likely be elective procedures that are consented to by the patient after discussion with the dentist.
- Limiting fees for non-covered services will force dental practices to cost shift. This will result in higher fees charged to uninsured patients and reduced participation in low-reimbursement plans, such as a Medicaid.
- Rhode Island enacted a prohibition on non-covered fee limits in June 2009.
- The National Conference of Insurance Legislators is now considering model legislation to prohibit non-covered service fee limits. Federal legislation is also being pursued to prohibit this practice by ERISA plans not regulated under state laws.

This directory does not yet contain any files.

**Supplied by Academy of General Dentistry: <http://www.agd.org/issuesadvocacy/hotissues/casonfees/>*

1/19/2010

Putting Caps on Fees for Non-Reimbursed Services

Several major dental benefits carriers are adding language to provider participation agreements to allow them to set fees for dental services that they do not pay for, i.e., non-covered services. That is, if a dentist agrees to the contract language, he or she will be required to charge the patient what the carrier has told him or her to charge even when the carrier will not pay for the service.

To enact a fee cap on non-covered services, a dental benefits carrier must amend the current contract it has with its existing providers. Here's an example of such an amendment:

Dentist may bill a Member for non-covered services (which are defined as any service for which no payment is made under the applicable plan or arrangement for any reason, including but not limited to, services in excess of contractual maximums, services not covered under plan design, and services denied due to contractual limitations). Dentist's charge to Member for non-covered services may not exceed the Maximum Allowable Charge for the applicable CDT code as specified in the most current Maximum Allowable Charge schedule. Fees for all non-covered services will be collected from the Member, and not billed to the Carrier.

Note that this is just one of many variations of such a provision that you may find in your participation contract. The provider then has the choice of signing the new contract, thus accepting the new fee caps, or terminating his or her contract. If the provider elects not to sign, then he or she will be excluded from the provider networks presented to patients by that carrier's dental plans.

What are the non-covered services?

Non covered services are those services that a patient's dental plan has chosen not to pay for. Note that a carrier may offer numerous dental plans. Often however, dental plans without coverage for expensive, cosmetic, or other dental services are cheaper for employers to purchase for their employees. This is especially attractive to employers in the current economic climate. Each dental plan may have a different list of non-covered services, and therefore one cannot specify any particular services as universal "non-covered services."

Scope of the issue

Because dental benefits carriers can fall under the protection of the Employee Retirement Income Security Act of 1974 (ERISA), this is both a national and state issue. ERISA is a federal law that sets minimum standards for retirement and health benefit plans in private industry. Insurers that cover large employee groups who self-insure will more likely fall under ERISA. Some state laws do not exempt dentists from ERISA dental insurance plans that want to implement this policy change.

Rationale of carriers enacting such policy

To stay competitive with one another, dental benefits carriers use the argument of market pressure or gaining a marketing advantage as one of the reasons they are implementing this policy. Market need, the carriers assert, is being driven by patients who can save money on services not covered by their dental benefits plan and see value in limiting their out-of-pocket expenses. However, limiting dentists' charge to patients for non-covered services allows these carriers to market their dental plans as costing patients less without bearing any of the financial risk of the discount; that is, these carriers gain the marketing advantage by shifting the risk to the providers. Therefore, the market trend will drive all carriers to implement similar restrictions in order to avoid a competitive disadvantage. Accordingly, any legislation enacted against the practice of fee-capping for non-covered services must be sufficiently broad to prevent all carriers from engaging in this practice.

Impact to Patients and the Practice of Dentistry

As primary care providers of oral health care, general dentists strive first and foremost for access to quality care for all as the ultimate goal of the profession. However, to serve its patients, a dental office must be viable and sustainable. Today, more patients than ever rely upon dental insurance to be able to afford oral health care. Studies have shown that, without dental insurance, far fewer persons will choose to see a dentist. Understandably, in the present economy, each of us must make cutbacks to our expenses in order to survive. Public awareness and understanding of the impact of oral health on systemic health issues such as diabetes and cardiovascular afflictions is still at its fledgling stages. Therefore, out-of-pocket expenses for oral health are often among the first to be avoided by the public.

Concurrently, businesses including those of dental benefits carriers and employers are also seeking cutbacks. Carriers striving to maintain or increase their revenues and marketshare in this economy offer employers cheaper plans for their employees by covering fewer services and paying less than true market value even for those services they cover. However, by covering fewer services, carriers compel patients to pay for more services out-of-pocket, which they may be unable or unwilling to do. Second, by paying less for the services they do cover, carriers compel dentists to function at a net loss when providing these covered services.

Therefore, today's dentist must often rely upon billing at market rates for non-covered services to compensate for the loss he or she absorbs in accepting paltry fees from carriers for covered services. However, unlike the carriers' actions of limiting services they cover, the dentists' actions do not impose an undue burden upon patients. Here's why. In the absence of fee-caps for non-covered services, dentists work with each patient on a case-by-case basis to charge what each patient may be able to afford with an understanding that some patients may be able or willing to afford more than others.

Fee capping takes away this opportunity! If fees for non-covered services are capped across the board without regard to what each patient can afford, the practice of the participating dentist may become unsustainable. The result may be two-fold. He or she may no longer be able to offer that specific service to that carrier's patients, thus limiting the patients' treatment options. In some markets, providers may feel compelled to stop participating with certain carriers in order to survive. In either case, the patients would face decreased access care.

Oral Health 2000: Facts and Figures

- The oral health of children has improved significantly over the past few decades.
- Today most American children enjoy excellent oral health, **but a significant subset suffers a high level of oral disease. The most advanced disease is found primarily among children living in poverty, some racial/ethnic minority populations, disabled children, and children with HIV infection.**
- We know enough about health promotion and disease prevention measures to improve the oral health and well-being of all children.
- Tooth decay remains one of the most common diseases of childhood – 5 times as common as asthma and 7 times as common as hay fever.
- More than half of children aged 5-9 have had at least one cavity or filling; 78 percent of 17-year-olds have experienced tooth decay.
- By age 17, more than 7 percent of children have lost at least one permanent tooth to decay.
- Each year, 8,000 babies are born with cleft lip and/or cleft palate, making these among the most common birth defects. Cleft lip and cleft palate interfere with normal appearance, eating, and speech.
- Injuries to children, intentional and non-intentional, often involve trauma to the head, neck, and mouth. The leading causes of oral and head injuries are sports, violence, falls, and motor vehicle crashes.
- Tobacco-related oral lesions are common in teenagers who use spit (smokeless) tobacco. The lesions occur in 35 percent of snuff users and 20 percent of chewing tobacco users.
- One in four American children are born into poverty (annual income of \$17,000 or less for a family of four). Children and adolescents living in poverty suffer twice as much tooth decay as their more affluent peers, and their disease is more likely to go untreated.
- **Children from families without medical insurance are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely than insured children to have unmet dental needs.**
- **For every child without medical insurance, *there are 2.6 who lack dental insurance.***
- **Fewer than one in five Medicaid-covered children had a preventive dental visit during a recent year-long study.**
- The daily reality for children with untreated oral disease is often persistent pain, inability to eat comfortably or chew well, embarrassment at discolored and damaged teeth, and distraction from play and learning.

***Surgeon General fact sheet on oral health Children's Oral Health, National Center for Chronic Disease Prevention and Health**

- More than 51 million school hours are lost each year because of dental-related illness.
- Pregnant women should get prenatal care and eat a healthy diet that includes folic acid to prevent neural tube defects and possibly cleft lip/palate. During pregnancy avoid tobacco and alcohol, and check with a doctor before taking any medications.
- Put only water in your baby's bottle at bedtime or naptime. Milk, formula, juices, and other drinks contain sugar. Prolonged exposure to sugary drinks while baby sleeps – when saliva flow is reduced – increases the risk of tooth decay.
- **Take your child for an oral health assessment between ages 1-2, and every six months thereafter.**
- Protect your child's teeth with fluoride. Use a fluoridated toothpaste, putting only a pea-sized amount on your child's toothbrush. If your drinking water is not fluoridated, talk to a dentist or physician about the best way to protect your child's teeth.
- Encourage your children to eat regular nutritious meals and to avoid frequent between-meal snacking.
- Talk to your child's dentist about dental sealants, which protect teeth from decay.
- Make sure your child wears a helmet when bicycling and uses protective headgear and mouth guards in other sports activities.
- The nation's oral health is the best it has ever been, yet oral diseases remain common in the United States.
- The burden of oral diseases is spread unevenly throughout the population. Many more poor people and some racial/ethnic minority groups have untreated oral disease than does the population as a whole.
- Safe and effective measures for preventing oral disease are underused. These include water fluoridation, dental sealants, and regular professional care, as well as tobacco cessation.
- Tooth decay is one of the most common childhood diseases—5 times as common as asthma and 7 times as common as hay fever in 5-to-17-year-olds.
- **18 percent of 2-to-4-year-old children have experienced tooth decay, and 16 percent have untreated decay.**
- Only 23 percent of 8-year-old children have at least one dental sealant on their molar teeth.
- By age 17, 78 percent of young people have had a cavity, and 7 percent have lost at least one permanent tooth.
- Among adults aged 35 to 44 years, 69 percent have lost at least one permanent tooth.
- Among adults aged 65 to 74, 26 percent have lost all their natural teeth.

***Surgeon General fact sheet on oral health Children's Oral Health, National Center for Chronic Disease Prevention and Health**

- Untreated tooth decay remains a problem. About one-third of persons across all age groups have untreated decay.
- Among adults aged 35 to 44, 48 percent have gingivitis, and 22 percent have destructive gum disease. Tobacco use increases the risk of gum disease.
- In the U.S., 30,000 people are diagnosed with mouth and throat cancer each year, and 8,000 die of these cancers.
- Mouth and throat cancers are the sixth most common cancers in U.S. males and the fourth most common in African American men.
- Oral clefts are one of the most common birth defects in the United States. The prevalence of cleft lip/palate in the general population is about 1 per 1,000 births.
- Community water fluoridation reaches over 144 million people, or 62 percent of Americans on public water supplies. One hundred million Americans do not have fluoridated water.
- In 1998, a total of \$53.8 billion was spent on dental care—48 percent was paid by dental insurance, 4 percent by government programs, and 48 percent was paid out-of-pocket. Expenditures in the year 2000 are expected to exceed \$60 billion.
- More than 108 million Americans do not have dental insurance. For every child without medical insurance, there are 2.6 without dental insurance.

Division of Oral Health, MS F-10
4770 Buford Highway, NE
Atlanta, GA 30341
1-888-CDC-2306
<http://www.cdc.gov>

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Oral Health, MS F-10
4770 Buford Highway, NE
Atlanta, GA 30341
1-888-CDC-2306
<http://www.cdc.gov>
National Institute of Dental and Craniofacial Research
National Institutes of Health
Building 45, Room 4A5-19
45 Center Drive MSC 6400
Bethesda, MD 20892-6400
<http://www.nidcr.nih.gov>

From the office of the Surgeon General

4770 Buford Highway, NE
Atlanta, GA 30341
1-888-CDC-2306
<http://www.cdc.gov>

Content source: [Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion](#)



February 18, 2010

The Honorable Bob Herron and Wes Keller
Co-Chairs, House Health & Social Service Committee
The Alaska State Legislature
Capitol Building
Room 106
Juneau, Alaska 99801

Dear Chairmen Herron and Keller;

The National Association of Dental Plans (NADP) would like to comment on Alaska House Bill 309 regarding oral health, specifically Section 1 (a) (4) on dental non-covered services. The bill is on the agenda to be discussed by the House Health & Social Service Committee on February 11, 2010.

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental HMOs, dental PPOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to over 82% of the 176 million Americans with dental benefits, including 282,000 consumers with private policies in the state of Alaska. Our members include major commercial carriers, regional and single state companies, as well as companies organized as non-profit plans.

HB 309 prohibits a dental plan from requiring a dentist to accept a negotiated fee set by the dental plan unless the dental plan compensates the dentist for such services. This type of payment agreement is common in many dental carriers' provider contracts, a standard aspect of their contractual relationship that serves to defray the cost of dental care for plan enrollees when they need services that the purchaser or employer may have chosen not to cover in the interest of keeping their group dental premium affordable. Dentists knowingly enter into contracts with these provisions in return for the increased patient volume that comes with joining a dental plan network.

NADP respectfully opposes the HB 309, and encourages the Health & Social Service Committee to fully investigate the ramifications this bill may have on their constituents and employers in the state.

- Consumers' out-of-pockets expenses may increase due to the loss of the discounts on certain dental procedures.
- Employers may experience complaints due to employee dissatisfaction at increased costs for non-covered services.

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Executive Director
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National Association
of Dental Plans
Dallas, TX

[The text in this section is extremely faint and illegible, appearing to be a list of names or entries.]

Background:

- Dentists choose to join a dental network and accept the contracted fees in return for increased access to patients who are customers of the dental carrier.
- While most policies cover the majority of frequently utilized procedures, a range of dental benefit plans, with appropriately varied premium ranges, is available in the marketplace to meet employer and employee budgets.
- Employers' demand for flexibility and affordability means not every dental plan design covers every single procedure on a dentist's contracted fee schedule. Often, the insurer pays 80% and the insured pays 20% of the contracted fee for a category of procedures that is selected and specified by the purchaser, in consultation with a benefits broker, consultant or the dental carrier. For other categories of specified services, the insurer pays 100% and the insured pays 0% of the contracted fee. Non-covered services are those for which the insurer pays 0% and the insured pays 100%. The value of having dental coverage when choosing these services lies in the lower rate the dentist has agreed to when collecting 100% of the contracted fee.

In short, prohibiting contracted discounts for non-covered services is financially harmful to the consumer, leads to higher costs and ultimately is confusing for individuals and families.

Attached is a detailed overview of non-covered services which was developed for the National Conference of Insurance Legislators as they deliberated a non-covered services draft model last November. The draft model was tabled until this March due to voiced concern from several legislators on the interference of business contracts by the draft model. This legislation is a stated priority of organized dentistry at state and national levels, with the primary purpose to increase dentist income which ultimately raises out of pocket costs directly from consumers. In Virginia, opposition has been heard from state groups such as the local chamber of commerce, AFL-CIO, the state employees, and more.

NADP greatly appreciates the opportunity to share our views, and we are available to answer any of the Committee's questions. In addition to the NCS summary, we have also attached our Alaska State Fact Sheet for your review. Please feel free to contact me directly at 972.458.6998x111 or khathaway@nadp.org.

Sincerely,



Kris Hathaway
Director of Government Relations

cc: Representative Wilson, Vice Chair
Representative Lynn
Representative Seaton
Representative Cissna
Representative Homes

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud. The document outlines the various types of records that should be maintained, including receipts, invoices, and bank statements. It also discusses the importance of regular audits and the role of internal controls in ensuring the accuracy of the records.

The second part of the document focuses on the role of the auditor in the financial reporting process. It describes the various types of audits that can be performed, including internal audits, external audits, and forensic audits. It also discusses the importance of the auditor's independence and the need for a strong audit culture. The document outlines the various steps involved in the audit process, from planning to reporting, and discusses the various challenges that auditors may face.

The third part of the document discusses the importance of transparency and accountability in the financial reporting process. It emphasizes that transparency is essential for the confidence of investors and other stakeholders in the financial system. The document outlines the various ways in which transparency can be achieved, including the use of clear and concise financial statements, the disclosure of all relevant information, and the establishment of strong internal controls. It also discusses the importance of accountability and the need for individuals and organizations to take responsibility for their actions.



An Overview of Dental Non-Covered Services

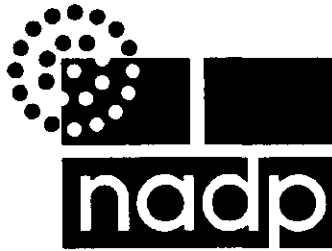
NCOIL is considering an Act that would prohibit a dental insurance plan from requiring a contracted dentist to accept a payment fee set by the dental plan unless the dental plan compensates the dentist for such services. While prohibiting discounts on non-covered services does not impact the plan's revenue, it will have a direct and lasting negative impact on a consumer's out-of-pocket costs.

Dental plans cover a wide array of dental services; however, most have an annual maximum benefit per plan year. After the annual maximum amount is met, consumers can continue to benefit from insurance coverage when discounts are afforded to them through contracted fees between their dental plan, and that plan's contracted dentists.

- **Prohibiting contracted discounts for non-covered services is financially harmful to the consumer and leads to higher costs and confusion for individuals and families.**

Minimizing American's out-of-pocket health costs is one of the primary goals for federal health care reform. Dental consumers, dental plans and dentists have a responsibility to work together to offer competitive costs for dental services. Dentists who contract with a dental plan may agree to accept the fees for dental services specified in the contract, regardless of the payment source. The dental plan pays for covered services in part or in whole, and the consumer pays for non-covered services. Regardless of the payment source, the total the dentist receives is the agreed upon contracted fee, thus providing benefits to the consumer and the employer as described below:

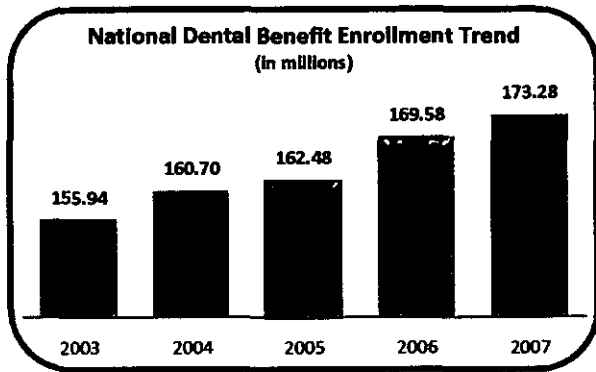
- **Contracted Fees - Benefits to the Consumer:**
 - Consumers receive the contracted fee even if the service is not covered by their insurance plan. Without the contracted fees, consumer costs for non-covered services are generally higher.
 - Cost of dental care is predictable for the consumer when the same contracted fees are applied to needed services even after the annual maximum is met. Dental plans and consumers can better calculate expected costs up front when a single fee schedule is adopted for all services, covered or not, and this helps avoid surprised "sticker-shock" that might otherwise result from non-contracted fees for dental services.
 - Cost savings realized when consumers receive non-covered services at a contracted fee encourages them to seek treatment in a timely manner and not delay care due to cost restraints. Paying a higher, non-contracted fee can put significant financial strain on individuals and families.
- **Contracted Fees - Benefits to the Employer:**
 - Due to rising medical premiums, employers are facing hard choices with their health care benefit options. A dental plan's ability to offer a single contracted fee schedule for all services under a group employer dental plan increases the scope of benefits without increasing premiums, thereby increasing the overall value of the program for employees.
 - Employers review their employees' utilization and customize their dental plan selection accordingly. The design of the dental policy selected by the employer dictates what services are covered under a plan. This allows the employer to offer a plan at an affordable cost to both the employer and the consumer. Dental plans contract fees with dentists, and offer multiple policies based on the contracted fee. The Act being considered by NCOIL would limit employer flexibility, and reduce their product choices.
- **Contracted Fees - Dentist Topics:**
 - Dentists may be initially in favor of prohibiting discounts on non-covered services; however, there is little evidence to support increased revenue by supporting this measure. A recent study by Delta Dental Plans Association of all Delta plans showed only a .44 percent difference in total approved claims costs are even affected. Dentists can do their part in health care reform by holding their costs to the contracted fees already agreed to for patients covered by dental insurance.
 - Dentists have the choice to join a dental plan's network and accept the contracted fees for both covered and



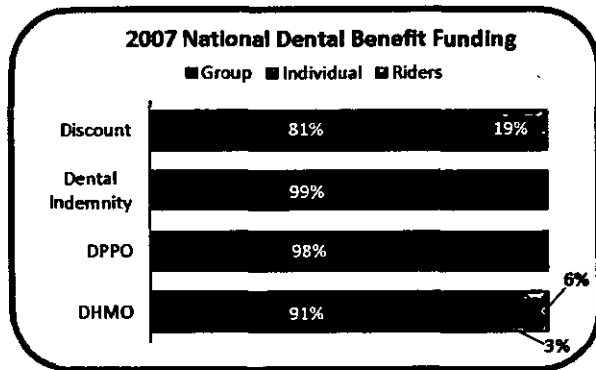
National
Association
of
Dental
Plans

Alaska 2008 Dental Benefits Fact Sheet

NATIONAL



In 2007, at least 57% of all Americans had some form of dental benefits.



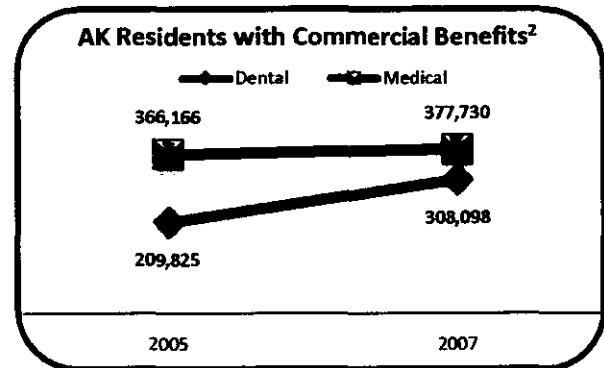
Nearly all enrollment in dental benefit plans is through group-sponsored plans while Discount Dental plans are offered more often directly to individuals.

ABOUT NADP

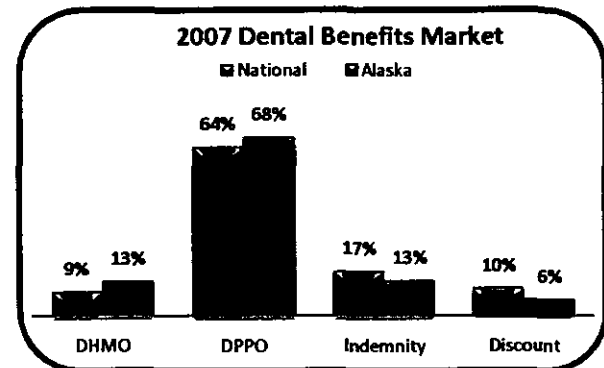
The National Association of Dental Plans (NADP), a nonprofit corporation with headquarters in Dallas, Texas, is the "representative and recognized resource of the dental benefits industry." NADP is the only national trade organization that includes the full spectrum of dental benefits companies operating in the United States.

STATE

In 2007, the estimated population of Alaska was 683,478.¹ NADP represents 35 plans operating both directly and indirectly in Alaska.



The chart below compares the prevalence of dental plan types based on total enrollment nationally and in Alaska.



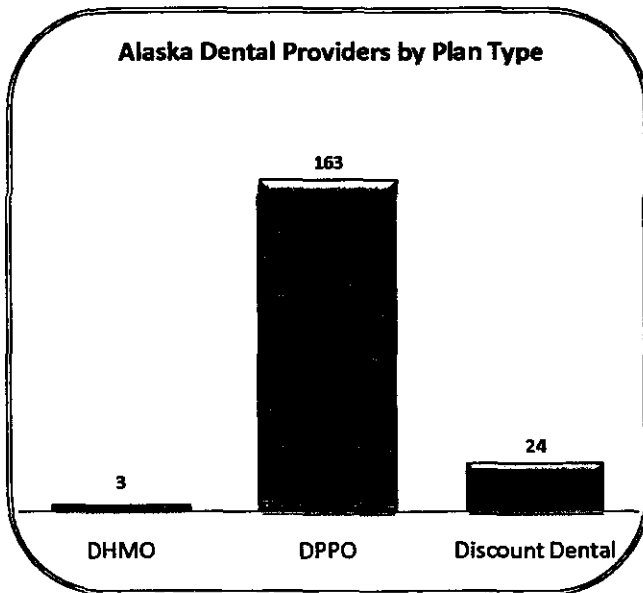


Alaska Dental Benefit Fact Sheet

PROVIDERS & NETWORKS

To be adequately served there should be 3.33 practicing dentists per 10,000 population.¹ There are 490 dentists actively practicing in Alaska or 7.17 per 10,000 population.²

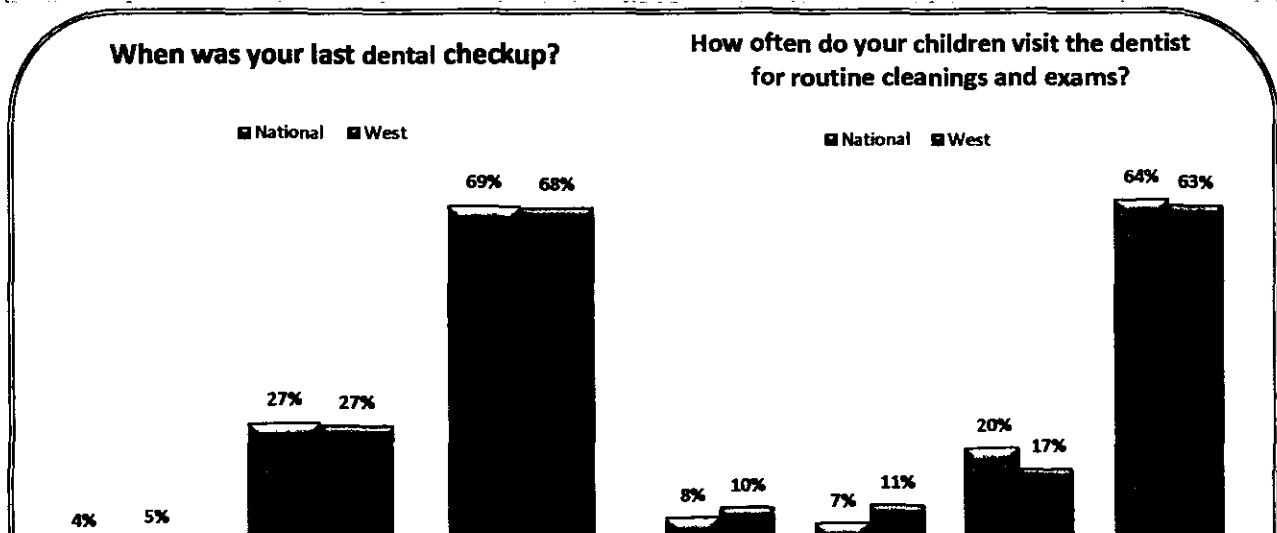
In total, Alaska consumers have access to an estimated 3 dental HMO providers, 163 dental PPO providers and 24 discount dental providers.



- 0.04 Alaska dentists provide services through a Dental HMO per 10,000 population statewide compared to 1.03 per 10,000 population nationally
- 2.39 Alaska dentists provide services through a Dental PPO per 10,000 population statewide compared to 3.42 per 10,000 population nationally
- 0.35 Alaska dentists provide services through a Discount Dental Plan per 10,000 population statewide compared to 2.34 per 10,000 population nationally

The ratio of dentists to population may vary by community.

CONSUMER ORAL HEALTH BEHAVIOR³



LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 24, 2010

SUBJECT: Limiting dental insurer policy (HB 309)
(Work Order No 26-LS1315\R)

TO: Representative Bill Thomas
Attn: Cecile Elliott

FROM: Dennis C. Bailey *DCB*
Legislative Counsel

You have asked whether the provision in HB 309 that prohibits an insurer who provides coverage for medical care from setting a fee for a service that is not covered under the insurer's policy violates art. I, sec. 15 of the Alaska Constitution.

Article I, sec. 15, provides:

SECTION 15. Prohibited State Action. No bill of attainder or ex post facto law shall be passed. No law impairing the obligation of contracts, and no law making any irrevocable grant of special privileges or immunities shall be passed. No conviction shall work corruption of blood or forfeiture of estate.

I assume that you are concerned with the "contracts clause," which states that "no law impairing the obligation of contract . . . shall be passed."

The contracts clause prohibits the passing of a law that changes an existing contract. The rule is based on preventing retroactive changes to contracts already in place. *See, Hageland Aviation Servs. v. Harms*, 210 P.3d 444 (Alaska 2009) (retroactive removal of existing contract rights . . . violated the contracts clause). Several Alaska cases have interpreted the contracts clause.¹

¹ *See Stepanov v. Homer Elec. Ass'n, Inc.*, 814 P.2d 731, 736 (Alaska 1991) (rejecting the claim that a state commission's effective revision of the claimants' contracts violated the Alaska and federal contract clauses); *Wien Air Alaska v. Arant*, 592 P.2d 352, 363 (Alaska 1979) (dismissing the argument that the maximum rate table of a workers' compensation law impairs obligations under the claimant's insurance contract in violation of the Alaska and federal contract clauses), overruled on other grounds by

Representative Bill Thomas
February 24, 2010
Page 2

The state commonly regulates the contents of insurance policies in AS 21. The effect of changes to the law are usually prospective not retrospective in order to avoid impairment of existing policies. A statute is prospective unless it is expressly made retrospective. AS 01.10.090.

In my opinion, the change in AS 21.42.392(a) that prohibits an insurer that provides dental insurance from limiting a fee set by a dentist for a service unless the service is covered by the policy would not violate art. I, sec. 15 of the Alaska Constitution. The provision has a prospective effect and does not impair or affect an existing contract.

Although not required, in order to emphasize the prospective effect of the change, you could add an applicability clause similar to the following:

*Sec. **. The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. The amendments to AS 21.42.392 enacted in secs. 1 and 2 of this Act apply to an insurance plan, contract, or policy that is offered, issued for delivery, delivered, or renewed on or after the effective date of this Act.

If I may be of further assistance, please advise.

DCB:ljw
10-129.ljw

Fairbanks N. Star Borough Sch. Dist. v. Crider, 736 P.2d 770 (Alaska 1987).

Hageland Aviation Servs. v. Harms, 210 P.3d 444, 452, n. 30 (Alaska 2009).

HB

328

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: February 5, 2010

FURTHER REFERRALS: Finance

Date of Committee Action: March 16, 2010

The HEALTH AND SOCIAL SERVICES Committee considered:

HB 328

HOUSE BILL NO. 328

"An Act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services."

HB 328-TRAUMATIC BRAIN INJURY:PROGRAM/MEDICAID

Recommends it be replaced with HCS or HCS for HB 328 (HSS)
 For Senate Bills with new title: Technical Title New Title: HCR _____ Same Title New Title

- attach amendments
- add new referral to _____ Committee
- Letter of Intent _____ Committee

List of Abbrev for Depts.:
 ADM
 CED
 COR
 CRT
 EED
 DEC
 DFG
 GOV
 DHS
 LWF
 LAW
 LEG
 MVA
 DNR
 DPS
 REV
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 UA

NEW FISCAL NOTES				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
DHS		6,272		
DHS				✓
			□□	

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

<u>Signing with recommendations</u>	Printed Last Name	DP	DNP	NR	AM
<i>Judith</i>	Holmes			X	
<i>Jamie Wilson</i>	T. Wilson			X	
<i>Paul Seaton</i>	LYNN SEATON			X	
<i>Shirley</i>	CISSNA			Y	
Chair: <i>Wes Keller</i>	Keller			X	
Chair: <i>John Herron</i>	HERRON			X	

ALASKA STATE LEGISLATURE

Interim:
716 West 4th Avenue, Suite 640
Anchorage, Alaska 99501
Phone (907) 269-0200
Fax (907) 269-0204
Rep. Craig.Johnson@legis.state.ak.us



Session:
State Capitol, Room 126
Juneau, Alaska
99801-1182
Phone (907) 465-4993
Fax (907) 465-3872

REPRESENTATIVE CRAIG JOHNSON
HOUSE DISTRICT 28

Sponsor Statement for HB 328

House Bill 328 establishes a traumatic or acquired brain injury program and registry in the Department of Health and Social Services. Alaska has no program specifically to deal with brain injury and yet Alaska has one of the highest rates in the nation. Annually, there are 800 Alaskans hospitalized with a traumatic brain injury each year resulting from falls, car crashes, domestic violence, All Terrain Vehicle crashes, and snowmachine crashes, among others. There are an approximately equal number of Alaskans suffering from acquired brain injuries resulting from stroke, aneurism, or tumors.

Alaska urban and rural residents, including military are being discharged to their homes with little understanding of brain injury or access to in-state rehabilitation, severely impacting their families. Limited education about the injury, learning to cope with a person who has changed, overwhelming stress from insurance, bureaucracy, and financial burdens and change in family roles may render families dysfunctional.

With appropriate and available care, rehabilitation, community and family support, even the individual who is most severely injured can live at home, return to school or work, or engage in meaningful and productive lives.

Funding a Traumatic or Acquired Brain Injury (T/ABI) Program gives authority to the department to collect data on the injured, positioning the state to access Medicaid funds for T/ABI. Medicaid services for T/ABI will be matched 50% by federal funds. The bill allows for streamlining department services and activities that are unique to T/ABI. This would better assist families and individuals with T/ABI in knowing how to access services and supports.

Early treatment may reduce future medical and social costs. Without appropriate services, some individuals with T/ABI may pose a threat to themselves or others. Without assistance, individuals with TBI often end up homeless, in jail or in nursing homes. Service coordination, rehabilitation, and appropriate supports can help to minimize these risks.

February 8, 2010

26-LS1355\E

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 9, 2010

SUBJECT: Sectional Summary (HB 328 (Work Order No. 26-LS1355\E))

TO: Representative Craig Johnson
Attn: Jeanné Ostnes

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds longitudinal data on traumatic or acquired brain injury from the registry established under sec. 5 of the bill to the list of databases that the Department of Health and Social Services is authorized to collect, analyze, and maintain.

Section 2. Adds case management services for traumatic or acquired brain injury to the optional services provided to recipients of state medical assistance (Medicaid).

Section 3. Defines "case management services for traumatic or acquired brain injury" and "traumatic or acquired brain injury" for purposes of the optional services added by sec. 2 of the bill.

Section 4. Requires the Department of Health and Social Services to provide medical assistance services under a waiver if approved by the federal government and if the legislature appropriates necessary funding for the services.

Section 5. Establishes a statewide traumatic or acquired brain injury program in the Department of Health and Social Services to evaluate the effectiveness and availability of information and services for the prevention and treatment of traumatic or acquired brain injury in the state. Requires consultation and collaboration with public and private entities to fulfill a list of programmatic requirements including development of a statewide service delivery plan and registry of information and evaluation of current laws and standards pertaining to traumatic or acquired brain injury.

JMM:plm
10-058.plm



COOK INLET
T R I B A L
COUNCIL, INC.

March 5, 2010

The Honorable Craig Johnson
Alaska State House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Johnson:

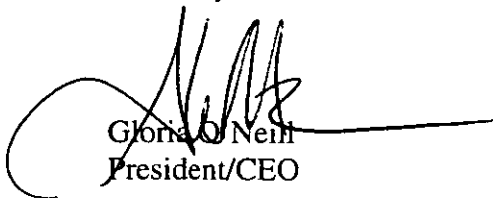
Thank you for your sponsorship of House Bill 328, which would establish a registry and program for Traumatic or Acquired Brain Injury (TABI) and provides for the inclusion of case management services to the Alaska list of optional Medicaid services. The reporting and data collection of Alaskans with these injuries is long overdue and would be of great benefit.

Cook Inlet Tribal Council (CITC) is about People, Partnership, and Potential. We serve 13,000 participants annually, administering 85 grants and contracts funded by federal, state, and private agencies. Our programs address many of the social, economic, and educational challenges faced by Native people in Anchorage and in the Cook Inlet Region. One of our main departments is Recovery Services. CITC provides outpatient services and also operates the Ernie Turner Center for residential care pertaining to alcohol and drug treatment.

CITC can attest to the high level of TABI cases in Alaska. Statistics from 2009 indicate that about 37% of our participants seeking intervention services (including brief treatment and outpatient recovery) report head trauma or have a history of TABI. From a sampling of 552 individuals seeking admission last year to the Ernie Turner Center (for detox or residential treatment), 46% of them had experienced some type of brain injury in their past.

If I can provide any further assistance with passage of this measure through the legislative process, please let me know. I would be willing to testify on the impact of TABI and the need for this bill to be enacted. On behalf of Cook Inlet Tribal Council and the many participants we serve, you have our full support for HB 328.

Sincerely,


Gloria O'Neill
President/CEO

3600 SAN JERONIMO DRIVE, ANCHORAGE, ALASKA 99508

FAX: (907) 793-3422

PHONE: (907) 793-3600



3745 Community Park Loop, Ste. 140
Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

The Honorable Craig Johnson
House of Representatives
Alaska State Capitol, Rm 126
Juneau, Alaska 99801

Dear Representative Johnson,

Thank you for introducing HB 328, the act which relates to medical assistance coverage for traumatic or acquired brain injury services and which will establish a traumatic or acquired brain injury program and registry within the Department of Health and Social Services.

The Alaska Brain Injury Network, Inc (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury. ABIN's eighteen member board represents all regions of Alaska and at least 50 percent are TBI survivors or family members.

The primary ABIN mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families. ABIN also serves as a statewide resource navigation agency specializing in information and referral for brain injury services and supports available in Alaska. ABIN has heard from 600 Alaskans requesting brain injury services since 2007. In addition, ABIN has heard public testimony from hundreds of Alaskans from Anchorage, Juneau, Fairbanks, Kenai, Barrow, Nome, Kodiak, Dillingham, Bethel, Copper River Basin, Tok, Ketchikan, Sitka, and more.

In the past several years, ABIN has worked collaboratively with the State of Alaska, Alaska Mental Health Trust Authority, the Alaska Native Tribal Health Consortium, Alaska Federal Health Care Partnership, major hospital providers, community providers, and many more agencies to coordinate the development of brain injury services in Alaska. We have coordinated meetings with these agencies to identify:

1. the services we have available in the State,
2. the services we do not have available,
3. which providers have the capacity to develop different segments in the continuum of care,
4. barriers; and
5. solutions for the development of this care.

The agencies participating and the findings are depicted in a document titled "Demonstrating the Need for Community-Based Rehabilitation."

Barriers to treating brain injury include:

- Brain injury as a medical condition versus a long-term condition: Patient often enters an injury-based medical model to treat what may become a manageable, chronic condition.
- Post-acute/Treatment/Rehabilitation funding for those who are Medicaid eligible: Currently, Medicaid funding is available for acute care, but does not cover brain injury specialty residential and day programs, often resulting in a higher level of care (more expensive) than what is needed.
- Workforce capacity- Alaska is too small of a state, with a strong yet limited workforce, to support separate brain injury systems of care in each service sector: military, tribal, and civilian.

- Screening/assessment in all state programs and primary care clinics- appropriate identification begins with screening and then assessment. Behavioral Health is the only state program that includes brain injury screening questions.

HB328 provides many direct and indirect opportunities to resolve these barriers:

- Creates longitudinal data on persons with brain injury to identify demographics, cause of injury, severity, diagnosis, treatments, medical and social costs which will help determine future policy and budget recommendations.
- Increases access to case management for those who are Medicaid eligible.
- Evaluates the need for and scope of acute, post-acute, long-term, and community treatment, care, and supports.
- Positions the state to identify the best 'menu' of brain injury services to include under a Medicaid Waiver.
- Positions the state to access federal funding for TBI services and for targeted case management.
- Encourages a seamless transition from acute settings to transitional and community settings.
- Establishes standards and recommendations for improvement of prevention, assessment, treatment, and care.

Indirect Opportunities

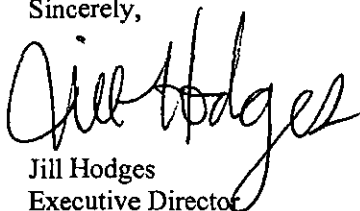
- Many Alaskans with undiagnosed or unrecognized brain injury currently access State of Alaska services and supports. The T/ABI program encourages screening and identification, as well as development of and access to appropriate treatment.
- A T/ABI program may create cost savings in acute care costs and existing state programs budgets, including behavioral health, juvenile justice, corrections, homeless initiatives, and long-term care in institutional facilities.
- Research shows, Medicaid funding specifically for brain injury services supports the growth of community-based rehabilitation programs (residential and day programs).
- Provides framework for the Department of Defense (DoD), Alaska Veterans Affairs Health System, Alaska Tribal Health System, State of Alaska, and private/non-profit entities to coordinate planning and implementation of rehabilitation and community re-entry programs.
- Development of these programs increases access for all Alaskans with a variety of pay sources, including insurance, private pay, and federal health care.
- Research shows early treatment and access to appropriate brain injury services may reduce future medical and social costs.

The Alaska Brain Injury Network has worked diligently to create a 'framework' for successful development of a seamless system of care for Alaskans with brain injury, including the development of a comprehensive plan and the coordination of the many key providers that will build the system. The State of Alaska T/ABI program will be the 'foundation' that will allow the 'entire state system' to develop and grow. The State T/ABI Program, the 'foundation', is the first step to resolving the barriers, so providers can act, and Alaskans will have an opportunity for a more successful and positive life.

The Alaska Brain Injury Network appreciates your ongoing support of this important legislation.

Our organization is made up of many professionals, providers, and specialists. If you have any questions I would be happy to answer them or connect you to someone with that knowledge.

Sincerely,



Jill Hodges
Executive Director

Attachment: ABIN Letter of Support for SB 219/HB 328

Why brain injury begins as an emergency medical condition and often becomes a social catastrophe?

Several decades ago brain injury was viewed solely as a medical condition, more specifically a life or death injury. Because of the advances in emergency medical services and intensive/acute care, more people are surviving very severe brain injuries. These advances have created an entire new system of care, a brain injury continuum of care. This system of care is essential because of the long-term cognitive effects caused by the injury. After 30 years of state and federal government recognition, research, and longitudinal studies, it is now understood that 'brain injury begins as an emergency medical condition, and often becomes a social catastrophe.' Because of the potential for many different social challenges, it is essential that those who survive brain injuries receive timely, appropriate services and ongoing supports.

How did other states develop brain injury programs?

In addition to the local networking, ABIN is well connected to many state brain injury programs (public and private) outside of Alaska. Through conferences and ongoing dialogue, ABIN has learned the role legislation (in other states) has played in developing a seamless, comprehensive service system for after hospital care for brain injury. In 1980 the first appropriation for brain injury funding for case management was accomplished in Missouri. Legislation for a T/ABI program soon followed. 2005 data shows at least 44 states had a formal T/ABI program in their state government or funded brain injury specific programs.

The following is an example of the order in which legislation and funding has progressed in other states.

Step 1: Establish a T/ABI program in statute

Step 2: Approve general funds for case management, position state to access federal funds to expand this service to more people (targeted case management).

Step 3: Approve a Medicaid brain injury waiver (50% Federal match)

Step 4: Prevention and concussion management legislation.

Step 5: Screening and case management for military

HB 328/SB 219 gives Alaska the opportunity to not only 'catch up' developmentally with other States, but it also positions Alaska to become a national leader in providing brain injury case management and treatment to rural and remote citizens across service sectors (military, tribal, civilian).

How do other states fund and sustain a T/ABI Program?

States use a variety and combination of funding streams for planning, policy, prevention and research activities, and to serve individuals with brain injuries and their families who have no other access to needed care or supports. Medicaid, Home and Community-Based Services and Medicaid Waivers, and Federal Block Grant programs are used to serve individuals with disabilities and special health care needs including people with brain injury. At the State level, common non-Federal funding sources for TBI service delivery include trust funds, general



revenue and special revenue. Often when two or more sources exist, funds from one are used to leverage funds from the other.

There are 24 States that have a Brain Injury Medicaid Waiver (2006). There are 20 states that have General Revenue or Special Revenue specific to brain injury (NASHIA 2005).

Medicaid waivers targeted to individuals with brain injuries operate in half of the states and are small when compared to waivers targeting other groups. These waivers provide significant cost savings, on average \$30,000 annually per person, when compared to institutional facility-based services (Rutgers 2008).

These waivers have been successful both programmatically and financially. In addition to cost savings, these waivers have provided other significant benefits. The existence of these waivers supports the growth of community non-profit brain injury agencies. There is clear evidence of the desirability of home and community-based services among those directly affected by brain injury: there has been growth of these waivers that has resulted in a doubling of the number of persons served over five years; in addition, there is a visible role played by advocates in encouraging states to develop these waivers. These waivers, over time, have contributed to states' efforts to create and grow an in-state service capacity to provide services to individuals with brain injuries.¹

¹Hendrickson, L. & Blume, R. (2008). Issue brief: A survey of Medicaid brain injury programs. *Rutgers Center for State Health Policy*



Mat-Su Health Services, Inc.

February 25, 2010

The Honorable Craig Johnson
120 4th St, State Capitol, Room 126
Juneau, AK 99801

Dear Representative Johnson:

I am writing in support of House Bill 328, an act concerning traumatic or acquired brain injuries. As a health care professional who administers an agency that provides both primary health care and behavioral health care I and my Agency are well acquainted with the devastating consequences of even a mild brain injury can have on individuals and their families. The bill you have sponsored, if passed, will enable the State to take important, concrete steps that are necessary in creating evidence based, coordinated and effective services to this group of citizens in need. The creation of an operational definition, the development and tracking of important incident data, the promotion of waiver services and the building of case management capacity are all important first steps.

Sincerely,

Kevin Munson
CEO

The TRUST

The Alaska Mental Health Trust Authority

February 10, 2010

The Honorable Craig Johnson
Alaska State Representative
Alaska State Capitol, Room 126
Juneau, Alaska 99801

Re: **Letter of Support for HB 328**

Dear Representative Johnson,

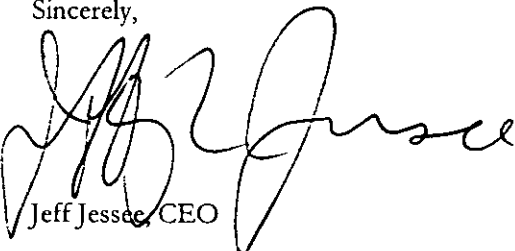
The Alaska Mental Health Trust Authority (The Trust) is pleased to support HB 328, an act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services (DHSS); and relating to medical assistance coverage for traumatic or acquired brain injury services. This bill is a significant step forward and will bolster the existing statewide efforts of a diverse and active committee which has been focused on brain injury services for several years.

The Trust is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of Trust beneficiaries who include individuals with mental illness, developmental disabilities, chronic alcoholism and those with dementia or other related disorders; many also have a co-occurring traumatic brain injury. Our goal is to partner with the Department of Health and Social Services as well as other state departments and branches of government, as a catalyst for change towards the improvement in Alaska's mental health continuum of care. The Trust has and will continue to partner with DHSS and the aforementioned statewide committee to ensure a system of care for Alaskans with brain injuries is developed.

It is an unfortunate reality that Alaska has one of the highest rates of TBI in the country. Upwards of 800 Alaskans are seriously injured or die from a TBI annually. It is estimated that at least 10,000 Alaskans are currently living with TBI in our communities, some with support services, most undoubtedly without. This bill will assure the development and implementation of services for Alaskans with brain injuries; specifically, it provides direction to the Department of Health and Social Services to assess prevalence, service gaps, and the development services in a targeted, effective, and fiscally responsible manner. Thereby, increasing and improving access to much needed services and supports for these Alaskans. Furthermore, this bill places the State of Alaska in position to access federal dollars for payment of these services through grants and Medicaid.

The Trust appreciates your leadership on this very important issue. Please let us know if there is anything we can do to further support your efforts and the successful passage of this bill.

Sincerely,



Jeff Jessée, CEO

February 11, 2010

To Whom It May Concern:

I worked for years as a Care Coordinator for people experiencing Alzheimer's and/or mental illness. As a professional in this field I helped many people find services and information. I didn't realize I'd be the one needing assistance so soon. For an unknown reason, I've lost my eyesight over the last couple of years. I'm in my 30's. While struggling to learn to live with a visual impairment, I lost my job. One of the dangers of living with a visual impairment that I had not anticipated was the numerous concussions I have experienced. The most serious of these was when my weed-whacker fell on my head causing a mild brain injury. It took me at least five to six months to feel "normal" again after that. I believe many people experiencing visual impairments are suffering brain injuries at a rather high rate.



Just as it is important for those with Alzheimer's to have access to services and information through a Care Coordinator, it is also important for those experiencing brain injury to have assistance. Accessing services is very difficult when your brain isn't functioning at its' best. Each person who has experienced a brain injury should be linked to a care coordinator so that they have help accessing services. It's hard enough for me to find the help with a visual impairment, it is even harder when I've suffered yet another concussion and can't remember who to call or don't know what services will help.

It's imperative that people with brain injuries have a good advocate. It can be very hard to access services even when they are available. Often times a person with a brain injury has difficulty remembering things, making phone calls, knowing how to ask the right questions to get an appointment, etc. Having strong advocates such as Alaska Brain Injury Network and a Care Coordinator is necessary for a good recovery.

I encourage you to please support Senate Bill 219 presented by Senator McGuire and House Bill 328 presented by Representative Johnson. Having a brain injury program as they describe would benefit many Alaskans currently struggling on their own. There is also \$350,000 currently in the budget for brain injury. Please support the bill and leave the funding that is in the budget there. Thank you for your support. This is something that mattered to me as a provider and now it matters to me on a personal level.

Sincerely,

Fay Nakamura

2746 W 42nd Place Apt #1

Anchorage, AK 99517

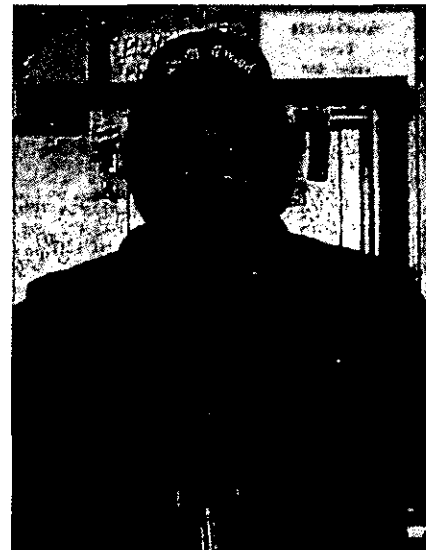
Note: I had assistance writing this letter.

Dave Eubank
9527 Victor Rd.
Anchorage, AK 99515

Good afternoon:

My name is Dave Eubank and I approve this message. A few long years ago I sustained an acquired brain injury, not to be confused with traumatic; it was pretty traumatic to me but acquired? I didn't ask for any of this but it seems as though it was required because I see life through a different set of eyes and have been blessed with a different set of values. I, as well as a host of many others, have had to work twice as hard to get back half of what I lost but I appreciate life more than twice as much so in a sense, ... doesn't that make me twice the person I once was?

Just for starters I have an awful lot of admiration for the people who are in the health care industry for the support, care, and understanding they provide to others who are less fortunate than you. The T.B.I. Resource Navigator allows access to monitor a wealth of information for this silent minority. The DHSS provides additional funding for thankful services to a thankful people. I am not thankless; I am thankful, I am thankful I do not require such needful things but I know. I know exactly what it's like to be on the inside looking out and I know exactly what it's like to have the ability to absorb the incoming information but not having the capability to process it and I know exactly how frustrating that can be and for some people there is no way out and I know that too.



You see, once upon a time, in a land far, far, away, I collapsed as the result of a life threatening, death defying, brain aneurysm; grade 5. You name it and I did not have it but in comparison to what I had lost, I have gained a whole lot more and what it was that I really lost, really was not even worth having and I am thankful for the things I have gained rather than being resentful over the things I have lost but it literally turned my life upside down yet here I am ... 10 years post, standing right side up and sitting right side down, still there are an awful lot of questions and *not* many answers; however:

Would a T.B.I. Care Coordinator have been helpful in my own recovery? Absolutely! We all have to crawl before we can walk and we seem to forget all about that but not me because in the bitter end of this past century I tried to walk before I could crawl and I fell flat on my face. But when I went down, I got up and when I got up, I woke up, and when I woke up, I got a grip and I can see much more clear this second time around but instead of taking my life, it gave me a life *however*; I may have gotten it a whole lot quicker with a T.B.I. Care Coordinator.

Would the funding for T.B.I. Care Coordination and Case Management have been helpful in my situation? Absolutely! I as well as a host of many others often felt like beating my head up against a brick wall but soon discovered that there was nobody home but suddenly on one bright, sunny, and cheerful summer day, a light bulb went off, BING!!! And as I wondered my way through this maze of uncertainty, I realized that I could not change people. I could not change anything about them. The only thing I could change was *myself* and when I changed myself? Poof!!! It was magic because I would change the perception of how others perceived me. A T.B.I. survivor is scarred for life and even though it may not be the kiss of death, there is a distinction and it is *not* a real good one but, ... *By choosing the path of least resistance and combining the elements of good with that of the bad, you rise above the distinguished height of an unjust society and you still embrace it* (Martin Luther King).....and yet it works.

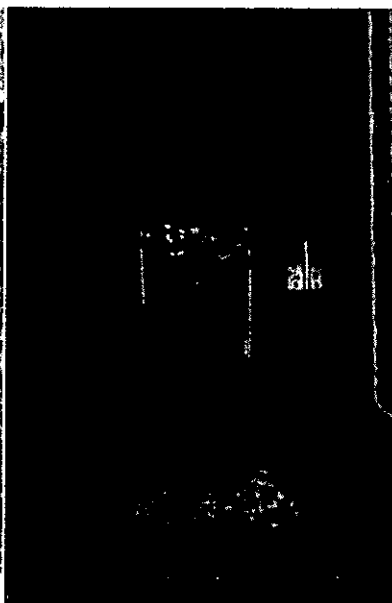
Do I have any regrets on how I've approached and sidestepped the obstacles that have obstructed my most difficult challenges? Absolutely not! Very few of us get out of here alive without being rudely slammed down by some sort of adversity but there's an old saying that adversity has a peculiar way of introducing you to yourself. Welcome to my world; we all make choices in life but I really don't know anyone who chose to walk a path which has no end and for some people there is no end but for others who wish to boldly go where many have gone before, with careful consideration of care coordination and case management there is. You probably think it's pretty easy for me to discuss this stuff; it's not easy, ... it's not easy at all. That's it, my work is done here.

Thank you

To Whom It May Concern:



With my son - before the brain injury



After my brain injury

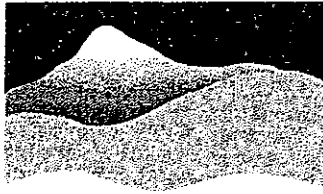
Apx 3years ago I was a Flight Attendant with Alaska Airlines. Now I dont swim, drive or do ANYTHING because overnight my life was CHANGED. Basically I had an ARYCHNOID CYCST which the Doctors watched, at Providence Hospital, since I was a teenager (although I was born with it) and suffered horrendous headaches. Noone ever told me that it could change my life so. In any case, I have two kids with Autism, 11 and 12 and a 15yr old with ADD so my life has been in shambles for quite sometime in any case. As for Providence, the commercials they put on TV are GREAT however noone ever tells you the BAD SIDE of things. I underwent surgery to no avail. There was NO PROBLEM until I came down with STAFF INFECTIONS that the doctors couldnt stop it. Needless to say, There was NOTHING in Alaska for me then and I was medivacked to Seattle after suffering Staff Infections but where the doctors only do ONE TYPE of surgery , basically up here it is OK if you have a broken arm or something but Brain Injury is nothing you want to MESS WITH. Needless to say I was put in OT, PT and SPEECH services and the only thing to come out of it all was that I had BRAIN INJURY! I couldnt, or still cannot, walk a straight line, I lost my job, what good is a F/A who cannot walk a straight line, I wear Prisms in my glasses now as well as DARK GLASSES, the sun hurts my eyes, I am in a Wheelchair and I was destined to live a life of NO DRIVING! Not even to the Grocery Store. Because I was married it was ASSUMED that my husband could work all day, do all the housework and watch the kids. I had three kids and he had Three kids and the BRADY BUNCH IT WASNT! In any case, my marriage has ended in divorce because of many different reasons however Brain Injury was NOT the least of the worries I had come to deal with! Only recently there is a hospital up here that deals with Brain Injury, at the Bases. It is HARD to find a doctor who knows ANYTHING about Brain Injury, much less a PCA (Personal Care Attendant) who knows anything about Brain Injury. I have had two PCA's quit on me and

am on my third, mainly because they are UNTRAINED in the needs of TBI. They were good as PCA's however NOT at Brain Injury and finding a doctor is a FIASCO because no doctors know about Brain Injury either. In any case, I was set to retire and "lost" my job and cannot get another one without alot of work and someone who knows about TBI. Brain Injury is EXPENSIVE to say the least and I am on Medicaid and Medicare due to all the tests I have to have done and all the medication I am on. For years I advocated for my kids with Autism however that was NOTHING COMPARED to what I go through now. I have managed to get around my house and take my own showers. Needless to say, even as a CONSUMER now there are certain things I will NOT, I am too proud, to let people do for me. Help me go to the bathroom is one of them but it is HARD and I rely on my BARS in the bathroom plus a toilet that is up a little higher. I am destined to be in a Wheelchair and flying, I am the Chair of the Governors Council now and need someone to go with me WHEREVER I GO! My life has CHANGED to say the least and I dont have the ability to be SELF SUFFICIENT in any case, I used to go to Prince William Sound Halibut fishing and owned a TimeShare in Puerto Vallarta where I caught a WORLD RENOWNED SailFish. THANK GOD FOR THOSE DAYS AND THOSE MEMORIES of which I have to look at pictures or have to be TOLD to remember, remember I have TBI so those dont come NATURALLY to me! Those times are all but over for me and even though I still love Fishing, I HATE THE WATER so fishing and I dont go together so well. In any case, I used to advocate for my kids and AUTISM, which I still do, but now I am a CONSUMER FOR BRAIN INJURY which has opened my eyes big time. I still go to Key Campaign and am on the BOD (Board of Directors) of the Key Coalition which deals with Legislatures on an ongoing basis and am a founding mother for LINKS in the Mat-Su. We are a Community PTI and work very closely with MATSU SCHOOL DISTRICT, and am past Chair of the EIC (Early Intervention Committee) of the Gov. Council, however that will not take away my problems and makes being involved very difficult for me. THANK GOD also for the Flight Attendants of Alaska Airlines because without them my kids wouldnt have had a Christmas! I can only say my life has taken a TURN and Brain Injury only takes a SECOND but can ruin your ENTIRE LIFE! This is something I will live with EVERY DAY and not something that will ever GO AWAY! In closing. I can say that life DOESNT END HERE! I have taken the "bull by the horns" so to speak and have become quite the advocate of Brain Injury on top of it all. I joke about Disabilities and it was my own mother who said she thinks I AM GETTING BETTER! When I asked WHY she said BECAUSE I CAN JOKE ABOUT IT NOW where before I could NOT.

Please oh please take this to heart. It can happen in an instant and take your entire life away from you. PLEASE CONSIDER what you can do to help not only people with BRAIN INJURY but to also get the word out that this EFFECTS THE REST OF YOUR LIFE! It is EXPENSIVE MONETARILY and HARD ON FAMILIES and ON THE CONSUMER AS WELL. Thank you for your time.

Donna Swihart, MAT-SU, ABIN ADVOCATE AND CONSUMER
5450 N. Rhonda Drive
Palmer, AK 99645

Anchorage Community



**Mental Health
Services, Inc.**

4020 Folker Street • Anchorage, Alaska 99508 • 907-563-1000 • (Fax) 907-563-2045 • e-mail: acmhs@acmhs.com • website: www.acmhs.com

17 February 2010

The Honorable Craig Johnson
Alaska State Capitol, Room 126
Juneau, Alaska 99801

Dear Representative Johnson:

First, thank you for your interest in traumatic or acquired brain injury. Second, thank you for supporting the development of specific services addressing traumatic or acquired brain injury.

Anchorage Community Mental Health Services serves a number of clients impacted by brain injury. Some have been impacted by stroke while others have injuries resulting from accidents. The long lasting impact of brain injury results in some of our clients having great difficulty in adapting to normal life. Issues include things like being able to maintain housing, being able to work and self care. Additional focus on developing community based brain injury rehabilitative services will be invaluable to this population and their families.

So, thank you for introducing House Bill 328. Let us know if we can be assistance in promoting passage.

Sincerely,

John Fugett, MA, LPC
Director, Adult Services

Jerry A. Jenkins, M.Ed., MAC
Executive Directors

Continued Care
2735 Tudor Rd.
562-7900

Senior Services
Day Break
9210 Jupiter Dr.
346-2234

Downtown Annex
610 E. Fifth Ave.
274-0352

Family Services
4045 Lake Otis Pkwy.
561-0954

Adult Services
4020 Folker Street
563-1000

Emergency Services
24 hrs
563-3200



Christine A. DeCourtney
6920 Gemini Dr.
Anchorage AK, 99504
February 15, 2010

The Honorable Lesil McGuire
Alaska State Capitol, Rm 125
Juneau, Alaska 99801

Dear Senator Lesil McGuire:

I am writing to request your support of Senate Bill 219: An Act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services. I wish to speak from two views:

- 1) I have worked in the healthcare field ever since I graduated from university
- 2) I have suffered two Traumatic Brain Injuries (TBI) and major surgery for a brain tumor in the last five years

I have worked in healthcare for many years, including ten years at the Bristol Bay Area Health Corporation in Dillingham and the past seven years at the Alaska Native Tribal Health Consortium. As such, I strongly believe that not only are there many people living in remote communities who have suffered a brain injury with no treatment available, I also believe that there are many people who have physical, mental and emotional problems as a result of an undiagnosed brain injury. The Trauma Registry only counts those that are hospitalized. It is critical that the people of Alaska have better access to brain injury prevention, treatment and rehabilitation services.

I suffered head and severe facial injuries from a bicycle fall in 2004. Though I spent many hours in the Emergency Room having many tests and 50 facial stitches, I received no information about head injuries. Eight months later, I was at a stop sign in downtown Anchorage and was hit in the driver's side by a van that came around the corner. This time I did not experience visible injuries. However, I suffered neck injuries and another TBI. It is not healthy to have another TBI so soon after the first one. It is also "easier" to have an injury that people can "see."

In spite of the fact that I am gainfully employed and insured, I have spent a great deal of out-of-pocket funds to try to "get better." While my insurer was quite willing to pay for physician visits and medications, which did not help me a great deal, they were not willing to pay for other therapies that have helped me. When I had out-of-state major neurosurgery two years ago, once again therapy modalities that helped me return to work and function at the level I am expected to by my employer, were denied.

My injuries and experiences are minor compared to some of the people in Alaska who now face a lifetime of problems so different from those that they had pre-TBI. The people of Alaska need to have prevention, treatment and rehabilitation services that can help increase awareness of preventing TBI's; treatment provided regardless of location or insurance availability and rehabilitation services that incorporate all programs and services that give the patient the best quality of life possible.

I never expected to be in a position of fighting to explain my difficulties as a result of a TBI or trying to find care that helped me get better. After all, being now defined as "average" should be ok. Right?

On behalf of myself and all the patients, families and providers who work to prevent TBI's, provide treatment and care for patients, I urge you to support SB 219.

Respectfully,



Christine A. DeCourtney



10/10/01

Honorable Craig Johnson
Alaska State Capitol, Rm 126
Juneau, Alaska 99801

Dear Representative Johnson,

Thank you for introducing the House Bill, establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services.

At St. Elias Special Hospital, we treat and assist many patients who are affected by brain injury. Our patients' stories are personal to them and to us. But the outcomes of their injuries effect us all. Frequently, many patients who have suffered from a brain injury will come to St. Elias on a ventilator and will be unable to speak, eat or walk. We have been fortunate to be able to watch many patients walk out of the hospital. Others have suffered significant injuries and are not that lucky. We are very concerned about the resources available to our patients after they leave St. Elias.

We, at St. Elias support the House Bill because it would provide a mechanism to better track the traumatic brain injury patients in Alaska. It would also identify services lacking for patients post hospital discharge. Sadly, some of our patients and their families are being required to leave the state for long term rehabilitative care because services are not always available in Alaska. This puts tremendous financial hardship on the families and patients both emotionally and financially and is also costly to the state. This House Bill would serve all Alaskans better by combining TBI reporting for all entities including those that are for profit and non-profit, including military and native services.

St. Elias Specialty Hospital is expanding its programs to better serve patients with traumatic and acquired brain injuries; however, this house bill could help us provide a better discharge plan for patients with brain injury, thereby allowing the patients to continue their recovery and lead

productive lives that could help TBI patients get early treatment and keep the patients healthier and more productive. Patients could become productive, contributing members of the Alaskan community.

Thank you, Representative Johnson, thank you so much for your support, consideration and concern for this issue in our state, hospitals and most importantly our patients.

Sharon Abatz, PhD
Chief Executive Officer
St. Elias Specialty Hospital

From: Murphy, Sean [Sean.Murphy@ascenergy.com]
Sent: Thursday, February 04, 2010 9:19 AM
To: Jeanne Ostnes
Cc: jill@alaskabraininjury.net
Subject: FW: SB 219
Attachments: TBI Accident.pdf

Sean & Dee Murphy
5745 Greece Dr.
Anchorage, AK 99516
Feb 3rd, 2010

Dear Representative Craig Johnson:

First, I would like to thank you for introducing the bill titled: An Act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services.

My name is Sean Murphy and I am recovering from a traumatic brain injury from a skiing accident two years ago at Whistler/Blackcomb B.C. I hit a tree at nearly 30 MPH head first, thankfully I was wearing a helmet or the recovery process could have been much worse. I was air lifted down the mountain to the clinic at W/B where they kept me on life support until the second air medivac was available to transport me to Vancouver General Hospital. Three days later I awoke from my coma and my wife realized she would have to raise another child (husband) since I could not talk, walk or even feed myself.

The bill gives the Department of Health and Social Services many specifics to help address issues related to TBI which are all necessary here in Alaska. However, the main reason for writing you today is not for me or the treatment and support from my injury; but the needed support for family members dealing with TBI patients. TBI patients often have emotional issues that impact the entire family. It was extremely difficult to obtain any information, a single agency to assist in identifying resources, support groups, etc. would have been most beneficial for families in this situation.

As I found out weeks or understood months later, was the amount of stress that my wife had to endure. From first, being out of the country, then in Seattle and then again in Anchorage my wife had to continually start the processes over again to get me needed treatment. Again, having case management services to assist would have been extremely helpful in finding a neurologist, physical therapist, and the resources needed to aide in the recovery process. While researching these types of injuries, my wife and I noticed that the majority of states have facilities to assist people in obtaining the information and contacts needed. We could not find this in the state of Alaska. With the many outdoor activities and amount of highway accidents in Alaska we were surprised to find that this was the case.

Attached is a letter my wife wrote from my injury and the stress she endured and difficulties she encountered along the way.

Sincerely,

Sean Murphy

My husband Sean and I spent a week in Whistler/Blackcomb, BC. Sean was skiing expert terrain all week. On the last day of the trip, he and his buddies stopped for a bowl of soup before heading home. After lunch, he got into his skis and picked a casual groomed ski trail to head down the mountain. He was the first one back in his skis as they started down the mountain. When his friends started down the trail, they saw him veer across the trail over an embankment into the tree line. To this day, having lunch is the last thing that he remembers. They both called down to see if he was ok, when he doesn't respond, one friend came down to check on him and found that he was not conscious. The second friend began stopping others for assistance. A doctor and nurse happened to ski near the accident and began CPR and a ski instructor stopped and contacted ski patrol. Ski patrol arrived within minutes and provided an open airway and artificial respiration while packaging Sean for transport to a helicopter arriving. We believe that due to preparation for the Olympics, the response time of the ski patrol and helicopter was extremely quick, within minutes, Sean was transported to the clinic at the base of the mountain, examined and prepped for another helicopter ride to Vancouver General Hospital.

Our friends and I packed and drove from Whistler to Vancouver only to discover that he had still not awoken and they might have to drill into his brain to release some of the pressure due to swelling caused from severe bruising and 8 sub dermal hematomas. The good news was that after a full body CAT scan to determine the extent of his injuries, other than the head injury, he had a broken finger. After three unconscious days in the ER Sean finally came out of a coma. The doctors asked if he knew what happened, he shook his head no, he asked if he knew who was next to him. All he could do was say wife, but that was more than enough considering we were told that his long term memory would probably be affected by the injury.

On the evening of the third day, Sean was transferred to the Neurological Intensive Care Unit. He was unable to speak coherently, sit up, walk, and other basic motor functions. The doctors informed me that the recovery process would more than likely take months and that we would need to stay in Vancouver until the pressure on his brain decreased considerably and he was able to walk with assistance. The Neurologist stated that if he hadn't been wearing a helmet he would not be here today. In fact, his helmet was used during several meetings to encourage the use of helmets with the staff at VGH.

Sean began the process of recovery, and I began the process of notifying employers and family of our situation. Luckily for me, two of the friends that were on vacation with us offered to stay in Vancouver for support. I was surprised to find out that Canada does not accept health insurance, so having to figure out how to pay for this care, and my stay in Vancouver and trying to keep our daughter from knowing how serious the injury was since she was alone in Anchorage was almost more than I could tolerate. To this day, I cannot thank our friends enough who stayed with us in Vancouver.

The days following consisted of me massaging his legs and arms, little stretches to keep him from stiffening up and numerous trips to the nurse's station trying to reach the Doctor for an update. I was told that he did not see patients during visiting hours because time was allotted for surgeries. The only care provide for the first two days in NICU were hourly vitals check by the nursing staff and my attempts to do stretches with him lying in bed. After 3 days in the NICU, and dozens of requests to see the doctor, he finally stopped in to provide an update. He stated that the bruising was improving, but had not decreased enough for air travel and that air travel could cause further damage to his brain. I asked about road travel so that we could get back to the US, he indicated that since he was barely able to feed himself, had not walked yet, and could not speak more than a word or two when responding to questions, that we needed to realize that long term hospital care and physical therapy was required. I asked when physical therapy would begin, and he indicated that the physical therapist would be by to see us that day.

I increased our efforts to get him to do more on his own. I asked that he feed himself; even though he wore more of the food then he ate. I got him to stand next to the bed with me and our friend on either side to see if he was able. He was not able to take a step or stand on his own, but it strengthened my resolve to get him walking again. Later that date, the PT examined Sean and gave us stretches that we could do to help him improve and that we could attempt to get him to stand periodically throughout the day. We followed the regiment for two days, than were given approval to see if he could walk. We began walking him to the restroom, which was only about 8-10 steps from the bed. The following day the Physical Therapist was surprised to see how much he had improved. Much less food on his clothes, able to speak short sentences and could walk with assistance to the restroom. She then gave us permission to walk the halls as long as our friend and I were with him at all times. We began this trek immediately after she left and continued every hour if he was awake. Day 8, he can walk two times around the NICU floor and we attempt the stairs without the PT's knowledge. He was able to take two steps. We continued to walk as often as possible so that he could build up his strength and improve his balance. The following day, I asked that he be examined again to see if the bleeding and swelling had gone down. It had, I then ask the PT if we can attempt the 5 steps so that we could travel to Washington by car. Sean climbed 5 stairs with Danny and me on either side. The PT consulted with the doctor and they gave us authorization to travel to Washington after resting at the hotel for 1-2 days to ensure that he is able to travel. I asked that they provide a CD of his cat scan and all medical records; they indicated that they would fax the reports to the doctor in Seattle and would provide the CD prior to checkout. So with a stop by accounting, I paid the bill by check and credit card. (I had contacted our credit card company earlier in the week and told them of the situation. They agreed to increase our limit enough to cover the hotel and hospital bill). Sean rested in the hotel and our friends from Seattle came to pick us up. I felt we were one step closer to getting home.

In Seattle, I made numerous calls to Neurologists, but none would take a new patient without a referral. After several calls to Vancouver General and little success in

getting help, our friend Jane said she had an appointment and we could go with her, so we did. We explained to her doctor why we were crashing Jane's appointment, and to our surprise, she examined Jane in 10 minutes and the remainder of the appointment was Sean's. She was astounded that this accident was less than two weeks prior and immediately contacted a Neurologist that she knew and had an appointment for Sean the following day. Again, we were told that it would be several weeks before we could travel and were surprised that we were given approval to leave Vancouver as there were still several areas still swollen and bleeding on the brain. Three times a week, Sean and I went to see the Neurologist. They worked motor skills and did brain teasers and each visit seemed to be better than the last. At the end of the third week, we were given the green light to travel home to Anchorage.

I thought the process would be much easier in Anchorage, only to find out we had to start the process all over again. Neurologists and Physical Therapists require a referral. We went to our family physician and were referred. My Dad agreed to come to Alaska to help care for Sean since he could not be left alone and I needed to get back to work since we had used all of our vacation time and all that could be done now FMLA, which is family medical leave without pay. Without both our incomes, this was not an option.

Sean could not be left alone, could not cook, could not take stairs on his own, etc. So I was so thankful that my Dad was with me to care for him because I needed to get back to work at least part time. As I finish this letter, I have a tough time keeping my composure, I reflect on the stress that I had to endure due to Sean's accident and the fact there wasn't someone I could talk to that understood what we were going through. The angry outburst from Sean which are typical of head injuries, the fact that he was basically having to develop mentally and physically, newborn through adult hood all over again.

After two years, there are still outburst, but they are less frequent, and his short term memory has been affected where he must keep more detailed notes. But on a positive note, the recovery was much quicker than anyone thought it would be and physically he is in the best shape of his life. He is running under 6 minute miles now and he continues to improve emotionally, mentally and physically.

Jeanne Ostnes

From: Andi Nations [nationsa.silc@gmail.com]
Sent: Monday, January 25, 2010 12:34 PM
To: Rep. Craig Johnson
Subject: Traumatic Brain Injury Service Coordination

Thank you for sponsoring a House Bill relating to an act establishing a traumatic (or acquired) brain injury program. This legislation will make great strides towards providing needed services for Alaskans who have been impacted by brain injuries. We look forward to working with you on this important issue.

--
Andi Nations
Statewide Independent Living Council of Alaska
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Anchorage, AK 99503
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FOR IMMEDIATE RELEASE: Personal Stories and HB 328 and SB 219

March 2010 is Brain Injury Awareness Month!

Anchorage, Alaska –

March 2010 will mark the commencement of Brain Injury Awareness Month! The Alaska Brain Injury Network, Inc. (ABIN) encourages you to develop stories to raise awareness of "the silent epidemic."

Brain injury can affect any one of us...in an instant. Not only are the personal stories gripping, but the impact on the family can often end up inspiring or devastating. Families that endure life after brain injury need acknowledgement. Many of the strongest family units are torn apart after a traumatic injury. Why do Alaska families and communities end up devastated, torn apart, and defeated? Is this a personal issue or a system's issue? Often times it is both, but who is to blame families when the state does not have a single program specifically to deal with brain injury treatment, rehabilitation, and support? There are very few in-state resources to help individuals learn to live again and to support families through this often lifelong process. Alaskans deserve better.

ABIN is connected to hundreds of Alaskans and their families that have been affected by brain injury: Alaska natives, military, urban residents, children, adults, CEO's, nurses, teachers, and more. If you are looking for a heart-wrenching and news worthy story, we can connect you to these individuals and families across the State.

In addition to personal stories, there are two companion bills in the legislature that will build state capacity to develop brain injury specialty programs. House Bill 328, sponsored by Representative Craig Johnson, and Senate Bill 219, sponsored by Senator Lesil McGuire, establishes a traumatic or acquired brain injury (T/ABI) program and registry within the Department of Health and Social Services.

HB 328 and SB 219 provides the leadership and incentive to create a service delivery system where children, adults, and service members who sustain a brain injury and their families, will have the opportunities that all Alaskans desire; to learn, love and be loved, and find meaningful work or activities.

Statistics: The Alaska's Department of Health and Social Services show that traumatic brain injury is a leading cause of death and disability among children and young adults in the State of Alaska; an estimated 12,000 people in the State of Alaska have suffered a traumatic brain injury; approximately 800 people in the State of Alaska report traumatic brain injuries each year; the number of Alaskans with a traumatic brain injury is increasing significantly as military service members injured overseas return home to Alaska; 20 percent of traumatic brain injuries result in death; many people who suffer traumatic brain injuries live with permanent disabilities; most cases of traumatic brain injury are preventable; and the lack of public awareness is so vast that traumatic brain injury is known in the disability community as the nation's "silent epidemic"

For general information or media information, contact Jill Hodges at (907) 274-2824 or jill@alaskabraininjury.net.

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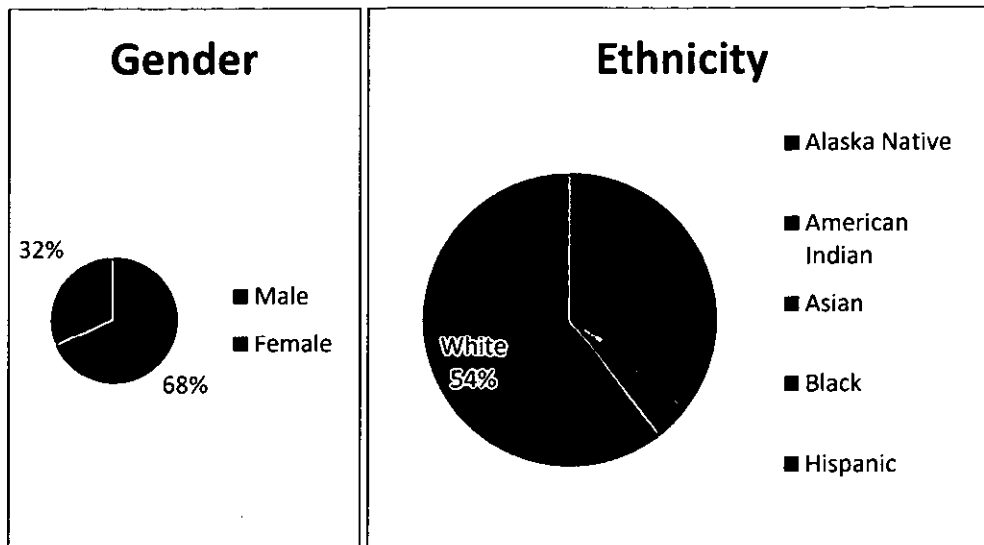


Figure 1: Males sustain TBI at twice the rate of females

Figure 2: TBI's are sustained primarily by White and Alaska Native populations

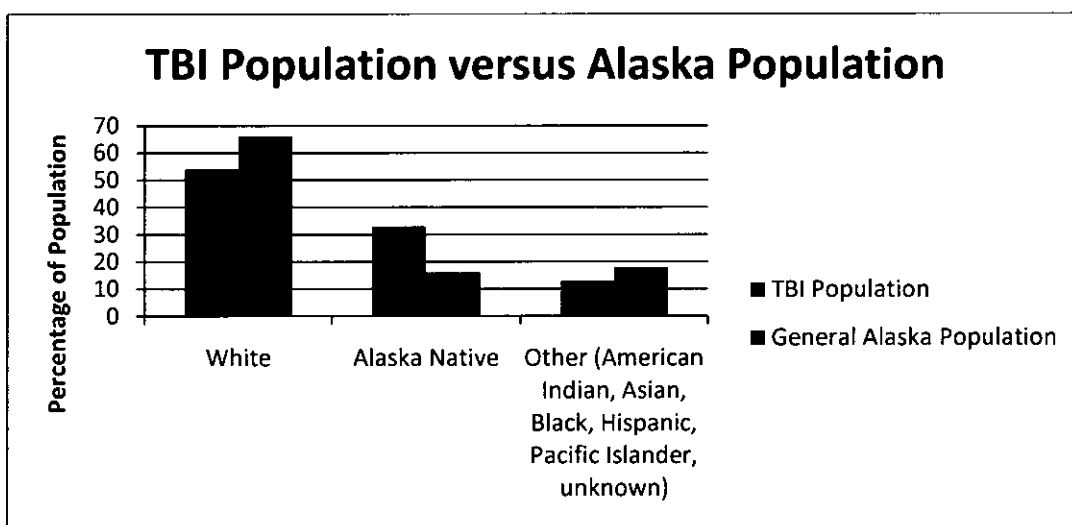


Figure 3: Alaskan Natives and rural residents sustain TBI at disproportionate rates compared to census data

TBI in Alaska, 1995-2005 Hospitalization greater than 24 hours

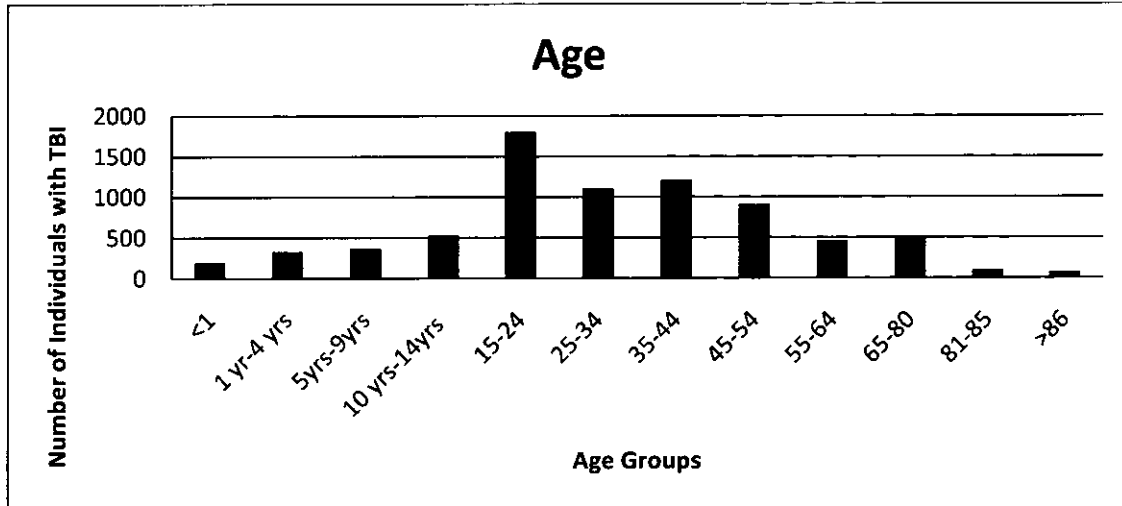


Figure 4: Highest incidence rates are among 15-24 year old males. The highest prevalence rates are among Elders who fall.

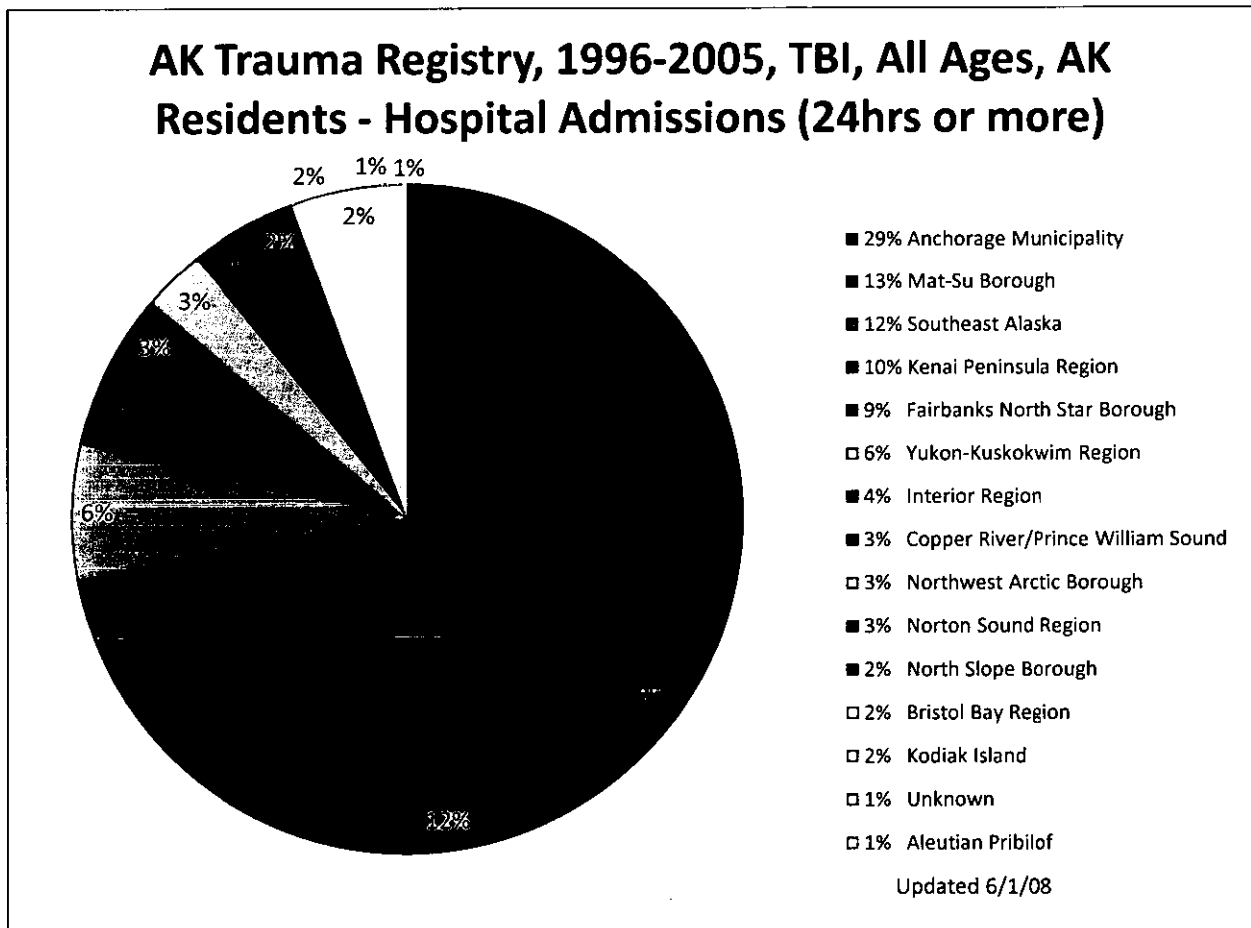


Figure 5: Highest incidence rates are among Anchorage, Mat-Su, and Southeast regions. The highest prevalence rates are in the Yukon-Kuskokwim Region.

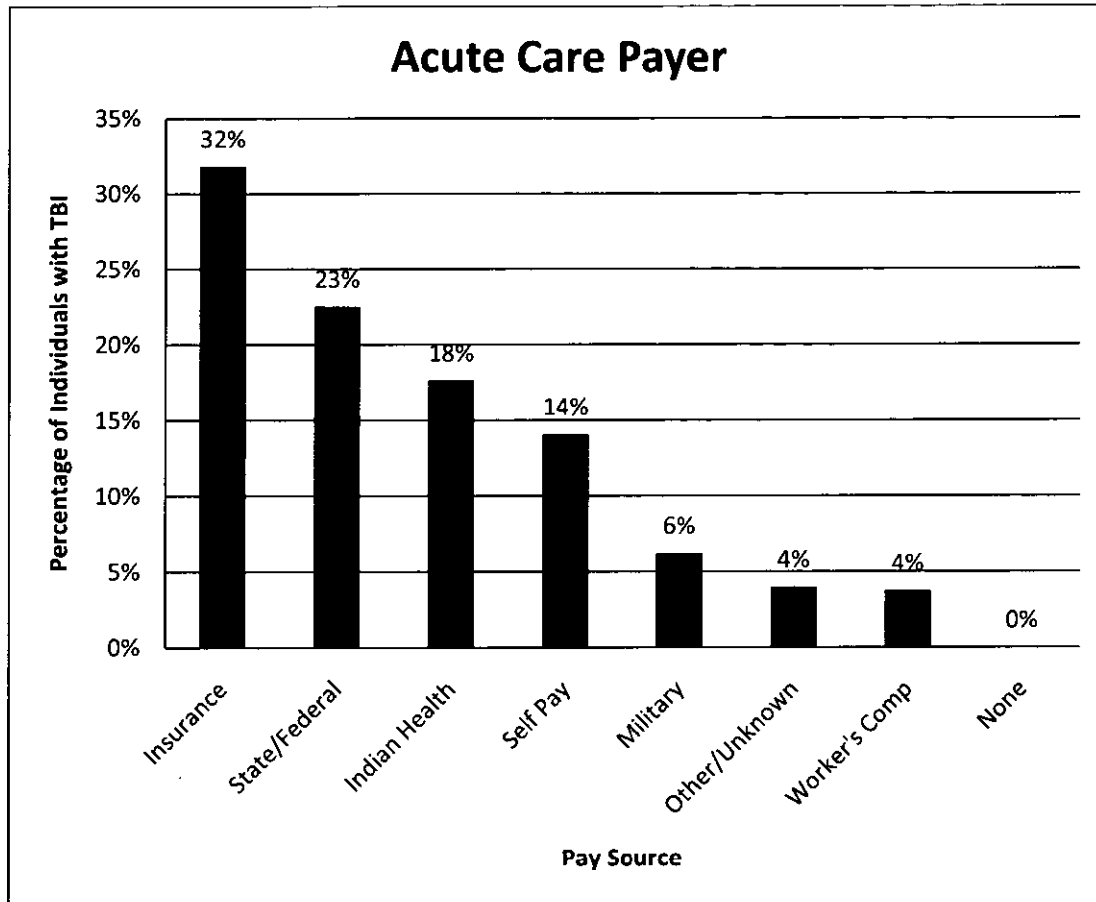


Figure 6: Acute care costs are paid by major payers. Inpatient and post-acute rehabilitation is limited. There is not a post-acute rehabilitation facility in-state.

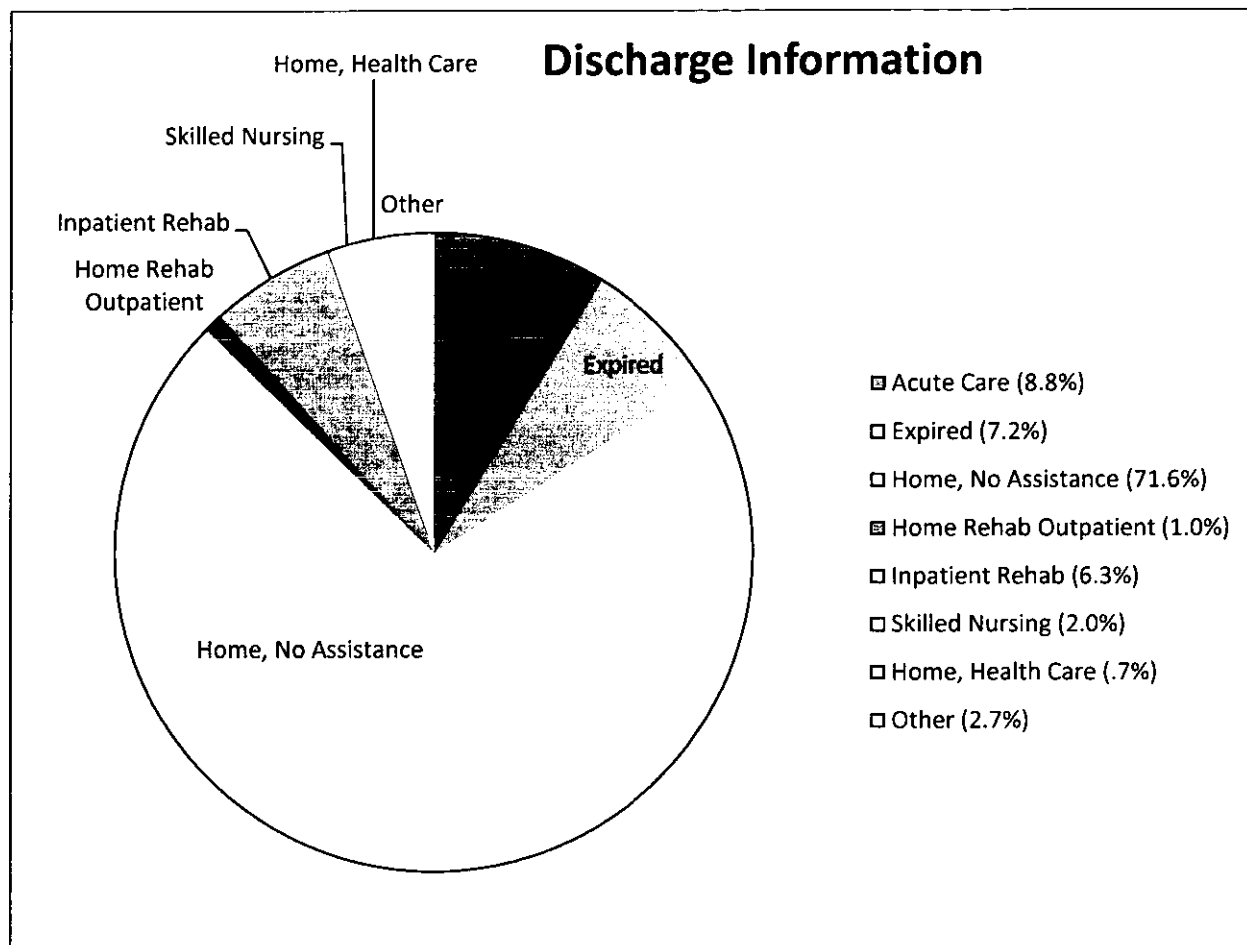


Figure 7: 72% of TBI survivors are sent home with no assistance. 1% of TBI survivors have access to rehab once they return home.

Alaska Brain Injury Network			
Alaska Scorecard and TBI Dashboard – (DRAFT)			
DRAFT #1 – May 22, 2008			
○ Getting worse		↔ Not changing	● Improving
	5-year Trend	Current Data	Source
SCORECARD: A “scorecard” provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	●	98.6	1
Causes			
Falls	○	28.7	1
Motor Vehicle Transportation Occupant	●	24.7	1
Assault	●	12.2	1
ATV	○	6.5	1
Bicycle	●	4.5	1
Snowmachine	●	4.4	1
Pedestrian	●	3.6	1
Sports	●	1.8	1
Water Transport	↔	1.3	1
Suicide Attempt	●	.8	1
Gender			
TBI percentage among males		65.4 %	1
TBI percentage among females	↔	33.2 %	1
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	1.a
Percentage of TBI population that is White		53%	1.a
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	1.a
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	1
Females age 80+		217.2	1
Males age 70-79		215.7	1
Males age 15-19		200.9	1
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

- 1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
- 1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
- 1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
- 2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population

○ Getting worse

↔ Not changing

● Improving

Dashboard: Behavioral Health

TBI and Mental Health	Spot look trend	Current Data	Source
Percentage BH clients screening positive for TBI	↔	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	1
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	4

Dashboard: Education

Special Education	Spot look trend	Current Data	Source
Number of children in Special Education statewide with TBI diagnosis (2007)	↔	66	5

Dashboard: Justice

Corrections	Spot look trend	Current Data	Source
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6

Dashboard: Employment

Vocational Rehabilitation	Spot look trend	Current Data	Source
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		\$12.54	7

Dashboard: Providence

ImPACT Program			
Number of baselines (ImPACT)		57	8
Number of student/athletes seen in program (ImPACT)		25	8
Emergency Department			
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8

Dashboard: Alaska Brain Injury Network

TBI Advisory Board			
Est. Board Member Volunteer hours/year	⊕	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation			
Average new consumer contacts per month	⊕	30	9
Average unique visitors/month to ABIN website	⊕	750	9
Number of people on Alaska Brain Matters Listserve	⊕	100+	9

- | | |
|-------------------------------------------------------------------------------------|------------------------------------------------|
| 3 AKAIMS | 7 Division of Vocational Rehabilitation (FY07) |
| 4 Suicide Follow-back Study | 8 Providence Neuroservices |
| 5 http://www.eed.state.ak.us/stats/ | 9 Alaska Brain Injury Network |
| 6 Trust/DOC Study 07 | |



Traumatic Brain Injury:

A Guide for Criminal Justice Professionals

Many prison and jail inmates are living with traumatic brain injury (TBI)-related problems that complicate their management and treatment while incarcerated. Because most inmates will be released, these problems also pose challenges when they return to the community. The Centers for Disease Control and Prevention (CDC) recognizes TBI in prisons and jails as an important public health problem.

What is Traumatic Brain Injury?

- A traumatic brain injury (TBI) is defined as a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain.¹
- Not all blows or jolts to the head result in a TBI. The severity of such an injury may range from "mild," with a brief change in mental status or consciousness, to "severe," with an extended period of unconsciousness or amnesia after the injury.¹
- A study of young adults found that those with a TBI were at risk for sustaining another,^{2,3} and that a history of multiple TBIs is associated with slower recovery.⁴

How many people have TBI?

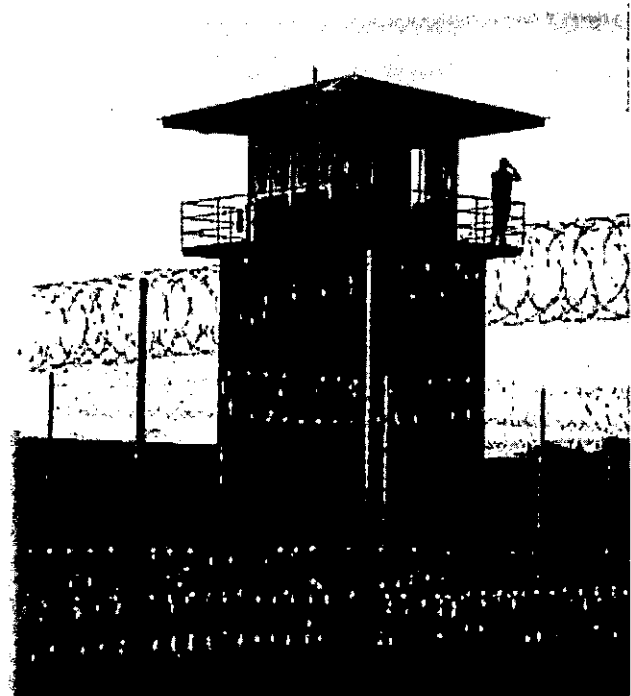
- Each year, on average 1.4 million people in the United States sustain a TBI. Of this number, 50,000 die, 235,000 are hospitalized, and 1.1 million are treated and released from an emergency department.⁵
- At least 5.3 million Americans are living with TBI-related disabilities.⁶
- The number of people with TBI who are not seen in an emergency department or who receive no care is unknown.⁷

What are the causes of TBI?

- The leading causes of TBI are falls, motor vehicle-traffic crashes, struck by or against events, and assaults.⁵
- Blasts are the leading cause of TBI among active duty military personnel in war zones.⁸

What are the long-term consequences of TBI?

- A person with a TBI can experience short- or long-term problems, requiring help in performing activities of daily living.^{1,6}
- A TBI can cause a wide range of problems in thinking, sensation, learning, language, behavior, and/or emotions.⁹⁻¹¹
- Persons with TBI may experience mental health problems such as severe depression,¹² anxiety,¹³ difficulty controlling anger¹⁴ and alcohol or substance abuse.^{15,16}



- TBI can also cause epilepsy and increase the risk for both Alzheimer's and Parkinson's diseases and other brain disorders associated with increasing age.⁹

What is known about the extent of TBI and related problems within the criminal justice system?

General:

- According to jail and prison studies, 25-87% of inmates report having experienced a head injury or TBI¹⁷⁻¹⁹ as compared to 8.5% in a general population reporting a history of TBI.²⁰
- Inmates who reported head injuries are more likely to have disciplinary problems during incarceration.²¹
- Inmates with head injuries may have seizures¹⁹ or mental health problems such as anxiety²² or suicidal thoughts and/or attempts.^{22,23}
- Studies of inmates' self-reported health indicated that inmates with one or more head injuries have significantly higher levels of alcohol and/or drug use during the year preceding their current incarceration.²²
- The U.S. Department of Justice has reported that 52% of female and 41% of male offenders were under the influence of drugs, alcohol, or both at the time of their arrest,²⁴ and that 64% of male arrestees tested positive for at least one of five illicit drugs (cocaine, opioids, marijuana, methamphetamines, or PCP).²⁵
- Although more than half of prison inmates have a lifetime history of drug use disorders,²⁶ fewer than 15% receive substance abuse treatment services while in prison.²⁷

Women and Families:

- Female inmates who are convicted of a violent crime, are more likely to have sustained a pre-crime TBI and/or some other form of physical abuse.²⁸
- Children and teenagers who have been convicted of a crime are more likely to have sustained a pre-crime TBI²⁹ and/or some other form of physical abuse.²⁹⁻³¹

- Among male inmates, a history of TBI is strongly associated with perpetration of domestic violence and other kinds of violence during their lifetimes.³²

Corrections and Law Enforcement Officers:

- Corrections personnel and law enforcement officers are at risk for head injury or fatal head trauma.^{33,34}
- Interactions with suspects prior to arrest and with inmates during their incarceration are considered high risk situations for injury or death due to head trauma.³⁵

How might inmates with TBI and others be affected by TBI-related problems?

Within the correctional setting, TBI can contribute to situations that lead to disciplinary action. Here are some common TBI problems and strategies for management:

- Attention deficits may make it difficult for the inmate with TBI to focus on a required task or respond to directions given by a corrections officer. Either situation may be misinterpreted, thus leading to an impression of deliberate defiance on the part of the inmate.^{17,36}
 - Management strategies:
 - Ask the inmate to repeat what you have said to confirm that he or she has heard and understood your directions
 - Encourage the inmate to write down steps for the task
 - Allow extra time for the task to be done
 - Clear or reduce environmental distractions
- Memory deficits can make it difficult to understand or remember rules or directions, which may lead to disciplinary actions by jail or prison staff.²¹
 - Management strategies:
 - Explain rules or directions slowly, step-by-step

- Ask the inmate to repeat the steps and encourage him or her to write down the information
 - Provide examples and ask the inmate to provide his or her own
 - Teach the inmate to ask questions when he or she doesn't understand
- Slowed verbal and physical responses may be interpreted by corrections officers as uncooperative behavior.^{36,37}
 - Management strategies:
 - Give directions, or ask questions, slowly; repeat if necessary
 - Allow the inmate additional time to respond
- Irritability or anger may be difficult to control which can lead to an incident with another inmate or corrections officer. Such incidents can lead to further injury for the inmate with TBI and others.^{37,38}
 - Management strategies:
 - Avoid arguing with the inmate
 - Try re-phrasing the problem, breaking it down into parts
 - Reinforce positive behaviors
- Uninhibited or impulsive behavior, including unacceptable sexual behavior, may provoke other inmates or result in disciplinary action by jail or prison staff.^{36,39}
 - Management strategies:
 - Tell the inmate calmly that the behavior is unacceptable
 - Seek assistance from mental health professionals

How can the problem of TBI in prisons and jails be addressed?

A recent report from the Commission on Safety and Abuse in America's Prisons recommended increased health screenings, evaluations, and treatment for inmates and development of partnerships with community health providers to assure continuity of care and case management for released inmates.⁴⁰

In addition, TBI experts and some prison officials have suggested the following:

- Routinely screen jail and prison populations to identify a history of TBI.^{41,42}
- Screen inmates with TBI for possible alcohol and/or substance abuse and provide treatment for these co-occurring conditions.^{25,43,44}
- Conduct additional evaluations to identify specific TBI-related problems and determine how they should be managed.⁴¹ Special attention should be given to impulsive behavior, including violence,³⁹ sexual activity,³⁶ and suicide risk if the inmate is depressed.⁴⁵

How should TBI-related problems be addressed after release from jails and prisons?

Lack of treatment and rehabilitation for inmates with mental health and substance abuse problems while incarcerated increases the probability that they will again abuse alcohol and/or drugs when released.^{25,44} Persistent substance abuse can lead to homelessness,⁴⁶ return to illegal drug activities,⁴⁷ re-arrest,⁴⁸ and increased risk of death⁴⁹ after release. As a result, criminal justice professionals and TBI experts have suggested the following:

- Community re-entry staff should be trained to identify a history of TBI and have access to appropriate consultation with other professionals with expertise in TBI.^{29,41,42}
- Transition services should be capable of accommodating the effects of an inmate's TBI upon their release and return to the community.^{29,41,42}
- Released inmates with mental health and/or substance abuse problems should receive case management services and assistance with placement into community treatment programs.^{40,43,49}

CDC supports new research to develop better methods for identifying inmates with a history of TBI and related problems and for determining how many are living with such injury.

Further information is available from these websites:

Traumatic Brain Injury (TBI):

CDC, National Center for Injury Prevention and Control
www.cdc.gov/ncipc/tbi/TBI.htm

This site provides information for professionals and the general public regarding TBI. Topics include prevention, causes, outcomes, and research. Data reports on TBI in the United States and many free publications and fact sheets can be downloaded. Materials are available in English and Spanish.

Health Issues in Correctional Settings:

CDC, National Center for HIV, STD, and TB Prevention
www.cdc.gov/nchstp/od/cccwg/default.htm

This site provides information for public health and criminal justice professionals about health topics with an emphasis on infectious diseases in the correctional setting. It also includes materials for the general public with links to related organizations.

Intimate Partner Violence (IPV):

CDC, National Center for Injury Prevention and Control
www.cdc.gov/ncipc/factsheets/ipvfacts.htm

This site provides information for professionals and the general public regarding IPV. The site contains an overview and fact sheet about IPV, prevention strategies, links to other IPV organizations, and a list of current CDC publications.

Legal Issues of Persons with TBI within Correctional Settings:

National Disability Rights Network
www.ndrn.org/aboutus/consumer.htm

This site provides information about the laws protecting the civil and human rights of people with disabilities including those with TBI. Inmates with disabilities or their families can receive help from the Network about inmates' legal rights, access to mental health services and/or medication, and restoration of benefits upon release.

Substance Abuse:

Substance Abuse & Mental Health Services Administration
www.samhsa.gov

This site provides information for professionals and the general public regarding treatment resources for persons with, or at risk for, mental health and/or substance abuse problems. It also has materials for specific populations and age groups and hotlines.

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Summary: State Legislation on Returning Troops and Veterans

October 1, 2008

Overview

Increasingly, state legislatures and governors are calling for state leadership in providing outreach, information and resources to returning troops, veterans and their families with regard to traumatic brain injury (TBI), post traumatic stress disorder (PTSD) and related issues.

In July 2007, Illinois Governor Rod R. Blagojevich and the Director of the Illinois Department of Veterans' Affairs announced a first-of-its-kind program to screen every returning Illinois National Guard member for TBI and to provide a 24-hour toll-free psychological assistance for veterans suffering from PTSD. Similar efforts are beginning in other states. Below is a summary of legislation that has passed over the past two years pertaining to these and other efforts as reported in *State Watch* produced by the Federal HRSA TBI Program's Technical Assistance Center at NASHIA.

Study Commissions

NH – On June 26, 2008, Governor John Lynch signed H.B. 1335 establishing a commission to study the effects of PTSD and TBI suffered by New Hampshire soldiers and veterans returning from Iraq and Afghanistan.

NJ – In August 2007, Governor Jon Corzine signed A.B. 3281 requiring state officials to study community-based care alternatives for the state's disabled veterans to avoid placement in a nursing home or other long-term care facility.

WV – Legislators passed H.C.R. 75 requesting the Joint Committee on Government and Finance to make a study of the needs of soldiers and veterans who have been injured in the Iraq/Afghanistan wars for the purpose of making recommendations on how the State of West Virginia can assist in getting them the care they deserve. The Division of Veterans Affairs, West Virginia Congressional Delegation and the National Guard are to help with the study and recommendations.

Screening and Outreach

CA – On September 30, 2008, Governor Arnold Schwarzenegger signed S.B. 1401, requiring the

Department of Veterans Affairs and the Military Department to develop outreach plans to National Guard members or veterans returning to California from combat and assist them in obtaining a screening for PTSD and TBI. The bill takes effect January 1, 2009

MI – On May 28, 2008 Governor Jennifer M. Granholm signed S.B. 731, that requires the Department of Military and Veterans Affairs to administer a PTSD and a TBI questionnaire to an officer or enlisted person serving in the National Guard who has returned from Operation Iraqi Freedom or Operation Enduring Freedom, unless he or she has completed similar questionnaires approved by the US Departments of Veterans Affairs or Defense.

Referral, Counseling, Services and Coordination

MN – On May 29, 2008, Governor Tim Pawlenty signed H.B. 1812 appropriating \$500,000 for casework services for veterans, including in-home counseling. The bill also directed the veterans' agency to design a treatment program for veterans with TBI within the State Veterans Homes.

Other budget items included funding for the Linkvet telephone line service for veterans; a grant to the Minnesota Assistance Council for their work in helping veterans and their families affected by homelessness; for the veterans claims office for outreach and training to improve services and benefits; a pilot program for peer-to-peer counseling among combat veterans; and for an intergovernmental and veterans strategic planning study for the Minnesota Veterans Homes, with special emphasis on exploring alternative models to help veterans to live more independently.

In addition, the Department of Military Affairs received permanent funding for a "State Navigator" to coordinate state agency programs and activities to support and assist soldiers and their families during and after the reintegration process. The "State Navigator" position is viewed as an extension of the nationally recognized "Beyond the Yellow Ribbon" program.

VA -- The Virginia General Assembly appropriated \$4.5 million for wounded warrior legislation passed to provide assistance for soldiers with TBI. On March 12, 2008, Governor Tim Kaine signed H.B. 475 and on March 12, 2008, he signed S.B. 297, that requires the Department of Veterans Services, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse and the Department of Rehabilitative Services to establish a program to monitor and coordinate mental health and rehabilitative services support for Virginia veterans, members of the Virginia National Guard and Virginia residents in the Armed Forces Reserves not in federal service. The program is to also support family members affected by covered military members' service and deployments.

The purpose of the program is to ensure that adequate and timely assessment, treatment and support for stress-related injuries and TBI resulting from service in combat areas are available to veterans, service members and affected family members. Subject to the availability of public and private funds appropriated for them, these services include case management services, outpatient, family support and other appropriate behavioral health and brain injury services necessary to provide individual services and support to military service members and their families.

VT -- Governor Jim Douglas signed H.B. 691, May 20, 2008, creating the Traumatic Brain Injury Fund to serve Vermonters with TBI, including residents who have served in the Armed Forces in Operation Iraqi Freedom and Operation Enduring Freedom.

TX -- On June 15, 2007, Governor Rick Perry signed S.B. 1058, relating to reintegration counseling services and related resources for military servicemembers. The legislation enabled veterans in parts of Texas that are served by the Texas Information and Referral Network (2-1-1) to call that service to receive information on services for veterans and military personnel. S.B. 1058 requires a comprehensive array of governmental agencies to identify state, local and private or government resources--medical, social and economic--that are available to military personnel and their immediate families.

Suicide Prevention and Mental Health Services CA -- On September 30, 2008, Governor Arnold Schwarzenegger signed A.B. 3083 to extend mental health services provided by the Adult and Older Adult Mental Health System of Care Act to include veterans, and requires counties to provide mental health services to veterans to the extent such services are available to other adults. The bill takes effect January 1, 2009

MN -- On May 4, 2007, Governor Tim Pawlenty signed H.B. 2227, an appropriations bill that appropriated \$50,000 to fund a study on the mental health needs of returning servicemen and women to be conducted by the National Guard Adjutant General and the Commissioner of Veterans Affairs, and \$30,000 to create a telephone hotline to refer veterans to available mental health services.

Resolutions

Several state legislatures have adopted resolutions to express gratitude for the sacrifices made by veterans who have sustained medical or mental health conditions or TBIs as the result of serving in the United States Armed Forces; and have urged Congress to ensure adequate funding for veterans' health care.

These states include Alaska (S.J.R. 11); Louisiana (H.C.R. 23); Vermont (H.J.R. 57); Texas (S.R. 594; H.C.R. 1) in 2007; and Michigan (H.R. 175) also in 2007.

Vermont lawmakers also urged the US Department of Defense to screen all military personnel leaving a combat theater for traumatic brain injury, urged the US Department of Veterans Affairs to create a traumatic brain injury registry; a comprehensive program to provide long-term traumatic brain injury rehabilitation; and a pilot program in Vermont to deliver traumatic brain injury screening, readjustment counseling, mental health services, and benefits outreach to rural veterans through mobile Vet Centers.

For copies of these cited bills or resolutions please contact the National Association of State Head Injury Administrators at:

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NASHIA assists state government in promoting partnerships and building systems to meet the needs of individuals with brain injuries and their families.

Traumatic Brain Injury and Domestic Violence Facts:

What is Traumatic Brain Injury?

A traumatic brain injury (TBI) is an injury to the head that results from a blow to the head of sufficient force to create blunt trauma, such as being hit in the head with a baseball bat or having one's head slammed against a hard object, the result of trauma secondary to a penetrating object into the brain itself, for example, a bullet entering the brain or the result of rapid movement of the brain within the skull, e.g., repetitive shaking of the body/head.



What is Domestic Violence?

Domestic violence is a deliberate pattern of abusive tactics used by one partner in an intimate relationship to obtain and maintain power and control over the other. (Alabama Coalition Against Domestic Violence)

How are Traumatic Brain Injury and Domestic Violence linked?

Research studies on the incidence of traumatic brain injury in domestic violence cases have revealed greater than 90% of all injuries secondary to domestic violence occur to the head, neck or face region (Monohan and O'Leary 1999). In a 1998 study by Jackson and Phillips of 53 women living in a domestic violence shelter on average the women experience five (5) brain injuries in the prior year. Almost 30% reported 10 injuries the prior year. Valera, in 2003, found that of the 99 battered women he studied, 75% sustained at least one partner related brain injury and 50% sustained multiple partner-related injuries.

Unfortunately repeated brain injury is typical of ongoing domestic violence leading to increased thinking, physical and emotional dysfunction over time, with the most disabling problems in the thinking process.

How do Domestic Violence victims become Brain Injured?

For victims of domestic violence, physical assault and/or use of violence are the assumed major causes of traumatic brain injury. The following are some ways in which victims of domestic violence sustain a brain injury:

- Blow to the head with any object
- Pushed against a wall or any other solid surface
- Punched in the face or head
- Strenuous shaking of the body
- Falling and hitting your head
- Being strangled
- Near drowning
- Being shot in the face or head

How does a Brain Injury and Domestic Violence increase the victim's risk of continued harm?

Abused individuals typically lack the knowledge of the long-term consequences of a brain injury and therefore do not seek specialized services. In addition service providers are often unaware of the high risk of a traumatic brain injury in victims. As a result professionals fail to link the psychodynamic issues presented by the victims and the challenges emerging from an undiagnosed brain injury. Without linking domestic violence and brain injury, they fail to recognize brain injury so are unable to refer for appropriate brain injury services and related rehabilitation services. Thus the lack of knowledge about brain injury serves to increase the likelihood of failure in intervention and rehabilitation success. In addition, once individuals experience one TBI they have an increased risk of having another TBI. Several things may happen after a TBI: the person's reaction time may be slower, judgement may be off, she may be more impulsive and inattentive to what might increase her likelihood of a second injury. The risk of repeated TBI is even greater for individuals who are victims of domestic violence since the most common target of abuse is the head, neck, and face. Repeated brain injuries increase symptoms. Each time the domestic violence victim comes into the shelter they may be a less functional as a result of a traumatic brain injury.

What are the symptoms of a Brain Injury?

An individual sustaining a brain injury generally experiences a period of altered mental state or a brief loss of consciousness following the blow to the head. Some of the common initial symptoms are as follows:

- Headaches
- Dizziness
- Slowed processing of information
- Forgetfulness
- Fatigue
- Sensitivity to noise and lights

Most of the symptoms will disappear after a period of time.

What are the most common problems a victim of Domestic Violence and a Brain Injury might exhibit?

The person may be more difficult to engage in planning, and show poorer follow-through on tasks. She may have greater difficulty adjusting to group living with shared responsibilities. She may be more likely to "not remember" prior discussions or routines. She may exhibit greater behavioral control issues. These things can result in the person having difficulty profiting from a shelter program.

What are the most common problems after a Brain Injury?

Physical Changes: Specific physical changes are more frequently reported after a TBI. These changes include

- *Overall slowing/Clumsiness*-- A person can have motor difficulties, meaning that they have trouble moving their arms, legs, and so forth. This may be a generalized weakness or it can be very specific to one part of the body. In most cases motor difficulties tend to improve fairly quickly.
- *Decreased vision/hearing/smell*-- All can be affected by a TBI
- *Dizziness*-- A person can experience significant dizziness as a result of a head injury caused by trauma to the inner ear.
- *Headaches*-- A fairly common problem among people with traumatic brain injury; and can persist for

many weeks or months.

- **Fatigue**- It is not uncommon for people with traumatic brain injury to have significant fatigue to the extent that they tire very quickly. Things that are easy for us to do physically may require much more effort for them.
- **Increased sensitivity to noise or to bright lights**

The most common and persistent complaints are headache and excessive fatigue.

Thinking Changes: Reduced attention and processing speed are two common changes after a TBI.

- **Attention problems**- difficulties with concentration, paying attention to visual details, and dividing one's attention between two differing tasks.
- **Processing speed**- A person may report that all actions have slowed down. moving, talking, thinking and reading. They often feel that they are in slow motion.
- **Communication**- People may complain of problems with word finding and having trouble staying organized when talking with others.
- **Learning and memory**- These are almost universal problems after a brain injury. Information learned before the TBI remains intact, however memory for new information after the TBI is impaired.

Executive Functioning: A person often has an impairment in various combinations of the following that create the most difficulty in day-to-day functioning:

- difficulty planning and setting goals
- difficulty being organized
- difficulty being flexible
- difficulty problem solving
- difficulty prioritizing
- decreased awareness of thinking changes in self



The individual may still function under the idea of who they were before the injury without the same functioning ability.

Emotional/Behavioral/Social changes: The most common emotional changes following a brain injury are depression and anxiety. These are sometimes exhibited as sadness, loss of interest, feelings of worthlessness and hopelessness. These may be the result of difficulties in reasoning as a result of the TBI. If an individual is no longer able to do things they took for granted after a TBI they can become frustrated and even depressed. In addition, if an individual can't reason their way out of a situation they may become anxious.

After a brain injury an individual may have difficulty with self-monitoring. This may result in a rapid loss of emotional control. As adults the emotions we all feel, but not always express, are under control because of a gating mechanism. We may feel certain emotions but not necessarily exhibit them. When somebody has a significant brain injury, the gating mechanisms keeping those emotions under control are often disrupted. The gates are knocked askew and things come out that the person used to be able to control. Hence their emotions are displayed very readily. This can extend to the point of being irritable.

Other changes after a brain injury may include:

- Difficulty with self-initiation
- Impatience
- Inability to get along with others
- Increased risk taking
- Increased impulsivity
- Irritability or agitation

- Intolerance
- Socially inappropriate behavior

How do I recognize if my client experienced a Brain Injury?

A "Brief Screening for Possible Brain Injury" was developed for use by domestic violence shelter staff as a tool to pre-screen survivors who may have experienced a brain injury during the course of a domestic violence incident. This tool is the first step. Part 1 questions the victim about events where a blow to the head may have occurred. Part 2 concerns common post TBI symptoms. If the screening results are positive you should consider referral to the Alabama Head Injury Foundation at 1-800-433-8002 for further assessments.

What approach should be used to address challenges of resulting from a TBI?

Depending on the specific symptoms your client is experiencing, there are a number of things you can do to help them compensate for the brain injury. Examples of compensations for challenges individuals with a brain injury may experience are as follows:

Physical-

- Allow extra time for your client to get from place to place
- Keep the environment quiet with noises and bright lights to a minimum.
- Keep sessions with the client short.
- Schedule rest periods and breaks from planned activities.



Thinking-

- Work on one task at a time.
- Meet in a quiet room to limit distractions
- Have client become active in discussions and plan development, rechecking to ensure comprehension
- Slow down your speed of discussion to allow time for client to process what you are saying.
- Allow the client additional time to provide written and/or verbal responses
- Encourage client to prepare an "agenda" for your meetings in advance, when issues/questions occur to her.
- Cue client if she is experiencing difficulty finding the words to express her ideas or thoughts
- Provide written documentation/information to supplement verbal discussions.
- Encourage client to write down instructions/information in a notebook she keeps with her
- Present information in factual manner, avoid abstract concepts
- Provide several solutions to the problem and encourage client to make the best choice
- Help client to prioritize and organize tasks

Emotional/Behavioral-

- Minimize anxiety with reassurance, education and structure.
- Provide neutral, but direct feedback if client behaves inappropriately.

Where can I go for help in serving my client who acquires a brain injury?

If you suspect your client may have acquired a traumatic brain injury your first point of contact should be the:

Alabama Head Injury Foundation
HelpLine 1-800-433-8002

This statewide team of family resource coordinators serve all ages affected by brain injury.

CHAPTER 4: TBI IN ALASKA

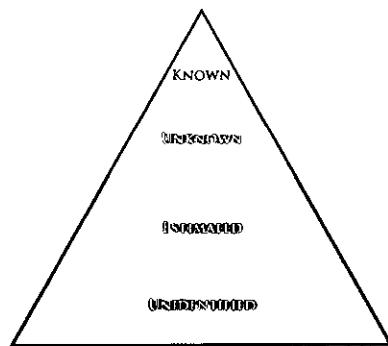
OVERVIEW

Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S. Thirty years ago, only half of all people with brain injury survived... now 78 percent survive. This means that many individuals now live with significant disability requiring a full range of services.

Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or death. The CDC estimates that almost 3,000 Alaskans visit the emergency department each year with a mild TBI. There are an estimated 10,000 plus Alaskans currently living with a disability due to their TBI.

Of recent significance and currently unknown, is the number of Alaskan service members returning with diagnosed and undiagnosed TBI.

TBI PYRAMID



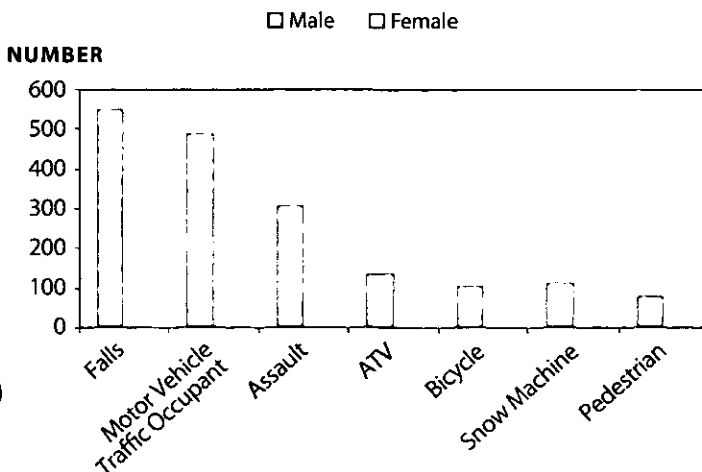
Known 800 hospitalized or fatal TBI/year

Unknown About 3,000 Emergency Visits with mild TBI per year

Estimated 10,000+ Alaskans living with TBI

Unidentified Symptoms not recognized as TBI

ALASKA TRAUMA REGISTRY NON-FATAL TBI HOSPITALIZATIONS OF ALASKA RESIDENTS, 2001-2005



- The three top causes of TBI among those admitted to a hospital from 2001-2005 were falls, motor vehicle traffic crashes and assaults.
- Off-road motor vehicle crashes, snow machine and ATV combined, ranks a close fourth.
- The rate of TBI injury for males is nearly twice that of females. The male rates are significantly higher in all age groups and for all major injury categories.
- Data show that alcohol was involved in one-third of the TBI events.

CHAPTER 4: TBI IN ALASKA

OVERVIEW

The highest rates of TBI are among Alaska Natives, residents of rural Alaska, youth age 15-19 in motor vehicle crashes, and elder falls. The crude rate of non-fatal hospitalized TBI in Alaska for the five year period (2001-2005) was 98.6 per 100,000.

Non-Fatal TBI Hospitalization Rate per 100,000

All Alaskans.....	98.6
Males age 80+	301.3
Females 80+.....	217.2
Males age 15-19	215.7
Males age 70-79.....	200.9



Males 15-19



Males and females 80+



Hospitalized for TBI

TBI's among Alaska Natives and rural Alaskans are overrepresented. The Alaska Native population comprises about 16 percent of the population; however, the TBI population is 34 percent Alaska Native. Similarly, highest rates of TBI occur to the residents of the regions of the Northwest, North Slope, Norton Sound, and the rural Interior Region.

Alaska Native Atlas of Injury Morbidity and Mortality

Injury Deaths 1999-2005, and Injury Hospitalizations 1991-2003, reports the following statistics:

- Injuries (unintentional and intentional combined) were the leading cause of death among Alaska Natives.
- Unintentional injuries alone were the third leading cause of death. The rate was twice that of all Alaskans and three times greater than the rate among the U.S., all races, population.
- Falls were the leading cause of injury hospitalization and suicide attempt the second leading cause among Alaska Natives.
- 70 percent of all injury hospitalizations for Alaska Natives were among young persons (age 0-39).
- 80 percent of all injury hospitalizations for Alaska Natives 70 years of age or older were caused by falls.
- 13.5 percent of injury hospitalizations were for traumatic brain injury (TBI). The most common causes of TBI were falls, motor vehicles, assault, ATVs, and snow-machines.
- Alcohol was a factor in 69 percent of the assault injury hospitalizations.

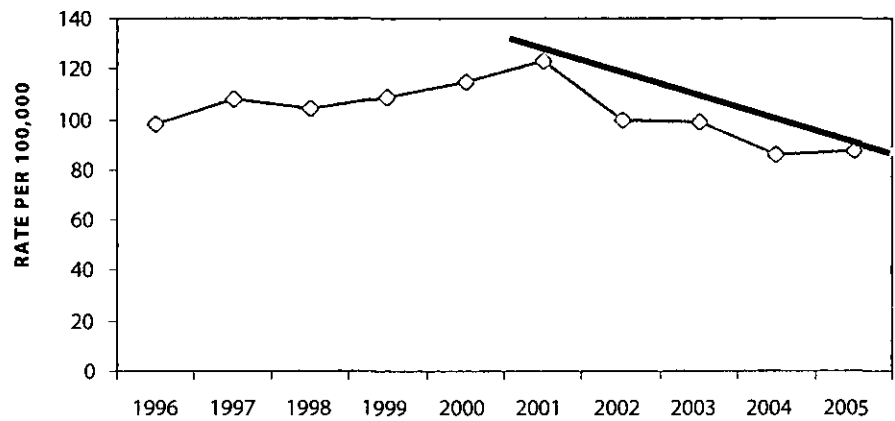
CHAPTER 4: TBI IN ALASKA

SUCCESS HIGHLIGHTS

THE RATE OF TBI HAS FLUCTUATED OVER TIME BUT APPEARS TO BE DECLINING SINCE 2001.

The State of Alaska initiated programs to improve TBI awareness and services in the late 1990's.

ALASKA RATE OF HOSPITALIZED TBI BY YEAR

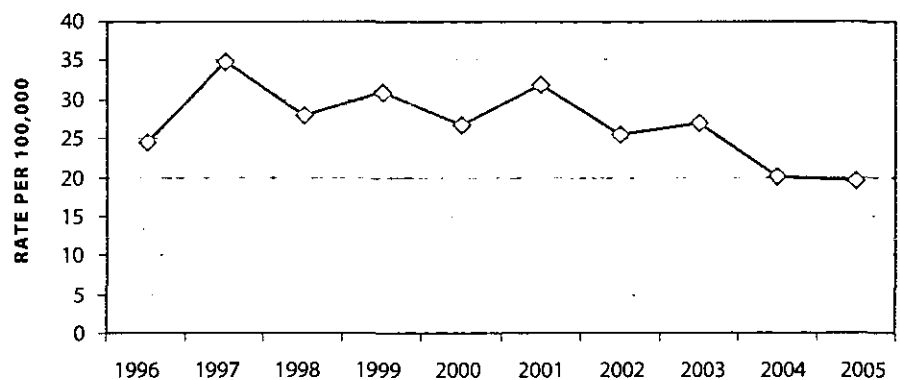


THE TBI RATE DUE TO MOTOR VEHICLE CRASHES ON THE HIGHWAY HAS DECREASED 38 PERCENT FROM 2001 TO 2005.

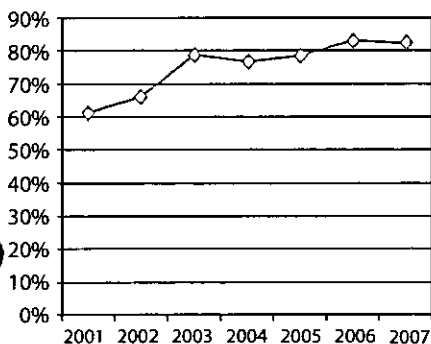
Primary Enforcement Seatbelt Law

On May 1, 2003 Alaska passed a law to change their seatbelt law from secondary to primary enforcement, i.e. a vehicle can be stopped solely for seat belt non-use by an occupant. A study of Alaska has seen a steady increase in seatbelt use in the last decade. In 2007, the percent use as seen in the annual observations study was 82.4 percent. The national rate is 82 percent. The NHTSA goal is 95 percent use.

HOSPITALIZATION TBI BY YEAR DUE TO MOTOR VEHICLE CRASH



SEATBELT USE OBSERVATION STUDIES ALASKA



States with primary seatbelt laws on average had seat belt use rates about 10 percentage points higher than States without primary laws in 2005. Wearing a seat belt is the best defense for an occupant in a motor vehicle crash and the single most effective measure to prevent serious traumatic brain injury. 56 percent of Alaskans with TBI resulting from motor vehicle crash on the highway were not wearing seat belts. If every state with a secondary seat belt law upgraded to primary enforcement, about 1,000 lives and \$4 billion in crash costs could be saved each year.

CHAPTER 4: TBI IN ALASKA

SUCCESS HIGHLIGHTS

BICYCLE HELMET USE INCREASES WITH HELMET ORDINANCES

Bicycle helmets are 85-88 percent effective in mitigating head and brain injuries. Every dollar spent on a bike helmet saves \$40 in direct medical costs and other costs to society. (NHTSA)

A baseline observation survey of bicycle rider's helmet use was conducted during the summer of 2000 by the Alaska Injury Prevention Center in nine communities and then repeated in 2006 in 12 communities. The mean average of bicycle helmet usage rate for all the communities surveyed was 39 percent, compared to 31 percent in 2000.

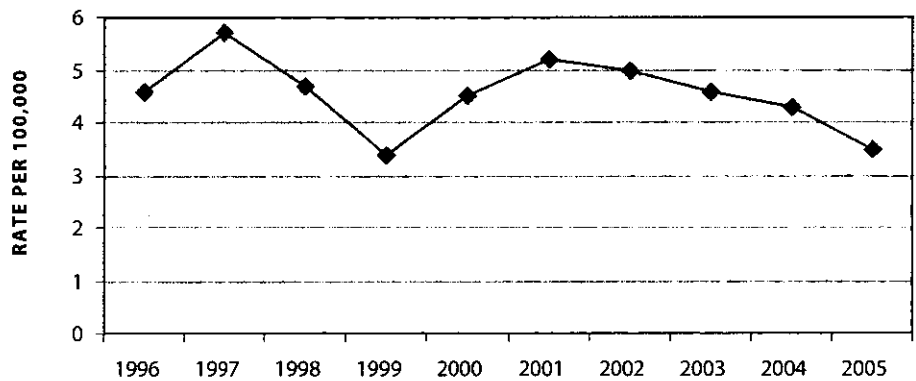
Four of the twelve communities surveyed in 2000 and in 2006 had recently passed ordinances requiring helmet use for children. The average change for bicycle helmet use in the "helmet ordinance" communities was +56 percent, while the communities with no ordinance had an average change of +17 percent.

[Alaska Bicycle Helmet Use Observational Surveys May-August 2006, Ron Perkins, Alaska Injury Prevention Center]

BICYCLE CRASH

Every dollar spent on a bike helmet saves \$40 in direct medical costs and other costs to society.

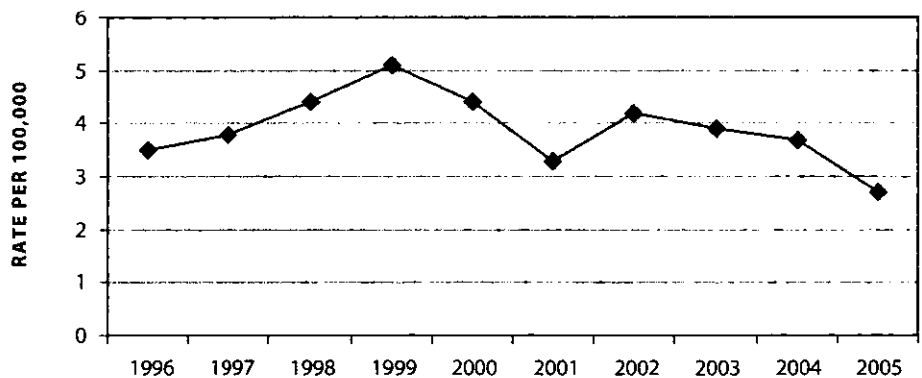
HOSPITALIZATION TBI BY YEAR DUE TO BICYCLE CRASH



PEDESTRIAN INJURY

There is no clear trend in pedestrian injuries.

HOSPITALIZATION TBI BY YEAR DUE TO PEDESTRIAN INJURY



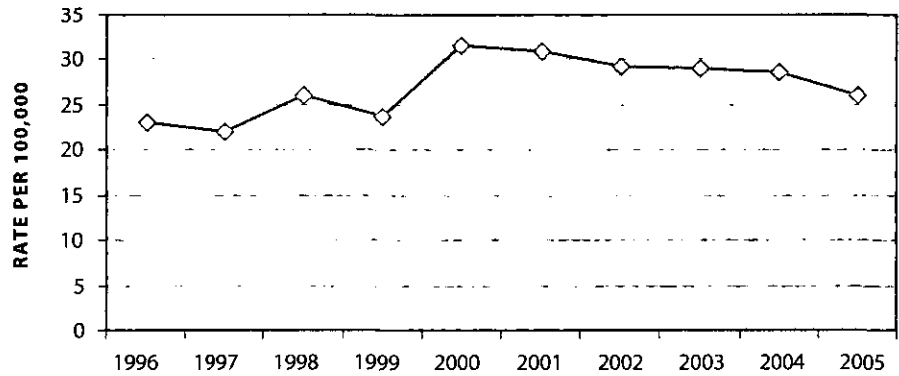
CHAPTER 4: TBI IN ALASKA

CHALLENGES TO ADDRESS

FALLS

Falls are the leading cause of TBI among the elderly. Programs which emphasize a multidisciplinary approach for prevention have been found most effective. These programs address strength and balance conditioning, treatment of medical conditions, prescription evaluation, and modifying the environment.

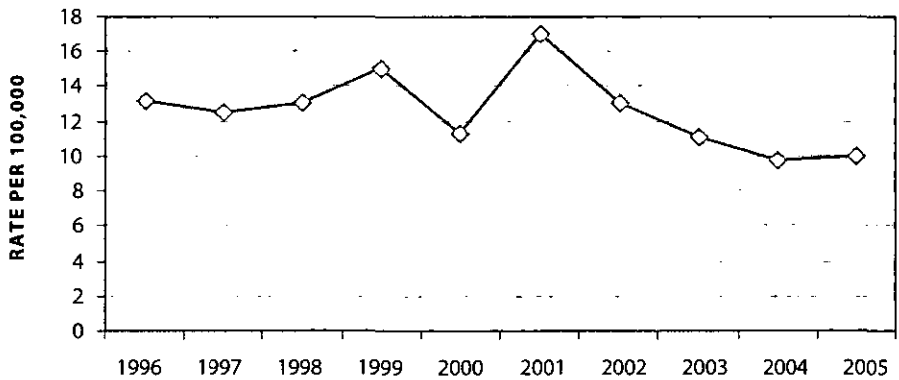
HOSPITALIZATION TBI BY YEAR DUE TO FALLS



ASSAULTS

Data shows that alcohol was involved in one third of TBI events.

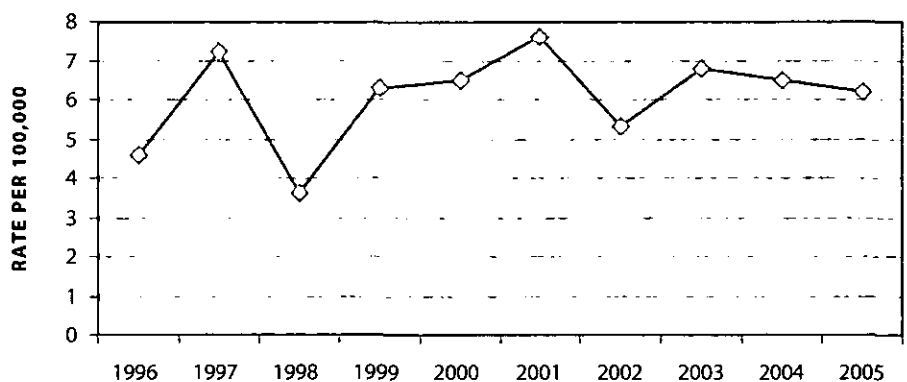
HOSPITALIZATION TBI BY YEAR DUE TO ASSAULT



ATV CRASHES

In rural Alaska helmet use is not always culturally or traditionally accepted and changes in behavior are the most challenging injury prevention model. Many programs have been piloted and implemented using role models, incentives, TBI advocates, local helmet use ordinances, and helmet clinics.

HOSPITALIZATION TBI BY YEAR DUE TO ATV CRASH



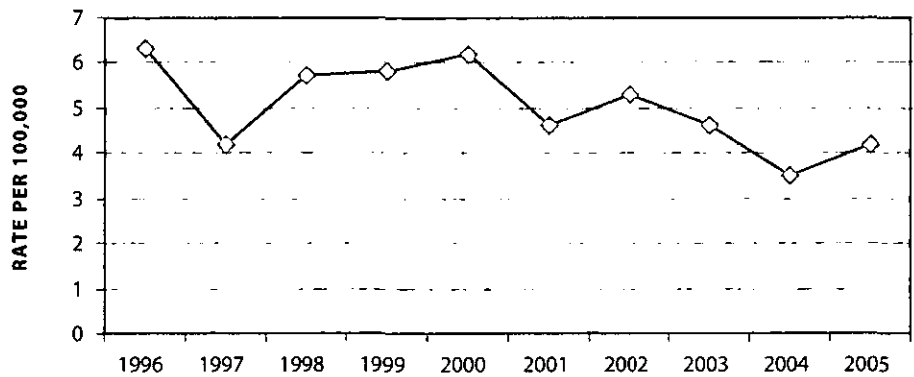
CHAPTER 4: TBI IN ALASKA

CHALLENGES TO ADDRESS

SNOW MACHINE CRASHES

Helmets must be warm and fog-free to meet the needs of Alaskans.

HOSPITALIZATION TBI BY YEAR DUE TO SNOW MACHINE CRASH



Rutgers Centers for State Health Policy, Issue Brief: A Survey of Medicaid Brain Injury Programs, March 2008

State	Waiver year ending	Number Served	Expenditures (GF and Federal match)	Annual Per Capita Costs	Average Length of Stay	Per Diem Costs
New York	2006	1953	\$79,029,120	\$40,465	310	\$131
Illinois	2006	3,601	\$42,541,226	\$11,814	264	\$45
Connecticut	2006	344	\$25,691,011	\$74,683	305	\$245
Wisconsin	2006	334	\$20,095,110	\$60,165	351	\$171
New Jersey	2006	276	\$18,374,797	\$66,575	329	\$202
South Carolina	2006	497	\$12,247,128	\$24,642	338	\$73
New Hampshire	2006	140	\$11,487,626	\$82,054	332	\$247
Iowa	2006	825	\$10,883,459	\$13,192	296	\$45
Colorado	2006	293	\$9,027,736	\$30,811	247	\$125
Pennsylvania	2005	152-324	\$6,897,762	\$45,380	285	\$159
	2005	98	\$6,532,587	\$66,659	285	\$234
Kansas	2006	269	\$6,289,071	\$23,379	242	\$97
Florida	2006	283	\$5,903,410	\$20,860	316	\$66
Massachusetts	2006	90	\$4,883,813	\$54,265	315	\$172
Wyoming	2006	137	\$3,940,878	\$28,766	297	\$97
Indiana	2006	131	\$3,390,758	\$25,884	355	\$73
Utah	2006	91	\$2,079,141	\$22,848	333	\$69
Maryland	2006	23	\$1,489,321	\$64,753	255	\$254
Idaho	2006	19	\$1,133,542	\$59,660	354	\$169
North Dakota	2006	29	\$797,371	\$27,496	315	\$29
Nebraska	2006	26	\$733,247	\$28,202	335	\$84
Vermont	2006	68		\$5,500/month	no data	
Alaska	2008		\$0.00*			

\$150,000 FY10 MHTAAR for brain injury case management-DHSS SDS Administration

Blue states have been identified as having waiver programs that may meet Alaska's needs (more up to date funding levels needed)

Yellow areas are waiver programs that have a rehabilitation focus and long-term care option

Brain Injuries in Alaska

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- What are the causes of TBI?
- How many Alaskans are affected?
- Can the brain recover after an injury?
- How is brain injury treated?
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- How does TBI affect families?
- Can brain injury be prevented?

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Traumatic Brain Injury in Alaska



What is traumatic brain injury (TBI)?

TBI is a jolt, blow to the head, or penetrating head injury that disrupts the function of the brain. (TBI has many names: concussion, head injury, head trauma, bump on the head, bell rung, and hit my head and saw stars).

What are the top 5 causes of hospitalizations due to brain injury in Alaska? (highest to lowest incidence) ⁱ

1. Falls
2. Motor Vehicle Crashes
3. Domestic Violence/Assault
4. ATV/Snowmachine crashes
5. Bicycle crashes

Did you know?

- Brain injury is the leading cause of death and disability among children and youth in the nation and the world. ⁱⁱ
- Alaska has no program specifically to deal with brain injury.
- Only 1% of Alaskans have access to brain injury rehabilitation, and that is often outside the state. ⁱⁱⁱ
- Alaska's annual brain injury rates are more than new diagnoses for breast and lung cancer combined. ^{iv}

How many brain injuries occur statewide each year?

- An estimated 3,000 visit ERs and go home. ^v
- An additional 800 are hospitalized due to severe TBI. ^{vi}
- An estimated 22-32% of returning war-wounded have TBI. ^{vii}

Can the brain recover after a brain injury?

- With mild brain injuries, 80-90% of individuals recover fully.
- With moderate to severe injuries, recovery and relearning is possible with intensive treatment and rehabilitation.
- Long-term recovery is often a life-long process.

How is brain injury treated?

Once a severe brain injury occurs, rehabilitation greatly increases the probability of recovery.

Brain injury treatment includes a multidisciplinary array of services including cognitive, speech, occupational, and physical therapy; medication management; educational/vocational services; and counseling.

There is nowhere in the state to receive these services in a coordinated manner.

What other problems often result from untreated TBI?

People with TBI often have cognitive, behavioral, and emotional impairments. These can lead to short-term memory loss, aggressive social interactions, job loss, divorce, substance abuse, bankruptcy, incarceration, and homelessness.

How does brain injury affect families?

Alaskans are being discharged to their homes with little understanding of or access to rehabilitation. Alaskan families are often torn apart after brain injury because of limited access to in-state services, limited education about the injury, learning to live and cope with a person who has changed, change in family roles, and overwhelming stress from insurance, forms, bureaucracy, and financial burdens.

Can brain injury be prevented?

Some brain injuries can be prevented. TBI from motor vehicles crashes has decreased due to use of seat belts. Using helmets when riding ATV, snowmachines, and bicycles is having a positive effect.

Brain injuries caused by unforeseen accidents will continue to occur. ***Brain injury can happen to anyone, in an instant.***

Next steps will need State of Alaska support and leadership

We ask that Policy Makers...

- Support SB 219 and HB 328 related to a Traumatic/Acquired Brain Injury Program
- Support \$350,000 in FY11 Governor's Operating Budget for Brain Injury Service Coordination
- Provide feedback on the planning efforts and the 10 Year Plan for TBI in Alaska.
- Partner with Alaska Brain Injury Network and the various military, tribal, and private/public providers in determining TBI rehabilitation options including funding levels, eligibility, and how to best support military members.

TBI Program may consist of the following: A TBI Program will provide services and create a multiplier effect for additional funding and service providers.

- Pilot brain injury rehabilitation options: Adult NeuroRehabilitation, Adult NeuroBehavioral, Supportive Living, Adolescent Integration, and Host Home.
- Change Medicaid program and waivers to include residential TBI rehabilitation.
- Support and expand case management to support and educate families concerning available services and funding options.
- Establish brain injury screening across existing programs, i.e. emergency rooms, primary care, schools, juvenile justice, and corrections.
- Direct other Departments and Divisions to coordinate planning and service delivery.
- Support existing information and referral services.
- Support brain injury prevention and public awareness, including mandating sports concussion training.
- Improve workforce ability to identify TBI and provide appropriate treatment.

Results of funding a TBI Program

- Medicaid services for TBI will be matched 50% by federal funds by FY12.
- In addition to cost savings, brain injury waivers have provided other significant benefits. The existence of these waivers supports the growth of community non-profit brain injury agencies.
- Department of Defense, Alaska Veteran Affairs Health Systems, Alaska Tribal Health System, and private providers will have the opportunity to coordinate planning and implementation of rehabilitation and community re-entry programs.
- Alaska Veterans, Active Duty, National Guard members, civilian children/youth, adults, and Alaska Native/rural residents will be able to obtain coordinated, and much needed, brain injury education, screening, assessment, and treatment, without leaving the state.
- Alaskans with brain injury will have increased opportunity to return to work and school, maintain family roles, and positively participate in their community.
- Early treatment may reduce future medical and social costs.
- Potential cost savings in acute care, existing state programs; behavioral health, juvenile justice, corrections, homeless activities, and long-term care in institutional facilities.
- Prevention funding and public awareness efforts may help reduce the future escalation of costs for the TBI Program over time.



What planning has been completed to better meet the needs of Alaskans with brain injury?

1996-State of Alaska, DHSS, Public Health identifies traumatic brain injury has a public health crisis. Public Health applies for, but is unsuccessful in receiving, the Health Resource Services Agency TBI Planning Grant.

1999- State of Alaska, DHSS, Mental Health Developmental Disabilities (now Behavioral Health) applies for and is awarded the HRSA TBI Planning Grant (3 year grant).

2000-Alaska Traumatic Brain Injury Advisory Board is formed.

2001-Formal TBI Needs Assessment completed

2002-State TBI Action plan developed

2003-2nd TBI Needs Assessment completed (283 pages of information)

2004-2009 Senator McGuire sponsors resolution for Brain Injury Awareness Month.

2004- DBH receives HRSA TBI grant (additional 3 years)

2005- Behavioral Health mandates brain injury screening and data collection for all grantees.

2006-TBI Consumer Satisfaction Survey completed.

2007- AMHTA funds TBI information and referral

2007- ABIN organizes TBI Partnership to include all military partners in Alaska.

2008- \$100,000 for brain injury funding included in FY09 Governor's Budget, but moved to and approved in the MHTAAR budget

2008- Senior and Disabilities Services becomes lead agency for brain injury for State of Alaska

2008- The "10 Year Plan for TBI in Alaska" was developed by ABIN in conjunction with the Department of Health and Social Services, the Alaska Mental Health Trust Authority, and numerous public and tribal partners.

As a result of the "10 Year Plan for TBI in Alaska," 2009 activities have focused on brain injury rehabilitation

Senator McGuire and Senator Paskvan sponsor Senate Bill 118, Medicaid: Traumatic Brain Injury Services

2nd TBI Consumer Satisfaction Survey completed.

AMHTA (the Trust) funds TBI Care Coordination demonstration project.

Senior and Disabilities Services works with ABIN and consultant to develop TBI Care Coordination programs including policies and procedures manual.

Senator McGuire, Representative Johnson and ABIN host "Roundtable Discussion on Brain Injury Rehabilitation" with a focus on military research and programs.

ABIN hosts the Directors of the Defense and Veterans Brain Injury Center and the National Intrepid Center for Excellence for Psychological Health and Traumatic Brain Injury.

ABIN meets with Alaska Federal Health Care Partnership.

Senior and Disabilities Services applies for Federal HRSA TBI Implementation grant program.

10 Year Plan for TBI recognized by the North American Brain Injury Society as a model for other states to follow.

Received input from highest officials in Alaska and in the field of brain injury: Col. Michael Jaffee, Dr. James Kelly, Col. Paul Friedrichs, Mr. Alex Spector, Don Kasheveroff, Commissioner Bill Hogan, AMHTA Trustees and CEO.

ABIN researches other state brain injury programs, sustainable funding options, including Medicaid and grant programs.

ABIN drafts options for Governor Parnell's review and recommendations.

Projected savings when brain injury rehabilitation is available in-state

***Emergency Room and Acute Care Savings, length of stay and # visits^{viii}**

Because there is not a post-acute rehabilitation program in-state, Alaskans are using acute care beds longer than needed.

Also, Alaskans with brain injury are returning to emergency rooms and acute care more often than the general public because there are no community programs to support them.

The following information relates to TBI patients held in an acute care hospital due to non-availability of a rehabilitation facility.

	Average	Highest	Lowest
Costs	\$143,000	\$276,000	\$34,000
Hospital Stay	43 days	123 days	11 days

***State Budget Savings**

When programs specific to brain injury are not available other state programs are burdened.

Untreated or undiagnosed TBI may lead to individuals becoming functionally disabled in the society, and may fall into other state programs as their lives decline.

The following programs may see cost savings if a TBI Program were funded

State of Alaska	As relates to TBI	Funding ^{ix}
Corrections ^x	25-87% TBI history	GF \$212.2 million
Juvenile Justice ^{xi}	Significant portion	GF \$52.5 million
Behavioral Health ^{xii}	32% TBI history	GF \$66.3 million
Homeless	53% ^{xiii}	\$8 million total

***Long-Term Care Savings^{xiv}**

Brain injury waivers provide significant cost savings, on average \$30,000 annually per person, when compared to institutional facility-based services.

Costs associated with providing continuum of brain injury rehabilitation programs^{xv}

Continuum of Rehabilitation Program (Residential)	Range: Per Diem Costs	Annual Costs for eight participants (high range)
Adult NeuroRehabilitation	\$450-\$780	\$2.3 million
Adult NeuroBehavioral	\$450-\$780	\$2.3 million
Supported Living	\$300-\$595	\$1.8 million
Adolescent Integration	\$600	\$1.8 million
Host Home (no therapies included)	\$163-\$198	\$600,000
Total		\$8.8 million

National Medicaid Brain Injury Program Facts^{xvi}

# of States participating	24 states have a brain injury Medicaid program
Funding range	\$80.0 million-\$800,000
Numbers Served	3,600-26
Annual per capita costs	\$82,000-\$12,000
Per diem costs	\$247-\$45

Current State of Alaska Funding Levels^{xvii}

Programs	Prevalence	GF Funds
Seriously Mentally Ill	21,754	\$11.6 million
Behavioral Health (Grants)	17,000	\$13.7 million
Behavioral Health (Medicaid)		\$52.8 million
Severely Emotionally Disturbed Youth	12,725	\$11.6 million
Developmental Disabilities (Grants)	12,185	\$13.7 million
Traumatic Brain Injury	12,000	\$0.00

Alaskans share their story

William Barrington, teenager, Anchorage



- Memorial Day weekend – State Motocross Races – Kincaid Park, wearing all protective equipment including a helmet
- Set of triples – hit 2nd, headfirst into 3rd
- Unresponsive – rushed to Providence
- 3 hour surgery – bleeding and clotting in the brain – no external injuries
- Diagnosis – TBI – due to weakened blood vessels bursting in the brain
- **Cause of weakened blood vessels? Multiple sports injuries**

First 47 days in the hospital

- Day 1-12 Medicated Coma
- Day 13 Sign language/whiteboard



- Day 14 Learning to swallow
- Day 19 First real food and water
- Day 23 First sounds/ Day 24 words at a whisper
- Day 32 Walked with walker
- Day 46 First movement in arm system
- Day 47 Discharged from hospital

Life after hospital- Family search for resources takes one full year!

Will's schedule one year after injury

- Monday – 4 classes-West High , pickup by Dad-to Sylvan,3:30 I take to Counseling, 5-Acupuncture
- Tuesday – 4 classes at West High, pickup by uncle Nate-to Sylvan, 2pm mom takes to physical and speech therapy
- Wednesday - 4 classes-West High, pickup by Dad to Sylvan, 3:30 mom takes to wheelchair basketball
- Thursday - 4 classes-West High, pickup by Uncle Nate to Sylvan, 2pm mom takes to occupational therapy
- Friday – 4 classes-West – in office until 2, rides bus home, 3:30 mom takes to Acupuncture, 6 to wheelchair soccer
- Sunday – Youth group at church

What is next?

- Family is looking for new therapy ideas for Will's hand
- Will is in his senior year of high school. Preparing for college – studying for SAT/ACT; utilizing Accuplacer and King Career Center
- Will is deciding where to go for College – Possibly UAA or a college with wheelchair basketball?
- Will is learning to drive – preparing to get his driver's license

The Barrington Family

Why did their journey after brain injury have advantages as compared to the majority of Alaskans?

Advantage	Why is this important?
Will was unconscious; no doubt he had an injury to the brain.	<p>Within hours of the injury, there is an accurate diagnosis, focus on prevention of further injury, focus on minimizing the severity of the injury.</p> <p>Many brain injuries go undiagnosed leading to further injury, lack of understanding of changes, and inappropriate or no treatment.</p>
Family had comprehensive insurance, no question in receiving acute intensive care.	<p>Less than 6% of Alaskans hospitalized with TBI have access to inpatient rehabilitation. If there is a physical disability, it is easier to qualify for inpatient rehabilitation as compared to only a cognitive disability.</p> <p>Few Alaskan families are able to access the neurorehabilitation unit because of financial limitations (restricted or lack of insurance).</p>
Access to <u>inpatient rehabilitation</u> was challenged but allowed, due to Will's age.	<p>He was accepted into adult neuro-rehab program even though he was 14 years old.</p> <p>There are no inpatient neurorehabilitation programs for children/youth in Alaska.</p> <p>Families that do go out of state often have to be separated and bear greater financial burden maintaining two households. Only 1% of Alaskan families have access to outpatient rehabilitation.</p>
Will had mom to advocate and coordinate treatment, educational resources, emotional supports, and community support services	<p>Many Alaskans do not have a person to make this happen for them. Nature of their injury prevents them from doing it on their own.</p> <p>Mom starting from scratch. Took over a year to find resources that were appropriate and available in-state for Will.</p> <p>Brain injury rehabilitation program would have had all the resources coordinated and delivered soon after the injury which is when these services are most important.</p>
Will had access to some outpatient rehabilitation.	<p>There is not a residential/outpatient program specifically for brain injury in Alaska (children, adults, or service members)</p> <p>Had to be creative to get outpatient services at the level needed to support his recovery. Limited to 75 visits/year. Insurance was exhausted only 4 months into his rehabilitation. Had to find alternative treatments until the beginning of the calendar year when he could resume much needed therapies</p> <p>Will had the best insurance there is, and he was still limited in getting what he needed to recover.</p>
Will's injury was not a frontal lobe injury. It was a deep bleed in the temporal lobe (side of the brain).	<p>Didn't have the personality change, mood swings, that many people with brain injury have.</p> <p>Brain injury treatment teaches individuals and families how to recognize and cope with the cognitive, emotional, and behavioral changes after brain injury.</p>
Will had/has lots of community support and faith-based family.	<p>Depression is often an outcome after brain injury. Both individual and family need the support to keep moving forward with life after brain injury.</p> <p>There are many families that take care of their loved one with a TBI. With rehabilitation, treatment, and natural supports, individuals can get better.</p> <p>Families need access to these programs to support their efforts; brain injury is a lifelong process.</p>

Alaska organizations ready to see State of Alaska take a leadership role in brain injury rehabilitation

Department and Health and Social Services-
Senior and Disability Services and Behavioral
Health
Department of Labor- Vocational Rehabilitation
Alaska Mental Health Trust Authority
Alaska Federal Health Care Partnership
Elmendorf, 3rd Medical Unit
Alaska VA Health Systems
Alaska National Guard
Service/Family Resource Center -Warrior
Transition Battalion
Alaska Vet Centers
Representatives for the Marines
Alaska Native Tribal Health Consortium
Alaska Native Medical Center
Southcentral Foundation
Providence Alaska Medical Center
St. Elias Specialty Hospital
Mat-Su Health Services
Natural Health Center
Anchorage Community Mental Health Services
Alaska Brain Injury Network
Governor's Council on Disabilities and Special
Education
Alaska Commission on Aging
Alaska Mental Health Board/Advisory Board on
Alcoholism and Drug Abuse
Statewide Independent Living Council
Disability Law Center
Rural/Tribal Hospitals and Clinics

ABIN has heard from over 1000 Alaskans directly affected by brain injury

Alaska Communities ABIN has visited, who are asking for brain injury services and education include:

Anchorage, Atmautluak, Barrow, Bethel, Dillingham, Fairbanks, Galena, Juneau, Kenai Peninsula communities, Ketchikan, Kodiak, Kotzebue, Nome, Palmer, Prince of Wales, Sitka, Tok, and Wasilla.

For more information, contact Jill Hodges, Executive Director, Alaska Brain Injury Network (ABIN), www.alaskabraininjury.net or call (888)-574-2824.

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- ⁱ AK DHSS Division of Public Health, Section of Injury Prevention and EMS, Alaska Trauma Registry (email correspondence with T. Ali, 2009)
ⁱⁱ World Health Organization (WHO), www.projectbrain.org
ⁱⁱⁱ Alaska Trauma Registry, TBI hospitalizations 1995-2005
^{iv} Cancer Incidence and Mortality in Alaska 1996-2004
<http://www.hss.state.ak.us/dph/chronic/cancer/assets/cancerRegistry1996-2004.pdf>
^v National Association of State Head Injury Administrators State Fact Sheet
^{vi} Alaska Trauma Registry, 2006
^{vii} RAND Study
^{viii} January, 2001 - June, 2004 Alaska Trauma Registry Data on 13 Patients
^{ix} Alaska FY10 Budget
^x CDC, TBI in Prisons and Jails: An Unrecognized Problem
^{xi} Virginia Study for Joint Legislative Audit Committee
^{xii} AKAIMS, Alaska Behavioral Health 2006
^{xiii} Stephen W. Hwang, MD MPH, et al. *The effect of traumatic brain injury on the health of homeless people*. CMAJ; October 7, 2008; 179 (8).
^{xiv} Rutgers Center for State Health Policy, Issue Brief
^{xv} MentorABI, Tori Harding email correspondence 11/8/09
^{xvi} Rutgers Center for State Health Policy, Issue Brief: Medicaid Brain Injury Programs, March 2008
^{xvii} Alaska FY10 Budget



At A Glance...

Who is ABIN?

The Alaska Brain Injury Network, Inc (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of 18 directors represents all regions of Alaska, and at least 50 percent are TBI survivors or family members.

The ABIN vision encompasses a lifetime of care and services, which are both affordable and close to home.

The ABIN mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families.

History

Alaska's Division of Public Health received funding from the U.S. Centers for Disease Control and Prevention to initiate traumatic brain injury (TBI) surveillance beginning in 1998. This funding began to systematically quantify what had previously been believed anecdotally to be a significant and growing public health problem.

In 1999, the State of Alaska, Department of Health & Social Services, Division of Mental Health & Developmental Disabilities, now known as Behavioral Health (DBH), successfully applied for HRSA TBI Planning & Implementation Grants. DBH held the grant for 9 years. In 2009, Senior and Disabilities Services transitioned to the lead agency role.

The original HRSA grant required that Alaska fulfill the following:

- Identify a State Lead Agency: The State of Alaska, Department of Health and Social Services, Division of Behavioral Health (then DMHDD)
- Establish a Statewide Advisory Board: **Alaska Brain Injury Network, Inc.**, (Formerly, the Alaska Traumatic Brain Injury Advisory Board)
- Conduct a statewide needs and resources assessment
- Craft an implementation plan (completed March 2003)

The Alaska Traumatic Brain Injury Advisory Board (ATBIAB) was formed in 2000 to fulfill the requirements of the grant and conduct business as an advisory board, holding quarterly board meetings and inviting public comment. ATBIAB earned non-profit status in 2003 and changed its name to the Alaska Brain Injury Network, Inc. in 2006.

Current Program Activities

ABIN has two primary functions: TBI Advisory Board and TBI Resource Navigation Agency.

Advisory Board

- Visit both urban and rural communities, and listen to the stories that the public shares about the issues facing Alaskans with brain injuries.
- Collaborate with our partner boards to affect changes in policies to improve programs and services.
- Advocate for safety legislation, in-state brain injury rehabilitation, and TBI Waiver services.
- Bring TBI professional training to Alaska.
- Conduct 'needs assessment' surveys of survivors, family members, and health workers.
- Maintain up to date information on emerging issues identified through callers, public testimony, and the media.

Resource Navigation (Information and Referral)

- Respond to requests for assistance, information, resources, and referral.
- Distribute a brain injury resource directory with statewide and local resources and supports available to individuals, families, friends, professionals, caregivers and the general public.
- Work to establish a TBI hotline and brain injury support groups.
- Distribute educational and informational resources to the public.

Accomplishments

TBI Advisory Board

- Visited 15 Alaska communities since 2003, hosted public comment 27 times, and heard public comment from an estimated 300 Alaskans.
- Developed the Comprehensive "10 Year Plan for TBI in Alaska".
- Increased brain injury awareness in the state.
- Advocacy efforts resulting in Alaska Mental Health Trust Authority Authorized Receipts and Authority Grant Funding approved:
 - TBI Advisory Board (FY01-FY11)
 - TBI Resource Navigation (FY07-FY11)
 - TBI Training (FY09-FY11)
 - TBI Care Coordination (FY10-FY11)
- Organized the TBI Partnership with Military including 3rd Medical Unit, Elmendorf; Veteran Affairs; Vet Centers; National Guard; and Marines.
- Instrumental in the Comprehensive Integrated Mental Health Plan, Alaska Scorecard highlights traumatic brain injury prevalence.

Accomplishments

TBI Resource Navigation

- Developed Statewide TBI Resource Directory.
- Provided information and referral to 500 Alaskans.
- Developed a 'hospital packet' of TBI information; distributed to 34 Alaska hospitals.
- Developed online discussion group for brain injury; 130 Alaskans participate.
- Organized more than 30 trainings, workshops, forums about brain injury.
- Provided technical assistance to six (6) head injury support groups. New support group organized in Mat-Su.

Resource Navigation Success Stories

A woman of approximately 48 years old called ABIN. She was "couch surfing" and had been living under a bridge and at the Brother Francis Shelter for several years. She had maintained a career as a nurse until multiple brain injuries left her unable to work or drive. Due to several referrals that ABIN's Resource Navigator made, she has now been connected with services that have significantly improved her life. She is now on disability with a payee assisting her; has bought a house with a friend who is helping look out for her; has PCA services; and has started her own business in her home with the help of Nine-Star.

ABIN received an email through the website from a woman in distress. The first line read "I am so alone – please help. 5 concussions / TBI's in the last 3 years have changed who I am. I have come to realize that my isolation will only increase without serious intervention..." After she joined the online discussion group, Alaskan Brain Matters and received lots of support and good ideas her email read: "It's only been 4 days since I contacted ABIN my life is already improving and becoming less stressful. I am so grateful!" Since then, with the help of the referrals from ABIN's Resource Navigator, she is now on social security disability income and her situation is improving.

A woman and her caregiver called. Due to a brain injury from many years ago, she developed a seizure disorder that needs further medical treatment. She was told she would need to travel to Seattle for the necessary treatment. The travel arrangements had been lingering on for a year since she lives in a remote part of Alaska where she could only get to a phone about once a week. ABIN's Resource Navigator assisted by passing detailed messages between the caregiver and the person arranging the treatment and transportation. The situation was finally resolved by mid April 2008.

ABIN Funding

Alaska Mental Health Trust Authority
State of Alaska, Department of Health and Social Services,
Division of Senior and Disabilities Services via
Federal HRSA TBI Implementation Grant
Alaska Native Tribal Health Consortium
State of Alaska, Department of Commerce, Community,
and Economic Development
U.S. Department of Health and Human Services/HRSA-
Special Congressional Initiative
Individual Donors

To learn more about ABIN:

visit our website: www.alaskabraininjury.net

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Regional Traumatic Brain Injury Information



TBI in Southcentral Alaska

How many Southcentral Alaskans are hospitalized due to a brain injury?

Reports show over **2300 residents** have been hospitalized over a 7 year period (An average of 338 residents/year).

What are the top 3 causes of brain injury in Southcentral Alaska?

- Motor Vehicle Accidents
- Falls
- Assault

Did you know?

Over a 7 year period, over 200 people in Southcentral Alaska were hospitalized with a TBI due to assault.

TBI in Southeast Alaska

How many Southeast residents are hospitalized due to a brain injury?

Reports show nearly **430 residents** have been hospitalized over a 7 year period (An average of 61 residents/year).

What are the top 3 causes of brain injury in Southeast Alaska?

- Falls
- Motor Vehicle Accidents
- Assault

Did you know?

In Southeast Alaska over a 7 year period, there were almost twice as many TBI hospitalizations from falling (162) as for TBI due to motor vehicle accidents (92).

TBI in Southwest Alaska

How many Southwest Alaskans are hospitalized due to a brain injury?

Reports show over **450 residents** have been hospitalized over a 7 year period. (An average of 64 residents/year).

What are the top 3 causes of brain injury in Southwest Alaska?

- ATV/Snowmachine
- Falls
- Assault

Did you know?

The Southwest region of Alaska has the highest prevalence rates of traumatic brain injury (TBI), *per capita*, in the state.

TBI in Interior Alaska

How many Interior Alaskans are hospitalized due to a brain injury?

Reports show over 450 Interior Alaskans have been hospitalized over a 7 year period (An average of 66 residents/year).

What are the top 3 causes of brain injury in Interior Alaska?

- Motor Vehicle Accidents
- Falls
- Assault

Did you know?

Over a 7 year period, the Interior region of Alaska had the second highest incidence rate of hospitalizations due to TBI.

TBI in Far North Alaska

How many Far North region Alaskans are hospitalized due to a brain injury?

Reports show nearly 250 Far North Alaskans have been hospitalized over a 7 year period. (An average of 35 residents/year).

What are the top 3 causes of brain injury in the Far North region of Alaska?

- ATV/Snowmachine
- Falls
- Assault

Did you know?

Over a 7 year period, the Far North region of Alaska had more TBIs caused by ATV/Snowmachine accidents (100) than falls and assault combined (98).

BARRIERS
and
RECOMMENDATIONS

Addressing the Challenge of Brain Injury in America

2008

A report provided by the
Brain Injury Consensus Conference

Executive Summary

Introduction

Brain injury has created serious challenges for both the Department of Defense and the Department of Veterans Affairs; these challenges exist because brain injury has been, and continues to be, a critical healthcare problem in America.

Survivors, family members, and professionals all meet with a number of barriers that impede best practices in brain injury treatment and create debilitating hardships.

This report addresses those barriers, and calls for unified efforts between civilian and military systems, agencies, and organizations. Today, more than 5.3 million American civilians face challenges resulting from a brain injury. Additionally, 19.5 % of US servicemembers who have returned from Afghanistan and Iraq report experiencing a traumatic brain injury during deployment.¹

As recently as 2006, an Institute of Medicine report stated:

"...many people with TBI experience persistent, lifelong disabilities. For these individuals, and their caregivers, finding needed services is, far too often, an overwhelming logistical, financial, and psychological challenge. Individuals with TBI-related disabilities, their family members, and caregivers report substantial problems in getting basic services, including housing, vocational services, neurobehavioral services, transportation, and respite for caregivers. Yet efforts to address these issues are stymied by inadequate data systems, insufficient resources, and lack of coordination. TBI services are rarely coordinated across programs except in some service sites. Furthermore, in most states, there is no single entry point into TBI systems of care."

Brain injury is also a leading cause of death and disability among Americans. Data indicates that approximately 1.6 million Americans sustain a brain injury each year, and 125,000 are permanently disabled.^{2,3} Economically, the total impact of direct and indirect medical and other costs in 1995 dollars is reported to exceed \$56 billion.⁴ Despite the prominence of affects of brain injury in the United States, it remains one of the least understood and recognized healthcare issues in our nation.

Addressing the Challenge of Brain Injury in America

History

On November 2, 2007, more than one hundred of the nation's most respected authorities on brain injury convened in Washington D.C. to highlight accomplishments in brain injury treatment and to provide recommendations where barriers to care exist. Called the Brain Injury Consensus Conference, the two-day workgroup produced the groundwork for **Barriers and Recommendations: Addressing the Challenge of Brain Injury in America.**

Participants included members from:

- Department of Defense (DOD),
- Department of Veterans Affairs (VA)
- Defense and Veterans Brain Injury Center (DVBIC)
- Brain Injury Association of America (BIAA)
- North American Brain Injury Society (NABIS)
- National Association of State Head Injury Administrators (NASHIA)
- American Neuropsychiatric Association (ANPA)
- Over 30 other civilian public and private organizations

This report represents the results of an authoritative, cross-systems assessment on the state of brain injury in America. It addresses the treatment of all survivors across the continuum of care, from the point of injury through lifelong needs. It also includes the input of a number of other brain injury professionals who were unable to attend the conference.

This report is a free, publicly available document intended for multiple applications. It can be used as an advocacy tool, an informational resource, and a call to action. It was created to draw attention to the challenges that face Americans with brain injury, for the ultimate purpose of creating better identification of brain injury, access to care and overall bettering of their lives.

The civilian sector, the military, and the VA have made considerable strides in dealing with brain injury, and their focus and energies are to be applauded. However, brain injury in America remains a larger problem than any one entity can manage alone; it is only through a renewed spirit of collaboration that the following barriers can be managed effectively.

For more information on this report, visit: www.nabis.org

Barriers & Recommendations

BARRIER ONE

Screening protocols for brain injury are not consistent across military, civilian, and public systems, and each system poses the risk for various gaps in the identification and assessment of brain injury. Currently, no initiatives have been put forward to remedy this disparity in injury screening.

Recommendation

The screening of brain injury to date is based on a detailed account of the injury event and the resultant alteration in consciousness. To accurately assess brain injury, this screening should offer a standardized, thorough, historical account of the injury event. This is particularly important because the individual involved may have altered perception, and lack insight into the injury sustained. A neurocognitive assessment such as the Standardized Assessment of Concussion is helpful in determining the extent of injury at the point of injury, but limited thereafter.

We recommend the further development of screening tools to be used to screen for TBI in diverse populations. Individuals who screen positive should then undergo further diagnostic testing including: neuroimaging studies, neuropsychological evaluation and neurophysiologic studies.

Furthermore, for populations who are occupationally at increased risk, having a regular baseline cognitive test(s) is of benefit for comparison if risk of injury is present or sustained. Finally, we recommend an evaluation for assistive technologies and compensatory aids and strategies.

BARRIER TWO

The current classification of brain injury as Mild, Moderate, and Severe are inadequate to describe various and complex sequelae resulting from a brain injury.

Recommendation

There is much confusion as to the extent of the actual injury severity. Various cognitive impairments can improve or diminish over a period of time. Although gradual improvements can follow the injury event, impairments can manifest even after other symptoms of brain injury have resolved. Confusion is introduced by the fact that years later, debilitating life-long residual effects may exist, yet the results of that injury may be mistakenly diagnosed based on initial trauma.

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Repetitive concussions are dangerous and result in cumulative brain injury. The classification of traumatic brain injury should sufficiently demonstrate residual functionality at various periods of time beyond the initial injury, and incorporate the understanding of brain injury as a disease process.⁵

BARRIER THREE

Persons accessing mental health services, special education services or imprisoned may have undiagnosed brain injury and the identification/screening for such would help identify effective treatment or placement alternatives. "Unidentified TBI is a major unrecognized cause of social failure: in educational, vocational and economic arenas. Complex barriers often prevent people with mild TBI from: (a) self-identifying as having a brain injury that is seen as the cause of the disabling symptoms they experience, (b) gaining access to help and (c) addressing long-term, TBI-related problems that affect their quality of life." (Gordon & Brown, 2008).

Recommendation

All mental health organizations that offer screening services should also screen for brain injury.

BARRIER FOUR

While a variety of best practices and evidence-based guidelines exist for the treatment of brain injury, there remain no comprehensive national guidelines for best practices in brain injury treatment.

Recommendation

Currently, the guidelines for best practices in brain injury treatment vary widely. It is recommended that a national guideline for best practices in brain injury treatment be created in order to ensure consistent, quality treatment across all systems.⁶ We acknowledge the excellent work toward this goal achieved by the Brain Trauma Foundation (BTF), in which an independent analysis of their guidelines on TBI outcomes and cost savings by the Centers for Disease Control and Prevention (CDC) found that that "if the BTF guidelines were used more routinely, there would be a 50% decrease in deaths, improved quality of life, and a savings of \$288 million a year in medical and rehabilitation costs."⁷ We also call for the identification, development and refinement of additional best practices in brain injury disease management.

Barriers & Recommendations

BARRIER FIVE

Persons with brain injury often have difficulty accessing the necessary type of services needed due to finances, geography or a failure to provide best practices.

Recommendation

We recommend the development of system-wide access to treatment and support protocols to ensure the right treatment at the right time. This includes entitlement to post-acute active rehabilitation incorporating best practices including cognitive rehabilitation, independent living skills training, vocational rehabilitation and leisure therapy. This also includes access to graduated levels of support in the community, in-home, or 24-hr. supported living, allowing for efficient episodes of treatment across the lifespan in order to ensure retention of skills and enhanced quality of life. Until comprehensive guidelines in brain injury disease management are available, we recommend adherence to the Brain Injury Medical Treatment Guidelines of Colorado.⁸

Treatment and supports are needed to address the complexity of individuals with brain injury including substance issues, Post Traumatic Stress Disorder, psychiatric and significant behavioral issues.

Development of geographically disperse rehabilitation and support options are necessary to address the needs of persons in rural settings. Collaboration with civilian and public partners may be needed for servicemen and women to access timely, appropriate levels of care closer to home.

Benefits packages provided by TRICARE, the VA and Medicaid must be reviewed in order to ensure optimum uniform coverage including providing same payment for same services, access to levels of care including post-acute and cognitive rehabilitation and extension of active duty benefits to reimburse necessary after-hospital treatment.

With respect to cognitive rehabilitation, the effectiveness of cognitive rehabilitation has unfortunately proven difficult to study due to several factors, including the heterogeneity of subjects, interventions and outcomes studied, as well as the difficulty involved in attempting to control for spontaneous recovery.

Clinical consensus, along with widespread professional opinion, must be taken into account, in addition to the research evidence attesting to the efficacy of cognitive rehabilitation.⁹

Civilian and military coverage plans must be sufficient to rehabilitate patients and return them to productivity. Moreover, cognitive therapy is an essential component of the rehabilitation process for persons with brain injury and should also be a covered therapy.

BARRIER SIX

Advances in brain injury care are implemented too slowly between systems. Currently, any current cross-system coordination efforts do not include strategies for effectively supporting person with brain injury over the lifespan. Additionally, case managers/care coordinators are commonly unfamiliar with protocols and practices outside their respective system, causing unnecessary complexity for the survivor who moves between systems. No formal body exists which coordinates an effective communication between systems.

Recommendation

As the military continues to make advances in the area of brain injury treatment, a vehicle for sharing of information must occur between systems. The advances learned from the resultant military experience from the effects of blast, particularly primary blast, from helmet sensors to balance tables, from screening with standardized assessment tools at point of injury to post deployment health assessment (PDHA), must be shared with other systems in order to allow for more effective brain injury trauma care for all Americans.

Veteran's Administration and Department of Defense hospital data are not included in the states' trauma system data. We recommend coordination and communication between Department of Defense, Veteran's Administration, and civilian agencies, allowing the civilian system to accurately anticipate the impact of wounded veterans as they return to their communities. Seamless coordination should not only occur between military systems, but between military, public, and private systems as well.

Military and civilian case managers must have opportunities to learn each other's systems of care, funding mechanisms, treatment programs, community resources, and communicate with one another. We encourage the DoD, the VA, and the public/private sector to jointly engage in educational and training seminars that allows each entity to benefit from the other's successes and to learn from their challenges.

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We also recommend the formation of a Federal Brain Injury Council, established in statute for the purpose of communication and system coordination. Members may include representatives from Federal agencies, advocacy organizations, professional associations/societies, and others.

The Council may be an effective mechanism to foster successful collaborations such as those currently in place between the Centers for Disease Control and the Social Security Administration as well as formal Memoranda of Understanding as are in place between DoD and VHA for the Office of Seamless Transition and for spinal cord injury care and neuro-optometric rehabilitation. The proposed Federal Brain Injury Council will use a variety of mechanisms to facilitate and foster ongoing communication, collaboration, and system coordination among its members. Since the Commission on Accreditation of Rehabilitation Facilities (CARF) is actively engaged with many of the members of the proposed Council, the standards that address the use of feedback from stakeholders for program development, strategic planning, resource planning and performance improvement can be used as innovative practice tools for members to foster these relationships.

In the interim, it is suggested that civilian sector advisors be added to the Senior Oversight Committee for DoD/VA Wounded, Ill and Injured. Further, it is recommended that VHA conduct a formal gap analysis, publicize its needs, as appropriate, and outreach to private sector to obtain assistance in meeting those needs.

BARRIER SEVEN

Brain injury care does not receive research funding on parity with other disease processes.

Recommendation

In 2007, the Federal AIDS budget was \$22.8 billion dollars. Parkinson's disease received \$250 million dollars. The HRSA Traumatic Brain Injury Program was allotted \$8.5 million dollars in 2007, and in 2008 President Bush proposed eliminating the funding. We recommend that brain injury treatment receive funding on parity with other disease processes

BARRIER EIGHT

Following brain injury, family members and case managers (care coordinators) are not effectively incorporated into treatment, particularly in the acute phase of care. The family often becomes the primary support unit. Families are typically ill-equipped to respond to the complexity of issues a person with brain injury may experience.

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Recommendation

Encouraging family members to participate in educational programs and follow-up appointments is important to ensure an accurate account of the patient.

Case Managers are helpful in tracking and supporting those requiring follow up care. We recommend that all brain injury care providers provide educational and case management services from the moment of injury. When home placement is advised, family members should be trained in maintaining quality care at home.

BARRIER NINE

There are few or no support systems that consistently monitor care and patient satisfaction throughout the continuum of care.

Recommendation

Programs should be a collaborative effort; as much as possible, the program should be directed by the person with the brain injury, but there must also be an adequate support system that monitors, advocates, and intervenes on that person's behalf as necessary.

Moreover, mental health supports are also needed, with personnel trained in and knowledgeable about the effects of brain injuries. This level of support should include a continuum of care from a brief counseling session, to an ongoing, in-depth counseling program, to an intensive crisis intervention by a mobile crisis response team. Police departments, the criminal justice system, and emergency health care providers must be trained to prevent the inappropriate placement of an individual with brain injury in psychiatric hospitals or jail.

BARRIER TEN

Across the lifespan, brain injury programs do not address all aspects of treatment. Instead, only specific symptoms receive care.

Recommendation

Brain injury programs must address every area of the person's life, including physical, financial, emotional, intellectual, vocational, recreational, and spiritual. The effect of holistic treatment is synergistic, with small efforts in many areas combining to have a large impact on overall success. We recommend adherence to the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities, as supported by the World Health Organization.¹⁰ These rules govern areas that span Medical Care, Rehabilitation, Support Services, Accessibility, Education, Employment, Income Maintenance and Social Security, Family Life and Personal Integrity, Culture, Recreation and Sport, and Religion.¹¹

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BARRIER ELEVEN

Respite care services are difficult for most family members and caregivers to access, leading to caregiver burnout, compassion fatigue, and overall lack of quality of care.

Recommendation

Respite care should be a regular and accessible service for family members and caregivers.

For mentors and life coaches, a delicate balance is required to provide necessary daily structure to ensure health and safety, while simultaneously fostering independence.

BARRIER TWELVE

Over the lifespan, offers of independent living and life-skills training are arbitrary, and sometimes unsupported.

Recommendation

Independent living and life skills training must be offered on a regular basis. As the person with a brain injury works to re-enter the community and rebuild his or her life, he or she will need to be trained in independent living and life skills.¹²

BARRIER THIRTEEN

Treatment plans for brain injury do not include strategies for dealing with aging-related issues, nor do they anticipate that brain injury is disease-causative and disease-accelerative.

Recommendation

Aging issues must be addressed by case managers/care coordinators in the treatment plan. As the person's condition changes, he or she may need additional care including physical, occupational, speech, or recreational therapies, cognitive remediation, psychiatric interventions, or pre-vocational services. We recommend new treatment plans that allow for brain injury disease management.

BARRIER FOURTEEN

Long-term, supervised housing and other residential programs for persons with brain injury are regularly denied services under most funding systems.

Recommendation

Access to affordable housing with associated services, physical access, and support must be financially attainable. Individuals may need long-term, supervised residential programs with related support care sensitive to their specific needs. Others may require a day-treatment program, where they can participate in supervised, meaningful activities. In conjunction with such programs, we recommend the provision of life care planning services such as financial resource management, legal arrangements for durable power of attorney and healthcare, wills, family and/or personal estate planning, health insurance purchase and availability, life insurance purchase and availability, and family member life insurance as a financial planning tool.

Moreover, we recommend a coordinated approach to state and federal assistance programs that are available for housing, food stamps, maternal assistance programs, child nutrition programs, Meals on Wheels, independent living programs, caregiver resources programs, public transportation assistance options, Social Security, aid to dependent families assistance, public utility relief programs, Medicare and Medicaid eligibility and pharmaceutical assistance programs.

BARRIER FIFTEEN

Transportation issues plague survivors of brain injury the duration of their lives.

Recommendation

While some individuals will be completely independent in their transportation needs, others will require assistance with accessing public transportation. Still others will be unable to access or deal with public transportation. Life care planners, case managers, and long-term care providers are encouraged to advocate within the community for supportive transportation services.

BARRIER SIXTEEN

Across all systems, case management services are not consistent. In military and VA settings, case management and care coordination services may be complicated, confusing survivors and family members; in the private sector they are either difficult to access or unavailable.

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(Barrier 16 Cont'd) Recommendation

We encourage all case managers, care coordinators, and case management organizations who are experienced, trained and certified in disease management of brain injury to participate in collaborative initiatives to form guidelines that ensure care that offers a particular focus on the many personal needs of survivors of brain injury.

Where services are absent, we call on state healthcare officials to conduct an assessment of needs report detailing the challenges that face their respective population of survivors. We encourage the National Association of State Head Injury Administrators to facilitate dialogue and actions that promote the use of case management services where needed, and programs which help individuals access the service.

===== BARRIER SEVENTEEN =====

Despite the complexity of brain injury, there is no national certification or training for brain injury case management. Few organizations outside direct care providers encourage personnel to receive certification as a brain injury specialist (CBIS).

Recommendation

We encourage the Case Management Society of America, the Commission for Case Management Certification, and the American Academy of Certified Brain Injury Specialists to collaborate and create an effective credential that educates and empowers case managers involved in the treatment of brain injury.

Furthermore, we recommend that institutions such as mental health centers, community colleges, veterans centers, the criminal justice system, and social service systems all designate individuals who can serve in the capacity of a certified brain injury specialist.

===== BARRIER EIGHTEEN =====

For brain injury survivors under 21, case managers are underutilized or uninvolved in the creation and development of Individualized Education Plans (IEPs).

Recommendation

In the case of individuals with TBI under the age of 21, case managers should provide input to school districts

to develop Individualized Education Plans (IEP) specific to brain injury issues and educational goals.¹³

The 1975 Federal Public Law 94-142 (Disabilities Education Act- IDEA) maintains that states and school districts must develop and implement annual Individual Educational Plans (IEP) on all individuals with disabilities. Community case managers are an asset to the patient's school district in this process.

===== BARRIER NINETEEN =====

Survivors of brain injury do not typically receive special accommodations for their cognitive deficits in state and federal courts.

Recommendation

Self-advocacy and self-representation in court are basic needs that can be thwarted by cognitive deficits. Most courts currently accommodate language and physical disabilities with the necessary supports. We recommend additional cognitive deficit accommodation by the court system, particularly in matters involving the social agency interactions and medical decision-making transactions.

===== BARRIER TWENTY =====

Throughout all systems, there is a well-documented personnel shortage of healthcare professionals that provide valuable services to survivors of brain injury.¹⁴

Recommendation

We recommend that university health science programs incorporate brain injury treatment into their curricula and actively recruit healthcare professionals for the purpose of specialization in brain injury. We also suggest that community-based organizations, professional societies, and schools of higher education provide continuing education opportunities on the topic of brain injury.

Barriers & Recommendations

CONCLUSION

The Department of Defense, the Department of Veterans Affairs, and numerous organizations in the public and private sector have made tremendous strides in the treatment and care of brain injury, and they have demonstrated outstanding abilities to meet their responsibilities.

By addressing the barriers to brain injury care, we hope to encourage these different systems to renew their efforts to form collaborations, and to address gaps in service where they exist.

With respect to TBI survivors from Operation Iraqi Freedom and Operation Enduring Freedom, members of the media have been an extremely positive influence in raising public awareness and understanding of TBI and in garnering altruistic feelings for survivors, especially service members, and their and families.

The efforts of military, veteran and civilian advocacy organizations are currently synergized into a political will for TBI care that is unmatched in U.S. history. It is incumbent upon the leaders in civilian, military and veterans' systems to work cooperatively to build on strengths and minimize weaknesses to improve the quality of research, treatment and life-long living for all individuals with brain injury.

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North American Brain Injury Society

Monica Rodgers
North American Brain Injury Society

Kya Matthews
George Washington University

April Watkins
George Washington University

Acquired Brain Injury

Functional and cognitive deficits resulting from injuries to the main and associated structures that:

- 1) Are results from injury post partum
- 2) Are not a result of a congenital disorder
- 3) Are not a result of a deteriorating disorder related to age (i.e. dementia, picks, etc) a

And fall within in the broad categories:

- a. Hypoxic or Anoxic events
- b. Chemical induced except alcohol related
- c. Medical accidents (i.e. stroke, aneurysm)
- d. Viral, bacterial or parasitic attack
- e. Radiation poisoning
- f. Medication effects (prescribed)
- g. Idiopathic causes

The deficits must be long-standing, significantly below baseline, impact productivity in the three areas, school, work, relationship, and affect the life trajectory of the individual

Supporting information for HB 328

State of Alaska, Department of Health and Social Services Alaska Waiver and Service Options for Alaskans with Congenital and Degenerative Brain Injury

According to state law (AS. 47.80.900 (7)), the **term developmental disability (DD) means** a severe, chronic disability that: Is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely;

- results in substantial functional limitations in **three or more** of the following areas of major life activity:
 - self care
 - receptive and expressive language;
 - learning;
 - mobility;
 - self direction; capacity for independent living;
 - economic self-sufficiency;
- and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic assistance, supports or other services that are of lifelong or extended duration and are individually planned and coordinated.

Examples of types of developmental disabilities are mental retardation, cerebral palsy, autism, and seizure disorder. **Mental illness and Fetal Alcohol Syndrome may also be developmental disabilities. However, the disability must result in substantial functional limitations and meet the other criteria in the definition in order to qualify as a DD.**

FASD: FETAL ALCHOL SPECTRUM DISORDERS

88 possible slots: 10 currently on waiver, 8 in the works, 70 open slots

Definition: **Congenital** brain injury- the youth's mother consumed alcohol during pregnancy.

Eligibility: Youth must be:

- Under age 21 years
- Eligible for Medicaid
- Have an evaluation by a psychiatrist within 60 days of admission to the program, that identifies a need for the level and intensity of services provided in a Residential Psychiatric Treatment Center (RPTC)
- Have a diagnosis of Fetal Alcohol Spectrum Disorder. (If a youth is suspected of having an FASD, but has not yet received a diagnosis, the youth may receive an FASD diagnosis as part of the screening process)
- Want to receive services in community based services in Alaska instead of in an RPTC.

Waiver services include:

1. Mentoring Services
2. Daily and hourly respite
3. Residential habilitation
4. Day habilitation
5. Supported employment
6. Training and Consultative services

The Plan of care will be tailored to the specific needs of each individual program participant

ADRD: ALZHEIMER'S DISEASE AND RELATED DISORDERS

Definition of Alzheimer's disease: Degenerative

Because Alzheimer's disease and Related Disorders (ADRD) is so difficult to diagnose, the U.S. Department of Health and Social Services Advisory Panel on Alzheimer's disease recommends that ADRD be defined by functional impairment and dependency rather than diagnosis or the causes of the disease. The current working definition of ADRD used by Alaska Commission on Aging grantees, reviewed and refined at a grantee meeting in October 1996, reflects this recommendation.

For the purpose of this report an ADRD includes:

Alzheimer's, Dementia (any type), Parkinson's, Lewy Body, Creutzfeld-Jacob, Huntington, Pick's, Wernicke-Karsakof, Cerebral degeneration.

AS of 2/24/2010 from Joann Gibbens,

Senior and Disabilities Services

Total number of OA, APD or PCA individuals with Alzheimer's or dementia in their most recent diagnosis

	with ADRD	TOTAL	non ADRD
Older Adults (OA) only	416	775	359
Adults with Physical Disabilities (APD) only	61	413	352
Personal Care Attendant (PCA) only	172	2271	2099
PCA with (OA or APD)	263	1697	1434
Unduplicated count (PCA, OA or APD)	912	5156	4244

	under 60	60-64	65-69	70-79	80-89	90-99	100+	TOTAL
APD, OA or PCA	69	40	52	237	373	136	5	912

Older Alaskans Waiver (OA)

Eligibility: Over 65 years of age and nursing home level of care.

OA Waiver Services:

1. Adult day services
2. Care Coordination
3. Respite
4. Chore
5. Environmental modifications
6. Meals
7. Residential Supported living
8. Specialized medical equipment and supplies
9. Specialized private nursing duties
10. Transportation

Alaskans With Physical Disabilities (APD)

Eligibility: Ages 21 -64, disabled meeting nursing level of care

APD Waiver Services:

1. Adult Day Services
2. Care Coordination
3. Day Habilitation
4. Residential Habilitation
5. Respite
6. Supported Employment
7. Chore
8. Environmental modifications
9. Intensive Active Treatment
10. Meals
11. Residential Supported Living
12. Specialize Medical Equipment
13. Specialized Private Nursing Duty
14. Transportation

Alaska is Combating Traumatic Brain Injury

Jill Hodges
Executive Director
Alaska Brain Injury
Network

Jeff Jessee
Chief Executive Officer
Alaska Mental Health
Trust Authority

Pat Hefley
Deputy Commissioner
Department of Health
and Social Services

Past legislative hearings

2007- What is traumatic brain injury?
What does treatment look like?

Guest presenters: Dr. Tina Trudel (national expert) and partner boards

2008- Impact of TBI on the state.

Military issues related to TBI

Guest presenters: Capt. Richard Barker, Elmendorf; Dr. Russell Cherry, Providence; Stephanie Tanner, military wife of TBI survivor

2009- Importance of Medicaid Waiver to develop coordinated, comprehensive brain injury services in-state

Guest Presenters: Dr. Christie Artuso, Providence Neuroscience Director

Today's presentation- State System Development, ready to operationalize

- Jill Hodges, Past 20 years of AK efforts
- Jeff Jessee , Trust Role
- Pat Hefley , DHSS Role
- Public testimony:
 - Martha Moore, ABIN Chair
 - Providers, partnerships essential
 - Consumer, treatment works, family support
- Jill Hodges-Questions and Solutions
 - State and Legislature

TBI Systems Development in Alaska 1990-2000

Phase 1: 1990-1995

Advocacy

- Brain injury survivors mobilize
- Early 1990's
 - Testimony to GDCSE
 - Registration of MHTTA
- Brain Injury Association of Alaska organizes

Phase 2: 1995-2000

Advocacy Continues

State of Alaska

- State of Alaska-Public Health recognizes TBI
- Public Health awarded CDC grant
 - TBI Registry
- MHDD awarded Federal Grant-systems

TBI Systems Development in AK 2000-2007

Phase 3: 2000-2003

Advocacy

State of Alaska

Federal TBI HRSA Grant

- Needs Assessment
- 1st State Action Plan
- TBI Program Coordinator (FTE)
- Advisory Board

AMHTA-beneficiary group

Alaska Brain Injury Network

- TBI Advisory Board (ABIN) organizes and becomes 501 c3

Phase 4: 2003-2005

Advocacy/TBI Advisory Board

State of Alaska

- Behavioral Health (lead agency)

Data/Surveillance

- DBH mandates screening data collection
- Consumer Satisfaction Survey
- AK Trauma Registry

Phase 5: 2005-2007

State of Alaska: TBI Dir. turnover

Data- AKAIMS(32% in BH screen TBI)

Workforce: 1st AK Brain Injury Conf

Momentum builds- 2007-2009

Phase 6: 2007-2009

ABIN

- "Service" recommendation

Info and Referral

Case Management

AMHTA-Funds ABIN recomm.

State of Alaska

- Lead agency transfers to SDS
- TBI Case Management Program developed

Workforce:

Intro to TBI Course

Advance Brain Injury

Workshop

Vocational Rehabilitation

Counselors

Legislation

- SB 118 introduced-medical assistance for TBI

Medicaid Funding: Waivers

- Preliminary research on Medicaid Waivers
- Targeted Case Management

Treatment

- After Hospital/Post-Acute

- Site Visits

- AK Providers Coalition

- Military/Tribal partnership sought

Key Points

- System Planning—
created framework
and foundation for
action
- Next step:
operationalize
- General Funds or
GF/MH essential
- Phases 1-4 (1990-2005)
 - advocacy programs
 - increasing awareness
- Phases 5-6 (2005-2009):
 - Direct 'services':
 - info and referral;
 - case management
 - Workforce development
- Phase 7 – 10 (2010-2020)
 - Case Management
 - Treatment: Funding
 - Residential and Day Programs
 - Workforce

2010 Session SB 219 and HB 328

SB 219 and HB 328

- Gives statutory authority to develop/improve program.
- Establishes standards for treatment and services.
- Defines brain injury.
- Develops cost/ longitudinal data
- Planning for Medicaid Waiver/Targeted Case Management

Opportunities

- Positions the state to access federal funding for TBI services.
- The existence of brain injury waivers supports the growth of community-based rehabilitation programs.
- DoD/VA/Tribal/State coordinate planning and implementation of rehabilitation and community re-entry programs.
- Early treatment may reduce future medical and social costs.
- Potential cost savings in acute care, existing state programs; behavioral health, juvenile justice, corrections, homeless activities, and long-term care in institutional facilities.

The Trust's Role- Jeff Jessee

- TBI as a beneficiary group (late 1990's)
- Trust role: planning, demonstration
- Maximize collaboration
- Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State)
- Treatment: General Fund commitment

Past 10 years, Trust has invested \$2.8 million in brain injury systems development

- Trust FY09 Funding specifically for brain injury program: \$628,000

Core Services Development

- Information and Referral
- Case Management
- Technical Assistance for planning treatment

Systems Development

- Public Awareness-anti stigma
- Workforce development
- Statewide planning- TBI Advisory Board

Department of Health and Social Services Role - Pat Hefley

- Development, now operationalizing.
- 44 States use General Revenue and Medicaid Waivers for brain injury treatment/services.
- TBI folks are already in the system - need to move them into specialty programs in order to see results.
- Appropriately staged incremental GF/MH budget requests.

Upcoming 2010 Activities

- Federal Grant- \$250.0/year 4 years
 - lead agency: Senior and Disabilities Services
- State of Alaska T/ABI program
 - Case Management
 - Research federal funding opportunities: Medicaid Waiver/Targeted Case Management
- Data/Prevention: regional study, Alaska Native and Non-Native

Public testimony

Martha Moore: ABIN Chair

Recommendation Philosophy
 Respects State role (data
 collection) and ABIN chair.

Alaska providers: readiness to
 partner- TBI post-acute
 programs

Dr. Lester, St. Elias
 Margaret Carlom, RN
 Nurse, ANMC

- Shannon- Juneau resident,
 experienced TBI

TBI treatment work

Family support

Many of Alaska's challenging questions
been asked and answered by other States

- Alaska can learn from 30 years of state system experience; and
- treatment research by the Federal Government, State experiences, military advances

Questions and Solutions

Is brain injury
impacting
State
government?

1980 findings...

- Uninsured or underinsured
- Unemployment
- Trauma/EMS
- Long-term care and support needs
- Family Support

1990 findings...

- Educational System
- Vocational Rehabilitation

2000 findings...

- Criminal Justice
- Behavioral Health

Question and Solutions

How will State
Gov't know
how to develop
TBI systems?

TBI Act of 1996

- Federal Statute
 - Defined TBI in Federal statute
 - authorized funding to HHS
 - Established TBI program in VA
 - Created State grant program
- State experience has broadened program definition to ABI- same service needs.
- National Association of State Head Injury Administrators (1990)
- TBI Technical Assistance Center-specifically for state administrators (since 1996)

Question and Solutions

Is recovery
possible after a
TBI?

Does treatment
work?

- Feds fund TBI model systems since 1987, over 20 years of longitudinal data- yes with specialized support, recovery/independence is possible
- Research at acute/medical level led to need for community reentry programs
- Military funding is supporting research of community reentry programs and Mild TBI assessment and treatment

Question and Solutions

How will States
pay for brain
injury
treatment?

- 1990's, Centers for Medicare/Medicaid Services (CMS) developed TBI HCBS Waiver prototype
- IDEA 1990 added TBI as disability to report
- State General Funds
- TBI Trust Funds

Question and Answer

How will states
develop treatment
and prepare a
specialty
workforce?

- Many providers have 30 years of experience.
 - Utilize existing models: medical, community, clubhouse, and long-term living.
- TBI specific workforce will build as TBI programs are operationalized.
 - Professional/para-professional specialists on the job training, must take special educational training.

Question and Answer

How will rural residents have access to these treatment and services?

- Military and a few states utilize telemedicine for treatment.
- Opportunity for Alaska to become the national leader in providing care to rural areas?

Question and Answer

What type of legislation is/has been successful?

- Resolutions- awareness
Last five years
- Prevention
(AK primary seatbelt law
safety/ booster sea.)
- T/ABI Program into Statute
SB 219 and HB Compas
- Interagency Taskforce
- Prevention-concussion management
- Military-screening

Alaska has an opportunity

- Alaska can operationalize at a faster rate.
- Alaska can become the leader in rural TBI treatment and supports

Alaskans Thank the Legislature

For recognizing

the needs of

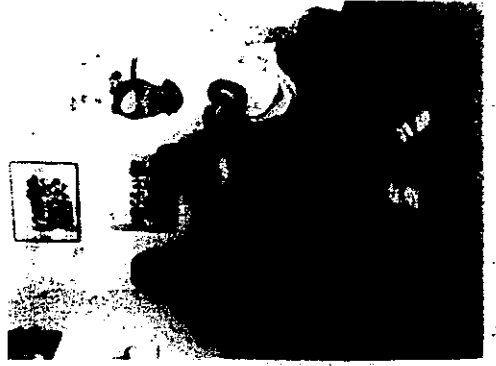
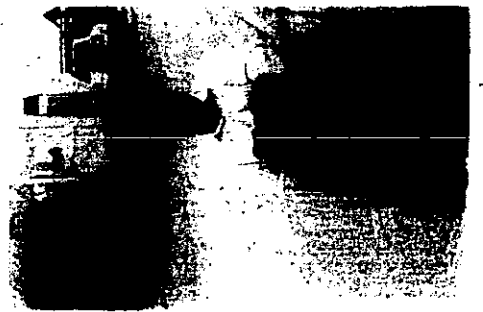
Alaskans with

physical disabilities

and the need to

improve the

quality of



Mr. Trautman's Brain Injury Model Systems of Care

11/11/11
11/11/11



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Derivates a system

Part of several types

• Service inter-station

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FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB328
 () Publish Date: _____

Identifier (file name): HB328-DHSS-SDMS-03-15-10 Dept. Affected: Health & Social Services
 Title: Traumatic Brain Injury: Program/ Medicaid RDU: Senior and Disability Services
 Component: Senior and Disability Medicaid Services
 Sponsor: Johnson
 Requester: House HSS Component Number: 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	1,272.0		1,221.0	1,230.0	1,239.0	1,248.0	1,257.0	
Miscellaneous								
TOTAL OPERATING	1,272.0	0.0	1,221.0	1,230.0	1,239.0	1,248.0	1,257.0	

CAPITAL EXPENDITURE							
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CHANGE IN REVENUES							
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	777.4		610.5	615.0	619.5	624.0	628.5
1003 GF Match	494.6		610.5	615.0	619.5	624.0	628.5
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	1,272.0	0.0	1,221.0	1,230.0	1,239.0	1,248.0	1,257.0

Estimate of any current year (FY2010) change: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if nece:

HB 328 requires the Department of Health & Social Services (DHSS) to establish a traumatic or acquired brain injury (TABI) program and to provide Medicaid coverage for TBI services.

Section 2 amends the Medicaid statutes to include case management services for individuals with TABI to the list of optional Medicaid services. The provision adding TABI case management services to Alaska's optional Medicaid services has the potential to increase Medicaid utilization. This would necessitate an amendment to the state Medicaid Plan.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
 Division: Health Care Services

Phone 269-7827
 Date/Time 3/15/10 4:25 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 3/15/2010

ANALYSIS CONTINUATION

Assumptions:

The Alaska Brain Injury network estimates approximately 1,300 new hospital discharges per year due to TABI. The department estimates approximately 20% of new TABI discharges would be on Medicaid, which is the same prevalence of Medicaid enrollees in the general population. Also the number of new TABI cases is expected to grow with the population at 1% per year.

$1,300 * 0.20 = 260$ new cases in FY11

$260 * 1.01 = 262.6$, rounded to 263 new cases in FY12, and so on

Case management services, based on an examination of similar services covered by Medicaid, is estimated to cost \$250/month for new TABI cases.

New Case Cost for FY12: $263 * (12 * 250) = 789,000$

In addition, there were approximately 9,200 hospital discharges due to TABI from 2001-2007 and it is estimated that 30% of these discharged individuals are still living with TABI related effects. It is estimated that 30% of people living with disabilities or effects from past TABI (existing cases) are currently on Medicaid. This estimate is somewhat higher than the general population due to a higher prevalence of disability, unemployment and lower income in this group.

$9,200$ past discharges * 0.30 living with effects from TABI = $2,760$

$2,760 * 0.30$ on Medicaid = 828 existing TABI cases

It is expected that approximately half of those cases would continue services. For existing cases - Medicaid currently has about 100 persons on waiver due to TABI (see below).

$828 - 100$ on waiver = 728

This would mean approximately 360 existing cases using case management services in FY11. Although it is anticipated that in the first year there would be a higher demand for services that in following years meaning an additional 50 cases in FY11. Future years the demand would level at about 360 continuing cases each year.

It is estimated that these existing cases would use services, but at a lower level than new cases, so \$100/month for 12 months.

Continuing Case Cost for FY12: $360 * (12 * 100) = 432,000$

Total FY12 Case Management Costs Estimate: $432,000 + 789,000 = 1,221,000$

For 2011, Title XIX services are expected be reimbursed at 61.12%, in further years, the federal reimbursement rate is estimated at 50%.

The department will also be required to either develop a new TBI Medicaid waiver or modify an existing waiver to accommodate the needs of TABI survivors. Federal regulations require that in order for individuals to be eligible for home- and community-based waivers, they must meet the state's criteria as needing an institutional level of care. Currently, those individuals with TABI who meet this level of care are already being served under the current waiver program. As of February 1, 2010 that number is 102 individuals. An increase in the cost of waiver service is not expected with this bill.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB328
 () Publish Date: _____

Identifier (file name): HB328-DHSS-SDSA-03-16-10 Dept. Affected: Health & Social Services
 Title Traumatic Brain Injury: Program/ Medicaid RDU Senior and Disabilities Services
 Component Administration
 Sponsor Johnson
 Requester House HSS Component Number 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill will establish a Traumatic or Acquired Brain Injury (TABI) Registry; establish a TABI case management program within the Division of Senior and Disabilities Services; and add case management services for people with TABI to the list of optional Medicaid services available in Alaska.

Two positions will be tasked with implementing the proposed legislation: a TABI Program Manager who will supervise data collection and analysis, coordinate services to people with TABI, evaluate standards and laws related to TABI, assess the availability of and evaluate acute and long-term care community services, investigate model community services, and coordinate funding of TABI care; and a Research Analyst to develop procedures for the collection of TABI information statewide, design and present statistical data, construct and modify research procedures and instruct others in their proper use. Current resources within the Division of Senior and Disabilities Services are sufficient to meet program needs.

Prepared by: Rebecca Hilgendorf, Director Phone 269-2083
 Division Division of Senior and Disabilities Services Date/Time 3/16/10 2:10 PM
 Approved by: Alison Elgee, Assistant Commissioner Date 3/16/2010
DHSS Finance & Management Services

AMENDMENT

OFFERED IN THE HOUSE
TO: HB 328

BY REPRESENTATIVE JOHNSON

- 1 Page 4, lines 7 - 8:
- 2 Delete "and laws pertaining to the prevention of traumatic or acquired brain injury
- 3 and"
- 4 Insert "pertaining"

Conceptional Amendment No. _____

26-LS1355\E.WK2

To House Bill 328

Proposed by: Representative Keller

Offered in the House

Amendment to Page 2, line 25 –page 3 line 6

- 1 Delete all material.
- 2 Insert “services furnished to assist individuals who reside in a community setting or who
- 3 are transitioning to a community setting to gain access to needed medical, social,
- 4 educational, and oher available services,”

New Text Underlined [DELETED TEXT BRACKETED]

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 9, 2010

SUBJECT: Sectional Summary (HB 328 (Work Order No. 26-LS1355\E))

TO: Representative Craig Johnson
Attn: Jeanne Ostnes

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds longitudinal data on traumatic or acquired brain injury from the registry established under sec. 5 of the bill to the list of databases that the Department of Health and Social Services is authorized to collect, analyze, and maintain.

Section 2. Adds case management services for traumatic or acquired brain injury to the optional services provided to recipients of state medical assistance (Medicaid).

Section 3. Defines "case management services for traumatic or acquired brain injury" and "traumatic or acquired brain injury" for purposes of the optional services added by sec. 2 of the bill.

Section 4. Requires the Department of Health and Social Services to provide medical assistance services under a waiver if approved by the federal government and if the legislature appropriates necessary funding for the services.

Section 5. Establishes a statewide traumatic or acquired brain injury program in the Department of Health and Social Services to evaluate the effectiveness and availability of information and services for the prevention and treatment of traumatic or acquired brain injury in the state. Requires consultation and collaboration with public and private entities to fulfill a list of programmatic requirements including development of a statewide service delivery plan and registry of information and evaluation of current laws and standards pertaining to traumatic or acquired brain injury.

JMM:plm
10-058.plm

Amendment request for HB 328 and or SB 219

Page 4 line 7 and 8

06 (3) evaluation of standards [*and laws pertaining to the prevention of*
07 *traumatic or acquired brain injury*] and to the treatment, care, and support of persons
08 with traumatic or acquired brain injury;

HB

361



Alaska State Legislature

Representative Anna Fairclough – House District 17

House Bill 361

“An Act requiring 911 dispatchers to be trained in cardiopulmonary resuscitation; and providing for an effective date”

Currently in Alaska State Statute there is no provision requiring 911 dispatchers to be certified in cardiopulmonary resuscitation (CPR). Most people are told that during an emergency you should call 911 immediately and someone will be able to help you. In the event that the caller does not know how to perform CPR, is unsure or panicking during the 911 call the operator should be able to not only calm the person down, but also be able to walk the caller through the process while help is on the way.

Most of the 911 dispatchers in the state are certified as Emergency Medical Dispatchers (EMD) which covers CPR. But for those remote regions in the state that don't have certified EMDs or dispatchers trained in CPR the passage of this bill may ultimately save lives.

Thank you for your consideration and I urge your support on the passage of legislation.

CS FOR HOUSE BILL NO. 361()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES FAIRCLOUGH, Dahlstrom

A BILL

FOR AN ACT ENTITLED

1 **"An Act moving the statewide 911 coordinator position to the Department of Public**
2 **Safety; requiring 911 dispatchers to be trained in cardiopulmonary resuscitation; and**
3 **providing for an effective date."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1.** AS 18.60 is amended by adding a new section to read:

6 **Article 13. Statewide 911 Coordinator.**

7 **Sec. 18.60.870. Statewide 911 Coordinator.** A statewide 911 coordinator is
8 established in the Department of Public Safety to coordinate and facilitate the
9 implementation of 911 systems throughout the state. The 911 coordinator shall

10 (1) participate in efforts to set uniform statewide standards for
11 automatic number identification and automatic location identification data
12 transmission for telecommunications systems;

13 (2) make recommendations as necessary for implementation of basic
14 and enhanced 911 service;

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(3) facilitate and monitor the training of emergency dispatchers in cardiopulmonary resuscitation; in this paragraph, "dispatcher" has the meaning given in AS 29.35.132.

* Sec. 2. AS 29.35 is amended by adding a new section to read:

Sec. 29.35.132. Training of emergency dispatcher. A municipality shall require that emergency dispatchers on the 911 system be trained and currently certified in cardiopulmonary resuscitation. In this section, "dispatcher" has the meaning given the term "call taker" in AS 29.35.131(k).

* Sec. 3. AS 26.23.170(b) is repealed.

* Sec. 4. This Act takes effect September 1, 2010.

Carson City 911 dispatcher gives instructions to save baby

BY F.T. NORTON

A Carson City dispatcher likely saved a newborn's life Wednesday morning.

When a call came in to emergency dispatch at 8:22 a.m., communications supervisor Cindy Merrell heard a distraught mother, barking dogs and a crying toddler. But what anyone else would have missed in the cacophony was what the woman said between screams — "My baby's not breathing!" Merrell heard it right away.

"The baby's not breathing," the veteran emergency dispatcher can be heard repeating on the 911 call recording.

Merrell said she turned to coworker Liz Hertz and relayed the information. Hertz called out medics. Then Merrell, herself a mother of four and grandmother of six, went to work. She opened flip cards and tried to get the woman's attention.

"I'm going to help you," Merrell shouted over the din. "I need you to calm down so we can help your baby. OK!" When the mother responded that she understood, Merrell began giving her directions. "I need you to put your baby on a flat surface," said Merrell. "Tilt the head back and see if he's breathing."

The woman wailed as a toddler could be heard in the background crying.

"I want you to breathe two puffs of air into the baby's lungs, just enough to make the chest rise," said Merrell.

The line became silent as the mother did as she was told. Then the woman can be heard crying. "Oh my God. My son's dead, my son's dead."

"Don't give up," said Merrell. "I need you to help the baby." She instructed the mother to do chest compressions. Through the line Merrell could hear the thumping as the woman did as she was told.

Everyone in the dispatch center became fixated on what was unfolding, including John Mason, a system technician with AT&T, who hours later was still in awe of what he'd witnessed. "It was just so amazing," he said.

Merrell worried the mother was going to stop because she kept repeating her son was dead.

"Don't give up. Just keep going until the medics get there. Keep going. Keep going," Merrell said. "I need you to help the baby. Don't give up."

For six minutes, Merrell remained calm while the frantic mother wailed, the dogs barked and a toddler cried.

And then, Merrell heard a weak cry.

"Oh, he just started crying," the mother yelled.

When paramedics arrived, Merrell hung up.

The baby's family declined to comment. According to Renown Regional Medical Center in Reno, the 3-week-old infant is in good condition.

"It's absolutely amazing — Cindy staying on the phone, calming the lady down and talking her through it, probably saved the baby's life," said Sheriff Ken Furlong. "Cindy doesn't get rattled. She's an amazing woman."

Merrell said normally after an emotional call, she will get up from her desk and go into another room to cry.

"But John Mason was in the room," she said with a laugh. "I turn around and he's got these tears, and Liz has got these tears, so I had to be like, 'Oh, it's just a job.'"

For Mason, however, the experience was unforgettable.

"I got to just sit there and listen to this dispatcher and the way she took control of the situation and actually saved the baby's life," said Mason, a former Marine. "I've seen a lot of stuff that didn't affect me. This actually touched me. When that baby coughed we were (cheering).

"We were just overwhelmed with joy that one life was saved by the training and composure of this particular dispatcher," Mason said. "I think she's a hero." Merrell was more humble about her actions.

"I was just glad that the baby was alive and I could help the mom," said Merrell.

<http://www.nevadaappeal.com/apps/pbcs.dll/article?>

Brookline 911 dispatcher praised for helping to save a life

E-mail|Link|Comments (0) Posted December 18, 2009 12:01 PM

By Brock Parker, Globe Correspondent

Authorities in Brookline are praising the work of a rookie 911 dispatcher who helped a local man perform CPR on his wife last month until emergency medical technicians arrived.

The woman survived, and now Emergency Dispatcher Siobhan McIntyre, who has been on the job since May, has received a commendation from police for her efforts.

"There's nothing like it," McIntyre said. "I saved a life. I had a hand in this."

David Connolly, the chief emergency dispatcher for Brookline, said McIntyre was working on Nov. 13 at 5:22 a.m. when a Brookline man called 911 because he'd found his wife unresponsive in their home.

The woman, who asked to remain anonymous, was in cardiac arrest and her husband did not know how to perform CPR, Connolly said.

"He asked me numerous times: 'What do I do? What do I do?'" McIntyre said. "I was just trying to calm him down. It was frightening to say the least."

McIntyre began walking the man through the steps to perform CPR. She instructed him about how to breathe into his wife and how to perform chest compressions, which he did. At that point, emergency responders arrived and used a defibrillator to revive the woman, Connolly said.

Connolly said McIntyre gets the credit for helping to save the woman's life because she was able to stay calm, get emergency responders in route and help talk the man through performing CPR all at the same time.

"And she's only been on the job since May," Connolly said.

McIntyre, 26, said that while she started in May, she had been training with a partner until she began working on her own in October.

While she is happy to have helped save a life, McIntyre said she's hoping the situation won't arise again any time soon.

"I hope it's a while," she said. "You never want to be in that position again."

INTRODUCTION TO CPR

IMPORTANT ANNOUNCEMENT: In March 2008 the American Heart Association published an advisory statement outlining "hands-only" or "compression-only" CPR. This statement is a clarification addendum to the 2005 AHA Guidelines for CPR and ECC which dictates that lay persons who are unable or unwilling to provide rescue breaths may perform hands-only CPR. This updated recommendation does not apply to first responders and/or medical personnel with access to CPR barrier or a mechanical respirator; unwitnessed cardiac arrest, cardiac arrest in children and infants, or cardiac arrest presumed to be of non-cardiac origin (drowning, trauma, airway obstruction, acute respiratory diseases, drug overdose, etc). AHA study concedes that when performed correctly, conventional CPR continues to prove a more effective rescue method for victims of cardiac arrest and as such we will continue to educate our students in ventilation as well as compressions.

Recent statistics suggest that sudden cardiac arrest is rapidly becoming the leading cause of death in America. Once the heart ceases to function, a healthy human brain may survive without oxygen for up to 4 minutes without suffering any permanent damage. Unfortunately, a typical EMS response may take 6, 8 or even 10 minutes.

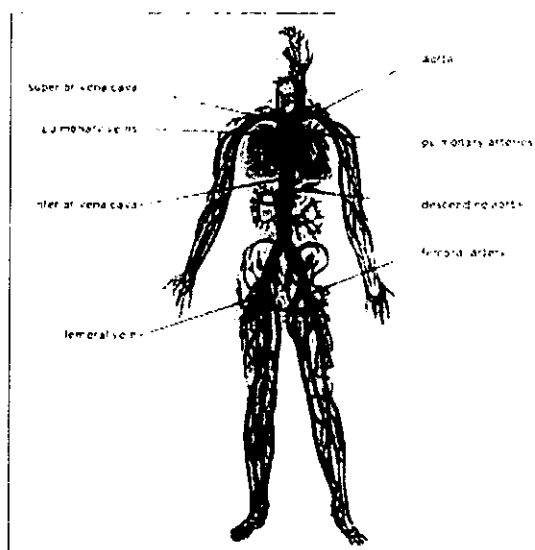
It is during those critical minutes that Cardio Pulmonary Resuscitation can provide oxygenated blood to the victim's brain and the heart, dramatically increasing his chance of survival. And if properly instructed, almost anyone can learn and perform CPR.



HOW CPR WORKS

The air we breathe in travels to our lungs where oxygen is picked up by our blood and then pumped by the heart to our tissue and organs. When a person experiences cardiac arrest - whether due to heart failure in adults and the elderly or an injury such as near drowning, electrocution or severe trauma in a child - the heart goes from a normal beat to an arrhythmic pattern called ventricular fibrillation, and eventually ceases to beat altogether. This prevents oxygen from circulating throughout the body, rapidly killing cells and tissue. In essence, Cardio (heart) Pulmonary (lung) Resuscitation (revive, revitalize) serves as an artificial heartbeat and an artificial respirator.

CPR may not save the victim even when performed properly, but if started within 4 minutes of cardiac arrest and defibrillation is provided within 10 minutes, a person has a 40% chance of survival.



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Invented in 1960, CPR is a simple but effective procedure that allows almost anyone to sustain life in the first critical minutes of cardiac arrest. CPR provides oxygenated blood to the brain and the heart long enough to keep vital organs alive until emergency equipment arrives. To make learning CPR easier, a system was devised that makes remembering it as simple as "ABC":

- Airway
- Breathing
- Circulation

WHEN TO DIAL 9-1-1

It is critical to remember that dialing 9-1-1 may be the most important step you can take to save a life. If someone besides you is present, they should dial 9-1-1 immediately. If you're alone with the victim, try to call for help prior to starting CPR on an adult and after a minute on a child. Before we learn what to do in an emergency, we must first emphasize what NOT to do:

- DO NOT leave the victim alone.
- DO NOT try to make the victim drink water.
- DO NOT throw water on the victim's face.
- DO NOT prompt the victim into a sitting position.
- DO NOT try to revive the victim by slapping his face.

Always remember to exercise solid common sense. When faced with an emergency situation we may act impulsively and place ourselves in harm's way. Although time should not be wasted, only approach the victim after determining that the scene is safe: always check for cars, fire, gas, downed electrical lines, and any other potential hazards before attempting to perform CPR.

ADULT CPR

Definition

Because there is no single anatomic or physiologic characteristic that distinguishes a "child" victim from an "adult" victim and no scientific evidence that identifies a precise age to initiate Adult rather than Child CPR techniques, the ECC scientists made a consensus decision for age delineation that is based largely on practical criteria and ease of teaching. However, American Heart Association's guidelines dictate that Adult CPR is performed on any person over the age of approximately 10 to 14 years (or post-adolescence, as defined by the presence of secondary sex characteristics).

Assessing the situation

If you suspect that the victim has sustained spinal or neck injury, do not move or shake him.

1 person CPR

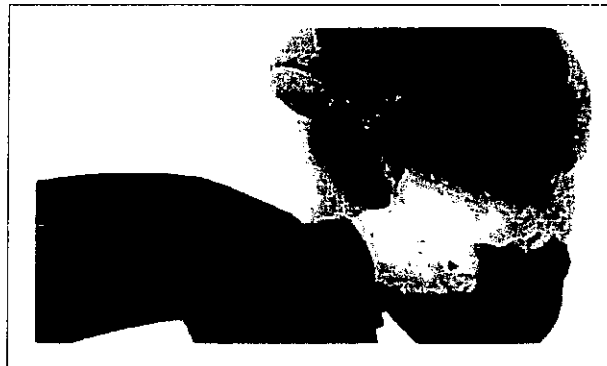
- Verify that the victim is unresponsive by shaking the victim gently and shouting "Are you okay?"
- If there is no response, dial 9-1-1
- Retrieve an AED if one is available
- Begin CPR and use the AED as appropriate

2 person CPR

- Verify that the victim is unresponsive by shaking the victim gently and shouting "Are you okay?"
- A trained rescuer should remain with the victim to begin CPR
- Second rescuer telephones 9-1-1 and, if available, retrieves an AED
- Continue CPR and use the AED as appropriate

A-B-C of CPR

"A" is for AIRWAY. If the victim is unconscious and is unresponsive, you need to make sure that his airway is clear of any obstructions. The breaths may be faint and shallow - look, listen and feel for any signs of breathing. If you determine that the victim is not breathing, then something may be blocking his air passage. The tongue is the most common airway obstruction in an unconscious person and it may be necessary to perform a finger sweep in order to move the tongue or any other foreign object away from the air passage. With the victim lying flat on his back, firmly hold his chin with one hand while using the finger of your other hand in a sweeping motion. Once the airway is unblocked, place your hand on victim's forehead and your other hand under the tip of the chin and gently tilt his head backward. In this position the weight of the tongue will force it to shift away from the back of the throat, opening the airway. If the person is still not breathing on his own after the airway has been cleared, you will have to assist him breathing.



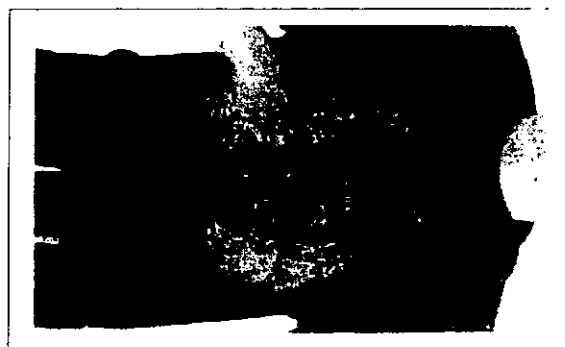
"B" is for BREATHING. With the victim's airway clear of any obstructions, gently support his chin so as to keep it lifted up and the head tilted back. Pinch his nose to prevent air from escaping once you begin to ventilate. Take a full breath, place your mouth tightly over the victim's (use a shield barrier if one is available) and blow until the victim's chest rises. Maintain a tight seal around his mouth and be careful not to over-inflate his lungs as this may force air into the stomach, causing him to vomit. If this happens, turn the victim's head to the side and sweep any obstructions out of the mouth before proceeding. Between each breath allow the victim's lungs to relax - place your ear near his mouth and listen for air to escape and watch the chest fall as he exhales. If the victim remains unresponsive (no breathing, coughing or moving), check his circulation.



"C" is for CIRCULATION. In order to determine if the victim's heart is beating, place two fingertips on his carotid artery, located in the depression between the windpipe and the neck muscles, and apply slight pressure for several seconds. If there is no pulse then the victim's heart is not beating, and you will have to perform chest compressions.

Chest compressions

When performing chest compressions, proper hand placement is very important. Place two fingers on the victim's sternum and then put the heel of your other hand next to your fingers. Now you need to place your hand on top of that hand and interlace the fingers. Lock your elbows and using your body's weight, compress the victim's chest. The depth of compressions should be approximately 1½ to 2 inches - remember: 2 hands, 2 inches at a rate of 100 compressions per minute. If you feel or hear slight



cracking sound, you may be pressing too hard. Do not become alarmed and do not stop your rescue efforts! Damaged cartilage or cracked ribs are far less serious than a lost life. Simply apply less pressure as you continue compressions.

1 person CPR

Count aloud as you compress 30 times at the rate of about 3 compressions for every 2 seconds. Finish the cycle by giving the victim 2 breaths. This process should be performed 5 times - 30 compressions and 2 breaths - after which remember to check the victim's carotid artery for pulse (for no longer than 10 seconds) and other signs of consciousness. If you definitely not feel a pulse within 10 seconds, you should begin cycles of chest compressions and ventilations. Continue until an advanced airway is in place or victim regains consciousness.



2 person CPR

Count aloud as you compress 30 times at the rate of about 3 compressions for every 2 seconds. Finish the cycle by giving the victim 2 breaths. To prevent fatigue and deterioration in quality and rate of chest compressions the rescuers should change compressor and ventilator roles every 2 minutes - the switch should be accomplished as quickly as possible to minimize interruptions in compressions. Continue until an advanced airway is in place or victim regains consciousness.



Click here to print or select **File** then **Print** from your browser.

Close Window

911 Claims Operators Don't Need to Know CPR

A Shocking Revelation by the *Today Show* Reveals 18 State Behind the Curve

By Ryan Christopher DeVault

The 911 system in this country is broken, and the *Today Show* showed us just how broken it is. In a *Today Show* investigation of the 911 system, it was revealed that 18 states around the country do not require that their operators know CPR to be on the job. It seems that one of the reasons that the story was being done in the first place was that a city manager in Murphy, Texas said that his operators didn't know CPR because they weren't required to know it. Does this sound like a good excuse? Or does it sound like laziness where the city could be putting its residents at risk by not actually taking on training that could save lives?

Let's all just agree that knowing CPR is an important tool and that when someone takes the initiative to actually learn CPR that they are working towards the greater good. The fact is that nobody does CPR to help themselves out because obviously CPR is a tool you use to help out someone else in need. Those who go through the training to help save the lives of other people are commendable, and it creates more and more people that are capable of helping people with a medical emergency. With that in mind shouldn't anyone that could be placed in a position to use CPR go through the training simply because they can?

If you haven't learned CPR, and your child is suddenly having trouble breathing, who do you call? We are all told that you should call 911 immediately, but what are you expecting when you call 911? As a parent I would hope for immediate help with the situation, but there are 18 states (listed on page 2) around the country that don't care enough to make sure that the callers can receive help from their operators. I am of the opinion that it is important for parents to learn CPR, but if they haven't had the money to pay for the training, what are their options in those 18 states where you can't rely on 911 to help you out? I wish I had the answer to that question.

The reason that the city of Murphy, Texas is being brought up in this article is that they had a woman whose child had stopped breathing call into their 911 dispatch to receive help with CPR. The operator couldn't help, and the excuse that the city is giving is that they aren't required to know how to do CPR in Texas, and that they did nothing wrong. Maybe they learned their lesson in Murphy though, because the claim by the city manager of Murphy (to the *Today Show*) is they are now going to train their operators. It won't bring back the child that died in the sad case, but maybe it can be a warning sign for residents to take up the cause in their states for 911 operators to be required to know CPR. Unless you can answer for me the following question, "who do I call for help with CPR while in the middle of trying to save a life?"

States that DON'T require CPR Training for 911 Operators

Idaho
Nevada
Colorado
South Dakota
Nebraska
Kansas
Oklahoma
Wisconsin
Michigan
Indiana
Arkansas
Mississippi
Alabama
Florida
New York
West Virginia
Alaska
Hawaii

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HB

392

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CS FOR HOUSE BILL NO. 392()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE HERRON

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing a loan repayment program and employment incentive program for**
2 **certain health care professionals employed in the state; and providing for an effective**
3 **date."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1.** AS 14.43 is amended by adding new sections to read:

6 **Article 8A. Health Care Professions Loan Repayment.**

7 **Sec. 14.43.430. Loan repayment; purpose.** (a) The commission shall repay a
8 portion of education loans made to eligible tier I and tier II health care professionals
9 under the health care professions loan repayment and employment incentive program
10 established in AS 18.29.010 and the loan repayment procedures established under this
11 section.

12 (b) The Department of Health and Social Services shall administer the health
13 care professions loan repayment program under AS 18.29.010 - 18.29.099. The
14 commission shall act as a disbursing agent in carrying out the provisions of

1 AS 14.43.430 - 14.43.449.

2 (c) Loan repayments under this section shall be made with funds appropriated
3 by the legislature for that purpose. The loan repayments made under this section do
4 not constitute a financial obligation of the corporation.

5 **Sec. 14.43.435. Eligibility.** To be eligible for loan repayment under
6 AS 14.43.430, an individual must

7 (1) meet eligibility and priority criteria established under
8 AS 18.29.030;

9 (2) have an unpaid balance on one or more education loans verified by
10 the commission; and

11 (3) meet other criteria established by the commission.

12 **Sec. 14.43.440. Conditions and limitations on loan payments.** (a) A loan
13 repayment under AS 14.43.430 - 14.43.449 shall be in an amount not to exceed 33.3
14 percent of the unpaid loan balance existing in the first year of program participation,
15 multiplied by the percentage of full time equivalent employment for each of up to
16 three years of qualified employment less a matching loan or incentive amount from an
17 employer or other entity as determined under AS 18.29.020.

18 (b) The commission shall make a loan repayment under this section in
19 quarterly installments payable to the lending institution. A loan repayment made under
20 this section may not exceed the annual benefit amounts established under
21 AS 18.29.020(b). The commission may not make a loan repayment installment for an
22 employment period of less than one calendar quarter.

23 (c) A loan or interest on a loan is not eligible for repayment under this section
24 if the loan or interest is eligible for repayment from another source, including another
25 loan repayment or forgiveness program or an employer-sponsored repayment
26 program.

27 **Sec. 14.43.449. Definitions.** In AS 14.43.430 - 14.43.449,

28 (1) "qualified employment" has the meaning given in AS 18.29.099;

29 (2) "tier I health care professional" means a dentist, pharmacist, or
30 physician;

31 (3) "tier II health care professional" means a dental hygienist,

1 registered nurse, certified nurse practitioner, physician assistant, physical therapist,
2 clinical psychologist, or clinical social worker holding at least a master's degree in
3 social work.

4 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:

5 **Chapter 29. Health Care Professions Loan Repayment and Incentive Program.**

6 **Sec. 18.29.010. Health care professions loan repayment and incentive**
7 **program; purpose; advisory body.** (a) The health care professions loan repayment
8 and incentive program is established in the department for the purpose of addressing
9 the worsening shortage of certain health care professionals in the state by increasing
10 the number and improving the distribution of health care professionals who provide
11 direct patient care.

12 (b) The program established under this section must include

- 13 (1) loan repayments made under AS 14.43.430 - 14.43.449;
14 (2) direct incentives paid under AS 18.29.020;
15 (3) procedures for the commissioner's designation and prioritization of
16 sites eligible for participation in the program;
17 (4) an application process for participation in the program as
18 (A) an eligible site; or
19 (B) a tier I or tier II health care professional;
20 (5) the dissemination of public information and notices pertinent to the
21 program;
22 (6) classification by the commissioner of each eligible site as having
23 either regular or very hard-to-fill positions, or both;
24 (7) a lifetime maximum period of six years for participation in the loan
25 repayment and direct incentive aspects of the program by a tier I or tier II health care
26 professional; and
27 (8) annual program evaluations and reports.

28 (c) Except as provided under AS 14.43.430, the program shall be administered
29 by the commissioner in consultation with an advisory body appointed by the
30 commissioner. The advisory body is made up of members with health care expertise,
31 including expertise in economic issues affecting the hiring and retention of health care

1 professionals in the state. Members of the advisory body serve at the pleasure of the
 2 commissioner to provide recommendations for and oversight and evaluation of all
 3 aspects of the program. The commissioner shall accept a recommendation of the
 4 advisory body on a matter pertaining to the identification and monitoring of areas of
 5 shortages, eligible sites, payment priorities, or evaluation of the program, unless the
 6 commissioner finds, in writing, that the recommendation cannot be financially or
 7 otherwise supported by the department.

8 **Sec. 18.29.020. Direct incentives.** (a) The department shall provide direct
 9 incentives in the form of quarterly cash payments to eligible tier I and tier II health
 10 care professionals engaged in qualified employment. The department may not make an
 11 incentive payment

- 12 (1) before the employment period begins;
- 13 (2) for a period of qualified employment of less than three months; or
- 14 (3) under a contract term that is less than one calendar quarter.

15 (b) Payments made under this section, when combined with a loan repayment
 16 amount paid under AS 14.43.440, if any, may not exceed

- 17 (1) \$35,000 annually for a tier I health care professional employed in a
 18 regular position;
- 19 (2) \$47,000 annually for a tier I health care professional employed in a
 20 very hard-to-fill position;
- 21 (3) \$20,000 annually for a tier II health care professional employed in
 22 a regular position; or
- 23 (4) \$27,000 annually for a tier II health care professional employed in
 24 a very hard-to-fill position.

25 (c) The commissioner shall calculate the annual incentive payment amount by
 26 multiplying the annual maximum payment under (b) of this section by the percentage
 27 of full time equivalent employment for each of not more than three years of qualified
 28 employment less a matching payment amount as determined under (d) of this section
 29 and loan repayment amount, if any, under AS 14.43.440.

30 (d) An employer or other entity that employs an eligible tier I or tier II health
 31 care professional at an eligible site shall make nonrefundable quarterly matching

1 payments to the department. The payments must be in an amount that is

2 (1) not more than half of the combined annual incentive payment made
3 under (c) of this section and the loan repayment amount paid under AS 14.43.440(a),
4 as determined by the commissioner; and

5 (2) based on the employer's or entity's ability to pay, as determined by
6 the commissioner, in consultation with the program advisory body.

7 (e) A payment made under (d) of this section shall be combined with the
8 payment made to the professional by the department.

9 **Sec. 18.29.025. Number of participants.** (a) The number of participants to
10 whom the commissioner may provide a direct payment, loan repayment, or both under
11 the program established under AS 18.29.010 may not exceed 90 participants annually
12 as described in (b) of this section, regardless of whether the participant is a new or
13 continuing participant.

14 (b) The commissioner shall provide direct incentive payments, loan
15 repayments, or both, to not fewer than three participants employed in very hard-to-fill
16 positions at an eligible site in each of the 10 tier I and tier II health care professions.

17 **Sec. 18.29.030. Eligibility and priority.** (a) To be eligible for a direct
18 incentive payment under AS 18.29.020, an individual shall

19 (1) submit an application on a form approved by the commissioner;

20 (2) be engaged in qualified employment;

21 (3) be licensed as a tier I or tier II health care professional in the state
22 within 90 days after the first day of employment;

23 (4) meet a priority for payment established under (b) of this section;
24 and

25 (5) meet other criteria established by the commissioner.

26 (b) The commissioner shall establish priorities for payment of a loan and
27 incentive under the program based on the recommendations of the program advisory
28 body and the availability of funding. The commissioner shall prioritize eligible sites
29 based on the percentage of patients treated at the site who

30 (1) are uninsured;

31 (2) have or are eligible for medical assistance or Medicare coverage; or

1 (3) have or are eligible for other federal health program benefits.

2 **Sec. 18.29.099. Definitions.** In AS 18.29.010 - 18.29.099,

3 (1) "commissioner" means the commissioner of health and social
4 services;

5 (2) "department" means the Department of Health and Social Services;

6 (3) "eligible site" means a service area or health care facility that the
7 commissioner has designated as located in a health care services shortage area based
8 on a needs assessment and employment statistics for qualified tier I or tier II health
9 care professionals;

10 (4) "program" means the health care professions loan repayment and
11 incentive program;

12 (5) "qualified employment" means employment of a tier I or tier II
13 health care professional at an eligible site at which the health care professional is hired
14 and paid to work

15 (A) in a full-time or not less than half-time position;

16 (B) for a contract term that is not less than three years; and

17 (C) not less than 50 percent time on direct patient health care
18 services;

19 (6) "tier I health care professional" means a dentist, pharmacist, or
20 physician;

21 (7) "tier II health care professional" means a dental hygienist,
22 registered nurse, certified nurse practitioner, physician assistant, physical therapist,
23 clinical psychologist, or clinical social worker holding at least a master's degree in
24 social work.

25 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

Talking Points HB 392: Loan Repayment and Direct Incentives for Certain Medical Providers

- Financial incentives of various types—loan repayment, moving costs, housing assistance and tax breaks—can influence a provider's decision to practice in Alaska.
- Research on support-for-service programs indicate that these programs bring health care providers to needy communities where they remain in practice for many years. Of all types of programs, loan repayment and direct financial incentives that target the practitioner after training show the broadest success.¹
- HB 392 establishes in the Dept. of Health and Social Services a loan repayment and incentive program for medical providers who serve in health care shortage areas in Alaska.
- This bill will provide a combination of loan repayment or cash incentives for up to 90 applicants per year in 10 different health care occupations that fall into tier I or tier II categories.
- Tier-1 includes dentists, pharmacists, and physicians (MD and DO); and Tier-2 includes dental hygienists, nurse practitioners, nurses (RN), physical therapists, physician assistants, psychologists, and clinical social workers (LCSW).
- The amount of monetary incentive will vary with each slot, according to the category of healthcare provided and the location. The Commissioner, based on a needs assessment and employment statistics, designates sites as very hard-to-fill or regular.
- 30 slots each are reserved for very hard-to-fill sites and regular sites and 30 slots can be assigned to either category at the discretion of the Commissioner.
- Priority will be given to sites that treat patients who are uninsured and who have medical assistance or Medicare coverage.
- The combination of loan repayment and incentives cannot exceed \$47,000 at a very hard-to-fill site and \$35,000 at a regular site for a tier I medical provider.
- For a tier II provider the maximum is up to \$27,000 per year for three years at a very hard-to-fill site and up to \$20,000 per year for three years at a regular site.
- HB 392 will be one of the only programs that would allow incentives to mid-career professionals and thus will be a powerful recruitment tool. Forty-four states have "support-for-service programs" and Alaska cannot compete with these states when attempting to recruit health care professionals.
- Once HB 392 goes into effect, it will immediately begin to remedy the shortage of health care professionals within the state of Alaska. In combination with current programs aimed at students, e.g. WWAMI, we can greatly enhance the availability of medical services in our underserved areas, getting this important population the access to health care that they deserve.

¹ Donald E. Pathman, M.D., et al, *Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians*, Medical Care, Vo. 42, No. 6, Juneau 2004, p. 567

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

SARAH PALIN, GOVERNOR

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Alaska Commission on Aging

March 18, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska State Capitol, Room 411
Juneau, AK 99801-1182

Subject: Support for HB 392, Incentives for Certain Medical Providers

Dear Chair Keller and Chair Herron:

The Alaska Commission on Aging (ACoA) encourages support for HB 392 by the House HSS Committee, a bill to establish a loan repayment program to build Alaska's health care workforce by increasing the recruitment and retention of targeted health care professionals in urban and rural, underserved communities. This bill is authored by Representative Bob Herron.

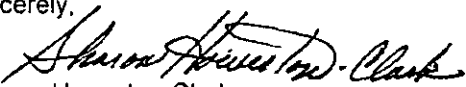
Alaska, as with the rest of the nation, is experiencing a shortage of health care workers as fewer students are entering the health care profession and many of those already working in health care are preparing for retirement. Alaska is one of five states that does not offer a state-sponsored loan repayment program for health care professions. As a result, our hospitals, clinics, and communities lose potential health care workers to other states that incentivize their workforce with loan repayment programs.

Access to quality health care is a priority for all Alaskans and a critical need for people age 65 years and older. Older Alaskans benefit from regular health care services which enhance their overall health and decrease the need for more expensive, intensive treatment and emergency visits.

Alaska continues to lead all states with the fastest growing senior population currently comprising about 12 percent of our state's population and is projected to increase by five to six percent each year until 2020. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors, as demand increases and providers are reaching retirement age. If older Alaskans are unable to find a health care provider, they may be forced to leave the state in search of access to health care professionals. As a result, Alaska could suffer from a loss of retirees, who contribute more than \$1.7 billion to the state's economy in addition to their significant volunteer service, caregiving activities, and community leadership.

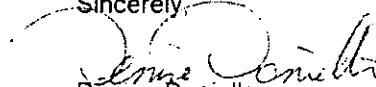
ACoA supports HB 392 and believes that the proposed legislation will help to build a qualified health care workforce who will be available to meet the health care needs of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information about our position. Thank you.

Sincerely,



Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director

Cc: Representative Tammie Wilson, Vice-Chair
Representative Bob Lynn
Representative Paul Seaton

Cc: Representative Sharon Cissna
Representative Lindsey Holmes

From: donotreply@votervoice.net [mailto:donotreply@votervoice.net]
Sent: Thursday, March 18, 2010 11:40 AM
To: Ann Ehret
Subject: Confirmation of: HB 392 - Loan repayment

Please do not reply to this email--this confirmation simply lets you know that your message was sent.

Your message has been sent to the following recipients:

- * Representative Paul Seaton
- * Representative Sharon Cissna
- * Representative Wes Keller
- * Representative Bob Herron
- * Representative Lindsey Holmes
- * Representative Bob Lynn
- * Representative Tammie Wilson

The content of your message is as follows:

Dear [The message(s) you sent had each recipient's name here]:

I am writing to urge you to support this legislation for the loan repayment and incentive program in Alaska. As a physician who works 75% time in the Aleutians I am not eligible for federal loan repayment toward my \$150,000.00 medical school loans. After three years in our community health center at a average salary, I am no longer financially able to sustain the cost of living, monthly loan payments without loan repayment of some sort. I am seriously considering moving out of state to obtain more flexibility in the reimbursement options. If this legislation passes, I will stay in Alaska to provide rural primary care to under served populations.

Sincerely,

Dr. Ann Nora Ehret

Rob Earl

From: Marguerite Stetson [mstetso1@alaska.edu]
Sent: Thursday, March 18, 2010 11:29 AM
To: Rob Earl
Subject: Health Care Loans to providers

Representative Herron

As I understand it, this HB 392 would provide loans to providers in order to attract more providers to Alaska.

It is apparent that there is a problem now in accessing care when you are on Medicare.

I would support this bill to help ease the problem of care.

Sincerely,

Marguerite Stetson
1810 Ponds Cir
Anchorage, AK 99507

Rob Earl

From: Heather Goecke [hgoecke@scf.cc]
Sent: Thursday, March 18, 2010 10:55 AM
To: Rob Earl
Subject: HB 392

Representative Herron

Alaska needs to establish a Loan Repayment & Incentive Program so we can recruit and retain the providers we need and to help solve the shortage problem.

Average debt for occupations - especially tier 1: range 100,000 to 400,000 (like a mortgage!)

Cost of doing nothing? Economics of no action:

- Without action, ongoing recruitment costs and high locum tenens costs due to high turnover and length of vacancies will continue to increase health care costs in Alaska
- Without action, Alaska will continue to trend toward a public health crisis in pockets of the state
- Without action, Alaska can expect increased ER use, increased Medivac use, increased Medicaid travel costs, and increased costs associated with chronic disease

Sincerely,

Heather Goecke
4040 N Preston Ave
Wasilla, AK 99654

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182

Phone: (907) 465-4942 • Fax: (907) 465-4589



House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

House Bill 392 – Loan Repayment and Incentives for Certain Medical Providers Version 26-LS1528\R

SPONSOR STATEMENT

Akiachak
Akiak
Atmautluok
Bethel
Chefornak
Eek
Goodnews Bay
Kasigluk
Kipnuk
Kongiganak
Kwethluk
Kwigillingok
Lower Kalskag
Mekoryuk
Mertarvik
Napakiak
Napaskiak
Newtok
Nightmute
Nunapitchuk
Oscarville
Platinum
Quinhagak
Toksook Bay
Tuluksak
Tununak
Tuntutuliak
Upper Kalskag

House Bill 392 establishes a loan repayment and direct incentive program in the Department of Health and Social Services (DHSS), for certain health care professionals employed in the state of Alaska. The goals of the program are to increase the quality and quantity of medical services in underserved regions using a combination of loan repayment and direct monetary incentives to recruit and retain experienced health care professionals.

Alaska has long faced a health care provider shortage that is expected to worsen. The lack of health care providers is apparent not only in urban regions but also in rural communities where it is especially difficult to recruit health care practitioners. The intent of HB 392 is to create a competent and competitive workforce that has the experience necessary to serve our citizens.

HB 392 is one of the only programs that would allow incentives to mid-career professionals and thus will be a powerful recruitment tool. Forty-four states have "support-for-service programs" and Alaska cannot compete with these states when attempting to recruit health care professionals. HB 392 is a much-needed solution to our shortage of health care professionals because the bill will allow for the employment of up to 90 participants in any given year.

DHSS would run the program and serve as the fiscal agent making quarterly loan payments directly to eligible lenders and incentive payments directly to practitioners from 10 different health care occupations.

The amount of loan repayment and/or direct incentive payment would depend on the location of the position and the category of health care provided. There are currently two tiers of practitioners: Tier-1 includes dentists, pharmacists, physicians (MD and DO); and Tier-2 includes dental hygienists, nurse practitioners, nurses (RN), physical therapists, physician assistants, psychologists, and social workers (LCSW).

A provider in Tier-1 who serves in a designated "very-hard-to-fill" position could receive up to an extra \$47,000 and in a "regular" position an extra \$35,000 per year for up to three years. A provider in Tier-2 who serves in a designated "very-hard-to-fill" position could receive up to an extra \$27,000 and in a "regular" position an extra \$20,000 per year for up to three years.

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182

Phone: (907) 465-4942 • Fax: (907) 465-4589



House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

Akiachak

Akiak

Atmaulluk

Bethel

Chefnork

Ek

Goodnews Bay

Kasigluk

Kipnuk

Kongiganak

Kwethluk

Kwigillingok

Lower Kalskag

Mekoryuk

Mertarvik

Napakiak

Napaskiak

Newtok

Nightmute

Nunapitchuk

Oscarville

Platinum

Quinhagak

Toksook Bay

Tuluksak

Tununak

Tuntutuliak

Upper Kalskag

To address the shortage of health care providers in rural areas 30 of the 90 slots would be reserved for "very-hard-to-fill" positions, which are designated by the Commissioner of Health and Social Services based upon a needs assessment and employment statistics for Tier-1 and Tier-2 health care professionals.

Once HB 392 goes into effect, it will immediately begin to remedy the shortage of health care professionals within the state of Alaska. In combination with current programs aimed at students, e.g. WWAMI, we can greatly enhance the availability of medical services in our underserved areas, getting this important population the access to health care that they deserve.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

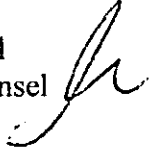
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 11, 2010

SUBJECT: Sectional Summary (HB 392; Work Order No. 26-LS1528\R)

TO: Representative Bob Herron
Attn: Nikoosh Carlo

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Requires the Alaska Commission on Postsecondary Education to repay education loans made to health care professionals, as defined, under eligibility criteria established in sec. 2. Specifies that the loan repayment obligation is not a financial obligation of the corporation. Provides for quarterly payments based on the fulfillment of qualified employment at eligible sites located in the state.

Section 2. Establishes the health care professions loan repayment and incentive program in the Department of Health and Social Services for the purpose of addressing a shortage of certain health care professionals in the state and for improving the distribution of those professionals. Requires the commissioner of health and social services to administer the program, to designate and prioritize eligible employment sites, and to monitor the program in consultation with an advisory body established under this section. Provides for maximum combined loan repayment and employment incentives based on the type of employment.

Section 3. Provides for an immediate effective date for the bill.

JMM:med
10-036.med

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB392
() Publish Date: _____

Identifier (file name): HB 392-DHSS-MAA-03-18-10

Dept. Affected: Health & Social Services

Title Incentives for Certain Medical Providers

RDU Health Care Services

Component Medical Assistance Administration

Sponsor Herron

Requester House HSS

Component Number 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required		Information				
	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES							
Personal Services	89.3		89.3	89.3	89.3	89.3	89.3
Travel	6.0		6.0	6.0	6.0	6.0	6.0
Contractual	2,777.4		2,742.4	2,742.4	2,742.4	2,742.4	2,742.4
Supplies	2.0		2.0	2.0	2.0	2.0	2.0
Equipment	7.6						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	2,882.3	0.0	2,839.7	2,839.7	2,839.7	2,839.7	2,839.7

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	2,036.3		2,036.3	2,036.2	2,036.2	2,036.2	2,036.2
1004 GF	167.3		124.7	124.7	124.7	124.7	124.7
1005 GF/Program Receipts	678.7		678.7	678.8	678.8	678.8	678.8
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	2,882.3	0.0	2,839.7	2,839.7	2,839.7	2,839.7	2,839.7

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

HB 392 creates a loan repayment program for identified health professional occupations and provides for cash incentives for eligible health professionals engaged in qualified employment. The intent of the legislation is to "address the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care."

Division of Health Care Services estimates that it will need a total of 1 FTE to fully administer the loan repayment and employment incentive programs.

(continued on next page)

Prepared by: William J. Streur, Deputy Commissioner
Division DHSS Health Care Services

Phone (907) 269-7827
Date/Time 3/15/10 8:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 3/18/2010

ANALYSIS CONTINUATION

Health Care Professions Loan Repayment & Incentive Program

The Division assumes it will need \$2,715.0 for practitioner payments in FY2011. This funding will be used for either practitioner payments as cash incentives, or payments to lender institutions for loan repayments, or there can be a combination of the two types of payments. Maximum payments established for any combination of loan repayment and cash incentive are: \$35.0 annually for tier I health care professionals employed in "regular" positions; \$47.0 annually for tier I health care professionals employed in "very hard-to-fill" positions; \$20.0 annually for tier II health care professionals employed in "regular" positions; and \$27.0 annually for tier II health care professionals employed in "very hard-to-fill" positions. The need for \$2,715.0 in FY2011 assumes the following:

Tier I 27 Practitioners \$1,161.0 (assumes 9 participants from each of 3 types comprising tier I at \$387.0 for each type)
 Tier II 63 Practitioners \$1,554.0 (assumes 9 participants from each of 7 types comprising tier II at \$222.0 for each type)
 Total 90 Practitioners \$2,715.0

The Division assumes the employing entities will provide 25% of the \$2,715.0 as contributing match as specified in HB392. Therefore, the expected GF match is \$2,036.3 The match for the employing entities is \$678.7.

Incentive payments are available to professionals for up to 3 years of qualified employment with a lifetime maximum participation of six years in the loan repayment and direct incentives aspects of the program by a tier I or tier II health care professional. The total number of participants in the program may not exceed 90 participants annually, regardless of whether the participant is a new or continuing participant.

On the fiscal note, the payments for practitioners will be paid from the contractual line:

Item	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016
Practitioner Payments	\$2,715.0	\$2,715.0	\$2,715.0	\$2,715.0	\$2,715.0	\$2,715.0
Evaluation Contract	\$ 18.0	\$ 18.0	\$ 18.0	\$ 18.0	\$ 18.0	\$ 18.0
Staff Contractual Costs	\$ 9.4	\$ 9.4	\$ 9.4	\$ 9.4	\$ 9.4	\$ 9.4
ACPE Software	\$ 35.0	\$	\$	\$	\$	\$
Total:	\$2,777.4	\$2,742.4	\$2,742.4	\$2,742.4	\$2,742.4	\$2,742.4

Administrative Costs

1 Health Program Manager II, \$89.3 (includes fringe benefits). Assumes \$9.4 per FTE annually for office space, phones, and other contractual costs; \$2.6 one time costs per FTE for computers and software; \$5.0 one time costs per FTE for office equipment; \$2.0 per FTE annually for supplies; \$6.0 per year for travel; \$18.0 each year for a program evaluation contract.

Health Program Manager II.

This position will serve as lead program manager for the loan repayment and employment incentive program and will: establish procedures for the commissioner's designation and prioritization of sites eligible for participation in the program, develop the application process for participation in the program for sites and professionals, develop and disseminate public information and notices pertinent to the program, lead the development of the methodology and procedures for classifying each eligible site as having either regular or very hard-to-fill positions, prepare annual reports that document the successes and challenges of the program, facilitate the creation of and ongoing work of the advisory committee, and establish procedures and manage the employer contribution portion of the program.

Assumes one time costs of \$35.0 for contractual services/software development for Alaska Commission on Postsecondary Education (ACPE).

ACPE will facilitate the disbursement of the loan repayment benefit. It will not be the budgetary agency for requesting and receiving the funds. After HCS selects program participants, ACPE will verify the existence of their qualifying education debt, and, on a periodic basis, transmit the appropriate benefit amount to the individual's lender.

Health Professional Shortage Area (HPSA) and Medically Underserved Areas and Populations (MUA/MUP) Listing 3/2009
(Listing does not include the automatic Primary Care HPSAs for Alaska Native Tribal Populations, which are available to meet designation requirements)

Census Area/Borough	Primary Care HPSA	Dental HPSA	Mental Health HPSA	MUA (Medically Underserved Area)	MUP (Medically Underserved Population per Governor's Request)
013 - Aleutians East Borough	yes	yes	yes	y	
016 - Aleutians West Census Area	yes	yes	yes	y	
020 - Anchorage Borough	CHC	CHC	CHC		y (North)
050 - Bethel Census Area	yes	CHC (applied for geographic DHPHA)	yes	y	
060 - Bristol Bay Borough	CHC	yes	applied/CHC	y	
068 - Denali Borough	yes	applied; CHC site	yes		y
070 - Dillingham Census Area	only AN; CHC shortly	yes	applied for geographic; CHC		y
090 - Fairbanks North Star Borough	Low income	CHC; applying for low income	CHC		y
100 - Haines Borough	CHC	-	yes		y
110 - Juneau Borough	-	-	-	-	-
122 - Kenai Peninsula Borough	CHC	CHC	CHC; Seward subarea is MHPSA		y
130 - Ketchikan Gateway Borough	-	-	-	-	-
150 - Kodiak Island Borough	CHC	CHC	CHC		y
164 - Lake and Peninsula Borough	yes	yes	yes	y	
170 - Matanuska-Susitna Borough	yes (north); 2 CHCs	yes (north); 2 CHCs	2 CHCs		y
180 - Nome Census Area	yes	yes	yes	y	
185 - North Slope Borough	yes	yes	yes	y	
188 - Northwest Arctic Borough	yes	yes	yes	y	
201 - Prince of Wales-Outer Ketchikan Census Area	CHC (lost geo)	CHC	CHC	y	
220 - Sitka Borough	-	-	-	-	-
232 - Skagway-Hoonah-Angoon Census Area	yes	yes	yes	y	
240 - Southeast Fairbanks Census Area	yes	-	-		y
261 - Valdez-Cordova Census Area	Cordova geo (and CHC); CHC Copper Valley	2 CHCs	2 CHCs	y part (Copper Valley)	y part (Cordova; Whittier)
270 - Wade Hampton Census Area	yes	yes	yes	y	
280 - Wrangell-Petersburg Census Area	CHC	CHC	yes		y
282 - Yakutat Borough	yes	yes	CHC	y	
290 - Yukon-Koyukuk Census Area	yes	yes	yes	y	

 data from www.hrsa.gov March 3, 2009

<http://www.hpsafind.hrsa.gov/HPSASearch.aspx>

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.

 USDHHS HRSA: [More about shortage areas](#)

 Alaska Primary Care Office information: http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_Home.htm

"Yes" in HPSA columns means there is a "geographic" HPSA designation approved by HRSA Office of Shortage Designation, for all or part of the census area or borough.

"CHC" indicates there is at least one Community Health Center with automatic HPSA designation. Where geographic HPSAs exist, the geographic area score is generally higher than the CHC score. Most of the areas with geographic designations also have CHCs in one or more sites within the census area or borough.

Prepared by Health Planning and Systems Development Section, Health Care Services, Alaska Department of Health and Social Services 3/19/2009



2007 Alaska Health Workforce Vacancy Study Research Summary

Key Findings: Alaska is confronted by severe shortages of professional health workers, primarily in high-level primary care occupations that include Family Physician, General Internist, Critical Care Nurse, Nurse Case Manager, Family Nurse Practitioner, Physician Assistant, Pharmacist,

Dentist, Physical/Occupational/Speech Therapist, and Behavioral Health occupations. Shortages in RNs and Allied Health are much less acute. Most affected are rural areas and Tribal Health Organizations, though growth-driven high vacancy rates affect the Anchorage-Matsu region as well.

BACKGROUND

Alaska is confronted by a "perfect storm" of health professional shortages. The state has long suffered from a deficient "supply side" characterized by insufficient numbers of key health workers whose recruitment, retention and training have been impeded by Alaska's remoteness, harsh climate, rural isolation, low population density and scarce training resources. Now exacerbating this already difficult situation is a burgeoning "demand side" for increased health services for a steadily growing and aging population. The health services industry is the fastest growing sector of Alaska's economy, employing over 7% of the state workforce.

METHODOLOGIES

The key questions this study sought to answer were: What health occupations were at this time most critically affected by shortages? Exactly how many budgeted positions existed and how many of these currently remained unfilled? Where were these vacancies regionally and in what types of organizations? What did employers perceive to be the major underlying causes of their vacancies? How many new trainees/graduates could the job market actually absorb annually and how many organizations could absorb them?

Four hundred seventy-six (476) purposively sampled Alaska health service organizations of all types responded to the study survey (Figure 1). Survey data was used to generate estimates of positions and vacancies for the entire state of Alaska.

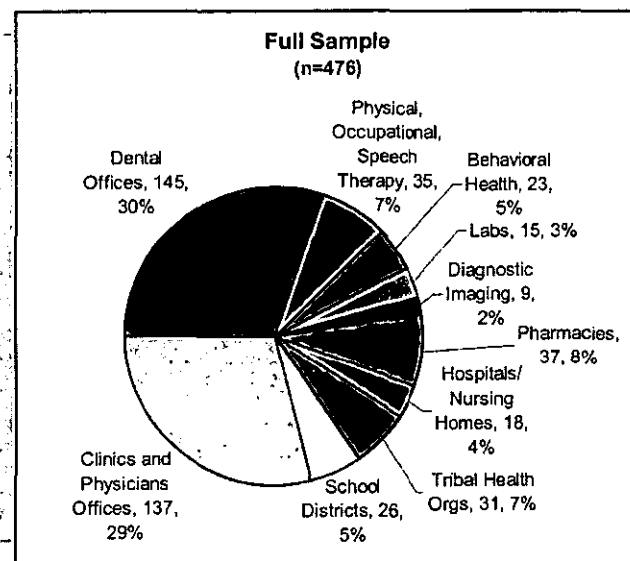


Figure 1

KEY FINDINGS

The findings confirm and quantify the trends cited in recent studies and accumulating anecdotal evidence: despite the recent progress in training and deploying health personnel, such as Registered Nurses, critical shortages persist (Tables 1,2).

The situation for key primary care occupations – Family Physician, General Internist, Nurse Practitioner, and Physician Assistant – was troubling, particularly in the rural areas, with numerous estimated vacancies and high estimated state vacancy rates between 15% and 20%.

Though vacancies for Psychiatrists were not numerous, they were particularly in demand (19.0% estimated vacancy rate) and difficult to recruit (mean vacancy length of 34.5 months).

This study was funded by the Office of Associate VP for Health, University of Alaska Anchorage, through Center for Disease Control and Prevention grant #5-H755-DP024673, and by the Alaska Mental Health Trust Authority.

The national Pharmacist shortage has hit Alaska hard and affects every region, with high estimated vacancy numbers (98), and an estimated vacancy rate of 23.7%.

Therapists of all kinds – Physical, Occupational, Speech, and Speech-Language Pathologists – were in short supply, with estimated vacancy rates ranging from 15.6% to 29.3%. No part of the state escaped the shortages; vacancy rates were most acute in rural areas, but numerically high in the Anchorage Mat-Su region.

High numbers of vacancies and high vacancy rates were reported for key specialized nursing occupations, particularly for Nurse Case Manager, Family Nurse Practitioner, and Critical Care Nurse. These appeared to be the current areas of most critical shortage in nursing.

The estimated Registered Nurse vacancy rate was moderate (8.0%), but this masked 10% rates in hospitals and tribal health organizations, and an estimated rural rate of 16.1%.

While the estimated vacancy rate for Dentist was 10.3%, this masked a 15.3% estimated rural rate and a very high 42.0% rate for tribal health organizations, which had 39% of estimated Dentist vacancies.

Table 2. Key occupations

Key Occupations (high numbers of vacancies, high vacancy rates)	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Family Physician	252	48	18.3%	675	107	15.8%
General Internist	71	15	21.1%	200	40	20.0%
Psychiatrist	36	10	27.8%	93	18	19.0%
Registered Nurse	3109	299	9.6%	5489	439	8.0%
Critical Care Nurse	497	43	8.7%	629	60	9.5%
Nurse Case Manager	136	42	30.9%	209	49	23.4%
Family Nurse Practitioner	155	36	23.2%	364	71	19.5%
Physician Assistant	207	32	15.5%	515	98	19.0%
Pharmacist	302	73	24.2%	413	98	23.7%
Physical Therapist	271	29	10.7%	510	84	16.5%
Dentist	319	47	14.7%	692	71	10.3%
Human Services Worker	1568	170	10.8%	4800	697	14.5%
Behavioral Health Clinician	297	35	11.8%	555	71	12.8%
Case Manager/Care Coordinator	505	52	10.3%	1163	164	14.1%
Physical Therapy Assistant	35	11	31.4%	62	18	28.6%
Medical Assistant	367	38	10.4%	1092	102	9.3%
CHA/P	552	100	18.1%	552	100	18.1%
Certified Coder	85	6	7.1%	209	22	10.6%
Medical Director	49	6	12.2%	120	18	14.8%
Behavioral Health Supervisor	82	13	15.9%	176	22	12.5%

Table 1. Occupational Groups

Occupational Groups	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
All Occupations	18158	1866	10.3%	34738	3529	10.2%
Physicians	730	109	14.9%	1931	226	11.7%
Professional Nurses	4202	462	11.0%	7139	696	9.8%
Other Nursing Staff	1769	135	7.6%	1762	111	6.3%
Professions/ Therapists	1240	217	17.5%	2281	404	17.7%
Behavioral Health	2938	327	11.1%	7450	1033	13.9%
Allied Health	3209	291	9.1%	5523	434	7.9%
Public Health/ Nutrition	154	18	11.7%	189	ND	ND
Other Primary Care (PA & CHAP)	759	132	17.4%	1067	198	18.5%
Managers	1337	69	5.2%	2947	160	5.4%
Health Information/ Reimbursement	1816	106	5.8%	4451	253	5.7%

In the Behavioral Health occupational group, the most acute shortages – with both extremely high vacancy numbers and high vacancy rates – appeared to be among Human Services Workers. In addition, overall estimated Behavioral Health occupation vacancies were extremely numerous (1033), around 29% of all estimated vacancies – more than any other occupational group.

Among Allied Health occupations, high vacancy rates were affecting employers of Physical Therapy Assistants and Respiratory Therapists. Sonographer vacancies were difficult to fill, and Surgical Technician vacancies, though not numerous, were averaging 3 to 4 years in length.

One hundred (100) vacancies and a vacancy rate of 18.1% were reported for Community Health Aide/Practitioners (CHA/Ps).

Among “front office” and “back office” occupations, Coding Specialist and Certified Coder had 11% estimated vacancy rates and very long mean vacancy lengths.

The managerial occupations for which high vacancy rates were reported were healthcare related: Behavioral Health Supervisor, Clinical Department Manager, Health Information Manager, Medical Director, Nurse Manager, and Practice Manager. Behavioral health organizations had the most estimated managerial vacancies.

Looking at respondent types, tribal health organizations reported the highest overall vacancy rate (16.5%). These organizations reported 87 CHA/P vacancies; approximately half of all estimated vacancies for Nurse Case Manager, Pharmacist, Chemical Dependency Counselor, Dentist, Medical Lab Tech, Medical Technologist, and Health Educator; and all the estimated vacancies for Coding Specialist. But every respondent type was a locus for acute shortages in key occupations, such as clinics/offices of physicians for PAs, hospitals/nursing homes for RNs, pharmacies for Pharmacists, behavioral health organizations for Human Services Workers, and school districts for Speech-Language Pathologists.

Higher vacancy rates were generally found in the rural respondents, particularly in the North/West and Southwest regions, which reported double digit vacancy rates for nearly all occupational groups, and overall vacancy rates of around 20% (Table 3, Figure

2). Occupations with much higher rural estimated vacancy rates included RN (6.9% urban, 16.1% rural), Behavioral Health Clinician (9.3% urban, 22.9% rural), Dentist (7.2% urban, 15.3% rural), Physical Therapist (13.5 urban, 31.6% rural), and PA (14.7% urban, 26.8% rural) (Table 4).

DISCUSSION

The "supply side" shortages apparently persist. "Inadequate Pool of Qualified Workers" was the top reason given for vacancies, cited by 54% of respondents, followed by "Transience/Moving Away" (28%), "Insufficient Compensation" (18%), and "Rural Isolation" (16%). Many tribal health organizations also reported "Insufficient/Expensive Housing" as a top reason for unfilled vacancies. The data also indicated a burgeoning "demand side," where shortages were exacerbated by population growth and an increased need and demand for health services, particularly in the high-growth Anchorage Mat-Su region.

Table 3. Regional vacancy rates

Occupational Group	Regions (Study Sample - n=476)						
	North/West (n=10)	Southwest (n=17)	Interior (n=72)	Anchorage Mat-Su (n=232)	Gulf Coast (n=69)	Southeast (n=70)	Statewide/Multiregional (n=6)
Physicians	26.7%	21.2%	21.6%	12.6%	10.4%	6.8%	30.3%
Professional Nurses	26.0%	21.6%	5.9%	11.1%	8.0%	5.9%	12.1%
Other Nursing Staff	18.6%	18.8%	5.8%	6.2%	4.6%	2.3%	8.8%
Dentists/Pharmacists/Therapists	32.4%	32.4%	20.7%	15.9%	16.5%	16.3%	12.4%
Behavioral Health	19.0%	22.7%	13.1%	8.3%	7.1%	11.1%	11.6%
Allied Health	17.0%	24.6%	7.3%	6.5%	8.4%	7.7%	8.6%
Public Health/ Nutrition	30.0%	6.3%	0.0%	4.0%	18.9%	0.0%	10.5%
Other Primary Care (PA & CHA/P)	19.7%	18.6%	24.5%	9.0%	9.1%	4.0%	0.0%
Managers	13.8%	2.4%	3.5%	3.2%	6.4%	11.7%	4.0%
Health Information/ Reimbursement	15.9%	16.9%	2.0%	5.3%	6.6%	2.8%	7.2%
All Occupations	20.1%	20.3%	9.0%	8.6%	8.1%	7.7%	10.2%

Table 4. Urban vs. Rural vacancies and vacancy rates

Occupation	Urban		Rural	
	Estimated Vacancies	Estimated Vacancy Rate	Estimated Vacancies	Estimated Vacancy Rate
Family Physician	68	14.9%	38	17.6%
General Internist	27	18.8%	13	23.1%
RN	339	6.9%	94	16.1%
Family Nurse Practitioner	36	13.3%	34	36.4%
Pharmacist	68	22.7%	30	25.9%
Behavioral Health Clinician	36	9.3%	34	22.9%
Human Services Worker	158	8.5%	209	10.1%
Dentist	32	7.2%	38	15.3%
Dental Hygienist	14	3.6%	17	10.0%
Dental Assistant	27	4.4%	64	14.9%
Physical Therapist	59	13.5%	26	31.6%
PA	50	14.7%	47	26.8%
All Occupations	1998	8.1%	1162	13.3%

Many respondents provided commentary with their surveys and noted positions that are particularly difficult to fill:

- "We have been hiring travelers for Physical Therapy positions at \$67/hr - we can't find therapists to employ. We have been looking for 2 years." (Urban Medical Clinic).
- "Without a state Physical Therapy program it is very difficult to get PT staff. Usually this area is staffed by PTs that leave competing PT clinics." (Urban Physical Therapy Office)
- "We really need a pharmacy school in Alaska. It took two years to fill our last pharmacist position." (Urban Pharmacy)
- "Pharmacists are always the most difficult position to fill." (Rural Pharmacy)

The availability of military spouses has apparently alleviated some of the workforce pressure, but has exacerbated the “transience” problem. Also affecting the shortages was the absence of local training resources (such as medical, dental, pharmacy, and therapy schools) to provide a local workforce pipeline. In the qualitative data, common refrains were, “we need a pharmacy school,” “we need a dental school,” “we need a physical therapy school.”

The acuity of workforce shortages was also reflected by the high percentage of estimated vacancies the responding employers would consider filling with new grads (Table 5). Respondents indicated that they had the capacity to hire sizeable graduating cohorts of Family Physicians, PAs, Occupational and Physical Therapists, Pharmacists, and Dentists. These may be the occupations likely to yield optimal responses to substantial investments in preparation and training programs and/or targeted recruitment and retention campaigns.

Copies of the full study can be downloaded from the ACRH website at:

<http://nursing.uaa.alaska.edu/acrh/>

Table 5. New Grad Vacancies

Occupation	Study Sample (n=476)	Statewide Estimate
Human Services Worker – HS diploma	68	266
Registered Nurse	93	226
Human Services Worker – AA degree	47	195
Case Manager/Care Coordinator	37	120
Family Physician	25	89
CHA/P	88	88
Pharmacist	46	84
Medical Assistant	21	84
Physician Assistant	23	80
Occupational Therapist	21	75
Dental Assistant	26	75
Dentist	27	67
Physical Therapist	23	62
Speech-Language Pathologist	28	53
Behavioral Health Clinician	19	53

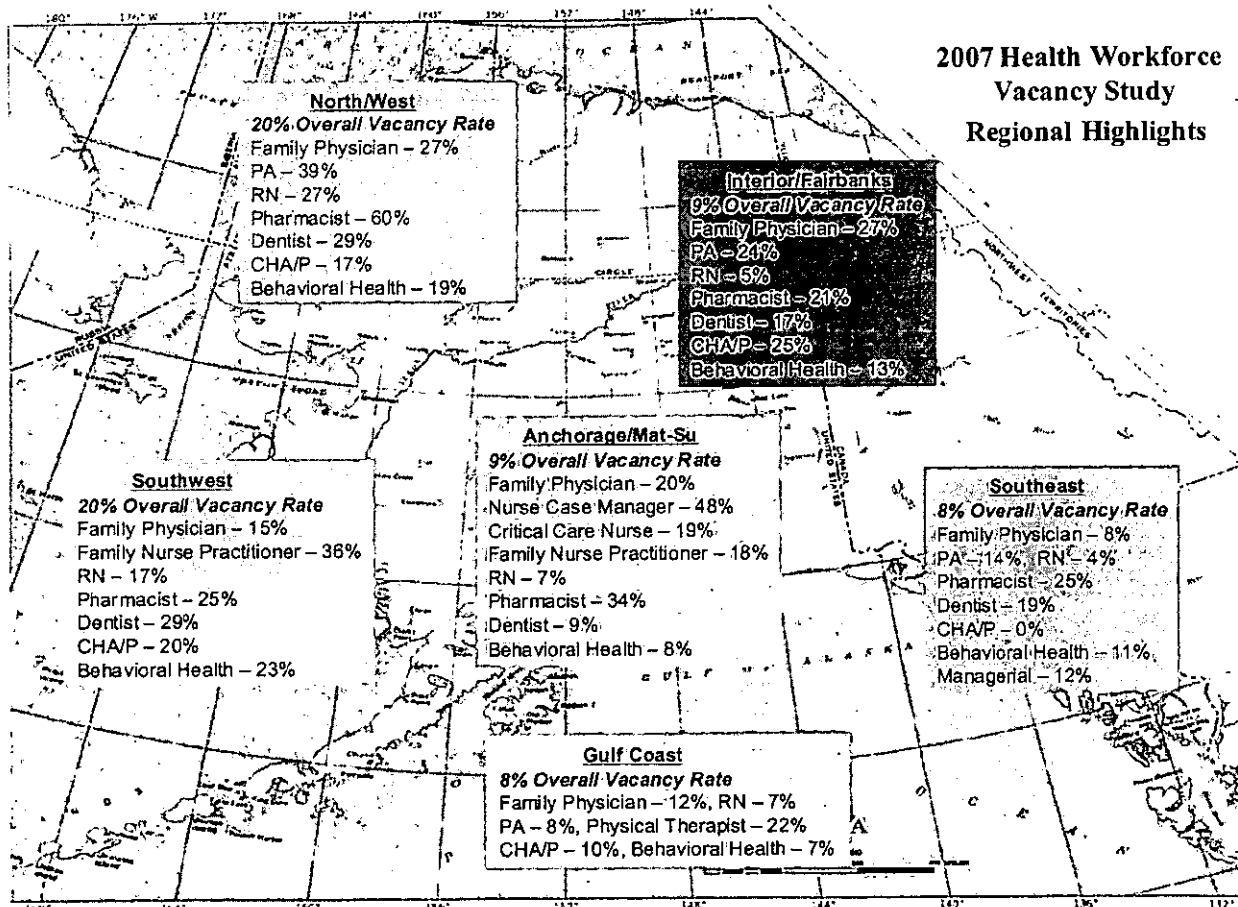


Figure 2. Regional Highlights

How Hard Is It for Alaska's Medicare Patients to Find Family Doctors?

By Rosyland Frazier and Mark Foster

UA Research Summary No. 14 • March 2009

Institute of Social and Economic Research • University of Alaska Anchorage

In the past few years, Alaskans have been hearing reports that some primary-care doctors won't see new Medicare patients. Medicare pays these doctors only about two-thirds of what private insurance pays—and that's after a sizable increase in 2009. But most Americans 65 or older have to use Medicare as their main insurance, even if they also have private insurance. Just how widespread is the problem of Alaska's primary-care doctors turning away Medicare patients? ISER surveyed hundreds of doctors to find out—and learned that so far there's a major problem in Anchorage, a noticeable problem in the Mat-Su Borough and Fairbanks, and almost no problem in other areas.

Medicare is the federal health insurance program for older Americans and for some younger people with disabilities. At issue is what Medicare pays primary-care doctors for their services—not what it pays for other medical costs. Alaska's 50,000 Medicare enrollees are almost all in the "fee for service" plan, which pays doctors standard fees for their services.*

Why is it so worrisome if primary-care doctors won't see Medicare patients? These are the doctors who provide broad care, track patients' overall health, and coordinate care with specialists. That's very important for older people, who often have various medical problems and chronic conditions. And the number of Alaskans over 65 is growing fast—it's expected to double in the next 15 years.

To learn how hard it is for older Alaskans to find primary-care doctors, in 2008 we tried to survey all those who could see the general population of Medicare patients. We were able to interview 229 doctors or their staffs—about 85% of those we tried to reach.

But Medicare payments for Alaska doctors increased in 2009, thanks to efforts of Alaska's U.S. senators. So we recently called back the doctors who had told us they weren't taking new Medicare patients. None of them had opened their doors to significant numbers of new Medicare patients. Four said they now see a very limited number of new Medicare patients, under special circumstances. Two doctors in a joint practice who still didn't see new Medicare patients had hired a nurse practitioner who did.

It's certainly also possible that without the 2009 increase, even more doctors would have decided not to see Medicare patients. Figure 1 shows what our 2008 and 2009 surveys found.

It's mainly doctors in Alaska's larger urban areas who are declining to see new Medicare patients. But that's where the majority of older Alaskans live. Most doctors (even in Anchorage) will still see established patients—that is, patients they've seen in the past.

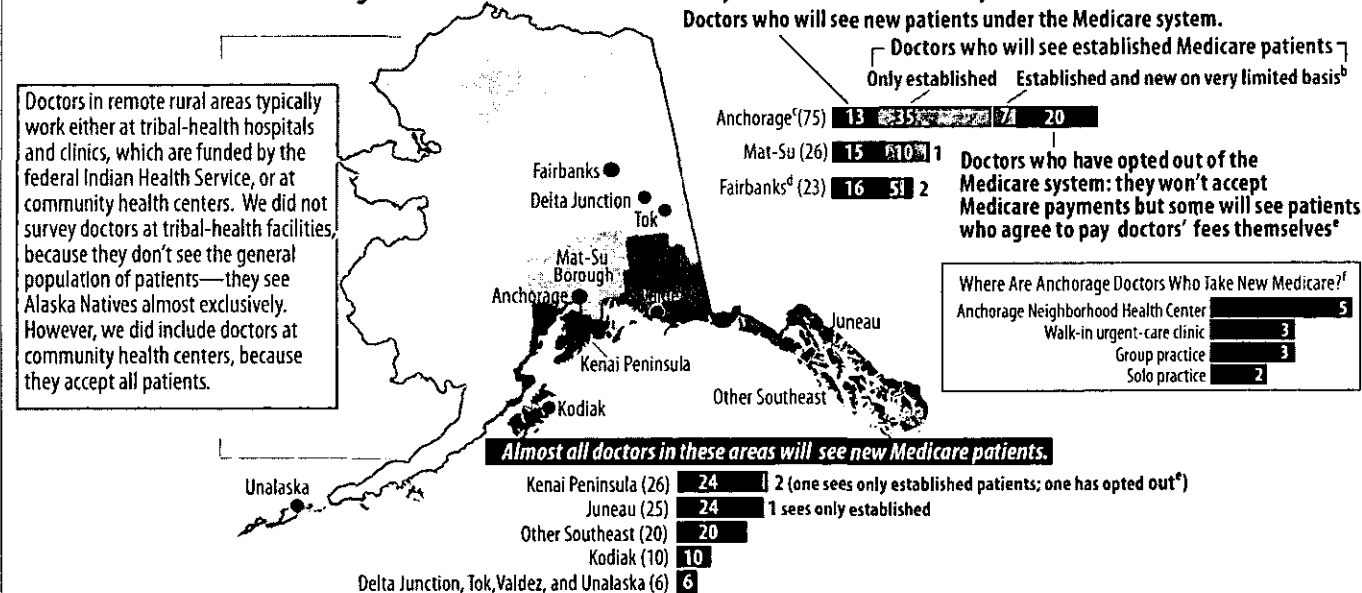
Almost all doctors in smaller communities take new Medicare patients. Rural places have few doctors—so doctors probably feel more of an obligation to see all patients. For patients (Medicare or otherwise) in rural Alaska, the challenge is more likely to be recruiting and keeping doctors.

One in ten doctors we surveyed has opted out of the Medicare system. Most are in Anchorage. They will not accept Medicare payments, but some will see patients who agree to pay the entire doctor's bill themselves.

The Anchorage Neighborhood Health Center, which accepts all patients, saw twice as many Medicare patients in 2007 as in 2001. It has become the only choice for many of Anchorage's Medicare patients.

Medicare patients are not relying more on emergency rooms, if figures for Providence Hospital's emergency room in Anchorage are typical. Numbers of Medicare patients there haven't changed much in the past several years.

Figure 1. Medicare Policies of Primary-Care Doctors We Surveyed^a



^aIn 2008 we surveyed 229 doctors; 15 weren't taking any new patients at all; 3 had no Medicare patients. In 2009 we re-surveyed doctors who didn't take new Medicare patients in 2008. ^bTen doctors (7 in Anchorage, 2 in Fairbanks, 1 in Mat-Su) accept a few new Medicare patients under special circumstances, but don't typically see new Medicare patients. ^cIncludes Eagle River/Chugiak. ^dIncludes North Pole. ^eSee Figure 9. ^fSee page 3.

*Nationwide, 21% of beneficiaries have enrolled in Medicare Advantage programs—which means they become members of private health plans, and Medicare then pays the plans a set monthly amount for each Medicare enrollee.

SURVEY OF PRIMARY-CARE DOCTORS

We surveyed only primary-care doctors. So far there hasn't been any sign that specialists are declining to see Alaska's Medicare patients—not surprising, since Medicare tends to pay them closer to private-insurance rates.

We first had to determine how many doctors fit our survey criteria: those who currently practice general, family, or internal medicine at least 20 hours a week and who could see the average Medicare patient, if they chose to.

About 700 primary-care doctors are licensed in Alaska, but most aren't available to see the general population of Medicare patients. Hundreds work for government agencies, are in public health, or see only specific groups (Figure 2).

Among those who didn't fit our criteria are doctors working for tribal-health facilities that provide Indian Health Service programs for Alaska Natives. These doctors do see Alaska Native Medicare patients.

We estimated that 264 doctors were left, after we took out those who didn't fit our criteria. In 2008 we tried to reach all 264. We were able to talk with about 85%—229 doctors or their staffs. We asked them to tell us their policies for seeing Medicare patients and to rank reasons why they might be limiting or turning them away. The top reason they cited was "inadequate reimbursement"—that is, Medicare payments aren't enough to cover the costs of seeing patients.

We also followed up, in 2009, with doctors who had told us in 2008 that they weren't taking new Medicare patients. We reached all but two.

MEDICARE VERSUS PRIVATE INSURANCE

The federal Center for Medicare and Medicaid Services (CMS) calculates Medicare payments for doctors under a complex formula that takes into account geographic differences in costs around the country. Alaska's doctors have historically been paid more than the U.S. average for seeing Medicare patients.

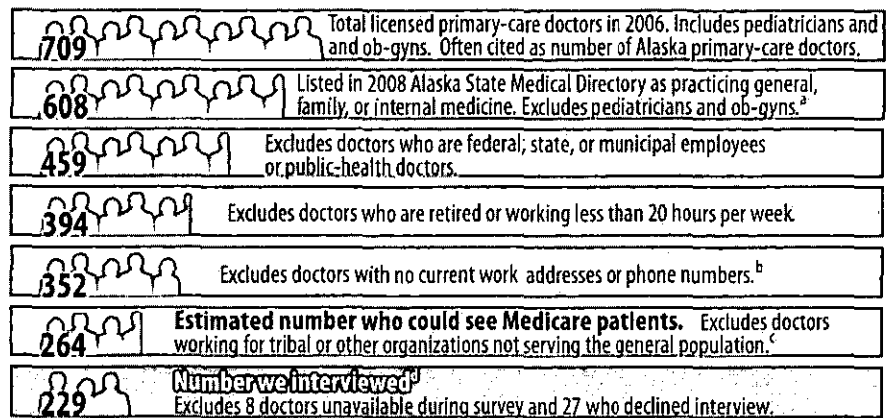
The CMS formula actually includes three geographic differentials: one for "physician work" itself, one for doctors' costs of operating practices, and one for doctors' costs of carrying liability insurance.

In 2008, Congress set the Alaska geographic differential for "physician work" at 50% above the U.S. average, effective in 2009. Alaska's U.S. senators Lisa Murkowski and Ted Stevens were instrumental in gaining that increase for Alaska doctors. But combined with the other differentials—set by CMS—the overall Medicare geographic differential for Alaska doctors in 2009 is 29% above the U.S. average. Figure 3 shows the differential since 2000.

• From 2000 to 2003, the geographic differential for Alaska doctors was about 12% above the U.S. average. That differential was set entirely under CMS's administrative process.

• In 2004 and 2005, the differential for Alaska doctors jumped to 67% above the U.S. average. Ted Stevens, at that time Alaska's senior U.S. senator, spearheaded the legislation that led to the substantial but temporary increase. In those two years, Medicare paid Alaska doctors as much as private health insurance (Figure 4).

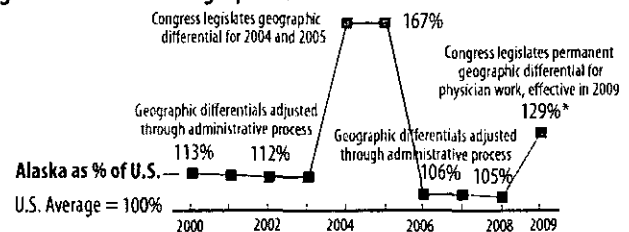
Figure 2. How Many Primary-Care Doctors Are Available to See Medicare Patients?
(Among Alaska Doctors Practicing General, Family, or Internal Medicine at Least 20 Hours per Week)



^aWe excluded pediatricians and obstetrician-gynecologists, who are often included in definitions of primary-care doctors, because they don't routinely see older patients. ^bAbout 42 doctors were not at the addresses and phone numbers in the medical directory. We tried but weren't able to find them, and we assume they have left the state or are not practicing. ^cWe excluded doctors working for tribal-health organizations, the military, the Veterans' Administration, and Planned Parenthood, because they don't see the general population of Medicare patients. Doctors who work for tribal-health facilities do see Alaska Native Medicare patients. ^dWe interviewed either doctors or members of their staffs.

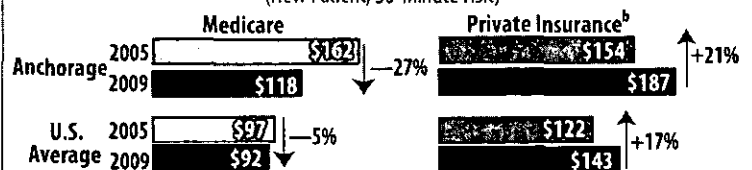
- After that legislation expired, the Medicare differential dropped sharply, to about 5% above the U.S. average from 2006 to 2008.
- In 2009, the cost differential for Alaska doctors climbed to 29% above the U.S. average, due to new federal legislation—as we just discussed. But Medicare still pays doctors less now than it did in 2005 (Figure 4).
- Medicare pays about two-thirds of what private insurance pays, in Alaska and on average nationwide. (But in the adjacent markets of Washington state, Medicare pays 68% to 75% of what private insurance pays.)
- That nationwide gap helps explain why more Medicare patients are having trouble finding doctors. Recent national surveys sponsored by the Medicare Payment Advisory Commission found that 17% of Medicare patients in the U.S. had "a big problem" finding family doctors in 2007, up from 13% in 2005. Alaska may be the harbinger of a national trend.

Figure 3. Medicare Geographic Cost Differential* for Alaska Doctors



*This is a weighted average of three geographic cost differentials the Center for Medicare and Medicaid Services uses in a complex formula that determines what doctors are paid. One of those is the differential for "physician work," and Congress set that at 150% of the U.S. average for Alaska doctors, effective in 2009. But the other differentials—for physicians' costs of operating their practices and for carrying liability insurance—are set by CMS and can vary from year to year. Source: Center for Medicare and Medicaid Services; Medicare Payment Advisory Committee

Figure 4. Medicare and Private Insurance Payments^a To Primary-Care Doctors, Anchorage and U.S. Average, 2005 and 2009
(New Patient, 30-Minute Visit)



^aFigures include the amount Medicare or private insurance pays and the amount the patient pays. ^bMedian payments. Source: Ingenix National Fee Analyzer

WHERE ARE THE MEDICARE PATIENTS?

Nearly 70% of non-Natives over 65 live in Anchorage, the Mat-Su Borough, and the Fairbanks area. Figure 5 shows only where older non-Natives live, because older Alaska Native patients have access to doctors through tribal-health care facilities. For them, the issue is not that doctors won't see them but that there may not be enough doctors, especially in rural areas.

WHO ACCEPTS MEDICARE PATIENTS?

Besides the doctors who will see new or established patients, some doctors have made another choice: they've opted out of the Medicare system. They don't accept any Medicare payments (see Figure 9), but some will see Medicare patients who agree to pay the doctor's fee themselves. Patients who can do that have more choices. But for those who need Medicare to help pay the bill, the access problem is the worst in Anchorage.

We found only 13 primary-care doctors seeing the general population of new Medicare patients in Anchorage. Of those, 3 were at walk-in, urgent-care clinics, which mostly just treat minor injuries and illnesses (Figure 1).

Five of the 13 Anchorage doctors seeing new Medicare patients in 2008 were at the Anchorage Neighborhood Health Center. That's one of dozens of federally funded community health centers in Alaska. There are hundreds more across the U.S. These centers are open to everyone, but they are mainly for medically "under-served" groups of people—poor and uninsured, for instance—or areas of the country without adequate local medical care, like many of Alaska's rural communities.

The Anchorage Neighborhood Health Center is the main choice for growing numbers of Medicare patients. Both the number of Medicare patients coming to the clinic and the percentage they make up of all patients doubled between 2001 and 2007 (Figure 6). That growth did flatten out in 2004 and 2005, when Medicare paid doctors at a level comparable to private insurance. But after that, the numbers climbed. (In Fairbanks, the community health center saw a similar percentage increase. In the Mat-Su Borough, a health center just opened in 2005, so data are limited.)

Until recently there was another choice for Anchorage's Medicare patients—the Alaska Family Medicine Residency Program, where some family doctors get their final phase of training. These resident doctors see patients, and they had been accepting growing numbers of Medicare patients. But to make sure the residents see a variety of patients, the program has now capped the number of Medicare patients it accepts.

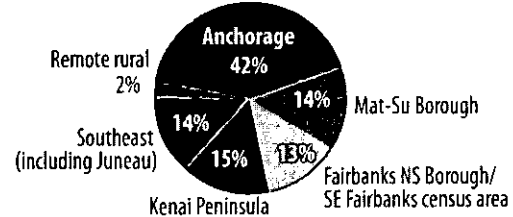
Anchorage's Medicare patients don't seem to be turning more to emergency rooms. Data from Providence Hospital's emergency room show that visits by older patients have stayed mostly steady, with seasonal variations, since 2004 (Figure 7). But some health-care providers think that Medicare patients may be postponing care they need and coming in only when medical problems get much worse.

MEDICARE PAYMENTS TO DOCTORS AND TO HEALTH CENTERS

Medicare pays doctors and community health centers differently. Some people believe that Medicare uniformly pays health centers more than it pays private doctors, making it more feasible for health centers to see Medicare patients. But the reality is more complex.

Medicare pays health centers the same fee for seeing Medicare patients for any visit, but private doctors more for longer, more complex visits. Figure 8 compares payments for 30- and 60-minute visits with new patients, at doctors' offices and the Anchorage Neighborhood Health Center (ANHC). For a 30-minute visit, Medicare pays ANHC \$119 and doctors about \$95. But for a 60-minute visit, it still pays ANHC \$119, but the doctors \$189.

Figure 5. Where Do Non-Native Alaskans Over 65 Live?
(2006 Estimate: 38,227)

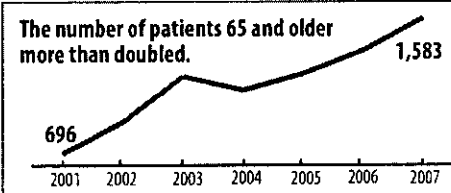


Source: Alaska Department of Labor, Research and Analysis section, 2006 bridge estimates

Figure 6. Growth in Number of Patients 65 and Older at Anchorage Neighborhood Health Center, 2001-2007

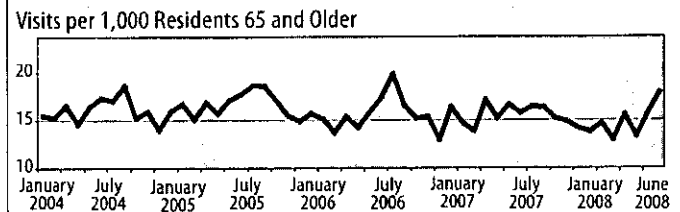
Patients over 65 jumped from 6% to nearly 14% of all patients who came to the clinic.

Year	Percentage
2001	6%
2007	13.5%



Source: Uniform Data System Reports, U.S. Department of Health and Human Services, Health Resources and Services Administration

Figure 7. Visits to Providence Hospital's Emergency Room in Anchorage, Patients 65 and Older, 2004 to 2008



Source: Providence Alaska Medical Center

Figure 8. Medicare and Patient Payments to Private Doctors and Anchorage Neighborhood Health Center, 2009

Visit Type	Provider	Payment	
		Medicare	Patient
30-minute visit	Doctor	\$94.90	[\$23.72 ^a] = \$118.62
	ANHC	\$119.28	[\$39.60 ^b] = \$158.88
1-hour visit	Doctor	\$189.56	[\$47.39 ^a] = \$236.95
	ANHC	\$119.28	[\$76.20 ^b] = \$195.48

^aPatient co-pay: 20% of total payment. ^bFacility fee charged to patient, but many are not able to pay full charge. Patients with incomes up to 200% of federal poverty line pay on a sliding fee scale.

Sources: Anchorage Neighborhood Health Center; Ingenix National Fee Analyzer

What Medicare patients pay at health centers and at doctors' offices is also determined in different ways. Essentially, Medicare allows the health centers to take their own fees into account when determining what patients are charged. But Medicare doesn't allow doctors to use their own fees; instead, Medicare sets a maximum allowable charge for specific kinds of visits, and patients pay a portion of that (see Figure 9).

Neither ANHC nor the doctors' offices necessarily collect the amounts shown in Figure 8 as payments from patients. At ANHC, patients with incomes up to 200% of the federal poverty line are charged on a sliding fee scale. Likewise, private doctors may not always be able to collect the patient's share. And both private doctors and ANHC report losing money when they see Medicare patients.

DOCTORS AND THE SYSTEM

Primary-care doctors who see Medicare patients have three choices for getting paid. Figure 9 describes those choices among doctors we surveyed.

About 85% choose the standard Medicare process ("participating"). Another 4% still work with the Medicare system but charge patients somewhat more ("non-participating"). The final 11% have opted out of the Medicare system, but will still see patients who agree to foot the bill.

Patients also pay different amounts, depending on their doctors' policies. For a service with an allowable Medicare fee of \$100, patients seeing doctors who accept that fee would pay \$20—but only after Medicare paid the other \$80. Patients seeing "non-participating" doctors would pay the doctors \$109.25; Medicare would later reimburse the patients \$76, so their final cost would be \$33.25. Patients seeing doctors who have opted out of the Medicare system would pay a fee determined by the doctor—perhaps a negotiated fee, but still typically more than Medicare pays.

CONCLUSION

With few exceptions, Americans 65 or older who are retired have to use Medicare as their primary insurance—even if they also carry private health insurance or have retirement benefits that include health-care coverage. Any other insurance they have can *only* be used to help pay *their share of the allowable Medicare charge*. They can't use private insurance to pay doctors more than Medicare allows.

As more Alaskans turn 65, the access problem will get worse, unless something changes. Growing numbers of Medicare patients around the country are also reporting access problems. And the American College of Physicians has reported that a nationwide shortage of primary-care doctors is looming—which would make the problem even worse.

This summary talks about just a very narrow slice of the multitude of issues facing Medicare. It's one of the largest and fastest-growing federal programs, and President Obama has said reforming it will be part of his plan to improve the U.S. health-care system. How potential reforms might affect Medicare patients' access to family doctors isn't clear today.

Because Medicare is a federal program, the state's options for helping improve access are limited. But Alaskans are talking about various possibilities—like recruiting more doctors and offering them bonuses to see Medicare patients, and either establishing an Anchorage clinic for Medicare patients or expanding the Anchorage Neighborhood Health Center.

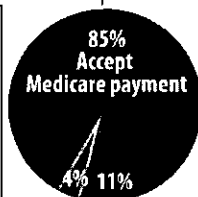
In a publication later this year, we'll look at the implications of various ways of trying to improve access for Medicare patients. We'll also report what family doctors themselves told us—how they make decisions about seeing Medicare patients and what might make them willing to see more.

Figure 9. How Do Alaska Primary-Care Doctors Who See Medicare Patients Deal with the System?

(Among 211 Surveyed Who See New or Established Patients)

Most doctors accept standard Medicare fees and bill Medicare. They are called "participating." Medicare sets maximum allowable charges for various services. Participating doctors agree not to charge more than the allowable rate, and Medicare pays them 80% of that. The patients (and their secondary insurance, if they have any) pay the other 20%.

A few doctors (called non-participating) can charge up to 9% more than the allowable Medicare charge. But Medicare pays less and patients pay more. Here's how it works. The patient pays the entire bill, but the doctor submits a statement to Medicare so the patient is paid for the Medicare share. But instead of paying 80% of the charge, Medicare pays only 76%. The patients (and their secondary insurance, if they have any) pay the rest of the bill.



Some doctors don't accept Medicare payments for their fees. They are said to have "opted out." They will still see Medicare patients, but patients must agree to pay a fee the doctor sets. Medicare doesn't pay either doctors or patients, and patients can't bill any secondary health insurance they may have. Remember that patients pay only the fee for the doctor. They still use Medicare to help pay hospital and other medical costs. Doctors who opt out have to re-confirm their decision with Medicare every two years. They can also apply to come back into the system after two years.

Example: How Much Would Patients Pay for a Service with an Allowable Medicare Charge of \$100?

	Participating Doctors Charge \$100	Non-Participating Doctors Can Charge \$109.25	Doctors Who Have Opted Out Can Set Their Own Fees
Medicare pays	\$80	\$76	\$0
Patient pays	\$20 ^a	\$33.25 ^b	Entire doctor's fee ^b

^aPatients can bill secondary insurance to help pay their share. ^bPatients can't bill secondary insurance to pay any amount.

Sources: American Academy of Family Physicians; Government Accountability Office

Figure 10. Alaska Medicare Enrollment, 2005

People 65 and older **41,469 (81%)**
 People with certain disabilities **9,612 (19%)**

Source: Alaska Department of Health and Social Services, Alaska Health Care Data Book 2007

Figure 11. Non-Native Alaskans 65 and Older

1960 **4,085**
 1980 **8,193**
 2000 **31,467**
 2006 **38,227**
 Projected
 2020 **86,112**

Sources: U.S. Bureau of the Census; ISER estimates based on census data; Alaska Department of Labor, Research Analysis, 2006 estimates and mid-range 2020 projections

Back-up materials for figures in this summary are available from ISER. Call the authors at 907-786-7710 with questions. We've also developed a basic model that doctors—or anyone else—can use to estimate how changing the balance between patients paying with Medicare and with private insurance could affect doctors' revenues. To try that model, go to ISER's Web site:

www.iser.uaa.alaska.edu

The authors thank the doctors and others in health care who took the time to help us. We especially thank doctors Leslie Bryant, Richard Neubauer, and Thomas Nighswander; Joan Fisher of the Anchorage Neighborhood Health Center; James Jordan of the Alaska State Medical Association; and Providence Alaska Medical Center, Providence Health and Services - Alaska.

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Editor: Linda Leask

Graphics: Clemencia Merrill



Summary of SB 139 / HB 392 Proposal for Alaska: Health Care Professions Loan Repayment & Incentive Program



The following organizations support the loan repayment and incentive solution in SB 139 / HB 392 Incentives for Certain Medical Providers:

Alaska State Medical Association
 • Alaska Dental Society •
 Alaska Primary Care Association •
 Alaska Osteopathic Medical Association • Alaska State Hospital and Nursing Home Association • Alaska Mental Health Trust Authority • Alaska Native Health Board • Alaska Pharmacists Association •
 Alaska Physical Therapy Association • AARP-Alaska • Advisory Board on Alcoholism and Drug Abuse • Alaska Behavioral Health Association • Alaska Mental Health Board • Alaska Mental Health Trust Authority • Alaska Public Health Association • Alaska Hygienists Association • Commonwealth North • Iliuliuk Family and Health Services, Inc. • Maniilaq Association • Municipality of Anchorage Senior Citizens Advisory Board • Mary Willard, DDS, Clinical Site Director, Alaska Native Tribal Health Consortium • Alaska Chapter National Association of Social Workers • Nome Eskimo Community • SEARHC • School of Social Work- UA • Dental Hygiene Program- UA • Sunshine Community Health Center

Problem:

Having a sustainable and competent practitioner workforce is vital to the health of Alaskans. However, Alaska is at a serious disadvantage as it competes in the national health care labor market. In other states, "support-for-service programs" (SFSPs) have shown substantial and long-standing success as a cost-effective public strategy to address workforce shortages (e.g., loan repayment and direct incentive). A key problem is that Alaska does not have a robust SFSP while 44 other states have one or more SFSPs.

Solution:

The Health Care Professions Loan Repayment and Incentive Program (HCPLRIP), as outlined in Senator Olson's SB 139 and in Representative Herron's HB 392 will make Alaskan health care employment competitive and attractive enough for practitioners to want to work in Alaska, particularly in hard-to-fill localities. State funds will be used to insure that Alaskans with the greatest difficulty in obtaining care due to limited financial resources, cultural barriers, and geography will have access to professional health care services.

Program Description:

1) **Oversight Entity**

- Health Planning and Systems Development, Department of Health & Social Services will serve as the Oversight Entity.
- DHSS Commissioner will appoint a HCPLRIP Council to make recommendations regarding program administration & this Council will serve as primary communication between providers and program administrators.

2) **Fiscal Agent**

- Alaska DHSS will serve as Fiscal Agent. DHSS will make loan payments directly to eligible lenders and incentive payments directly to practitioners.

3) **Practitioner Eligibility**

- DHSS Commissioner will annually prioritize the 10 eligible practitioner types:
 - Tier-1: Dentists, Pharmacists, Physicians (MD and DO)
 - Tier-2: Dental Hygienists, Nurse Practitioners, Nurses (RN), Physical Therapists, Physician Assistants, Psychologists, Social Workers (LCSW)
- A practitioner's clinical duties must constitute at least 50% of duties to be eligible.
- A part-time practitioner may participate and be eligible for pro-rated payments.
- Practitioners are not eligible while fulfilling other service obligations (NHSC or IHS loan repayment, WWAMI obligations, service-option scholarships, etc.) but may subsequently participate in the program.
- Preference may be given to current Alaskan residents.

4) **Site Eligibility:**

- DHSS Commissioner will rank eligibility of sites annually and determine any area and/or population in Alaska as a “shortage priority.” These may include, but are not limited to, federally defined Health Professional Shortage Areas.
- Preference will be given to sites that provide care to individuals regardless of their ability to pay, including persons who are uninsured or have Medicare and/or Medicaid.

5) **Payment Detail:**

- Placement Type

	Regular	Hard-to-Fill
○ Tier 1:	up to \$35,000/year	up to \$47,000/year
○ Tier 2:	up to \$20,000/year	up to \$27,000/year
- Payment details are same for two component types: loan repayment and incentives.
- Duration of award is for a 3-year period of service.
- Payments will be made every quarter following a completed full quarter of service.
- A program practitioner in good standing may re-apply for a 2nd period of service.
- Lifetime participation cap is six years regardless of component type.

6) **Program Evaluation:**

- The Oversight Entity will conduct annual survey of program practitioners, exit interviews, and tracking of alumni.
- The Oversight Entity will develop measures to make workforce projections, according to practitioner type category and may assess sustainability, cost-benefit issues, and rural and remote benefits of program.
- The Oversight Entity will develop evaluation policy and procedures.
- The HCPLRIP Council will adopt an evaluation plan within 12 months of initial program funding and amend annually.
- HCPLRIP will assess adequacy and distribution of the Alaska health care workforce for all program eligible-practitioner types annually.
- The Commissioner will report to the Legislature every three years whether payments are adequate to meet program goals. The Oversight Entity will have specified discretion based on HCPLRIP Council’s review of report to adjust payment rates.

7) **Funding:**

- An in-cash “employer match” is required and is paid annually by eligible sites to DHSS. The level of required match will be adjusted according to the ability of the eligible site to contribute and may be set between 0% and 100%
- Program funds will not be used to offset current or expected provider supports.
- Funding will be provided to allow DHSS to (1) conduct program management; (2) monitor placements & practice environments; (3) resolve placement issues; and (4) assess the statewide health care workforce regarding the program practitioner types.
- Proposed total funding for FY11 is \$2.7 million. A total of \$7.1 million, expensed across 3 years, will fund at least 90 participants for 3-year contracts; that is, approximately 9 practitioners (at least) in each of 10 occupational categories.

Health Care Professions Loan Repayment Program

Concept Proposal

Submitted by
Pat Carr, Chief
Health Planning & Systems Development
Department of Health & Human Services
State of Alaska

on
September 11th, 2007

via
PCC Workforce Subcommittee

to
Alaska Primary Care Council

Health Care Professions Loan Repayment Program

Summary

Problem

Alaska is competing with other states and nations for the finite pool of available healthcare professionals. This competition will only intensify since the growth of supply is continuing to fall behind that of demand.

A common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSP's). Good outcomes have been achieved with these. There are five types: scholarships, service-option loans, loan repayment, direct financial incentives, and residency support programs. All SFSP's have the same public goal: To improve healthcare staffing in shortage areas. National studies have determined loan repayment programs to be one of the most effective of the several support-for-service strategies - in terms of both recruitment and retention (see: *HCPLRP: Issue Paper, 2007*)

A key problem is that Alaska does not have a robust support-for-service program while most other states do, many have several, and further, some of those are growing. In sum, Alaska is at a substantive disadvantage as it necessarily competes in the national healthcare labor market.

Discussion

Alaskan health care provider agencies use many approaches to recruit and retain staff. This has proved difficult, however, and particularly so where (1) federal loan repayment programs do not apply, or, (2) there is insufficient resource available to meet need. More tools are needed to confront the problem of steadily growing vacancies in the Alaskan healthcare workforce.

Most all other states have state-sponsored programs that influence health professionals' geographic and specialty distributions. Programs that integrate a number of strategies for attracting and retaining health professionals have had a greater likelihood of success than have programs which rely on a single strategy. Substantial evidence indicates that state-level support-for-service programs typically are a fundamental part of those strategies.

Support-for-Service Programs

It is well-established that many healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away. For instance, in 2004, young physicians' educational debt averages stood at over \$109,000 and this cost was increasing at the rate of more than \$4,000 per annum.

There are several types of support-for-service programs. One of the two most common types of such programs is the service-requiring scholarship program. These pay tuition and other costs for healthcare students while obligating them to a period of service that begins when they complete residency (or similar post-graduate training) years later. The other common program type is loan repayment. Loan repayment programs recruit healthcare practitioners as they complete their training and are ready to begin service in exchange for paying off the traditional education loans

they acquired years earlier. Programs of both types typically require one year of service for each year of training cost support they provide.

Considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel. Overall, 81 state-level programs were identified. There were 44 states with at least one program (88% of states). Fully 21 states had two or more programs (47%), with highs found in New Mexico (at 5) and Minnesota (at 7). On average, the 44 states had nearly two programs (1.8) each.

Loan Repayment Programs

In national studies, loan repayment has been found to be a successful strategy to recruit and retain health care professionals. Twenty-five years of program evaluations have clarified many of the outcomes possible from healthcare training support-for-service programs. Furthermore, studies have demonstrated that loan repayment programs, as a whole, have better outcomes than scholarship programs. Studies have shown that there are several benefits which can accrue from loan repayment programs. Selected examples include: (a) high position-fill rates, (b) high service-completion rates, and (c) high retention rates.

These programs are successful because the benefit of loan repayment is clear to potential applicants, and programs typically only provide payments to participants after they complete each 3 or 6 months of work; therefore, if a participant leaves or otherwise fails to work in the agreed upon area or practice, payments simply stop and there is no need to enforce penalties.

In 2006, the Alaska Physician Supply Task Force recommended a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need. One of the PSTF findings was that loan repayment is a proven strategy for recruiting physicians, and the federal loan repayment programs currently available to Alaska physicians need to be stabilized financially and supplemented with Alaska-based programs.

Conclusion

Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report], and comparisons with national norms [PSTF report] suggest that Alaska currently experiences a shortage of healthcare professionals, and, that shortages exist in several key occupational categories. Loan repayment programs have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages.

Recommendation

It is recommended that Alaska create a "Health Care Professions Loan Repayment Program".

To do this, a planning process should be established. This process should define and prepare for adoption at least the following program elements: (a.) organizational support, (b.) oversight, (c.) fiduciary agent, (d.) practitioner eligibility, (e.) site eligibility, (f) repayment details, (g.) program design & management, and (g) program evaluation.

Resource

Health Care Professions Loan Repayment Program: Issue Paper (2007). Health Planning & Systems Development, Alaska Department of Health & Social Services.

Health Care Professions Loan Repayment Program Issue Paper

Abstract

This paper: (1.) illustrates the current and expected healthcare workforce needs of Alaska; (2.) indicates the widespread use elsewhere of support-for-service programs, and in particular loan repayment; and (3.) recommends that Alaskans should now explore creation of a Health Care Professions Loan Repayment Program (HCPLRP).

Main Issue

Alaska is increasingly vulnerable to the competitive challenges posed by other states and nations for the finite pool of available healthcare graduates. This vulnerability will increase during coming years because of two factors. (1.) The need for health care professionals in Alaska is steadily rising, and, shortages are now evident in some categories. (2.) Further, these trends are national. These workers are part of, and often respond to, nationwide labor markets. Further, these trends are expected to accelerate. This is particularly true in those states that do not produce adequate numbers of their own health workers in the given disciplines. This puts such states at a marked disadvantage. Financial incentive programs are particularly important for those states, and Alaska is one of these. As a result, several other states have become robust competitors in recruitment of the healthcare workforce, and some are planning new and expanded loan repayment programs (Pathman, 2007).

A fundamental, and common, state-level response to these pressures is the use of financial inducements, these collectively known as support-for-service programs (SFSP's). Excellent outcomes are readily achievable from these efforts. There are five types: scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs. All support-for-service programs have the same key public goal: To improve healthcare staffing in shortage area communities.

National studies have determined loan repayment programs to be one of the most effective of the several support-for-service strategies - in terms of both recruitment and retention. As compared to the other SFSP options, here loan repayment participants sign support-for-service contracts after they complete their training, when they are older and better informed as to their career options. These professionals make commitments at the time they are ready to begin their service-obligations. They are more likely to know their own needs and those of their families at this later juncture. They know where they will serve and have a sense as to how well their chosen worksites will "fit" their needs.

Problem

This section presents evidence which indicates that:

- A healthcare workforce shortage currently exists in several occupations.
- Under current conditions these shortages will continue into the foreseeable future.
- In several occupations, these shortages will escalate.

Trends in National Workforce

Numerous, prominent sources indicate that there is a growing national shortage in the rural health care workforce. Two examples follow.

GAO Position (2001): In 2001, the General Accounting Office's (GAO's) director of health care-public health issues testified before Congress regarding growing concerns about the adequacy of the health care work force and lessons learned from the experience of the National Health Service Corps (NHSC) in addressing the maldistribution of health care professionals (Heinrich, 2001). Selected key points were:

- Recruitment and retention of adequate numbers of qualified health care workers are major concerns for many health care providers today.
- Available evidence suggests emerging shortages in some fields (e.g. nurses).
- Vacancy rates for HC workers in rural areas and inner cities are especially high.
- Although demand for most health workers will continue to grow, the increasing age of Americans, and their workforce may limit supply.
- The National Health Services Corp (NHSC) illustrates the challenges in addressing shortages of health professionals in certain locations.
- Better placement coordination with waivers for J-1 visa physicians is needed.
- Loan repayment is a better approach than service-requiring scholarships, to which individuals commit when they are still students.

NOSORH Position (2006): A representative and recent understanding can be gained from the National Organization of State Offices of Rural Health (NOSORH). In September 2006 NOSORH issued a Statement of National Priorities. Presented below are selected summaries of that document, without further comment. Interested readers should see:
http://www.nosorh.org/pdf/Rural_Impact_Study_States_IT.pdf

- While most rural communities in the U.S. already experience health care workforce shortages, the demand for health care workers nationwide is projected to grow faster than the supply. This shortage of health care workers can impact health care in a variety of ways, including: decreasing quality of care, decreasing access to care, increasing stress in the workplace, increasing medical errors, increasing workforce turnover/decreasing retention rates, and increasing health care costs.
- Most rural areas ... are classified by the federal government as Health Professional Shortage Areas (HPSAs) for primary medical care. A HPSA designation is made using a formula that includes a ratio of physician to population that is greater than 1:3,500. A population is considered "adequately served" when the ratio is 1:2,000. In 1997, more than 2,200 additional physicians would have been needed in non-metropolitan areas to eliminate HPSA designations. SORH directors consider the workforce shortage to be one of the greatest issues facing rural health, in particular shortages related to physicians and nurses.

- Certain national health workforce trends that will have a profound impact on rural populations and exacerbate the current rural health workforce shortages. Examples follow:
 - If health care consumption patterns and physician productivity remain constant over time, the aging population will increase the demand for physicians per thousand population from 2.8 in 2000 to 3.1 in 2020. Demand for fulltime-equivalent RNs per thousand population would increase from 7 to 7.5 during this same period.
 - Minority and female physicians have a greater propensity than do non-minority and male physicians to practice in urban communities. Meanwhile the percentage of physicians that are minorities and women is increasing.
 - The Bureau of Health Professions projects that there will be a 33-44% increase in demand for physicians, 41 percent for RNs, and 46 percent for LPNs from 2000 to 2020.
 - According to the Bureau of Health Professions, there is an acute shortage of pharmacists in the U.S. In February 1998, there were 2,670 unfilled full and part-time positions in the U.S. as compared to 6,920 in February 2000. Adding to this, enrollment rates in U.S. schools of pharmacy declined during this period.
 - In 1970, women accounted for 13 percent of the nation's pharmacists as compared to 2000 when they were 46 percent of the nation's pharmacists. Women tend to elect part-time work as pharmacists.
 - From 1990 to 1999, there was a 46 percent increase in the number of prescriptions dispensed from hospitals.
- NOSORH concluded the following in its 2006 statement of national priorities: ...SORH directors around the U.S. determined that they are most concerned with issues related to rural health workforce, health care services, and the needs of special populations. Research suggests that this concern is warranted as: demand for health care workers is increasing while the supply is decreasing; rural health care facilities continue to be fragile, there are gaps in these services, and all of these rural health services are critical to the health and well-being of the U.S.; and the needs of rural populations are changing, however, the programs serving them are unable to meet their needs. While SORHs respond to a variety of rural health needs and issues, new health care policies and additional rural health programs and funding will be needed if states are to address these increasingly important rural health issues and concerns.

Growth in Alaskan Jobs

Healthcare Workforce Overall: In 2004 there were 301,300 jobs in Alaska, with 32,700 (10.9 percent) of these in health care and social assistance (HCSA). By 2014, the overall job count is projected to be 349,550, with the HCSA workforce at 43,650 (12.5 percent). Thus by 2014, the number of HCSA jobs is projected to grow by 10,950 (34 percent), accounting for 22.7 percent of overall statewide job growth for the period. By 2014, health care and social assistance is projected to be the largest single industry workforce category in Alaska with 43,650 workers. (AHCDB, 2007, Table 3.300).

Social Service Occupations: For 2004, employment in community & social service (CSS) occupations was estimated to be 6,025 jobs. By 2014, this category of jobs is forecasted to be at 7,487, a rise of 1,462 (24 percent). The highest projected growth rates from 2000-2014 are projected to include mental health & substance abuse social workers (36.2 percent), social & human service assistants (34.6 percent) and mental health counselors (32 percent). (AHCDB, 2007, Table 3.310).

Selected Occupations: Review of 42 particular healthcare occupations indicates that these held 14,083 jobs in 2000, and that these are forecasted to reach 25,009 by 2010, an overall rise of 10,926 jobs (78 percent). Registered nursing positions are expected to grow the most, from 4,439 in 2000 to 8,556 in 2010, a gain of 4,117 jobs or (93 percent). All but one of the examined occupations is expected to have more jobs available by 2010. Further, of the 42 occupations presented, employment in 8 of these will more than double (e.g. AHCDB, 2007, Table 3.330).

Shortage in Alaskan Workforce

Health Professional Shortage Areas: Alaska has a large number of federally designated "Health Professional Shortage Areas" (HPSAs), the point of these designations being to aid in health care planning and finance. Typically these are determined by the existence of: (1.) a relative lack of desired personnel, and (2.) the existence of particular socio-economic conditions. A second route to HPSA designation, which is automatic, is via the existence of a federally funded community health center (CHC). HPSAs are of three types. Statewide in 2007 the following HPSAs existed: 28 in Primary Care (with 16 scored, and 12 via CHCs), 27 in Mental Health (with 14 scored, and 13 via CHCs), and 24 in Dental Health (with 7 scored, & 17 via CHCs). (Alaska Health Care Databook, 2007, Table 3.360). However, an important caveat is that many observers feel that the federal HPSA designation process underestimates the extant need for more healthcare professionals (e.g. US GAO, 1995). Thus, these designations should be considered as a conservative method for establishing need for the healthcare workforce.

Medically Underserved Areas: Alaska also has numerous federally designated "Medically Underserved Areas" (MUA) and "Medically Underserved Populations" (MUP). These designations identify shortages of primary medical care, dental health or mental health providers. Designations may be either geographic (MUA, i.e. a county or service area), or demographic (MUP, i.e. low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services). Each designation is assigned an Index of Medical Underservice (IMU) score, which is used to determine the eligibility of an area or population for MUA/MUP status. For 2007, there were 17 area designations and 11 population designations. (Alaska Health Care Databook, 2007, Table 3.350).

Resident Workers with Age: Two aspects of worker demographics further suggest the likelihood of a workforce shortage in the health care and social assistance (HCSA). The first of these regards "resident workers with age". In 2005 total employment in all HCSA occupations stood at 28,356. Of resident workers in all HCSA occupations statewide, 40 percent were age 45 and older; 27 percent were age 50 and older. Of resident workers who were in health care practitioner occupations per se, 47 percent were age 45 and older; and 31 percent were age 50 and older. Therefore, succession planning will be of concern over the next two decades as today's mature health care professionals retire (Alaska Health Care Databook, 2007, Table 3.320).

Non-Resident Workers: A second workforce demographic issue regards the sizeable number of "non-resident" workers. Overall, 10 percent of the workforce was non-residents in 2005, with a

high of (13 percent) among non-resident health care practitioner and technologist occupations. Expect additional pressure to build on the health care system if non-resident (itinerate) workers are not available to fill Alaska health care workforce gaps (e.g. AHCDB, 2007, Table 3.320).

Selected Occupations: Physicians

Physician Shortage – 1997: A decade ago Johnson and Norris (1997) conducted a comprehensive study to describe Alaska's geographic distribution of generalist physicians relative to population. These investigators queried all 443 generalist care physicians (family, general, general internal medicine, and pediatric) or their offices as to their specialties, employers, populations served, hours spent per week offering direct patient care, and locations. The results indicated a 30% overall shortage of generalist physicians for the state, representing roughly 141 full-time-equivalent generalists relative to national practice patterns and trends of health maintenance organizations. Of 17 primary health care areas, including the Anchorage area, 15 showed a need for additional generalist physicians. Most areas had a 20 to 40% shortage.

Physician Shortage – 2004: In 2004, a survey by the American Medical Association showed that, nationally, there were 2.38 practicing physicians per 1,000 people. Alaska's rate of practicing physicians was 2.05 per 1,000 people. Based on Alaska's 2004 population estimate of 656,834 and the national average of 2.38 physicians per 1,000 people, Alaska should have had 1,565 practicing physicians to be on par with national averages. The actual number of physicians practicing in Alaska was 1,347, indicating a shortage of 14 percent or 218 physicians. In areas outside of Anchorage, the rate of physician deficiency was 16 percent. (Alaska Health Care Databook, 2007, Table 3.370).

Physician Shortage – 2006: In 2006, the AK DHSS and the University of Alaska jointly assembled the "Alaska Physician Supply Task Force" (PSTF). This group then conducted a large inter-agency study, issuing the authoritative report, "*Securing an Adequate Number of Physicians for Alaska's Needs*". It found that Alaska had a shortage of physicians. Although not at crisis levels, the shortage was affecting access to care throughout the state, and, increasing cost to hospitals and other health care organizations. Up to 16% of rural physician positions in Alaska were vacant in 2004. Patients with Medicare were having difficulty finding a primary care physician. Several important specialties were in serious shortage in Alaska. It concluded that:

- The shortage is very likely to worsen over the next 20 years as the state's population increases and ages. Physician supply nationwide is entering a period of shortage, according to the best current predictions. Physicians in Alaska are aging and one-third may be retiring in the next 10-15 years. The new generation of physicians wants a more balanced life, meaning fewer hours on duty and more predictable schedules. These trends mean that more physicians will be required to serve the same population. Technology and scientific advances have increased the amount of medical care available, also adding to the need for physicians, as the patients expect more care than previously.
- As the supply of physicians shrinks, recruitment will become more competitive. Alaska's traditional system of recruiting physicians from federal assignment in the military and Indian Health Service is much less effective with changes in these systems. Alaska is far behind the other states in production capacity. (1-2) Long-range planning, even if it includes a four-year medical school in Alaska, will not address current physician needs in a timely fashion, so interim measures are needed. (59)

Selected Occupations: Nurses

Nursing Shortage – 2003: The nursing shortage is particularly acute, both in Alaska and nationwide. It is estimated that during this decade the need for RN's will increase by 4,117 (in 2000: 4,439; in 2010: 8,556) (Fried, N. & Keith, B. (2003). National shortages will make recruitment yet more difficult. As a result, Alaska will have a great need to recruit and retain registered nurses. Addressing the need of rural and remote areas will be yet more difficult and expensive than to do so for urban areas.

Impact on CHC's

Rosenblatt, et al. (2006) examined the status of provider workforce shortages such as these may limit CHC expansion. They noted that the federal government has continued to expand the capacity of community health centers (CHCs) to provide care to underserved populations. The researchers therefore conducted a survey of all 846 federally funded US CHCs that directly provide clinical services and are within the 50 states and the District of Columbia (May-Sept, 2004). Questionnaires were completed by the chief executive officer of each grantee. Overall response rate was 79.3%. Information was supplemented by data from the 2003 Bureau of Primary Health Care Uniform Data System and weighted to be nationally representative.

Rosenblatt, et al (2006) found that primary care physicians made up 89.4% of physicians working in the CHCs, the majority of whom are family physicians. In rural CHCs, 46% of the direct clinical providers of care were non-physician clinicians compared with 38.9% in urban CHCs. There were 428 vacant funded full-time equivalents (FTEs) for family physicians and 376 vacant FTEs for registered nurses. There were vacancies for 13.3% of family physician positions, 20.8% of obstetrician/gynecologist positions, and 22.6% of psychiatrist positions. Rural CHCs had a higher proportion of vacancies and longer-term vacancies and reported greater difficulty filling positions compared with urban CHCs. Physician recruitment in CHCs was heavily dependent on National Health Service Corps scholarships, loan repayment programs, and international medical graduates with J-1 visa waivers. The study concluded that CHCs face substantial challenges in recruitment of clinical staff, particularly in rural areas. The largest numbers of unfilled positions were for family physicians at a time of declining interest in family medicine among graduating US medical students. They stated that success of the current US national policy to expand CHCs may be challenged by these workforce issues.

Strategy

It is essential to enhance the capacity of Alaskan health care provider agencies to recruit and retain staff where: (1.) federal loan repayment programs either do not apply, or, (2.) there are insufficient resources available to meet need. More tools are needed to confront the problem of steadily growing vacancies in the Alaskan healthcare workforce.

Most other states have programs that influence health professionals' geographic and specialty distributions. Programs that integrate a number of strategies for attracting and retaining health professionals have a greater likelihood of success than do programs which rely on a single strategy. Substantial evidence indicates that state-level support-for-service programs should be, and typically are, a fundamental part of those strategies.

Debt from Health Care Training

What follows are brief summaries of recent, representative studies which suggest that:

- Health care student debt affects subsequent practitioner career choices;
- Loan repayment options support recruitment goals; and
- These programs directly help to correct practitioner maldistributions.

Factors in Recruitment & Retention: Daniels, et al. (2007) sought to identify factors associated with rural recruitment and retention of graduates from a variety of health professional programs in the southwestern United States. They conducted a longitudinal study by mailing a survey to graduates from 12 health professional programs in New Mexico. The main outcomes examined were: (1.) first rural employment, and, (2.) aspects of any rural employment, since graduation. Daniels, et al. (2007) concluded that rural background and preference for smaller sized communities are associated with both recruitment and retention. In addition, however, they stated that loan forgiveness and rural training programs appear to support recruitment. Retention efforts must focus on financial incentives, professional opportunity, and desirability of rural locations

Medical Student Debt & Career Choice: Rosenblatt & Andrilla (2005) examined the notion that medical students' rising total educational debt is one of the factors that explains the recent decline in students' interest in family medicine and primary care. They analyzed the results from questions on the Association of American Medical Colleges' 2002 Medical School Graduation Questionnaire that focused on students' debt and career choices. Students reported that higher levels of debt influenced their future career choices. An inverse relationship was observed between the level of total educational debt and the intention to enter primary care, with the most marked effect noted for students owing more than \$150,000 at graduation.

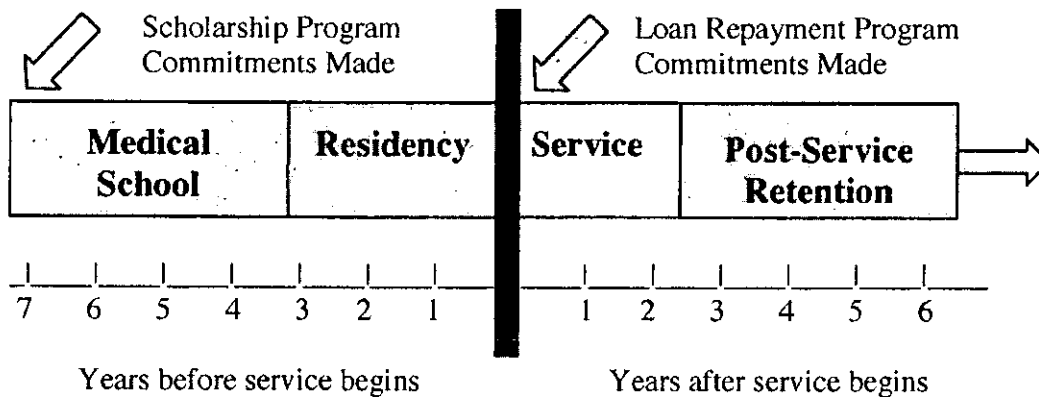
Medical Training Debt & Service Commitments: Pathman, et al (2000) assessed how student loan debt and scholarships, loan repayment and related programs with service requirements influence the incomes young physicians seek and attain, influence whether they choose to work in rural practice settings and affect the number of Medicaid-covered and uninsured patients they see. Data are from a 1999 mail survey of a national probability sample of 468 practicing family physicians, general internists and pediatricians who graduated from U.S. medical schools in 1988 and 1992. A majority of these generalist physicians recalled "moderate" or "great" concern for their financial situations before, during and after their training. Eighty percent financed all or part of their training with loans, and one-quarter received support from federal, state or community-sponsored scholarship, loan repayment and similar programs with service obligations. In their first job after residency, family physicians and pediatricians with greater debt reported caring for more patients insured under Medicaid and uninsured than did those with less debt. For no "specialty" was debt associated with physicians' income or likelihood of working in a rural area. Physicians serving commitments in exchange for training cost support, compared to those without obligations, were more likely to work in rural areas (33 vs. 7 percent, respectively, $p < 0.001$) and to provide care to more Medicaid-covered and uninsured patients (53 vs. 29 percent, $p < 0.001$), but did not differ in their incomes (\$99,600 vs. \$93,800, $p = 0.11$). Thus, among physicians who train as generalists, the high costs of medical education appear to promote, not harm, national physician work force goals by prompting participation in service-requiring financial support programs and perhaps through increasing student borrowing.

Support-for-Service Programs

It is well-established that a sizeable number of healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away. For instance, training to become a physician is expensive, as 80 percent of medical students who graduate in debt will attest (e.g. Jolly, 2005). In 2004, young physicians' educational debt averages stood at over \$109,000 and was this cost was increasing at the rate of more than \$4,000 per annum (e.g. AAMC, 2004). Nonetheless, educational costs and students' fears of acquiring six-figure debts have created a market for government programs that link support for healthcare training costs to a period of obligated clinical work in shortage areas.

There are several types of financial "support-for-service programs" (SFSP's). These include: scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs. One of the two most common types of such programs is the service-requiring scholarship program. These pay tuition and other costs for healthcare students while obligating them to a period of service that begins when they complete residency (or similar post-graduate training) years later. The other common program type is loan repayment. Loan repayment programs recruit healthcare practitioners as they complete their training and are ready to begin service in exchange for paying off the traditional education loans they acquired years earlier. Programs of both types typically require one year of service for each year of training cost support they provide.

Figure 1 - Timeline of physicians' training years, signing of commitments with service-requiring scholarship and loan repayment programs, service periods (typically two-to-four years) and post service retention.



(After: Pathman, D.E. (2006). What Outcomes Should We Expect From Programs That Pay Physicians' Training Expenses in Exchange For Service? *NCMEDJ*, 67(1), pg. 77)

Support-for-service programs appear to be a natural solution to both the students' and the public's needs. They have grown in popularity over the past 25 years in tandem with rising tuition costs, with both federal and state agencies using them. In one well-known federal example, in 2005 the Bureau of Health Professions reported that the National Health Service Corps (NHSC) was providing an obligated physician workforce of about 1,700 scholars and loan re-payers. As a result of NHSC shifting most of its funding to loan repayment, more workers were immediately brought into the fold, and that census has now roughly doubled. In addition, most states also

sponsor their own support-for-service programs. In 1996 there were a total of 69 state programs with an estimated workforce of 1,300 practicing physicians. These state programs doubled in number from 1990 to 1996 and very likely have grown further since (Pathman, et al. 2000).

State Scholarship, Loan Forgiveness, and Related Programs: Pathman, Taylor, et al (2000) noted that in the mid-1980s, states expanded their initiatives of scholarships, loan repayment programs, and similar incentives to recruit primary care practitioners into underserved areas. These programs have since grown substantially during the ensuing two decades. The authors thus sought to identify and describe state programs that provide financial support to physicians and midlevel practitioners in exchange for a period of service in underserved areas, and to begin to assess the magnitude of the contributions of these programs to the US health care safety net. This cross-sectional, descriptive study established the number and types of state support-for-service programs in 1996; trends in program types and numbers since 1990; distribution of programs across states; numbers of participating physicians and other practitioners in 1996; numbers in state programs relative to federal programs; and basic features of the state programs.

The study found that in 1996 there were 82 eligible programs operating in 41 states, including 29 loan repayment programs, 29 scholarship programs, 11 loan programs, 8 direct financial incentive programs, and 5 resident support programs. Programs more than doubled in number between 1990 (n = 39) and 1996 (n = 82). In 1996, an estimated 1306 physicians and 370 midlevel practitioners were serving obligations to these state programs, a number comparable with those in federal programs. Common features of state programs were a mission to influence the distribution of the health care workforce within their states' borders, an emphasis on primary care, and reliance on annual state appropriations and other public-funding mechanisms.

The authors concluded that as of 1996 the several states had fielded an obligated primary care workforce comparable in size to the better-known federal programs. Thus, these state programs constitute a major portion of the US health care safety net. The study emphasized that such state programs should be considered in plans to further improve health care access.

Experience of Other States

State-Level Support-for-Service Programs (2007): Considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel. Tables 1, 2 & 3 here-present listings of those state-level support-for-service programs that were web-posted by the Association of American Medical Colleges (as of 8/10/07). These provide a selective look at state and federal loan repayment, forgiveness and scholarship programs available to allopathic medicine and other health professions students. This compilation is not exhaustive, and at present, our office is not aware of one that is. The here-derived tables shows that, overall, there were 81 programs. There were 44 listed states with at least one program (88% of US states). Fully, 21 of these states had two or more programs (47% of listing), with highs found in New Mexico (at 5) and Minnesota (at 7). On average, the 44 listed states had nearly 2 programs (1.8) each. Table 1 presents 43 listings that were designated as "state programs". Table 2 presents another 20 listings that were designated as "federal/state programs". Finally, Table 3 presents another 18 programs were not otherwise classified, though quick inspection of titles suggests that many can be readily classified. Those programs that were categorized as (strictly) "federal" (e.g. NIH, military) are not further considered. Click on any program title for more programmatic detail.

State-Level Offices: Service-for-Support Programs

Table 1: Designation as: "State Program"

<u>State</u>	<u>Program</u>
Arizona	<u>Arizona Medical Student Loan Program</u>
Arkansas	<u>Community Match Physician Recruitment Program</u>
Arkansas	<u>Physician Grant Recruitment and Retention Program</u>
Colorado	<u>Colorado Health Professions Loan Repayment Program</u>
Georgia	<u>State Medical Education Board of Georgia Scholarship Program</u>
Indiana	<u>Indiana Primary Care Scholarship Program (IPCSP)</u>
Iowa	<u>Osteopathic Physician Recruitment Program (O.P.R.P.)</u>
Kansas	<u>Kansas Bridging Plan</u>
Maine (2)	<u>Maine Health Professions Loan Program</u>
Maryland	<u>Loan Assistance Repayment Program for Primary Care Physicians</u>
Minnesota	<u>Minnesota Dentist Loan Forgiveness Program</u>
Minnesota	<u>Minnesota Nurse Loan Forgiveness Program</u>
Minnesota	<u>Minnesota Rural Mid-level Practitioner Loan Forgiveness Program</u>
Minnesota	<u>Minnesota Rural Physician Loan Forgiveness Program</u>
Minnesota	<u>Urban Physician Loan Forgiveness Program</u>
Mississippi (2)	<u>Family Medical Education Loan/Scholarship Program</u>
Mississippi	<u>State Medical Education Loan/Scholarship Program</u>
Missouri	<u>Primary Care Resource Initiative for Missouri (PRIMO)</u>
Montana (3)	<u>Montana Rural Physician Incentive Program (MRPIP)</u>
Montana	<u>WICHE Professional Student Exchange Program</u>
Montana	<u>WWAMI Medical Exchange Program</u>
Nebraska	<u>Nebraska Student Loan Program</u>
Nevada	<u>Nevada Health Service Corps</u>
New Mexico (5)	<u>Allied Health Loan-for-Service Program</u>
New Mexico	<u>New Mexico Health Professions Student Loan-for-Service Program</u>
New Mexico	<u>Nursing Loan-for-Service Program</u>
New Mexico	<u>Osteopathic Medical Student Loan for Service Program</u>
New York	<u>Regents Physician Loan Forgiveness Award Program</u>
North Carolina (4)	<u>Community Practitioner Program</u>
North Carolina	<u>NC Student Loan Program for Health, Science and Mathematics</u>
North Carolina	<u>North Carolina State Loan Repayment Program</u>
Ohio	<u>Ohio Physician Loan Repayment Program</u>

Table 1: "State Program" (continued)

Oklahoma (3)	<u>Family Practice Resident Rural Scholarship Loan Program</u>
Oklahoma	<u>Oklahoma Rural Medical Education Scholarship Loan Program</u>
Oklahoma	<u>Oklahoma State Loan Repayment Program</u>
Oregon	<u>Oregon Rural Health Services (RHS) Loan Repayment Program</u>
South Dakota	<u>South Dakota Midlevel Tuition Reimbursement Program</u>
Tennessee (2)	<u>Health Access Incentive Program: Incentive Grant: Mid-Levels</u>
Tennessee	<u>Health Access Incentive Program: Incentive Grant: Physicians</u>
Virginia	<u>Virginia Loan Repayment Program</u>
Washington (2)	<u>WA State Health Professional Loan Repayment Program</u>
West Virginia	<u>Medical Student Loan Program</u>
Wyoming	<u>Wyoming WWAMI Medical Education Program</u>

State-Level Offices: Service-for-Support Programs

Table 2: Designations as: "Federal/State Program"

Connecticut	<u>Connecticut State Loan Repayment Program</u>
Delaware	<u>Delaware State Loan Repayment Program</u>
Illinois	<u>Illinois/National Health Service Corps Loan Repayment Program</u>
Iowa (2)	<u>Iowa PRIMECARRE Loan Repayment Program</u>
Louisiana	<u>Louisiana State Loan Repayment Program</u>
Maine	<u>Maine State Loan Repayment Program</u>
Massachusetts	<u>Massachusetts State Loan Repayment Program</u>
Minnesota	<u>Minnesota State Loan Repayment Program</u>
Missouri (2)	<u>Physician Loan Repayment</u>
New Hampshire	<u>NH Primary Loan Care Repayment Provider Plans</u>
New Jersey	<u>Primary Care Loan Redemption Program of New Jersey</u>
New Mexico	<u>Health Professional Loan Repayment Program (HPLPP)</u>
Ohio	<u>NHSC / BHPr Ohio Loan Repayment Program</u>
Pennsylvania	<u>Pennsylvania's Primary Health Care Practitioners Loan Repayment Program</u>
Texas	<u>Physician Education Loan Repayment Program of Texas</u>
Utah	<u>Utah Health Care Workforce Financial Assistance Program</u>
Virginia (2)	<u>National Health Service Corp-VA Loan Repayment Program</u>
Washington	<u>WA State Health Professional Scholarship Program</u>
Wisconsin (2)	<u>Wisconsin Health Professions Loan Assistance Program</u>
Wisconsin	<u>Wisconsin Physician Loan Assistance Program</u>

(number in parentheses indicates total state-office programs for that state that are not "federal" per se)

State-Level Offices: Service-for-Support Programs

Table 3: Programs – “Not Otherwise Designated”

Arizona (3)	<u>Arizona Loan Repayment Program</u>
Arizona	<u>NHSC/Arizona Department of Health Services</u>
Arkansas (3)	<u>Arkansas Rural Medical Practice Student Loan/Scholarship Program (ARMPSLSP)</u>
California (2)	<u>Dr. James L. Hutchinson & Evelyn Ribbs Hutchinson Medical School Scholarship</u>
California	<u>NHSC/CA State Loan Repayment Program</u>
Georgia (2)	<u>Georgia Physician Loan Repayment Program</u>
Kentucky	<u>Rural Kentucky Medical Scholarship Fund (RKMSF) Grant Program</u>
Michigan	<u>Michigan Essential Health Provider Program/SLRP</u>
Minnesota (7)	<u>Federal National Health Service Corps (NHSC) Loan Repayment Program</u>
Nebraska (2)	<u>Nebraska Loan Repayment Program</u>
North Carolina	<u>Loan Repayment Program</u>
North Dakota (2)	<u>The Medical Personnel Loan Repayment Program</u>
North Dakota	<u>The State Community Matching Physician Loan Repayment Program</u>
Rhode Island	<u>Rhode Island Health Professional Loan Repayment Program</u>
South Dakota (3)	<u>NHSC/Loan Repayment and Scholarship Program</u>
South Dakota	<u>South Dakota Physician Tuition Reimbursement Program</u>
Vermont (2)	<u>Freeman Educational Loan Repayment for Physicians Program</u>
Vermont	<u>Vermont State Loan Repayment Program</u>

(number in parentheses indicates total state-office programs for that state that are not “federal” per se)

Loan Repayment Programs

In national studies, loan repayment has been found to be a successful strategy to recruit and retain physicians and nurses. Twenty-five years of program evaluations have clarified many of the outcomes possible from healthcare training support-for-service programs. Furthermore, studies have demonstrated that loan repayment programs, as a whole, have better outcomes than scholarship programs. Results of these comparisons have proved compelling. For example, studies demonstrating the strengths of loan repayment programs prompted Congress recently to allow the NHSC to make more loan repayment and fewer scholarship awards (e.g. Bureau of Health Professions, 2005) and led some states to expand their loan repayment programs (Pathman, et al. 2000).

Studies have shown that there are several benefits which can accrue from loan repayment programs. Selected examples follow:

High Position Fill-Rates: Some programs, including the NHSC, have many more applicants than their funds can support and regularly fill all funded positions; other programs have many unfilled positions for lack of applicants.

High Service Completion Rates: Very few loan repayment programs, accordingly, have found a need to set any buy-out penalties; as a group, their service completion rates average 93% without them (Pathman, et al, 2004). It is the physician-program-community fit and the financial attractiveness of the program that prompts physicians to complete their obligations with service (the "carrot"), not financial and legal threats (the "stick").

High Retention Rates: Beyond merely completing obligations with service, there has long been the hope that obligated physicians will remain in their service communities for years afterwards ... In fact, data show that physicians participating in state-run support-for-service programs remain in their service sites as long on average as other young physicians remain in practices of all types nationwide. Physicians obligated to state-run loan repayment programs remain substantially *longer* than other young physicians (e.g. Pathman, 2004).

Effectiveness of Support-for-Service: Sempowski, I.P. (2004) attempted to evaluate the effectiveness of programs that provide financial incentives to physicians in exchange for a rural or underserved area return-of-service (ROS) commitment. This was done via a systematic literature review using Medline and Ovid HealthSTAR databases were searched from 1966 to 2002. The initial search yielded 516 results. Bibliography review yielded additional references. Ten publications were selected as the highest level of evidence available. The main outcome measures were: (a.) initial recruitment of physicians, (b.) buyout rates, and (c.) long-term retention.

The majority of studies reported effective recruitment despite high buyout rates in some US-based programs. The one prospective cohort study on retention showed that physicians who chose voluntarily to go to a rural area were far more likely to stay long term than those who located there as an ROS commitment. Multidimensional programs appeared to be more successful than those relying on financial incentives alone. Sempowski, I.P. (2004) concluded that ROS programs to rural and underserved areas have achieved their primary goal of short-term recruitment but have had less success with long-term retention. However, this study combined different types of support-for-service programs within its analysis thus somewhat preventing conclusions as to loan repayment programs, per se.

Loan Repayment vs. Payback Programs: Miller & Crittenden (2001) sought to determine and contrast the possible impact that two different types of support-for-service programs might have on medical school choice, and, students' intentions to return to their home states. The authors examined difference in preferences for: (a.) payback programs regarding state-subsidized medical education which are designed to increase the rate of graduates returning to those states to practice; and (b.) loan repayment programs that are designed to entice medical school graduates from rural states to return to their home states.

Miller & Crittenden (2001) surveyed 229 medical students (response rate 80 percent). The questionnaire collected background information on the students and addressed the possible

impact of payback and loan repayment policy proposals on student plans. Forty-seven percent of students reported that they would attend a different medical school if a required payback program were in place. Students who were more competitive at the time of admission to medical school were significantly more likely to say they would attend another medical school than were less competitive students. In contrast, 48 percent of students reported that they would be more likely to return to their home states if expanded loan repayment programs were available for service in areas of need. The findings suggest that payback programs may dissuade more competitive students from entering medical schools with such requirements, compromising the pool of students most likely to return to rural areas. Conversely, medical students appear willing to consider loan repayment programs upon completion of their training.

Why Do Loan Repayment Programs Work? Expert opinion was sought for insights into why loan repayment programs work. Donald Pathman, MD, MPH, (Univ. of North Carolina) was queried as to his view. Dr. Pathman stated:

“As a whole, state-run (loan repayment) programs are successful but not because they are run well---- most are under-funded, under-staffed and can't offer individualized assistance to the health care practitioners they support. They are successful because the benefit of loan repayment is clear to potential applicants and programs typically only provide payments to participants after they complete each 3 or 6 months of work; therefore, if a participant leaves or otherwise fails to work in the agreed upon area or practice, payments simply stop and there is no need to enforce penalties.” (Pathman, 2007)

Does a Loan Repayment Program Make Sense for Alaska? Expert opinion was sought for perceptions as to whether a loan repayment program makes sense for Alaska. Again, Donald Pathman, MD, MPH, (Univ. of North Carolina) was queried as to his view. Dr. Pathman stated:

“I am glad to hear that Alaska is thinking of expanding loan repayment opportunities. I visited Alaska for the first time this past spring for the National Rural Health Association meeting, in Anchorage, with a side trip to Minto and Fairbanks. What an amazing place! I spoke with several folks working with the Native American health corporation in the state, and realize the physician shortages for the populations they serve. I was impressed that they knew little about how to attract and keep a physician. Lots of opportunities there for improvement in programs.” (Pathman, personal communication, 2007)

Position of the Alaska Physician Supply Task Force (2006): The PSRF recommended a number of specific strategies and action steps to achieve four main goals related to assuring an adequate supply of physicians to meet Alaska's need. One of the PSRF findings was that Alaska's clinics and hospitals receive inquiries from physicians about the availability of loan forgiveness often. Loan repayment is a proven strategy for recruiting physicians, and the federal loan repayment programs currently available to Alaska physicians need to be stabilized financially and supplemented with Alaska-based programs. For detail, see: “*Securing an Adequate Number of Physicians for Alaska's Need*” (2006).

Precedents in Alaska: There are, and have been, other circumspect loan repayment programs for health professionals here in Alaska. These have typically been via categorical federal funding. Examples include Indian Health Service supports, and use of the National Health Service Corp. There have also been selected opportunities via the regional health corporations, and certain hospitals. Further, the Alaska Mental Health Trust has recently considered some loan repayment supports in the behavioral health field. While promising, these will collectively still fall far short of garnering the needed workforce to face projected need.

Recommendation

Recommended: Alaska should establish a Health Care Professionals Loan Repayment Program (HCPLRP). Decisions as to particular program elements must await further public process. Questions should be addressed regarding at least the following program elements:

- Organizational Support: What are the best ways to build legislative and public understanding and support on this issue? For instance, members of the Alaska Physician Supply Task Force supported a loan payback provision for physicians.
- Oversight: What is that governance entity most suited to provide leadership and oversight of this program? Similarly, which entity is most suited to administer the program? There is evidence that no single entity has the expertise to properly oversee and administer such a program. This might argue for a blended or interagency oversight structure. One agency might provide programmatic administration, while the other might serve as fiduciary agent.
- Fiduciary Agent: It may prove both workable and preferred that fiduciary mechanics and other administrative aspects be organizationally separated. If so, which agency is most to assume this fiduciary role? One approach might be to have the program work in tandem with the Alaska Commission on Postsecondary Education (ACPE). It is possible that the functions of the Alaska Commission on Postsecondary Education could be amended as these relate to repayment provisions healthcare degree program participants. It appears likely that no substantive change would be necessary for ACPE to act strictly as fiscal agent for participant payments. Further, this would not be a recommendation to change the scope of the ACPE mission to include direct workforce development. This later function would likely be accomplished by another state agency via interagency partnership.
- Provider Eligibility: Which healthcare occupations are to be deemed as eligible for the HCPLRP? Are all eligible occupations to benefit equally from the HCPLRP, or, will the occupations differ in terms of: (a.) maximum financial benefit, (b.) length of service required, (c.) specificity of service location, and, (d.) penalty for early-quit? There is evidence that for a loan repayment program, marked penalties are not needed, and, are actually likely harm outcomes.
- Repayment Details: Several policy and procedural decisions must be concluded. Examples follow. What is an adequate period of service-payback? What is the proportionality of payback when scheduled over years? What are the most useful policies with which to govern service payoff?
- Work Processes: Several work-process details will need to be established as regards management client relationships. Programmatically, what ways do we want to work, one-on-one, with program applicants to help them find suitable communities/positions? What types of assistance do we most want to provide to applicants, practices and communities?
- Program Evaluation: An ongoing evaluation should be installed and maintained as an expected part of any proposed support-for-service program (e.g. Henderson & Fox-Grage, 1997). It is in everyone's interest, and particularly in those of Alaska's medically underserved communities, that such programs: (a.) have explicit outcome objectives, (b.)

are regularly monitor as to those outcomes, (c.) openly acknowledge weaknesses, and (d.) embrace change as needed. Many different types of outcomes might be monitored. Reasonable measures might include:

- Practice in specific needy communities (e.g. HPSAs)
- Serve high-priority patient groups (e.g. Medicaid)
- Service completion of participants
- Retention rate of participants
- Satisfaction of participants
- Indictors as to the content of practice/work of program participants (e.g., proportion that provide inpatient care, that provide obstetrical care, or whatever specific services are deemed to have critical workforce shortages)

Other Support-For-Service Options to Consider:

As robust as a state-level loan repayment is likely to prove, there are other programmatic strategies. At least two other strategies should also be thoroughly examined: (a.) service-option loans, and (b.) direct incentives.

- Strategy: Service-Option Loan Programs

Consider provision of educational loans to all citizens of Alaska who undertake health professions training, where the loans will be forgiven if they work within Alaska after graduation. This would provide added incentive for health care students who were raised in Alaska to return to Alaska to practice, rather than being wooed away by the states/communities where they receive their training. There is evidence that these have worked well elsewhere, given attention to key programmatic details. For Alaska, a service-option loan program should nicely complement a loan repayment program; because the former would address only Alaska residents and the latter would primarily attract those health practitioners coming from out-of-state.

- Strategy: Direct Incentive Programs

Consider provision of direct incentive programs. In these, funding is provided to practitioners who agree to work in needy settings whether or not they have educational loans to be repaid. There is no reason to believe that only young practitioners-with-debt are suited to work in rural areas and/or with underserved populations.

Loan repayment programs only target recent graduates who have weighty educational debts. For instance, as regards physicians, many recent graduates carry minimal debt (perhaps 40%). Further, a large portion of those physicians who are potentially recruit-able to Alaska are 10 or 20 years out of training and have no educational debts. It is possible, even likely, that "an Alaskan adventure" would appeal to some number of mid and late-career physicians. It may prove informative to assess the State's medical licensure files to learn the average/median/quartiles of age of physicians as to when they gain their first Alaska license. If, indeed, many are older, then this is a group that should be targeted. Direct incentive programs target those practitioners without loans, and, older practitioners.

Finally, support-for-service programs (of all types) constitute only one way to help bolster recruitment and retention of health care professionals. Alaska must develop a multi-pronged approach to confronting our growing healthcare workforce shortage.

Conclusion

Substantial evidence shows that Alaska currently experiences a shortage of healthcare professionals, and, that this shortage exists in several key occupational categories.

There are several types of support-for-service programs, and the national experience has proven loan repayment programs to be robust. These have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages. To quote from Pathman, et al. (2004),

“As a whole, states’ support-for-service programs bring physicians to needy communities where they find satisfying work caring for at-risk patient populations and remain for many years. Of all program types, the loan repayment and direct financial incentive forms, which target physicians after training, show the broadest successes. The successes of these state programs warrant their continued support and perhaps expansion to remedy the continuing maldistribution of physicians.” (pg. 567).

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March 10, 2010

Re: Support for Alaska Health Care Professions Loan Repayment & Incentive Program

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the National Association of Social Workers – Alaska Chapter strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the Lower 48 in recruitment of providers from a shrinking national pool.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Health Care Professions Loan Repayment & Incentive Program proposal – SB 139 and HB 392 – bring to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

We recommend the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program.

Respectfully,

/s/

LaVerne Demientieff
President, NASW-AK

...the power of social work



ИЛИУЛИУК

Iliuliuk Family and Health Services, Inc.

P.O. Box 144
Unalaska, Alaska 99685

Phone: (907) 581-1202
Fax: (907) 581-2331

Re: Support for HB 392 Incentives for Certain Medical Providers

March 11, 2010

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, Iliuliuk Family and Health Services, Inc. (IFHS) strongly supports HB 392 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

Our organization, IFHS, is the only comprehensive service provider for medical, dental and behavioral health services within 800 air miles of Unalaska. We are remote, and we frequently find that we are unable to compete with "lower 48" medical practices for providers, since we also cannot compete effectively with salaries. State loan repayment options for our providers would help us offer a competitive package.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

It takes IFHS over a year to recruit a single doctor; six months to recruit a behavioral health specialist, and the last time we recruited a dentist, it took us four years to do so. We cannot recruit RNs – until July of 2009, we had two open RN positions for over two years, and currently have one RN position that has been open for over three years. A state-sponsored support-for-service program would help make our recruitment package more appealing and more competitive.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. HB

"Serving Unalaska, the Aleutian Islands and the Bering Sea"

392 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

IFHS supports HB 392 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

A handwritten signature in cursive script, reading "Sonia Handforth-Kome".

Sonia Handforth-Kome
Executive Director



The Honorable Bob Herron
Alaska State House of Representatives
State Capitol, Room 411
Juneau, Alaska 99801

Re: Support for HB 392 Incentives for Certain Medical Providers

March 10, 2010

Dear Representative Herron,

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans. The APCA represents 26 health care organizations operating 142 Community Health Center (CHC) clinic sites, as well as other primary care safety net providers, throughout Alaska. Currently, health professional workforce shortages are impacting the ability of CHC clinics and other health entities to provide access to health care services for Alaskans. The CHCs in Alaska exist to provide care for medically underserved populations and communities; however, the CHCs are having great difficulty recruiting and retaining providers. The CHCs provided primary health care services to over 81,000 patients (1 in 9 Alaskans) last year with the following estimated vacancies: 22 physicians, 20 physician assistants, 26 nurse practitioners, 6 dentists, and 10 licensed clinical social workers – to name a few.

Not only is Alaska suffering from labor shortages in most professional health care occupations,² but there is a national shortage of primary care providers as well. With most areas of Alaska designated as a Health Professional Shortage Area or a Medically Underserved Area,³ the national shortages have made recruitment and retention even more challenging for clinics here. All but six of the fifty states have addressed similar professional health provider shortages by implementing state sponsored support-for-service programs which have helped to attract and retain health care providers.⁴

The APCA hears routinely from frustrated medical directors throughout Alaska that they are “losing candidates to other states.” Expensive temporary hires and repeated recruitment costs are driving up the cost of health care. The lack of continuity of providers is impacting health care access and outcomes for Alaskans. It is time for

Alaska Primary Care Association
903 W Northern Lights Blvd, Suite 200
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www.alaskapca.org

Alaska to establish a state-sponsored loan repayment and incentive program to help mitigate the health care workforce shortage problem.

In closing, the Alaska Primary Care Association strongly supports HB 392 and the creation of a "Health Care Professions Loan Repayment and Incentive Program" in Alaska. Thank you for your efforts to expand access to health care for all Alaskans.

Respectfully,



Regan Mattingly
State Affairs Coordinator



Shelley S. Hughes
Government Affairs Director

¹ Bureau of Primary Health Care. "Alaska Section 330 Grantees Uniform Data System (Provider Utilization)."

² Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007.

http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.

³ US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage

⁴ Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska

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Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."



Alaska Primary Care Association Board of Directors

RESOLUTION 2009-02

Health Care Professions Loan Repayment and Incentive Program for Alaska

WHEREAS the Alaska Primary Care Association strives toward the goal of a healthy population, it recognizes that a robust health care workforce is necessary to provide adequate health care access for all Alaskans and is a key ingredient in improving the public health of all Alaskans; and

WHEREAS Alaska is competing with other states and nations for the finite pool of available health care professionals; and

WHEREAS Alaska is suffering from labor shortages in most professional health care occupations¹, and these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS most of the State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area;² and

WHEREAS a common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSPs), and good outcomes have been achieved with these;³ and

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective of the several SFSP strategies in terms of both recruitment and retention;⁴ and

WHEREAS a key problem is that Alaska does not have a robust SFSP while most other states do, many have several, and further, some of those are growing;⁵ and

WHEREAS most all other states have state-sponsored SFSPs that influence health professionals' geographic and specialty distributions;⁶ and

WHEREAS it is well-established that many health care professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away; and

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."



WHEREAS for areas in the state where providers are required to work in professional isolation due to remote settings, direct incentives are needed to attract more experienced health care providers who do not carry debt and are considered desirable placements; and

WHEREAS considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of health care personnel; and

WHEREAS in 2006, the Alaska Physician Supply Task Force recommends a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need, including creation of a SFSP, and the 2007 Alaska Workforce Vacancy Study and the 2005-2006 Status of Recruitment Resources and Strategies (SORRAS II) point to the need for a state loan repayment and incentive program in order for Alaska to compete with the lower 48 to recruit from a limited pool of numerous types of health care providers nationwide; and

WHEREAS a concept proposal submitted to the Alaska Primary Care Council by Pat Carr, Chief Health Planning and Systems Development for the Department of Health and Human Services, concludes the following:

Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report], and comparisons with national norms [PSTF report] suggest that Alaska currently experiences a shortage of healthcare professionals, and, that shortages exist in several key occupational categories. Loan repayment programs have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages;⁷ and

WHEREAS the above proposal recommends that "Alaska create a 'Health Care Professions Loan Repayment Program.'"⁸

THEREFORE BE IT RESOLVED that the Alaska Primary Care Association supports the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" and will advocate for the necessary authorizing and fiduciary legislation.

SUBMITTED BY:

Regan Mattingly, State Affairs Coordinator
Shelley S. Hughes, Government Affairs Director
Marilyn Kasmar, Executive Director

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."



DONE AND DATED THE 21st DAY OF January IN THE YEAR 2009

SIGNED BY

A handwritten signature in cursive script, appearing to read "Sonia Handforth-Kome".

Sonia Handforth-Kome, APCA Board President

¹ Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007. http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.

² US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. <http://hpsafind.hrsa.gov/>.

³ Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska DHSS. September 11, 2007. <http://www.hss.state.ak.us/primarycare/assets/loan-proposal.pdf>.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Health Planning & Systems Development, Alaska Department of Health & Social Services. *Health Care Professions Loan Repayment Program Concept Proposal*, September 11, 2007.

⁸ Ibid.

**Mat-Su Health Foundation Resolution to Support
Health Care Professions Loan Repayment & Incentive Program for Alaska**

WHEREAS the Mat-Su Health Foundation's mission is to enhance the health of Alaskans living in Mat-Su, where health is in part determined by access to primary, behavioral, and dental care and preventive services;

WHEREAS an adequate healthcare workforce is necessary to provide this access, and according to the *2005-2015 Mat-Su Borough Health Plan*, Mat-Su has an "inadequate number of providers to meet the demands of a growing population" in both the core area and the outlying rural areas of the borough;ⁱ

WHEREAS Mat-Su is designated a Medically-Underserved Area/Population by the U.S. Health Resources and Services Administration and has sub-regions designated Primary Care Health Professional Shortage Area, Mental Health Professional Shortage Area, and Dental Care Health Professional Shortage Area;ⁱⁱ

WHEREAS the Mat-Su Borough is the fastest growing area of Alaska, growing from 5,188 in 1960 to 82,515 in 2008 due to both positive birth and in-migration rates; and the AK Department of Labor projects that all Mat-Su age groups will continue to grow through 2020;ⁱⁱⁱ

WHEREAS the Mat-Su Borough is experiencing one of the highest rates of population growth in the state among senior citizens, who use the healthcare system disproportionately more than any other age group; and the Alaska Commission on Aging reports Mat-Su's senior growth rate at 11.6%, which includes a net gain from a senior in-migration rate that is almost double its senior out-migration rate;^{iv}

WHEREAS the Alaska Health Care Commission has designated Medicare-access as one of its six focus areas; and the University of Alaska Anchorage Institute of Social and Economic Research has reported that access to primary care for Medicare beneficiaries is problematic in Mat-Su, where data reveals that only 57.7% of Mat-Su primary care physicians will see new Medicare patients;^v

WHEREAS the Mat-Su Health Foundation believes that an investment in the education of Mat-Su residents will help to build the healthcare workforce of the future and an engaged citizenship with a higher capacity to address the health-related challenges impacting Mat-Su and Alaska; and to this end has offered scholarships to help defray the cost of higher education and encourage Mat-Su residents to complete a degree or certificate program that emphasizes health and/or wellness; but also recognizes that more needs to be done to bolster the healthcare workforce in Mat-Su and Alaska;

WHEREAS Mat-Su Regional Medical Center has spent \$6,238,438 on contract labor over the last five years on temporary health professionals from outside the state to fill current needs;

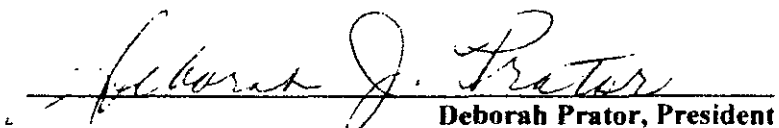
WHEREAS Alaska is competing with other states for the finite pool of available health care professionals; and over 40 states currently offer Support-for-Service Programs (SFSPs) that have influenced health professionals' geographic and specialty distributions;

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective strategies in terms of both recruitment and retention;^{vi}

WHEREAS without this incentive, it will be challenging for Alaska to compete for medical and health professionals, especially to work in rural areas;

BE IT THEREFORE RESOLVED that the Mat-Su Health Foundation promotes and advocates for the establishment of the Health Care Professions Loan Repayment & Employment Incentive Program to bring more qualified medical professionals to Alaska and will advocate for the necessary authorizing and fiduciary legislation.

Approved by the Mat-Su Health Foundation Board of Directors on January 18, 2010.


Deborah Prator, President

¹ 2005-2015 Mat-Su Borough Health Plan. Information Insights. January 2006.

http://www.matsugov.us/planning/index.php?option=com_content&view=article&id=69:mayors-blue-ribbon-taskforce-on-forming-a-health-and-social-service-board&catid=29:health-and-human-services-board&Itemid=20147#.

² U.S. Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. <http://datawarehouse.hrsa.gov/GeoAdvisor/shoragedesignationadvisor.aspx>.

³ Matanuska-Susitna Borough, Alaska Department of Labor, Division of Research & Analysis.

<http://laborstats.alaska.gov/cgi/databrowsing/localAreaProfileQSRResults.asp?geogArea=0204000170&population=census:data:Population&B1:View:Report>.

⁴ Alaska State Plan for Senior Services FY2008-FY2011. Alaska Commission on Aging. June 2007.

http://www.hss.state.ak.us/acoa/documents/statePlan/finalFY08_FY11.pdf.

⁵ How Hard Is It for Alaska's Medicare Patients to Find Family Doctors? University of Alaska Anchorage Institute of Social and Economic Research. UA Research Summary No. 14. March 2009.

http://www.hss.state.ak.us/healthcommission/200905/iser_doctors.pdf

⁶ Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska DHSS. September 11, 2007. http://www.hss.state.ak.us/primary_care/assets/loan-proposal.pdf.



Shawnie Olson – Counseling Services

Box 2914
Homer, AK 99603
907-235-8808 or 235-8886
saje@ak.net

Dear Representative Herron,

Recently I was informed about HB392 and SB139. The bill seeks to address the shortage of certain health care professionals in Alaska by increasing their numbers. Unfortunately the bill does not include Licensed Professional Counselors who now constitute one of the largest bodies (if not THE largest body) of mental health professionals working in our state. As Chair of the Board of Professional Counselors, I feel it is imperative to ask you to support an amendment to add this group of licensed professionals to this bill.

As you are probably aware, there are roughly 450 Licensed Professional Counselors in Alaska. These mental health care providers have gone through a process of qualifications that is demanding, academic, and professionally challenging. They must have a minimum of 3,000 hours of counseling and a sixty credit master's degree in counseling or a closely related field before they can even consider pursuing a license. In a field that has only existed for less than ten years in Alaska, LPCs have caught up to many of the other mental health care providers in numbers and have surpassed many of them with their requirements. I recently attended the American Association of State Counseling Boards yearly conference where I represent Alaska. At this meeting I always provide a workshop which enables me to closely compare notes with LPC requirements from other states. I can honestly report to you that Alaskan standards are the highest for licensure of LPCs.

To my knowledge, Psychological Associate Licenses are not given in other states. Many of the students graduating with a master's level psychology degree end up before my board requesting an LPC. Licensed Profession Counseling Licenses are easily transferable 'outside'. LPC work is almost identical to PA work with the exception of two types of psychological testing that LPCs do not provide (although we do many other types of testing).

I am requesting that you consider amending HB392 Sec. 18/29/009 (b)(7) to include counselors who have a master's degree from a program that qualified them as a professional counselor. As you know, the need for mental health professionals in Alaska continues to grow and here is a qualified group of people ready to take up the challenge

Most Sincerely,
Shawnie Olson
Board of Professional Counselors, Chair
LPC license 25

Nikoosh Carlo

From: Linda King [lking@hotmail.com]
Sent: Saturday, February 27, 2010 10:18 PM
To: Rep. Bob Herron

Dear Representative Herron,

As the President of AKAMFT, I am writing you on behalf of our members and profession.

Just this morning I was informed about HB392 and SB139. The stated objective of the bills is to address "the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care", yet the bill omits one of the largest bodies of mental health professionals working in Alaska.

It is my understanding that currently LPC's and MFT's make up the majority of licensed counselors in our state. There is not a school in Alaska that offers a Marriage and Family Therapist program, so most therapists in Alaska have received their education in others states or were grandfathered in. This year MFT's became recognized in all fifty states and is a recognized licensure by the VA and other federal programs. I have personally know several people who have left our state to get a MFT degree and then returned to work in Alaska. To get a MFT license more education is required in families, systems and working with couples. Licensing requirements for MFT's in all fifty states are as stringent or higher than that of psychologist and master level clinical social workers.

I don't understand the omission of both LPC and LMFT qualified master's level graduates. Alaska Pacific University graduates about 20 master's level psychologists per year—they eventually get the LPC license. UAA and UAF graduates scores of people yearly with master's degrees—many of whom also seek the LPC. The reason master's level grads go for the LPC is because the master's level Psychological Associate license is not recognized outside of Alaska. However the LPC is now a license type in all 50 states. We may be late to the party, but we have a big presence—especially here where in fewer than 10 years of licensing LPC's have virtually caught up with social workers for numbers and presence across the state. We do all of the same work as the other disciplines with the exception of two types of psychological testing—but can do all other types of testing.

The bottom line is that I am encouraging you to amend HB392 Sec. 18.29.009 (b)(7) to include something like the following language: or a counselor holding a master's degree from a program that qualifies them for professional counselor or marital and family therapist license. I also believe that hundreds of other licensed professionals—who will also not utilize the opportunities of this bill, would encourage the passage of this bill. There are too few of us and the need is great.

This change will optimize the possibilities for increasing access to behavioral health/mental health professionals in rural Alaska.

Thank you for your support.

Linda R. King, MS, LMFT Alaska License #230
President, AKAMFT

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Group advocates incentives to lure health care workers**SHORTAGE: Problem is especially acute in alaska's rural areas, planner says.**

By ROSEMARY SHINOHARA

rshinohara@adn.com

(02/15/10 21:37:22)

Armed with reports of continued shortages of doctors and other health care workers in Alaska, a group of health care organizations is pushing for the state to begin offering doctors, dentists, nurses and others money to come practice in Alaska.

Shelley Hughes of the Alaska Primary Care Association, one of the backers of financial incentives for health care workers, led a workshop to talk about the idea Monday at the Alaska Native Tribal Health Consortium.

Her group represented 142 community health clinics -- nonprofits that offer health care on a sliding scale to anyone. Their turnover of doctors, physician assistants and nurse practitioners is about one-third every year, Hughes said.

Statewide, the number of doctors with active licenses in Alaska increased by 2 percent from 2007 to 2009 -- barely keeping up with population growth, and not keeping up with the health care needs of Alaska's growing number of senior citizens, said Alice Rarig, a planner with the state Department of Health and Social Services.

Rarig said the problem is especially acute in some rural areas and for primary care doctors. For example, in Anchorage and Mat-Su, there's a doctor for every 352 people, but in northern and Southwest Alaska, the ratio is closer to one doctor for more than 950 people.

Alaska has a pretty good supply of specialists in urban areas but not enough internists -- primary care doctors -- and psychiatrists, she said.

The Primary Care Association, Alaska State Hospital and Nursing Home Association, Alaska State Medical Association, Alaska Native Health Board, AARP-Alaska and numerous other groups are supporting SB 139, a bill in the Legislature that calls for the state to spend \$7.9 million over the next three years on drawing people to work in medical professions in Alaska.

The bill, introduced by Sen. Donny Olson of Nome, has been approved by one committee and now sits in the Senate Finance Committee.

Under the bill, the state would repay student loans over a three-year period for health care professionals recently out of school. It would give direct payments to already-established health care workers in exchange for their practicing in Alaska, also over three years.

The \$7.9 million would cover at least 90 positions, with payments ranging from \$20,000 to \$27,000 per year for those in jobs such as nurse practitioner, physician assistant and physical therapist, and \$35,000 to \$47,000 annually for doctors, dentists and pharmacists, said Hughes.

People who took especially hard-to-fill positions, such as in remote areas, would get the highest

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

March 18, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska State Capitol, Room 411
Juneau, AK 99801-1182

Subject: Support for HB 392, Incentives for Certain Medical Providers

Dear Chair Keller and Chair Herron:

The Alaska Commission on Aging (ACoA) encourages support for HB 392 by the House HSS Committee, a bill to establish a loan repayment program to build Alaska's health care workforce by increasing the recruitment and retention of targeted health care professionals in urban and rural, underserved communities. This bill is authored by Representative Bob Herron.

Alaska, as with the rest of the nation, is experiencing a shortage of health care workers as fewer students are entering the health care profession and many of those already working in health care are preparing for retirement. Alaska is one of five states that does not offer a state-sponsored loan repayment program for health care professions. As a result, our hospitals, clinics, and communities lose potential health care workers to other states that incentivize their workforce with loan repayment programs.

Access to quality health care is a priority for all Alaskans and a critical need for people age 65 years and older. Older Alaskans benefit from regular health care services which enhance their overall health and decrease the need for more expensive, intensive treatment and emergency visits.

Alaska continues to lead all states with the fastest growing senior population currently comprising about 12 percent of our state's population and is projected to increase by five to six percent each year until 2020. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors, as demand increases and providers are reaching retirement age. If older Alaskans are unable to find a health care provider, they may be forced to leave the state in search of access to health care professionals. As a result, Alaska could suffer from a loss of retirees, who contribute more than \$1.7 billion to the state's economy in addition to their significant volunteer service, caregiving activities, and community leadership.

ACoA supports HB 392 and believes that the proposed legislation will help to build a qualified health care workforce who will be available to meet the health care needs of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information about our position. Thank you.

Sincerely,



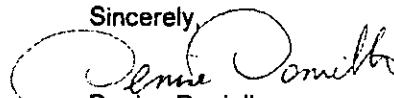
Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Cc: Representative Tammie Wilson, Vice-Chair
Representative Bob Lynn
Representative Paul Seaton

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

Sincerely,



Denise Daniello
ACoA Executive Director

Cc: Representative Sharon Cissna
Representative Lindsey Holmes



ALPHA

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

March 18, 2010

Dear Senate and House Members of the Alaska State Legislature:

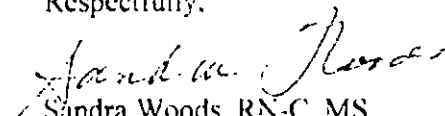
Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Public Health Association (ALPHA) strongly supports HB 392 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

ALPHA supports HB 392 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,


Sandra Woods, RN-C, MS
President
ALPHA Board of Directors

212 Front Street, Suite 100 Fairbanks, AK 99701 907.450.2459 e-mail: publichealth@alaska.net
www.alaskapublichealth.org

Rob Earl

From: Janie Fillman [akjanie1@hotmail.com]
Sent: Thursday, March 18, 2010 12:52 PM
To: Rob Earl
Subject: HB 392 Makes Sense: Please Support

Representative Herron

I live in a rural area, Glennallen, Alaska. We have one primary care center to serve the entire Copper River Valley which is the size of the entire state of Ohio. Our residents range from upper middle class and below (I believe). Cross Road Medical Center has a high turnover of providers, making it hard to have continuity of care; many people drive the approximately 400 mile round trip to get primary care. We have many seniors who simply leave our area. Please support HB 392 as it will help rural under served area's such as the one I live in, plus help our urban areas to have higher level providers (ie there is no cardiologist in all of South East Alaska. UA has a "grow our own" philosophy, but cannot grow enough of our own fast enough; some schooling isn't even available in Alaska such as dentistry and pharmacy. We truly need your help!

Sincerely,

Janie Fillman
PO Box 575
Glennallen, AK 99588

Rob Earl

From: Dariene Buttolph [iindab@ptialaska.net]
Sent: Thursday, March 18, 2010 11:58 AM
To: Rob Earl
Subject: I support HB 392 We need your help.

Representative Herron

I support HB 392 as we need it so bad. I also believe All Doctors should have to take a % of Medicare. I bless the ones that do. They care for the people not their pockets. We need this bill so bad. What are we seniors to do for a Doctor??? No one can find one to care for us. We all have paid into Medicare all our lives for what ? One of the best programs the government every come up with. It needs to go on plus social security. It adds to our retirement so one can retire. Everyone goes on Medicare at 65 so we need to support HB 392

Sincerely,

Darlene Buttolph
2001 Shore Dr
Anchorage, AK 99515

Rob Earl

From: Ann Ehret [aehret@ifhs.org]
Sent: Thursday, March 18, 2010 11:40 AM
To: Rob Earl
Subject: HB 392 - Loan repayment

Representative Herron

I am writing to urge you to support this legislation for the loan repayment and incentive program in Alaska. As a physician who works 75% time in the Aleutians I am not eligible for federal loan repayment toward my \$150,000.00 medical school loans. After three years in our community health center at a average salary, I am no longer financially able to sustain the cost of living, monthly loan payments without loan repayment of some sort. I am seriously considering moving out of state to obtain more flexibility in the reimbursement options. If this legislation passes, I will stay in Alaska to provide rural primary care to under served populations.

Sincerely,

Dr. Ann Nora Ehret
PO Box 920091
Dutch Harbor, AK 99692

Rob Earl

From: Sharon Montagnino [smontagnino@sunshineclinic.org]
Sent: Thursday, March 18, 2010 10:21 AM
To: Rob Earl
Subject: HB 392 Good solution for health care workforce strategy

Representative Herron

As executive director for the Sunshine Community Health Center, I cannot tell you how valuable a loan repayment and incentive program is to recruiting potential medical and dental providers.

Sunshine has been actively recruiting for a dentist now for 14 months and while there are other obstacles (i.e. licensing for one) that hamper our efforts, loan repayment has become the number one question asked by candidates. In addition to our dental vacancy, we have been recruiting for a medical provider and the last three candidates said loan repayment was critical in their choice of employment.

While AK certainly has a lot of offer we cannot compete with clinics and centers in the lower 48 if the playing field is not level. One-way to make this happen to approve a loan and incentive program in Alaska.

I urge you to support this bill because without it there is the potential of clinics closing or scaling back hours due to no providers/staff (happened in S.E. when dentist retired and there was no replacement).

Sincerely,

Sharon Montagnino
HC 89 Box 8190
Talkeetna, AK 99676

Rob Earl

From: Nancy Bryan [nabryan46@yahoo.com]
Sent: Friday, March 19, 2010 4:46 PM
To: Rob Earl
Subject: Written HB 392 Testimony (H)HSS

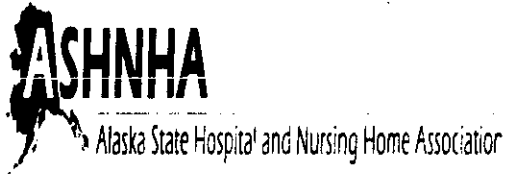
Representative Herron

To have seasoned professional Medical staff able to come to Alaska and build our health community, in my opinion, is so valuable for our growing needs. This would perhaps be a step forward to making this state competitive to lower 48 states with new ideas, that open up great incentives to better the health care areas here. To become self sufficient in Alaska has always been our motto of looking forward has it not? Then make it possible to help those that want to make the journey here perhaps for the first time, and stay in our great state and bring the knowledge they have as well as their wonderful medical ideas to us.

Thank you.
Nancy Bryan

Sincerely,

Nancy Bryan
22479 E Clare Way
Palmer, AK 99645



426 Main St
Juneau, Alaska 99801
(907) 586-1790
www.ashnha.org

**TESTIMONY ON House Bill 392
March 17, 2010**

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

ASHNHA's membership strongly supports **HB 392**.

Health care occupation workforce shortages continue to persist throughout Alaska but are most critical in rural areas of the State.

The Alaska Legislature has been extremely responsive to addressing these shortages by providing increased funding to the University of Alaska to expand health care education programming, and by expanding the WWAMI program from 10 to 20 educational placements each year.

HB 392 complements these other initiatives by establishing a new program that will give the Department of Health & Social Services authority to attract already trained health care professionals in 10 critical occupation categories. The Department will offer either loan repayment or cash incentives commitment to willing providers in exchange for time served in health care shortage areas in Alaska. Up to 90 health care professionals could be attracted to Alaska each year through this program.

Extensive study of Alaska's health care workforce needs have been completed and those data disclose shortages that cannot be overcome by expanded educational programming or WWAMI enrollments alone. These investments, while extremely important, will take from 4 years to 10 years to produce trained clinicians depending on the health care occupation chosen for study. HB 392 will bridge the gap Alaskans face today in many rural and underserved communities throughout the State.

ASHNHA has worked with a large group of other stakeholders to help develop the program outline contained in HB 392. Passage of this measure will help Alaska become competitive with other states in attracting 'practice ready' professionals from around the country.

HB 392 has the strong support of many organizations concerned about the severe shortage of health care professionals in many rural areas of the State. The Alaska Health Care Commission recommended consideration of a loan repayment and incentive program in their report to the Governor and the Legislature.

ASHNHA respectfully urges your support for HB 392 and passage of this bill from House HSS to the next committee of referral.

Thank you for your consideration.

For questions please contact:
Rod Betit, President & CEO
ASHNHA
rbetit@ashnha.com or call 907 586-1790

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.



AARP Alaska
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TTY 1-877-434-7598
www.aarp.org/ak

March 17, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 411
Juneau, AK 99801-1182

RE: HB 392 (Herron)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support HB 392, authored by Committee Co-Chair Herron.

The intent of HB 392 is to provide incentives for health care providers, especially for expertise that is in short supply in Alaska as well as to secure providers in our many underserved geographic areas.

AARP approaches HB 392 from the standpoint of the customer. Our members are the group most likely to need health care services and are often the first ones to face critical health care problems because they cannot find a provider.

You are well aware of our health care workforce shortages in Alaska. If our members cannot find a health provider, the results can be bad for them as well as for the state.

Postponing a needed health visit often results in health deterioration and, in many cases, more intense and more expensive treatment. With an increase in providers, our members are more likely to seek prevention and early treatment. The overall health status of older Alaskans will improve.

However, if our members cannot find a health care provider, Alaska will be the loser.

As you know, prior to 1990 many older Alaskans left the state after retirement because they could not count on finding medical facilities and providers to meet their needs.

This trend reversed and now Alaska has the highest percentage of older people who decide to stay in their home state after retirement. The economic value of these retirees is estimated at over \$1.7 billion.

We want our citizens to stay here after retirement. The most significant determination of where retirees decide to live is the availability of quality health care. We must have an adequate health care workforce if we are going to keep older Alaskans in our state.

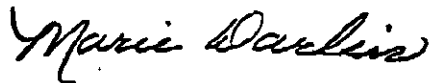
HB 392 will go a long way in helping us secure that workforce.

AARP recommends an "AYE" vote on HB 392.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Representative Tammie Wilson
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes

Rob Earl

From: Sonia Handforth-Kome [skome@ifhs.org]
Sent: Tuesday, March 23, 2010 11:06 AM
To: Rob Earl
Subject: HB 392 Testimony (H)HSS

Representative Herron

I am writing to urge you to support and pass HB 392. I am the executive director of the community health center in Unalaska. We budget for four physicians, three mid-levels, three RNs, two counselors, one physical therapist and one dentist. Our center currently has two open RN positions, one of which has been open for three years, one open counselor position and one open physical therapy position. One of our physicians is considering leaving because, even several years out of school, she still owes over \$100,000 and is not eligible for NHSC loan repayment. Our dentist gave us a three year notice six months ago because he knew it would take that long to fill the position. We must compete nationally for our health care providers. HB 392 would be enormously helpful to us in recruiting and retaining vital staff members. Please support HB392. Thank you.

Sincerely,

Sonia Handforth-Kome
Executive Director
Iliuliuk Family and Health Services, Inc.
PO Box 144
Unalaska, AK 99685

Nikoosh Carlo

From: drobbins@gci.net on behalf of Doris Robbins [drobbins@gci.net]
Sent: Tuesday, March 23, 2010 12:23 PM
To: Rep. Tammie Wilson; Rep. Wes Keller; Rep. Bob Herron
Cc: Rep. Lindsey Holmes; Rep. Sharon Cissna; Rep. Paul Seaton; Rep. Bob Lynn
Subject: Support for HB 392 INCENTIVES FOR CERTAIN MEDICAL PROVIDERS

Co-Chair Herron,
Co-Chair Keller,
Vice-Chair Wilson,
House HSS Committee,

RE: HB 392 INCENTIVES FOR CERTAIN MEDICAL PROVIDERS

For several election cycles I have watched us lose more professionals who treat patients for their illnesses one-on-one and in auxiliary roles as well. Support for physicians and medical professionals to practice in Alaska is so long overdue. We have a crisis in interior Alaska!

The lack of proper care resulted in my daughter, who has very good insurance, being rushed through a quick clinic, being told that she just had a virus and to go home and treat it with fluids and rest. A week later, no better, she went back again. She went back for additional treatment, was handled quickly, and given some kind of antibiotic as she continued to cough and become more weak.

Finally, she wrangled an office visit with a physician in an outlying area through a family contact. He examined her thoroughly to find that she had been trying to function with walking pneumonia and had developed damage to one lung. She was required to have bed rest with antibiotics and inhalers, and then was restricted to only very minimal activity, as necessary to prevent the loss of her job, so that her lung could heal. She, having deteriorated from lack of early care, had more antibiotics, inhalers and months of re-exams and repeated X-rays to make sure her lung healed. This is a lady who has completed the Fairbanks Equinox Marathon at least 5 times, so it wasn't because she was a softie!

This is one reason that we must act to make physicians and other medical professionals work in Alaska. Remember that Alaska serves a large number of military dependents that add to our patient population. It is no longer only those who are on Medicare. We have a critical shortage for a conglomerate of reasons. Typically, an appointment for someone who is currently ill, not a check-up, has a 6-week wait. If you get very ill, rather than have a regular patient go into emergency for a "temporary patch job" your doctor will likely try to get you in where someone cancelled or between appointments during his lunch time.

Please pass HB 392 so that over time we will have some improvements in our situation.

Thank you,

Doris Robbins

1281 Overhill Dr.
Fairbanks AK 99709
(907) 374-0597
drobbins@gci.net

Rob Earl

From: James Atti [jamesatti8@gmail.com]
Sent: Tuesday, March 23, 2010 12:59 PM
To: Rob Earl
Subject: Please support HB 392 in House HSS

Representative Herron

Please support and pass HB 392.

We need Health Care Providers and this bill will help us attain our providers as a great incentive to work at our Community Health Clinic. We certainly need leverage to attract health professionals in our clinic.

Thank-you for your support.

Sincerely,

James Atti
PO Box 2714
Bethel, AK 99559

Rob Earl

From: Mabei Smeitzer [mmses@kpunet.net]
Sent: Monday, March 22, 2010 6:13 PM
To: Rob Earl
Subject: Request that you please support HB392

Representative Herron

We need to retain our providers in order to give the care that is needed and to support caregivers. There is a shortage of practitioners in Alaska which hinders adequate health care that is needed.

We urge you to vote in favor of this bill in order to fill the vacancies that exist throughout the area and bring medical care to the community.

Please vote your support of HB392

Sincerely,

Mabel Smeltzer
2729 Tongass Ave Apt 304
Ketchikan, AK 99901

Rob Earl

From: James Lepich [j.lepich@skagway.org]
Sent: Tuesday, March 23, 2010 8:57 AM
To: Rob Earl
Subject: Support and Testimony for HB 392

Representative Herron

I am writing you in regards to HB 392. I believe this bill to be of utmost importance to the future health of Alaska residents. I came to Alaska this past summer in hopes of acquiring loan repayment through the National Health Service Corps, a process that is arduous and drawn-out. When preparing for this move, I had spoken with several colleagues who had stated that they would be greatly interested in joining the ranks of Alaska Health Care Professionals, however, there is little incentive to do so. They spoke of the high cost of living and that their loans were minimal or already payed down. These are experienced individuals who have a great deal to give to this state. HB 392 and its incentive aspect would be a considerable draw for these people.

The National Health Service Corps does indeed bring many people to this state to fill openings in the health care system, however, as I stated previously, this can be a monstrous undertaking due to working with the Federal bureaucracy. This system also is flawed in that the required time of service is two years, then the people have a choice to stay or move on. It also pays up front, where HB 392 pays out after time has been delivered. My understanding of HB 392 is that it would help people choose to stay in the state due to these requirements.

By taking hold of this at the state level, Alaska can bring in qualified individuals to work and stay in our communities, many of whom will bring a great deal of needed experience.

Thank you considering my testimony and, Please, consider this bill's passing.

Sincerely,

James Lepich
Advanced Nurse Practitioner
PO Box 537
Skagway, AK 99840

Rob Earl

From: Donna Phillips [donnaphill@acsalaska.net]
Sent: Monday, March 22, 2010 6:53 PM
To: Rob Earl
Subject: Please support loan repayment for health care professionals

Representative Herron

I have been an RN in hospital facilities for the past 31 year. I have spent 15 years in AK caring for the critically ill AK citizens and visitors to this state. Many of my new nurse colleagues come out of school with several thousands of dollars in school loans. The only facility that I am aware of that helps with loan repayment is the ANMC. It would help to keep the students educated in AK to stay in AK if they would get loan repayment assistance. I like this bill because the cost to the state is as the professional completes a certain length of time, they then receive payment.

Many states and facilities offer competitive loan repayment programs in order to get professionals to work in their state.

I urge you to look at this bill closely for securing the health care future for the state. Thanks.

Sincerely,

Donna Phillips
PO Box 1178
Girdwood, AK 99587

Rob Earl

From: Sandra Knight [twowid2@yahoo.com]
Sent: Tuesday, March 23, 2010 7:15 AM
To: Rob Earl
Subject: HB 392 health care workforce

Representative Herron

I am a retiree and concerned about the dirth of available health care for our great State of Alaska.

As I read this bill, it would provide rather immediate financial incentive for sorely needed professionals statewide. Please support HB 392.

Thank you.

Sincerely,

Sandra Knight
8101 Peck Ave
Anchorage, AK 99504

Rob Earl

From: Marguerite Stetson [mstetso1@alaska.edu]
Sent: Tuesday, March 23, 2010 7:39 AM
To: Rob Earl
Subject: HB 392 Alaska needs help in getting more health care professionals

Representative Herron

I have experienced the shortage of physicians and nurses in Alaska. I would urge that you pass this legislation to provide loan repayment and incentive programs for Alaska.

Sincerely,

Marguerite Stetson
1810 Ponds Cir
Anchorage, AK 99507

HB

423

Alaska State Legislature

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INTERIM ADDRESS:
600 E Railroad Avenue
Wasilla, AK 99654
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Fax: (907) 376-4768

Representative Carl Gatto

DATE: April 1, 2010
TO: Rep. Wes Keller
FROM: Rep. Carl Gatto
SUBJECT: HB 423 The Alaska Health Freedom Act

The mission of the Liberty Caucus, as articulated by Representative Kelly at its inception, is to fight government overreach "at the expense of personal liberty and state's rights." The recently passed federal *Patient Protection and Affordable Care Act* is the most egregious example of such overreach in a generation, if not in a century. Accordingly, the enclosed members of the Liberty Caucus stand in resolute opposition to this unprecedented usurpation of individual freedom and disregard for the popular will.

The *Alaska Health Freedom Act*, offered by the House Judiciary Committee at the request of Representative Carl Gatto, affirms the right of all Alaskans to choose their own "mode of securing health care services." It also bars state officials from imposing fines or fees on any Alaskans who choose not to participate in the federal government's unconstitutional health care experiment. Finally, it compels the Attorney General to stand up for the Tenth Amendment of the U.S. Constitution and the sovereignty of the State of Alaska.

As members of the Liberty Caucus, we insist that federal law can only be supreme if it is indeed constitutional. The myriad of unnamed rights reserved to the States and the people are equally important to our system of government as the relatively few powers constitutionally granted to the federal government. People across this nation have begun to stand up for individual freedom, limited government, and an end to generational debt. We ask the members of the committee to join us in standing with them and asserting that, at least in Alaska, we still believe in government "of the people, by the people, and for the people."

Alaska State Legislature

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Representative Carl Gatto

Sponsor Statement HB 423

March 29, 2010

For over a year, this nation has been locked in a battle over health care. Roughly 55% of the public, and the entirety of Congressional Republicans, opposed the passage of so-called "health reform" and would like to see the recently-passed health care legislation overturned.¹ Opponents of the health care initiative point to the bill's hidden costs, special exemptions for certain states, and the nineteen point gap between those who strongly support the plan and the larger group that strongly opposes it. Accordingly, I am proposing the *Alaska Health Freedom Act*. The bill is modeled after Idaho HB 391 (and a similar package of legislation in Virginia), which became the first statute enacted by a state legislature to directly challenge the provisions of federal health care "reform."

The *Alaska Health Freedom Act* would:

- Argue that the power to regulate or require a person's health care delivery choices is not found in the U.S. Constitution and is therefore reserved to the people and the States by the 9th and 10th Amendments, respectively
- Establish that every Alaskan "has the right and is free to choose or decline any mode of securing health care services."

¹ Rasmussen, Scott. "Health Care Reform." *Politics*. Rasmussen Reports, 21 Mar. 2010.
<http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/september_2009/health_care_reform>

Rasmussen, Scott. "55% Favor Repeal of Health Care Bill." *Politics*. Rasmussen Reports, 05 Mar. 2010.
<http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/march_2010/55_favor_repeal_of_health_care_bill>

- Require the Attorney General to actively protect the aforementioned right to choose a mode of health care services
- Bar public employees and officials from enforcing, imposing, implementing, or collecting any penalty for resisting government-run healthcare.

The four main tactics being employed among states that oppose the federal government's health care overreach are²:

- **Legislative Discontent Model**: under this plan, states would pass a resolution discouraging the federal government from implementing nationalized medicine; the recent passage of the federal *Patient Protection and Affordable Care Act* makes mere statements of the Alaska Legislature's disapproval fairly moot.
- **Constitutional Amendment Model**: following this model, state legislatures would offer a constitutional amendment to the voters that would enshrine the right of individuals to make their own health care determinations in the state's constitution; the constitutional amendment model, pursued through Alaska HJR 35, has not garnered sufficient support in the legislature, particularly given the time-sensitive nature of this issue.
- **Statutory Model**: in the statutory model, states enact statutes through the regular legislative process that either establish the freedom to make one's own health care decisions as a right or discount the so-called "right of universal healthcare;" these bills also prohibit state officials and agencies from enforcing, collecting, or implementing fees imposed under the new federal health care plan and direct the state's Attorney General to actively defend the provisions of the bill in court
- **Nullification Model**: finally, states following the nullification model to oppose nationalized health care would enact legislation declaring the *Patient Protection and Affordable Care Act* unconstitutional and null and void within the state's jurisdiction.

² "Health Care Freedom Act." *Legislative Tracking*. The Tenth Amendment Center. 29 Mar. 2010. <<http://www.tenthamendmentcenter.com/nullification/health-care/>>.

The problems with the legislative discontent model now that Congress has actually passed health care "reform" are readily apparent. In addition to the issues mentioned above, the constitutional amendment model is problematic because of the Supreme Court's general hesitation to hear conflicts between the federal and state constitutions (i.e. gay marriage in MA, CA). The nullification model is the most popular alternative, but seems inherently flawed. There is little-to-no chance the federal courts would rule that states can pass legislation with a simple majority and overturn duly enacted federal law. Unlike the nullification model, the statutory model challenges the constitutionality of the new federal health care statute without limiting our attorney general to a nullification argument. The Alaska Health Freedom Act does not presume to overturn federal legislation, but instead adopts a distinct public policy for Alaska under the reasoning that the *Patient Protection and Affordable Care Act* misinterprets the Constitution. If universal health care is a "right," shouldn't the freedom to make one's own health care decisions be protected from government intrusion? Also, is there no limit on Congress' power under the Commerce and General Welfare clauses? If Congress can mandate the purchase of any private commodity it so chooses, then what control does an individual really have over their own "pursuit of happiness?"

I hope that this sponsor statement effectively communicates the urgency and practicality of the *Alaska Health Freedom Act*. Questions or concerns can be directed to my staffer, Thomas Reiker, at 465-3163 or Thomas.Reiker@legis.state.ak.us. I thank you for your time and respectfully request a hearing for HB 423.

Sincerely,

Representative Carl Gatto
Alaska House of Representatives
District 13

GOLDWATER

I N S T I T U T E

in defense of liberty

The Health Care Freedom Act: Questions & Answers

by Clint Bolick, Litigation Director, Goldwater Institute

The Health Care Freedom Act will appear as a proposed constitutional amendment on Arizona's 2010 election ballot, and similar measures are under consideration in more than 30 other states. With the possibility that Congress will enact some sort of national health insurance legislation, questions are being raised about the scope of the Health Care Freedom Act and its effect should a federal bill become law. In the following pages, Clint Bolick, who helped to author the Health Care Freedom Act, answers frequently asked questions.

Q: What is the Health Care Freedom Act?

A: The Health Care Freedom Act is a proposed amendment to the Arizona Constitution that would preserve certain existing rights that individuals have regarding health care. It was initially proposed by two Arizona physicians, Dr. Eric Novack and Dr. Jeffrey Singer, with drafting assistance from the Goldwater Institute. The measure qualified as a voter initiative on the 2008 ballot, and despite a well-financed opposition campaign, it was defeated by less than one-half of 1 percent of the vote. Changes were made to address concerns raised by the opponents, and the Arizona Legislature voted to refer the revised version to the 2010 ballot.

The American Legislative Exchange Council adopted model legislation based on the Arizona measure, and activists and legislators in at least 35 additional states are pursuing constitutional amendments or statutes based on the Arizona model.

Q: What are the key provisions?

A: Although the precise language varies from state to state, the Health Care Freedom Act seeks to protect two essential rights. First, it protects a person's right to participate or not in any health care system, and prohibits the government from imposing fines or penalties on that person's decision. Second, it protects the right of individuals to purchase—and the right of doctors to provide—lawful medical services without government fine or penalty. The Health Care Freedom Act would place these essential rights in the state constitution (or, in some states, it would protect them by statute).

Q: What motivated the Health Care Freedom Act?

A: No one questions the need for serious health care reform. However, the proponents of the Health Care Freedom Act believe that regardless of how such reform is fashioned, either at the state or federal level, the essential rights protected by the Health Care Freedom Act should be preserved. Many advocates of a larger government role in regulating or providing health insurance support a mandate that would compel individuals to join a government-approved health insurance plan, whether or not they can afford it and whether or not the system best fits their needs. In some countries in which government plays a large role in providing health insurance, medical services are rationed and individuals are prevented or discouraged from obtaining otherwise lawful medical services. Supporters of the Health Care Freedom Act have a variety of perspectives on the form that health care reform should take. But they agree that no matter what legislation is passed, it should not take from Americans their precious right to control their own medical affairs.

Q: By what authority can states pass the Health Care Freedom Act?

A: It is well-established that the U.S. Constitution provides a baseline for the protection of individual rights, and that state constitutions may provide additional protections—and all of them do. For instance, some states provide greater protections of freedom of speech or due process rights. Because the Health Care Freedom Act offers greater protection than the federal constitution, states are allowed to enact it.

Q: Does it matter whether the Health Care Freedom Act is passed as a statute or as a constitutional amendment?

A: A state constitution is the organic law of the state, reflecting the most fundamental values shared by the citizens of the state. Moreover, a state constitutional amendment will ensure the state legislature can never infringe upon the protected rights. So a constitutional amendment is preferable, especially to protect against legislative tinkering. However, for purposes of a federalism defense against excessive federal legislation, it should not matter whether the people of the state have acted through their constitution or by statute.

Q: Does the Health Care Freedom Act attempt to “nullify” federal health insurance legislation?

A: Absolutely not. If federal legislation is enacted, individuals would still have the option to participate in federal health insurance programs. This act simply protects a person’s right not to participate.

Q: To the extent that the Health Care Freedom Act conflicts with provisions of federal legislation, isn't the state law automatically preempted by the Supremacy Clause of the U.S. Constitution?

A: No. In any clash between state and federal provisions, at least four federal constitutional provisions are relevant. The Supremacy Clause establishes the Constitution as the supreme law of the land and provides that federal laws prevail over conflicting state laws where Congress has the legitimate authority to enact the legislation and where it does not impermissibly tread upon state sovereignty. The federal government will have to demonstrate that its legislation legitimately is derived from congressional authority to regulate interstate commerce. It will also have to show the legislation does not violate the 10th Amendment, which reserves to the states all government power not expressly delegated to the national government; and the 11th Amendment, which protects states from being used as mere instrumentalities of the national government. This constitutional construct is known as federalism.

Q: Are certain provisions of proposed federal health care legislation vulnerable to constitutional challenge even without the Health Care Freedom Act?

A: Yes, in at least three ways. First, to the extent that the legislation purports to regulate transactions that do not directly affect interstate commerce, such as mandating insurance for individuals, Congress may lack authority to do so under the Commerce Clause. Several relatively recent decisions by the U.S. Supreme Court have invalidated federal legislation on this basis. In *U.S. v. Lopez* (1995), the Court struck down federal laws that restricted guns in school zones; and in *U.S. v. Morrison*, it struck down a federal statute involving violence against women. In both cases, the Court found the subject matter of the federal laws did not "substantially affect" interstate commerce, so Congress had no power to regulate it under the circumstances presented.

Second, to the extent the legislation interferes with the individual's right to choose health insurance providers, doctors, or lawful medical services, it may violate the right to medical self-determination recognized under the U.S. Constitution. As the Court declared in *Griswold v. Connecticut* (1965), "We have recognized that the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause." Several of the early abortion cases involved what Justice William O. Douglas, concurring in *Doe v. Bolton* (1973), described as the "right to seek advice on one's health and the right to place reliance on the physician of one's choice." Whether or not one agrees with those abortion rulings, they establish a strong basis for challenging certain federal and state intrusions.

Third, several recent decisions have invalidated federal laws that "commandeer" state governments to do their bidding. In *New York v. United States* (1992), for instance, the Court struck down federal rules requiring states to take ownership of certain radioactive waste and to expose themselves to liability. Speaking for the Court, Justice Sandra Day O'Connor ruled that

“no matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate.” Tellingly, she added “the Constitution protects us from our own best intentions: It divides power among sovereigns . . . precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.” To the extent that federal health insurance legislation forces states to implement its provisions, it could be subject to robust constitutional challenge.

Q: Could the Health Care Freedom Act provide additional protection against federal health insurance legislation that violates protected rights?

A: Yes. Although the federal government usually prevails in federalism clashes, the current U.S. Supreme Court is the most pro-federalism Court in decades. There are no cases precisely on point, but the Court under Chief Justice John Roberts has sided with the states in at least three major recent federalism clashes. In the case most closely on point, *Gonzales v. Oregon* (2006), the Court upheld the state’s “right-to-die” law, which was enacted by Oregon voters, over the objections of the U.S. Attorney General, who argued that federal law pre-empted the state law. Applying “the structure and limitations of federalism,” the Court observed that states have great latitude in regulating health and safety, including medical standards, which are primarily and historically a matter of local concern. Holding that the attorney general’s reading of the federal statute would mark “a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality,” the Court interpreted the statute to allow Oregon to protect the rights of its citizens.

Horne v. Flores (2009) considered a measure adopted by Arizona voters to require English immersion as the state’s educational policy for students for whom English is a second language. Lower federal courts had imposed an injunction based on a finding that Arizona was failing to comply with federal bilingual education requirements. The Supreme Court held that injunctions affecting “areas of core state responsibility, such as public education,” should be lifted as quickly as circumstances warrant. It observed that “federalism concerns are heightened when . . . a federal court decree has the effect of dictating state or local budget priorities.” The Court remanded the case to lower courts to reconsider the injunction.

In *Northwest Austin Municipal Utility District No. 1 v. Holder* (2009), the Court examined a challenge to section 5 of the Voting Rights Act, which places certain states and localities in a penalty box, requiring them to obtain “pre-clearance” by the U.S. Department of Justice for any changes that impact voting. The Court was sharply critical of the “federalism costs” imposed upon the covered jurisdictions. It avoided the constitutional question by applying the federal law in a way that allowed the utility district to “bail out” from pre-clearance requirements under section 5.

In each of these cases, the Court sided with states in federalism disputes with the federal government.

Q: Will the Health Care Freedom Act affect future state legislation regarding health insurance?

A: Yes. If it is passed as a constitutional amendment, it would prevent any future legislation that infringes upon the rights protected by the amendment.

Q: Won't this be really expensive for the states to defend in court?

A: The Goldwater Institute has offered to defend the constitutionality of the Health Care Freedom Act at no cost to any state. Because legal challenges would involve purely constitutional issues and would not require expensive trials, to the extent that states become involved in litigation, they should be able to do so within existing Attorney General litigation budgets. Moreover, depending on the details of national health insurance legislation, the cost of federal mandates is likely to far exceed the cost of litigation.

Q: Even if the states and individuals did not prevail in a challenge to intrusive federal health insurance legislation, would there be reasons to support the Health Care Freedom Act?

A: Yes. First, if these rights are given additional protection under state constitutions, they will create an absolute barrier to future state legislation that violates those rights. Moreover, efforts to enact the Health Care Freedom Act send a powerful message to our nation's capitol that people at the grassroots take these rights very seriously and intend to protect them.

Q: Does the Health Care Freedom Act impair drug laws?

A: Absolutely not. It protects the right to purchase or provide "lawful" medical services. It does not limit the power of any government to determine what constitutes lawful medical services.

Q: Does the Health Care Freedom Act affect the issue of abortion?

A: No. Again, to the extent that states may regulate abortion under applicable constitutional doctrine and state or federal law, this measure would not alter that power in any way. The Health Care Freedom Act does, however, prevent the government from forcing individuals into health care systems against their will, and matters of conscience may influence such individual decisions.

Q: Does the Health Care Freedom Act affect Veterans' Administration programs, workers' compensation, Medicare, Medicaid, or state health-care systems?

A: Generally, no. The Health Care Freedom Act leaves intact any rules and regulations that were in place as of January 1, 2009. The only way such programs could be affected is if they are changed in the future in ways that violate the freedom of choice protected by the Health Care Freedom Act.

Q: Will this restrict the government from limiting the choice of providers or imposing other limits for the people who do opt-in to a government health care system?

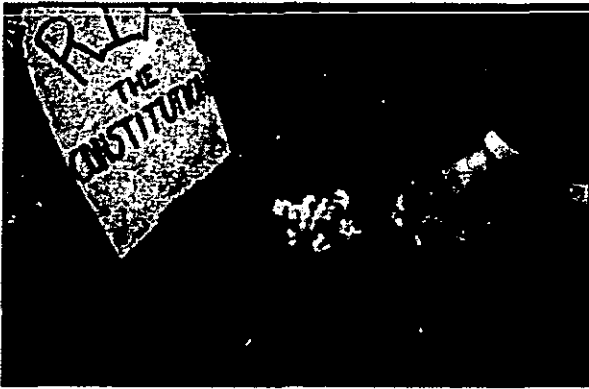
A: No and yes, respectively. If a person voluntarily joins a government health care system, the government may set the terms and conditions, including choice of providers. However, the government cannot prevent a person from purchasing, or a health care professional from providing, lawful medical services outside that system.

Q: Is the Health Care Freedom Act supported financially by insurance companies?

A: No. Many insurance companies support an individual mandate (requiring individuals to buy health insurance or face government fines), which the Health Care Freedom Act would prohibit. An individual mandate guarantees a customer base to the insurance industry. It is present in some legislative proposals as a means to subsidize health insurance for others. If insurance companies play a role in the battle over the Health Care Freedom Act, we expect they will oppose it, possibly with significant resources.

Q: Are there other ways in which freedom advocates can use state constitutions to protect their liberties?

A: Absolutely. State constitutions are full of provisions unknown to the U.S. Constitution that are designed to protect individual liberty and limit the power of government, such as the line-item veto, anti-monopoly provisions, prohibitions against corporate subsidies ("gift clauses"), constraints against earmarks ("special law clauses"), and the like. Citizens and legislatures can amend their state constitutions to add additional protections; and taxpayers can enforce their state constitutional rights in state courts. State constitutions were intended to be the first line of defense in protecting the freedoms of the people. As the power of government grows at every level, we need to use whatever tools are available to us to safeguard our rights. For more on how state constitutions can protect liberty, see the recent Goldwater Institute report, "**50 Bright Stars: An Assessment of Each State's Constitutional Commitment to Limited Government.**"



by Brion McClanahan

When Idaho Governor C.L. “Butch” Otter signed HO391 into law on 17 March 2010, the “national” news media circled the wagons and began another assault on State sovereignty. The bill required the Idaho attorney general to sue the federal government over insurance mandates in the event national healthcare legislation passed. The lead AP reporter on the [story](#), John Miller, quoted constitutional “scholar” David Freeman Engstrom of Stanford Law School as stating that the Idaho law would be irrelevant because of the “supremacy clause” of the United States Constitution.

In his words, “That language is clear that federal law is supreme over state law, so it really doesn’t matter what a state legislature says on this.” Now that Barack Obama has signed healthcare legislation into law, almost a dozen States have filed suit against the federal government, with Idaho in the lead. Battle lines have been drawn. Unfortunately, the question of State sovereignty and the true meaning of the “supremacy clause” may be swallowed up in the ensuing debate.

Engstrom’s opinion is held by a majority of constitutional law “scholars,” but he is far from correct, and Idaho and the thirty seven other States considering similar legislation have a strong case based on the original intent of the powers of the federal government vis-à-vis the States.

The so-called “supremacy clause” of the Constitution, found in Article 6, states, “This Constitution, and the Laws of the United States *which shall be made in Pursuance thereof*; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding [emphasis added].”

The key, of course, is the italicized phrase. All laws made in pursuance of the Constitution, or those clearly enumerated in the document, were supreme, State laws notwithstanding. In other words, the federal government was supreme in all items clearly listed in the document.

A quick reading of the Constitution illustrates that national healthcare is not one of the enumerated powers of the federal government, so obviously Engstrom’s blanket and simplistic statement is blatantly incorrect, but his distortion of the supremacy clause goes further.

The inclusion of such a clause in the Constitution was first debated at the Constitutional Convention on 31 May 1787. In Edmund Randolph’s initial proposal, called the Virginia Plan, the “national” legislature had the ability to “legislate in all cases to which the separate states are incompetent...” and “to negative all laws passed by the several states contravening, in the opinion of the national legislature, the Articles of Union...” John Rutledge, Pierce Butler, and Charles Pinckney of South Carolina challenged the word “incompetent” and demanded that Randolph define the term. Butler thought that the delegates “were running into an extreme, in taking away the powers of the states...” through such language.

Randolph replied that he “disclaimed any intention to give indefinite powers to the national legislature, declaring that he was entirely opposed to such an inroad on the state jurisdictions, and that he did not think any considerations whatever could ever change his determination [emphasis added].” James Madison, the author of the Virginia Plan, was not as forthcoming as to his sentiment. Ultimately, Madison preferred a negative over State law and wished the national legislature to be supreme in all cases. But he was not in the majority.

The Convention again broached a federal negative on State law on 8 June 1787. Charles Pinckney, who presented a draft of a constitution shortly after Randolph offered the Virginia Plan, believed a national negative necessary to the security of the Union, and Madison, using imagery from the solar system and equating the sun to the national government, argued that without a national negative, the States “will continually fly out of their proper orbits, and destroy the order and harmony of the political system.” Such symbolism made for a beautiful picture, but it belied reality.

To most of the assembled delegates, the national government was not the center of the political universe and the States retained their sovereignty. Hugh Williamson of North Carolina emphatically stated he “was against giving a power that might restrain the states from regulating their internal police.”

Elbridge Gerry of Massachusetts was against an unlimited negative, and Gunning Bedford of Delaware believed a national negative was simply intended “to strip the small states of their equal right of suffrage.” He asked, “Will not these large states crush the small ones, whenever they stand in the way of their ambitious or interested views?”

When the negative power was put to a vote, seven States voted against it and three for it, with Delaware divided (and Virginia only in the affirmative by one vote). Roger Sherman of Connecticut summarized the sentiment of the majority when he stated he “thought the cases in which the negative ought to be exercised might be defined.” Since the negative did not pass, such a definition was unnecessary.

Thus, the federal government was supreme only in its enumerated powers and it did not have a negative over State law. Supremacy had limits.

By the time the Constitution was debated in the several State ratifying conventions in 1787 and 1788, the “supremacy clause” galvanized opponents of the document. The Constitution, they said, would destroy the States and render them impotent in their internal affairs. The response from *proponents* of ratification illuminates the true intent of the clause. William Davie, a delegate to the Constitutional Convention from North Carolina and proponent of the Constitution, responded to attacks levied on the “supremacy clause” by stating that:

This Constitution, *as to the powers therein granted*, is constantly to be the supreme law of the land. Every power ceded by it must be executed without being counteracted by the laws or constitutions of the individual states. *Gentlemen should distinguish that it is not the supreme law in the exercise of power not granted. It can be supreme only in cases consistent with the powers specially granted, and not in usurpations* [emphasis added].

Davie wasn't alone in this opinion. Future Supreme Court justice James Iredell of North Carolina argued that, “This clause [the supremacy clause] is supposed to give too much power, when, in fact, it only provides for the execution of those powers which *are already given in the foregoing articles*... If Congress, under pretence of executing one power, should, in fact, usurp another, they will violate the Constitution [emphasis added].”

Furthermore, in a foreshadowing of nullification, Iredell argued that, "It appears to me merely a general clause, the amount of which is that, when they [Congress] pass an act, if it be in the execution of a power given by the Constitution, it shall be binding on the people, *otherwise not* [emphasis added]. Other ratifying conventions had similar debates, and proponents of the Constitution continually reassured wavering supporters that the Constitution would only be supreme within its delegated authority.

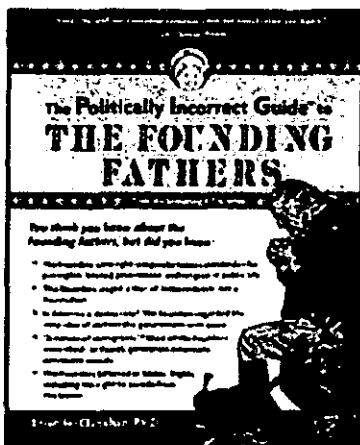
Most bought their assurances, though to staunch opponents, the Constitution still vested too much power in the central authority. The States would lose their sovereignty, they argued, and as a result, these men demanded an amendment to the Constitution that expressly maintained the sovereignty of the States and placed limits on federal power. Even several moderate supporters of the Constitution embraced this idea.

Ultimately, the three most powerful States in the Union, New York, Massachusetts, and Virginia, demanded that a bill of rights be immediately added to the Constitution; near the top of those recommended amendments on every list, a State sovereignty resolution. These ultimately became the Tenth Amendment to the Constitution, which reads, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

Clearly the intent of this amendment was to mitigate any design the federal government had on enlarging its powers through the "supremacy clause." If the power was not enumerated in the Constitution and the States were not prohibited by the Constitution from exercising said power, then that power was reserved to the States.

Several other constitutional "scholars" have weighed in on the debate in the last week, and each has invoked the "supremacy clause" to defend their opposition to State action against healthcare. Duke Law Professor Neil Siegel went so far as to suggest that the States are not reading the Tenth Amendment correctly. In perhaps the most outlandish statement of the debate, he also said, "Any talk of nullification bothers me because it's talk of lawlessness."

I guess Mr. Siegel has failed to consider that Idaho bill HO391 was passed by a legitimate legislative body elected by the people of the State. That would make it lawful.



Of course, this debate ultimately boils down to loose interpretation verses strict construction. Thomas Jefferson had the best line on this issue. When asked to read between the lines to "find" implied powers, Jefferson responded that he had done that, and he "found only blank space."

The original intent of both the "supremacy clause" and the Tenth Amendment indicate that Idaho and the other States challenging Obamacare are justified and correct and that the legal profession is either in the tank for the federal government or has not read either the debates of the Constitutional Convention and/or the State ratifying debates. This should make people like Engstrom and Siegel, rather than legitimate State law directed at unconstitutional authority, irrelevant.

Brion McClanahan holds a Ph.D in American history from the University of South Carolina and is the author of The Politically Incorrect Guide to the Founding Fathers (Regnery, 2009).

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States Launch Legal Challenge to Health Care Law

At Least 14 States File Suit Challenging Constitutionality of Health Care Law

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President Obama signs the Affordable Health Care for America Act during a ceremony with fellow... (Win McNamee/Getty Images)

State Legislatures to Challenge Health Care Law

In addition to constitutional challenges to the law, legislators in at least 36 states are attempting to limit, alter or oppose some of its provisions through state constitutional amendments or laws, according to the National Conference of State Legislatures.

Many of the proposals seek to keep health insurance coverage optional for individuals and exempt employers from penalties if they don't offer coverage for workers.

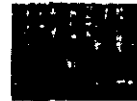
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Earlier this month, Virginia and Idaho became the first states to enact laws specifically stating that health insurance coverage is not required.

Still, many legal experts say these legislative efforts will ultimately be trumped by the so-called supremacy clause in the U.S. Constitution, which says federal laws "shall be the supreme law of the land."

"State law cannot nullify federal law," Timothy Stoltzfus Jost, a health law expert at Washington and Lee University School of Law, writes in the New England Journal of Medicine.

"This principle is simply beyond debate, and state legislators, many of them lawyers, know that. The purpose of these laws, therefore, is not legal but rather political

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Indiana joins 13 states to challenge health reform

13 other states raise constitutional questions about the new legislation

By Bill Ruthhart

Posted: March 30, 2010

Indiana became the 14th state Monday to challenge the constitutionality of the federal health-care legislation, but legal experts warned the lawsuit faces an uphill climb against previous court rulings.

After reviewing the sweeping health-care reforms, Indiana Attorney General Greg Zoeller announced he would join a lawsuit already filed jointly by 13 other attorneys general in a Florida federal court.

At the core of Zoeller's decision to join the suit is the charge that Congress does not have the power to force Americans to buy health insurance coverage or require them to pay a fine if they fail to do so.

"It's really critical that we have these questions asked and answered," he said, "so that the Supreme Court's final word as to whether the new reach of the federal government in this statute meets constitutional muster."

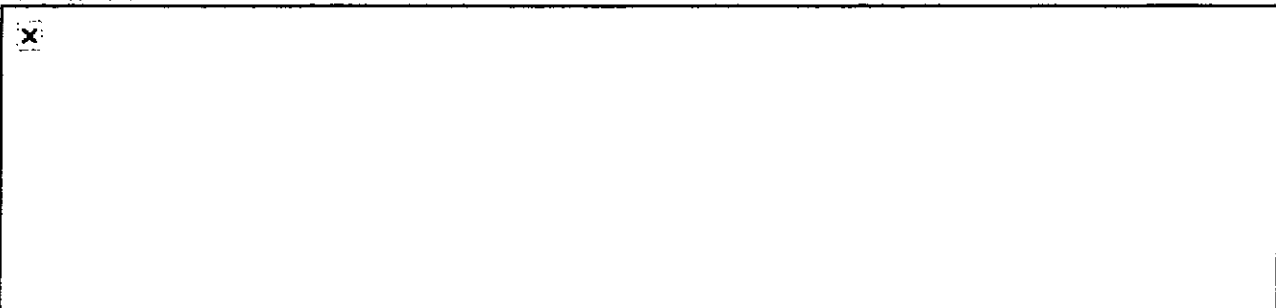
Zoeller also argued that the new reforms impinge on states' sovereignty by requiring states to set up health insurance exchanges for their residents to purchase coverage.

Democrats immediately accused Zoeller of playing politics. Of the 13 other attorneys general who have joined the lawsuit, 12 are Republicans.

"This is purely politics, nothing but," said Indiana Democratic Party Chairman Dan Parker. "The legal argument is weak, the political argument is weak. It's all based on false information, and the opponents of this couldn't stop it, so they're grasping at straws and this is the final straw to grasp."

Zoeller's announcement came after Gov. Mitch Daniels said Friday he had encouraged Zoeller to join the suit, even though Daniels said he was skeptical of

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its chances for success. The attorney general said Monday he made the decision based on the case's merits and independent from any political input.

"It's unfortunate that the entire subject matter has been politicized," Zoeller said, "but that was done in Washington before we ever joined (the lawsuit)."

Parker declared the suit a waste of taxpayer dollars.

Zoeller said he could not give an estimate of how much the lawsuit would cost but said he has no plans to hire outside counsel. He said the state's initial cost would be its undetermined share of a contract capped at \$50,000 with a Washington, D.C., law firm hired to handle the case.

Indiana Republican Party Chairman Murray Clark said the lawsuit has merit.

"I think it's the right decision," he said. "Clearly, there's some constitutional questions that need to be asked and answered in light of one of the largest federal government overreaches we've seen in a long time."

The key question the lawsuit raises is whether the new law's requirement that all Americans carry health insurance coverage or be forced to pay a penalty should serve as a new test to the Constitution's commerce clause, which gives Congress the power to regulate business.

Over the past several decades -- starting in the 1930s -- constitutional law experts say, the courts and lawmakers have broadly interpreted that clause, giving Congress wide-ranging regulatory power.

Most legal scholars think those precedents would make it difficult for the Supreme Court, or any other, to rule that Congress does not have the power to add the new insurance regulations, said Carl Tobias, a constitutional law expert at the University of Richmond in Virginia.

Furthermore, he said, backers of the bill will defend the prospective fine for those who don't buy insurance under the taxing power that the Constitution gives Congress.

"The precedents all favor constitutionality," Tobias said. "There's nothing exactly the same as this challenge, but the relevant precedents, if

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you analogize from them, lead you to the conclusion that this challenge won't succeed."

But that's not to say the lawsuit isn't a worthy one, he said.

"I think it might have merit, but I just don't think it's going to win," Tobias said. "I think the best argument is about the individual mandates, but I think a fair number of constitutional scholars, and I agree, think that it's probably going to withstand the challenge."

Charles Rice, a constitutional law expert at the University of Notre Dame, said the case certainly is worth litigating.

"I think it's a legitimate thing to do. The outcome is not certain," Rice said. "It's really interesting, because it brings in precedents from a lot of the cases involving the Social Security Act and things like that, and it could provide the opportunity, if it gets to the Supreme Court, for the case to go either way."

Key to its outcome could be how the American public views the new law in the future, said Gerard Magliocca, a constitutional law professor at Indiana University School of Law-Indianapolis.

"This likely wouldn't be decided for two years, and a lot will depend on what people think of the health-care bill," Magliocca said. "If it's very unpopular, the courts are more likely to find a reason to declare it unconstitutional

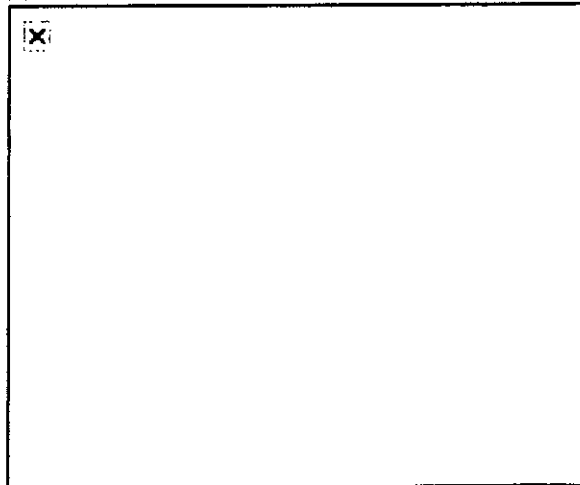
than if it turns out to be popular."

Parker, the state Democratic Party chairman, said Zoeller's decision would cost the attorney general in his next election in 2012, when he will have to explain why he fought against a bill that reformed the insurance industry to the benefit of so many Hoosiers. "Greg Zoeller is going to be on the wrong side of history on this one," Parker said.

Zoeller countered that almost everyone agrees the new law has raised fresh constitutional issues that the courts need to resolve.

"There aren't many people who say there isn't a new question here, because this is the first time the federal government has required people to purchase a commercial good, a commercial product," he said. "This is an insurance product that everyone, as a condition of being a citizen of the United States, will be required to purchase under the threat of penalty."

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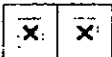
In the end, Magliocca said, he gives the lawsuit a 25 percent chance of success.

"There is a plausible argument for saying this is unprecedented," he said. "It has a chance, but I think most everybody, most legal scholars, think it's unlikely this suit will succeed."

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March 24, 2010

HEALTH CARE REFORM: WHO WINS AND WHO LOSES

While the health care bill is not as sweeping as many had once hoped (or others had feared), make no mistake: The new legislation will dramatically change the nation's health care system.

So who wins and who loses? "The people who gain the most are low-income people who do not get health insurance from an employer," says John Goodman, president, CEO and the Kaitie Wright Fellow of the National Center for Policy Analysis. "Just about everybody else loses."

Groups that will especially bear the burden include:

- Generation Y: Most of the 19 million uninsured Americans between the ages of 18 and 34 will be forced to buy coverage -- coverage likely more expensive than they might have otherwise chosen.
- Anyone who earns more than \$200,000: Workers earning more than \$200,000 a year or couples with a combined income over \$250,000 will pay an additional 0.9 percent in federal income tax to help fund Medicaid expansion starting in 2013, and will likely pay a new 3.8 percent Medicare tax on all investment income.
- Individuals with so-called Cadillac health insurance: A 40 percent tax will be levied on plans with premiums of \$10,200 or more per person.

Goodman also notes that "as many as 8.5 million seniors could lose their Medicare Advantage coverage altogether" under government plans to reduce benefits offered under the program.

Advocates of the legislation argue that winners include anyone with a preexisting condition, recent college graduates who can now get coverage through their parents, small businesses who will have access to insurance pools and doctors who will get paid for seeing uninsured patients they were treating for free.

In addition, individuals aged 60 to 64 - the oldest age demographic not eligible for Medicare - will pay no more than three times the cost of the premium paid by a healthy 20-something. But as Goodman notes, "People who are 60 to 64 are going to pay lower premiums than they otherwise would because people who are 20 to 24 are going to pay higher premiums."

Source: Catherine Holahan, "Health Care Reform: Who Wins and Who Loses," CBS MoneyWatch, March 22, 2010.

Link to text:

<http://moneywatch.bnet.com/economic-news/article/health-care-reform-summary-who-wins-and-who-loses/406279/>

For more on Health Issues:

http://www.ncpa.org/sub/dpd/index.php?Article_Category=16



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March 24, 2010

8 WAYS THAT HEALTH REFORM WILL AFFECT YOU

The health care legislation could "have an effect on almost every citizen," according to Kaiser Health News. So what should you expect?

Within six months after the bill is signed into law:

- Health insurers will no longer be allowed to impose lifetime caps on coverage.
- Parents who have insurance through their employers will be allowed to continue coverage for their unmarried dependents up to age 26.
- Health insurers will be required to cover certain preventive services like osteoporosis screening for women over 65, smoking cessation counseling and interventions, and screenings for diabetes and sexually transmitted diseases.
- And later this year, people with serious health conditions that have prevented them from obtaining coverage will be eligible to purchase a policy from a high-risk pool in a government-subsidized exchange at a cost similar to healthy individuals' premiums.

Individuals will also be required to obtain health insurance or face a fine. Government subsidies will be available on a sliding scale for people making up to \$43,000 per year (or nearly \$90,000 per year for a family of four), but those who don't qualify for government subsidies should expect to pay about \$5,000 a year for a policy on the exchange, while families should expect to pay about \$15,000, says John Goodman, president, CEO and Kellye Wright Fellow of the National Center for Policy Analysis.

The penalty starts in 2014 at \$95 or up to 1 percent of income for individuals, whichever is greater, and rises to \$695 by 2016 or 2.5 percent of income, whichever is greater. Families pay heftier fines - \$2,085 or 2.5 percent of income by 2016.

Other changes:

- Insurers won't be able to deny coverage based on preexisting conditions.
- Maternity support will be increased for women in the workplace.
- Additional, less expensive insurance options will be available when you lose or quit your job.

Increasing the number of insured individuals, however, will also mean longer waits to see a new doctor. In Massachusetts, for example, where health insurance is universal, Boston residents have to wait about twice as long to see a doctor as people in any other U.S. city, says Goodman.

Source: Deborah Kotz, "8 Ways Health Reform Will Affect You," U.S. News and World Report, March 22, 2010

For text:

<http://www.usnews.com/health/managing-your-healthcare/insurance/articles/2010/03/22/8-ways-health-reform-will-affect-you.html>

For more on Health Issues:

http://www.ncpa.org/sub/dpd/index.php?Article_Category=16



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March 24, 2010

20 WAYS OBAMACARE WILL TAKE AWAY OUR FREEDOMS

It is worthwhile to take a comprehensive look at the freedoms we will lose under ObamaCare, says blogger David Hogberg. Among them:

- You are young and don't want health insurance? You are starting up a small business and need to minimize expenses, and one way to do that is to forgo health insurance? Tough. You have to pay \$750 annually for the "privilege." (Section 1501).
- You are young and healthy and want to pay for insurance that reflects that status? Tough. You'll have to pay for premiums that cover not only you, but also the guy who smokes three packs a day, drinks a gallon of whiskey and eats chicken fat off the floor. That's because insurance companies will no longer be able to underwrite on the basis of a person's health status. (Section 2701).
- You're a single guy without children? Tough, your policy must cover pediatric services. You're a woman who can't have children? Tough, your policy must cover maternity services. You're a teetotaler? Tough, your policy must cover substance abuse treatment. (Add your own violation of personal freedom here.) (Section 1302).
- You are an employer in the small-group insurance market and you'd like to offer policies with deductibles higher than \$2,000 for individuals and \$4,000 for families? Tough. (Section 1302 (c) (2) (A)).
- If you are a physician and you don't want the government looking over your shoulder? Tough. The Secretary of Health and Human Services is authorized to use your claims data to issue reports that measure the resources you use, provide information on the quality of care you provide, and compare the resources you use to those used by other physicians. Of course, this will all be just for informational purposes. It's not like the government will ever use it to intervene in your practice and patients' care. Of course not. (Section 3003 (i)).
- You will have to pay an additional 0.5 percent payroll tax on any dollar you make over \$250,000 if you file a joint return and \$200,000 if you file an individual return. What? You think you know how to spend the money you earned better than the government? Tough. (Section 9015). That amount will rise to a 3.8 percent tax in 2013 and will also apply to investment income, estates, and trusts. You think you know how to spend the money you earned better than the government? Like you need to ask. (Section 1402).

Source: David Hogberg, "20 Ways ObamaCare Will Take Away our Freedoms," Investors Business Daily, March 22, 2010.

For text:

<http://blogs.investors.com/capitalhill/index.php/home/35-politicsinvesting/1563-20-ways-obamacare-will-take-away-our-freedoms>

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Bonnie Gruening

From: Jen [jen@conservativepatriotsgroup.org]
Sent: Monday, March 29, 2010 8:14 PM
To: Rep. Carl Gatto
Subject: CPG Health Care Repeal Petition
Attachments: Petition1.pdf

There are 700 names and more are coming. For your information. Jen

PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

With the passage of the Health Care Reform Bill, America is teetering toward tyranny. A mandate requiring all individuals to purchase health insurance is an unprecedented form of federal action. A legal challenge by the States appears to be the only hope of protecting the American people from this unprecedented attack on our system of government.

At least fifteen states are instituting legal action to challenge the constitutionality of the health care reform bill. Alaska should take its place in this list of States and join in the legal fight.

By signing this petition you are demanding the Governor and Attorney General join in the legal action to repeal the Health Care Bill.

	Print Name	Signature	Address	Phone No.	email
1	DAN SENTZ	Dan Lent	901 McAdoo Way	376-4574	Lake7@Rogerssa.com
2	Mary Spaulding	Mary Spaulding	PO Box 1129 Chickaloon AK	746-2216	-
3	VERNE RUPRIGHT	Verne Rupright	866 W. SPEAR AVE, WASILLA, AK	373-3223	-
4	KATHY Rocci	Kathy Rocci	912 S. PINNACLE MTN DR, PALMER	746-0309	
5	Billy KROESTER	Billy Kroester	2206025 200th A NE Fairington	360-435-6205	
6	Maureen McGready	Maureen McGready	470 E. Silver Fox Ln #2 Wasilla	376-2951	
7	JON CRESS	Jon Cress	50374 Spear Hill St-Kenai	976-3776	
8	Tom JURABEK	Tom Jurabek	5377 RIDGEFORD PALM CR		
9	CATHIE BIRRE	Cathie Birre	700 Manay Wasilla	757-7280	
10	Steve Brown	Steve Brown	4410 E. Echo Wasilla	864-9087	
11	Scott Work	Scott Work	1835 Caribou Loop Wasilla	357-1895	
12	Bradley Pietila	Bradley Pietila	1601 S Pioneer Dr	982-5070	scott16work@alaska.com
13	Trisha Pietila	Trisha Pietila	1991 S Badenbury / Palmer	745-1194	
14	Tym MILLER	Tym Miller	1991 S Badenbury Palmer	745-1194	
15	John A. Morris	John A. Morris	2501 E NAOMI AVE WASILLA	252-6773	
16	GEORGE BUCKE	George Bucke	P.O. Box 52743 Big Lake AK	907-515-1797	humboldt@thecross.com
17	Hyla Kestor	Hyla Kestor	P.O. Box 3166 PALMER, AK 99645	746-2849	
18	Johann Merels	Johann Merels	P.O. Box 3766 Palmer, AK 99645	746-2849	
19	James C. Norris	James C. Norris	1943 Kullberg Dr, Chugiak, AK 99577	441-8817	
20	James C. Norris	James C. Norris	P.O. Box 521742 Big Lake, AK 99654	575-8786	Hanki-1@kno.com

Return to: Conservative Patriots Group, Inc. 1830 E Parks Hwy. A-113 #535, Wasilla, AK 99654 PH: 907-354-8360

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	Print Name	Signature	Address	Phone No.	email
1	Gene Jordan		P.O. Box 100331 Anchorage 99516	907-240-8089	
2	Rick Lindsay		7362 W Pines Hwy PMB625 Wasilla AK 99684	907 557-3090	
3	FREDERICKS HANSON		5530 E RAVICH CIR PALM AK 99677	907-357-3443	
4	Travis Oaks		17915 SEVIERSON Circle ER, AK 99577	907 694-1095	
5	DON HARRIS		8227 RUBEN Rd 99504	907 311-1894	
6	ISAAC HERVEY		4250 E SNIDER D WASILLA AK	907 7156930	
7	MIKE HERVEY		2840 ALMA DR WASILLA AK	907-841-8224	
8	JOE MOSS		13451 E. NORMAN Palmer AK	907 746-5022	
9	CLAY DASH		1721 DRIFWOOD CIR Palmer AK	907 357-1180	
10	Michele Lecours		6070 N. Talbot View Dr Wasilla AK 99684	907 662-3930	mlecdurs@live.com
11	Mona Connors	Mona Connors	4950 E. Cispin Wasilla 99684	907-376-0079	
12	TERRY E. Buxbaum		1101 Tina Lane Palmer 99645	907-746-2258	
13	Bonnie Buxbaum		1101 Tina Lane Palmer 99645	907-746-2238	
14	Jixie Banner		400 Crestwood Ave, Wasilla 99654	907-250-6321	
15	Dave WARTH		1120 HUFFMAN #371 Anchorage AK 99503	907 319-6670	
16	MILLE PENNEMART		P.O. Box 875501 Wasilla 99687	907 715-6155	
17	Julie Hays		PO Box 875503 Wasilla 99687	907 715 6159	
18	Kristin Hunt		5421 E. 131st Ave Anchorage AK 99516	907-830-6881	
19	Jon Hunt		5421 E. 131st Ave Anchorage AK 99516	907-301-5155	
20	Emily Frye		4231 E. Highline Ln Wasilla AK 99684	907 229-7558	

PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	Thomas R. Russell	Thomas R. Russell	HC 34 - Box 2051 ^{Wasilla AK 99654}	373-1956	TRBARUSSELL@GMAIL.COM
2	BARBARA RUSSELL	Barbara Russell	H.C. 34 - Box 2051 ^{Wasilla AK 99654}	373-1956	Sana
3	Sina Sena	[Signature]	2712 Strawberry Rd Anchorage AK 99507	248-7848	sinasena7@yahoo.com
4	Tim Baker	Tim Baker	600 E. McAdoo Way ^{Wasilla AK}	373-9921	jbaker@MTAonline.net
5	Serry Delaney	[Signature]			Mintail@dayloop.com
6	Amy Childers	Amy Childers	1325 W. Bluffview Dr. ^{Wasilla AK}	230-8664	
7	Jeremy Hoagland	Jeremy Hoagland	2701 Nancy Way Wasilla AK	355-2522	malich@mtaonline.net
8	Dennis Gouret	[Signature]		841-8886	
9	Jaron John	[Signature]	1030 Seneca Dr. Wasilla, AK	357-2462	jjohns@q.com
10	Tommy Russel	[Signature]	574 SARANS WAY	376-6974	
11	RANDY APLING	[Signature]	3360. N. TRAVELER DR. ^{Wasilla AK 99654}	373-4824	Randy@PaxsonSupply.com
12	Brian Fulkerson	[Signature]	PO BOX 59362 ^{North Anchorage AK 99705}	590-2416	fulkerson@mtaonline.net
13	Rachel Courtney	Rachel Courtney	PO Box 873212 Wasilla 99687	376-7100	
14	Nathan Courtney	[Signature]	PO Box 873212 Wasilla 99687	376-7100	
15	Elizabeth Townes	[Signature]	PO Box 24161 Palmer 99645	715-0008	
16	Kenneth Fedeli	[Signature]	PO Box 873671, Wasilla AK 99687	758363	
17	Joann Judkins	[Signature]	PO Box 874124 Wasilla AK	373-3599	
18	Joshua Wood	[Signature]	5935 Birch Park Cir Eagle River	522-4846	
19	Gary Gudz	[Signature]	560 N. Pine Ridge Loop. Wasilla AK	373-5271	ggudz@MTAonline.net
20	Sean Bidlon	[Signature]	5913 N. Solitude Wasilla AK	232-5922	eldertrath855@yahoo.com

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	Print Name	Signature	Address	Phone No.	email
1	Hal Frye	<i>[Signature]</i>	4231 E. Highline Luvassik, AK	907-224-4416	
2	James DENSEL	<i>[Signature]</i>	360 N. Bonanza Palmer, AK	775-0329	jdanzig@frontiernet.com
3	Robert Doyle	<i>[Signature]</i>	1900 E. Porcupine Trail Wasilla, AK	373-3147	bdoyle@netnet.net
4	Karen Doyle	<i>[Signature]</i>	1900 E. Porcupine Trail, Wasilla, AK	373-3147	
5	Dale Carlson	<i>[Signature]</i>	11315 E. Equustrain ST	746-1335	airdale@gci.net
6	Valerie J Lindeman	<i>[Signature]</i>	3465 E. Naomi Ave Wasilla, AK	907-376-9057	vlindeman@gci.net
7	Christopher C Horacek	<i>[Signature]</i>	1150 S. Colony Way STE 3 PHB176 ^{Palmer AK 99645}	907-746-3527	choracek@gci.net
8	Rick Kinman	<i>[Signature]</i>	1711 Centurion Dr Wasilla AK 99684	907-355-9253	rickkinman@yahoo.com
9	Jim Lindeman	<i>[Signature]</i>	3465 Naomi Ave. WASILLA ⁹⁹⁶⁸⁴	907-376-9057	jvlindeman@gci.net
10	Piper Marsh	<i>[Signature]</i>	2923 S Avalon Cir #3 Wasilla 99684	907-373-3133	
11	Jessica Ringas	<i>[Signature]</i>	5270 E Kanan Cir Wasilla AK	907 225 5180	jrings@netnet.net
12	Jeff Whitten	<i>[Signature]</i>	7121 Wellington Dr WASILLA AK	907 324 8924	jeff-e-guy@yahoo.com
13	Cameron Gunderen	<i>[Signature]</i>	6577 Resner Cir Wasilla AK	(907)329-1291	
14	Rick C. Ellis	<i>[Signature]</i>	341 S. GASTMAN CT, WASILLA, AK ⁹⁹⁶⁸⁴	(907)376-6702	rickellis@yahoo.com
15	Gaylene Ellis	<i>[Signature]</i>	341 S. Gastman Ct Wasilla, AK ⁹⁹⁶⁸⁴	907 376 2703	
16	Sully S Lund	<i>[Signature]</i>	3862 N. Charley Dr.	907-376-7908	aklund@mtaonline.net
17	Cristina McAulley	<i>[Signature]</i>	2925 W. Bayridge Circle, Wasilla ⁹⁹⁶⁸⁴	357-3501	
18	Michael C McAulley	<i>[Signature]</i>	2925 W. Bayridge Cir Wasilla, AK ⁹⁹⁶⁸⁴	357-3501	
19	Glen Verplanken	<i>[Signature]</i>	501 E Heather Way Wasilla AK ⁹⁹⁶⁸⁴	357-4480	gverpl@peoplepc.com
20	Robert Hall	<i>[Signature]</i>	Box 871906 Wasilla AK ⁹⁹⁶⁸⁴	373 6555	grilla@calaska.net

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	Print Name	Signature	Address	Phone No.	email
1	Thomas G. Yates	<i>Thomas G. Yates</i>	2050 E. Black Bear Dr 99654		Yatesrowdy@msn.com
2	ERIC I. WHITFORD	<i>Eric I. Whitford</i>	4882 E. ALDER Rd 99654		SilverDragon36@Yahoo.com
3	Curie J. Whitford	<i>Curie J. Whitford</i>	4882 E. Alder Rd Wasilla 99654		quiltz41@gmail.com
4	CAROL WERNER	<i>Carol Werner</i>	3100 N Palmcrest Ln Palmer 99645	745 3532	Carolw@mtaonline.net
5	JASON WERNER	<i>Jason Werner</i>	643 S Gulkana St	745 0176	Ja-wer@yhu.com
6	Marvin Baker	<i>Marvin Baker</i>	26016 N. Glenn Hwy	746-6531	pinnadepent@mtaonline.net
7	James Jewett	<i>James M. Jewett</i>	1961 W. Rivier St NE Wasilla, AK 99654	355 5359	arkme4ycw@ymail.com
8	Laurie Schillberg	<i>Laurie Schillberg</i>	3991 Tambert Wasilla AK 99654	373 3946	
9	Robert L. Bathary Sr	<i>Robert L. Bathary Sr</i>	16905 ELEONORA ST Eagle River 99577	907/694-1778	
10	Paula L. Anderson	<i>Paula L. Anderson</i>	PO Box 873644 Wasilla, AK 99687	907-376-3680	
11	Richard W Anderson	<i>Richard W Anderson</i>	3660 N TRAVELER DR AK 99654	907-351-2342	
12	DAN DOWNING	<i>Dan Downing</i>	POB 967, Willow, AK 99688	907 495 2871	ddd@mtaonline.net
13	Ron Lyons	<i>Ron Lyons</i>	7362 W. Parks Hwy #633 99654	907 315-5532	ronald.lyons@hotmail.com
14	Ronald Smith	<i>Ronald Smith</i>	1089 Oak Crest Ct N.P. AK 99705	907 488 3281	ronald.smith6@comcast.net
15	Roger Schilling	<i>Roger Schilling</i>	3644 W. Birch Meadows Rd Wasilla AK 99654	907 684 4024	
16	West McCollum	<i>West McCollum</i>	P.O. Box 873578 Wasilla, AK 99687	907 354-8949	westhmc@yaho.com
17	Todd LeCours	<i>Todd LeCours</i>	6020 N. Talbot View Dr AK 99654	907 402 3222	tulecours@msn.com
18	ALEX CANNORS	<i>Alex Cannors</i>	4950 E. ASPEN ST	376-0079	cable@mtaonline.net
19	Bob Bless	<i>Robert B Bless</i>	P.O. Box 874100 Wasilla, AK 99687	715-0990	
20	Ashley Lauer	<i>Ashley Lauer</i>	1301 671 967 Chugach AK 99561	686-1321	desaad@gmail.com

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	Print Name	Signature	Address	Phone No.	email
1	Diane Pankowski		PO BOX 520675 BIG LAKE AK 99652	907-892-7413	
2	Jim Carlin		PO Box 3957 Palmer AK 99645	276-346	
3	REX MUNTIER		P.O. Box 873472 WASILLA ⁹⁹⁶⁸¹	376-7427	
4	Portia Babcock		11404 Discovery Park Dr. Anch. ⁹⁹⁵⁰⁵	250-9972	portia@alaska.com
5	D J Maurin		1116 Josselin Ln Palmer	746-4262	
6	JP Coleman		7740 E Timberline Rd Palmer	746-0887	
7	Tracey Correa		PO Box 870074 Wasilla, AK ⁹⁹⁶⁸¹	841-1262	wasak2005@yahoo.com
8	Tony Porreca		PO Box 810074 Wasilla, AK	811-888	
9	ROXANNE L. GREGORY		3481 N BANNERWAY, WASILLA AK	376-9718	RLGREGORY@FIRSTAM.COM
10	Kittana Butt		7320 No Esther Dr Palmer, AK	746-6362	kittana5@yahoo.com
11	WILLIAM BASSETT		P.O. Box 90507 - Anchorage AK ⁹⁹⁵⁰⁹	351-2579	
12	Donald W. Krieger		PO Box 553 Sutton AK 99674	745-2003	
13	Olivia Jones		4000 Morgan Way 99502	907-242-2132	Olivia.jones@emson.com
14	WILLIAM M. SOUTHCOTT		PO Box 4993 Palmer AK 99645	746-3925	MA.SOUTHCO@AONLINE.NET
15	Sherrill E. Storing		P.O. Box 2601 Palmer AK 99645	745-4496	
16	Ramona J. Norman		2300 N Skwentna Bay WASILLA, AK ⁹⁹⁶⁵⁴	357-8425	mrnorman-ak@gsi.net
17	Glen Rowe		551 E Barma Loop Wasilla	957-8859	
18	Ryan Friesen		801 W. Nelson Ave Wasilla	376-7076	
19	Tomie Friesen		801 West Nelson Ave Wasilla	276-7076	Tomie.Friesen@yahoo.com
20	ROBERT ANTHONY		3725 S. EMBERT BAY DR. WASILLA	373-2227	

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	Print Name	Signature	Address	Phone No.	email
1	Albert LaValley	<i>Albert LaValley</i>	PO Box 875291 Wasilla AK	357-5561	
2	Debra S. Davis	<i>Debra S. Davis</i>	PO Box 870627 Wasilla AK	315-6107	
3	Tyler Vaughan	<i>Tyler Vaughan</i>	4050 N. Charley Dr Wasilla AK	373-2651	
4	Mike Hales	<i>Mike Hales</i>	4630 W Rangeview Dr	315-1019	
5	Kelly McManus	<i>Kelly McManus</i>	PO Box 871905 Wasilla AK	876-8488	
6	Maath Mankay	<i>Maath Mankay</i>	160 W 68th Street Anchorage AK	715-7404	
7	Ron Miller II	<i>Ron Miller II</i>	P.O. Box 877610 Wasilla AK 99687	376-8702	
8	Kim Werner	<i>Kim Werner</i>	643 S. Gulkana Palmer AK 99645	745-0176	
9	Randy Lawrence	<i>Randy Lawrence</i>	474 W. Heritage Dr 99154	373-8520	
10	Christopher S. Dotz	<i>Christopher S. Dotz</i>	3060 E. Lakerose Rd. Wasilla, AK 99654	373-3744	
11	Eric Dink	<i>Eric Dink</i>	851 W. Selden #1 Wasilla AK 99654	352-3959	
12	Barbara Brueggebars	<i>Barbara Anne Brueggebars</i>	PO Box 203 Willow AK 99688	495-3246	
13	PHIL KOWALSKI	<i>Phyllis Kowalski</i>	PO Box 520349 Big Lake, AK 99552	892-6411	
14	Doug Scholbers	<i>Doug Scholbers</i>	3991 TAMMERT DR Wasilla AK	373-3946	
15	Caray Wells	<i>Caray Wells</i>	5930 E. Alder Cir. Wasilla AK	232-4966	
16	Bobby W King	<i>Bobby W King</i>	6240 N TALGACH WAY DR WASILLA AK 99654	373-3585	
17	MARILYN D. FENNER-KING	<i>Mary D Fenner King</i>	6290 N. TALGACH WAY DR WASILLA AK	373-8785	
18	Albert Edwards	<i>Albert Edwards</i>	13627 Vasili Dr. Eagle River, AK	726-1283	
19	AL DANKER	<i>Al Danker</i>	700 E CEDARWOOD WASILLA AK	376-5540	
20	Brandon Allred	<i>Brandon Allred</i>	1261 Bardi Dr. Wasilla, AK 99654	907-941-1709	

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	Print Name	Signature	Address	Phone No.	email
1	PRISCILLA REEVES	<i>Priscilla Reeves</i>	3608 LOCARNO Anch	561 3553	PRIS @ AK.NET
2	Josh Drury	<i>Josh Drury</i>	2775 W Stoneridge Ct Wasilla	907-322-7367	the-1-bachelor@y-hoc.com
3	KEVIN MAXWELL	<i>Kevin Maxwell</i>	3756 N INSPIRATION LP W/A	907-373-4787	KEVIN.MAXWELL@GMAIL.COM
4	Nyan George	<i>Nyan George</i>	Box 877141 Wasilla, AK 99687	907-376-9052	nyangeo@gmail.com
5	Scott Lueise	<i>Scott Lueise</i>	1325 OLD TAUNE PALMER AK 99644	907-301-2584	lueise@stg-blive.com
6	Jessica Christensen	<i>Jessica Christensen</i>	PO Box 975402 ^{Wasilla AK}	907-373-5453	jessicachristensen@akco.com
7	DEBRA D PARIS	<i>Debra D Paris</i>	P.O. Box 873341 ^{Wasilla AK}	357 2167	TEARRA@MTAONLINE.NE
8	TERRY FOREMAN	<i>Terry Foreman</i>	11551 Glacier Vista Chugiak AK 99567	688-3807	tforeman@getinet
9	Craig Lance	<i>Craig Lance</i>	PO Box 672390, Chugiak 99567	688-4404	lances@aci.net
10	Heidi Cline	<i>Heidi Cline</i>	P.O. Box 1075 Seward AK 99664	907-3621290	
11	David Lassette	<i>David Lassette</i>	P.O. Box 875572 Wasilla AK	907-272-8779	
12	MARGARET SHAPIRO	<i>Margaret Shapiro</i>	10357 E. WINDMILL Cir. Palmer	907-223-8837	
13	Ellen Godfrey	<i>Ellen Godfrey</i>	1200 S. Badger Palmer AK ⁹⁹⁶⁴⁵	907-746-6626	godfrey@mtaonline.ak
14	Charlote Cookingham	<i>Charlote Cookingham</i>	17268 Hideaway Ridge Dr ER	907-947-4766	clccookingham@gmail.com
15	MARTIN L-GOFF	<i>Martin L Goff</i>	P.O. Box 872492 Wasilla AK	376-1162	goffm@mtaonline.ak
16	Stefani Nordland	<i>Stefani Nordland</i>	79 Heitz Schultz Dr Wasilla	820 0255	kines-stefani@hotmail.com
17	DANIEL BULTZEN	<i>Daniel Bultzen</i>	POB 870931 Wasilla	841-4195	
18	VICTORIA L. WHITE	<i>Victoria L White</i>	POB 2482, Palmer 99645	745-6587	LVWhite@Rosenstia.com
19	Mark Chryson	<i>Mark Chryson</i>	2140 E Wolverine Cir	376-8285	Mark@web-ak.com
20	Tim Diste	<i>Tim Diste</i>	5713 Relit Wasilla AK	864 0762	tim777@MTAonline.ak

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	Print Name	Signature	Address	Phone No.	email
1	George Tobe	<i>George Tobe</i>	872354 Wasilla AK 99627	357-6779	
2	William Ryder	<i>William Ryder</i>	524 Kimberly Wasilla AK 99654	357-3560	m.dntsen@alaska.net
3	Lisa Whollet	<i>Lisa Whollet</i>	PO Box 2103 Palmer, AK 99645	982-2998	
4	CHRISTOPHER F. LUND	<i>Chris F. Lund</i>	1715 PIPESTONE DR WASILLA AK	376-6051	
5	Michael J Despain	<i>Michael J Despain</i>	2241 Belmont Dr. Anch	306-0992	despain64@hotmail.com
6	Mary Patrice	<i>Mary Patrice</i>	2041 Belmont Dr 99517	306-0991	ariana029@hotmail.com
7	PAUL D. HOUSER	<i>Paul D. Houser</i>	29698 E. KNIK RIV. RD. PALMER AK 99645	745-1745	
8	EVA STREET	<i>Eva Street</i>	4630 Reka Dr. Anch 99508	222-0833	
9	David Schmidt	<i>David Schmidt</i>	4330 Tara St Wasilla AK 99654	357-4330	david.h.schmidt@comcast.com
10	David Merwin	<i>David Merwin</i>	PO Box 671624 Clingfield AK 99587	888-3046	dmerwin@msn.com
11	Deborah Kessler	<i>Deborah Kessler</i>	2381 S Paddock Dr. 99651	631-3920	
12	THOMAS GEORGE	<i>Thomas George</i>	P.O. BOX 671589 CHUGIAT AK	688-5015	
13	ROGER ERDMAN	<i>Roger Erdman</i>	PO Box 824690 WASILLA AK 99654	631-2542	
14	Norman Wakeman	<i>Norman Wakeman</i>	PO Box 797, Willow, AK	495-9267	
15	JASON BRYAN	<i>Jason Bryan</i>	PO Box 875161 WASILLA AK 99654	373-1624	GJALLETTER@HOTMAIL.COM
16	Carol R Russell	<i>Carol R Russell</i>	PO Box 4259 Palmer AK	745-1470	
17	Richard H Russell	<i>Richard H Russell</i>	PO Box 4259 Palmer	745-1470	chrussell67@yahoo.com
18	Shawn Graumann	<i>Shawn Graumann</i>	PO Box 875724 Wasilla AK 99687	907-357-1047	shawngr - alachodmail.com
19	Beth Bayer	<i>Beth Bayer</i>	PO Box 875724 Wasilla AK 99687	907-354-0469	lilbayer49@hotmail.com
20	PHIL DOWNING	<i>Phil Downing</i>	9561 N PALMER ESTATES PALMER AK 99645	907-745-6662	

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	Print Name	Signature	Address	Phone No.	email
1	PATRICK HEADSEY		Box 871301 WASILLA AK 99627	746-7077	
2	WILLIAM FORSTER		850E McAdams Way, Wasilla	376-9556	
3	Don Ridge		PO Box 875605 AK 99687	7457110	
4	SCOTT ANDREWS		1000 EISENHOWER, WASILLA AK	900-6938	
5	Valerie Andrews	Valerie Andrews	23505 NE 229th St. Cattle Ground WA ⁹⁹⁶⁰⁷	(360)687-3371	
6	Ellen Baker	Ellen Baker	PO Box 521085 Big Lake AK	812-7780	ellenid@mtaonline.net
7	FLOYD E SENA, Jr		2712 STRAWBERRY RD Anch AK	350-6221	floydsena@ymail.com
8	Wade E. Paile	Wade Paile	6861 E. Kings Salmon dr. Wasilla AK	354-2867	
9	Marjorie Sullivan		" " " "	775-3161	
10	Elizabeth Pavuk	Elizabeth Pavuk	3431 W. Wren Rd Wasilla 99654	357-1119	lizpavuk@mtaonline.net
11	George Taft	George Taft	PO Box 875485 Wasilla AK 99687	357-4213	gtaft@msn.com
12	Loni Hippler	Loni Hippler	PO Box 873991, Wasilla 99687	376-9231	
13	Terry Baker	Terry Baker	15312 Huges Circle Anchorage AK 99583	384-4241	
14	Jason Childers		1325 W. Bluffview Dr.	376-1325	honore@jci.net
15	ROBERT C. NASH	Robert C. Nash	HC 34 Box 2224 WASILLA, AK ⁹⁹⁶⁵⁴	892-6830	RENASH22@GMAIL.COM
16	JOHN RIGGS	John Riggs	137E ARCTIC AV, PALMER AK 99645	745-6980	john@mtaonline.net
17	RICK SALYER	Rick Salyer	6005 N. Little Rock Cir WASILLA AK 99654	804-0094	ALBULLDOG74@YAHOO.COM
18	KIRK BROWN		461 E Barrow Lp Wasilla	376-6165	
19	Matthew Reiford		PO Box 73672 Eagle River AK 99577	250-7193	
20	Benton Spencer	Benton Spencer	3951 S Cook Inlet Cir Wasilla AK 99654	376-0071	bjspencer99@HOTMAIL.COM

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PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	JAMES WOLFE	<i>James Wolfe</i>	4405 E. Echo Wasilla, Ak	357-9298	seef@jct.net
2	JOHN CHAPMAN	<i>John E. Chapman</i>	3150 N LIVES DR. Palmer ⁹⁹⁶⁴⁵ AK	355-7939	
3	MERLE FRANK	<i>Merle R Frank</i>	1780 W Lake Lucille DR	373-5867	
4	DOROTHY FRANK	<i>Dorothy D. Frank</i>	1780 W. LAKE LUCILLE DR. ^{Wasilla} 99654	373-5867	
5	Jeremy Goff	<i>Jeremy Goff</i>	⁹⁹⁶⁰⁰ PO Box 3603, Nikiški, Ak, 99635	252-0527	
6	James Savage	<i>James Savage</i>	1051 N Reinhard Dr	775-0234	
7	Larry E. White Jr	<i>Larry E. White Jr</i>	POB 2482 Palmer AK. 99645	745-6587	
8	Howard Koniaski	<i>Howard Koniaski</i>	PO Box 899448 Wasilla 99627	355-1062	
9	Howard Bryan Wuollet	<i>Bryan Wuollet</i>	PO Box 2108 Palmer 99645	232-0861	
10	B. WERKMAN	<i>B. Werkman</i>	6d. Edward Way, 1/2 Ak	373-6574	
11	Johnny Bourgeois	<i>Johnny Bourgeois</i>	PO Box 872975 Wasilla AK	7752157	
12	Inezia Marum	<i>Inezia Marum</i>	BX 671624 Chugiak AK	6883046	
13	Steven E. Kessler	<i>Steven E. Kessler</i>	2381 S. Paddock Drive Wasilla ⁹⁹⁶⁵⁴ AK	907-631-3326	stevekessler@hotmail.com
14	TAMI M. George	<i>Tami M. George</i>	P.O. Box 671589 Chugiak, AK 99567	907-688-5013	
15	Brad Porter	<i>Brad Porter</i>	7362 W PARKS HWY #880 Wasilla	232-6731	
16	Marianne DeHart	<i>Marianne DeHart</i>	PO Box 873094 Wasilla	315-3893	
17	Fred DeHart	<i>Fred DeHart</i>	PO. Box 873094 Wasilla	315-3892	
18	Gail Just-Cornelius	<i>Gail Just-Cornelius</i>	PO Box 1124, Willow, AK	355-4063	
19	Christopher Russell	<i>Christopher Russell</i>	831 N. Colonial Dr. Wasilla AK	229-0124	
20	Dolores Forster	<i>Dolores Forster</i>	850 E McHardy Way, Wasilla, AK ⁹⁹⁶⁵⁴	376-9874	

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	Print Name	Signature	Address	Phone No.	email
1	Nancy E. Docket	Nancy E. Docket	2243 W. Ridgewood Dr	223-4617	Stridngal@mta.
2	Barbara Carter	Barbara Carter	701A Lucille	907-7361	br_listings@yahoo.com
3	Steven M Johnson	Steven M Johnson	PO Box 875526	748-5345	
4	Susan M Johnson	Susan M Johnson	PO Box 875526	748-5346	akmom1@mtaenlac.net
5	Gerald Killion	Gerald Killion	3133 Naomi dr	354-4613	Killion@cci.wt
6	Keith Schaefer	Keith Schaefer	7302 W Parks Hwy #716 Wasilla	715-9476	
7	Donald A. Grimes	Donald A. Grimes	HC 38 Box 2667 Wasilla AK	841-0907	arcticdor@hotmail.com
8	Vicki J Grimes	Vicki J Grimes	HC 38 Box 2667 Wasilla AK	892-0907	VICKI@ALASKA@hotmail.com
9	Zac Bonnette	Zac Bonnette	3703 N Copperspike St Wasilla AK	357-8850	
10	Levi McArthur	Levi McArthur	860 N. Win Circle Wasilla, AK	841-4417	
11	Clifford Schaefer	Clifford Schaefer	2243 W Ridgewood Dr ^{WA} AK	382-1865	
12	Rodney Van Sciver	Rodney Van Sciver	PO Box 773464 Eagle River AK	3733123	AAK415@MISJ.com
13	Steven DeHart	Steven DeHart	3200 E. Naomi, Wasilla	357-3528	
14	Arlay Delaney	Arlay Delaney	PO Box 870922 Wasilla	892-7755	
15	Connie DeHart	Connie DeHart	3200 Naomi Dr, Wasilla	357-3528	
16	John Christian	John Christian	4850 W Stratford Ct, Wasilla	841-4760	skydive_44028@yahoo.com
17	Connie Schwaner	Connie Schwaner	4850 W Stratford Ct Wasilla	841-5077	ConnieSchwaner@yahoo.com
18	Ron Haynes	Ron Haynes	2801 Jude Dr. Wasilla AK	357-5790	akbludog@yahoo.com
19	James Jones	James Jones	1760 South Out St. Wasilla AK	357-7150	James Jones@angie.net
20	Jana Zur	Jana Zur	3505 S. Rebecca Ln. Palmdale ^{CA} AK	745-7167	Krzysztof@Herman.com

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	Print Name	Signature	Address	Phone No.	email
1	GERALD M. EMERSON JR	<i>[Signature]</i>	PO Box 872491	907-357-6568	g_emer@yahoo.com
2	Diana Pinard	<i>[Signature]</i>	P.O. Box 871347	907-232-1347	pinard@mtsonline.net
3	PAUL PINARD	<i>[Signature]</i>		907-232-1347	Paulpinard@hotmail.com
4	Allyssia Soros	<i>[Signature]</i>	1760 S. Cat St Wasilla, AK	907-357-7750	alysia.soros@alaska.com
5	ALLISON VERBOS	<i>[Signature]</i>	P.O. Box 871852, WASILLA	357-3473	
6	Connie Woodard	<i>[Signature]</i>	BOX 936, Willow, AK	232-3127	
7	Stephen Hill	<i>[Signature]</i>	19206 Clear Falls Cir., ^{English River} AK	696-5952	
8	Karl Van Buechel	<i>[Signature]</i>	PO Box 757 Seward AK	224 5536	
9	Wade Thomas	<i>[Signature]</i>	7362 W. Parks Hwy Box 242 ^{Wasilla}	222 9631	
10	Bryanna Pearce	<i>[Signature]</i>	7561 N. Beach Harbor Rd.	907-892-8894	
11	Frank Phillips	<i>[Signature]</i>	7362 W. Parks Hwy #271	307-231-2074	
12	Tyler V	<i>[Signature]</i>	4424 E. Mariah dr	227-2230	
13	Kurt Keroschel	<i>[Signature]</i>	9712 Siding	696-2671	
14	Mark Frank	<i>[Signature]</i>	2750 N Tamar Cir	376-8660	markfrank@hotmail.com
15	Miriam Jesik	<i>[Signature]</i>	2750 N Tamar Cir. ^{Wasilla AK}	376-8660	miriamjesik.net
16	Lisa Perkins	<i>[Signature]</i>	1930 E Parks Hwy PMB 278 ^{Wasilla}	376-6723	
17	RICK HARRINGTON	<i>[Signature]</i>	15055 E. KENT ST.	745-2578	rickenharrington.net
18	CASSANDRA PAUL	<i>[Signature]</i>	1302 W. PARK HWY #683 ^{Wasilla}	357-5210	
19	GEORGE PARK	<i>[Signature]</i>	7362 W. PARKS HWY #476 ^{Wasilla}	892-7733	
20	ANTHONY BURRELL	<i>[Signature]</i>	725 N. Aurora Trimmer. ^{Wasilla}	376-0319	17KRELL@AOL.COM

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EMERSON@AOL.COM

PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	John Reed		P.O. Box 298667, Wasilla, AK	(907) 376-4289	
2	JIM LAND		1805 W. Whirlpool Cir Wasilla AK	(907) 631-4990	
3	James H. Bishopman		P.O. Box 2991 Seldovia AK	907-394-1507	
4	Steve Colligan		P.O. Box 874894 Wasilla AK	238-3922	STEE@CAMPcolligan.com
5	Michael Heppshman		P.O. Box 1024 Palmer, AK	907-306-3888	MLK241@hotmail.com
6	Russell Collini		3531 Lunan Dr. Anch. AK	907-333-4179	RACOLLIN@G.C.ink.net
7	Ben Young		550 E. Burwood Dr. Wasilla AK	357-3529	
8	Walt Deal		1100 Tringon Dr. Wasilla, AK 99657	444-6280	WaltDeal907@yahoo.com
9	Tom LeCroy		2715 Cotton Creek, W. Wasilla	841-8091	Fair-Sensit-Property@aol.com
10	Tom LeFest		6150 N. Tallachy Way	373-3805	
11	Artheia C. Dickerson		P.O. Box 873675 Wasilla, AK	373-7498	amedickc5@yahoo.com
12	DEAN W. L. Amerson		P.O. Box 632717 Chugiak 99516	775-4609	
13	James B. Hammyk		22634 Judd Dr Chugiak AK 99507	907-688-6407	
14	Sherry Hammock		22634 Judd Dr Chugiak, AK 99507	907-688-6407	
15	Scott Anderson		20325 Leproschaw Chugiak, AK	907-688-6833	
16	Becki Anderson		20325 Leproschaw Chugiak AK	907-688-6833	
17	KEITH ADERS		P.O. Box 874854 WASILLA AK	99687 907320 4715	
18	RUDOLPH FERDINAND		USIN Freedom Ln Wasilla AK	357-4530	FerdieD@AOL.com
19	LAWRENCE R. OLIVER		10662 Brigantine Circle Anch. 99170	273-9234	ROOLIVER8713@AOL.com
20	James Paulauskas		P.O. Box 520675 Big Lake AK 99652	892-3833	

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	Print Name	Signature	Address	Phone No.	email
1	Amber Bertorello	Amber Bertorello	P.O. Box 775910 PMB 165	631-4956	Amber.Bertorello@gmail.com
2	Michael D. Sain	Michael D. Sain	2800 W. Alaska Dr. Wasilla AK	376-8085	
3	Tom Hubble	Tom Hubble	8910 Kak Island, E.R. AK	242-5083	
4	Bobby Turner	Bobby Turner	11911 Resency DR, E.R. AK	622-6041	
5	Bryce Ojalehto	Bryce Ojalehto	3320 Pintail Cr. Wasilla	232-5883	
6	Debra Bates	Debra Bates	PO Box 875094 Wasilla AK	376-2253	
7	Mike Buirge	Mike Buirge	7475 N. Grouse Loop Wasilla AK	376-9358	mbuirge@gmail.com
8	Ernest W Jones	Ernest W Jones	10822 SLENDER Loop, E.R. AK	726-5813	
9	Jean Calkins	Jean Calkins	2701 W Stonebridge Dr Wasilla	357-3223	
10	Margaret E. Lovejoy	Margaret E. Lovejoy	7362 W. Parks Hwy # 734 Wasilla	376-6927	
11	JERALD CONN	Jerald Conn	5890 E Cambridge DR Palmer	376-5960	
12	SANDRA GOWS	Sandra Gows	Po Box 4229 Palmer 99645	745-6779	
13	Robert Garcia	Robert Garcia	P.O. Box 825643 Wasilla, AK	306-2544	
14	SD COBB	SD COBB	Po Box 84651, Fair, AK		
15	Marty Pajin	Marty Pajin	2901 N Brewnas way, Wasilla AK	631-5096	
16	Karen Alder	Karen Alder	9431 W Con Conan Wasilla	354-8708	
17	Jeff Kruger	Jeff Kruger	4875 East Birch, Wasilla AK	357-8345	
18	John Lewellyn	John Lewellyn	22232 woodcreek CT Chugiak, AK	684-4524	
19	Cheryl Clow	Cheryl A Clow	200311. Saddle Horse Wasilla AK	357 7237	
20	Cindy Turkey	Cindy Turkey	4000 Grey Wolf Dr. Wasilla AK 99654	841-2206	Cindy.turkey@gmail.com

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1	Deanna A Taylor		7223 EG TH AVE ANCH AK 99504	907-244-4951	
2	Tim L Galloway		1893 N. Citation Cir. Palmer AK	907745196	
3	Doug Thissen		189 E Nelson Ave 224 Wasilla	9078543999	
4	Steve Schultz		11095 Equestrian Dr. Palmer	9079462507	
5	Cindy Deal		1100 Tiogovis Dr Wasilla	907-982-9086	
6	Carson Bales		P.O. Box 875094 Wasilla	907376-2283	
7	Kim LeGray		2715 Cotton Creek Cr. Wasilla	907-357-3413	
8	Dianna Herfesty		16150 N. Talgach Way Wasilla	907-373-3265	
9	Lee Koss		1000 Golden Hills Dr, Palmer AK	907-746-6057	
10	HENRIETTA L. FROVOST		PO BOX 4445 HOUSTON, AK 99694	907-882-7963	
11	JAMES R. CALKINS		2701 W. STONEBRIDGE DR. WASILLA AK 99754	907-357-2225	JCALKINS@MTACONLINE.COM
12	Rebecca Tucker		PO Box 672317 Chugiak AK 99567	907-376-0956	
13	WALTER LOVEJOY		7360 W Parks Hwy #724 Wasilla 99754	907-376-6727	
14	Michael Coyle		PO Box 4225 Palmer AK 99645	907-745-1779	
15	Michelle L Ramirez-Roh		3265 S Dimmock Dr Wasilla AK 99754	907-373-4196	
16	ROBERT BURBAN		3100 WARD PLACE #24, ANCH AK	(907)444-2800	AK-ROB@LIVE.COM
17	Steve Borgen		1341 W. 70th Ave Anch AK 99518	(907)344-1322	
18	Paul Meyer		PO Box 875002, Wasilla 99754	907-350-1361	meyerpsj@juno.com
19	Jacqueline Meyer		PO Box 875002, Wasilla, 99754	907-350-0758	" "
20	RICHARD CLINE		2003 N. Saddle Horse Dr. Wasilla 99754	907-359-7237	rc-cline@me.com

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	Print Name	Signature	Address	Phone No.	email
1	Rouvenh Duncan		PO Box 873012 WASILLA AK 99604	907-841-7198	KLQTSO@hotmail.com
2	Jeff Pedersen		P.O. Box 39275 N. Anchorage, AK 99509	907-252-1233	stowaway@hotmail.com
3	Shannon Connelly		PO Box 172 Palmer AK 99645	745-7046	skconn@mtaonline.com
4	Joseph Bantz		P.O. Box 1894 Palmer AK 99645	746-5064	jo1774@mtaonline.com
5	Helen Bantz		PO BOX 1784 Palmer AK 99645	746-5064	"
6	ANNETTE HARPSTER		PO Box 2846 PALMER AK 99645	746-1740	
7	James A. Harpster		P.O. Box 2846 Palmer AK 99645	746-1740	
8	STEVE A COOK		# 205 E. Eagle Vista Cir Wasilla	373-6968	peccook@mtaonline.com
9	Carol Rice		3751 Cottonwood Way Wasilla	350-2669	
10	George Rice		3751 Cottonwood Way Wasilla	350-2444	
11	KEVIN OUTINEN		1051 E Bogard Rd #9	373 2566	puuk@mtaonline.com
12	Cheryl Land		185 W. Lehigh Cir, Wasilla	1231-4990	
13	Sherry Hill		6880 S. Andrew Cir Palmer	357-2431	
14	RON ARVIN		189 E Nelson #136 wasilla ak 99654	373-6688	ron@ronarvin.com
15	Sandra Kottre		PO box 877670 wasilla 99687	376 8597	
16	Edmund MacLeod		9116 E Avine meadow drive Palmer AK 99645	907-230-5998	emac@mtaonline.com
17	Kambria Hopshman		PO box 1024 Palmer AK, 99645	907 306-3888	mik246@hotmail.com
18	Julee K Sain		2800 N. Aurora	376-8295	
19	Jay L. Johnson		735 W Fern Ave Palmer AK 99645	315-4861	
20	Don Bantz		374 Eastwood rd sp. 45654	631-4556	

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	Print Name	Signature	Address	Phone No.	email
1	Steve Runyan	<i>Steve Runyan</i>	P.O. Box 1223, Willow, AK 99686	907-495-2697	steve.runyan@alaska.com
2	Paula Runyan	<i>Paula Runyan</i>	PO Box 1223, Willow, AK 99686	907-495-2697	Paula-Jo.Arnold@alaska.com
3	SUSAN ORR	<i>Susan Orr</i>	7701 Wildflower Ct., Anchorage, AK 99594	907-332-4492	
4	Bill Collins	<i>Bill Collins</i>	P.O. Box 940027, Houston, AK 99694	907-891-2455	
5	Kyle Christiansen	<i>Kyle Christiansen</i>	1680 CATAUNA DR WASILLA AK 99654	907-841-6764	KYLEAK@HOTMAIL.COM
6	Travis Young	<i>Travis Young</i>	2751 E Fullbrook Ct. Wasilla, AK 99654	907-832-1912	TYOUNG323@Yahoo.com
7	Darwin Aho	<i>Darwin Aho</i>	PO Box 825910-233	907-376-3468	darwin@mtc.com
8	DENNIS SPURRIER	<i>Dennis Spurrer</i>	P.O. Box 284, Seward, AK 99840	907-983-2326	
9	Cris Alan Houghton	<i>Cris Alan Houghton</i>	3400 S. Dowman Dr., Wasilla, AK 99654	907-357-4721	oshacraig@gmail.com
10	BRIAN BUHLER	<i>Brian Buhler</i>	905 W. FRANKER DR WASILLA, AK 99654	907-376-0920	
11	Chris Coock	<i>Chris Coock</i>	7330 E. Aspen Ridge Rd.		
12	David Petty	<i>David Petty</i>	7362 W. Park, Hwy #706		
13	Mark Bradshaw	<i>Mark Bradshaw</i>	7145 E. SPRINGWOOD DR WASILLA 99654	746-4770	
14	SYDNEY J. CUMMINGS	<i>Sydney Cummings</i>	114225 CLEMMA AVE. PALMER, AK 99645		
15	JATHAN MAXI	<i>Jathan Maxi</i>	4300 E. MARIA WAASILLA AK	(907)541-6661	
16	Travis Pettko	<i>Travis Pettko</i>	PO Box 875025 Wasilla, AK 99654		
17	Lorraine Hibbsman	<i>Lorraine Hibbsman</i>	PO Box 2991, Seldovia, AK 99669	(907)953-2611	
18	TIMOTHY KATRE	<i>Timothy Katre</i>	PO Box 877670 WASILLA	376-8597	
19	MARGARET MACLEOD	<i>Margaret MacLeod</i>	9116 E. ALPINE MEADOW DR, PALMER	745-5570	
20	Douglas C. Sorensen	<i>Douglas C. Sorensen</i>	1532 A Pittman Rd Wasilla, AK	323-0250	

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	Print Name	Signature	Address	Phone No.	email
1	Paula J. Miller	Paula J. Miller	4515 N. McKean Dr. Palmer AK	(907) 745-0265	
2	Tina Walter	Tina Walter	650 Teohengale Wasilla AK	(907) 357-5620	
3	BRETT WALTER	Brett Walter	650 Teohengale Circle Wasilla AK	907 257-5620	
4	Willy Rumbö	Willy Rumbö	7040 W. Wellington Wasilla AK	(907) 631-8840	
5	JAMES R. INCLIN	James R. Inclin	707 West Rockside Road, Wasilla AK	907-244-7631	
6	Mark E. Clyde	Mark E. Clyde	5823 E. Morning Mist Drive Palmer AK	373-6291	
7	CONNIE BARRITT	Connie Barritt	7180 S. Territorial Wasilla	373-3442	
8	Larry Hart	Larry Hart	17152 Charity Circle	907-496-4110	hart2hos@GCI.net
9	Debra Lighthart	Debra Lighthart	HC 32 Box 6538 Wasilla	907-746-1804	
10	Susan Barnes	Susan Barnes	950 S. Joanne Dr Palmer AK	745-8911	
11	David Barnes	David Barnes	950 S. Joanne Dr Palmer AK	745-8911	
12	Craig Sandefur	Craig Sandefur	5915 S. Hanson Ln Wasilla AK	373-0703	
13	Sherril Sandefur	Sherril Sandefur	5925 S. Hanson Ln Wasilla AK	373-0703	
14	Looy E. Thacker	Looy E. Thacker	231 E. Wasilla Ave Wasilla AK	631-5216	
15	Kathleen E. Aultson	Kathleen E. Aultson	2841 Alouge Court Wasilla AK	696-6620	
16	Paula Aho	PAULA AHO	PO Box 8755/10-2331 Wasilla	376-3468	
17	Gilbert L. Gowitt	Gilbert L. Gowitt	3601 N. Traveler Dr. Wasilla AK	376-3728	
18	Dale Dormer	Dale Dormer	PO Box 8700/77 Wasilla AK	376-9428	
19	BILL LIPP	Walter O. Lipp	PO 298214 WASILLA AK	99629 3766533	
20	Darci Dean	Darci Dean	4261 N. Quebec St Wasilla, AK	9418 631-4930	

PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	Chad M Schuenthler		20650 Mountinside Dr Pungla River AK 99577	907-28-0608	Chad.Schuenthler@mtaonline.net
2	Kenneth Heaton		Box 874379 Wasilla AK	907-357-1934	Keljayce@Tand.com
3	Lloyd B. Rudd		P.O. Box 298664 Wasilla AK 99629	907-376-3648	
4	Joyce D. MARKS		P.O. Box 871228 Wasilla AK 99687	376-0672	diligas@mtaonline.net
5	Garth Milton		630 S. Lower Rd, Palmer AK 99645	223-4819	
6	Jay Burke		P.O. Box 940045, Houston, AK 99674	892-2226	jayburke@mtaonline.net
7	Don Smith		P.O. Box 298461 Wasilla AK 99629	892-6078	dsmith@mtaonline.net
8	Kevin Quinn		P.O. Box 940361 Houston, AK 99674	357-8684	
9	Kyle Maxwell		2018 N. Tolosa Court, Palmer, AK 99645	892-4333	Kyle@KIMDS.com
10	Michael Sawyer		P.O. Box 671151 Chugiak, AK 99654	(907) 357-4955	
11	Diane Sunderlin		1532 N Pittman Rd Wasilla AK 99687	373-0250	dauydl@mtaonline.net
12	GEORGE KOVAL		1632 TRAIL CIRCLE WASILLA, AK 99687	907-357-2253	PERSONKOWAL@GMAIL.NET
13	Harkleroad, Daniel		315 E. Dolphin Ave Palmer AK 99645	907-7461922	
14	Art Fern				WFern@Hotmail.com
15	Brandon Bennett		17096E Plumley RD. Palmer AK 99645	907-841-8018	
16	Steven Sandberg		P.O. BOX 107092 Chugiak AK 99567	907-688-2147	jane@mtaonline.net
17	Bobby A Lucas		P.O. Box 871229 Wasilla AK 99687	357-6100	
18	Michael Dieck		4460 W Seward St Wasilla AK 99687	357-8192	mdieck@mtaonline.net
19	ANDY STANTON		1150 S. COLONY WAY 3-226 PALMER AK 99645	746 0390	
20	Linda B. McCombs-Rouse		P.O. Box 874652 Wasilla AK	373-2630	enlrows@mtaonline.net

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1	HARRY F. BENINATI		7051 Clairmont Cir. Anchorage AK 99507	907 337 4079	HBeninati@AK.com
2	JOEL LAURUP		5294 MORROW MESS DR PALMER 99645	907 841 3231	JOEL 7576 @YAHOO.COM
3	DON OLSTAD		PO. Box 873912 Wasilla, AK 99651	907 232-7705	
4	DON PICKETT		BOX 874793 WAS 99653	841 351	892-2010
5	JACIE KOPY		2435 Ravensflight WAS, AK 99654		
6	DONNA CHILDRESS		PO Box 1438 Palmer AK	746-5212	
7	CATHERINE HICKS		1029A Tomahawk Dr. Ft. Richardson	412 844 1177	
8	MARCUS T. RAUM		2602 E. Kates Dr. Anchorage AK 99504	354-7365	marcus.raum@gmail.com
9	PAUL ZITKO		PO BOX 940171 Kodiak AK 99694	PRIVATE	PRIVATE
10	DANIEL C. CARTER		PO BOX 298653 Wasilla AK 99629	907-354-1904	pcarter@rudeonline.net
11	BETH M. GRAHAM		6910 Dickerson Dr. Anchorage AK 99504	907-29-1040	
12	TABARI NATHAN		20331 Granite Park Cir Eagle River 99571	907-622-8620	
13	SARAH E. ERSON		17741 E Castle Rock Ln Palmer 99645	907-745-0926	sera@sjinell.com
14	SHARON K WATSON		2043 Cannoneer Cr Anchorage AK 99507	907-644-8563	skw@qci.net
15	TIM SWEEK		4181 S. ETOBE Circle		timsweek@hotmail.com
16	DEANIS WOLIN		4250 E. Palmdale	232-2252	
17	JOSEPH T. HAWKINS		791 Husler, Dr. Wasilla AK	376-4104	
18	FRANCES B. WILSON		1830 Nipitwood Circle Palmer	376-0284	
19	ARRETT FINLEY		2625 PTARMIGAN PL WASILLA AK	357-5685	FINLEY375@YAHOO.COM
20	ROBERT WALL		16249 Turhalie Dr. Eagle River AK	446-1621	

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	Print Name	Signature	Address	Phone No.	email
1	Charles Spaulding		P.O. Box 1129 CHICKALGOON ⁹⁹⁶⁷⁴	907-246-2216	chuck@nova.laska.com
2	Larry Clankins		2099 S. Sweedie Pic St. Wasilla ⁹⁹⁶⁵⁴	907-277-5846	alaskhawk@aol.com
3	Nathan Mitchell		7708 E. Breckenridge Dr Wasilla ⁹⁹⁶⁵⁴	907-764-8120	
4	Evika Mitchell		7708 E. Breckenridge Dr Wasilla ⁹⁹⁶⁵⁴	907-775-5311	
5	GARY D RAAB		11474 Discovery View Dr. Anch AK		907-344-2467
6	LYNDA PARKER		POB 342 PALMER ⁹⁹⁶⁴⁵		907-285-3828
7	Eleanor Koveroff		P.O. Bx 302 Talkeetna		KLIXT@Hotmail.com
8	Elizabeth Tudy		P.O. Box 1673 Valdez AK ⁹⁹²⁸⁶	907-461-3022	
9	William Wise		1045 North Sun Street Anchorage ^{AK 99504}	907-376-9833	WISW219@alcoo
10	Rhea Carlson		P.O. Box 871631 ^{Wasilla AK}	372-0880	
11	Dale Carlson		"	"	
12	MIKE ALEXANDER		PO Box 521171 ^{Big Lake AK}	907-892-4845	
13	Robert Wallick		17546 Rachel Cir Eagle River, AK	907-301-8235	wallickr@alaska.net
14	Taylor Crocker		1011 N Amber Dr Wasilla, AK ⁹⁹⁶⁵⁴	907-841-6381	clivkri44@hotmail.com
15	WILLIAM BURKE		1135 E. KSMY CR PALMER ^{AK 99645}	907-745-4451	riverat@al.net
16	JON R. DENARDI		4945 HONEY DR. WASILLA AK ⁹⁹⁶⁵⁴	907-376-4680	ta25th@nitaonline.net
17	PATRICIA A DENARDI		4945 HONEY DR. WASILLA AK ⁹⁹⁶⁵⁴	907-376-4680	ta25th@nitaonline.net
18	Joyce E. HEATON		PO Box 874379 Wasilla AK ⁹⁹⁶⁵⁴	907-557-1934	Kjoyce@juice.com
19	STAN MURDOCK		PO Box 2476 PALMER AK ⁹⁹⁶⁷⁶	907-357-4368	
20	Jaime Keene		8033 W Tia Terrace ⁹⁹⁶⁵⁴	907-373-5684	keenes@nitaonline.net

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	Print Name	Signature	Address	Phone No.	email
1	Eugene W. Jockey	Eugene W. Jockey	21931 Rebecca Cir ^{Chugiak} AK 99555	688-1527	gene.jock@gsi.net
2	Stephen K Sweetland	Stephen K Sweetland	Po Box 870584 Wasilla AK 99687	357-3533	
3	Cole Justice	Cole Justice	Po Box 877508 Wasilla AK 99687	768-661-5675	justice@gsi.net
4	Seremich Winkos	Seremich Winkos	Po Box 231666 Anchorage AK 99546	414-4274	
5	Christopher Evans	Chris Evans	7672 E. Aspen Ridge Rd ^{Wasilla AK} 99654	382-8129	
6	Judy A. Hills	Judy A. Hills	980 S. Betham Way Wasilla AK 99654		
7	John M. Tuohy	John M. Tuohy	4501 RICHARDSON HWY, VALDEZ, AK 99686	831-1805	
8	Christopher M Turky	Chris Turky	300 W Spruce Ave Apt 4 Wasilla AK 99654	907-841-8479	
9	Alexander A Mungast	Alexander A Mungast	11400 Kay Smith Rd Palmer AK 99449	907-746-2205	
10	Zach Schwetzer	Zach Schwetzer	3505 Bergman Rd ^{Palmer AK} 99645	746-4133	
11	ELLIOT NIEMI	Elliot Niemi	9165 Huana Rd Eagle River, AK	980-5719	NORTHOF60.NET
12	Amber Shea	Amber Shea	230 E. Spruce Ave B Wasilla 99654	841-4673	
13	Brian Shea	Brian Shea	" " "	841-1739	
14	Jack Sisson	Jack Sisson	Po Box 873522 Wasilla AK 99647	357-2195	jack@gsi.net
15	Michele Entwistle	Michele Entwistle	7411 W. Indigo Dr. ^{Wasilla AK} 99654	376-6054	
16	Tom Roach	Tom Roach	2409 N. Saddle Horse ^{Wasilla AK} Pr 99654	373-0665 460-6202	jroach@entwistle.net
17	THOMAS B. JENSEN	Thomas B. Jensen	Po Box 876455 WASILLA AK	907-357-2020	
18	Frdelia K. Matranga	Frdelia K. Matranga	1132 Placer Cir, Eagle River, AK	907-696-1872	
19	Richard B Davis	Richard B Davis	11132 " "		
20	Todd Wessels	Todd Wessels	3720 E. ^{MARK RD} WASILLA, AK	907-541-2440	

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	Print Name	Signature	Address	Phone No.	email
1	Irene Taylor	Irene Taylor	1000 Rosehip, Wasilla	373-0816	
2	Gilbert Gorman	Gilbert Gorman	1010 Cassia Lane Palmer AK	746-2994	
3	David George	David George	16922 Kiyora Cir., E R AK	862-4065	
4	SHANE MCKEE	Shane McKee	13840 E. HAYWAGON WAY PALMER AK	2148845636	
5	Jordan A Hedden	Jordan A Hedden	200 W. 34 th Ave #2991 Anchorage AK 99503	907-278-2493	
6	MARILYN N HEDDEN	Marilyn Hedden	200 W 34 th Ave #2991 Anchorage AK 99503	907-278-2493	
7	D. George Richardson	D. George Richardson	3132 E. Tamarack Wasilla AK 99654	357-0243	
8	Judith White	Judith M. White	1844 E 26 th Anch. AK 99508	867-5939	
9	Diane Crockett	Diane Crockett	1846 E. Tux-Al Dr. Wasilla, AK 99654	(907) 441-8640	Flyonion@yahoo.com
10	Dae Poteet	Dae Poteet	205319 W Deneki Drive	775 3859	
11	Gabriela Olide	Gabriela Olide	PO BOX 870584 Wasilla AK 99654	841-3808	
12	Richard Lovaas	Richard Lovaas	18085 E. Walling Rd. Palmer AK 99645	746-0985	
13	Ernest Fanning	Ernest Fanning	4245 Chess Dr	444-4896	
14	THOMAS W. DEKLE	Thomas W. DeKle	4350 Fox Trot Wasilla AK	232-6782	black6out@online.net
15	Ron Palmer	Ron Palmer	1600 W Melonie Ave.	376-2518	
16	RICK TRONY	Rick Trony	4600 N. GARY WAY PALMER WASILLA	232 6550	rick2ee@gmail.com
17	CHARLES DEFREEST	Charles Defreest	20450 Lils Way Chickaloon	745-1022	Lillian@NAsnl.com
18	Kevin Wellington	Kevin Wellington	16555 E. Palmer Way, Palmer	745-5885	GlennWar@comcast.net
19	Bence Wellington	Bence Wellington	"	"	"
20	Charity Kaland	Charity Kaland	3261 N. Caribou St Wasilla	907-265588	

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1	Brock Nelson	Brock Nelson	900 Enterprise drive	907-232-5152	gkhouchrider@hotmail.com
2	Kathryn Eckmann	Kathryn A Eckmann	7801 Schuss Cir Anch 99507	907-345-6333	
3	Herbert Sammons	Herbert Eckmann	- - -	- - -	
4	Picky Roberts	Picky Roberts	3635 N. Fortune Cir Wasilla 99654	907-357-4867	
5	VEN NELSON	Ken Nelson	12125 Hazel St	907-357-5901	Kenmaynelson@hotmail.com
6	Richard Burns	Ric Burns	1600 Lacy Loop	232-1307	
7	Daryl Smith	Daryl Smith	10339 Stewart Dr, Eagle River AK	696-7646	
8	Steven Kelly	St. Kelly	5429 N. Samplewood Ln	746-0662	
9	Rhonda Weinrick	Rhonda W	3400 E Neomi Ave Was 99654	376-3400	RhondaCharron@aol.com
10	LONNIE WOOD	Lonnie Wood	5670 N Wildwood Dr, Was 99654	357-1853	
11	Lynn Slusher	Lynn Slusher	3941 E. Tambart Wasilla 99654	376-7835	
12	OWEN WESTER	Owen Wester	P.O. BOX 874296 WASILLA AK 99654	351-7748	owenwester329@aol.com
13	Sandra J BUZMAN	Sandra J Buzman	1010 Josselin Lane Palmer	746-2994	quzmanmomb@aol.com
14	ROBERT J GROTHER	Robert J Grother	2880 S. Dawson Wasilla AK 99654	621-0644	
15	Van Sam E	Van Sam E	6812 Stone Ln Wasilla AK 99654	357-9290	csposy@alaska.net
16	David McKee	David McKee	13840 E Hwy Wagonway Palmer AK	952-0532	slurfox@hotmail.com
17	Tyler Sutcliffe	Tyler Sutcliffe	2055 Cranberry Ct Wasilla AK	907-354-1327	Tylerbrinsutcliffe@hotmail.com
18	JUDITH C. RICHARDSON	Judith C Richardson	3132 E Temdrak Ave Wasilla AK	907-359-0243	
19	Ray Hafen	Ray Hafen	3361 Tungsten Dr Wasilla AK 99654	907-441-9811	
20	DAVID CROCKETT	David Crockett	6946 E TEX-AL DR WASILLA, AK 99654	907-242-5571	

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1	Ellen B. Bettine	<i>Ellen B. Bettine</i>	7362 W. Parker Hwy 343	897-6971	jen@prosewatingph...
2	Lynn Gathas	<i>Lynn Gathas</i>	1650 N. Shoreline Dr		
3	KENNETH BARBER	<i>Kenneth Barber</i>	17267 E. Melin Rd Palmer 99645	745-4446	
4	Scathan Foster	<i>Scathan Foster</i>	3611 N Bald Eagle Dr 99654	557-6795	
5	Patti Barber	<i>Patti Barber</i>	17367 E. Melin Rd Palmer 99645	746-4446	pkbarber@ge.net
6	BILL EVERSON	<i>Bill Everson</i>	36708 MORGAN LOOP ¹⁰⁰⁰⁰ _{AK 99649}	260-5723	freedomline@usa.net
7	Sherry Jackson	<i>Sherry Jackson</i>	100 E. Inverness Dr. Wasilla AK 99654	373-6227	jackson5@ak.net
8	JAMES HASTING	<i>James Hasting</i>	200 N. Plymouth Cir. Wasilla, AK 99654	557-1043	jhasting3@usaonline.net
9	DAN McDowell	<i>Dan McDowell</i>	5801 MADON RD WASILLA AK 99654	232-8051	Dan @ Laserent.com
10	Mike Heidson	<i>Mike Heidson</i>	9900 S. Saimobow 99654	377-5434	
11	Philip Ward	<i>Philip Ward</i>	PP Box 878635 Wasilla AK ⁹⁹⁶⁵⁴	841-1509	
12	MAX SAGER	<i>Max Sager</i>	3781 Ruth on Wasilla AK	373-0520	MSAGER@ge.net
13	Greg Busch	<i>Greg Busch</i>	AK 35 BX 2423 Wasilla AK 99654	842-7593	
14	LaVonne Boyd	<i>LaVonne Boyd</i>	6820 Leekwald Wasilla AK	841-6951	
15	John Ace	<i>John Ace</i>	6991 W. Wellington, Wasilla AK	907-877-0091	jrace91@ge.net
16	Traci & Erik	<i>Traci & Erik</i>	P.O. Box 877385 Wasilla AK 99654	357-50024	
17	Julie Gillette	<i>Julie Gillette</i>	4301 S. Well Site Rd Wasilla 99654	376-5455	hunts@akonline.net
18	FRANCISCO CAMPBELL	<i>Francisco Campbell</i>	3061 SATTAN Drive WASILLA 99654		
19	Amy Campbell	<i>Amy Campbell</i>	3061 S. Rattan Dr. Wasilla AK 99654		
20	Suzi Hartmann	<i>Suzi Hartmann</i>	14300 E. Norman Ave. 99645	746-5880	hartmannge@hotmail.com

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	Print Name	Signature	Address	Phone No.	email
1	Robert Mann	<i>R. Mann</i>	7362 W. Arctic Hwy #63, Wasilla	373-2121	
2	Webb Garrison	<i>Webb Garrison</i>	801 Sulatna Bay Wasilla	373-2098	
3	WILLIAM W	<i>W. L. Williams</i>	4721 S. Treadwell Cove Dr.	373-1252	
4	Relsey Trimmer	<i>R. Trimmer</i>	P.O. Box 87312 Wasilla, AK 99687	841-8632	
5	Teresa M. Willman	<i>M. Willman</i>	3555 N. Snow Goose Dr. Wasilla AK 99654	357-1211	
6	Sue Willman	<i>Sue Willman</i>	3555 N. Snow Goose Dr. Wasilla AK 99654	357-1211	
7	Mark Farrar	<i>Mark Farrar</i>	1830 E. Parks Hwy #A113-572 Wasilla, AK 99654	957-6955	
8	Nancy Laabs	<i>Nancy Laabs</i>	4175 N. Clarkwolverine Rd Palmer AK 99675	746-4666	
9	John Pulling	<i>John Pulling</i>	P.O. Box 1445 KENAI, AK 99611	776-8770	
10	J D Biggs	<i>J D Biggs</i>	P.O. Box 521208 Prig Lake AK 99662	592-4152	
11	ANDY KENDRO	<i>Andy Kendro</i>	P.O. Box 1269 PALMER, AK 99645	907-982-9028	ckendro@hotmail.com
12	ROLAND KIRTOW	<i>R. Kirtow</i>	P.O. Box 87111 WASILLA AK 99687	907-376-3657	
13	Patrick Bromley	<i>Patrick Bromley</i>	2100 S. Nylon Circle Wasilla AK 99654	907-776-7642	
14	Charles Miller	<i>Charles Miller</i>	550 Barco Loop Wasilla AK 99654	907-376-9571	
15	Auron Pfluck	<i>Auron Pfluck</i>	P.O. Box 4938 Palmer, AK 99645	841-9848	
16	Tom L. Huff	<i>Tom L. Huff</i>	17207 Sani Tway Dr. Prig Lake AK 99662	917-694-2326	
17	Dan Taylor	<i>Dan Taylor</i>	1090 S. Rosehip Pl. AK 99654	907-373-0816	
18	Christina Guzman	<i>Christina Guzman</i>	183 N. Jessica Ln Palmer AK 99645	907-550-8001	
19	Karen Gauthier	<i>Karen Gauthier</i>	2880 S. Donovan Dr. Wasilla AK 99654	907-6318374	Kgauthier-086@comcast.com
20	Heidi Schlichte	<i>Heidi Schlichte</i>	2055 N. Cranberry Ct Wasilla AK 99654	357-0904	yoonao1994@yahoo.com

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	Print Name	Signature	Address	Phone No.	email
1	Carburg Shew	Carburg Shew	1052 Frank Smith Way #104	907-357-5008	
2	Susan Colds	Susan Colds	11551 Tanglewood Lakes Circle	907-345-3650	
3	David Hecker	David Hecker	189 E. Nelson Ave #117	907-252-4749	
4	Charles Templeton	Charles Templeton	2970 S Aimees Cir Wasilla	373-0134	
5	Twila Templeton	Twila Templeton	2970 S Aimees Cir Wasilla	373-0134	
6	Bruce Walden	Bruce Walden	3850 Tustin Dr Palmer, AK	707-1035	
7	Sonya Walden	Sonya Walden	3850 Tustin Dr Palmer, AK	707-1035	
8	JASON C GREEN	JASON C GREEN	P.O. Box 876647 WASILLA AK 99687	354-3873	
9	Amey Thomas	Amey Thomas	915 Colonial Drive, Wasilla AK 99654		
10	Jim BREUN	Jim Breun	4175N. CLARK WOLVERINE PALMER	99645	
11	Betty Pulling	Betty Pulling	P.O. Box 770742 Eagle River AK	99577	
12	Christopher Teal	Christopher Teal	4778 Gray Loop Unit P Fairbanks	503-894-1774	
13	Alicia Taal	Alicia Taal	4778 Gray Loop Unit D 99506	503-894-1779	
14	Jacquie Carpenter	Jacquie Carpenter	900 enterprize Dr 99654	907-357-8712	
15	JOHN NISCHAN	John A. Nischan	3635 N FORT NE CAC 99654	" 357-4887	
16	Cheryl KIRTON	Cheryl Kirton	PO BOX 877711 Wasilla, AK 99687	376-3657	
17	Roz Nelson	Roz Nelson	12125 HAWKES Ln 99654	357-5901	
18	Andrew Bramley	Andrew Bramley	2100 Pylon Circle Wasilla, AK 99654	376-3642	
19	DERRELL JENSEN	Derrell Jensen	4601 S CENTER C, 2 WASILLA 99654	376-5267	
20	DIANE J HENDERSON	Diane J. Henderson	PO Box 873546 WASILLA AK 99687	907-357-4204	

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	Print Name	Signature	Address	Phone No.	email
1	WILLARD H WAMSGANTZ	Willard H Wamsgantz	1524 RAVEN DR WASILLA 99654	907 357 2820	
2	PAUL McROBERTS	Paul McRoberts	P.O. Box 521292 Anchorage 99555	907-892-7089	
3	WILLIAM B CHILDRESS	William B Childress	P.O. Box 1438 PALMER	907 3784019	
4	John Kalehmainew	John Kalehmainew	1251 N. Catalano DR, Palmer 99645	907 754 5646	
5	Peggy LaFe	Peggy LaFe	2345 Lynx Cir Wasilla 99654	907-3734186	
6	Robert D Graham	Robert D Graham	690 Dickerson Dr. Anchorage 99504	907-929-6040	
7	CARA BROWN	Cara Brown	17714 E. Castle Rock Ln Palmer		CHAN-CHORAGE@Hotmail.com
8	MILES HAISTER	Miles Haister	4101 S. EIDER CIR WAsILLA	907 376 6844	
9	NANCY KOVAL	Nancy Koval	1032 Trail Cir, Wasilla 99654	907-357-2253	
10	MARCO TEBILE	Marco Tebile	401 W Dover Cir Wasilla AK 99654	907-590-0292	marco.tebile@hotmail.com
11	Curt Birch	Curt Birch	3001 Whispering Woods Dr Wasilla AK	907-332-8778	
12	JANET L. STANTON	Janet L. Stanton	1150 S. Colony Way #306 Palmer	907-746-0880	janlyse@aol.com
13	Walter L Miller	Walter L Miller	41515 N McKeen Dr, Palmer AK 99645	907-545-0265	millers@marl.com
14	Nelvie Rumba	Nelvie Rumba	P.O. Box 877456 Wasilla, AK 99687	520-200-5244	drumba46@yahoo.com
15	Nancy Hendrickson	Nancy Hendrickson	P.O. Box 877301 Wasilla, AK 99687	907-373-7544	figgare@mtaonline.net
16	Julia D. Smith	Julia D. Smith	2440 E. Tudor Rd. #1117 Anch. AK 99507	907-947-9303	
17	EDITH SCHUTTEN	Edith Schutten	11574 E. Annie Ln.	907-745-2235	
18	Ronald C Hills	Ronald C Hills	980 S. Bettina Way Wasilla 99654	(907) 376 2668	
19	William G. Burke	William G. Burke	2234 E. Village Loop	907 376 2268	
20	T-S_OAR	T-S_OAR	7701 Wildbrook Court	907 332-4482	

PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	JAMIE Lu SMITH	Jamie Smith	HC34 Box 2131 M Wasilla, AK 99654	376-7863	topgun@mtaonline.net
2	Lindy Schmeltz	Lindy Schmeltz	631 Crestwood Ave Wasilla AK 99654	373-3435	Schmeltz-01@hotmail.com
3	John Quackelaar	John Quackelaar	5949 A Goodwin Ave EAFB 99506	830-3165	jquack03@gei.net
4	Gary Morgan	Gary Morgan	17305 N. Tugaita LP, Eagle River 99577	310-6343	GARY.MORGAN@live.com
5	Jack A. Ross	Jack A. Ross	2221 Muldoon Rd, H515	744-6664	JackofAll@alaska.com
6	Isaac	Isaac	64223 S Praks Hwy, Willow, AK		
7	Jana Johanson	Jana Johanson	P.O. Box 81711 Wasilla, AK 99687	892-7421	forfanny@jamesp.yahoo.com
8	Michael DALL	Michael DALL	5341 Highland Dr, Wasilla, AK	745-5357	
9	Tom KIRK	Tom Kirk	7410 SILVERBIRCH DR, PALMER AK 99645	243-3123	
10	Madonna S. Southcott	Madonna S. Southcott	PO Box 4993 Palmer, AK	746 13925	msouth@mtaonline.net
11	Jim Whitecavage	Jim Whitecavage	18535 Crestview Ln ER	6749335	165avage@mtaonline.net
12	Gordon Burt	Gordon Burt	7320 West Dr Palmer AK 99645	354 0633	gordonb7320@gmail.com
13	Suzanna LaValley	Suzanna LaValley	PO Box 875291, Wasilla, AK	357-5561	suzannalavalley@gei.net
14	Nel Sady	Nel Sady	4043 N. ALVINS ALLEY, WASILLA 99654	373-5477	nel.sady@mtaonline.net
15	Eric Yould	Eric Yould	P.O. Box 3415 Palmer, AK 99645	745-8367	eyould@alaska.com
16	Patricia Yould	Patricia Yould	"	"	"
17	Elizabeth Lawrence	Elizabeth Lawrence	474 W. Heritage Drive Wasilla	301-8525	REALSETHRA@AOL.NET
18	Karin Byman	Karin Byman	950 N. Shumardale Wasilla, AK 99654	357-2690	
19	Josh Bolinder	Josh Bolinder	155 S. Valley Way Palmer AK 99645	232-2838	bolinderjosh@yahoo.com
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PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	GUARDIAN KENTON	[Signature]	2148 W. BRIDGE PATH DR.	457-1407	spokane@yahoo.com
2	David R Brown	David R Brown	39073 N. NITLIK AK	567-3545	
3	David Ewings	[Signature]	18732 Price Island Cir ER, AK	250-3297	
4	Janet Ewings	Janet Ewings	18732 Rice Island Cir ER AK	250-3297	
5	Tim Brown	Tim Brown	Po Box 874331 Wasilla AK 99687	376-9489	
6	Shayne Coisman	[Signature]	1000 Serrano Dr Wasilla AK	373-3315	
7	Len Betts	Len Betts	3090 N. Bald Eagle Dr, Wasilla AK 99659	373-5413	KLZLB@afedna.com x
8	RALPH SAMUELS	[Signature]	8220 FRANK ST. ANCHORAGE AK 99518	410-7253	
9	DALE BUNNIS	Dale Bunnis	1200 N. CACHE AVE. WASILLA AK	378-8508	
10	John Pennell	[Signature]	2700 Garnet Lane, Wasilla, AK	357-1618	
11	Donald Marpin	Donald Marpin	910 Edinborough Park, Anchorage AK	746-0788	marpin@gci.net
12	DONALD CLEMEN	[Signature]	2221 Muldrow Rd #404 Anchorage AK	240-1649	
13	Brian Agee	[Signature]	2001 W. That Rd Wasilla	357-3755	
14	LISA M. JHANNSEN	[Signature]	PO BOX 871741 Wasilla AK 99687	892-7420	alajo94@yahoo.com
15	Tim K. Halverson	[Signature]	3150 S. Pheny Wasilla AK	376-2121	
16	MARK W NORMAN	[Signature]	2300 N SKWENTNA BAY WASILLA AK	357-8425	MARKW-NORMAN@GCI.NET
17	ROGER D. JONES	Roger D Jones	4000 MARQUIS WAY ANCHORAGE AK 99502	245-2132	rogerjones@gci.net
18	SUDDY E KIRAL	[Signature]	7180 Bridgeway Dr	373-5107	kral@alaska.com
19	Heather Jones	[Signature]	20875 S. Birchwood Ln	550-5689	hvj@alaska@yahoo.com
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PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

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	Print Name	Signature	Address	Phone No.	email
1	DARIN BERTOLINI	<i>Darin Bertolini</i>	375 N BEAVER LODGE RD.	907 943-5038	<i>darwin.s.bertolini@gmail.com</i>
2	RICK C. ELLIS	<i>Rick C. Ellis</i>	341 S. GASTMAN CT. WASILLA	376-6703	<i>3pik97582@comcast.net</i>
3	KEVIN VANCE	<i>Kevin Vance</i>	477 N. CHUGACHA ST	745-8118	
4	PHIL KNIGHT	<i>Phil Knight</i>	2098 W Church Ave, Wasilla	795-8908	<i>pknight52@alaska.com</i>
5	KAREN HOY	<i>Karen Hoy</i>	PO BOX 870797, WASILLA AK 99687	357-6273	<i>hoykaren@alaska.com</i>
6	LARRY WOOD	<i>Larry Wood</i>	4750 Chugiach Blvd, Wasilla AK 99615	746-4981	<i>lwood@alaska.com</i>
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Return to: Conservative Patriots Group, Inc. 1830 E. Parks Hwy. A-113 #535, Wasilla, AK 99654 PH: 907-354-8360

PETITION DEMANDING ALASKA JOIN IN LEGAL ACTION TO REPEAL HEALTH CARE BILL

With the passage of the Health Care Reform Bill, America is teetering toward tyranny. A mandate requiring all individuals to purchase health insurance is an unprecedented form of federal action. A legal challenge by the States appears to be the only hope of protecting the American people from this unprecedented attack on our system of government. At least fifteen states are instituting legal action to challenge the constitutionality of the health care reform bill. Alaska should take its place in this list of States and join in the legal fight. By signing this petition you are demanding the Governor and Attorney General join in the legal action to repeal the Health Care Bill.

	Print Name	Signature	Address	Phone No.	email
1	Wayne Foust	<i>Wayne Foust</i>	1830E Parks Hwy P.O. # 665 S	1-907-372-9941 A-113	Geiss@mtaonline.net
2	Jason Wood	<i>Jason Wood</i>	P.O. B. 111769 Anch. AK 99511	242-9612	
3	CHAD RUSSELL	<i>Chad Russell</i>	P.O. Box 231921 Anch. AK 99523	440-9275	
4	Margaret Branley	<i>Margaret Branley</i>	P.O. Box 298217 Wasilla 99629	373-7420	herbpassion@ymail.com
5	Charles Branley	<i>Charles Branley</i>	P.O. Box 298217 Wasilla 99629	373-7420	adam@ak@yaho.com
6	Rominske Keith A.	<i>Keith Rominske</i>	H.C. 32, 6535 T Wasilla 99654	746-7209	
7	Amenke St. Peter	<i>Amenke St. Peter</i>	1428 N. Tanand. Wasilla, AK	373-1157	
8	Kyle St. Peter	<i>Kyle St. Peter</i>	1428 N. Tanand. Wasilla AK	373-1157	
9	John Carr	<i>John Carr</i>	3900 STEVEN dr Wasilla	355-0752	Richcarr@mtaonline.net
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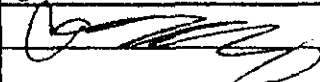
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	Print Name	Signature	Address	Phone No.	email
1	Ray Kreig	<i>[Signature]</i>	3818 Clay Products Rd #107	276 2025	ray@kreig.com
2	John A. Gimarc	<i>[Signature]</i>	1155 BUFF CREEK CIRCLE 99515	3450629	ajimarc@ak.net
3	Glen M. Kiegel	<i>[Signature]</i>	5451 Barry Ave 99507	346-6244	gkiegel@ak.net
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	Print Name	Signature	Address	Phone No.	email
1	Carolyn Kuckert		9401 Commons Place Anchorage AK 99503	748-7714	ckuckert@alaska.com
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HJR

10

**CS FOR HOUSE JOINT RESOLUTION NO. 10(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION**

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): REPRESENTATIVES GUTTENBERG, Kawasaki, Salmon, Kerttula, Gruenberg, Cissna, Lynn

A RESOLUTION

1 **Urging the United States Congress to improve health care for veterans.**

2 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 **WHEREAS** the Veterans Health Administration in the United States Department of
4 Veterans Affairs, the gateway to veterans' health care, is backlogged because of inadequate
5 resources; and

6 **WHEREAS** the Partnership for Veterans Health Care Budget Reform is composed of
7 the American Legion, AMVETS, Blinded Veterans Association, Disabled American
8 Veterans, Jewish War Veterans, Military Order of the Purple Heart, Paralyzed Veterans of
9 America, Veterans of Foreign Wars, and Vietnam Veterans of America; and

10 **WHEREAS** the Partnership for Veterans Health Care Budget Reform has found the
11 current funding mechanism for veterans' health care to be unreliable and vulnerable to
12 political posturing, cost cutting, and budget gimmickry; and

13 **WHEREAS** the number of veterans increases every day as members of the military
14 return from overseas and re-enter civilian life; and

15 **WHEREAS** the medical needs of returning veterans, especially those suffering from
16 traumatic brain injury, post-traumatic stress syndrome, and other combat-related

1 psychological injuries, must be met; and

2 **WHEREAS** the Veterans Affairs Healthcare System facility in Anchorage, the
3 Veterans Affairs Community-based Outpatient Clinics at Fort Wainwright and in Kenai, and
4 the soon to open facilities in the Matanuska-Susitna Borough, Juneau, and Homer provide
5 outpatient services for Alaska's veterans; and

6 **WHEREAS** the Veterans Health Care Budget Reform and Transparency Act of 2009,
7 introduced in the 111th Congress, allows for a two-fiscal-year budget authority for veterans'
8 health care programs and requires the Comptroller General of the United States to conduct a
9 study on the adequacy and accuracy of baseline model projections for veterans' health care
10 expenditures of the United States Department of Veterans Affairs; and

11 **WHEREAS** the Partnership for Veterans Health Care Budget Reform endorses the
12 Veterans Health Care Budget Reform and Transparency Act of 2009;

13 **WHEREAS** veterans of the United States-led wars in Afghanistan and Iraq are
14 entitled to five years of health care without charge from the United States Department of
15 Veterans Affairs regardless of the priority group to which they are assigned, but are
16 reimbursed for the cost of traveling to access that care only if they meet the eligibility criteria
17 in the travel regulations of the United States Department of Veterans Affairs; and

18 **WHEREAS** United States Senator Lisa Murkowski conducted a hearing under the
19 auspices of the Senate Committee on Indian Affairs in November 2007 which established that
20 veterans of the wars in Afghanistan and Iraq who live in rural Alaska have limited, or no
21 access to their earned United States Department of Veterans Affairs health benefits and that
22 the Alaska Native health system and Community Health Centers, which are severely under
23 funded, are providing care to these veterans without reimbursement from the United States
24 Department of Veterans Affairs at the expense of the Native health system's and Community
25 Health Centers' primary missions; and

26 **WHEREAS** the Secretary of Veterans Affairs "CARES Decision" states, "Medical
27 care is a key component of the benefits and services enacted by Congress in recognition of the
28 service, and sometimes the sacrifice, of the men and women whose military service preserved
29 and protected America's freedoms."; and

30 **WHEREAS** in written testimony to the United States House Committee on Veterans
31 Affairs, Andy Behrman, Rural Health Policy chair of the National Rural Health Association,

1 asserted that "The disproportionate numbers of rural Americans serving in the military has
2 created a disproportionate need for veterans' care in rural areas and yet rural areas are less
3 likely to have VA services available to them," that "time and distance prevent many rural
4 veterans from getting their healthcare benefits through a VHA facility," and that other
5 approaches are "readily available in the VA system and in the rural health landscape that
6 could improve this situation"; and

7 **WHEREAS** the written testimony of the National Rural Health Association also
8 stresses the problem that "Federally Qualified Community Health Centers (CHCs) serve
9 millions of rural Americans, but most veterans cannot use their VA health benefits to receive
10 care at these CHCs" because a "national policy advocating VHA-CHC collaboration has not
11 emerged in an effective way"; and

12 **WHEREAS** the written testimony of the National Rural Health Association
13 emphasizes that a "limited number of collaborations between the VHA and CHCs already
14 exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in
15 remote areas" and that this "model of collaboration between VHA and CHCs might do well in
16 other rural states and with other rural providers and systems of care and should be
17 implemented further"; and

18 **WHEREAS** a report written by David R. Selig, Chief Executive Officer of the
19 Community Care Network of Virginia, provides a concrete proposal of collaboration between
20 community health centers and the United States Department of Veterans Affairs by
21 suggesting that community health centers "serve as a vehicle for increasing access to primary
22 care for Veterans" and presents a model where community health centers "function as a
23 Community Based Outpatient Clinics (CBOCs) as defined by the Department of Veterans
24 Affairs"; and

25 **WHEREAS** the existing Community Health Centers and tribal health organizations
26 infrastructure in Alaska should be used to its full potential to provide access to cost-effective,
27 quality care for Alaska Veterans whether through a Community Based Outpatient Clinic
28 arrangement, a network arrangement, or individual arrangements with individual Community
29 Health Centers or tribal clinics; and

30 **WHEREAS** Community Health Centers and tribal health organizations provide
31 comprehensive primary care and mental health and substance abuse services to medically

1 underserved areas and populations, including veterans who do not reside near a VA health
2 care facility;

3 **BE IT RESOLVED** that the Alaska State Legislature urges the United States
4 Congress to provide adequate funding and resources to enable the Veterans Health
5 Administration to properly care for the health care needs of all veterans by adopting a method
6 similar to that proposed in the Veterans Health Care Budget Reform and Transparency Act of
7 2009; and be it

8 **FURTHER RESOLVED** that the Alaska State Legislature urges the United States
9 Congress to provide the United States Department of Veterans Affairs with sufficient, timely,
10 and predictable funding for veterans' health care programs; and be it

11 **FURTHER RESOLVED** that the Alaska State Legislature urges the United States
12 Congress to ensure that health care services follow veterans to where they live and work so
13 that veterans are not obligated to search for the veterans' services to which they are entitled;
14 and be it

15 **FURTHER RESOLVED** that the Alaska State Legislature urges the United States
16 Congress to increase funding for research into traumatic brain injuries; and be it

17 **FURTHER RESOLVED** that the Alaska State Legislature urges the United States
18 Congress to encourage the Veterans Health Administration to improve its electronic claims
19 filing process and its ability to use information contained in military records; and be it

20 **FURTHER RESOLVED** that the Alaska State Legislature supports federal and state
21 funding and other efforts to ensure that veterans across the state have access to quality health
22 care at Community Health Centers, community mental health centers, substance abuse
23 treatment centers, tribal health organizations, and other appropriate local providers in the
24 outlying areas where the United States Veterans Administration does not have clinics.

25 **COPIES** of this resolution shall be sent to the Honorable Barack Obama, President of
26 the United States; the Honorable Joseph R. Biden, Jr., Vice-President of the United States and
27 President of the U.S. Senate; the Honorable Robert C. Byrd, President Pro Tempore of the
28 U.S. Senate; the Honorable Nancy Pelosi, Speaker of the U.S. House of Representatives; the
29 Honorable Daniel Akaka, Chair of the U.S. Senate Committee on Veterans' Affairs; the
30 Honorable Bob Filner, Chair of the U.S. House Committee on Veterans' Affairs; the
31 Honorable Eric K. Shinseki, United States Secretary of Veterans Affairs; the Honorable

1 Michael B. Donley, United States Secretary of the Air Force; the Honorable Pete Geren,
2 United States Secretary of the Army; and the Honorable Lisa Murkowski and the Honorable
3 Mark Begich, U.S. Senators, and the Honorable Don Young, U.S. Representative, members of
4 the Alaska delegation in Congress.

Session:
State Capitol
Juneau, Alaska 99801
(907) 465-4457 Office
(907) 465-3519 Fax
(800) 928-4457 Toll Free

Alaska House of Representatives
David Guttenberg



District 8

Interim:
1292 Sadler Way
Suite 304
Fairbanks, Alaska 99701-3171
(907) 456-8172
(907) 456-2490 Fax

MEMO

To: **Representative Wes Keller, Co-Chair**
Representative Bob Harron, Co-Chair
House Health and Social Services Committee

From: Representative David Guttenberg

Date: March 2, 2009

Re: Hearing request for CS HJR 10, resolution urging the United States Congress to improve health care for veterans.

I respectfully request that CS HJR 10 be scheduled for a hearing in the House Health and Social Services Committee at your earliest Convenience.

Included you will find:

- The current version of CS HJR 10
- Sponsor statement
- Letters of support

I look forward to discussing the merits of this resolution in the House Health and Social Services Committee. My staff, Chris Reid, is assigned to this legislation if there are any questions, 465-4457. Any additional materials we wish to place before the committee will be submitted no later than 24 hours prior to the scheduled hearing.

Anderson • Cantwell • Chena • Denali Park • Ester • Geist • Goldstream • Healy • Pike
University Campus • University Hills • University West
Representative_David_Guttenberg@legis.state.ak.us

ALASKA STATE LEGISLATURE



Sponsor

Statement

SESSION:

Alaska State Capitol, Room 418
Juneau, AK 99801
(907) 465-4457 Office
(907) 465-3519 Fax
(800) 928-4457 Toll Free

INTERIM:

1292 Sadler Way, Suite 304
Fairbanks, AK 99701
Office (907) 456-8172
Fax (907) 456-2490

Representative David Guttenberg

“A Resolution urging the United States Congress to improve health care for veterans”

The United States government has a responsibility to all veterans for their service to our state and nation. HJR- 10 urges the United State Congress to live up to that responsibility by providing veterans with adequate and improved health care. Alaska has the highest per capita population of veterans in the nation.

The Partnership for Veterans Health Care Budget Reform (a non profit whose mission is to support sufficient, timely and predictable funding for veteran health care) has found the current funding mechanism for veterans' health care to be unreliable and vulnerable to political posturing, cost cutting, and budget gimmickry. Our veterans deserve better than that. Along with the increasing number of veterans is the increasing number of traumatic brain injury and combat-related psychological injuries.

Without a streamlined and comprehensive health care system, veterans are being denied the health care they are entitled to. This house joint resolution seeks to establish the voice of the 26th Alaska State Legislature in favor of better health care reform for all veterans.

Representative.David.Guttenberg@legis.state.ak.us
<http://guttenberg.akdemocrats.org>

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHJR 10(MLV)
(H) Publish Date: 2/25/2009

Identifier (file name): _____ Dept. Affected: _____
Title CSHJR 10 VETERANS' HEALTH CARE RDU _____
Sponsor Representative David Guttenberg Component _____
Requester Military and Veterans' Affairs Committee Component Number _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES								
CHANGE IN REVENUES ()								

FUND SOURCE (Thousands of Dollars)

	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

Prepared by: House Military and Veterans' Affairs Committee Phone _____
Division _____ Date/Time _____
Approved by: Representative Carl Gatto Date 2/24/2009

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

February 23, 2009

The Honorable Carl Gatto
House Military and Veterans' Affairs
Alaska State Capitol, Room 108
Juneau, Alaska 99801-1182

Subject: Support for HJR 10

Dear Chair Gatto:

The Alaska Commission on Aging (ACoA) encourages support for HJR 10 sponsored by Representative Guttenberg, Representative Kawasaki, Representative Salmon, Representative Kerttula, Representative Gruenberg, and Representative Cissna that encourages the United States Congress to improve health care and access for veterans. ACoA supports this resolution and its intent for Congress to provide sufficient, timely, and stable funding for veterans' health programs and to improve service delivery.

Health care is a key benefit of the services provided to persons who served in the armed forces. The number of veterans returning from military duty, in addition to veterans who are aging, is increasing along with the associated health care expenses. Although Alaska has the highest per capita population of veterans in the nation, our state remains as one of three states in the nation without a veterans' hospital that provides acute care inpatient services.

Moreover, Alaskan veterans come from all areas of the state. Veteran clinic facilities are located only in Anchorage, Fairbanks, Juneau, and Kenai. If a veteran lives outside of these areas and his/her medical condition is not 51% or more service-related, that individual is responsible for paying their own travel expenses. The Commission on Aging supports the Resolution's recommendation of a special "Heroes Health Card" to provide veterans access to health care in communities where they live, including those without veteran clinic facilities, by coordinating care provided by local medical providers and community health care facilities with care provided by military doctors and medical facilities.

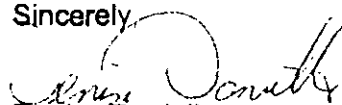
ACoA supports HJR 10 and believes that veterans who served our country deserve decent health care. It is our responsibility and obligation to provide quality and accessible health care for veterans who joined the armed forces to serve and protect our nation. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,



Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello,
ACoA Executive Director

Cc: Representative Harris
Representative Olson
Representative Buch

Representative Lynn
Representative Ramras
Representative Kawasaki

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SARAH PALIN, GOVERNOR

P.O. BOX 110608
431 N. Franklin Street, Suite 200
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: (888) 464-8920

February 10, 2009

Representative David Guttenberg
Alaska State Capitol, Room 418
Juneau, Alaska 99801

Re: Support for HJR 10

Representative Guttenberg:

The Advisory Board on Alcohol and Drug Abuse and the Alaska Mental Health Board appreciate your recognition of our nation's responsibility to our returning veterans and military service members. We support HJR 10 calling for a comprehensive national response to our service members' health care needs and offer our assistance in helping to pass this important resolution.

We respectfully recommend the inclusion of a specific provision to address the behavioral health needs of veterans and returning service members. We also recommend specifically including tribal health organizations as an important resource in the coordination of care for returning service members, since many Alaskan veterans return to rural communities served exclusively by tribal health organizations. We also would strongly recommend that any expansion of veterans' health care services be carefully constructed so as not to result in a reduction of services already being provided to veterans with service-connected disabilities.

We respectfully offer the following language to be considered as a possible amendment to the resolution:

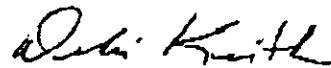
27 **FURTHER RESOLVED** that the Alaska State Legislature encourages the United
28 States Department of Veterans Affairs to create a special health pass or "heroes health card"
29 to provide veterans with health care in local communities by coordinating care provided by
30 local doctors, [and] community health care facilities, community mental health centers and
31 substance abuse treatment centers, and tribal health organizations with care provided by
32 military doctors and medical facilities.

We appreciate your advocacy on behalf of our military service members and look forward to working with you on this issue.

Sincerely,



Lonnie Walters, Chair
ABADA



Debi Keith, Chair
AMHB

Chris Reid

From: k8819tejk@netscape.net
Sent: Friday, February 13, 2009 5:53 AM
To: Chris Reid
Subject: Leeter of Agreement

Thomas E. Kopaceski

February 13, 2009 P. O. Box 871115 Wasilla, Ak.

99687-1116

Dear Representative David Guttenberg,

Since I am a Viet Nam veteran, I have reviewed HJR10 Resolution. I am in total support of HJR10.

Sincerely,

Thomas E. Kopaceski

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

SARAH PALIN, GOVERNOR

P.O. BOX 110693
 JUNEAU, ALASKA 99811-0693
 PHONE: (907) 465-3250
 FAX: (907) 465-1398

Alaska Commission on Aging

March 4, 2009

The Honorable Bob Herron
 The Honorable Wes Keller
 House Health and Social Services
 Alaska State Capitol, Rooms 415 and 13
 Juneau, Alaska 99801-1182

Subject: Support for CSHJR 10 (MLV)

Dear Chair Herron and Chair Keller:

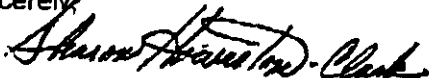
The Alaska Commission on Aging (ACoA) supports CSHJR 10 sponsored by Representative Guttenberg, Representative Kawasaki, Representative Salmon, Representative Kerttula, Representative Gruenberg, Representative Lynn, and Representative Cissna. ACoA concurs with this resolution and its petition to Congress to improve health care and access for veterans by providing sufficient, timely, and stable funding for their health programs and enhanced service delivery.

Health care is a key benefit of the services provided to persons who served in the armed forces. The number of veterans returning from military duty, in addition to veterans who are aging, is increasing along with the associated health care expenses.

Alaskan veterans come from all areas of the state. Veteran clinic facilities are located only in Anchorage, Fairbanks, Juneau, and Kenai. If a veteran lives outside of these areas and his/her medical condition is not 51% or more service-related, that individual is responsible for paying their own travel expenses. The Commission on Aging supports the Resolution's recommendation of a special "Heroes Health Card" to provide veterans access to quality health care in communities where they live, including those without veteran clinic facilities, by coordinating care provided by local medical providers, community health care facilities, mental health centers, substance abuse treatment centers, tribal health organizations, and other appropriate providers with care provided by military doctors and medical facilities. In addition, ACoA supports the Resolution's request for Congress to increase funding for research into traumatic brain injuries and to improve its electronic claims filing process.

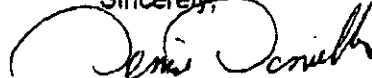
ACoA supports CSHJR 10 and believes that veterans who served our country deserve decent health care where they live. It is our responsibility and obligation to provide quality and accessible health care for veterans who joined the armed forces to serve and protect our nation. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,



Sharon Howerton-Clark
 Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello,
 ACoA Executive Director

Cc: Representative Coghill
 Representative Seaton

Representative Lynn
 Representative Cissna

Representative Holmes

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."



Honorable Carl Gatto, Chair
House Military and Veterans Affairs Committee
State Capitol, Room 108
Juneau, Alaska 99801

February 24, 2009

Re: Support of HJR 10 *Veterans' Health Care*

Dear (H)MVA Chair, Representative Gatto,

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans and is strongly in support of HJR 10 *Veterans' Health Care*. Many of the veterans in Alaska reside in medically underserved areas; with the current funding levels and criteria for VA sponsored health care, many of our Alaskan veterans do not have adequate primary care access. When the medical condition is not service-related and does not exceed a certain degree of disability, these veterans in outlying areas have primarily three choices: 1) cover their own expenses to fly in to Anchorage or Fairbanks to access VA care; 2) go without care; or 3) access services at a non-VA clinic, very likely to be one of the 141 Community Health Center (CHC) sites in the state.

For those veterans who opt for the third choice above, often, the CHC does not receive reimbursement because the veteran did not file the necessary paperwork in advance. The CHC typically eats the cost. The APCA is working at this time with the Alaska VA Health Care System to increase access for all the veterans who live in areas outside of the vicinity of the VA clinics, including all the veterans who have gone without but need care and all those who have had limited care because of the cost of travel.

It is very important that Congress adequately fund VA health care so that veterans from every corner of Alaska have appropriate access – all veterans, those returning from the current conflict with pressing issues as well as those who served previously and are experiencing increasing health care needs as they age. The APCA urges congress to utilize the CHC infrastructure across Alaska rather than duplicate services by establishing new VA clinics where there is already a CHC.

The Alaska Primary Care adamantly supports HJR 10 and appreciates the Alaska State Legislature working to promote health care access for veterans throughout the state by passing this important resolution in order to communicate this priority to the U.S. Congress.

Supporting health care for Alaska's veterans,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

Marilyn Kasmar
Executive Director

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SARAH PALIN, GOVERNOR

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TOLL FREE: (888) 464-8920

March 6, 2009

Representative David Guttenberg
Alaska State Capitol, Room 418
Juneau, Alaska 99801

Re: Support for CSHJR 10

Representative Guttenberg:

The Advisory Board on Alcohol and Drug Abuse and the Alaska Mental Health Board appreciate your recognition of our nation's responsibility to our returning veterans and military service members. We support CSHJR 10 calling for a comprehensive response to our service members' health care needs, including the behavioral health needs of veterans and returning service members.

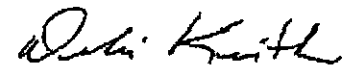
We support expanded cooperation between the Veteran's Administration and Alaska's community health care providers to increase access for returning veterans with service-connected disabilities. Many veterans are returning to rural communities. The most effective and efficient way for them to access needed health care is through community mental health centers, substance abuse treatment centers, community health centers, and tribal health organizations. By expanding partnerships between the Veteran's Administration and local health care providers, we can insure that veterans with service-connected disabilities receive the health care they need as close to home as possible.

We appreciate your advocacy on behalf of our military service members and look forward to continuing work with you on this issue.

Sincerely,



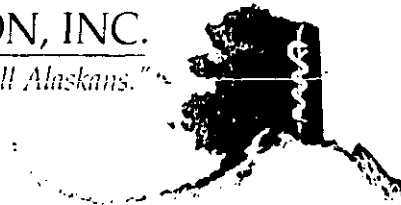
Lonnie Walters, Chair
ABADA



Debi Keith, Chair
AMHB

ALASKA PRIMARY CARE ASSOCIATION, INC.

"... Uncompromising in the pursuit of access to primary care for all Alaskans."



Honorable Wes Keller, Co-Chair
Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
State Capitol
Juneau, Alaska 99801

March 6, 2009

Re: Support of CSHJR 10 (MLV) *Veterans' Health Care*

Dear (H)HSS Co-Chairs Keller and Herron and Members of the House Health & Social Services Committee,

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans and is strongly in support of CSHJR 10 (MLV) *Veterans' Health Care*. Many of the veterans in Alaska reside in outlying areas where they are unable to access VA health care facilities. When their medical conditions are not service-related and do not meet certain criteria, these veterans in outlying areas have three choices: 1) cover their own expenses to travel to access VA care; 2) go without care; or 3) access services at a non-VA clinic, very likely to be one of the 141 Community Health Center (CHC) sites in the state.

For those veterans who opt for the third choice above, often, the CHC does not receive reimbursement because the veteran did not file the necessary paperwork in advance. The CHC typically eats the cost. Although the APCA has been working with the Alaska VA Health Care System to increase access for all the veterans who live outside the vicinity of the VA clinics, little progress has been made due to federal barriers within the VA system. Currently, veterans cannot readily use their VA health benefits to receive care at CHCs because a national policy advocating VA-CHC collaboration has not emerged in an effective way. CSHJR 10 (MLV) would encourage such collaboration.

The APCA urges the VA system to utilize the CHC infrastructure across Alaska rather than duplicate services by establishing new VA clinics where CHCs already exist. CHCs are well-positioned to provide access to cost-effective, quality care for Alaska's veterans whether through a CBOC arrangement, a network arrangement, or individual arrangements with individual CHCs

Lastly, it is very important that Congress adequately fund VA health care so that veterans from every corner of Alaska have access – all veterans, those returning from the current conflict with pressing issues as well as those who served previously and have increasing health care needs as they age.

The Alaska Primary Care adamantly supports CSHJR 10 (MLV) *Veterans' Health Care* and appreciates the Alaska State Legislature working to promote health care access for veterans throughout the state by passing this important resolution in order to communicate this priority to the U.S. Congress.

Supporting health care for Alaska's veterans,

Shelley S. Hughes
Government Affairs Director

Phone 907 929 2722

Fax 907-929-2734

www.alaskapc

903 West Northern Lights Blvd. Suite 200 Anchorage, Alaska 99503

AK Primary Care

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."



Alaska Primary Care Association Board of Directors

RESOLUTION 2009-10

Veteran Access to Health Care (State and Federal)

WHEREAS the mission of the Alaska Primary Care Association is to improve access to primary care for all Alaskans by supporting Community Health Centers (CHCs) and safety net providers throughout the state; and

WHEREAS CHCs provide comprehensive primary care services to medically underserved areas and populations including but not limited to uninsured and underinsured individuals, low income families, Veterans, seniors, seasonal workers, non-English speaking individuals; and

WHEREAS a National Rural Health Association (NRHA) Written Testimony by Andy Behrman, NRHA Rural Health Policy Board Chair, prepared for the Health Subcommittee of the House Committee on Veteran's Affairs, asserts, "The disproportionate number of rural Americans serving in the military has created a disproportionate need for veteran's care in rural areas and yet rural areas are less likely to have VA services available to them;"¹ and

WHEREAS the above mentioned written testimony states that "time and distance prevent many rural veterans from getting their healthcare benefits through a VHA facility" and that approaches, including CHCs, are "readily available in the VA system and in the rural health landscape that could improve this situation;"² and

WHEREAS the written testimony also stresses the problem that "Federally Qualified Community Health Centers (CHCs) serve millions of rural Americans, but most veterans cannot use their VA health benefits to receive care at these CHCs" because a "national policy advocating VHA-CHC collaboration has not emerged in an effective way;"³ and

WHEREAS the NRHA written testimony emphasizes that a "limited number of collaborations between the VHA and CHCs already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas" and that this "model of collaboration between VHA and CHCs might do well in other rural states and with other rural providers and systems of care and should be implemented further;"⁴ and

WHEREAS a report written by David R. Selig, Chief Executive Officer of the Community Care Network of Virginia, provides a concrete proposal of collaboration between CHCs and the VA by suggesting that CHCs "serve as a vehicle for increasing access to primary care for Veterans" and



Military Order of the
Purple Heart
Department of Alaska



Date: March 6, 2009

**The Honorable Carl Gatto
House Military and Veterans Affairs
Alaska State Capitol, Room 108
Juneau, AK 99801-1182**

Subject: Support for HRJ 10.

Dear Chairman Gatto, and other sponsors/supporters of HJR 10.

The MOPH, Department of Alaska, is in full support of HJR 10 and its intent to provide the best health care available to our veterans. Those who answered the call to defend our country have fully earned the right to have the country be there for them in their time of need.

As the current military conflict continues there will be an ongoing need to care for those who will stand among others who served previously. It is only fair for our nation to provide the care and assistance that our veterans have rightfully earned. Reasonable access to that health care is equally important, especially to those who suffer the most and often need special assistance just to get to the location providing that health care. While many veterans are fortunate to be able to drive to and walk to the point of health care assistance, it is important to not forget about those who need wheel chairs or other special assistance. The need to reach out to provide adequate care can be stated like this "LET NO VETERAN BE LEFT BEHIND" and that responsibility falls on the system charged with providing the health care that has already been paid for by our nations veterans.

HRJ 10 is a commendable approach in proving that Alaska truly cares about its veteran population. As such HRJ 10 has the support of the MOPH, Department of Alaska.

Ron Siebels

**Ron Siebels
MOPH, Department Commander, Alaska**

MOPH Alaska



Jill Hodges
Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99501
March 6, 2009

Representative David Guttenberg
Alaska State Legislature
State Capitol Building
Juneau, Alaska 99801

Dear Representative Guttenberg:

Thank you for your continued concern for returning service members in Alaska, as well as traumatic brain injury research. The Alaska Brain Injury Network supports HJR 10 – Veterans Health Care.

The Alaska Brain Injury Network is a non-profit 501 (c) 3 whose mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for survivors of traumatic brain injury and their families.

ABIN supports the need for traumatic brain injury research; yet also requests the committees take into consideration equal access to rehabilitation and ongoing support programs for all Alaskans with cognitive disabilities.

Recent studies show at least 20% of service members will return from war with a traumatic brain injury. Additionally, there are 800 Alaskans each year hospitalized for more than 24 hours with a moderate to severe traumatic brain injury (Alaska Trauma Registry). There is an estimated 3000 Alaskans that visit the Emergency Department each year (CDC). Falls, motor vehicle crashes, assault, ATV/Snowmachine and bicycle crashes are the leading causes of traumatic brain injury in Alaska. The Alaska Brain Injury Network, "10 Year Plan for TBI in Alaska" highlights the many recommendations needed to provide information and referral, case management, acute and post-acute rehabilitation, educational supports, vocational supports, and long-term care to all Alaskans with brain injuries. (http://www.alaskabraininjury.org/documents_akbrain/10%20Year%20TBI%20Plan.pdf)

It is important to understand brain injury affects Civilians and Military Members alike. The health care issue is a matter of access, as well as availability of services locally and payment for those serves. Currently the Alaska VA Health Systems and the Department of Defense, 3rd Medical Unit are developing TBI clinics, polytrauma clinics and brain injury rehabilitation and ongoing support services which will benefit both active duty and veterans; however these programs are being built with little coordination among the state and community providers. At the same time Alaska community providers are planning the development of brain injury residential programs because currently there are civilians who are not receiving the care they need to recover and/or

best learn to live with their cognitive disability. Alaska does not have the workforce to operate three separate brain injury service delivery systems (including the Tribal system).

ABIN Activities Promoting Coordination among Military, State, Tribal, and Community

ABIN has been meeting with military partners since October 2007 for the purposes of determining the impact of returning service members with brain injuries and the impact it will have on state and community providers and resources. Participants have included 3rd medical unit, Elmendorf, TBI Clinic; Alaska VA Health Systems Polytrauma and Neuropsychology program; National Guard; Service and Family Assistance Center-Warrior Transition Battalion; Marines; Vet Center representatives; and Alaska Federal Health Care Partnership. We have learned that we can share outreach and awareness resources, but with program planning and implementation there has been little collaboration.

Potential Challenges

It is important to recognize how service members with brain injury may have challenges without the proper services and supports and are at risk for additional brain injuries. Highest rates of brain injury in civilians are among rural Alaskans and Alaska Natives. Many national guardsmen/women live in rural Alaska. A risk factor for a brain injury is history of brain injury; i.e. A national guardsperson is in an IED blast in Afghanistan. He/she returns to Alaska and may have challenges with balance, memory, attention, etc. He is riding his snowmachine and crashes, no helmet or maybe even with a helmet, he sustains an additional brain injury. There is potential for an influx of brain injuries in the next 5-20 years; a coordinated TBI prevention program and service delivery system would benefit all Alaskans.

Recommendations

The leadership and collaboration among State Government, Tribal Systems, Military and Veterans, and Community Providers is key to developing appropriate, timely, and coordinated brain injury services in Alaska.

If we do not have the essential brain injury awareness and treatment in Alaska

- Alaskans are at risk for bankruptcy, homelessness, divorce, or institutional care.
- This impacts State and local behavioral health, corrections, and educational systems greatly.

The Alaska Brain Injury Network encourages coordination in planning and implementation of brain injury programs in-state, as well as a state funding source to support the payment of brain injury rehabilitation and long-term care for both military and civilians.

The Alaska Brain Injury Network supports HJR 10-Veterans Health Care. We also support collaboration efforts in the planning and implementation of the services that are needed in both rural and urban Alaska to support veterans and civilians.

Sincerely,

Jill Hodges

HJR

35

Alaska State Legislature

Juneau

State Capitol Bldg., Rm. 513
Juneau, AK 99801-1182
Phone (907) 465-4976
Fax (907) 465-3883
Toll Free 866-465-4976



Fairbanks

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Fairbanks, AK 99701
Phone (907) 452-6084
Fax (907) 452-6096

Member

House Finance Committee

Representative Mike Kelly

House District 7

SPONSOR STATEMENT

HJR 35 – HEALTHCARE FREEDOM ACT

“Proposing amendments to the Constitution of the State of Alaska prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system.”

HJR 35 would give Alaskans the opportunity to vote on a Constitutional Amendment prohibiting the passage of laws that would force any person or employer to participate in a particular health care system or plan. Similar measures are under consideration in 35 states.

The Health Care Freedom Act seeks to protect two essential rights. First, it would protect a person’s right to participate or not in any health care system, and it would prohibit the government from imposing fines or penalties because of that person’s decision. Second, it would protect the right of an individual to purchase – and the right of doctors to provide – lawful medical services without government fines or penalties. HJR 35 would place these essential rights in the state constitution.

Few Alaskans question the need for effective health care reform to improve access, quality and affordability while ensuring that personal health care is patient-driven. Advocates of a larger government role in regulating and providing health insurance and care support forcing individuals to join a government-approved health insurance plan, whether or not they want it, can afford it, or it best meets their personal needs. But the overwhelming majority of Alaskans oppose this mandate.

If the federal government adopts nationalized health care and a significant block of states change their constitutions to protect their citizens, a legal clash may well be winnable for the states. This United States Supreme Court may just be in the mood to protect individual liberty and state sovereignty in such a private matter as personal health care.

Alaska State Legislature

Juneau

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Fax (907) 452-6096

Member

House Finance Committee

Representative Mike Kelly

House District 7

MEMORANDUM

DATE: February 8, 2010
TO: Representative Kelly
FROM: Derek Miller
RE: Sectional Analysis for HJR 35
(26-LS1063\R)

A sectional summary of a bill should not be considered an authoritative interpretation of the bill. The bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1.

Proposes to amend Article 1, Section 15 of the State of Alaska Constitution by inserting **(a)** before the clause.

Section 2.

Proposes to amend Article 1, Section 15 of the State of Alaska Constitution by inserting a new section that would prohibit the passage of laws that prohibit a person or penalize a person for making direct payments to a health care provider for tendering health care services or prohibit or penalize the purchase of health care insurance from a privately owned health care insurance company. The section also prohibits the passage of laws that compel a person, employer, or health care provider to participate in a health care system or that penalizes a person, employer, or health care provider for declining to participate in a health care system. The section exempts a health care system that provides indemnity and medical benefits to injured workers.

Section 3.

Places the amendments proposed by this resolution before the voters of the state at the next general election in conformity with Article 13, Section 1 of the Constitution of the State of Alaska and the election laws of the state.

Alaska State Legislature

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Member

House Finance Committee

Representative Mike Kelly

House District 7

MEMORANDUM

DATE: February 15, 2010

TO: Representative Mike Kelly

FROM: Derek Miller

RE: Answers to Questions @ 2/9/10 HESS Hearing

-
- 1) **Does HJR 35 prevent the State of Alaska from initiating a new tier to the state retirement system? How would this constitutional amendment impact future changes to the current State of Alaska retirement system?**

This resolution does NOT prevent the State from initiating a new tier to the state retirement system. Changes can be made to the retirement system as long as those changes aren't a mandate on individuals or employers to purchase insurance. The state would also be prohibited from passing laws that penalize or fine individuals or employers from choosing not to purchase coverage.

- 2) **Does this resolution prevent the federal government from making changes to Medicare, Tricare, Indian Health Services, etc...?**

This resolution does NOT preclude the federal government from doing anything. Individuals would still have the option to participate in the federal health insurance program. This act simply protects a person's right not to participate.

- 3) **How does this legislation address the problems the HESS committee has looked at? Example: Access, quality, affordability? Are there any fixes in the bill?**
HJR 35 prevents a one-size-fits-all universal coverage system. Alaska legislators must work on a targeted set of policy solutions to cover the uninsured and there are reforms that will advance this goal, along with HJR 35.
- 4) **Does this bind future legislatures from adopting the program the federal government comes up with?**
Yes, if that program includes mandating individuals and employers to purchase insurance or penalizes individuals for choosing not to purchase insurance. Individuals however, would still have the option to participate in the program.
- 5) **Does this amendment prevent the state from implementing a plan if it penalized employees and employers for not purchasing health insurance?**
Yes.
-

Source:

Christie Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
1101 Vermont Avenue, N.W., 11th Floor
Washington, D.C. 20005
Direct: 202-742-8505

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HJR35
 () Publish Date: _____

Identifier (file name): HJR-035-OOG-DOE-2-9-10 Dept. Affected: OOG
 Title: Constitutional amendment prohibiting passage of laws that RDU: Elections
interfere with direct payments for health care services.... Component: Elections
 Sponsor: Reps. Kelly, Keller, P. Wilson, Gatto, Ramras, T. Wilson
 Requester: House Health & Social Services Component Number: 21

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual			1.5					
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	1.5	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1002 Federal Receipts							
1003 GF Match							
1004 GF			1.5				
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	1.5	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The passage of this resolution would require the constitutional amendment to appear on the 2010 general election ballot. The cost of providing information about the constitutional amendment in the Official Election Pamphlet, as required by AS 15.58 is \$1.5. Should the addition of this question require printing an 8-1/2 by 18 inch ballot, the cost will increase to \$22.0.

Prepared by: Gail Fenumiai, Director
 Division: Division of Elections
 Approved by: Linda Perez, Director
Division of Administrative Services

Phone 465-4611
 Date/Time 2/9/10, 8:53am
 Date 2/9/2010

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

ALEC

ISSUE ALERT

To: Alaska ALEC Members
From: ALEC's Health and Human Services Task Force
Re: Alaska House Joint Resolution 35
Date: February 9, 2010

It has come to our attention that Alaska Joint Resolution 35 will be heard by the House Health and Social Services Committee today. HJR 35 would preserve in the Alaska Constitution the right of patients to make their own health care choices, and is modeled after ALEC's own *Freedom of Choice in Health Care Act*. In total, 36 states have either filed, prefiled, or have announced their intentions to file this legislation.

ALEC applauds HJR 35 and urges all Alaska ALEC members to consider the following key points about this legislation:

HJR 35 Ensures Access to Health Services—Without Waiting Lists

Single-payer systems, like in Canada, make it illegal for citizens to go outside of the government's health care plan and contract for their own medical services. HJR 35 would make this fundamental provision of single-payer health care unconstitutional. Citizens should have the right to pay directly for health care services with their own money. When government controls the dollars, they make treatment decisions based on what is best for government, not what is best for the patient.

HJR 35 Stops Health Mandates That Don't Work

It is important for people to have health insurance coverage, but a government requirement to purchase health insurance is ineffective, bureaucratic, and costly. In Massachusetts, a state that has imposed an individual and employer mandate since 2006, more than 1/3 of the uninsured still don't have coverage; health insurance costs 40% more than in the rest of the country; it's harder for the newly-insured to see a doctor; and legislators expect a \$2-4 billion shortfall over the next decade.

An individual mandate would harm patients, and an employer mandate would threaten our fragile economy. HJR 35 would protect Alaska from these threats.

HJR 35 May Help Shield Alaskans from a Federal Individual Mandate

HJR 35 would render any state attempt to require an individual to purchase health insurance—or to forbid an individual from securing medical care outside of the required health care system—unconstitutional. HJR 35 may also cause a federalism clash if Congress passes a law with either of these provisions.

This is a legal battle that has been fought before and won before. ALEC recognizes that the Supremacy Clause renders federal law as the law of the land. However, states may provide stronger protection of individual freedoms than the U.S. Constitution allows, and the federal government has limited recourse in violating those protections. In the case of federal-state conflict, courts must balance the competing interests—and recent Supreme Court cases have upheld the power of states to protect individual freedoms.

Thank you for your attention in this matter. Should you have any questions on HJR 35, please contact the director of ALEC's HHS Task Force, Christie Herrera, at 202-742-8505 or christie@alec.org.

GOLDWATER I N S T I T U T E

The Health Care Freedom Act: Questions & Answers

by Clint Bolick, Litigation Director, Goldwater Institute

The Health Care Freedom Act will appear as a proposed constitutional amendment on Arizona's 2010 election ballot, and similar measures are under consideration in more than 30 other states. With the possibility that Congress will enact some sort of national health insurance legislation, questions are being raised about the scope of the Health Care Freedom Act and its effect should a federal bill become law. In the following pages, Clint Bolick, who helped to author the Health Care Freedom Act, answers frequently asked questions.

Q: What is the Health Care Freedom Act?

A: The Health Care Freedom Act is a proposed amendment to the Arizona Constitution that would preserve certain existing rights that individuals have regarding health care. It was initially proposed by two Arizona physicians, Dr. Eric Novack and Dr. Jeffrey Singer, with drafting assistance from the Goldwater Institute. The measure qualified as a voter initiative on the 2008 ballot, and despite a well-financed opposition campaign, it was defeated by less than one-half of 1 percent of the vote. Changes were made to address concerns raised by the opponents, and the Arizona Legislature voted to refer the revised version to the 2010 ballot.

The American Legislative Exchange Council adopted model legislation based on the Arizona measure, and activists and legislators in at least 35 additional states are pursuing constitutional amendments or statutes based on the Arizona model.

Q: What are the key provisions?

A: Although the precise language varies from state to state, the Health Care Freedom Act seeks to protect two essential rights. First, it protects a person's right to participate or not in any health care system, and prohibits the government from imposing fines or penalties on that person's decision. Second, it protects the right of individuals to purchase—and the right of doctors to provide—lawful medical services without government fine or penalty. The Health Care Freedom Act would place these essential rights in the state constitution (or, in some states, it would protect them by statute).

Q: What motivated the Health Care Freedom Act?

A: No one questions the need for serious health care reform. However, the proponents of the Health Care Freedom Act believe that regardless of how such reform is fashioned, either at the state or federal level, the essential rights protected by the Health Care Freedom Act should be preserved. Many advocates of a larger government role in regulating or providing health insurance support a mandate that would compel individuals to join a government-approved health insurance plan, whether or not they can afford it and whether or not the system best fits their needs. In some countries in which government plays a large role in providing health insurance, medical services are rationed and individuals are prevented or discouraged from obtaining otherwise lawful medical services. Supporters of the Health Care Freedom Act have a variety of perspectives on the form that health care reform should take. But they agree that no matter what legislation is passed, it should not take from Americans their precious right to control their own medical affairs.

Q: By what authority can states pass the Health Care Freedom Act?

A: It is well-established that the U.S. Constitution provides a baseline for the protection of individual rights, and that state constitutions may provide additional protections—and all of them do. For instance, some states provide greater protections of freedom of speech or due process rights. Because the Health Care Freedom Act offers greater protection than the federal constitution, states are allowed to enact it.

Q: Does it matter whether the Health Care Freedom Act is passed as a statute or as a constitutional amendment?

A: A state constitution is the organic law of the state, reflecting the most fundamental values shared by the citizens of the state. Moreover, a state constitutional amendment will ensure the state legislature can never infringe upon the protected rights. So a constitutional amendment is preferable, especially to protect against legislative tinkering. However, for purposes of a federalism defense against excessive federal legislation, it should not matter whether the people of the state have acted through their constitution or by statute.

Q: Does the Health Care Freedom Act attempt to “nullify” federal health insurance legislation?

A: Absolutely not. If federal legislation is enacted, individuals would still have the option to participate in federal health insurance programs. This act simply protects a person’s right not to participate.

Q: To the extent that the Health Care Freedom Act conflicts with provisions of federal legislation, isn't the state law automatically preempted by the Supremacy Clause of the U.S. Constitution?

A: No. In any clash between state and federal provisions, at least four federal constitutional provisions are relevant. The Supremacy Clause establishes the Constitution as the supreme law of the land and provides that federal laws prevail over conflicting state laws where Congress has the legitimate authority to enact the legislation and where it does not impermissibly tread upon state sovereignty. The federal government will have to demonstrate that its legislation legitimately is derived from congressional authority to regulate interstate commerce. It will also have to show the legislation does not violate the 10th Amendment, which reserves to the states all government power not expressly delegated to the national government; and the 11th Amendment, which protects states from being used as mere instrumentalities of the national government. This constitutional construct is known as federalism.

Q: Are certain provisions of proposed federal health care legislation vulnerable to constitutional challenge even without the Health Care Freedom Act?

A: Yes, in at least three ways. First, to the extent that the legislation purports to regulate transactions that do not directly affect interstate commerce, such as mandating insurance for individuals, Congress may lack authority to do so under the Commerce Clause. Several relatively recent decisions by the U.S. Supreme Court have invalidated federal legislation on this basis. In *U.S. v. Lopez* (1995), the Court struck down federal laws that restricted guns in school zones; and in *U.S. v. Morrison*, it struck down a federal statute involving violence against women. In both cases, the Court found the subject matter of the federal laws did not "substantially affect" interstate commerce, so Congress had no power to regulate it under the circumstances presented.

Second, to the extent the legislation interferes with the individual's right to choose health insurance providers, doctors, or lawful medical services, it may violate the right to medical self-determination recognized under the U.S. Constitution. As the Court declared in *Griswold v. Connecticut* (1965), "We have recognized that the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause." Several of the early abortion cases involved what Justice William O. Douglas, concurring in *Doe v. Bolton* (1973), described as the "right to seek advice on one's health and the right to place reliance on the physician of one's choice." Whether or not one agrees with those abortion rulings, they establish a strong basis for challenging certain federal and state intrusions.

Third, several recent decisions have invalidated federal laws that "commandeer" state governments to do their bidding. In *New York v. United States* (1992), for instance, the Court struck down federal rules requiring states to take ownership of certain radioactive waste and to expose themselves to liability. Speaking for the Court, Justice Sandra Day O'Connor ruled that

“no matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate.” Tellingly, she added “the Constitution protects us from our own best intentions: It divides power among sovereigns . . . precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.” To the extent that federal health insurance legislation forces states to implement its provisions, it could be subject to robust constitutional challenge.

Q: Could the Health Care Freedom Act provide additional protection against federal health insurance legislation that violates protected rights?

A: Yes. Although the federal government usually prevails in federalism clashes, the current U.S. Supreme Court is the most pro-federalism Court in decades. There are no cases precisely on point, but the Court under Chief Justice John Roberts has sided with the states in at least three major recent federalism clashes. In the case most closely on point, *Gonzales v. Oregon* (2006), the Court upheld the state’s “right-to-die” law, which was enacted by Oregon voters, over the objections of the U.S. Attorney General, who argued that federal law pre-empted the state law. Applying “the structure and limitations of federalism,” the Court observed that states have great latitude in regulating health and safety, including medical standards, which are primarily and historically a matter of local concern. Holding that the attorney general’s reading of the federal statute would mark “a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality,” the Court interpreted the statute to allow Oregon to protect the rights of its citizens.

Horne v. Flores (2009) considered a measure adopted by Arizona voters to require English immersion as the state’s educational policy for students for whom English is a second language. Lower federal courts had imposed an injunction based on a finding that Arizona was failing to comply with federal bilingual education requirements. The Supreme Court held that injunctions affecting “areas of core state responsibility, such as public education,” should be lifted as quickly as circumstances warrant. It observed that “federalism concerns are heightened when . . . a federal court decree has the effect of dictating state or local budget priorities.” The Court remanded the case to lower courts to reconsider the injunction.

In *Northwest Austin Municipal Utility District No. 1 v. Holder* (2009), the Court examined a challenge to section 5 of the Voting Rights Act, which places certain states and localities in a penalty box, requiring them to obtain “pre-clearance” by the U.S. Department of Justice for any changes that impact voting. The Court was sharply critical of the “federalism costs” imposed upon the covered jurisdictions. It avoided the constitutional question by applying the federal law in a way that allowed the utility district to “bail out” from pre-clearance requirements under section 5.

In each of these cases, the Court sided with states in federalism disputes with the federal government.

Q: Will the Health Care Freedom Act affect future state legislation regarding health insurance?

A: Yes. If it is passed as a constitutional amendment, it would prevent any future legislation that infringes upon the rights protected by the amendment.

Q: Won't this be really expensive for the states to defend in court?

A: The Goldwater Institute has offered to defend the constitutionality of the Health Care Freedom Act at no cost to any state. Because legal challenges would involve purely constitutional issues and would not require expensive trials, to the extent that states become involved in litigation, they should be able to do so within existing Attorney General litigation budgets. Moreover, depending on the details of national health insurance legislation, the cost of federal mandates is likely to far exceed the cost of litigation.

Q: Even if the states and individuals did not prevail in a challenge to intrusive federal health insurance legislation, would there be reasons to support the Health Care Freedom Act?

A: Yes. First, if these rights are given additional protection under state constitutions, they will create an absolute barrier to future state legislation that violates those rights. Moreover, efforts to enact the Health Care Freedom Act send a powerful message to our nation's capitol that people at the grassroots take these rights very seriously and intend to protect them.

Q: Does the Health Care Freedom Act impair drug laws?

A: Absolutely not. It protects the right to purchase or provide "lawful" medical services. It does not limit the power of any government to determine what constitutes lawful medical services.

Q: Does the Health Care Freedom Act affect the issue of abortion?

A: No. Again, to the extent that states may regulate abortion under applicable constitutional doctrine and state or federal law, this measure would not alter that power in any way. The Health Care Freedom Act does, however, prevent the government from forcing individuals into health care systems against their will, and matters of conscience may influence such individual decisions.

Q: Does the Health Care Freedom Act affect Veterans' Administration programs, workers' compensation, Medicare, Medicaid, or state health-care systems?

A: Generally, no. The Health Care Freedom Act leaves intact any rules and regulations that were in place as of January 1, 2009. The only way such programs could be affected is if they are changed in the future in ways that violate the freedom of choice protected by the Health Care Freedom Act.

Q: Will this restrict the government from limiting the choice of providers or imposing other limits for the people who do opt-in to a government health care system?

A: No and yes, respectively. If a person voluntarily joins a government health care system, the government may set the terms and conditions, including choice of providers. However, the government cannot prevent a person from purchasing, or a health care professional from providing, lawful medical services outside that system.

Q: Is the Health Care Freedom Act supported financially by insurance companies?

A: No. Many insurance companies support an individual mandate (requiring individuals to buy health insurance or face government fines), which the Health Care Freedom Act would prohibit. An individual mandate guarantees a customer base to the insurance industry. It is present in some legislative proposals as a means to subsidize health insurance for others. If insurance companies play a role in the battle over the Health Care Freedom Act, we expect they will oppose it, possibly with significant resources.

Q: Are there other ways in which freedom advocates can use state constitutions to protect their liberties?

A: Absolutely. State constitutions are full of provisions unknown to the U.S. Constitution that are designed to protect individual liberty and limit the power of government, such as the line-item veto, anti-monopoly provisions, prohibitions against corporate subsidies ("gift clauses"), constraints against earmarks ("special law clauses"), and the like. Citizens and legislatures can amend their state constitutions to add additional protections; and taxpayers can enforce their state constitutional rights in state courts. State constitutions were intended to be the first line of defense in protecting the freedoms of the people. As the power of government grows at every level, we need to use whatever tools are available to us to safeguard our rights. For more on how state constitutions can protect liberty, see the recent Goldwater Institute report, "**50 Bright Stars: An Assessment of Each State's Constitutional Commitment to Limited Government.**"

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

ALEC

Questions and Answers: ALEC's *Freedom of Choice in Health Care Act* *For more information, contact Christie Herrera, director of ALEC's Health and Human Services Task Force, at (202) 742-8505 or christie@alec.org.*

Why does my state need the *Freedom of Choice in Health Care Act*?

Efforts in our state capitol, and in Washington, are gaining steam to put complete control over your health care in the hands of government bureaucrats and appointed "experts." Government control means you will have less freedom to make the health care choices that are best for you and your family. The *Freedom of Choice in Health Care Act* will protect your health care freedom from these threats.

What does the *Freedom of Choice in Health Care Act* do?

The *Freedom of Choice in Health Care Act* will preserve and protect your right to make your own health care and health insurance choices. Specifically, it would protect your right to pay directly for medical care, and it would prohibit any individual or employer from being penalized for not purchasing government-defined health insurance.

Why should my state's constitution protect the right of patients to pay directly for medical care?

Single-payer systems, like in Canada, make it illegal for citizens to go outside of the government's health care plan and contract for their own medical services. The *Freedom of Choice in Health Care Act* would make this fundamental provision of Canadian-style, single-payer health care unconstitutional.

Patients should have the right to pay directly for medical services with their own money. When consumers control the dollars, they make the treatment decisions. When the government controls the dollars, they make treatment decisions based on what's best for the government, not what's best for the patient.

The consequences of government making medical decisions are often dire, and sometimes deadly. In New Zealand, breast cancer patients were blocked from accessing the lifesaving drug Herceptin because it cost too much. In Sweden the wait for heart surgery can be as long as 25 weeks. In Canada more than 800,000 patients are currently on waiting lists for medical procedures.

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The *Freedom of Choice in Health Care Act* will ensure that patients, not government bureaucrats, decide which doctor to see or what medical treatments to get.

More information about the consequences of single-payer health care can be found in:

* Michael Tanner, "The Grass Is Not Always Greener: A Look at National Health Systems Around the World," Cato Institute Policy Analysis No. 613, March 18, 2008: <http://www.cato.org/pubs/pas/pa-613.pdf>.

* John C. Goodman, Linda Gorman, Devon Herrick, and Robert M. Sade, *Health Care Reform: Do Other Countries Have the Answers?*, National Center for Policy Analysis, March 10, 2009: http://www.ncpa.org/pdfs/sp_Do_Other_Countries_Have_the_Answers.pdf.

* <http://BigGovHealth.org>: A website with "single-payer horror stories" and fact sheets on the U.S. and worldwide infant mortality/life expectancy statistics; whether the U.S. Veterans Administration is a model for health reform; and much more.

Why should my state's constitution block penalties for individuals or employers who don't purchase health insurance?

It is important for people to have health insurance coverage, but a government requirement to purchase health insurance is ineffective, bureaucratic, and costly. The *Freedom of Choice in Health Care Act* would strike at heart of individual and employer mandates—implemented in Massachusetts, Hawaii, and elsewhere—that just don't work.

In Massachusetts—a state that imposed an individual mandate and an employer mandate in 2006—more than 1/3 of their uninsured still don't have coverage; health insurance is 40% more expensive than in the rest of the country; it's getting harder to see a doctor since before "reform" was enacted; and legislators expect a \$2-\$4 billion shortfall over the next decade.

The Massachusetts mandate didn't just affect the uninsured. The Massachusetts government actually told 20% of its already-insured citizens to buy more health insurance, because their existing coverage wasn't "good enough." When the government enforces a requirement for people to buy health insurance, they need to define what "insurance" is. The Cato Institute estimates that a federal individual mandate will force 100 million Americans to drop their existing plans and buy more expensive health insurance that is "good enough" for bureaucrats.

Employer mandates don't yield universal coverage and are harmful for consumers and workers. Hawaii has had a "pay or play" employer mandate for 35 years, and yet the number of uninsured has remained the same because employers shifted jobs to (exempt) part-time employees. And when the government forces businesses to buy health insurance for their



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workers, it really means higher taxes and fewer jobs. When businesses face cost increases, they'll pass on those costs in the form of increased prices, job cuts, or wage freezes.

An individual mandate would harm patients, and an employer mandate would threaten our fragile economy. The *Freedom of Choice in Health Care Act* would protect our citizens from these threats.

More information about the consequences of individual and employer mandates can be found in:

* Michael Tanner, "Massachusetts Miracle or Massachusetts Miserable: What the Failure of the 'Massachusetts Model' Tells Us About Health Reform," Cato Institute Briefing Paper No. 112, June 9, 2009: <http://www.cato.org/pubs/bp/bp112.pdf>.

* Michael F. Cannon, "All the President's Mandates: Compulsory Health Insurance Is A Government Takeover," Cato Institute Briefing Paper No. 114, September 23, 2009: <http://www.cato.org/pubs/bp/bp114.pdf>.

* James Sherk and Robert A. Book, "Employer Health Care Mandates: Taxing Low-Income Workers to Pay for Health Care," Heritage Foundation WebMemo No. 2552, July 21, 2009: http://www.heritage.org/Research/HealthCare/upload/wm_2552.pdf.

Does supporting the *Freedom of Choice in Health Care Act* mean that I favor "free riders" who choose to not purchase health insurance and then show up in the emergency room?

Free riders do present a cost-shifting problem as uncompensated care costs are borne by the already-insured—although researchers estimate uncompensated care to be just 2-3% of overall health costs. The Massachusetts data reveal that at best, an individual mandate didn't affect ER visits at all—and at worst, an individual mandate actually increased ER usage by 17%.

The Massachusetts example shows that an individual mandate alone will not decrease ER usage. One Massachusetts survey reported that although the newly-insured had "insurance coverage" on paper, 90% of them did not have access to care from a non-ER provider. Other reports indicate that average wait times to get appointments with doctors in Boston ranged from 21 days for cardiologists to 70 days for obstetrician-gynecologists. And the Massachusetts Medical Society reports that the average wait to see a primary care doctor is 36 days.

Lawmakers cannot artificially create a growing demand for care without other policies (encouraging "minute clinics," enacting medical liability reform to encourage more doctors to practice, loosening scope of practice laws, etc.) to encourage healthcare supply. And those reforms can be achieved without a bureaucratic, ineffective, and costly requirement to



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purchase health coverage.

More information about the why an individual mandate won't solve the "free rider" problem can be found in:

* Minna Jung, "What Massachusetts Teaches Us About Emergency Departments and Reform," Robert Wood Johnson Foundation's User's Guide to the Health Reform Galaxy Blog, October 5, 2009: <http://rwjfblogs.typepad.com/healthreform/2009/10/what-massachusetts-teaches-us-about-emergency-departments-and-reform.html>.

* Liz Kowalczyk, "ER Visits, Costs in Massachusetts Climb," *Boston Globe*, April 24, 2009: http://www.boston.com/news/local/massachusetts/articles/2009/04/24/er_visits_costs_in_mass_climb/.

Does the *Freedom of Choice in Health Care Act* only benefit insurance companies?

The *Freedom of Choice in Health Care Act* prohibits the forced purchase of private health insurance plans. This benefits patients, not insurance companies.

How will the *Freedom of Choice in Health Care Act* affect Medicaid, SCHIP, or Medicare?

The *Freedom of Choice in Health Care Act* will not in any way impact the funding of, or functioning of Medicaid, SCHIP, or Medicare. The language "This section does not affect laws or rules in effect as of January 1, 2009" clarifies this matter. Citizens will be free to participate in any safety net program (Medicaid, Medicare, SCHIP) to which they are entitled, as well as participate in any proposed programs (the public option or the national health insurance exchange) as they do today. The *Freedom of Choice in Health Care Act* simply ensures that citizens are not forced into these programs.

Does the *Freedom of Choice in Health Care Act* enable my state to block any kind of federal health reform?

No. The *Freedom of Choice in Health Care Act* would not attempt to block implementation of any federal law as long as the federal law does not require an individual/employer mandate, or forbid patients from paying directly for medical services.

Congress is still debating health reform. Doesn't this solve a problem that doesn't yet exist?

Two hundred and twenty years ago, some founders questioned the need for the Bill of Rights to be included in the U.S. Constitution. Eventually, they realized that the Bill of Rights was essential in protecting the people from a powerful central government. Today, the First through Tenth Amendments preserve our freedoms—and the *Freedom of Choice in Health Care Act* will protect our right to health care freedom in the same way.



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But this is more than an issue of federal encroachment. Threats of single-payer health care, or of an individual/employer mandate, also exist at the state level. In 2009, 14 states introduced legislation to enact state-based, single-payer health care. Countless other states have proposed requirements for individuals or employers to purchase health coverage or else pay a fine to the state. The *Freedom of Choice in Health Care Act* would make these state-based assaults on patients' rights unconstitutional.

Does supporting the *Freedom of Choice in Health Care Act* mean that I am against health reform? Doesn't this tie our hands with future reforms?

No. The *Freedom of Choice in Health Care Act* simply states that the cornerstone of any future health care reform must be the preservation and protection of patients' rights.

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Governor Sean Parnell
STATE OF ALASKA

January 13, 2010

The Honorable Lisa Murkowski
United States Senate
709 Hart Senate Office Building
Washington, DC 20510

The Honorable Mark Begich
United States Senate
144 Russell Senate Office Building
Washington, DC 20510

The Honorable Don Young
United States Congress
2111 Rayburn House Office Building
Washington, DC 20515

Dear Senators Murkowski and Begich and Congressman Young,

As Congress contemplates final passage of the proposed health care reform legislation, I ask that you consider the concerns raised by my administration on behalf of Alaska's residents. As I have previously communicated to you, both publicly, and through my staff, the current federal proposal does little to address the main health care issues facing Alaskans – cost and access.

The current health care reform legislation before Congress is troubling on several levels. For the many Alaskans currently unable to afford insurance, the proposal, as outlined by Congress, will do nothing but mandate they purchase it, while increasing the insurance premiums. I am particularly concerned with the increase in costs by the pending legislation for Alaska's seniors, families, small businesses, and physicians. Beyond this burden, which is placed squarely on the shoulders of Alaskans, the legislation will put a significant strain on the State of Alaska's General Fund budget.

In addition to the enormous cost Alaskans would face, the proposal does little to address Alaska's health care workforce shortage; requiring individuals to purchase health insurance does not guarantee that people will have access to health care.

Beyond the practical concerns about the benefits of this legislation that I have raised, I am concerned about the constitutionality of forcing Americans to purchase health insurance. As you know, I have directed Alaska's Attorney General to conduct a review of the reform legislation, including this requirement.

So that you are fully aware of the State of Alaska's concerns, I am including two supplementary documents provided to you over the course of the health care reform debate. The first document updates a previously submitted policy review of the healthcare legislation passed by the Senate. The second document provides Alaska's perspective on the so-called "Nebraska Compromise" whereby the cost of

The Honorable Lisa Murkowski
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Medicaid expansion in Nebraska will be indefinitely supported by the federal government. As you will note, this expansion will cost Alaskans \$700 million over the first 20-year window of implementation while Nebraskans will not be responsible for paying anything.

Finally, I ask that you consider securing a 100-percent federal Medical Assistance Percentage for services rendered to Native Americans and Alaska Natives outside of Tribal facilities. Such a provision would be advantageous to Alaska and other states with large Native populations. Supporting documents outlining this request have previously been submitted to you.

Thank you for your serious consideration of my concerns regarding the proposed legislation. I look forward to continue to work with you to ensure that Alaskans are treated fairly, and that the health care needs of the citizens of this great state are adequately met.

Sincerely,



Sean Parnell
Governor

Enclosures

January 13, 2010

The Honorable Harry M. Reid
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable John Boehner
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Senator Reid, Senator McConnell, Speaker Pelosi, and Representative Boehner:

As governors, we believe the reform of the health care system can be very beneficial to our nation's economic future and the well-being of our citizens; however, the current health care bills are a lost opportunity to improve the lives of Americans, create a sustainable system of health care and help stabilize both our state and national economies.

Health care reform should be about fixing our broken Medicaid and Medicare systems; instead, the current health care bills entitle 15-20 million more people to Medicaid. While providing health care to low income individuals is important, the net result of this entitlement expansion will be a significant cost shift to those privately insured around the country. According to the Congressional Budget Office (CBO), the unfunded mandate to states and territories is \$25 billion; although many states disagree with that figure. For example, Texas costs are estimated to be \$21 billion over ten years.

The National Association of State Budget Directors (NASBO) has demonstrated states/territories are in no position to comply with the maintenance of effort provisions found in the bills or to accept any increased costs or additional administrative burdens to expand Medicaid. State general fund expenditures have dropped for the second year in a row. The December 2009 survey shows that the budget situation faced by states truly is unprecedented. Many states cannot afford their current share of the Medicaid program, and they will also have to face a funding cliff whenever the stimulus-enhanced FMAP dollars are exhausted. States have already been forced to cut vital services with 30 states cutting education, 29 states cutting Corrections, and 28 states already cutting Medicaid.

Current federal proposals would strip the states of our ability to negotiate Medicaid provider rates, and we believe that states and territories should be allowed to negotiate Medicaid provider rates as found in current law. The pending bills cause states and territories to lose money through the bills' treatment of the prescription drug rebate provisions. States and territories also should not be asked to forego a share of the savings from any new Medicaid rebates collected for the dual eligible population receiving prescription drugs through the Medicare Part D program.

These bills also impose a one-size-fits all federally-designed health insurance exchange and the insurance rating rules tie states' and territories' hands. Health insurance exchanges desired by any state should be state-based and state-designed to ensure maximum state flexibility to design and operate exchange mechanisms that facilitate the purchase of insurance. Utah should not be forced to replicate Massachusetts' exchange, and vice versa. In the same vein, the health insurance rating rules should account for the existing variation in state and territory statutes and the state and territory should retain the authority to provide oversight and adopt tighter rating bands if necessary.

In order to pay for the bills, the legislation cuts Medicare \$571 billion in the House bill and \$466.7 billion in the Senate bill. Also included are far-reaching massive tax increases which will impact American individuals and families at all income levels. From employer mandates and taxes on high-value insurance plans to taxes on both branded and generic drugs and medical devices, these bills are funded, and thereby the bills' costs are lowered, by taking more from taxpayers and reforming the health care system less. In particular, the Senate's \$6.7 billion insurance premium tax will be passed directly to consumers and will impose new costs on Americans who already have coverage. The unfunded mandates to states likely will require many states to necessarily raise taxes, too.

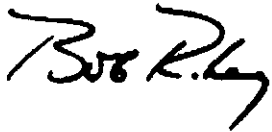
Although CBO has scored the Senate bill at \$842 billion and the House bill at \$1.3 trillion both bills are full of budget gimmicks. The bills delay spending until the fourth year and exclude the costly "Doc Fix" which ignores the over \$200 billion price tag associated with stopping the unavoidable cuts to physicians under the Medicare program.

Governors agree we should work to enhance the quality of health care while making it more affordable and efficient. Unfortunately, the opportunity to truly lower the cost of care has been lost in the rush to try to finish health reform. Both CBO and the Chief Actuary of the Centers for Medicare and Medicaid Services have warned the current legislation will increase the overall costs of health care. The federal government and the states should refocus efforts to lowering the cost of care which will in turn increase coverage, but simply increasing the number of individuals on the public plans without a plan to improve the public programs for participants is irresponsible.

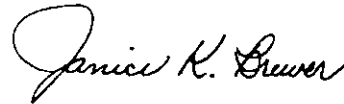
At this juncture, small businesses, seniors, states and territories, and taxpayers have anxiety about Congress' pending health care legislation and rightfully so-- one-sixth of our GDP is at stake. As Republican Governors, we believe in a system which eliminates red tape, empowers consumers to engage in making good health care decisions in the private market, and guarantees affordable coverage for patients with preexisting conditions. Missing from this important legislation is real medical liability reform and provisions which protect seniors' Medicare benefits and access to care. Several states have already implemented medical liability reform with good results; no real medical reform can be accomplished without tort reform. Instead, premiums are increased and small businesses are faced with onerous mandates rather than given the power to pool together and offer health care at lower prices, just as corporations and labor unions do.

Along with the majority of Americans and as leaders of 20 states and territories, we are disappointed with the lack of transparency. We urge you not to circumvent the normal committee process and to conduct an open, fully-bipartisan negotiation. It is time to slow down and pass meaningful health care reform, not hastily prepared partisan legislation which omits reform and saddles American taxpayers for generations to come.

Sincerely,



Governor Bob Riley, Alabama



Governor Jan Brewer, Arizona



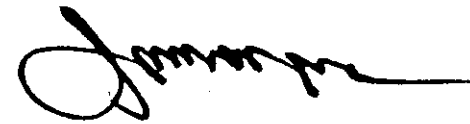
Governor Sean Parnell, Alaska



Governor Charlie Crist, Florida



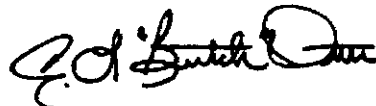
Governor Sonny Perdue, Georgia




Governor Felix Camacho, Guam



Governor Linda Lingle, Hawaii



Governor C.L. "Butch" Otter, Idaho



Governor Mitch Daniels, Indiana



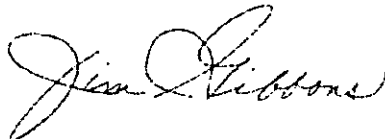
Governor Bobby Jindal, Louisiana



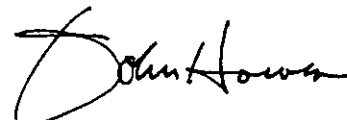
Governor Tim Pawlenty, Minnesota



Governor Haley Barbour, Mississippi



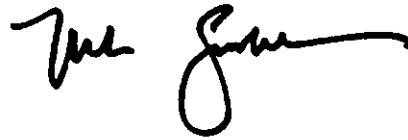
Governor Jim Gibbons, Nevada



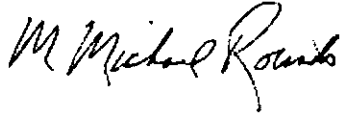
Governor John Hoeven, North Dakota



Governor Don Carcieri, Rhode Island



Governor Mark Sanford, South Carolina



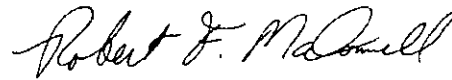
Governor Mike Rounds, South Dakota



Governor Rick Perry, Texas



Governor Gary Herbert, Utah



Governor-elect Bob McDonnell, Virginia



The Voice of Small Business®

ALASKA

January 19, 2010

The Honorable Mike Kelly
Room 513
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Kelly

RE: HJR 35

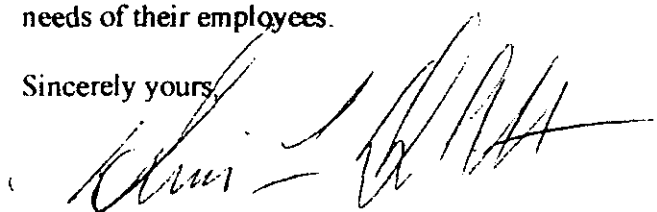
On behalf of the National Federation of Independent Business/Alaska, I wish to express our support for House Joint Resolution 35. The National Federation of Independent Business/Alaska is the largest small-business advocacy group in our state.

HJR 35 provides for placing an amendment to Alaska's Constitution before voters during the next general election making explicit the individual right to health care free choice. The constitutional amendment would prohibit passage of laws that compel any person or employer to participate in a particular health care system. The proposed constitutional change will also permit the purchase of private insurance and allow Alaskans to pay their own health care provider directly.

NFIB/AK is critically concerned about the cost and access to health care for Alaskans. The current versions of health care reform that have passed the U.S. House and U.S. will not address those issues. The mandates they include clearly impose unreasonable burdens on Alaskans and Alaskan businesses. These mandates cannot address the needs of Alaskans.

This proposal will protect Alaskans from the unconstitutional federal mandates to purchase health insurance that may not meet their needs. It will protect small businesses from being taxed for not providing health insurance designed by the federal government that may not meet the needs of their employees.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

April 14, 2010

To: Members of the Alaska House of Representatives

RE: HJR 35 (Kelly, Keller, Gatto, P. Wilson)—Oppose

On behalf of the members of AARP in Alaska, we encourage you to oppose HJR 35, authored by Representatives Mike Kelly, Wes Keller, Carl Gatto and Peggy Wilson, and co-sponsored by Representatives Tammie Wilson, Bob Lynn, Jay Rainras and Bill Stoltze.

In an attempt to stall or halt health care reform efforts at the national and/or state levels, legislators in several states have introduced legislation or resolutions to limit, alter, or oppose certain state or federal actions, including mandates that would require people to purchase insurance. HJR 35 is one of these.

HJR 35 would keep the purchase of health insurance optional and prohibit the "interference" in an individual's medical services choices.

Let's be honest about what HJR 35 actually is.

This is not just a simple resolution of protest to what Congress passed nor is it a simple political gesture.

HJR 35 seeks to change the Alaska Constitution.

Once we change it, we must live with the unintended consequences for a long time. Amending our state constitution is an inappropriate vehicle to show concern over national health care reform.

If passed, HJR 35 could tie the hands of current legislators as well as future ones. While the resolution's intent is to address a very specific issue of a non-existent federal health care law, if passed it could lead to a constitutional amendment that would be permanent for Alaska. It could block the ability of current and future lawmakers to fully tackle Alaska's health care issues and prevent them from accessing a full array of options.

Can the supporters of HJR 35 tell us what the impact will be?

The language is so vague and will be open to so many interpretations that it can only result in costly litigation for the state.

This movement across the nation in Alaska and other states is designed to create litigation and to challenge the US Constitution's supremacy clause. Supporters openly share this strategy on their various websites.

Our health care should not end up in litigation—that's nobody's idea of freedom of choice.

Congress has passed health care reform and, if we amend our Constitution as HJR 35 intends, it is entirely possible that existing programs could also be jeopardized including Medicaid matching funds and Denali KidCare.

This resolution could also impact the private sector too. It could result in insurance companies raising premiums, deductibles and co-pays—driving up already skyrocketing health care costs for individuals and businesses. Physicians and other providers, including our network of community health centers, hospitals and nursing homes, could lose future Medicaid reimbursement and would find themselves serving even more uninsured patients.

HJR 35 is a risky gamble. It is more than a political gesture to Washington, DC. HJR 35 raises too many unanswered questions and unintended consequences. Why bet Alaska's health care on an unproven idea?

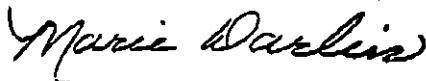
AARP is worked with Congress to ensure that, with the passage of health care reform, the implementation improves the state's ability to deliver health care for its citizens. Health care for our citizens is too important to become a turf war between the state and federal government.

AARP requests an "NAY" vote on HJR 35.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

HR

14

Alaska State Legislature

State Capitol, Room 208
Juneau, Alaska 99801-1182
Phone: 907-465-3779
Fax: 907-465-2833
Toll Free: 800-469-3779



145 Main St. Loop
Second Floor
Kenai, Alaska 99611
Phone: 907-283-7223
Fax: 907-283-7184

REPRESENTATIVE MIKE CHENAULT SPEAKER OF THE HOUSE

SPONSOR STATEMENT

HOUSE RESOLUTION 14: *Urging the United States Congress to oppose federal health care reform bills.*

House Resolution 14 requests the Alaska Congressional delegation to vote against current health care reform bills and to develop health care reform that is affordable and accessible to all legal residents. It also requests the Governor to review the constitutionality of the Nebraska Compromise that guaranteed Nebraskans would receive a break to pay for expanded access to Medicaid benefits. This exemption was granted in order to obtain Senator Ben Nelson's vote in order to get the 60 votes needed to send the health care reform legislation to the Senate floor. Vermont, Florida and Louisiana also received special deals in order to get Senators' votes to reach the 60 vote threshold.

As noted in the letter from the Republican Governors Association (RGA), "health care reform should be about fixing our broken Medicaid and Medicare systems; instead, the current health care bills entitle 15-20 million more people to Medicaid....the unfunded mandate to states and territories is \$25 billion."

Also noted by the RGA was the fact that the health care reform bills "impose a one-size fits all federally-designed health insurance exchange." Alaska, as well as the other states, needs the flexibility to design and operate mechanisms to purchase insurance. Alaska and the rest of the states will face increased health care entitlement costs every year if this legislation passes.

The proposed health care reform legislation is also opposed by small businesses around the state and country. NFIB/Alaska states "it fails to address fundamental small business priorities. It does not make health insurance more accessible or affordable to small businesses....this legislation actually increases the overall costs of doing business for small businesses."

A RESOLUTION

1 Urging the Attorney General of Georgia to begin preparations to challenge the
2 constitutionality of H.R. 3590, the federal "Patient Protection and Affordable Care Act"; and
3 for other purposes.

4 WHEREAS, recently, the United States Senate passed H.R. 3590, the "Patient Protection and
5 Affordable Care Act"; and

6 WHEREAS, H.R. 3590 expands citizens' eligibility to receive Medicaid services if they earn
7 less than 133 percent of the federal poverty level; and

8 WHEREAS, in Georgia alone, this expansion of Medicaid is estimated by the Georgia Senate
9 Budget Office to add \$1 billion to state health care entitlement costs every year; and

10 WHEREAS, the impact of H.R. 3590 on Georgians is enormously costly and could be a risk
11 to maintaining many essential state programs; and

12 WHEREAS, in order to obtain the 60 votes required to send the legislation to the Senate
13 floor for a vote and final passage, the United States Senate leadership included an
14 unprecedented special exemption called the Nebraska Compromise to obtain Senator Ben
15 Nelson of Nebraska's key 60th vote to pass the bill; and

16 WHEREAS, the Nebraska Compromise guaranteed Nebraskans that they would never have
17 to pay for their citizens' expanded access to Medicaid benefits included in H.R. 3590; and

18 WHEREAS, the Nebraska Compromise violates the principle that federal legislation must
19 have a legitimate national interest and cannot benefit any one state over another; and

23 WHEREAS, H.R. 3590 also creates a federal mandate requiring all Americans to participate
24 in one national health insurance program; and

25 WHEREAS, this unprecedented Congressional mandate threatens our individual liberty and
26 many legal experts believe that this federal mandate is unconstitutional; and

27 WHEREAS, the members of this body realize that Georgia does not yet have standing to sue
28 until President Obama signs H.R. 3590 into law; however, in light of the questionable
29 validity of this legislation and its potential negative effects on the budget of the State of
30 Georgia, it would be prudent to begin preparations now for a potential legal action
31 challenging this legislation should it become law by completing the necessary legal research
32 and preparing to join with what is reported to be at this time over a dozen other states to
33 challenge the constitutionality of this bill.

34 NOW, THEREFORE, BE IT RESOLVED BY THE SENATE that the members of this body
35 respectfully request the Attorney General of the State of Georgia to initiate a formal
36 investigation into the constitutionality of the special exemption set forth in the United States
37 Senate's version of this national health care legislation and explore the availability of all other
38 legal challenges that Georgia could pursue to oppose this unconstitutional provision as well
39 as research the federal mandated health care provisions in H.R. 3590.

40 BE IT FURTHER RESOLVED that the members of this body ask the Attorney General of
41 Georgia to join with the other state attorneys general who have publicly stated they intend
42 to investigate and collectively and individually sue to challenge the legality of any national
43 health care legislation that contains either the Nebraska Compromise or the federal
44 single-payer mandate.

45 BE IT FURTHER RESOLVED that the members of this body request that the Attorney
46 General of Georgia report to this body regarding how the Attorney General intends to address
47 this constitutionally flawed legislation which will financially harm every Georgian and
48 advise the members of this body when and if the Attorney General intends to sue the federal
49 government on behalf of the people of this state.

HOUSE COMMITTEE REPORT

(7)
 Date Referred to Committee: March 10, 2010 FURTHER REFERRALS: Finance

Date of Committee Action: March 30, 2010

The HEALTH AND SOCIAL SERVICES Committee considered: HOUSE BILL NO. 361

"An Act requiring 911 dispatchers to be trained in cardiopulmonary resuscitation; and providing for an effective date."

HB 361-CPR TRAINING FOR 911 DISPATCHERS

Recommends it be replaced with HCS or CS for _____ (_____)
 For Senate Bills with new title: Technical Title New Title: HCR _____ Same Title New Title

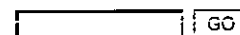
- attach amendments
- add new referral to _____ Committee
- Letter of Intent _____ Committee

List of Abbrev for Depts.:
 ADM
 CED
 COR
 CRT
 EED
 DEC
 DFG
 GOV
 DHS
 LWF
 LAW
 LEG
 MVA
 DNR
 DPS
 REV
 DOT
 UA

<u>NEW FISCAL NOTES</u>				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

<u>PREVIOUS FISCAL NOTES</u>				
List by Dept(s):	FN#	Fiscal	Indet.	Zero
DPS		✓		

<u>Signing with recommendations</u>	Printed Last Name	DP	DNP	NR	AM
	Holmes			X	
	T. Wilson	X			
	SEATON	X			
	CASSIA	✓			
	LYNN	X			
Chair:	Keller			X	
Chair:	HERRON	X			



Issues & Research » Health » State Legislation Opposing Certain Health Reforms,

Go 18906

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State Legislation Opposing Certain Health Reforms, 2009-2010

Updated: March 11, 2010 - subject to additions

by: Richard Cauchi, Program Director, NCSL Health Program

States have an extensive and complicated shared power relationship with the federal government in regulating various aspects of the health insurance market and in enacting health reforms.

As part of state-based responses to federal health reform legislation, individual members of at least **36 state legislatures** are using the legislative process to seek to limit, alter or oppose selected state or federal actions, including single-payer provisions and mandates that would require purchase of insurance. In general the measures seek to make or keep health insurance optional, and allow people to purchase any type of coverage they may choose. The individual state language varies.

Constitutional amendments: In 26 of the states, the proposals include a proposed constitutional amendment by ballot question. In a majority of these states, their constitution includes an additional "hurdle" for passage - requiring either a "supermajority of 60% or 67% for passage, or requiring two affirmative votes in two separate years, such as 2010 and 2011.

Changing state law: In 13 states proposed bills would amend state law, not the state constitution. These require a simple majority vote and action by the governor; they also can be re-amended or repealed by a future state law. So far in 2010,

Virginia became the first in the nation to enact a new statute section titled, " Health insurance coverage not required." It became law on March 4, 2010; see [SB 283 and related bills](#) below. NEW

A bill in **Utah** has passed both chambers and was enrolled on March 9; another bill in **Idaho** also passed both chambers and was enrolled on March 9. NEW

Unfunded mandates: New Hampshire has a bill that would prohibit any Medicaid expansion unless paid for by the federal government or approved by the NH Legislature.

Based on actions initially in Arizona, several states propose or may propose state constitutional amendments, using language such as:

"To preserve the freedom of all residents of the state to provide for their own health care... A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system ... A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services..."

[see full text in [Appendix 1](#)]

Arizona voters are scheduled to cast ballots on this constitutional amendment in November 2010. If adopted by voters, it could block future state health reforms and at least raise questions about some features within future federal health reforms.

According to *The New York Times*, "Conservatives and libertarians, mostly, have been advancing the theory lately that the individual mandate, in which the government would compel everyone to buy insurance or pay a penalty, is unconstitutional." (*NY Times*, 9/26/09) A current Massachusetts law, passed in 2006, includes an individual mandate, although it was written to be consistent with both state and federal constitutions. To the extent that congressional proposals provide for state opt-out or opt-in features, these proposals to restrict "reform" could well become more widely discussed.

Arizona Resolution passed, 2009



Related NCSL Resources:

[Federal Health Reform](#)

[State Health Reform](#)

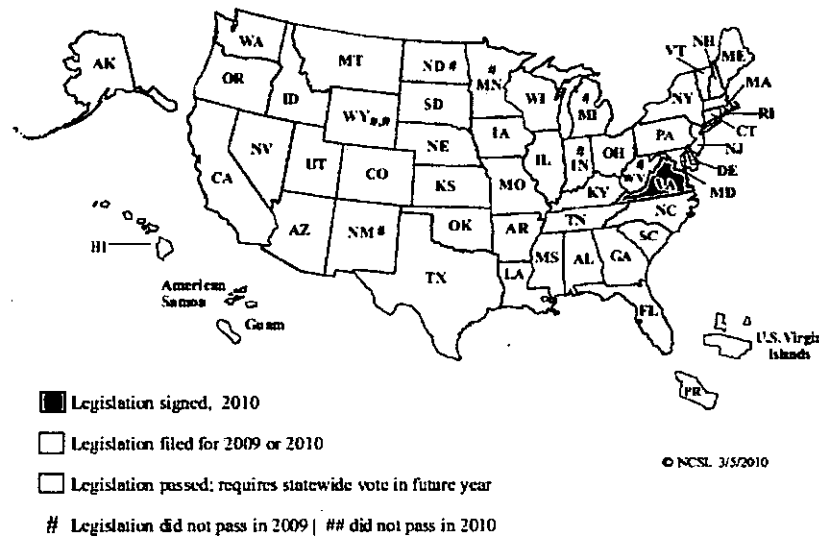
[Podcast audio](#) (11/20/09)

Health Reform: States Opting Out

(12/09) [Archive Recording](#) | [Slides](#)

[Recent News](#) NEW

36 States with 2009-2010 Legislation Opposing Certain Health Reforms (map updated 3/5/10)



As of early March, formal resolutions or bills had been filed in **Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin** and **Wyoming**. Up to three additional states were reported in media or association articles to have discussed future action or intentions; examples are [listed below](#).

Laws: On March 4, 2010 a **Virginia** law passed both Senate and House, was amended by the Governor and became law, becoming the first such statute in the nation.*

Passed bills: None of the other proposals listed have been finally approved; **Arizona's** resolution of June 2009 was the first measure to have passed the legislative process; **Idaho** and **Utah** bills have passed their initial chamber. Constitutional resolutions have advanced through initial steps in **Florida** and **Georgia**.

States with discussions but no known legislation are listed separately; information in the examples list below is based on media statements by individual legislators or legislative associations.^[1]

The issue has garnered state-level interest in part due to the American Legislative Exchange Council's (ALEC) [model "Freedom of Choice in Health Care Act,"](#) which was described as "How Your State Can Block Single-Payer and Protect Patients' Rights." The ALEC-endorsed language mirrors Arizona Proposition 101, which was narrowly defeated in 2008.

Several legal experts have expressed opinions on the validity of this approach. [See [Appendix 2](#) for comment and quotes.]

**Table 1:
Filed Bills and Resolutions for 2009-2010**

Table 1 indicates 1) Activity and status for measures filed;
2) the percentage of affirmative votes in the legislature required for approval;
3) the earliest date that a proposed constitutional amendment can appear on the statewide ballot. Timing and parliamentary steps vary among states.

The Constitutional process:

In 35 states, the legislature can enact a proposed constitutional amendment during a single session. [Appendix 3] This would allow passed measures to appear on the state ballot in 2010 or later. In 12 states the legislature must enact a proposed constitutional amendment during two sessions, which would make 2012 the earliest date for voter decisions.

STATE	ACTIVITY/LEGISLATION	REQUIRED FOR PASSAGE
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<p>Alabama</p>	<p><u>HB 42</u> by Rep. Bentley; <u>HB 47</u> by Rep. Gipson Would propose a constitutional amendment to prohibit any person, employer, or health care provider from being compelled to participate in any health care system. <i>(Prefiled 11/5/09 for 2010 session; sent to Health Committee 1/12/10)</i></p>	<p>60% both legislative chambers + 2010 ballot vote</p>
<p>Alaska <small>NEW</small></p>	<p><u>HJR 35</u> by Rep. Kelly filed for 2010 session Would propose a state constitutional amendment prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system. <i>(Filed & sent to Health & Human Services Comm. 1/19/10)</i></p>	<p>2/3rds both legislative chambers + 2010 ballot vote</p>
<p>Arizona (2009) Arizona (2010) <small>NEW</small></p>	<p><u>Resolution HCR 2014</u> of 2009 by Rep. Barto Refers to the November 2010 ballot a proposed amendment to the State Constitution "which provides that no law or rule shall compel any person or employer to participate in any health care system, a person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for doing so, a health care provider may provide directly purchased lawful health care services; prohibits the terms or conditions of a health care system from imposing certain mandates or limitations." <i>[full text in Appendix 1 below]</i> <i>(Filed 1/16/09; passed House 6/11/09; passed Senate 6/22/09) Also see 2008 ballot question history, below.</i></p>	<p>50% both legislative chambers <i>(Passed)</i> 2010 ballot vote</p>
	<p><u>HB 2443</u> by Rep. Burges Would add by state statute the Health Care Freedom of Choice Act requiring Arizona to exercise its option to decline the public health care plan if authorized by the federal government. <i>(Filed and sent to committees 1/26/10)</i></p>	<p>Proposed statute: majority both legislative chambers</p>
<p>Arkansas <small>NEW</small></p>	<p><u>ISP 2009-204</u> by Rep. Glidewell (Interim Study Proposal for 2010 Fiscal Session) Would add a state statute to "ensure freedom of choice in health care" for state residents; "to prevent involuntary enrollments in health care insurance programs" and providing that an "individual or an employer may make direct payment for lawful health care services and shall not be required to pay penalties or fines" for making direct payment for health services. <i>(Filed 12/17/09 for 2010 session)</i></p>	<p>Proposed statute: majority both legislative chambers</p>
<p>California <small>NEW</small></p>	<p><u>SCA 29</u> by Sen. Strickland Would propose a state constitutional amendment prohibiting the effectiveness or enforcement of a state or federal program that (1) requires individuals to obtain health care coverage, (2) requires health care service plans or health insurers to guarantee issue contracts and policies to all applicants, (3) requires employers to either provide health care coverage to their employees or pay a fee or tax to the state or the federal government in lieu thereof, (4) allows an entity created, operated, or subsidized by the government to compete with health care service plans and health insurers in the private sector, or (5) creates a single-payer health care system, unless the program is approved by the electorate by ballot measure. <i>(Filed 2/19/10)</i></p>	<p>2/3rds both legislative chambers + 2010 ballot vote</p>
<p>Colorado <small>NEW</small></p>	<p><u>HJR 10-1009</u> by Rep Acree Resolution stating the intent of the General Assembly, to "Reserve the opportunity and ability of the State of Colorado and its citizens, under the state's and the people's Tenth Amendment rights, to opt out of any obligations due or participation required in any new federal health care legislation. <i>(Filed and sent to committees 2/5/10)</i> A separate citizen initiative application was filed with Secretary of State. See footnote below</p>	<p>50% both legislative chambers</p>
<p>Florida</p>	<p><u>HJR 37</u> (Joint Resolutions filed for 2010) by Rep. Plakon; 39 co-sponsors; <u>SJR 72</u> by Sen Baker.</p>	<p>60% both legislative</p>

	<p>Joint resolutions would propose a State Constitutional amendment to prohibit laws or rules from compelling any person, employer, or health care provider to participate in any health care system; permits person or employer to purchase lawful health care services directly from health care provider, and permits health care providers to accept direct payment from a person or employer for lawful health care services.</p> <p><i>(HJR 37 prefiled 7/27/2009 for 2010 session; SJR 72 prefiled 10/5/09; sent to 3 committees 12/9/09; favorable comm. report 3/4/10)</i></p>	<p>chambers + 2010 ballot vote</p>
<p>Georgia</p>	<p>2010 resolutions: <u>HR 1086</u> by Rep. Calvin Hill; <u>HR 1107</u> by Rep. Mills; <u>SR 794</u> by Sen. Hill; <u>SR 795</u> by Sen. Harp.</p> <p>Would propose an amendment to the Constitution so as to provide that no law or rule or regulation shall compel any person, employer, or health care provider to participate in any health care system and to authorize persons and employers to pay directly for lawful health care services without penalties or fines; would provide for submission of the amendment for ratification or rejection.</p> <p>SR 795 would provide that residents would not be subject to penalties or fine for not having health insurance.</p> <p><i>(Prefiled 11/23/09 for 2010 session; SR 795 favorable report by Senate Judiciary 2/2/10; Senate 2nd Reading 2/3/10)</i> <i>(SR 794 Senate 2nd reading 2/11/10)</i> <u>SR 829</u> and <u>SR 830</u> by Sen. Hill.</p> <p>Resolutions would direct the Attorney General to "initiate a formal investigation into the constitutionality of the special exemption set forth in the United States Senate's version of this national health care legislation and explore the availability of all other legal challenges ." <i>(Filed 1/15/10; Senate Judiciary 2/2/10; Senate 2nd reading 2/11/10)</i></p>	<p>2/3rds both legislative chambers + 2010 ballot vote</p> <p>Resolutions; majority vote</p>
<p>Idaho <small>NEW</small></p>	<p><u>HB 391</u> by State Affairs Comm.</p> <p>Would amend and add to existing law to establish the Idaho Health Freedom Act, stating in part, "that every person within the state of Idaho is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty." <i>(Filed 1/19/10; passed House 52y-8n, 2/9/10; amended; passed Senate 24y-10n & enrolled, 3/9/10)</i></p>	<p>Proposed statute: majority both legislative chambers</p>
<p>Indiana (2009)</p> <p>Indiana <small>NEW</small> (2010)</p>	<p><u>SJR 65</u> by Sen. Waltz; <u>SJR 91</u> by Sen. Waltz; <u>SJR 111</u> by Sen. Waltz (Advisory resolutions for 2009)</p> <p>SJR 91: Resolved, "That the Indiana General Assembly must ensure that all residents of Indiana may enter into private contracts with health care providers for health care services and may purchase private coverage for health care services. That the Indiana General Assembly should not require an individual to participate in a health care system or plan or impose on an individual a penalty or fine of any type for choosing to obtain or decline coverage for health care services or participating in a particular health care system or plan." <i>(SR 65 - filed 4/7/09 - did not pass by end of session; SR 91 - filed 4/27/09 - did not pass by end of session; SR 111 - filed 4/28/09 - did not pass by end of session; Indiana does not carry over bills or resolutions to 2010)</i></p> <p><u>SJR 14</u> by Sen. Krause, <u>HR 6</u>; also non binding resolution <u>SCR 10</u></p> <p>Would propose a state constitutional amendment stating, "A person, an employer, or a health care provider shall not be compelled, directly or indirectly, to participate in any health care system. A person or an employer may pay directly for lawful health care services and shall not be subject to penalties or fines for paying directly for lawful health care services. A health care provider may receive direct payment for health care services from a person or an employer and shall not be subject to penalties or fines for accepting direct payment from a person or an employer." <i>(Filed 1/11/10)</i></p>	<p>Non-binding resolutions</p> <p>50% both legislative chambers + 2012 ballot vote</p>

Iowa <small>NEW</small>	<p><u>HJR 2007</u> by Rep. Upmeyer Would propose a state constitutional amendment prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system. <i>(Filed for 2010 session)</i></p>	50% both legislative chambers + 2012 ballot vote
	<p><u>HF 2214</u> by Rep. Upmeyer Would establish by statute that the people of Iowa have the right to enter into contracts with health care providers for health care services and to purchase private health care coverage. In addition, the general assembly cannot require any person to participate in any health care system or plan, or impose any type of penalty or fine on any person for choosing to obtain or declining to obtain health care coverage or for participating or declining to participate in any particular health care system or plan. <i>(Filed 1/26/10; motion to expedite failed 44y-53n, 2/12/10; pending in committee)</i></p>	Proposed statute: majority both legislative chambers
Kansas <small>NEW</small>	<p><u>SCR 1626</u> by Sen. Pilcher-Cook Would propose a state constitutional amendment providing that "A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system or purchase health insurance." (2) A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services. <i>(Filed & sent to committees 2/2/10, 2/17/10)</i></p>	2/3rds both legislative chambers + 2010 ballot vote
Kentucky <small>NEW</small>	<p><u>HB 307</u> by Rep Moore Would prohibit by statute any other law "from requiring any individual to participate in any health care system or plan, or to impose a penalty or fine regarding participation; permit an individual or an employer to pay directly for health care services and a health care provider to accept direct payment without penalties or fines. Also would prohibit the state executive branch from "participating in or complying with any federal law, regulation, or policy that would compromise the freedom of choice in the health care." <i>(Filed 1/21/10; sent to Banking & Insurance Comm. 1/26/10)</i></p>	Proposed statute: majority both legislative chambers
Louisiana <small>NEW</small>	<p><u>SB ___</u> by Sen. Crowe Would prohibit by statute any other law requiring a "person, employer, health care provider to participate" in a health system or insurance system; also would prohibit compelling participation in any health care system or health insurance plan. Would establish a misdemeanor offense and penalty (\$500 or five day in prison) for any state or local official who "attempts to coerce any individual to purchase health insurance." <i>(Measure drafted; to be filed for 2010 session) SA</i></p>	Proposed statute: majority both legislative chambers
Maryland <small>NEW</small>	<p><u>SB 397</u> by Sen. Pitkin Would propose a state constitutional amendment limiting the regulation of health care in the state; prohibiting a law from compelling residents to participate in any health care system; prohibiting residents from being required to pay penalties or fines for not participating in health insurance; specifying that the purchase or sale of specified health insurance may not be prohibited by law; authorizing residents to pay directly or accept direct payment for specified health care services. <i>(Filed and sent to committee 1/29/10)</i></p>	60% both legislative chambers + 2010 ballot vote
Michigan	<p><u>SJR K</u> of 2009 by Sen. Kuipers; <u>HJR CC</u> by Rep. Calley; <u>HJR Z</u> of 2009 by Rep. Amash Would propose a state constitutional amendment "to affirm the right to independent health care." Includes a statement that "a person or employer shall not be required to pay penalties or fines for paying directly for lawful health care services." <i>(Filed 8/1/9/09, 8/29/09 and 9/9/09; pending in Committee on Health Policy; no floor vote in 2009; carried over to 2010)</i></p>	2/3 both legislative chambers + 2010 ballot vote

Minnesota	<p>HF 171 by Rep. Emmer, S_325 by Sen. Koch, S_1282 by Sen. Hann Would propose an amendment to the Minnesota Constitution stating that "no law shall be passed that restricts a person's freedom of choice of private health care systems or private health plans of any type. No law shall interfere with a person's or entity's right to pay directly for lawful medical services, nor shall any law impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or health plan." <i>(Filed 1/22/09, 3/9/09; did not pass committee by end of 2009 session; subject to carryover to 2010)</i></p>	50% both legislative chambers + 2010 ballot vote
Mississippi <small>NEW</small>	<p>HCR 17 by Rep. Monsour Resolution, would propose a constitutional amendment to prohibit laws compelling any person, employer or health care provider to participate in any health care plan. Would provide that a "person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly." <i>(Filed; sent to Committee on Constitution 1/7/10)</i></p>	2/3 both legislative chambers + 2010 ballot vote
Missouri <small>NEW</small>	<p>HJR 48 by Rep. Davis; HJR 50 by Rep. Ervin; HJR 57 by Rep. Jones Ti; SJR 25 by Sen. Cunningham Joint resolutions, would propose a constitutional amendment which would prohibit compelling a person to participate in any health care system. "Upon voter approval, this proposed constitutional amendment prohibits any person, employer, or health care provider from being compelled to participate in any health care system. Individuals and employers may pay directly for lawful health care services, and health care providers can accept payment for health care services from individuals or employers without being subject to fines or penalties. The purchase or sale of health insurance in private health care systems cannot be prohibited by law or rule. <i>(Prefiled 12/1/09 , 12/4/09 & 1/6/10 for 2010 session) 4, 10</i></p>	50% both legislative chambers + 2010 ballot vote
Nebraska <small>NEW</small>	<p>LR 289CA by Sen. McCoy Proposed constitutional amendment stating "no law shall be passed that: (1) Restricts a person's freedom of choice of private health care systems or private health plans of any type; (2) Interferes with a person's or an entity's right to pay directly for lawful medical services; or (3) Imposes a penalty or fine of any type for choosing to obtain or decline health care coverage." <i>(Filed & sent to Health & Human Services Committee 1/13/10)</i></p>	60% both legislative chambers + 2010 ballot vote
New Hampshire <small>NEW</small>	<p>CACR 30 of 2010 by Rep. Renzullo Would propose a state constitutional amendment to establish a right stating, "People may enter into private contracts with health care providers for health care services and to purchase health care coverage." Also would prohibit the state legislature from requiring health insurance or imposing any fine or penalty for not having coverage. <i>(Filed 1/6/10; negative report; did not pass as "inexpedient to legislate" 2/3/10)</i></p>	60% both legislative chambers + 2010 ballot vote with 2/3rds popular vote
	Also see Financing category below	--
New Jersey <small>NEW</small>	<p>ACR 109 by Assemblymember Mchese; SCR 81 by Sen. Doherty Would propose a state constitutional amendment to prohibit state or federal law or regulation from compelling a person to obtain, provide, or participate in health care coverage. (New Jersey 's constitution requires a three-fifths vote in each chamber at one session [2010], or majority vote in each chamber for two successive sessions [for 2012]) (Filed 2/25/10)</p>	Both legislative chambers + ballot vote (see note)
New Mexico	<p>SJR 1 of 2009 by Sen. Sharer/ HJR 10 of 2009 by Rep. Gardner Proposed constitutional amendment stating, "No law shall be enacted that: A. restricts a person's freedom of choice of a private health care system or plan; B. interferes with a person's right to pay directly for lawful medical services; or C. imposes a penalty or fine of any type on a person for choosing</p>	50% both legislative chambers + 2010 ballot vote

	to obtain or to decline health care coverage or for participation in a particular health care system or plan." <u>Fiscal Impact Report</u> (SJR 1 filed 1/21/09; HJR 10 filed 1/28/09; failed to pass by end of session; no carryover)	
North Dakota	<u>HCR 3010</u> by Rep. Kasper (Joint Resolution), a proposed 2010 constitutional amendment based on Arizona language. Would propose an amendment to the State Constitution; relates to freedom of choice in health care; prohibits laws that restrict an individual's choice of private health care systems or private plans, interfere with a person's right to pay for lawful medical services, or impose a penalty or fine for choosing to obtain or decline health care coverage or for participation in any health care system or plan." (Filed 1/14/09, failed to pass House 3/4/09 by end of 2009 session; no regular session in 2010)	50% both legislative chambers + future year ballot vote
Ohio	<u>SJR 2</u> of 2009 by Sen. Coughlin; <u>SJR 7</u> by Sen. Grendell; <u>HJR 3</u> by Rep. Maag Joint resolutions for a proposed constitutional amendment to state, " The people of Ohio have the right to enter into contracts with health care providers ... and to purchase private health care coverage" Would prohibit state laws requiring coverage or imposing fines. For "obtaining or declining" coverage. (SJR 2 filed 2/24/09; pending in Senate committee as of 10/29/09) (SJR 7 filed 9/29/09; sent to Senate Insurance, Commerce Comm.) (HJR 3 filed 8/26/09; sent to Insurance Comm. 9/15/09; no floor votes in 2009; carried over to 2010)	60% both legislative chambers + 2010 ballot vote
Oklahoma <small>NEW</small>	<u>HJR 1054</u> by Rep. Ritze Joint resolution for a proposed constitutional amendment stating, "A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system; and A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines" for lack of insurance. (Filed 12/22/09; sent to Rules Comm. 2/2/10)	50% both legislative chambers + 2010 ballot vote
Pennsylvania	<u>HB 2053</u> by Rep. Baker Proposed statute "providing for the rights of individuals to purchase private health care insurance and prohibiting certain governmental action." States, "The people shall have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The legislature may not require any individual to participate in any health care system or plan, nor may it impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan." (Filed and sent to Insurance Committee, 10/21/09; no floor vote in 2009; carried over to 2010)	Proposed statute: majority both legislative chambers
South Carolina	<u>HJR 4181</u> by Rep. Scott; <u>SJR 980</u> by Sen. Bright; <u>SJR 1010</u> by Sen. Rose. Resolution for a proposed constitutional amendment, "prohibiting any law, regulation, or rule to compel an individual, employer, or health care provider to participate in a health care system, by allowing individuals and employers to pay directly for lawful health care services without penalties or fines for these direct payments, by providing that the purchase or sale of health insurance in private health care systems must not be prohibited by law, regulation, or rule." The resolution title states, "... to preempt any federal law or rule that restricts a person's choice of private health care providers or the right to pay for medical services." (HJR 4181 filed for 2010 session; sent to Committee on Labor, Commerce and Industry, 11/17/09) (SJR 980 and SJR 1010 filed; sent to Senate Judiciary Committee 1/12/10)	50% both legislative chambers + 2012 ballot vote
South Dakota <small>NEW</small>	<u>HJR 1001</u> by Rep. Jensen Resolution for a proposed constitutional amendment, stating "The Legislature may not enact a law that restricts an individual's freedom of choice of private	50% both legislative chambers

	health care systems or private plans of any type; a law that interferes with a person's right to pay directly for lawful medical services; or a law that imposes a penalty or fine of any type for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan." (Filed 1/28/10; sent to committees 2/10/10)	+ 2010 ballot vote
Tennessee <small>NEW</small>	SB 2490 by Sen. Black; HB 2622 by Rep. Lynn Would amend state law by adding a "Tennessee Freedom of Choice in Health Care Act." (Filed for 2010 session)	Proposed statute: majority both legislative chambers
Utah <small>NEW</small>	H 67 for 2010 session by Rep. Wimmer Would amend provisions related to the state's strategic plan for health system reform to respond to federal reform efforts; prohibits a state agency or department from implementing any provision of the federal health care reform without first reporting to the Legislature: whether the federal act compels the state to adopt the particular federal provision; consequences to the state if the state refuses to adopt the particular federal provision; and impact to the citizens of the state if reform efforts are implemented or not implemented; would require any agency of the state not to implement any part of federal health care reform passed by the US Congress after March 1, 2010, unless the department or agency reports to the Legislature and the Legislature passes legislation "specifically authorizing the state's compliance or participation in, federal health care reform." (Prefiled 12/23/2009; passed House amended, 53y-20n, 2/11/10; passed Senate 22y-7n; enrolled 3/9/10) News articles 4, 7	Proposed statute: majority both legislative chambers
Virginia <small>NEW</small>	HJ 7 by Del. Marshall Resolution for a proposed constitutional amendment, to protect "an individual's right and power to participate or to decline to participate in a health care system or plan; prohibiting any law that will infringe on an individual's right to pay for lawful medical services and prohibiting the adoption of any law that imposes a penalty, tax, or fine upon an individual who declines to enter into a contract for health care coverage or to participate in a health care system or plan. (Filed for 2010 and sent to committee 12/9/09) [Also see bills below]	50% both legislative chambers + 2012 ballot vote
	SB 283 by Sen. Quayle; SB 311 by Sen. Martin; SB 417 by Sen. Holtzman Vogel; HB 10 by Del. Marshall. Amends state law by adding a section, "Health insurance coverage not required. No resident of this Commonwealth, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the Commonwealth or the federal government, shall be required to obtain or maintain a policy of individual insurance coverage. No provision of this title shall render a resident of this Commonwealth liable for any penalty, assessment, fee, or fine as a result of his failure to procure or obtain health insurance coverage." It does not apply to Medicaid and CHIP coverage. (Filed for 2010 session 1/13/10; SB 283, SB 311 and SB 417 passed Senate 23y-17n, 2/1/10; passed House 67y-29n, 2/12/10; sent to governor; became law 3/4/10) <small>NEW</small> * Under Virginia law, the Governor exercised his option to return the bill to the legislature with a formal recommended amendment. Both branches of the legislature voted to accept the Governor's recommendation, at which point the bills became law without requiring the Governor's signature. [news articles: VA 2/10/2010; Boston Globe 3/8/2010]	Proposed statute: majority both legislative chambers
Washington	HB 2669 by Rep. Hinkle Would amend state law by adding a provision that the state "shall not directly or indirectly compel any person, employer, or health care provider to participate in any health care system." and that " A person or employer may	Proposed statute: majority both

	pay directly for lawful health care services and shall not be required to pay any penalty, fine, or other sanction for paying directly for lawful health care services. <i>(Filed & sent to Health & Wellness Comm. 1/12/2010)</i>	legislative chambers
West Virginia	H 3002 by Rep. J. Miller The "Health Care Freedom Act" states, "The people have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The Legislature may not require any person to participate in any health care system or plan, nor may it impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan." <i>(Filed 3/9/09; failed to pass by end of session; cannot carry over to 2010)</i>	Proposed statute: majority both legislative chambers (Did not pass)
West Virginia (2010) <small>NEW</small>	HJR 103 by Rep. J. Miller A proposed 2010 Constitutional amendment prohibiting compulsory purchases in healthcare and providing choice and in payment for health services. <i>(Filed 2/5/10; motion to discharge postponed 2/25/10)</i>	Vote in both legislative chambers + 2010 ballot vote
Wisconsin <small>NEW</small>	SJR 62 by Sen. Leibham A proposed 2012 Constitutional amendment <i>(Filed 2/22/10) [L. 3, 5]</i>	50% both legislative chambers + 2012 ballot vote
Wyoming (2009)	SJR 3 , by Sen. Pres. Hines A proposed 2010 Constitutional amendment based on Arizona language, "that protects individuals, employers and health care providers from having to participate in any health care system." Provides for "freedom of choice in health care; prohibits laws interfering with freedom of choice in health care" <i>(Filed 1/20/09; died in Senate committee 3/3/09; no carryover)</i>	2/3 both legislative chambers + 2010 ballot vote
Wyoming <small>NEW</small> (2010)	SJ 1 by Sen. Pres. Hines; HJ 12 by Rep. Lubnau Resolution for a proposed 2010 constitutional amendment for "Health freedom of choice," stating, "the federal government shall not interfere with an individual's health care decisions." Also would call for "prohibiting any penalty, fine or tax imposed because of a decision to participate in or decline health insurance, or to pay directly or receive payment directly for health care services." <i>(Filed 1/26/10; did not pass introduction 18y-12n, 2/9/10; HJ 12 did not pass introduction 38y-19n, 2/10/2010) [news article]</i> SB 49 by Sen. Jennings Resolution would direct the attorney general to investigate the state and federal constitutional effects of federal health care or health insurance reform legislation; requiring a report within 60 days of any future federal enactment; providing for the attorney general to seek legal remedies. <i>(Filed 2/3/10; did not pass introduction, 18y-12n, 2/9/10)</i>	2/3 both legislative chambers + 2010 ballot vote Proposed statute; 2/3 required for consideration in budget session

States Opposing Health Reform Financing and Unfunded Mandates

State	Activity/Legislation	Required for Passage
New Hampshire <small>NEW</small>	SB 417 by Sen. Bradley Would amend state law to prohibit the expansion of the Medicaid program if Congress passes a national health insurance plan unless the expansion is approved by the NH Legislature or is paid for by the federal government. <i>(Filed and sent to Senate Finance Committee 1/6/10; did not pass; voted as "inexpedient to legislate", 14y-10n, 3/3/10)</i>	Proposed statute: majority both legislative chambers

Sources: NCSL research; StateNet

Table 2**Examples of states with reported interest or pre-legislative steps toward a proposed constitutional amendment or statute.**

No formally filed legislation was reported in these three states as of February, 2010. NCSL provides links or references to third-party articles and information as a convenience. NCSL is not responsible for the accuracy or completeness of such material. Local news and opinion sources are listed as background only.

Montana ⁵ (next regular session in 2011)
Rhode Island ⁵ [updated 2/12/10]
Texas, source (next regular session in 2011)

Other states have not taken any action in the 2009-2010 session as of February 2010.

Recent News and Articles

"[Health Lobby Takes Fight to the States](#)" New York Times, 12/29/2009. <http://www.nytimes.com/2009/12/29/health/policy/29lobby.html>

"[Florida attorney general: healthcare reform unconstitutional?](#)" CS Monitor, 12/30/2009.

"[Some foes of health-care bill hope courts will stop legislation](#)" Washington Post, 1/3/2010.

"[Another Health-Care Obstacle Awaits in States](#)" - article; includes NCSL citation. Wall Street Journal, 1/20/2010.

Virginia "[Bill stating that no one can be forced to buy health insurance advanced.](#)" [The Roanoke Times](#), 1/26/2010.

"[Virginia Closer to Banning Insurance Requirement](#)" - NY Times, 2/2/2010.

"[States Look to Forstall Hypothetical Mandate](#)" - article; includes NCSL citation. NY Times, 2/8/2010

"[Bill to tell feds to back off health care fails in Wyo Senate](#)" - Cowboy State Free Press (WY), 2/9/2010 ^{NEW}

"[Can the States Nullify Health Care Reform?](#)" - New England Journal of Medicine - 2/10/2010

"[Va. health bill could foil Obama proposal: State questions constitutionality.](#)" - Boston Globe, 3/8/2010 ^{NEW}

APPENDIX 1 - The Arizona Proposed Constitutional Amendment

House Engrossed
 State of Arizona, House of Representatives
 Forty-ninth Legislature, First Regular Session, 2009

HOUSE CONCURRENT RESOLUTION 2014

A CONCURRENT RESOLUTION

PROPOSING AN AMENDMENT TO THE CONSTITUTION OF ARIZONA; AMENDING ARTICLE XXVII, BY ADDING SECTION 2, CONSTITUTION OF ARIZONA; RELATING TO HEALTH CARE SERVICES.

Be it resolved by the House of Representatives of the State of Arizona, the Senate concurring:

1. Article XXVII, Constitution of Arizona, is proposed to be amended by adding section 2 as follows if approved by the voters and on proclamation of the Governor:

2. Health care; definitions

section 2. A. To preserve the freedom of Arizonans to provide for their health care:

1. A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system.

2. A person or employer may pay directly for lawful health care services and shall not be required to pay penalties

or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.

B. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

C. This section does not:

1. Affect which health care services a health care provider or hospital is required to perform or provide.
2. Affect which health care services are permitted by law.
3. Prohibit care provided pursuant to article xviii, section 8 of this constitution or any statutes enacted by the legislature relating to worker's compensation.
4. Affect laws or rules in effect as of January 1, 2009.
5. Affect the terms or conditions of any health care system to the extent that those terms and conditions do not have the effect of punishing a person or employer for paying directly for lawful health care services or a health care provider or hospital for accepting direct payment from a person or employer for lawful health care services.

D. For the purposes of this section:

1. "compel" includes penalties or fines.
2. "direct payment or pay directly" means payment for lawful health care services without a public or private third party, not including an employer, paying for any portion of the service.
3. "health care system" means any public or private entity whose function or purpose is the management of, processing of, enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants.
4. "lawful health care services" means any health-related service or treatment to the extent that the service or treatment is permitted or not prohibited by law or regulation that may be provided by persons or businesses otherwise permitted to offer such services .
5. "penalties or fines" means any civil or criminal penalty or fine, tax, salary or wage withholding or surcharge or any named fee with a similar effect established by law or rule by a government established, created or controlled agency that is used to punish or discourage the exercise of rights protected under this section.

2. The article heading of article XXVII, Constitution of Arizona, is proposed to be changed as follows if approved by the voters and on proclamation of the Governor:

The article heading of article XXVII, Constitution of Arizona, is changed from "REGULATION OF PUBLIC HEALTH, SAFETY AND WELFARE" to "REGULATION OF HEALTH, SAFETY AND WELFARE".

3. The Secretary of State shall submit this proposition to the voters at the next general election as provided by article XXI, Constitution of Arizona.

Arizona 2008 History/Action: In 2008, Arizona Proposition 101 appeared on the ballot, referred to by proponents as the "Freedom of Choice in Health Care Act." If it had passed, it would have added the following language to the Arizona Constitution: "Because all people should have the right to make decisions about their health care, no law shall be passed that restricts a person's freedom of choice of private health care systems or private plans of any type. No law shall interfere with a person's or entity's right to pay directly for lawful medical services, nor shall any law impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan." Proposition 101 failed to pass by a vote of 1,048,512 in favor and 1,057,199 opposed, a difference of 8,687 votes. Arizona's Proposition 101 language from 2008 has served as the basis for 2009 legislative language drafted by the American Legislative Exchange Council (ALEC).

Arizona Opinions: ALEC article: "Arizona Poised to Block Single-Payer Health Care"
http://www.alec.org/am/pdf/Inside_July09.pdf

The 2009 legislative resolution was approved "along party lines." "I certainly would expect it would go to the courts as a states' rights issue," says Bert Coleman, manager of the Arizona campaign. Coleman adds that proponents of the efforts chose to go through the legislative route rather than a much slower citizen petition (as in 2008) process in order to be part of the ongoing discussion over health reform. "We wanted to be part of the debate now," Coleman stated to Inside Health Policy. "Will it influence the debate? I certainly hope so."

APPENDIX 2: Some Legal and Legislative Opinions on Anti-Reform State Actions

Rep. Nancy Barto, chairwoman of the Arizona House's Health and Human Services Committee, sponsored the bill that led to the ballot referendum. Her basic argument is that "there is no place for government between someone and their doctor," said Becky Blackburn, communications director for the Republican Caucus of the Arizona House of Representatives.

Rep. Linda Upmeyer, Iowa State Representative and the chair of ALEC's Health and Human Services Task Force stated, "Federal health care reform efforts may include a requirement that individuals purchase health insurance, and a so-called 'public option' which will result in less choices for consumers and new government mandates."

Thomas Miller, resident fellow at the American Enterprise Institute, stated that lawsuits are likely to challenge the mandate as an unprecedented violation of inherent individual rights under the U.S. Constitution in enforcing the purchase of a product "with no other reason other than the fact that you are just living in the country. "There's no clear Supreme Court precedent suggesting that this is going to be overturned constitutionally," he said. However, "give me the right five justices and anything's possible. Enforce it in a particularly onerous, all-encompassing, unfair manner and then it's more politically viable for judges to have problems with the way it comes out." [2]

The New York Times cited several legal experts who said "they saw little room for such a challenge:"

Mark A. Hall, professor of law and public health at Wake Forest University, says states don't have the power to override or "opt out" of, or not participate in the mandate. The debate is "a flash in a pan" set off by libertarians who say "Washington, D.C. shouldn't be telling us what to do," he said. "There is no way this challenge will succeed in court," adding that the state measures seemed more "an act of defiance, a form of civil disobedience if you will." [2] Hall has studied the constitutionality of mandates that people buy health insurance, for the O'Neill Institute at Georgetown University.

Timothy Stoltzfus Jost, a health law expert at Washington and Lee University School of Law, concludes that "States can no more nullify a federal law like this than they could nullify the civil rights laws by adopting constitutional amendments." [3, 8]

Randy E. Barnett, a Georgetown law school professor who has written about what he views as legitimate constitutional questions about health insurance mandates, seemed doubtful. "While using federal power to force individuals to buy private insurance raises serious constitutional questions," Professor Barnett said, "I just don't see what these state resolutions add to the constitutional objections to this expansion of federal power." [8]

Ruth Marcus, a legal analyst writing for the Washington Post (November 26, 2009), "Constitution no bar to health reform," seeks to make a detailed case that the latest federal proposals are constitutional. She states,

"Is Congress going through the ordeal of trying to enact health-care reform only to have one of the main pillars -- requiring individuals to obtain insurance -- declared unconstitutional? An interesting debate for a constitutional law seminar. In the real world, not a big worry. ... it's worth explaining where the Constitution grants Congress the authority to impose an individual mandate. There are two short answers: the power to regulate interstate commerce and the power to tax. The (Commerce) clause empowers Congress "to regulate commerce . . . among the several states," which may not sound terribly far-reaching. But since the New Deal, the Supreme Court has interpreted this authority to cover local activities with national implications.

... But the individual mandate is central to the larger effort to reform the insurance market. Congress may not be empowered to order everyone to go shopping to boost the economy. Yet health insurance is so central to health care, and the individual mandate so entwined with the effort to reform the system, that this seems like a different, perhaps unique, case. Congress clearly has authority to, in effect, require employees to purchase health insurance for their old age by imposing a payroll tax to fund Medicare.

The individual mandate is to be administered through the tax code: On their forms, taxpayers will have to submit evidence of adequate insurance or, unless they qualify for a hardship exemption, pay a penalty.

See full text [online](#).

Sources: NCSL provides links or references to third-party articles and information as a convenience. NCSL is not responsible for the accuracy or completeness of such material.

[1] American Legislative Exchange Council (ALEC) as quoted in article of August 12, 2009 and NCSL interview with Christie Herrera, ALEC Health Director, August 17, 2009.

[2] Insurance NewsNet: Legal Analysts: "[Suits May Challenge Constitutionality of Individual Mandate in U.S. Health Reform](#)," October 8, 2009.

[3] New York Times "[Health Care Overhaul and Mandatory Coverage Stir State' Rights Claims](#)," September 29, 2009

[4] CNS News.com, a subsidiary of the [Media Research Center](#). "[Nineteen States Move to Defend Individual Health Care Choice](#)," Tuesday, October 27, 2009

[5] Inside ALEC: "[Arizona Poised to Block Single-Payer Health Care](#)." Page 11, July 2009. [ALEC web site](#), accessed 1/31/2010.

[5A] Marsha Shuler, The Advocate, [Baton Rouge]. "[Louisiana state legislator pushing amendment addressing health-care changes](#)." August 11, 2009

[6] Gov. Perry told Dallas talk radio WBAP's Mark Davis; as reported by the Fort Worth Star-Telegram, 7/23/2009

[7] Deseret News, "[Pushing back against feds](#)," August 13, 2009

[8] Politico.com. [Professor Randy Barnett and Professor Timothy Jost: "Healthcare: Is 'mandatory insurance' unconstitutional?"](#) Sept. 18 2009:

[9] Inside ARM. [State Lawmakers Seek Legislative Solutions to Health Care Reform Mandates](#) - September 28, 2009.

[10] News-Leader (Missouri) [Lawmakers: Overhaul a threat to freedom](#). November 15, 2009

[11] Denver Post. [Efforts already underway in Colorado to blunt federal health care reforms](#). December 30, 2009

APPENDIX 3: Number of Sessions During Which Legislative Enactment Is Required

In the following 35 states, the legislature enacts a proposed constitutional amendment during only one session.

Alabama	Louisiana	North Dakota
Alaska	Maine	Ohio
Arizona	Maryland	Oklahoma
Arkansas	Michigan	Oregon
California	Minnesota	Rhode Island
Colorado	Mississippi	South Dakota
Florida	Missouri	Texas
Georgia	Montana	Utah
Idaho	Nebraska	Washington
Illinois	New Hampshire	West Virginia
Kansas	New Mexico	Wyoming
Kentucky	North Carolina	

In the following 12 states, the legislature must enact a proposed constitutional amendment during two sessions.

Delaware **	Nevada	Tennessee
Indiana	New York	Vermont
Iowa	Pennsylvania	Virginia
Massachusetts	South Carolina	Wisconsin

** Delaware does not require a public vote once a proposed amendment passes two consecutive sessions by a 2/3 vote.

In the following three states, the vote total determines the number of sessions during which a proposed constitutional amendment must be enacted.

Connecticut

New Jersey

Hawaii

Source for Appendix 3: Brenda Erickson, NCSL Legislative Management memorandum, 2009.

Related NCSL Resource Pages: [State Health Reform](#) | [Federal Health Reform](#)

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Republican Governors: Health Care Bills Omit Reform

Posted by admin in [Governors](#), [Policy](#) on January 13th, 2010 | 5 Responses

16
tweets

Join America's Governors - Sign Below

retweet

Name *

First

Last

Email (Stay updated on the Healthcare Bill) *

Zip Code

Sign the Petition

Twenty Republican governors and governors-elect sent a letter to Congressional leaders today urging them to refocus and pass "meaningful health care reform, not hastily prepared partisan legislation which omits reform and saddles American taxpayers for generations to come."

"Governors of both parties have said for months how bad this bill is for the states and our nation," said RGA Chairman Haley Barbour. "Now is the time for leaders in Congress to finally listen and restart this process so they can get health care reform right."

The governors criticized the lack of transparency in the legislative process and called the current health care bills "a lost opportunity to improve the lives of Americans, create a sustainable system of health care and help stabilize both our state and national economies."

The governors highlighted that the House and Senate bills fail to fix the broken Medicaid and Medicare systems and instead entitle 15-20 million more people to Medicaid. The net result of this

expansion “will be a significant cost shift to those privately insured around the country” and will further damage already hurting state budgets.

They also criticized the inflexibility forced upon states in the current bills. The governors write that the current proposals would eliminate the ability of states to negotiate Medicaid provider rates and force the states into a one-size-fits-all, federally-designed health insurance exchange.

Last, the governors urged Congress to take steps to create a system, which “eliminates red tape, empowers consumers to engage in making good health care decisions in the private market, and guarantees affordable coverage for patients with preexisting conditions.”

Full text of the letter can be found below:

Dear Senator Reid, Senator McConnell, Speaker Pelosi, and Representative Boehner:

As governors, we believe the reform of the health care system can be very beneficial to our nation's economic future and the well-being of our citizens; however, the current health care bills are a lost opportunity to improve the lives of Americans, create a sustainable system of health care and help stabilize both our state and national economies.

Health care reform should be about fixing our broken Medicaid and Medicare systems; instead, the current health care bills entitle 15-20 million more people to Medicaid. While providing health care to low income individuals is important, the net result of this entitlement expansion will be a significant cost shift to those privately insured around the country. According to the Congressional Budget Office (CBO), the unfunded mandate to states and territories is \$25 billion; although many states disagree with that figure. For example, Texas costs are estimated to be \$21 billion over ten years.

The National Association of State Budget Directors (NASBO) has demonstrated states/territories are in no position to comply with the maintenance of effort provisions found in the bills or to accept any increased costs or additional administrative burdens to expand Medicaid. State general fund expenditures have dropped for the second year in a row. The December 2009 survey shows that the budget situation faced by states truly is unprecedented. Many states cannot afford their current share of the Medicaid program, and they will also have to face a funding cliff whenever the stimulus-enhanced FMAP dollars are exhausted. States have already been forced to cut vital services with 30 states cutting education, 29 states cutting Corrections, and 28 states already cutting Medicaid.

Current federal proposals would strip the states of our ability to negotiate Medicaid provider rates, and we believe that states and territories should be allowed to negotiate Medicaid provider rates as found in current law. The pending bills cause states and territories to lose money through the bills' treatment of the prescription drug rebate provisions. States and territories also should not be asked to forego a share of the savings from any new Medicaid rebates collected for the dual eligible population receiving prescription drugs through the Medicare Part D program.

These bills also impose a one-size-fits all federally-designed health insurance exchange and the insurance rating rules tie states' and territories' hands. Health insurance exchanges desired by any state should be state-based and state-designed to ensure maximum state flexibility to design and operate exchange mechanisms that facilitate the purchase of insurance. Utah should not be forced to replicate Massachusetts' exchange, and vice versa. In the same vein, the health insurance rating rules should account for the existing variation in state and territory statutes and the state and territory should retain the authority to provide oversight and adopt tighter rating bands if necessary.

In order to pay for the bills, the legislation cuts Medicare \$571 billion in the House bill and \$466.7 billion in the Senate bill. Also included are far-reaching massive tax increases which will impact American individuals and families at all income levels. From employer mandates and taxes on high-value insurance plans to taxes on both branded and generic drugs and medical devices, these bills are funded, and thereby the bills' costs are lowered, by taking more from taxpayers and reforming the health care system less. In particular, the Senate's \$6.7 billion insurance premium tax will be passed directly to consumers and will impose new costs on Americans who already have coverage. The unfunded mandates to states likely will require many states to necessarily raise taxes, too.

Although CBO has scored the Senate bill at \$842 billion and the House bill at \$1.3 trillion both bills are full of budget gimmicks. The bills delay spending until the fourth year and exclude the costly "Doc Fix" which ignores the over \$200 billion price tag associated with stopping the unavoidable cuts to physicians under the Medicare program.

Governors agree we should work to enhance the quality of health care while making it more affordable and efficient. Unfortunately, the opportunity to truly lower the cost of care has been lost in the rush to try to finish health reform. Both CBO and the Chief Actuary of the Centers for Medicare and Medicaid Services have warned the current legislation will increase the overall costs of health care. The federal government and the states should refocus efforts to lowering the cost of care which will in turn increase coverage, but simply increasing the number of individuals on the public plans without a plan to improve the public programs for participants is irresponsible.

At this juncture, small businesses, seniors, states and territories, and taxpayers have anxiety about Congress' pending health care legislation and rightfully so— one-sixth of our GDP is at stake. As Republican Governors, we believe in a system which eliminates red tape, empowers consumers to engage in making good health care decisions in the private market, and guarantees affordable coverage for patients with preexisting conditions. Missing from this important legislation is real medical liability reform and provisions which protect seniors' Medicare benefits and access to care. Several states have already implemented medical liability reform with good results; no real medical reform can be accomplished without tort reform. Instead, premiums are increased and small businesses are faced with onerous mandates rather than given the power to pool together and offer health care at lower prices, just as corporations and labor unions do.

Along with the majority of Americans and as leaders of 20 states and territories, we are disappointed with the lack of transparency. We urge you not to circumvent the normal committee process and to conduct an open, fully-bipartisan negotiation. It is time to slow down and pass meaningful health care reform, not hastily prepared partisan legislation which omits reform and saddles American taxpayers for generations to come.

Sincerely,

Governor Bob Riley, Alabama

Governor Jan Brewer, Arizona

Governor Sean Parnell, Alaska

Governor Charlie Crist, Florida

Governor Sonny Perdue, Georgia

Governor Felix Camacho, Guam

Governor Linda Lingle, Hawaii

Governor C.L. "Butch" Otter, Idaho

Governor Mitch Daniels, Indiana

Governor Bobby Jindal, Louisiana

Governor Tim Pawlenty, Minnesota

Governor Haley Barbour, Mississippi

Governor Jim Gibbons, Nevada

Governor John Hoeven, North Dakota

Governor Don Carcieri, Rhode Island

Governor Mark Sanford, South Carolina

Governor Mike Rounds, South Dakota

Governor Rick Perry, Texas

Governor Gary Herbert, Utah

Governor-elect Bob McDonnell, Virginia

uberVU - social comments says:
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[...] This post was mentioned on Twitter by bridgettwagner, The RGA, The RGA, Alex Skatell, craigkirchoff and others. craigkirchoff said: Here's the letter the RGA sent today opposing the Health Care Reform Bill: <http://bit.ly/6S2LA6> [...]

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January 14, 2010 at 7:38 am

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Republican Governors: Health Care Bills Omit Reform « Republican ... | NFL Topics Blog says:
January 25, 2010 at 3:19 am

[...] By ROBB MANDELBAUM wrote a very interesting post today. Here's a quick excerpt: Twenty Republican governors and governors-elect sent a letter to Congressional leaders today urging them to refocus and pass "meaningful health care reform, not hastily prepared partisan legislation which omits reform and saddles ... [...]

Why Join?

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- *5Ready! Join today to lead The Comeback*

**FOR IMMEDIATE RELEASE – November 18, 2009 Contact: Blair Latoff
202-463-5682**

**U.S. Chamber Poll Shows Alaskans Opposed to
Current Health Care Reform Proposal**

WASHINGTON, D.C.—The U.S. Chamber of Commerce today released a public opinion poll showing that 55% of Alaskans oppose the health care reform plan currently being discussed in Congress while only 31% support it. The poll of 500 registered voters was conducted November 8-10 by Ayres, McHenry & Associates to gauge support for health legislation currently being proposed.

“Polling clearly shows that Alaskans overwhelmingly oppose the current direction of health care legislation,” said Bruce Josten, executive vice president of government affairs at the U.S. Chamber of Commerce. “The Chamber has been a strong advocate for reforms that improve access to quality care and lower costs but, like Alaskans, we are very concerned about the increased costs that would result from the legislation.”

The Chamber commissioned polls in seven key states – Alaska, Arkansas, Indiana, Louisiana, Nebraska, North Carolina, and Virginia – all of which showed voters in those states oppose current legislation, with substantial majorities saying it will increase the federal deficit and raise the cost of their health care.

Highlights of the Alaska poll findings include:

Overall

**Question Wording and State Results for Statewide Surveys on Health Care Reform
November 8-10, 2009**

Results are based on 600 respondents each in AR, IN, LA, NE, NC, and VA (Margin of Error \pm 4.00 percent).

Results are based on 500 respondents in AK (Margin of Error \pm 4.38 percent).

Percentages may not equal 100 percent due to rounding.

Which priority do you think the country should focus on first (ROTATE: improving the quality of health care, lowering the costs of health care, or covering more of the uninsured)?

	AK	AR	IN	LA	NE	NC	VA
Quality	19%	25%	22%	35%	22%	24%	24%
Costs	42%	45%	49%	41%	52%	41%	39%
Uninsured	23%	16%	19%	14%	16%	22%	22%
Don't Know	16%	14%	10%	10%	11%	12%	15%

One of the proposals suggested to address health care reform is to create a "public option," with the federal government selling health insurance. Do you support or oppose a government-run health insurance plan? IF SUPPORT/OPPOSE, ASK: Would that be strongly (support/oppose) or just somewhat (support/oppose)?

	AK	AR	IN	LA	NE	NC	VA
Strongly Support	21%	16%	17%	19%	15%	22%	23%
Somewhat Support	11%	11%	12%	14%	12%	15%	12%
Somewhat Oppose	8%	11%	12%	9%	11%	9%	8%
Strongly Oppose	47%	55%	52%	51%	56%	44%	44%
Don't Know	12%	8%	8%	7%	7%	11%	12%

Thinking about the overall health care reform plan being discussed in Congress, would you say you generally support or oppose that reform plan?

	AK	AR	IN	LA	NE	NC	VA
Support	31%	29%	31%	36%	29%	40%	40%
Oppose	55%	60%	59%	55%	63%	49%	48%
Don't Know	14%	12%	11%	9%	9%	12%	12%

Do you agree or disagree with each of the following statements about health care reform being discussed in Congress? (RANDOMIZE) IF AGREE OR DISAGREE, ASK: Would that be strongly (agree/disagree), or just somewhat (agree/disagree)?

A government-run public option will raise my health care costs.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	39%	47%	42%	43%	47%	42%	38%
Somewhat Agree	15%	14%	17%	13%	17%	15%	17%
Somewhat Disagree	12%	14%	15%	12%	14%	14%	14%
Strongly Disagree	22%	17%	19%	26%	16%	21%	21%
Don't Know	11%	7%	8%	7%	7%	9%	10%

The reforms being discussed will raise my health care costs.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	38%	50%	40%	45%	46%	40%	39%
Somewhat Agree	15%	14%	19%	14%	19%	16%	15%
Somewhat Disagree	12%	12%	16%	13%	15%	14%	17%
Strongly Disagree	19%	19%	16%	22%	13%	20%	20%
Don't Know	15%	6%	9%	7%	6%	10%	9%

The reforms being discussed will increase the deficit.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	56%	58%	56%	52%	62%	53%	50%
Somewhat Agree	15%	16%	20%	14%	18%	14%	18%
Somewhat Disagree	9%	8%	9%	12%	8%	13%	13%
Strongly Disagree	11%	13%	9%	15%	8%	13%	11%
Don't Know	9%	6%	7%	8%	4%	7%	9%

The reforms being discussed will cause my taxes to go up.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	54%	57%	56%	53%	62%	53%	51%
Somewhat Agree	16%	15%	18%	14%	18%	16%	19%
Somewhat Disagree	9%	8%	9%	11%	9%	10%	11%
Strongly Disagree	12%	15%	11%	18%	7%	16%	13%
Don't Know	9%	5%	6%	4%	4%	6%	6%

The reforms being discussed will expand government control over health care.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	51%	56%	53%	51%	55%	51%	51%
Somewhat Agree	20%	17%	20%	15%	22%	21%	21%
Somewhat Disagree	8%	8%	9%	9%	9%	10%	11%
Strongly Disagree	11%	15%	13%	20%	10%	13%	11%
Don't Know	9%	5%	5%	6%	5%	5%	7%

Any new taxes and fees charged to health care companies will get passed on and will mean higher health care costs for me.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	45%	54%	52%	50%	51%	48%	46%
Somewhat Agree	17%	16%	20%	11%	20%	15%	19%
Somewhat Disagree	12%	11%	10%	13%	11%	13%	12%
Strongly Disagree	16%	15%	11%	21%	11%	17%	15%
Don't Know	11%	4%	7%	5%	6%	7%	7%

The 400 billion dollars in cuts being proposed for Medicare will harm health care for seniors.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	41%	51%	43%	50%	47%	45%	43%
Somewhat Agree	13%	16%	17%	12%	18%	15%	15%
Somewhat Disagree	11%	10%	14%	11%	14%	14%	13%
Strongly Disagree	17%	15%	13%	20%	13%	15%	17%
Don't Know	18%	8%	13%	7%	8%	10%	12%

A government-run public option will cause employers to drop health insurance coverage and move their employees into the government-run plan.

	AK	AR	IN	LA	NE	NC	VA
Strongly Agree	34%	42%	42%	41%	41%	37%	36%
Somewhat Agree	20%	19%	20%	15%	20%	18%	16%
Somewhat Disagree	13%	11%	13%	13%	14%	15%	17%
Strongly Disagree	15%	18%	14%	25%	15%	17%	17%
Don't Know	18%	11%	11%	7%	11%	13%	14%

Methodology

These seven statewide surveys were conducted November 8-10, 2009 by telephone with live interviewers, with 600 respondents in Arkansas, Indiana, Louisiana, Nebraska, North Carolina, and Virginia, and 500 respondents in Alaska. All respondents were selected randomly from a list of registered voters in the state, and confirmed their registration. Quotas were set by race, gender, and geography consistent with previous elections.

The margin of error for responses with an even split – 50 percent for one response and 50 percent for another response – is plus or minus 4.00 percent for 600 respondents and plus or minus 4.38 percent for 500 respondents. The margin of error is smaller when one response receives a higher level of support. For example, the margin of error when 75 percent of respondents choose one response and 25 percent choose another response is plus or minus 3.46 percent for 600 respondents and is plus or minus 3.80 percent for 500 respondents.

NFIB

The Voice of Small Business®

ALASKA

February 17, 2010

The Honorable Mike Chenault
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Resolution 14

Dear Representative Chenault:

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully share our support for House Resolution 14. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

NFIB has vigorously opposed the current federal health care reform bill because it fails to address fundamental small business priorities. It does not make health insurance more accessible or affordable for small business. In fact, through new taxes, fees and government regulation, this legislation actually increases the overall costs of doing business for small businesses.

We join you in asking the Alaska Congressional delegation to vote against the current health care reform bills and to develop health care reform that is affordable and accessible to Alaska residents.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council
~~House Health and Social Services Committee~~

NFIB

The Voice of Small Business

ALASKA

February 25, 2010

The Honorable Mike Chenault
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Resolution 14

Dear Representative Chenault:

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully share our support for House Resolution 14 opposing current health care bills being considered in the U.S. Congress. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

No one has a larger stake in this. Small businesses have so much to gain yet so much to lose too. In economic times like these we must tread lightly and always remind our leaders in Washington to continuously check their policies by asking: Will this hurt or harm small business? Thus far, the bills passed hurt, rather than help, small businesses.

NFIB and its members have been constructive participants in the reform debate. We have worked to help our leaders understand the struggles small business owners face owning and operating their business. We have been, and will continue to be, committed to offering real solutions to real small business owners' problems. From pooling ideas to the optional free choice voucher we have pushed to be creative and constructive throughout the process.

The following are highlights of NFIB concerns with the federal bills:

Employer Mandate

Economic research has shown time and again that mandates are a "one-two punch" where the cost is first borne by the employer, but is ultimately paid by the employee – through job loss and lower wages. While we have strong concerns that the employer mandate in the Senate-passed bill will most greatly harm low-wage and entry-level workers, the approach in the House-passed legislation is even worse. A pay-or-play approach tied to payroll tax is exceptionally onerous because profitable *and* unprofitable small employers are forced to pay this tax. In addition, because the exemption thresholds in the House-passed bill are not indexed for inflation, the exemption will become a healthcare equivalent of the alternative minimum tax, hitting more and more employers until there is no one exempted at all.

Small Business Health Insurance Tax

Though small business has repeatedly called for reducing the cost of health insurance, the Senate-passed bill includes a devastating new \$60 billion dollar tax that will fall almost

National Federation of Independent Business – ALASKA

P. O. Box 34761 • Juneau, AK 99803-4761 • 907 723 6667 • www.NFIB.com

exclusively on small business. Today, 87 percent of small business owners purchasing insurance can only buy plans in the fully-insured market. They will actually bear the full weight of this "fee" through premium increases or face the possibility of forgoing insurance altogether. Early estimates indicated that this new tax could increase premiums by nearly \$500 per year for a family of four. Additionally, as a result of the changes made in the Manager's Amendment to the Senate bill, the exemptions to self-insured businesses and certain not-for-profit insurers will further increase those costs. These exemptions, meant to pacify and garner support from big business and to secure votes from specific state delegations, are a devastating blow to the very population the bill was purported to help: small business.

Construction Mandate

The recently-released December 2009 jobs report reinforces what so many in the construction industry already know: job loss is at historic levels. In December, 53,000 of the 85,000 jobs lost were in the construction industry. This narrowly-focused provision singles out one industry and excludes them from the small business exemption. This is an unprecedented assault on the construction industry. Worst of all, this mandate will kill jobs and is nothing more than a political payoff designed to make it easier for big unions to grow their membership rolls. In an industry where the national unemployment rate is exceeding 22 percent, this is NOT the reform our nation's construction industry needs or can afford. We strongly encourage you to support the removal of this arbitrary and onerous provision.

Paperwork Mandate

Both bills enact a new tax-compliance paperwork burden on all small businesses. The "corporate reporting" provision is an expansion on reporting requirements (for transactions of more than \$600), which increases the cost of operating a small business and diverts resources away from growing and creating jobs.

Medicare Payroll Tax

Since its creation, payroll taxes that fund Medicare programs have not been wage-based and have been dedicated specifically to funding Medicare. The Senate-passed bill increases the Medicare payroll tax and uses the additional revenue to pay for non-Medicare programs, creating a dangerous precedent to use payroll taxes to pay for more non-Medicare programs in the future.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council
House Health and Social Services Committee



February 24, 2010

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, D.C. 20510

Dear Leader Reid and Speaker Pelosi:

On behalf of the country's largest, oldest and most respected associations in the small business and self-employed communities, the Small Business Coalition for Affordable Healthcare is writing to reaffirm our dedication to developing responsible solutions that will constrain healthcare costs and improve access to quality, affordable healthcare. As Congress reassesses its role in the healthcare reform discussion, we urge you to listen closely to the input of those on Main Street in towns and cities across the United States of America - our small businesses.

Regardless of political party or philosophical persuasion, there is overwhelming agreement that small business owners and their employees are trapped in a broken insurance marketplace with no choices and high costs. For more than a decade these men and women have been some of the most active and vocal advocates for reform - but not just any reform. They have specifically sought reforms that lower costs, increase competition, and expand choice. While they have expressed opposition to both the House-passed "Affordable Health Care for America Act" (H.R. 3962) and the Senate-passed "Patient Protection and Affordable Care Act" (H.R. 3590), they remain steadfast in their commitment to continue advocating for policy solutions that lower healthcare costs, but do not increase the overall cost of doing business.

America's small business community has supported various incremental reform efforts and has worked to include similar provisions in comprehensive reform proposals. Healthcare reform that improves access to quality, affordable healthcare includes:

- New opportunities for small businesses to pool together and purchase insurance across state lines
- Balanced and responsible insurance market reforms
- Streamlined benefit packages
- Much-needed choices like SIMPLE cafeteria plans
- Tax equity for our nation's self-employed
- Meaningful liability reform

These types of provisions open the door to many potential benefits for small business. However, if the price for these benefits increases the cost of doing business, small businesses will not support the overall legislation. Our small business owners remain deeply concerned that if new taxes, new mandates and new government programs are used to finance healthcare reform, those costs would quickly erase any savings that could have been realized from the reforms outlined above. Simply put, healthcare reform that improves access to quality, affordable healthcare should not include:

- New taxes on small business health insurance

- An employer mandate that encourages job cuts, not job creation, including mandates targeted at specific industries
- Union and big business carve-outs
- Increases in Medicare payroll taxes
- New paperwork burdens and costs for small businesses
- New taxes specifically targeted at the small business community
- Prohibitions on HSAs, FSAs and HRAs that limit employer and employee flexibility and choice

For more than a decade, our nation's entrepreneurs in the small business and self-employed communities have called on Congress to address the most critical problem they face – high healthcare costs. Our small business owners remain focused on finding solutions and the Small Business Coalition for Affordable Healthcare remains a resource to those in Congress committed to advancing policies that make access to quality, affordable healthcare a reality for the men and women who drive the engine of our economy – small business.

Sincerely,

Aeronautical Repair Station Association
 American Bakers Association
 American Farm Bureau Federation
 American Hotel & Lodging Association
 American Veterinary Medical Association
 Associated Builders and Contractors
 Associated Equipment Distributors
 Associated Food and Petroleum Dealers
 Associated General Contractors
 Association of Ship Brokers & Agents
 Automotive Recyclers Association
 Bowling Proprietors Association of America
 California Tire Dealers Association
 Chesapeake Automotive Business Association (CABA)
 Commercial Photographers International
 Electronic Security Association
 Gasoline and Automotive Service Dealers Association
 Gasoline & Repair-Shop Association of New York, Inc.
 Independent Electrical Contractors, Inc
 Independent Office Products & Furniture Dealers Association
 International Franchise Association
 International Housewares Association
 International Sleep Products Association
 Mid-America Tire Dealers Association
 National Association of Home Builders
 National Association of Manufacturers
 National Association of Theatre Owners
 National Association of Wholesaler-Distributors
 National Club Association
 National Community Pharmacists Association
 National Federation of Independent Business

National Newspaper Association
National Retail Federation
National Roofing Contractors Association
National Tooling and Machining Association
National Utility Contractors Association
New England Service Station & Auto Repair Association
New York State Association of Service Stations and Repair Shops
New York Tire Dealers Association
North Carolina Tire Dealers and Retreaders Association (NCTDRA)
Ohio Tire and Automotive Association
Petroleum Retailers and Auto Repair Association (PRARA)
Precision Machined Products Association
Precision Metalforming Association
Printing Industries of America
Professional Golfer's Association of America
Professional Photographers of America
Repair-Shop & Gasoline Dealers Association
Service Station & Repair-Shop Association of Central New York, Inc.
Service Station Dealers of America and Allied Trades
Small Business & Entrepreneurship Council
Society of American Florists
Society of Sport and Event Photographers
Stock Artist Alliance
Tennessee Tire Dealers Association (TTDA)
Textile Rental Services Association
Tire Industry Association
U.S. Chamber of Commerce
Virginia Automotive Association
Washington Maryland Delaware Service Station and Automotive Repair Association (WMDA)

CC: Senate Minority Leader Mitch McConnell, House Minority Leader John Boehner

The White House's Web site has a section where you can "find out what health insurance reform would mean for you and your family." It then asks you to pick your situation (e.g. "I am a small business owner") and walks through a Q and A. The answers provided by the president for small businesses don't exhibit what we believe is a fair representation of the facts and real impact on small business owners. Below are the *real* answers you need to know to those questions.

What Will the President's Proposal Mean for You? (and The Real Answers)

Q: Will I be required to provide coverage that I can't afford?

A: President's answer: No.

The real answer: Yes.

Many businesses that have 50 or more workers consider themselves (and run their operations as) small businesses. These businesses will now have to pay a penalty of \$2,000 per worker if they do not offer healthcare coverage and have workers who access the exchanges. This penalty has *nothing* to do with affordability and *everything* to do with punishing businesses for something the government has decided businesses should be forced to provide. Worse, with new mandates like these, what incentive is there for a firm to grow any bigger than 50 employees when it means employers may face such stiff fines? This approach is the exact opposite of a recipe for incentivizing job growth.

Q: Why would it be easier to provide coverage than it is today?

A: President's answer: Reform will provide at least three tangible benefits that will make it easier and cheaper for small businesses to provide coverage...

The real answer: The only thing that will make it easier to provide coverage is to make it less expensive. Cost is the No. 1 problem facing small businesses.

The real issue that the president needs to focus on is controlling costs, this is the only way to make purchasing insurance "easier" for small business. Frankly, small business owners aren't interested in placing a \$1 trillion bet on a proposal that can't assure them that their costs won't go up.

The proposal ignores ideas that small business supports that will first and foremost reduce costs, which will make it less expensive and easier for businesses to offer coverage. One real and immediate solution the president could have provided to small businesses was something we have brought up frequently but wasn't included in his proposal. It is called the Optional Free Choice Voucher. This would allow employers to give pre-tax dollars to their workers and let the worker purchase the plan that best fits their needs. This idea creates choice, portability and puts the consumer in the driver's seat, a win-win for employers *and* workers.

Q: Will I be able to pool with other small businesses to buy coverage?

A: President's answer: Yes.

The real answer: Not in a way that is any different than you do today, and not across state lines.

Current law already requires each insurer to pool small businesses (small-group plans) together at the state level. But any small business that has received a premium increase that doesn't lower their costs because the pools are too small to bring about savings. But if they could pool across state lines

the pools would be bigger and the savings significant. However, the president's proposal does not allow pooling across state lines. If the president wants to give greater purchasing power to small businesses, he would let them pool their own risk together across state lines to purchase insurance just like big business and unions do today.

Q: Will my employees be able to buy coverage if I cannot afford to provide it?

A: President's answer: Yes.

The real answer: Yes. But you will still be paying for it.

Healthcare coverage is not free. Someone is going to pay if there are requirements on individuals and businesses to pay into the healthcare system. As the employer, if your employees go into the exchange, you'll be left footing a portion of that bill to help cover your workers, whether or not you can afford to provide health benefits.

One of the most common refrains in the healthcare debate is that there will be plenty of tax credits to help small businesses and individuals afford coverage. Tax credits seem to have become the magic elixir that cures all that ails small business and their employees. But not everyone will receive a tax credit. Tax credits for employees (individuals and families) are only available if you meet strict income level requirements.

Q: Will my taxes go up to pay for the cost of covering the uninsured?

A: President's answer: No.

The real answer: Yes, your taxes will go up.

A nearly \$1 trillion bill that the president says "will not add one dime" to the deficit has to be paid for somehow and that means taxes. The President's proposal includes even higher taxes and fees than the Senate bill, and they fall on small businesses, including a new \$60 billion tax on health insurance, increased Medicare payroll taxes and a new Medicare tax on investments.

The new \$60 billion tax on health insurance is an especially egregious tax, since it directly and specifically hits small businesses and individuals. Big businesses and unions were specifically exempted. The penalties of \$2,000 per worker levied on small businesses with more than 50 workers who can't afford to provide healthcare (and who have workers accessing the exchange) is another indirect tax, but a fee no less. Medicare payroll taxes will also be increased by .9 percent as well as a brand new 2.9 percent Medicare tax on non-wage income like dividends, interest and capital gains.

Q: What are you going to do about all the confusing forms I have to fill out?

A: President's answer: Make it simple.

The real answer: We'll have to wait and see...

But when have you known bureaucrats in Washington to ever make things "simpler?" The fact is that the cost of complying with onerous paperwork is especially burdensome to small businesses, who lack in-house finance departments and experts. For example, the cost of tax compliance is 66 percent higher for small businesses compared to large businesses. And their isn't a good track record on this, the recently-passed Senate bill added a new reporting requirement that will be levied on small businesses as a pay-for for healthcare reform. Sadly, the president did not exclude this pay-for in his proposal.

- March 11, 2010

Senate Health Bill Would Up Costs for Millions in Middle Class, Analysis Finds

A nonpartisan study is casting new doubt on President Obama's campaign pledge not to raise taxes on the middle class.

The Senate health care bill crucial to saving President Obama's signature domestic initiative will hit the wallets of a quarter of all Americans making less than \$200,000 per year, according to an analysis by the nonpartisan Joint Tax Committee that assessed the way the bill would hit taxpayers directly through new taxes and fees and indirectly through taxes levied on health care providers and passed on to consumers.

The committee also determined that the bill would subsidize insurance premiums for 7 percent of taxpayers -- about 13 million people -- while some 73 million people would face higher costs from the new fees and taxes.

The potential tax increases in the bill could pose significant problems for the president as he makes his final push for health care reform because he promised to protect middle-class Americans from any tax hikes. Republicans already are pouncing on the committee's analysis.

"For every family that gets some benefit from this program, in other words, a premium subsidy, three families are going to get a tax increase and those three families obviously include the bulk of people you'd call middle class America," Sen. Chuck Grassley, R-Iowa, told Fox News.

Democratic leaders are scrambling to gather enough votes to pass the bill in the House later this month so that changes House members want can be added in the Senate through reconciliation, an unusual tactic that allows a simple majority in the Senate to counteract a filibuster by the minority. The steps are part of Obama's final push to pass a comprehensive health care reform bill.

The analysis comes as the Congressional Budget Office updated its cost tally of the Senate bill, estimating that the last-minute changes made to the bill before it was passed Christmas Eve upped the price to \$875 billion from \$871 billion. The CBO also estimates that the bill would reduce the federal deficit by \$118 billion over a 10-year period, revised down from \$132 billion.

But the projection could be undermined by future spending needed to administer parts of the bill, including up to \$10 billion for the IRS, up to \$20 billion for Health and Human Services and up to \$50 billion for "grant programs and other provisions."

The new analysis highlighting the tax burdens of the Senate bill could undercut the president's push.

There's a long list of taxes in the Senate bill, including some paid directly by consumers. Other taxes are on providers who will simply pass it on to consumers.

"It has imposed a lot of taxes and fees on the drug companies, on the medical device manufacturers, on the insurance companies," said economist Doug Holtz Eakin. "All of that is going to show up in higher sticker prices for those that have health insurance."

And then there is the proposed tax on high-cost insurance plans, which was pushed back but will result in significantly higher tax payments by tens of millions of Americans who have generous insurance plans through their workplace.

Also, there would be a brand new Medicare tax on dividends and capital gains, which haven't been taxed before.

Analysis of Reid Health Bill with CBO Highlights

COST: The CBO Scores Reid's Bill at \$849, Republicans say the cost of the bill is \$2.5 trillion over 10 years of full implementation: The Republicans estimate is based on the *true* bill implementation date of 2014 (for ten years), rather than 2010, when revenues start being collected, but coverage doesn't occur until FOUR YEARS LATER. This results in a significantly higher score than that estimated by the CBO.

COVERAGE: Reid's bill will extend coverage to 31 million uninsured Americans covering 94% of the nation's population: According to the CBO, this still leaves 24 million nonelderly residents uninsured, about 1/3 of whom are undocumented immigrants. Currently 84% of the nation's population has health insurance.

ABORTIONS: The bill extends current law that prohibits federal funds from being used for abortions by requiring those funds be segregated by private insurers that offer abortion coverage. The bill does, however, allow the Health and Human Services Secretary to determine if the government plan will cover abortions. It would allow the public option to cover elective abortions as long as it uses money collected as premiums — not subsidies — to pay for the procedure, and as long as the government does not bear any "insurance risk" for the coverage.

INDIVIDUAL MANDATE: Penalties reaching \$750 per person for noncompliance by 2016. The penalties start in 2014.

	Single	Single +1	Single +2<
2014	\$95	\$190	\$285
2015	\$350	\$700	\$1050
2016 etc.	\$750	\$1500	\$2250

EMPLOYER MANDATE: According to the CBO, "*Employers with 50 or more workers that do not offer coverage would have to pay a fine of \$750 for each full-time worker if any of their workers obtained subsidized coverage through the insurance exchanges. This dollar amount would be indexed, and thus will increase as health care costs rise. If a full time worker is offered coverage through his employer, he would not be eligible for subsidies through the exchanges unless the worker had to pay more than 9.8 percent (in 2014, but indexed over time) of their income for employer insurance, in which case the employer would be penalized.*" CBO estimates a cost savings of \$28 billion/10 years.

MEDICARE PAYROLL TAX INCREASE: There will be an increase in the Medicare payroll tax of 1.95% (vs. the current 1.45%) for individuals making \$200,000 or more and couples earning \$250,000 or more to 1.95 percent. The income thresholds triggering the 0.5 percent increase in the Medicare payroll tax are not indexed for inflation, meaning it will trap more people each year. CBO estimates this raises \$54 billion/10 years.

	Wages (Employer/Employee)	Self-Employment Net Income
Current Law and New Rate on First \$200,000 (\$250,000 MFJ)	1.45%/1.45%	2.9%
New Rate on Amount Which Exceeds \$200,000 (\$250,000 MFJ)	1.45%/1.95%	3.4%

The 0.5% new rate addition is not deductible for the self-employment tax adjustment.

NEW TAXES:

Tax on high-cost "Cadillac" insurance plans: Plans valued at \$8,500 for individuals and \$23,000 for families will be subject to taxation. The Baucus plan had high-cost plans at \$8,000 individual and \$21,000 family. States with high health costs will get a \$3,000 increase in the thresholds. The CBO estimates this raises \$149 billion/10 years, which means the lion's share of paying for this bill is on the backs of those with robust health plans. Beginning in 2013, these Cadillac plan would be subject to a 40 percent excise tax. After 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

Medical Device Tax: \$2 billion per year. This has been cut in half (from an annual amount of \$4 billion/year) to appease Minnesota, Indiana and Massachusetts senators.

Insurers Tax: \$6 billion per year.

Pharma Tax: \$2 billion per year.

Medicine Cabinet Tax: No longer allowable to use health savings account (HSA), flexible spending account (FSA), or health reimbursement (HRA) pre-tax dollars to purchase non-prescription, over-the-counter medicines (except insulin). Raises \$5 billion/10 years.

HSA Withdrawal Tax Hike: Increases additional tax on non-medical early withdrawals from an HSA from 10 to 20 percent, disadvantaging them relative to IRAs and other tax-advantaged accounts, which remain at 10 percent. Raises \$1.3 billion/10 years.

FSA Cap: Imposes cap on FSAs of \$2,500 (now unlimited). Raises \$14.6 billion/10 years.

Raises Medical Itemized Deduction from 7.5% to 10% of AGI: Waived for 65+ taxpayers in 2013-2016 only. Raises \$15.2 billion/10 years.

MEDICARE CUTS:

Medicare Cuts: \$464.4 billion. The CBO says “[the Reid bill] substantially reduces the growth of Medicare’s payment rates for most services. The Medicare provisions that result in the largest budget savings include: permanent reduction in the annual updates to Medicare payment rates for most services in the fee-for-service sector (other than physicians’ services) yielding budget saving of \$192 billion over 10 years. The other cuts come from Medicare Advantage (\$118 billion over 10 years) and reducing Medicaid and Medicare payments (\$43 billion) to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (“DSH”) (pronounced DISH).

Independent Medicare Advisory Board (IMAB): Will be established to recommend changes to the Medicare program, in order to limit the rate of growth in that program’s spending. These recommendations go into effect automatically unless blocked by subsequent legislative action, similar to BRAC. IMABs recommendations will focus on reductions in subsidies for Medicare Advantage plans and changes to payment rates or methodologies for services furnished in the fee-for-Service sector by providers other than hospitals, physicians, hospices and suppliers of durable medical equipment. Its first set of recommendations will be in 2013 for implementation in 2015. The CBO estimates savings would be \$23 billion over the 2015-2019 period.

DEFICIT REDUCTION:

Reduces the deficit by \$118 billion/10 years and by \$640 in the out years (2019-2028): The CBO however says the following: “*In the subsequent decade (2019 and beyond), the collective effect of [the Reid bill] provisions would probably be small reductions in the federal budget deficits if all of the provisions continued to be fully implemented. Those estimates are subject to substantial uncertainty.*”

NEW MANDATORY/ENTITLEMENT SPENDING:

Medicaid: The non-elderly at or below 133 percent of FPL would be made eligible for Medicaid. According to the CBO, “*The federal government would pay all of the costs of covering newly eligible enrollees through 2016; in subsequent years the share of federal spending would vary somewhat from year to year but ultimately would average about 90 percent. Beginning in 2014, states would receive higher federal reimbursement for SCHIP beneficiaries, increasing from an average of 70 percent to 93 percent.*”

CLASS Act: The bill includes a long-term insurance program known as the CLASS Act that some senators have concerns with, saying its early savings would eventually be eaten up by benefits paid to enrollees. Reid has attempted to appease them by not applying the \$75 billion in

savings from the program to the offsets. The CBO and the Obama Administration's Chief Health Actuary have both said that the CLASS Act will run significant budget shortfalls outside the 10 year budget window. CBO wrote that under the current benefit structure, **"the program would add to future federal budget deficits in large and growing fashion."**

- Sen. Kent Conrad (D-N.D.) Chairman of the Senate Budget Committee, called the CLASS Act **"a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of,"** and he vowed to block its inclusion in the Senate bill.
- In its review of the House legislation, the Administration's Chief health Actuary said the CLASS Act would result **"in a net Federal cost in the longer term."** The Chief Actuary also determined that the program faces **"a significant risk of failure"** because the high costs will attract sicker people and lead to low participation.
- The Congressional Budget Office agreed, saying that **"the CLASS program included in the bill would generate net receipts for the government in the initial years when total premiums would exceed total benefit payments, but it would eventually lead to net outlays when benefits exceed premiums....** In the decade following 2029, the CLASS program would begin to increase budget deficits."
- The *Washington Post* called the CLASS Act a **"gimmick"** **"designed to pretend that health care is fully paid for."** The *Post* goes on to say that **"...the money that flows in during the 10 year budget window will flow back out again. These are not 'savings' that can honestly be counted on the balance sheet of reform."**

Medicare SGR: According to the CBO, *"[Under this bill] Physicians reimbursement rates will increase for 2010 but would be reduced by about 23 percent for 2011 and then remain at current-law levels for subsequent years. According to CBO, the legislation includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation."*

Prevention and Public Health Fund: This is a Harkin pet project that was included in the HELP bill. The Reid bill provides mandatory appropriations of \$15 billion to establish this fund. CBO estimates that outlays of these funds would total \$13 billion over ten years.

Key Talking Points:

- **Effective Dates:**
 - *The effective date of the Reid bill for the mandates and penalties to individuals and employers has been delayed by four years, to January 1, 2014 to take in people's money for four full years, before ever having to pay for health care coverage. This essentially means this bill would collect money for four years, and pay our benefits for six years, under the current CBO score. Moving back the effective date is a transparent budget gimmick designed to push spending outside the 10-year window.*
 - *Is our job here to do things for optics or are we here to implement changes to help struggling Americans, particularly in this time of economic downturn, be able to purchase health insurance despite a pre-existing condition?*

- *Keep in mind, taxes and penalties will increase before your health benefits start in 2014.*
- **Medicaid Expansion:**
 - *The provisions in this program would require states to expand their Medicaid programs but what if states aren't able to continue covering those lives after the federal match money decreases? Will our states be forced to push those lives off the Medicaid program or will states have to further reduce Medicaid reimbursement rates, and diminish access to patients?*
- **Premium Increases:**
 - *Premera Blue Cross Blue Shield of Alaska estimated that premiums will likely rise by 60-161% (\$1,500 - \$2,500 annually) (similar to the Senate Finance Committee passed bill) because of the increased requirement of a higher level of insurance coverage (65% actuarial value.)*
- **Medicare Tax Increase:**
 - *Nearly half a trillion in cuts to Medicare and no reform of the flawed SGR formula to ensure updates to doctors and nurses for caring for Medicare patients.*
- **Junk Lawsuit Reform:**
 - *This bill contains NO provisions to address what the CBO estimates would save nearly \$60 billion/10 years and independent studies have estimated could save between \$100-200 billion a year in limiting the cost of defensive medicine that affects our overall health care costs and premiums as well as the cost to the patients.*

What ISER – the Institute for Social Economic Research at the University of Alaska Anchorage - has said about Medicare in Alaska

- **Seniors in Low Paying Medicare States Will Be Forced to Wait In Line:** *Independent of the doc fix, in Alaska, the remainder of seniors are at risk of long lines to see a primary care doctor and overflowing to community health centers and hospital emergency rooms where existing capacity is highly likely to be quickly overwhelmed and long wait times become increasingly common*
- **Additional New Insured Patients Will Hurt Medicare Beneficiaries in this Low Paying Federal Health Program:** *Federal health care reform applied to Alaska likely to exacerbate an already very challenging access situation for Alaska's seniors as baby boomers age in to Medicare and find themselves waiting in line behind a rapidly expanding line of better paying private plans.*
- **In Alaska's Largest City, with the Highest Number of Seniors in Alaska, the Medicare Shortages Are Most Severe:** *17% of Primary Care Doctors – only 5 are accepting new Medicare patients in Anchorage. The five are at the Anchorage Neighborhood Health Center – a community health center that should be for those who are uninsured or poor, but are being utilized by seniors and the disabled who are on Medicare because these patients simply don't have access to a primary care doctor.*
 - **42% of all non-native Alaskans 65 and older live in Anchorage and 38% of all Alaska 65 and older are in Anchorage.**
 - **Due in large part to baby boomers (those born between 1946 and 1964) hitting Medicare age, one in four Alaskans is a baby boomer.**
 - **In 2008, there were 49,455 Alaskans 65 and over -- by 2015 – in 5 years, the number is expected to increase 50% to almost 75,000 by 2015.**
 - **By 2020, in just 10 years, the estimate is projected to increase to over 86,000 in Anchorage.**
 - Yet, we have fewer and fewer primary care doctors willing to accept Medicare patients and we're looking to cut half a trillion from Medicare to pay for a new government entitlement.
- **Medicare Patients Are Being Pushed Out of Doctors Offices Because of Low government Reimbursement Rates:** *The numbers of patients 65 and older at Anchorage Neighborhood Health Center (ANHC) and Anchorage's VA facilities have jumped on the order of 50% within a few years. The ANHC saw twice as many Medicare patients in 2007 as in 2001.*
 - Older Alaskans have also been visiting the emergency room at Providence Hospital in growing numbers. *Through early 2009, visits by older residents were growing just slightly – less than 3% a years over the past five years. But from May 2008 to September 2009, the number of visits increased at an annualized rate of 12%.*

ISER Report on Medicare in Western States as Compared to Private Insurance Rates:

- **According to a recent GAO study from 2006, the percentage of Medicare beneficiaries having “big problems” finding a personal doctor were most acute in states such as Alaska, Oregon, Nevada, Colorado and New Mexico. (*percentage indicates the number of Medicare beneficiaries reporting “big problems” finding a personal doctor)**
 - Alaska: 15% (One in 10 doctors surveyed has opted out of the Medicare program, and most are in Anchorage)
 - Oregon; Colorado; New Mexico; Nevada: 8-15%
 - Washington and Idaho: 6-8%
 - Utah; Arizona: 4-6%
 - *While we have growing problems in the Western part of the United States with fewer and fewer primary care doctors willing to accept Medicare patients, this health care bill before the Senate today seeks to cut half a trillion from Medicare to pay for a new government entitlement.*

- **Medicare versus Private Insurance Reimbursement for Physicians Services in 2008-2009:**
 - **Wyoming and Alaska:** Medicare ranks “substantially behind” both private insurance and Medicaid
 - **Montana, Idaho, Arizona and New Mexico, Washington, Oregon, Utah and Colorado:** Medicare ranks behind private insurance
 - *While we have already low reimbursement rates under Medicare in the Western part of the United States, this health care bill before the Senate today seeks to cut half a trillion from Medicare to pay for a new government entitlement.*

- **Why Primary Care Providers Won’t Accept New Medicare Patients:**
 - **Of the 142 primary care doctors in Alaska, 98% reported “Inadequate reimbursement” as the reason for not accepting Medicare. While this is Alaska specific, if your state is one of the states where your Medicare beneficiaries are facing major problems finding a primary care doctor, you can bet this statistic applies to your state as well.**
 - *So instead of addressing a long-term fix for how we reimburse primary care doctors under the Medicare program, this bill completely ignores the problems facing seniors throughout this country, and particularly in the western part of the U.S., by bringing to the Senate floor a health care bill that seeks to cut half a trillion from Medicare to pay for a federal expansion of health care and a new government entitlement program.*

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Obama wants side deals out of bill

By: Carrie Budoff Brown
March 10, 2010 08:11 PM EST

President Barack Obama is pushing Senate Majority Leader Harry Reid to go further than Obama has previously disclosed to strip the final health care reform bill of the narrow deals aimed at appeasing specific senators.

The president wants to eliminate more than just Sen. Ben Nelson's "Cornhusker Kickback" and Sen. Bill Nelson's agreement to shield 800,000 Florida seniors from Medicare Advantage cuts, the White House told POLITICO Wednesday in response to questions about other deals in the bill.

Obama has asked Reid to strike provisions requested by senators from at least five other states, in an unusual move that accentuates the culture clash between the president's rhetoric on changing the ways of Washington and the Senate leader's needs to exercise the old-fashioned tools of Congress to pass laws.

"We've removed many of the special provisions that initially found their way into the legislation, and we've made it clear to the Senate that the president's position is that the final bill shouldn't include any earmarks or provisions that would favor a single state or district over the rest of the country," White House spokesman Reid Cherlin said in a statement Wednesday.

Reid spokesman Jim Manley said the decision on what to keep in the bill rests with congressional leaders and that no determinations have been made.

Senators whose deals have been targeted — some of whom did not know the deals might be in danger — said they would fight to maintain them, arguing they are in no way as egregious as the Cornhusker Kickback.

"We have defended it, and we will defend it," said Sen. Bernie Sanders (I-Vt.), whose state picked up \$600 million in extra Medicaid funding for having already expanded its coverage of low-income individuals.

But ever since last-minute deal making helped sour voters on the Senate bill that passed on Christmas Eve, any provision identified by Republicans or the media as benefiting a single state or a small number of states has sat on shaky ground.

Obama tried to publicly distance himself from the deals, saying he wasn't in the room when they were struck, even though some of his aides were. The president rankled Reid and House Speaker Nancy Pelosi by criticizing them for doing what

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generations of their predecessors have done: cut deals. And in the process, he may have made it entirely untenable for them to deploy one of the tried-and-true methods for muscling major reforms through Congress.

"Legislators need pork to make things happen," Julian Zelizer, a Princeton University professor of history and public affairs, wrote in POLITICO Wednesday. "It is unrealistic to expect that legislative leaders won't use one of the few tools at their disposal to get things done."

Zelizer noted that then-Senate Majority Leader Lyndon B. Johnson promised the construction of a federal dam in exchange for votes for the Civil Rights Act of 1957 from a group of Western Democrats.

In a letter to congressional leaders last week, Obama targeted the Nebraska and Florida deals for elimination. (The Florida provision could also shield some seniors in California, New York, New Jersey and Pennsylvania, according Sen. Bill Nelson's office.) But in response to questions from POLITICO, the White House detailed other provisions that the president wants to see removed.

The so-called Louisiana Purchase is still safe, according to the White House, since the provision requested by Sen. Mary Landrieu (D-La.) would apply to any state in which all the counties have been declared a disaster zone. The Medicaid funding formula fix is worth \$300 million to Louisiana, according to Landrieu.

But Obama has asked Reid to strike a provision that would send \$1.1 billion in

extra Medicaid funding to Massachusetts and Vermont — states that have already expanded Medicaid coverage but would otherwise not be reimbursed at the same level as states that would boost their Medicaid populations for the first time under the bill's mandate.

"What I told Harry Reid is that Vermont does the right thing, and I don't want Vermont to be penalized for doing the right thing," Sen. Patrick Leahy (D-Vt.) said in a statement.

Through a spokeswoman, Sen. John Kerry (D-Mass.) said he, too, was working with the president "to make sure Massachusetts's past investment to expand health coverage to low-income individuals is recognized in health reform."

The president is also asking Reid to "look at removing" a \$100 million hospital grant program requested by Sen. Chris Dodd (D-Conn.), who has acknowledged that the University of Connecticut would qualify for the money.

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But the senator's aides added that university teaching hospitals in a dozen states would also qualify and that the program is not an earmark, since the money would be awarded on a competitive basis through the Department of Health and Human Services.

Another provision the president has asked Reid to consider removing was promoted by Senate Finance Committee Chairman Max Baucus (D-Mont.) on behalf of residents of Libby, Mont.

The bill includes language that would allow people who have been exposed to asbestos from a vermiculite mine in the town to receive Medicare assistance, although a Baucus aide said the language would apply to victims of any government-declared public health emergency. The language would fulfill the government's responsibility, first codified in a 1980 law, to provide health care to victims of public health emergencies, the aide said.

Libby was the first town to receive the emergency declaration, and implementing language is needed to finish the process, the aide said.

"The Senate bill meets the responsibility that was established in 1980, so I can't understand why anyone would want to make it impossible to meet our statutory obligation to address disasters of this magnitude, where more than 290 people have died from asbestos-related disease," Baucus said in a statement. "This type of tragedy could happen to any town, anywhere across the country, and all Americans deserve to have this protection."

The aide added: "The public health emergency provision is not a special deal."

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SB

10

Alaska State Legislature

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Senator Betty Davis

SB 10 - Cancer Clinical Trials

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health and Social Services to provide Medicaid services to persons who participate in clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

SPONSOR STATEMENT

Clinical trials are research studies that test how well new medical approaches work in patients. Each study answers scientific questions and tries to find better ways to prevent, screen for, diagnose, or treat disease. Patients who take part in cancer clinical trials have an opportunity to contribute to the knowledge of, and progress against cancer. They also receive state-of-the art treatment from experts in the field. The National Cancer Institute, as part of the U.S. National Institutes of Health, reports 6,000 cancer trials in the United States any one time. They include trials in prevention, screening, diagnosis, treatment, quality-of-life, and genetic studies.

SB 10 removes important barriers to the participation of patients in cancer clinical trials in Alaska. It requires that applicable health care plans, including Medicaid, cover routine patient care costs for patients enrolled in all phases of clinical trials, including prevention, detection, treatment, and palliation (supportive care) of cancer. Medicare, the VA and military insurance already cover the benefits that SB 10 provides. Currently Alaska health plans may exclude coverage for routine patient-care costs while a patient with cancer is enrolled in a clinical trial. Providers of health care plans often conclude that money is saved by excluding care while patients participate in clinical trials. But these patients, if not enrolled in clinical trials, will continue to receive conventional therapy at roughly the same or slightly increased costs.

Over 2600 Alaskans are diagnosed with cancer each year. In FY 2007 an estimated 4,600 patients received cancer treatments through Alaska's Medicaid program at a cost of \$21.5 million. The average payment per beneficiary was about \$4,675. The federal government reimburses the state at about 50% of the total costs. Without in-state facilities and support of clinical trials participants in Alaska currently have to travel out of state, increasing the cost of non-emergency transportation which is about 3% of total Medicaid costs.

Studies have shown that only 2% to 3% of adult cancer patients and less than 0.5% Medicare patients enroll in clinical trials of the approximately 20% who are eligible -largely due to fear of denial of insurance. A recent study found only slight increase in treatment costs for adult clinical trial patients compared to nonparticipants, \$35,418 versus \$33,248 or about 6.5% increase in costs for clinical trial participants compared to nonparticipants. Even if enrollment was increased to the full 20%, it is unlikely that these numbers will significantly impact overall costs to health plans. See National Conference of State Legislatures, "Clinical Trials: What are States Doing? February, 2009 Update," www.ncsl.org/programs/health/clinicaltrials.htm.

Twenty-three or more states have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care patients receive while participating in clinical trials. Passage of SB 10 will result in more successful outcomes in cancer treatments in Alaska, increase retention of patients in Alaska for their cancer care, and also, after full implementation, result in cost savings in the short and long term.

A description of "The Access to Cancer Clinical Trials Act of 2009" H.R. 716, 111th Congress 2009-2010, (Rep. Sue Myrick) per "The Hill's Congress Blog" January 30, 2009 sums up to a large extent what SB 10 is attempting to do:

"Clinical trials are so critical for patients and or medical research, yet many patients find that their health insurance won't cover the rest of their routine cancer treatment if they decide to enroll in clinical trials. We're not asking insurance companies to pay for clinical trials. This bill simply states that insurers must continue to pay for routine treatments — that they would be paying for regardless — if patients enroll in a clinical trial.

No patient should ever have to fear exploring all treatment options at the cost of losing coverage. We should be encouraging participation in clinical trials, not discouraging it by removing coverage for routine care. Were it not for patients who have enrolled in past trials, the medical advancements we've experienced toward finding a cure for cancer would not be possible."

LEGAL SERVICES

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Mail Stop 3101

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Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

April 17, 2009

SUBJECT: Mandatory health care insurance coverage for clinical trials for cancer (CSSB 10(HSS), Work Order No. 26-LS0073\S)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey *DCB*
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Requires health care insurers to cover approved clinical trials for cancer if there is no clearly superior noninvestigational treatment alternative, and available clinical or preclinical data provide a reasonable expectation that the treatment in the clinical trial will be at least as efficacious as any noninvestigational alternative; identifies the items that must be included in and excluded from the required coverage; makes coverage for clinical trials subject to standard policy provisions that are applicable to other benefits; and defines the meaning of an approved clinical trial.

Section 2. Allows the state health insurance plan provided by the Comprehensive Health Care Insurance Association to include clinical trials related to cancer in its minimum standard benefits.

Section 3. Requires the state Medicaid program to cover clinical trials related to cancer.

Section 4. Gives the Act a January 1, 2010, effective date.

DCB:ljw
09-262.ljw

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSSB10 (HSS)
 () Publish Date: _____

Identifier (file name): SB10CS(HSS)-CED-INS-3-2-10 Dept. Affected: DCCED
 Title Medicaid/Insurance for cancer clinical trials RDU Insurance (116)
 Component Insurance
 Sponsor Senator Davis
 Requester Senate Health and Social Services Component Number 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill requires companies that offer health care insurance in Alaska cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer. The coverage provided must include the costs of prevention, diagnosis, treatment, and palliative care of cancer. The health care insurer is required to provide coverage under this section only if the patient's treating physician determines that there is no clearly superior non-investigational treatment alternative; and available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any non-investigational alternative.

Prepared by: Linda S. Hall, Director
 Division Insurance
 Approved by: Emil R. Notti, Commissioner
Commerce, Community, and Economic Development

Phone 907-269-7900
 Date/Time 3/2/10 10:48 AM
 Date 3/2/2010

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB 010
() Publish Date: _____

Identifier (file name): SB010-DHSS-MS-02-11-09 Dept. Affected: Health & Social Services
Title: Medicaid/Insurance For Cancer Clinical Trials RDU: Health Care Services
Sponsor: Davis Component: Medicaid Services
Requester: Senate HSS Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

SB 010 amends the Medicaid statute (AS 47.07.030) to add a new subsection (e) that requires the program to pay for Medicaid covered services for Medicaid recipients even when provided as part of an approved clinical trial related to cancer.

The bill would be effective on January 1, 2010. It is not expected to result in an increase in Medicaid expenditures as Medicaid already covers these services.

Prepared by: William J. Streur, Deputy Commissioner Phone 907-269-7827
Division: Health Care Services Date/Time 2/10/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 2/11/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB10
() Publish Date: _____

Identifier (file name): SB10-CED-INS-2-4-09
Title: Medicaid/Insurance for cancer clinical trials
Dept. Affected: DCCED
RDU: Insurance (116)
Component: Insurance
Sponsor: Senator Davis
Requester: Senate Health and Social Services
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES ()							
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This bill requires companies that offer health care insurance in Alaska cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer. The coverage provided must include the costs of prevention, diagnosis, treatment, and palliative care of cancer. The health care insurer is required to provide coverage under this section only if the patient's treating physician determines that there is no clearly superior non-investigational treatment alternative; and available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any non-investigational alternative.

Prepared by: Linda S. Hall, Director
Division: Insurance
Approved by: Emil R. Notti, Commissioner
Commerce, Community, and Economic Development

Phone 907-269-7900
Date/Time 2/4/09 10:48 AM
Date 2/4/2009

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Juneau, Alaska 99801-1182
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MEMORANDUM

March 9, 2010

SUBJECT: Clinical trials; fraternal benefit societies (CSSB 10(HSS))
(Work Order No. 26-LS0073\S)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey *DCB*
Legislative Counsel

You asked for an explanation of a fraternal benefit society, which is excluded from the application of proposed sec. 21.42.410 under sec. 21.42.410(f).

A fraternal benefit society is described and regulated under AS 21.84. A fraternal benefit society is defined in AS 21.84.900, which provides:

(7) "fraternal benefit society" means an incorporated society, order, or supreme lodge, without capital stock, including one exempted under AS 21.84.700(a)(2), whether incorporated or not, that is conducted solely for the benefit of its members and their beneficiaries and not for profit, that is operated on a lodge system with ritualistic form of work, that has a representative form of government, and that makes provision for the payment of benefits under this chapter;

The following highlight the statutory sections relating to fraternal benefit societies. A fraternal benefit society:

- Must have a representative form of government. AS 21.84.005.
- Operates for the benefit of its members and their beneficiaries providing (1) death benefits, (2) endowment benefits, (3) annuity benefits, (4) temporary or permanent health care benefits, (5) hospital, medical, or nursing benefits, (6) monument or tombstone benefits, and (7) certain life insurance benefits. AS 21.84.015, AS 21.84.201.
- Operates for a social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purpose for the benefit of its members or others. The purposes may be carried out directly or through subsidiary or affiliated corporations. AS 21.84.015.
- Must have 500 initial applicants (AS 21.84.080 and 21.84.090) and must maintain 400 members. AS 21.84.530.

Senator Bettye Davis

March 9, 2010

Page 2

- Applicants pay premiums for the benefits. AS 21.84.090.
- May be converted to a mutual life insurance company under certain circumstances. AS 21.84.195.
- Shall issue a benefit contract to the contract owner describing the benefits provided. AS 21.84.255.
- Is subject to many of the laws applicable to insurance companies. AS 21.84.335.
- Are included in the definition of a health care insurer. AS 21.54.500.

Fraternal benefit societies are excluded from many of the mandatory health care benefits set out in AS 21.42. I do not know the reasons for these exclusions, but I presume the decision is a policy decision to treat fraternal benefit societies differently because they are non-profit organizations, they are relatively small in number and in size, and they provide benefits only to their members.

I routinely recommend that sponsors of bills that regulate insurance confer with the Division of Insurance to take advantage of the division's expertise. The division may have additional information concerning the workings of fraternal benefit societies.

If I may be of further assistance, please advise.

DCB:ljw
10-141.ljw



In English | En español

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States That Require Health Plans to Cover Patient Care Costs in Clinical Trials



Posted: 12/19/2002 Updated: 12/03/2009

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A growing number of states have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care you receive as a participant in a clinical trial.

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- [Funding Opportunities](#)
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- [Advisory Boards and Groups](#)
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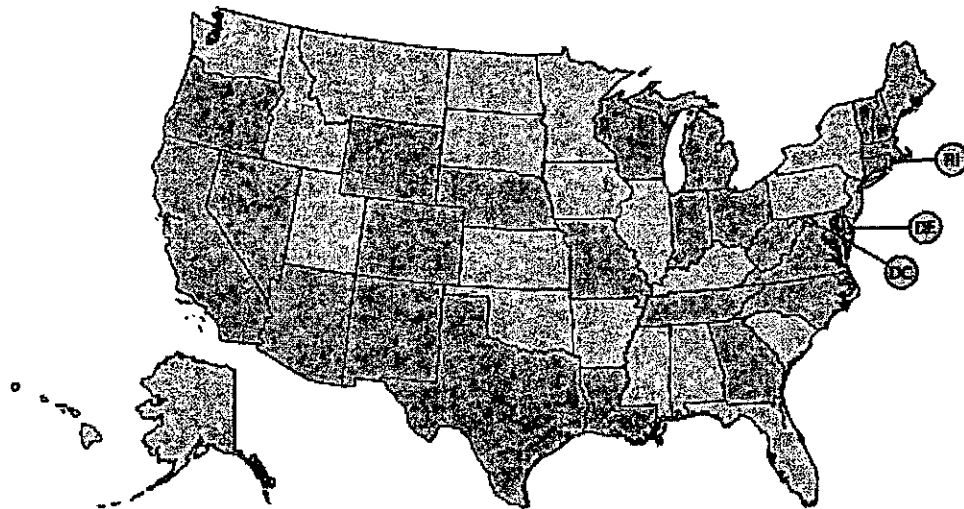
- Use this [map](#) or this [alphabetical list](#).
- [Overview](#) of the issue.
- [Other resources](#).

Questions about cancer?
• 1-800-4-CANCER

NCI Highlights

- [Restructuring the NCI Clinical Trials Enterprise](#)
- [Clinical Trials Reporting Program](#)
- [Coordinating Center for Clinical Trials](#)
- [States Requiring Coverage of Clinical Trial Costs](#)

Map (click on a blue-highlighted state/location to see the law or agreement and its key provisions)



Information by State (All States)

- | | | | |
|-----------------------------|-------------------------------|--------------------------------|----------------------------------|
| Alabama | Indiana | Nebraska | Rhode Island |
| Alaska | Iowa | Nevada | South Carolina |
| Arizona | Kansas | New Hampshire | South Dakota |
| Arkansas | Kentucky | New Jersey | Tennessee |
| California | Louisiana | New Mexico | Texas |
| Colorado | Maine | New York | Utah |
| Connecticut | Maryland | North Carolina | Vermont |
| Delaware | Massachusetts | North Dakota | Virginia |
| Florida | Michigan | Ohio | Washington |
| Georgia | Minnesota | Oklahoma | Washington, D.C. |
| Hawaii | Mississippi | Oregon | West Virginia |
| Idaho | Missouri | Pennsylvania | Wisconsin |
| Illinois | Montana | Puerto Rico | Wyoming |

Overview of the issue

"Routine patient care costs" are the usual costs of medical care, such as doctor visits, hospital stays, clinical laboratory tests, x-rays, etc., that you would receive whether or not you were participating in a clinical trial. Some health plans don't cover these costs once you join a trial, even though studies have shown that they are not appreciably higher than costs for patients who are not enrolled in trials. (See [Cost of Clinical Trials](#).)

Lack of such coverage is a significant barrier to many patients who might otherwise enroll in a trial. Lack of coverage also makes it harder for researchers to successfully conduct trials that could improve prevention and treatment options.

These laws and agreements do not cover the research costs associated with the conduct of the trial, such as tests purely performed for research purposes. In most cases, such costs would be paid for by the group sponsoring the trial, such as the National Cancer Institute or a pharmaceutical company.

For more of an overview, see [Clinical Trials and Insurance Coverage: A Resource Guide](#).

Other Resources

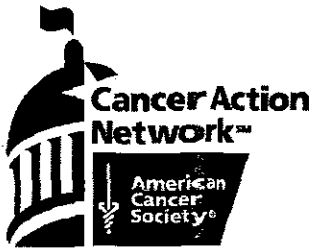
- To find specific trials in PDQ - the National Cancer Institute's database of ongoing cancer clinical trials - go to the [PDQ search page](#).
- To understand the basics of clinical trials, please see the variety of articles listed in the [Educational Materials About Clinical Trials](#) section of this Web site. Of particular interest might be [What is a Clinical Trial?](#)
- Another resource is [NCI's State Cancer Legislative Database Program](#).

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A Service of the National Cancer Institute





Clinical Trials

Primer

Clinical trials are essential gateways to developing better tools for cancer prevention, detection, treatment and care. The research conducted through clinical trials helps move scientific discoveries from the laboratory into new therapies that can be used at the bedside to improve the quality of patient care. Yet consistently low enrollment of adults in clinical trials, particularly among racial and ethnic minority groups and low income groups, delays our progress.

**Only 3-5% of adult cancer patients participate in clinical trials each year.
This slows the pipeline for bringing new cancer advances to patients.**

What is a clinical trial?

A clinical trial is a research study that answers specific questions about the safety and effectiveness of new drugs and treatments developed to address serious illness like cancer. Carefully conducted clinical trials are the fastest and safest way to find new vaccines, early detection tests, treatments, and therapies that support improved quality of life. There are no placebos in clinical trials for cancer treatment. Typically, researchers use trials to compare a new approach or agent to the most effective, standard therapy. Clinical trials may take place at a local hospital, university, cancer center, military or veteran's hospital, or even a physician's office.

Who sponsors clinical trials?

There are many different potential sponsors of clinical trials, including the federal government and drug or medical device companies. Many different agencies within the federal government such as the National Institutes of Health, the National Cancer Institute, and the Department of Veteran Affairs sponsor clinical trials.

Who is eligible for a clinical trial?

Each clinical trial has established protocols that identify patient eligibility requirements, all of which depend on the purpose of the particular study. Patients whose standard therapy is ineffective or patients for whom standard therapy may induce serious health risks may wish to seek treatment in a clinical trial.

Who pays for a clinical trial?

The trial sponsor (e.g., a drug company) generally pays for the investigational drug/treatment and any research-related costs such as data collection and analysis. Therefore, the only portion of the clinical trial that is not paid for by the sponsor is patient care costs—the costs for the care that a patient would receive whether they were receiving standard care or care provided through a clinical trial. Insurance coverage for patient care costs in clinical trials varies considerably across the country.

Why do so few patients enroll in clinical trials?

While about 20% of cancer patients in any given year meet eligibility requirements for participation in active clinical trials, fewer than 5% of all adult cancer patients actually enroll in a clinical trial. People with low income, the elderly, racial/ethnic minorities, women, and those living in rural areas represent the smallest percentage of clinical trials participants.

Many barriers to trials participation have been identified, including:

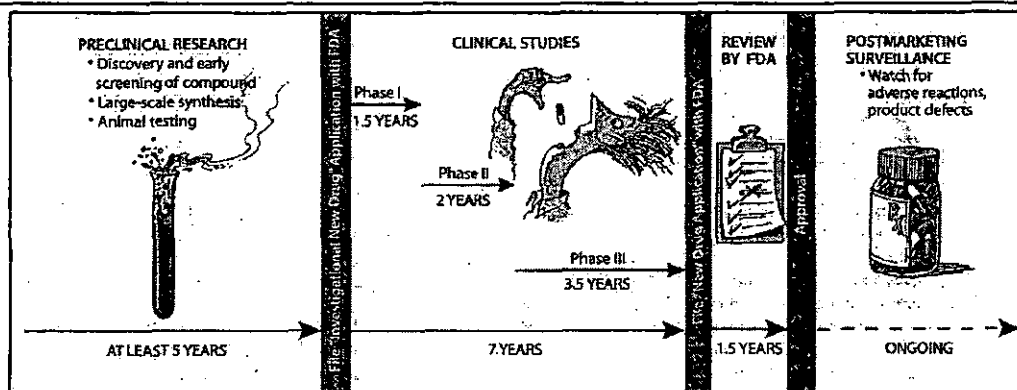
- Concerns about health insurance coverage for patient care costs in clinical trials
- Insufficient information, education and outreach directed toward healthcare professionals and their patients regarding the availability and location of cancer clinical studies
- Patient or family misunderstanding or fear about participating in a clinical trial
- Doctor does not recommend clinical trial participation to patient

Clinical Trials

Primer

What is the clinical trials process?

Traditionally, there are four phases of clinical trials. In phases one through three, the clinical trial enrolls progressively more participants—phase one trials involve only a handful of participants while phase three trials may involve thousands of individuals at multiple trials sites. New drugs or treatments must progress through each phase to establish safety and efficacy before they can be approved for broad use in the market. The fourth phase of a clinical trial takes place after the new drug or treatment has been released to the general public to continue monitoring the product and its effects in the broader population.



Are there different types of clinical trials?

Yes. There are four main types of cancer clinical trials: prevention, detection, treatment, and those focused on symptom management and other aspects of care supporting quality-of-life. Prevention trials are designed to evaluate cancer-causing behavior or anti-cancer development. Detection trials test new methods for detecting cancer in the disease's earliest stage. Treatment trials, the most common type of cancer clinical trial, test new and emerging therapies for cancer patients. Lastly, quality-of-life trials look at ways to increase the comfort and well-being of cancer patients.

How can patients find the right clinical trial for them?

They can contact the American Cancer Society at 1-800-ACS-2345 or by visiting www.cancer.org to get assistance in finding trials for which they may be eligible through its clinical trials matching service. The Society and the Coalition of Cancer Cooperative Groups joined forces to provide information to patients seeking clinical trials. After providing some demographic, clinical, and geographic information, the Society can provide information about available trials.

Why are some patients afraid of participating in a clinical trial?

One huge misconception about cancer clinical trials is that trial participants are treated like "guinea pigs." This is not true. Just as with standard care, individuals may have side effects or experience complications from treatments in trials, but great care and consideration goes into the health and safety of clinical trial participants in trial design and implementation. Participants also may drop out of the study at any time if they chose to do so.

Sponsors of clinical trials are monitored by several federal agencies to ensure participant safety, including the Office of Human Research Protections (OHRP) and the Food and Drug Administration (FDA). Trials are monitored closely at all times. For example, each Phase III trial is required to have a Data Safety Monitoring Board, which has the power to prematurely terminate a trial should the experimental therapy prove more effective than the standard therapy, or alternatively halt the trial immediately if significant adverse events arise. Each trial is responsible for meeting the Code of Federal Regulations for the Protection of Human Subjects and ensuring the safety of clinical trial participants. In order to do this, the trial must receive approval from an institutional review board (IRB).

How has clinical trial research help us win the cancer fight?

Cancer clinical trials have been dramatically successful in delivering progress for childhood cancer survival rates. Since 1960, mortality rates for all children with cancer have decreased 62%. Specifically, the survival rate for children with acute lymphocytic leukemia, the most common leukemia in children, has increased from 4% to approximately 80%.



Clinical Trials

The Costs of Patient Care

Numerous studies show that patient care in clinical trials costs approximately the same as care delivered in standard therapy. In some cases, because the third-party payer is not billed for the drug or treatment under investigation, care in a clinical trial can actually cost less than the care delivered in standard therapy.

Costs of patient care provided in a clinical trial are comparable to the costs of standard therapy.

Several studies on the costs of cancer clinical trials have been published in respected peer-reviewed publications.

- A pilot study conducted by the American Association of Cancer Institutes (AACI) showed that the total mean direct medical charges for patients enrolled in a clinical trial *were less than the charges for patients receiving standard therapy*.¹
- A December 2001 *Journal of Clinical Oncology* article similarly found that some clinical trials may actually result in *lower* patient care costs. In addition, in cases where trials resulted in modest increases in patient care costs, the authors concluded that these costs were justified by the benefits that clinical trials bring to all patients.²
- The Mayo Clinic has found that the cost of care for patients enrolled in clinical trials is often little more than for patients who received standard therapy.³
- Authors of a study conducted at Kaiser Permanente found that the cost of medical care for enrollees in clinical trials without bone marrow transplant were no higher than for patients who were not enrolled in a trial. Kaiser further states, "Kaiser has been participating in cancer clinical trials without substantial increases in the direct costs of medical care."⁴
- The most comprehensive study yet, published in 2003, also confirmed that there are only slightly higher patient-care costs associated with treating patients in cancer clinical trials compared to treating similar patients outside of trials.⁵

Some esteemed hospitals and universities have also conducted cost analysis studies.

- A study at Memorial Sloan-Kettering Cancer Center in New York City showed that the overall average cost of treating clinical trial patients was 17% *less* than treating patients receiving standard care.⁶
- A study conducted at the Karmanos Cancer Center in Detroit showed that the 6-month costs for treating advanced lung cancer were an average \$1,400 less for patients enrolled in a clinical trial.⁷

The Institute of Medicine has also concluded that the cost impact of providing coverage for routine patient care costs is likely to be "quite small."⁸ According to IOM, this is because:

- Reimbursement costs are limited to the cost of "standard care" which would be covered if the patient were not enrolled in the trial.
- Approximately 20% of adult cancer patients are eligible to participate in a clinical trial and approximately 3% of cancer patients actually do. Even if enrollment increased to the full 20% of eligible patients, it is unlikely that this would significantly impact overall costs to health plans.
- Through clinical trials, we will be able to also identify ineffective treatments, which could save health plans money and will benefit the nation as a whole.

Mandating coverage of routine care costs in clinical trials causes premiums to increase by less than 1%.

In general, mandates can potentially raise premiums. However, each mandate is different. Mandating that insurers pay for routine care costs in clinical trials has a minute effect on premiums. For instance, the Council for Affordable Health Insurance found that mandating coverage of routine care costs in clinical trials increased health insurance premiums by less 1%. There are several reasons for this.

- A small number of people enroll in clinical trials—roughly 3% of adult cancer patients.
- Routine care costs have been found to be, at most, marginally higher than care costs associated with standard treatment.

Sources:
1. Bennett CL, Stinson TJ, Vogel V, et al. Evaluating the financial impact of clinical trials in oncology: Results from a pilot study from the Association of American Cancer Institutes/Northwestern University Clinical Trials Costs and Charges Project. *J Clin Oncol* 2000;18:2805-10.
2. Bennett CL, Adams JR, Knox KS, Kelehan AM, Silver SM, Bales JS. Clinical trials: Are they a good buy? *J Clin Oncol* 2001;19:4330-9.
3. Wagner JL, Alberts SR, Sloan JA, et al. Incremental costs of enrolling cancer patients in clinical trials: a population-based study. *J Natl Cancer Inst* 1999;91:847-53.
4. Fireman BH, Fehrenbacher L, Gruskin EP, Ray GT. Cost of care for patients in cancer clinical trials. *J Natl Cancer Inst* 2000;92:136-42.
5. Goldman DP, Berry SH, McCabe MS, Kilgore ML, Potosky AL, Schoenbaum ML, Schonlau M, Weeks JC, Kaplan R, Escarot J. Incremental treatment costs in National Cancer Institute-sponsored clinical trials. *JAMA* 2003; 289: 2970-76.
6. Quirk J, Schrag D, Radzyner M, et al. Clinical trial costs are similar to and may be less than standard care and inpatient (InPT) charges at an academic medical center (AMC) are similar to major, minor, and non-teaching hospitals. *Proc Am Soc Clin Oncol* 2000;19:433a (abstr 1696).
7. Bennett CL, Stinson TJ, Vogel V, et al. Evaluating the financial impact of clinical trials in oncology: Results from a pilot study from the Association of American Cancer Institutes/Northwestern University Clinical Trials Costs and Charges Project. *J Clin Oncol* 2000;18:2805-10.
8. Aaron HJ, Gelband H, editors. Extending Medicare reimbursement in clinical trials. Washington, DC: National Academy Press; 2000. p 13.



Clinical Trials: What are States Doing? February 2009 Update



What is a Clinical Trial?

A clinical trial is a research study on human patients to test the safety and effectiveness of new treatments. These trials offer patients access to new and potentially life saving drugs and cures.

The dramatic progress made in treating childhood cancers in recent years, is attributable, in part, to clinical trials, because 60 percent of all children with cancer are enrolled in some kind of trial. A ten percent drop in breast cancer mortality for women under the age of 50 is said to be the result of clinical trials research conducted in the 1970's.

Who Enrolls in Clinical Trials?

Only two to three percent of eligible adult patients enroll in clinical trials. For cancer patients, clinical trials are often the last resort after exhausting all other approved means of treatment.

Only a small percentage (approximately 20%) of cancer patients are eligible to participate in a clinical trial and very few (approximately 3% of cancer patients and less than 0.5% of Medicare patients) currently enroll. Even if enrollment was increased to the full 20 percent, it is unlikely that these numbers will significantly impact overall costs to health plans;¹

Insurance Coverage for Clinical Trials

Typically, when a patient enrolls in a clinical trial, the cost of tests, procedures, drugs and any research activity directly associated with the investigation, are covered by the group sponsoring the trial, such as a pharmaceutical company or the National Cancer Institute.

However, because some health plans define clinical trials as "experimental" or "investigational," health insurance coverage may or may not include some or all of the costs of "routine patient care," such as the doctor visits, hospital stays, tests and x-rays, that a patient would normally receive whether or not they were enrolled in a trial.

A growing number of states have passed legislation or instituted special agreements requiring health plans to pay the cost of the routine medical care a patient receives as a participant in a clinical trial.

Advantages:

For cancer patients, properly designed and conducted clinical trials represent an important therapeutic option, as well as a critical means of advancing medical knowledge. Lack of insurance coverage is a barrier to patients who might otherwise participate. Sixty percent of patients in one survey cited fear of insurance denial as a major reason for not participating in clinical trials. And finally, a recent study found only a slight increase in treatment costs for adult clinical trial patients compared to nonparticipants--\$35,418 versus \$33,248.²

Some large HMOs have computed costs associated with patients in clinical trials. Kaiser Permanente discovered the cost of medical care for enrollees in clinical trials that haven't had bone marrow transplant were no higher than for patients who were not enrolled in a trial. The Kaiser report further states, "Kaiser has been participating in cancer clinical trials without substantial increases in the direct costs of medical care."³

Researchers at the Mayo Clinic found that patient care costs for those enrolled in clinical trials is only slightly more than for patients who received standard therapy protocols.⁴

The Institutes of Medicine has also found the following:

- The reimbursement costs are limited to the cost of "standard care" which would be covered if the patient were not enrolled in the trial;¹
- Only a small percentage (approximately 20%) of cancer patients are eligible to participate in a clinical trial and very few (approximately 3% of cancer patients and less than 0.5% of Medicare patients) currently enroll. Even if enrollment was increased to the full 20 percent, it is unlikely that these numbers will significantly impact overall costs to health plans;¹
- Through clinical trials, we will be able to identify ineffective treatments, which could save health plans money and will benefit the nation as a whole.¹

Disadvantages:

Even though the same recent study found only a slight increase in treatment costs, the 6.5 percent increase between participants and

nonparticipants in clinical trials translated into an additional \$16 million in 1999 spent on treatment costs for the 19,000 adult patients enrolled in National Cancer Institute-sponsored clinical trials.² These additional insurance costs, like other mandated benefits and services, may result in higher insurance premium rates, which are often cost-shifted onto workers in the form of higher deductibles and copayments.

For states without insurance mandates, it is possible that some physicians may enroll patients in clinical trials but not inform the patients' insurance companies, bypassing the reimbursement issue for the patient and potentially the physician.⁵

It may also be possible to encourage participation in clinical trials by working within networks of health care providers and industry, research facilities, patient groups, as well as major media outlets, without enacting a state wide insurance mandate.

Sources:

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Definitions of Phases:

A clinical trial study is conducted in four phases.

Phase I: Research is conducted on a small group of volunteers (20 to 80 people) for the first time to evaluate its safety, determine a safe dosage range and identify side effects.

Phase II: The experimental drug or treatment is given to or a procedure is performed on a larger group of people (100 to 300 individuals) to further measure its effectiveness and safety.

Phase III: Further research is conducted to confirm the effectiveness of the drug, treatment or procedure, monitor the side effects, compare commonly used treatments and collect information on safe use. Phase III trials are typically conducted on 1,000 to 3,000 individuals.

Phase IV: After the drug, treatment or medical procedure is marketed, investigators continue testing to determine the effects on various populations and whether there are side effects associated with long-term use.

Summary of State Laws as of December 2008

Table One provides a summary of the 23 states and District of Columbia that have enacted laws regarding mandated coverage of clinical trials.

Table One Clinical Trials Laws			
State Year of Enactment Bill Number and/or Citation	Who is Required to Pay?	What Services or Benefits are Covered?	Other Key Criteria:
Arizona (2000) Senate Bill 1213 20-2328	Hospital or medical service corporations, benefit insurers, health care service organizations, disability insurers, group disability insurers and accountable health plans	Patient costs associated with participation in Phase I through IV cancer clinical trials.	Trail must be reviewed by an Institutions Review Board in AZ. Health professional must agree to accept reimbursement from insurer as payment in full. Only covers trial when no clearly superior noninvestigational treatment exists. Trail must be in AZ.

California (2000) Senate Bill 37	All California insurers, including Medicaid and other medical assistance programs.	Routine patient care costs associated with Phase I through IV cancer clinical trials.	May restrict coverage to services in CA.
Connecticut (2001) Senate Bill 325 Public Act 01-171	Private insurers, individual and group health plans	Routine patient care costs associated with cancer clinical trials.	Prevention trials are covered only in Phase III and only if involve therapeutic intervention. Insurer may require documentation of the likelihood of therapeutic benefit, informed consent, protocol information and/or summary of costs.
Delaware (2001) Senate Bill 181	Every group of blanket policy, including policies or contracts issued by health service corporations	Routine patient care costs for covered persons engaging in clinical trials for the treatment of life threatening diseases under specified conditions.	Trial must have therapeutic intent and enroll individuals diagnosed with the disease. Trial must not be designed exclusively to test toxicity or disease pathophysiology.
District of Columbia (2008) Bill 17-469 (D.C. Law 17-166)	All insurers in the District	Routine patient care costs for people in clinical trials undertaken for prevention, early detection, treatment, or monitoring of cancer and approved or funded in full or in part by one of the following: National Institutes of Health or one of its cooperative groups or centers, Centers for Disease Control and Prevention, Agency for Health Care Research and Quality, Centers for Medicare and Medicaid Services, U.S. Food and Drug Administration (FDA), U.S. Department of Defense, U.S. Department of Veterans Affairs, U.S. Department of Energy, nongovernmental research entity that has been awarded a National Cancer Institute support grant.	Routine patient care costs shall not include tests or measurements conducted primarily for the purpose of the clinical trial involved. services or products provided solely for data collection and analysis purposes. services or products customarily provided free of charge to trial participants by the research sponsors.
Georgia* (1998) 33-24-59.1	Insurers and the state health plan	Routine patient costs incurred in Phase II and III of prescription drug clinical trial programs for the treatment of children's cancer.	For the treatment of cancer that generally first manifests itself in children under the age of 19.
Illinois (1999) House Bill 1622 (amended 2004) Senate Bill 2339 Public Act No. 93-1000 20 ILCS 1405/56.3**	HMOs and individual/group insurance policies to offer coverage to the applicant or policyholder (2004 amendment: Plans may not be canceled or non renewed based on an individual's participation in a qualified clinical trial)	Routine patient care if the individual participates in an approved Phase II through IV cancer research trial.	Coverage benefit can have annual limit of \$10,000. Trial must be conducted at multiple sites in state. Primary care MD must be involved in coordination of care. Researchers must submit results of trial for publication in nationally recognized scientific literature.
Louisiana (1999) RS 22:230.4	HMOs, PPOs, State Employee Benefits Program and other specified insurers	Patient costs incurred in Phase II through IV cancer clinical trials.	Only covers costs when no clearly superior, noninvestigational approach exists. Available data must support reasonable expectation that the treatment will be as effective as the noninvestigational alternative. Patient must sign an Institutional Review Board-approved consent form.
Maine (2000) 24-A-4310	Managed care organizations and private insurers	Routine patient care costs associated with clinical trial.	Participation must offer meaningful potential for significant clinical benefit. Referring physician must conclude that trial participation is appropriate.

Maryland*** (1998) Chap 146-15-827	Private Insurers and other specified managed care organizations.	Patient costs for Phase I through IV cancer treatment, supportive care, early detection, and prevention trials. Phase II through IV for other life-threatening conditions, with Phase I considered on a case-by-case basis.	There is no clearly superior, noninvestigational alternative. The data provide a reasonable expectation that the treatment will be as least as effective as the alternative.
Massachusetts (2002) Chap 176A Sec 8X	All health plans issued or renewed after Jan. 1, 2003	Patient care services associated with all phases of qualified cancer clinical trials.	Insurers must provide payment for services that are consistent with the usual and customary standard of care provided under the trial's protocol and that would be covered if the patient did not participate in the trial.
Missouri (2002) 376.429 (2006)- Phase II SB 567 & 792	All health benefit plans operating in the state	Routine patient care costs as the result of Phase II, III or IV clinical trials for the prevention, early detection, or treatment of cancer.	There must be identical or superior noninvestigational treatment alternatives available before providing clinical trial treatment, and there must be a reasonable expectation that the trial will be superior to the alternatives. Requires coverage of FDA-approved drugs and devices even if they have not been approved for use in treatment of patient's particular condition.
New Hampshire (2000) 415:18	Private insurers and specified managed care plans	Medically necessary routine patient care costs incurred as a result of a treatment for Phase I through IV cancer clinical trial or trial for a life-threatening disease.	Coverage for Phases I or II decided on a case-by-case basis. Coverage is required for services needed to administer drug or device under evaluation. Coverage is required for routine patient care associated with drugs or devices which are not subject of trial, as long as they have been approved by FDA.
Nevada (2003) (amended 2005) SB 29 NRS 695G.173	All health insurance insurers, medical service corporations, HMOs and managed care organizations	Patient costs associated with Phase I through IV cancer or chronic fatigue clinical trial	Healthcare facility and personnel must have experience and training to provide the treatment in a capable manner. There must be no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial. There must be a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment. Amendment revises type of medical treatment covered.
New Mexico (2002) (amended 2004 to delay repeal until July 1, 2009) 59A-22-43	A health insurer; a nonprofit health service provider; a HMO; a managed care organization; a provider service organization; or the state's medical assistance program.	Routine patient care costs incurred as a result of the patient's participation in a phase II, III or IV cancer clinical trial.	Must be undertaken for the purposes of the prevention of reoccurrence of cancer, early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists. Must not be designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent. Must be provided as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which includes specific provisions of scientific study.
New Mexico	Private insurers,	Routine patient care costs incurred as result of	Effective through July 1, 2004.

(2001) 59A-22-43	specified managed care plans, and Medicaid and other state medical assistance programs	Phase I through IV cancer clinical trial.	Trial must have therapeutic intent. Reasonable expectation that investigational treatment will be at least as effective as standard treatment.
North Carolina (2001) ? 58-3-255	All health insurance plans and teachers' and state employees' comprehensive major medical plan.	Medically necessary costs of health care services associated with Phase II through IV of covered clinical trials.	Patients suffering from a life-threatening disease or chronic condition may designate a specialist who is capable of coordinating their health care needs.
Ohio (2008) ORC Ann. 1751.01 (2008)	All health benefit plans including those for public employees.	Medically necessary costs of health care services associated with any stage of clinical trial.	Trial must be approved by NIH or another group under HHS, FDA, DOD or VA. May exclude coverage for service or product that is part of the investigative trial, item or procedure used only for data collection for the trial, item not approved by FDA, and transportation, lodging and food related to travel for participation in the trial.
Rhode Island (1994, 1997) 94-S 2623B 97-S 1A am	Private insurers and specified managed care plans	Coverage for new cancer therapies if treatment is provided under Phase II through IV cancer clinical trial.	
Tennessee (2005) HB 837	All health benefit plans	Routine patient care costs related to Phase I through IV cancer clinical trial.	Treatment must involve drug that is exempt under federal regulations from a new drug application, or approved by: NIH, FDA in form of new drug application, DOD, or VA.
Vermont (2001) (amended 2005 to remove March 1, 2005 sunset provision) Chap 107 7 4088b HB 6	All health insurance policies and health benefit plans, including Medicaid	Routine patient care costs incurred during the participation in a cancer clinical trial.	Providers and insurers required to participate in a cost analysis to determine impact of the program on health insurance premiums. Amended law allows for participation in trial outside of Vermont if patient notifies health benefit plan prior to participation, and no clinical trial is available at Vermont or New Hampshire cancer care providers.
Virginia (1999) ? 38.2-3418.8	Private insurers, specified managed care plans, and public employee health plans	Patient costs incurred during the participation in Phase II through IV cancer clinical trials. Coverage provided on a case-by-case basis for Phase I.	There must be no clearly superior, noninvestigational alternative. Data must provide a reasonable expectation that the treatment will be at least as effective as the alternative.
West Virginia (2003) 29-2-12	Individual and group insurers, health service corporations, health care corporations, HMOs, public employees insurance agency, Medicaid and the children's health insurance program	Patient costs associated with the participation in Phase II through IV clinical trial for treatment of life-threatening condition or the prevention, early detection and treatment of cancer.	Facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise. There must be no clearly superior, noninvestigational treatment alternative. Data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative.
Wisconsin AB 617 (2006) Act 194	Any health insurance plan offered by the state, any self-insured plans	Routine patient care costs incurred during the participation in all phases of a cancer clinical trial. No policy, plan, or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in a cancer	Trial must meet all criteria: 1. The purpose is to test whether the intervention potentially improves the trial participant's health outcomes. 2. The treatment provided as part of the trial is given with the intention of

		clinical trial satisfying the criteria under par. (c) and that would be covered under the policy, plan, or contract if the insured were not enrolled in a cancer clinical trial.	<p>improving the trial participant's health outcomes.</p> <p>3. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.</p> <p>4. The trial does one of the following:</p> <p>a. Tests how to administer a health care service, item, or drug for the treatment of cancer.</p> <p>b. Tests responses to a health care service, item, or drug for the treatment of cancer.</p> <p>c. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.</p> <p>d. Studies new uses of health care services, items, or drugs for the treatment of cancer.</p> <p>5. The trial is approved by one of the following:</p> <p>a. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services; federal food and drug administration; federal department of defense; federal department of veterans affairs.</p>
Wyoming SF 024 (2008 budget session)	All health insurance policies, contracts, and certificates providing coverage to any resident of this state.	Routine patient care for a person enrolled in a Phases II- IV clinical trial. Includes a medical service or treatment that is a benefit under a health plan that would be covered if the patient were receiving standard cancer treatment; or a drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal food and drug administration for use in treating the patient's particular condition.	<p>Trial must also be approved by NIH, FDA, Dept. of Defense, or Dept. of Veterans Affairs. The medical treatment must be provided by a licensed health care provider operating within the scope of his/her license in a facility whose personnel has the experience and training necessary to provide the treatment in a competent manner.</p> <p>The clinical trial participant must have signed an informed consent document prior to starting the trial.</p>

*In 2002, all major insurers in Georgia agreed to cover routine patient care costs associated with Phase I, II, III, or IV cancer clinical trials. Trials include those that involve a drug that is currently exempt under federal regulations from a new drug application or those that are approved by specified federal agencies or a local institutional review board. The agreement also provides for the coverage of cancer screens and examinations in accordance with the most recently published guidelines and recommendations established by any nationally recognized health care organization (see below).

**Illinois Executive Branch Administrative Code (20 ILCS 1405/1405-20) required the Department of Insurance to conduct an analysis and study of costs and benefits derived from the implementation of the coverage requirements for investigational cancer treatments. The study covered the years 2000 through 2002 and included an analysis of the effect of the coverage requirements on the cost of insurance and health care, the results of the treatments to patients, the mortality rate among cancer patients, any improvements in care of patients, and any improvements in the quality of life of patients.

***A 2003 Maryland law (S 128) repealed a reporting requirement for insurers, nonprofit health service plans, and HMOs to submit a report that described the trials covered during the previous year.

Sources: National Cancer Institute, Health Policy Tracking Service.

Summary of Other Actions

Table Two summarizes the special agreements some states have arranged with insurance companies to voluntarily provide coverage for

clinical trials.

Table Two Special Agreements			
State (Year Agreement Became Effective)	Who is Required to Pay?	What Services or Benefits are Covered?	Other Key Criteria:
Georgia (2002) <u>Georgia Cancer Coalition</u>	All major insurers	Routine patient care costs associated with Phase I through IV cancer clinical trials.	Trials include those that involve a drug that is currently exempt under federal regulations from a new drug application or those that are approved by specified federal agencies or a local institutional review board. Provides for the coverage of cancer screens and examinations in accordance with the most recently published guidelines and recommendations established by any nationally recognized health care organization.
Michigan (2002) Michigan Consensus Agreement	Private insurance plans, HMOs and Medicaid	Routine patient care costs associated with Phase II and III cancer clinical trials.	Coverage for Phase I trials is under consideration.
New Jersey (1999) New Jersey Consensus Agreement	All insurers	Routine patient care costs associated with all phases of cancer clinical trials.	
Ohio (1999) Ohio Med Plan	State employees on Ohio Med Plan	Routine patient care costs associated with Phase II and III cancer treatment clinical trials.	Preauthorization is required for clinical trial participation.

Federal Activity

In 2000, Medicare began covering beneficiaries patient care costs in clinical trials. While many state Medicaid programs have no legal requirements to cover clinical trials costs, many do cover all or some of the costs.

Additional Resources

American Cancer Society, National Government Relations memo on Clinical Trials.
http://www.indianacancer.org/documents/factsheet_ACS_clinical%20trials.pdf

National Cancer Institute, States That Require Health Plans to Cover Patient Care Costs in Clinical Trials. Information and Overview: <http://www.cancer.gov/clinicaltrials/ctlaws-home>

To legislators and legislative staff: For more information please contact Karmen Hanson at health-info@ncsl.org

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POSITION PAPER ON HEALTH PLAN COVERAGE FOR PATIENT CARE COSTS IN CANCER CLINICAL TRIALS

Sponsored by the Denali Oncology Group, the Alaska State Affiliate of the American Society of
Clinical Oncology

February 14, 2009

BACKGROUND:

1. Clinical trials for cancer patients provide state-of-the-art treatment for patients with life-threatening diseases. Cancer patients and their physicians typically look to clinical trials as an option when the investigational treatment offers as much or more benefit than standard treatment.
2. Currently, in Alaska, health plans can exclude coverage for routine patient care costs while a patient with cancer is enrolled on a clinical trial.
3. Since 2000, Medicare has provided coverage for beneficiaries for routine costs associated with cancer clinical trial enrollment. Results have shown increased enrollment, while no increase in cost has been identified.
4. Twenty-four states in the United States plus the District of Columbia have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care a patient receives while participating in a clinical trial.
5. Some health plans mistakenly think that money is saved by excluding care when patients participate in clinical trials. However, if not enrolled on a clinical trial, these patients will continue to receive conventional therapy. Studies have shown that there are not significant differences in cost of care for patients enrolled on clinical trials compared with patients on conventional therapy.
6. Results of clinical trials lead to more rational use of cancer treatment and more successful outcomes, resulting in short-term and long-term cost savings.

PROPOSED LEGISLATION:

We propose that the Senate and House of the State of Alaska pass a bill requiring that all health care plans, including Medicaid, cover routine patient care costs for patients enrolled in all phases of clinical trials, including prevention, detection, treatment and palliation (supportive care) of cancer.

BENEFITS:

1. Passage of this bill will remove an important barrier to the participation of patients in cancer clinical trials. It will result in physicians more often recommending patient participation and in patients having greater desire to enroll in clinical trials.
2. Greater participation by Alaskans in cancer clinical trials will result in improved care of our patients in the short- and long-term, improved doctor-patient relationship, increased patient satisfaction with treatment, and increased retention of patients in Alaska for their cancer care.
3. Alaska will be in the forefront in making meaningful progress in providing care for cancer and other life threatening conditions.

REFERENCES:

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<http://www.cancer.gov/clinicaltrials/learning/laws-about-clinical-trial-costs>
2. Clinical Trials and Insurance Coverage - A Resource Guide
<http://www.cancer.gov/clinicaltrials/learning/insurance-coverage/page1>
3. Coverage of Routine Patient Care Costs in Clinical Trials Position Statement
http://www.asco.org/asco/downloads/patient_care_costs_3.05.pdf
4. American Society of Clinical Oncology Response to CMS Town Hall Meeting "The Effect of Coverage and Payment on Clinical Research Study Participation and Retention" September 10, 2007
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American Society of Clinical Oncology

February 17, 2009

The Honorable Bettye Davis
Alaska State Senator
District K
Capitol Building Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

The Denali Oncology Group and American Society of Clinical Oncology are pleased to offer support for your legislation to require insurance coverage for people who participate in clinical trials. Our organizations represent physicians specializing in cancer treatment and clinical research, and clinical research is a vital mission of our membership.

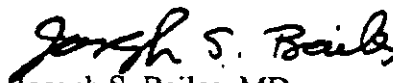
Clinical trials are critically important because they offer the promise of new cancer treatments. As you know from personal experience, they also provide an essential, state-of-the-art treatment option for current cancer patients. Therefore, insurance coverage of the routine patient care costs associated with clinical trials is vital for cancer patients.

For many people with cancer, participation in a clinical trial is often their best treatment option. Yet, as you know, many third-party payers take the position that routine patient care costs should be denied to anyone who enrolls in such trials. We believe such policy deprives beneficiaries of the value of their health insurance, wrongly restricts their treatment options, and inhibits medical progress against serious and life-threatening diseases. DOG and ASCO believe that insurers should cover all routine care costs for patients who are enrolled in cancer clinical trials. Your legislation is the key to making this happen.

DOG and ASCO applaud your leadership in pursuing legislation that provides this essential element of quality cancer care. We are eager to work with you to ensure passage. Please do not hesitate to contact Suanna Bruinooge, ASCO's Director of Research Policy, at 571-483-1613 or suanna.bruinooge@asco.org, or Dr. Mary Stewart at mstewartonc@yahoo.com or 907-279-3155.

Sincerely,

Mary Stewart, MD
President, Denali Oncology Group


Joseph S. Bailes, MD
Chair, ASCO Government Relations Council



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**American Society of Clinical Oncology
Statement In Support of Insurance Coverage for Clinical Trials**

With more than 26,000 members worldwide, ASCO is the leading medical society for physicians involved in cancer treatment and research. Engagement in clinical research is a vital mission of ASCO members. Unfortunately, many cancer patients have limited curative treatment options and enrollment in a clinical trial may offer hope for a response to a new drug or other intervention. Oncologists want their patients to consider enrolling in clinical trials, not only because of potential treatment benefits for the individual patient but also because it is through these trials that general progress against cancer is achieved. Patients are usually eager to participate if given the opportunity. ASCO considers the opportunity to participate in cancer clinical trials as an essential element of quality cancer care.

Unfortunately, participation in clinical trials is significantly deterred by the prospect that insurance coverage may be withheld on the ground that treatment provided in trials is "experimental" or "investigational." This position has been effectively discarded by the federal Medicare program, as well as by the Department of Defense health care system, and by many states. ASCO strongly supports state and federal efforts to ensure that patients enrolled in clinical trials receive coverage for the routine health care costs that would be covered if they did not participate on a trial. It is a basic issue of fairness, and it will help ensure that we continue to improve treatment options for cancer patients and learn about this devastating group of diseases.

What is a Clinical Trial?

Clinical trials are research studies involving people. Clinical trials are designed to evaluate whether a new treatment is safe, effective, and better than the current standard of care. These interventions can include new drugs, new combinations of existing therapies, new approaches to radiation therapy or surgery, new methods of treatment, complementary or alternative therapies, and new prevention methods. Cancer clinical trials are designed to compare an investigational therapy with the standard treatment regimen being used at the time. Placebo-controlled clinical trials in cancer research are rare, but are used when there is no effective, standard treatment available.

Cancer clinical trials have led to scientific advances that have increased doctors' understanding of how and why tumors develop and grow. The knowledge gained has helped scientists and doctors develop new ideas on how



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to slow, halt, and even prevent the development of the disease. Clinical trials are the most reliable route to definitive answers and are the only accepted scientific method to determine if a new treatment works better than the current standard of care.

Clinical trials undergo rigorous review prior to opening and involve regular oversight during and after a trial to protect the safety and rights of the participants involved. Each clinical trial follows a set of rules called a protocol. A protocol describes inclusion and exclusion criteria; the schedule of tests, procedures, medications, and doses; and the length of the study. While in a clinical trial, participants are seen regularly by the research staff to monitor their health and determine the safety and effectiveness of the treatment.

Precedents for Clinical Trials Coverage

For more than two decades, the cancer community has expressed its concerns about the negative impact of restrictions on coverage of clinical trials by third-party payers, both public and private. Such restrictions are harmful not only to individual patients but also to overall progress against cancer. In 1999, public authorities began to respond favorably to these arguments and to reform their coverage policies with respect to clinical trials.

Pursuant to a negotiated agreement between the National Cancer Institute (NCI) and the Department of Defense (DoD), the DoD's TRICARE health care plan commenced coverage of NCI-sponsored clinical trials in 1999. The original agreement, began as a pilot project, was made a permanent benefit in March 2008, accompanied by a DoD press release describing it as "a long successful project between the NCI and DoD."

In 2000, the Medicare program took a more expansive approach to clinical trial coverage. In an Executive Memorandum, President Clinton instructed Medicare officials to adopt a clinical trials policy covering not just cancer trials but all diseases and all phases. To implement the policy, the Centers for Medicare & Medicaid Services (then the Health Care Financing Administration) published a National Coverage Determination in September 2000.

State governments have also been active in ensuring coverage of clinical trials by private insurance plans under their control. Almost half of the states throughout the U.S. enjoy coverage of clinical trials, either through legislation



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or through voluntary consensus agreements with insurers, and more are considering such requirements.

Impact of Policy Changes on Clinical Trial Participation

One of the nation's leading cooperative research groups, the Southwest Oncology Group (SWOG), has conducted studies that underscore the impact of the Medicare coverage policy on clinical trial participation among the elderly. In 1999, SWOG published a study finding significant underrepresentation of the elderly in cancer clinical trials.¹ The study found that, whereas 63% of cancer patients were Medicare eligible, seniors were only 25% of those patients participating in SWOG clinical trials during the period 1993-1996. Following the Medicare coverage policy in 2000, a second SWOG study found there was a significant increase in participation among Medicare beneficiaries, with seniors representing 38% of SWOG trial participants in the period 2001-2003.²

Cost of Clinical Trials Coverage

While there have been no definitive studies of the cost consequences of clinical trial coverage, there have been a series of articles finding that participation in clinical trials "did not result in substantial increases in the direct costs of medical care,"³ that "[c]linical protocols may add relatively little to that cost,"⁴ and that "additional costs of an open reimbursement policy for government-sponsored cancer clinical trials appear minimal."⁵ And with almost eight years of experience with the 2000 Medicare coverage policy, there is no evidence of increased cost to the program.

Conclusion

In light of the experience described above, we heartily support efforts to ensure that health plans and all insurers provide coverage for the routine costs

¹ Hutchins et al., "Underrepresentation of Patients 65 Years of Age or Older in Cancer-Treatment Trials," *N Engl J Med* 341: 2061-2067 (1999).

² Unger et al., "Impact of the Year 2000 Medicare Policy Change on Older Patient Enrollment to Cancer Clinical Trials," *J Clin Oncol* 24:141-144 (2006).

³ Fireman et al., "Cost of Care for Patients in Cancer Clinical Trials," *J Natl Cancer Inst* 92:136-142 (2000).

⁴ Wager et al., "Incremental Costs of Enrolling Cancer Patients in Clinical Trials: a Population-Based Study," *J. Natl. Cancer Inst* 91:847-853 (1999).

⁵ Goldman et al., "Incremental Treatment Costs in National Cancer Institute-Sponsored Clinical Trials," 289:2970-2977 (2003).

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associated with clinical trials participation. ASCO members strive to ensure access to the best treatment options for their cancer patients, and this requires that health insurers offer clinical trials coverage. We think it is clear that best cancer care and best health care coverage require access to high quality cancer clinical trials.



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American Society of Clinical Oncology

December 1, 2008

Kevin J. Cullen, MD
Director, University of Maryland
Marlene and Stewart Greenebaum Cancer Center
22 South Greene Street
Baltimore, MD 21201

Dear Dr. Cullen:

This letter is written in follow-up to our recent discussions about Medicare coverage of routine patient care costs for beneficiaries participating in phase I cancer clinical trials. As the world's leading professional and scientific organizations representing oncology cancer care professionals, we write to affirm our position that phase 1 cancer clinical trials are the essential gateway for advancement of new cancer treatments—and a vital component of our cancer treatment armamentarium.

It is the view of the undersigned organizations that the current Medicare National Coverage Determination (NCD) (310.1) for Routine Costs in Clinical Trials explicitly includes coverage of phase I cancer clinical trials and that these trials should be covered.

Requirements for Medicare Coverage

The NCD lays out three basic requirements for Medicare coverage:

- The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physicians' service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).
- The trial must not be designed exclusively to test toxicity or disease pathophysiology. It must have therapeutic intent.
- Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.

The NCD also requires that clinical trials covered under the policy have seven "desirable characteristics."

1. The principal purpose of the trial is to test whether the intervention potentially improves the participants' health outcomes;
2. The trial is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

3. The trial does not unjustifiably duplicate existing studies;
4. The trial design is appropriate to answer the research question being asked in the trial;
5. The trial is sponsored by a credible organization or individual capable of executing the proposed trial successfully;
6. The trial is in compliance with Federal regulations relating to the protection of human subjects; and
7. All aspects of the trial are conducted according to the appropriate standards of scientific integrity.

The policy also states that certain trials "are presumed to meet these characteristics and are automatically qualified to receive Medicare coverage." Trials that are automatically deemed include:

1. Trials funded by NIH, CDC, AHRQ, CMS, DOD, and VA;
2. Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD and VA;
3. Trials conducted under an investigational new drug application (IND) reviewed by the FDA; and
4. Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) will be deemed automatically qualified until the qualifying criteria are developed and the certification process is in place. At that time the principal investigators of these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status."

Phase 1 Cancer Clinical Trials Have Therapeutic Intent

The National Cancer Institute's (NCI) Investigator Handbook is instructive as to the therapeutic intent of a Phase I trial. That handbook includes the following information about phase 1 cancer clinical trials (emphasis added):

Phase 1 trials determine a safe dose for Phase 2 trials and define acute effects on normal tissues. In addition, these trials examine the agent's pharmacology and may reveal evidence of antitumor activity. **Therapeutic intent is always present in Phase 1 trials; indeed, anticancer agents are not tested in patients unless preclinical activity studies have already demonstrated evidence of significant activity in laboratory models.**¹

The Food and Drug Administration (FDA) has also adopted a definition of phase 1 trials that is consistent with the NCI's definition. FDA states that phase 1 studies "are designed to determine the metabolic and pharmacologic actions of the drug in humans, the side effects associated with increasing doses, and, if possible, to gain early evidence of effectiveness." This early evidence of effectiveness is the grounding for therapeutic intent – both in the choice of oncologists and patients to enroll in the trial, and as one of the aims of the trial.

Although the scientific goals of a phase 1 trial are to determine the toxic effects, pharmacologic behavior, and recommended doses for future study of a new agent, there is always a strong preclinical

¹ Available on the NCI website at <http://ctep.cancer.gov/handbook/index.html>


rationale for bringing the drug into the clinic with the expectation of positive clinical outcomes for some patients.² In fact, Institutional Review Boards would not permit the administration of potentially toxic treatments to patients unless there was some reasonable prospect of antitumor effect.³ It is also important to note that phase 1 oncology treatment trials are never done in healthy volunteers because of the potential toxicities associated with the treatments under investigation.

Additionally, many of the NCI phase 1 trials involve agents that are already approved for the treatment of one type of cancer and are being studied in a different type of cancer, or in combination with other treatments. As a result, we have some evidence of therapeutic effectiveness that provides solid grounding on which to base therapeutic intent. Indeed, an analysis of 12,000 individuals who participated in 460 NCI-funded phase 1 trials done in 2005 found that 10.6% of patients experienced an objective response. This number increased to 17.8% of patients when one drug included in the trial regimen was already FDA-approved.⁴

Furthermore, our growing knowledge of the molecular basis of cancer is allowing us to increasingly develop treatments that are targeted to particular molecular pathways and personalized to specific patient populations. These types of agents will provide a "high pretreatment probability of achieving both an objective response and more subjective clinical benefit" for the trial participants.⁵

To bring about these exciting new developments in cancer treatment, clinical trials participation is required. It is particularly important in the Medicare-aged population not only because of the increased incidence of cancer in the elderly and but also to develop our understanding of how treatments work in this population. Both the NCI and FDA definitions demonstrate that phase 1 oncology trials meet the requirements for Medicare coverage, including therapeutic intent, and should be covered.

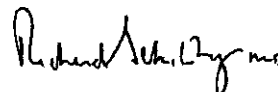
Sincerely,



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Edward J. Benz, Jr., MD
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January 27, 2009

Medicare Widens Drugs It Accepts for Cancer

By REED ABELSON and ANDREW POLLACK

Medicare, with little public debate, has expanded its coverage of drugs for cancer treatments not approved by the Food and Drug Administration.

Cancer doctors had clamored for the changes, saying that some of these treatments, known as off-label uses, were essential if patients were to receive the most up-to-date care. But for many such uses there is scant clinical evidence that the drugs are effective, despite costing as much as \$10,000 a month. Because the drugs may represent a patient's last hope, though, doctors are often willing to try them.

The new Medicare rules are the latest twist in a protracted debate over federal spending on off-label drugs — drugs prescribed for uses other than those for which they have been specifically approved.

Proponents of the changes say such spending not only helps patients, but can also enhance medical understanding of which treatments work against various forms of cancer.

But opponents argue that the new approach may waste money and needlessly expose patients to the side effects of drugs that may not help them. They also raise the possibility of conflicts of interest, because the rules rely on reference guides that in some cases are linked to drug makers.

The new policy, which took effect in November, makes it much easier to get even questionable treatments paid for, critics of the changes say. Medicare is providing "carte blanche in treatment for cancers," said Steven Findlay, a health policy analyst for Consumers Union. He said overly expansive coverage encourages doctors to use patients as guinea pigs for unproved therapies.

Because Medicare officials canceled a cost analysis of the changes, it is hard to predict how much spending will increase beyond the \$2.4 billion Medicare paid in 2007 for cancer drugs. But cancer doctors and other experts say the new policies, adopted in the final months of the Bush administration, seem almost certain to raise the federal drug bill, while making it more difficult for the new administration to rein in spending on unproven medical treatments.

Although President Obama has made a goal of controlling health care costs, a spokesman for the Obama administration declined to comment on the Medicare changes.

One of the many drugs whose use is likely to expand is the Eli Lilly product Gemzar, which costs \$2,500 to \$5,000 a month. The F.D.A. has approved it to treat only four types of cancer. But the new rules will virtually guarantee that Medicare will pay for its use for about a dozen other cancers, including advanced cervical cancer — even though the evidence supporting Gemzar for that use is "inconclusive," according to one of the reference guides Medicare will now be consulting.

In the case of Genentech's Avastin, one of the world's most expensive and widely used cancer drugs, Medicare

rejected in 2007 nearly all of the estimated \$16 million in requests from doctors' offices to cover its off-label use for ovarian cancer, according to claims specialists who work with Medicare data but declined to be identified because of the controversy over the topic. Under the new rules, Avastin will be routinely covered for ovarian cancer — as will at least some other off-label uses, including for brain and kidney cancer.

It is unclear how much precedent Medicare's new rules might have on private insurers, which often follow the agency's lead on paying for drugs.

Medicare officials defend the new policies, saying they respond to cancer doctors' concerns that the agency has been too slow to recognize promising new off-label treatments. Dr. Steve Phurrough, who has overseen coverage for the agency since 2003, noted that a 1993 federal law gave Medicare specific authorization to cover some unapproved uses of cancer drugs.

"Congress wanted a lesser level of evidence," Dr. Phurrough said. The question of what is adequate evidence is "not a line in the sand," he said. "It's a broad stripe in the sand."

The American Society of Clinical Oncology, which represents cancer doctors, has hailed the new rules, saying they will ensure that the appropriate off-label uses are covered.

But some specialists say that being able to offer off-label drugs can also let physicians avoid hard discussions with patients about a grim prognosis.

"It makes it easier to give drug after drug," said Dr. Andrew Berchuck, director of gynecologic oncology at Duke University, "and keep the fantasy alive."

The new rules expand the number of reference guides — or compendiums — that Medicare relies on for determining which off-label uses of cancer drugs to cover. The writers and editors of these compendiums, who work completely outside the federal government, scan the medical literature and evaluate the evidence in making their recommendations.

In 1993, Congress had authorized three compendiums for Medicare, all published by not-for-profit organizations. But by 2007 two had stopped publishing, leaving Medicare with a single compendium. Having selected three additional guides last year, the agency plans to review its choice of guides every year.

Under the old rules, Medicare representatives were supposed to consult the compendiums but also use their own discretion in interpreting the guides' recommendations. The new rules essentially delegate the decision to guides Medicare has selected, even when there is little clinical evidence behind a particular recommendation. As long as at least one of them recommends a cancer treatment, Medicare is essentially obliged to pay for it — unless one of the other guides specifically advises against it.

And some of these new compendiums have close financial ties to the drug industry, according to the draft of a report Medicare commissioned last year after Congress raised questions about possible conflicts of interest. The draft was completed in October, with a final version to be released soon.

The draft criticizes the new rules for essentially taking most decisions about off-label cancer drugs out of Medicare's hands, even when the agency is aware of potential conflicts. The guide's recommendation, the report says, "becomes the final word."

For some experts, the bigger concern about using some cancer drugs off-label without adequate evidence is that they may not only be useless — they may cause dangerous side effects.

"We have very little faith that those indications that make it into the compendia are safe, let alone effective," said Dr. Allan M. Korn, the chief medical officer for the Blue Cross and Blue Shield Association, who added that Medicare should cover off-label drugs only if the results of their use are carefully tracked afterward. There is no such requirement in the new Medicare guidelines.

There have been three different top Medicare administrators since the off-label rule changes were set in motion a few years ago. The second of them, Leslie V. Norwalk, chose to select the compendiums through a streamlined and internal administrative process, instead of the more elaborate and public process that Medicare often uses for broad coverage decisions.

"I did not see it as a significant step in coverage," said Ms. Norwalk, who left Medicare in 2007.

Drug makers say they welcome the Medicare changes. A spokesman for the Pharmaceutical Research and Manufacturers of America, the industry's main trade group, said the new rules ensured "that cancer patients have access to the treatments they need."

Many oncologists say they needed greater flexibility in using cancer drugs because it can take months or years for a new use to be approved by the F.D.A. They cite the example of Celgene's drug thalidomide, now a mainstay treatment for multiple myeloma, which was prescribed only off-label for years before the F.D.A. formally approved it for that use.

And in the case of rare types of cancer, there may be so few potential patients that companies have little financial incentive to undergo the formal F.D.A. process for approving a drug for expanded use. Only two drugs have been approved by the F.D.A. for brain cancer, for example, and cancer doctors say they need the ability to try other drugs or other combinations of treatments.

"To arbitrarily stop after two drugs to me is ludicrous," especially for younger patients, said Dr. Virginia Stark-Vance, a solo practitioner in Dallas and Fort Worth. She said one of her brain cancer patients had been kept alive for 10 years by off-label use of irinotecan, a colon cancer drug that was the ninth drug the patient tried.

Medicare seems to have ignored some concerns raised by a group of outside researchers whom the agency had asked to survey a half-dozen compendiums, including the four that Medicare has now adopted. That report, completed in 2007, found that the six guides "cited very little of the available evidence," said Dr. Amy P. Abernethy, a Duke oncologist who led the study.

The study also found great variability among the guides, in terms of what uses were recommended — or discussed at all.

Despite her study's findings, Dr. Abernethy says she does not oppose Medicare's new rules.

"I think the addition of the new compendia this year is an important increase in the bandwidth," she said.

Critics say the agency also seems to have played down the potential financial conflicts of interests between the drug industry and the producers of the compendiums. The draft study that was completed in October notes that one of the new guides is published by the National Comprehensive Cancer Network, a group of 21 leading

cancer centers that routinely employs experts who have financial ties to the drug industry.

William T. McGivney, the network's chief executive, said each committee of reviewers had 20 to 30 members, which "diminishes the opportunity for dominance of one person's opinion," regardless of any ties to drug makers.

Then there is the American Hospital Formulary compendium, the one that Medicare was using before the November changes and will continue to consult. It has long been published by the nonprofit American Society of Health-System Pharmacists. But last year the society forged a financial relationship with a foundation linked to drug companies and some cancer doctors' private practices.

A drug company can apply to that foundation, the Foundation for Evidence-Based Medicine, and pay a \$50,000 fee to have new uses of its drug reviewed by the compendium within 90 days. The foundation was started in 2007 by the Association of Community Cancer Centers, which represents oncology practices, and says it received about \$200,000 in initial funding from drug makers.

Gerald K. McEvoy, the guide's editor in chief, said the application fee was meant to raise money to pay for additional researchers, to address previous criticism that the publication was too slow to vet new evidence. The foundation insulates the guide's staff from industry pressure, he said, and fewer than one-third of the reviews under the new arrangement have resulted in a positive recommendation in the compendium.

Medicare officials acknowledge that some of the potential conflicts need to be addressed. But they say they have confidence in the guides they have chosen. "We had significant conversations with all the companies," Dr. Phurrough said.

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Coverage of Routine Patient Care Costs in Clinical Trials Position Statement

Approved by the ASCO Board of Directors, March 2005

For people with serious or life-threatening illness, like cancer, completely satisfactory or curative treatment often is not available. Those patients are nevertheless able to receive state-of-the-art therapy through high-quality clinical trials, offering not only an important treatment option but an opportunity to advance medical knowledge.

Cancer patients face a number of obstacles to clinical trials enrollment. One of the barriers is the potential denial of third party payment for the routine patient care costs for those enrolled in clinical trials. Historically, payers have denied coverage for care provided in a clinical trial, arguing that such care is "experimental" and therefore not a covered benefit.

Current Clinical Trials Coverage

The American Society of Clinical Oncology (ASCO) and its partners in the patient advocacy community have sought, over the course of more than a decade, to reform clinical trials payment policy in public and private health plans. These efforts have resulted in reforms in Medicare payment policy and in enactment of legislation to ensure clinical trials coverage in more than 20 states.

In 2000, in response to Congressional pressure and cancer community advocacy, the Clinton Administration issued an Executive Memorandum setting a policy for coverage of the routine patient care costs for Medicare beneficiaries enrolled in clinical trials for all diseases.

In addition to action by Medicare, a number of states have enacted legislation that would ensure coverage of routine patient care costs in clinical trials (coverage ranges from cancer clinical trials only to trials for all diseases) by those health plans that are regulated by the state. Some of those states have adopted, either in statute or in implementing regulations, the coverage standards of the Medicare program. In several states without clinical trials coverage mandates, third party payers have entered into voluntary agreements to cover routine costs in clinical trials. States continue to engage in efforts to improve coverage in state plans.

ASCO Position

These federal, state, and private sector initiatives reflect widespread recognition of clinical trials coverage as a critical element of quality cancer care. However, not all of the initiatives meet the standards for coverage endorsed by ASCO, and a significant number of cancer patients remain beyond the reach of these reimbursement reforms. ASCO recommends that every cancer patient should have access to clinical trials under the criteria defined below.

Standards for Clinical Trials Coverage

The following ASCO standards should remain the standard for Medicare coverage and should serve as the model for state legislative initiatives, including provisions governing coverage under state-funded programs like Medicaid, as well as mandates for private insurance and managed care plans.

The cost of medical care provided when a patient with serious or life-threatening disease is entered on a Phase I, II, III, or IV (post-marketing) clinical trial – including hospital, physician, and other health care items and services as well as the cost of approved drugs for labeled or unlabeled uses which might be part of the regimen¹ – should not be denied coverage when all of the following are demonstrated:

- Treatment is provided with a therapeutic intent²;
- Treatment is being provided pursuant to a clinical trial approved by one of the National Institutes of Health (NIH), an NIH cooperative group or an NIH center; the Food and Drug Administration (FDA) in the form of an investigational new drug (IND) or new device (IDE) exemption; the Department of Defense; the Department of Veterans Affairs; or a qualified non-governmental research entity as identified in National Cancer Institute guidelines or center support grants;
- The trial is conducted according to a written protocol, which includes the following elements: trial design and scientific justification, criteria for inclusion and exclusion, outcome measures, statistical analysis plan, conflicts and other ethical controls, and publication policy;
- The protocol has undergone scientific review by a group of independent and qualified experts;
- The clinical trial has been reviewed and approved by a qualified institutional review board (IRB);
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;
- There is no non-investigational therapy that is clearly superior to the protocol treatment; and
- The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as non-investigational therapy.³

Originally adopted February 1993
As amended June 1994 and March 2005

¹ Items and services required by the design of the trial should be covered, except those items or services normally paid for by other funding sources such as the cost of certain investigational drugs, the costs of any non-health services that might be required for a person to receive the treatment, and the costs of managing the research.

² Treatment with therapeutic intent may be aimed at improving patient outcome relative to either survival or quality of life.

³ While these standards refer to clinical trials involving “treatment” or “therapy”, the same principles would apply equally to trials of interventions to prevent, rather than treat, diseases.

POSITION PAPER ON HEALTH PLAN COVERAGE FOR PATIENT CARE COSTS IN CANCER CLINICAL TRIALS

Sponsored by the Denali Oncology Group, the Alaska State Affiliate of the American Society of
Clinical Oncology

February 24, 2008

BACKGROUND:

1. Clinical trials for cancer patients provide state-of-the-art treatment for patients with life-threatening diseases. Cancer patients and their physicians typically look to clinical trials as an option when the investigational treatment offers as much or more benefit than standard treatment.
2. Currently, in Alaska, health plans can exclude coverage for routine patient care costs while a patient with cancer is enrolled on a clinical trial.
3. Since 2000, Medicare has provided coverage for beneficiaries for routine costs associated with cancer clinical trial enrollment.
4. Twenty-three states in the United States have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care a patient receives while participating in a clinical trial.
5. Health plans mistakenly think that money is saved by excluding care while patients participate in clinical trials. However, if not enrolled on a clinical trial, these patients will continue to receive conventional therapy. Studies have shown that there are not differences in cost of care for patients enrolled on clinical trials compared with patients on conventional therapy.
6. Results of clinical trials lead to more rational use of cancer treatment and more successful outcomes, resulting in short-term and long-term cost savings.

PROPOSED LEGISLATION:

We propose that the Senate and House of the State of Alaska pass a bill requiring that all health care plans, including Medicaid, cover routine patient care costs for patients enrolled in all phases of clinical trials, including prevention, detection, treatment and palliation (supportive care) of cancer.

BENEFITS:

1. Passage of this bill will remove an important barrier to the participation of patients in cancer clinical trials. It will result in physicians more often recommending patient participation and in patients having greater desire to enroll in clinical trials.
2. Greater participation by Alaskans in cancer clinical trials will result in improved care of our patients in the short- and long-term, improved doctor-patient relationship, increased patient satisfaction with treatment, and increased retention of patients in Alaska for their cancer care.
3. Alaska will be in the forefront in making meaningful progress in providing care for cancer and other life threatening conditions.

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CANCER CLINICAL TRIALS FAST FACTS
DENALI ONCOLOGY GROUP, October 28, 2007

Frequently Asked Questions (FAQ)

1. **What is a clinical trial?** A clinical trial is a scientific way of studying a new treatment for a specific disease that may be better and/or safer than existing treatments.
2. **Why are clinical trials necessary?** Without these studies, we can not determine whether a new treatment is safe, effective, and better than existing options.
3. **What types of cancer clinical trials exist?** Trials may be for prevention, early detection, diagnosis, or treatment of cancer. There are also trials for reducing symptoms and improving quality-of-life.
4. **Why would a cancer patient consider participating in a clinical trial?**
 - a. Treatment given on the clinical trial offers the potential for better outcome (e.g. longer life or higher cure rate) than the standard treatment.
 - b. Results of the trial will help improve treatment for future patients.
5. **Is it risky to be on a clinical trial?** There are risks with any type of cancer treatment. Side effects that occur in patients on a clinical trial are monitored very closely and described in paperwork that patients receive (i.e., consent form).
6. **Are clinical trials available in Alaska?** Yes, more than 50 cancer clinical trials are open in Alaska for patients to receive treatment in-state.
7. **Do doctors or patients gain financially from participating in clinical trials?** We only support the conduct of studies where there is no financial gain for patients or physicians. Support is provided by the sponsor of the study to help pay for costs associated with the trial, such as research personnel and regulatory requirements.

Myths

1. **"I may receive placebo."** Placebo is rarely used in cancer clinical trials because there is usually an acceptable standard treatment. However, if the standard is to offer no treatment, then the new treatment under investigation will be compared to no treatment (i.e., placebo). Patients will always be informed of the potential to receive placebo.
2. **"I will be a guinea pig."** Patients on clinical trials are treated with respect, receive informed consent, and have all questions answered. They have the right to withdraw from the study at any time without compromising their future care.
3. **"I'm not sick enough for a clinical trial."** Many trials are studying ways to prevent cancer in healthy people at risk for cancer. Other trials are studying ways to improve upon the most common types of treatment used when patients are first diagnosed with cancer.

State Laws Addressing Third-Party Reimbursement for Clinical Trials for the Treatment of Cancer
(as of September 30, 2007)

State	Statute	Coverage Requirements			Types of Insurers Covered			Clinical Trial Phases Covered				
		Mandatory Coverage	Mandatory Offer	Prohibits Exclusion of Coverage	Private Insurers	Specified Managed Care	Medicaid/Other Medical Assistance	Public Employee Health Plans	Phase I	Phase II	Phase III	Phase IV
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1342.03, 20-826.01, 20-1057.07, 20-1402.01, 20-1404.01, and 20-2328	X ¹			X	X			X	X	X	X
California	CAL. HEALTH & SAFETY CODE § 1370.6; CAL. INS. CODE § 10145.4; and CAL. WELF. & INST. CODE § 14132.98	X ²			X	X	X		X	X	X	X
Connecticut	CONN. GEN. STAT. ANN §§ 38a-504a to 38a-504g and 38a-542a to 38a-542g	X ³			X						X	
Delaware*	DEL. CODE ANN. tit. 18, § 3567	X ⁴			X							
Georgia	GA. CODE ANN. § 33-24-59.1	X ⁵			X	X		X		X ⁶	X ⁶	
Louisiana	LA. REV. STAT. ANN. § 22:230.4	X			X	X		X		X	X	X
Maine*	ME. REV. STAT. ANN. tit. 24-A, §§ 4301-A and 4310	X			X	X						
Maryland	MD. CODE ANN., INS. § 15-827	X			X	X			X	X	X	X
Massachusetts	MASS. GEN. LAWS ANN. ch. 175, § 110L	X ⁴			X	X			X	X	X	X
Missouri	MO. REV. STAT. § 376.429	X			X	X				X	X	X
Nevada	NEV. REV. STAT. §§ 689A.04033, 689B.0306, 695B.1903, 695C.1693, and 695G.173	X			X	X			X	X	X	X
New Hampshire	N.H. REV. STAT. ANN. § 415:18-I	X ⁷			X	X			X	X	X	X
New Mexico	N.M. STAT. ANN. § 59A-22-43	X ⁴			X	X	X			X	X	X
North Carolina*	N.C. GEN. STAT. ANN. § 58-3-255	X			X	X				X	X	X
Rhode Island	R.I. GEN. LAWS §§ 27-18-36, 27-18-36.2, 27-19-32 to 27-19-32.3, 27-20-27 to 27-20-27.3, and 27-41-41 to 27-41-41.3	X			X	X				X	X	X
Tennessee	TENN. CODE ANN. § 56-7-2365	X ⁴			X	X			X	X	X	X
Vermont	VT. STAT. ANN. tit. 8, § 4088b ⁸	X			X	X	X					
Virginia	VA. CODE ANN. §§ 2.2-2818 and 38.2-3418.8	X			X	X		X	X ⁸	X	X	X

State Laws Addressing Third-Party Reimbursement for Clinical Trials for the Treatment of Cancer

(as of September 30, 2007)

State	Statute	Coverage Requirements			Types of Insurers Covered				Clinical Trial Phases Covered			
		Mandatory Coverage	Mandatory Offer	Prohibits Exclusion of Coverage	Private Insurers	Specified Managed Care	Medicaid/Other Medical Assistance	Public Employee Health Plans	Phase I	Phase II	Phase III	Phase IV
West Virginia	W. VA. CODE §§ 5-16-7d, 5-16-7e, 5-16B-6a, 5-16B-6b, 9-2-12, 9-2-12a, 33-25F-1, and 33-25F-2	X ⁴			X	X	X	X		X	X	X
Wisconsin	WIS. STAT. ANN. §§ 632.87 and 40.51			X ⁴	X			X	X	X	X	X

Note: Because arrangements for the reimbursement of clinical trials for several states fall outside the scope of the State Cancer Legislative Database protocols, those states are not included herein. Michigan and New Jersey, for example, instituted special non-legislative agreements whereby insurers voluntarily cover routine medical care that is part of a clinical trial. According to the state employee benefits handbook, Ohio provides coverage for cancer treatment clinical trials to state employees who are enrolled in the state employee health benefit plan. In Georgia, a non-legislative agreement among a number of private health plans and state-based plans provides coverage for adults and children.

* Laws in Delaware, Maine, and North Carolina provide coverage of clinical trials for life threatening medical conditions and not specifically for the treatment of cancer.

¹ Indicated insurers are only obligated to provide coverage for covered patient costs that are directly associated with the clinical trial.

² Coverage requirement applies only to routine patient care costs related to cancer clinical trials having a therapeutic purpose, upon recommendation by a treating physician.

³ In order to be eligible for coverage, clinical trials for the *prevention of cancer* must be a Phase III trial that involves a therapeutic intervention and is conducted at multiple institutions under the auspices of an independent peer-reviewed protocol approved by a specified Federal authority.

⁴ Coverage requirement applies only to clinical trials that have a therapeutic intent.

⁵ Coverage requirement applies only to routine patient care costs incurred in connection with clinical trials for the treatment of children's cancer.

⁶ Applies only to Phase II or III prescription drug clinical trial programs.

⁷ Coverage for Phase I and Phase II clinical trials is decided on a case-by-case basis.

⁸ Requires the state Department of Banking, Insurance, Securities, and Health Care Administration to issue regulations that specify the requirements for coverage of routine costs for patients who participate in approved cancer clinical trials conducted by specified providers. Coverage requirements are included in Regulation H-2001-04.

⁹ Treatment in a Phase I clinical trial may be covered on a case-by-case basis.

Clinical Trial Information

The greater the number of people who participate in clinical trials, the faster emerging anticancer therapies can be brought to market. US Oncology accrued more than 32,000 cancer patients to clinical trials, and is bringing the search for new therapies directly into local communities across America.

Our research team members conduct more than 50 clinical trials each year. While we have complete Phase I-IV capabilities, the majority of our research is in Phase II and III development stages.

Our extensive clinical trial program, plus our provision of care for approximately 200,000 new cancer patients each year, provides us with a unique research platform. In sharing what we learn with one another, we can more readily advance the latest developments as they relate to investigational drugs, the reduction of side effects, and new methods of care.

If you are interested in contacting a US Oncology-affiliated physician to learn more about our clinical trial program, please [click here](#).

Frequently Asked Questions About Clinical Trials

If you are a cancer patient or someone you know is a cancer patient, you may be interested in learning more about clinical trials. The information below offers a brief overview of the clinical trial process, with a look at key questions and terms.

What are Clinical Trials?

Clinical trials, or research studies, utilize patient volunteers to help investigate different ways to treat diseases - such as cancer. Clinical trials involve the use of investigational drugs (also known as study drugs) and drug delivery methods. Each study tries to answer specific scientific questions about different ways to prevent, diagnose, and treat whatever disease it is addressing.

Why are Clinical Trials Important?

Clinical trials contribute to the overall knowledge and progress made in developing therapies for diseases, such as cancer. These research studies are conducted to determine if a study drug or delivery method is safe and effective. Patients who agree to participate may possibly benefit from the research study, while receiving the best current standard treatment as well.

How are Clinical Trials Structured?

Clinical trials are structured into four phases:

In *Phase I clinical trials*, researchers test a study drug in a small group of people (20 to 80) for the first time to evaluate its safety, determine a safe dosage range, and identify side effects.

In *Phase II clinical trials*, the study drug is tested in a larger group of people (100 to 300) to measure its effectiveness and further evaluate its safety.

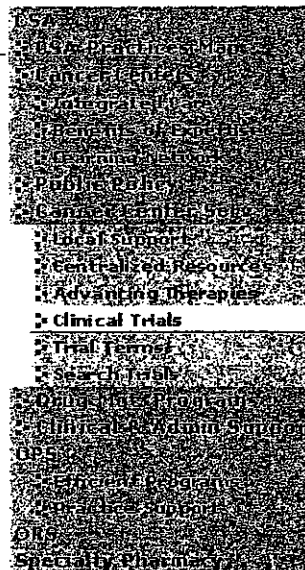
In *Phase III clinical trials*, the study drug is tested in large groups of people (1,000 to 3,000) to confirm its effectiveness, monitor side effects, compare it to approved standard treatments, and collect information that will allow the study drug to be used safely.

In *Phase IV clinical trials*, the drug is tested after it has been marketed to collect information about its effect in various populations and about any side effects associated with long-term use.

What Happens During a Clinical Trial?

In many trials, if the patient is eligible and agrees to participate through Informed Consent, the patient is randomized (by chance, like a coin toss) to either receive the current standard treatment, or the current standard treatment and the study drug regimen. If no standard treatment is available, a trial may compare the study drug to a placebo, which is similar to the study drug, but contains no active ingredient. During a trial, patients are treated and monitored by a team of health care professionals. This team will give the patient specific instructions about the trial, about more tests, and additional doctor's visits that might be required.

Throughout the clinical trial, you come first. If there is no improvement or you experience intolerable side effects, you and your physician can decide to discontinue trial participation and resume other



treatment options. Should you do so, your decision will be respected without any effect on future treatment plans.

Why Do Some Cancer Patients Choose to Participate in Clinical Trials?

Some cancer patients may participate because they are hoping for a possible cure and longer life or a way to feel better. Others find that the current standard therapies are not optimal for their cancer and wish to be among the first to participate in a research study and receive an investigational drug. Whatever the reason, participation could make a difference in a patient's future, as well as in the lives of future cancer patients.

How Do I Know If I Should Participate in a Clinical Trial?

The decision to participate in a clinical trial is one that only you can make, with the help of your physician and the people close to you. If you are interested in participating in a clinical trial, you will be informed of the clinical trial's potential benefits and drawbacks before making your decision. If the investigational drug is proven to be effective, you may be among the first to benefit. In addition, through your participation in a research study, you will also be helping future cancer patients.

Are There Risks Involved in Participating?

Because clinical trials are research studies, study drugs may not be better than current standard drugs or treatments. In addition, you may experience side effects that are worse than those of current standard drugs and treatments. Also, your health insurance company or managed care provider may not cover all of the patient care associated with a clinical trial. All of these factors should be discussed thoroughly with your physician and those close to you before deciding whether or not to participate in a clinical trial.

Where are the Trials Held?

Many clinical trials may be available right in your own community. Ask your physician for specific information or [search the US Oncology clinical trial list](#) to find a current US Oncology trial in your region.

How Do I Learn More About a Specific Clinical Trial?

Through a process called "Informed Consent," you will learn the key facts about a particular clinical trial before making a decision about participating. Your doctor will explain the purpose and requirements of the study, including any potential drawbacks and benefits. If you agree to take part in the trial, you will be asked to review and sign a form that outlines the study's details prior to participating.

How Do I Get More Information?

Consult your physician to find out whether or not there is a clinical trial that would be appropriate for your care. If you are a US Oncology patient, your physician has information on clinical trials that are being held throughout the company's national research network. Or you can [search a list of all current US Oncology clinical trials](#) for more specific information.

For more details on clinical trial research conducted by the US Oncology network, please click [USON Research](#).

For definitions of the clinical trial terms used on this site, please click [Trial Terms](#).

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Clinical Trials: Questions and Answers

Key Points

- **Clinical trials** are research studies that test how well new medical approaches work in people (see [Question 1](#)).
- Every clinical trial has a **protocol**, which describes what will be done in the study, how it will be conducted, and why each part of the study is necessary (see [Question 4](#)).
- **Informed consent** is a process by which people learn the important facts about a clinical trial to help them decide whether to participate (see [Question 6](#)).
- Payment of patient care costs in clinical trials varies by health insurance plan and by study (see [Question 11](#)).

1. What are clinical trials, and why are they important?

Clinical trials are research studies that test how well new medical approaches work in people. Each study answers scientific questions and tries to find better ways to prevent, screen for, diagnose, or treat a disease. People who take part in **cancer** clinical trials have an opportunity to contribute to knowledge of, and progress against, cancer. They also receive up-to-date care from experts.

2. What are the types of clinical trials?

There are several types of clinical trials:

- **Prevention trials** test new approaches, such as medications, **vitamins**, or other **supplements**, that doctors believe may lower the risk of developing a certain type of cancer. Most prevention trials are conducted with healthy people who have not had cancer. Some trials are conducted with people who have had cancer and want to prevent **recurrence** (return of cancer), or reduce the chance of developing a new type of cancer.
- **Screening trials** study ways to detect cancer earlier. They are often conducted to determine whether finding cancer before it causes **symptoms** decreases the chance of dying from the disease. These trials involve people who do not have any symptoms of cancer.
- **Diagnostic trials** study tests or procedures that could be used to identify cancer more accurately. Diagnostic trials usually include people who have signs or symptoms of cancer.
- **Treatment trials** are conducted with people who have cancer. They are designed to answer specific questions about, and evaluate the effectiveness of, a new treatment or a new way of using a **standard treatment**. These trials test many types of treatments, such as new drugs, **vaccines**, new approaches to **surgery** or **radiation therapy**, or new combinations of treatments.
- **Quality-of-life** (also called **supportive care**) trials explore ways to improve the comfort and quality of life of cancer patients and cancer survivors. These trials may study ways to help people who are experiencing **nausea**, **vomiting**, sleep disorders, **depression**, or other effects from cancer or its treatment.
- **Genetics studies** are sometimes part of another cancer clinical trial. The genetics component of the trial may focus on how **genetic** makeup can affect detection, **diagnosis**, or **response** to cancer treatment.

Population- and family-based genetic research studies differ from traditional cancer clinical trials. In these studies, researchers look at **tissue** or **blood** samples, generally from families or large groups of people, to find genetic changes that are associated with cancer. People who participate in genetics studies may or may not have cancer, depending on the study. The goal

of these studies is to help understand the role of genes in the development of cancer.

3. Who sponsors clinical trials?

Government agencies, such as the National Cancer Institute (NCI) and other parts of the National Institutes of Health (NIH), the Department of Defense, and the Department of Veterans Affairs, sponsor and conduct clinical trials. In addition, organizations or individuals, such as physicians, medical institutions, foundations, volunteer groups, and pharmaceutical companies, also sponsor clinical trials.

NCI sponsors a large number of clinical trials and has a number of programs designed to make clinical trials widely available in the United States. These programs include the following:

- **The Cancer Centers Program** provides support to research-oriented institutions, including those that have been designated as NCI Comprehensive or Clinical Cancer Centers for their scientific excellence. More information is available in the NCI fact sheet *The National Cancer Institute Cancer Centers Program*, which is available at <http://www.cancer.gov/cancertopics/factsheet/NCI/cancer-centers> on the Internet.
- **The Specialized Programs of Research Excellence (SPOREs)** bring together scientists and researchers to design and implement research programs that can improve prevention, detection, diagnosis, and treatment of specific types of cancer. More information about SPOREs is available at <http://spores.nci.nih.gov/index.html> on the Internet.
- **The Clinical Trials Cooperative Group Program** brings researchers, cancer centers, and doctors together into cooperative groups. These groups work with the NCI to identify important questions in cancer research, and design and conduct multisite clinical trials to answer these questions. Cooperative groups are located throughout the United States and in Canada and Europe. For more information, refer to the fact sheet *NCI's Clinical Trials Cooperative Group Program* at <http://www.cancer.gov/cancertopics/factsheet/NCI/clinical-trials-cooperative-group> on the Internet.
- **The Cancer Trials Support Unit (CTSU)** makes NCI-sponsored phase III treatment trials available to doctors and patients in the United States and Canada. Doctors who are not affiliated with an NCI-sponsored Clinical Trials Cooperative Group (see above) must complete an application process, which includes credential verification and site preparedness assessment, to become members of the CTSU's National Network of Investigators. CTSU members can enroll patients in clinical trials through the program's Web site, which is located at <http://www.ctsu.org> on the Internet. General information about the CTSU is also available on the program's Web site, or by calling 1-888-823-5923.
- **The Community Clinical Oncology Program (CCOP)** makes clinical trials available in a large number of communities across the United States. Local hospitals throughout the country affiliate with a cancer center or a cooperative group. This affiliation allows doctors to offer people participation in clinical trials more easily, so they do not have to travel long distances or leave their usual caregivers. The **Minority-Based Community Clinical Oncology Program** focuses on encouraging minority populations to participate in clinical trials. More information about the CCOP can be found in the NCI fact sheet *Community Clinical Oncology Program: Questions and Answers*, which is available at <http://www.cancer.gov/cancertopics/factsheet/NCI/CCOP> on the Internet.
- **The National Institutes of Health Clinical Center**, a research hospital located in Bethesda, Maryland, is part of the NIH. Trials at the Clinical Center are conducted by the components of the NIH, including the NCI. The NCI fact sheet *Cancer Clinical Trials at the National Institutes of Health Clinical Center: Questions and Answers* has more information about the Clinical Center. This fact sheet is available at <http://www.cancer.gov/cancertopics/factsheet/NCI/clinical-center> on the Internet.

4. How are participants protected?

Research with people is conducted according to strict scientific and ethical principles. Every clinical trial has a protocol, or action plan, which acts like a "recipe" for conducting the trial. The plan describes what will be done in the study, how it will be conducted, and why each part of the study is necessary. The same protocol is used by every doctor or research center taking part in the trial.

All clinical trials that are federally funded or that evaluate a new drug or medical device subject to Food and Drug Administration regulation must be reviewed and approved by an Institutional Review Board (IRB). Many institutions require that all clinical trials, regardless of funding, be reviewed and approved by a local IRB. The Board, which includes doctors, researchers, community leaders, and other members of the community, reviews the protocol to make sure the study is conducted fairly and participants are not likely to be harmed. The IRB also decides how often to review the trial once it has begun. Based on this information, the IRB decides whether the clinical trial should continue as initially planned and, if not, what changes should be made. An IRB can stop a clinical trial if the

researcher is not following the protocol or if the trial appears to be causing unexpected harm to the participants. An IRB can also stop a clinical trial if there is clear evidence that the new intervention is effective, in order to make it widely available.

NIH-supported clinical trials require data and safety monitoring. Some clinical trials, especially phase III clinical trials, use a Data and Safety Monitoring Board (DSMB). A DSMB is an independent committee made up of statisticians, physicians, and patient advocates. The DSMB ensures that the risks of participation are as small as possible, makes sure the data are complete, and stops a trial if safety concerns arise or when the trial's objectives have been met.

5. What are eligibility criteria, and why are they important?

Each study's protocol has guidelines for who can or cannot participate in the study. These guidelines, called eligibility criteria, describe characteristics that must be shared by all participants. The criteria differ from study to study. They may include age, gender, medical history, and current health status. Eligibility criteria for treatment studies often require that patients have a particular type and stage of cancer.

Enrolling participants with similar characteristics helps to ensure that the results of the trial will be due to what is under study and not other factors. In this way, eligibility criteria help researchers achieve accurate and meaningful results. These criteria also minimize the risk of a person's condition becoming worse by participating in the study.

6. What is informed consent?

Informed consent is a process by which people learn the important facts about a clinical trial to help them decide whether to participate. This information includes details about what is involved, such as the purpose of the study, the tests and other procedures used in the study, and the possible risks and benefits. In addition to talking with the doctor or nurse, people receive a written consent form explaining the study. People who agree to take part in the study are asked to sign the informed consent form. However, signing the form does not mean people must stay in the study. People can leave the study at any time—either before the study starts or at any time during the study or the follow-up period.

The informed consent process continues throughout the study. If new benefits, risks, or side effects are discovered during the study, the researchers must inform the participants. They may be asked to sign new consent forms if they want to stay in the study.

7. Where do clinical trials take place?

Clinical trials take place in doctors' offices, cancer centers, other medical centers, community hospitals and clinics, and veterans' and military hospitals in cities and towns across the United States and in other countries. Clinical trials may include participants at one or two highly specialized centers, or they may involve hundreds of locations at the same time.

8. How are clinical trials conducted?

Clinical trials are usually conducted in a series of steps, called phases. Treatment clinical trials listed in PDQ[®], the NCI's comprehensive cancer information database, are always assigned a phase. However, screening, prevention, diagnostic, and quality-of-life studies do not always have a phase. Genetics clinical trials generally do not have a phase.

- Phase I trials are the first step in testing a new approach in people. In these studies, researchers evaluate what dose is safe, how a new agent should be given (by mouth, injected into a vein, or injected into the muscle), and how often. Researchers watch closely for any harmful side effects. Phase I trials usually enroll a small number of patients and take place at only a few locations. The dose of the new therapy or technique is increased a little at a time. The highest dose with an acceptable level of side effects is determined to be appropriate for further testing.
- Phase II trials study the safety and effectiveness of an agent or intervention, and evaluate how it affects the human body. Phase II studies usually focus on a particular type of cancer, and include fewer than 100 patients.
- Phase III trials compare a new agent or intervention (or new use of a standard one) with the current standard therapy. Participants are randomly assigned to the standard group or the new group, usually by computer. This method, called randomization, helps to avoid bias and ensures that human choices or other factors do not affect the study's results. In most cases, studies move into phase III testing only after they have shown promise in phases I and II. Phase III trials often include large numbers of people across the country.
- Phase IV trials are conducted to further evaluate the long-term safety and effectiveness of a

treatment. They usually take place after the treatment has been approved for standard use. Several hundred to several thousand people may take part in a phase IV study. These studies are less common than phase I, II, or III trials.

People who participate in a clinical trial work with a research team. Team members may include doctors, nurses, social workers, dietitians, and other health professionals. The health care team provides care, monitors participants' health, and offers specific instructions about the study. So that the trial results are as reliable as possible, it is important for participants to follow the research team's instructions. The instructions may include keeping logs or answering questionnaires. The research team may continue to contact participants after the trial ends.

9. What are some of the benefits of taking part in a clinical trial?

The benefits of participating in a clinical trial include the following:

- Participants have access to promising new approaches that are often not available outside the clinical trial setting.
- The approach being studied may be more effective than the standard approach.
- Participants receive regular and careful medical attention from a research team that includes doctors and other health professionals.
- Participants may be the first to benefit from the new method under study.
- Results from the study may help others in the future.

10. What are some of the possible risks associated with taking part in a clinical trial?

The possible risks of participating in a clinical trial include the following:

- New drugs or procedures under study are not always better than the standard care to which they are being compared.
- New treatments may have side effects or risks that doctors do not expect or that are worse than those resulting from standard care.
- Participants in randomized trials will not be able to choose the approach they receive.
- Health insurance and managed care providers may not cover all patient care costs in a study.
- Participants may be required to make more visits to the doctor than they would if they were not in the clinical trial.

11. Who pays for the patient care costs associated with a clinical trial?

Health insurance and managed care providers often do not cover the patient care costs associated with a clinical trial. What they cover varies by health plan and by study. Some health plans do not cover clinical trials if they consider the approach being studied "experimental" or "investigational." However, if enough data show that the approach is safe and effective, a health plan may consider the approach "established" and cover some or all of the costs. Participants may have difficulty obtaining coverage for costs associated with prevention and screening clinical trials; health plans are currently less likely to have review processes in place for these studies. It may, therefore, be more difficult to get coverage for the costs associated with them. In many cases, it helps to have someone from the research team talk about coverage with representatives of the health plan.

Health plans may specify other criteria a trial must meet to be covered. The trial might have to be sponsored by a specified organization, be judged "medically necessary" by the health plan, not be significantly more expensive than treatments the health plan considers standard, or focus on types of cancer for which no standard treatments are available. In addition, the facility and medical staff might have to meet the plan's qualifications for conducting certain procedures, such as bone marrow transplants. More information about insurance coverage can be found on the NCI's *Clinical Trials and Insurance Coverage: A Resource Guide* Web page at <http://www.cancer.gov/clinicaltrials/learning/insurance-coverage> on the Internet.

Many states have passed legislation or developed policies requiring health plans to cover the costs of certain clinical trials. For more information, visit the NCI's Web site at <http://www.cancer.gov/clinicaltrials/developments/laws-about-clinical-trial-costs> on the Internet.

Federal programs that help pay the costs of care in a clinical trial include those listed below:

- Medicare reimburses patient care costs for its beneficiaries who participate in clinical trials designed to diagnose or treat cancer. Information about Medicare coverage of clinical trials is available at <http://www.medicare.gov> on the Internet, or by calling Medicare's toll-free number for beneficiaries at 1-800-633-4227 (1-800-MEDICARE). The toll-free number for the hearing impaired is 1-877-486-2048. Also, the NCI fact sheet *More Choices in Cancer Care: Information for Beneficiaries on Medicare Coverage of Cancer Clinical Trials* is available at <http://www.cancer.gov/cancertopics/factsheet/support/medicare> on the Internet.
- Beneficiaries of TRICARE, the Department of Defense's health program, can be reimbursed for the medical costs of participation in NCI-sponsored phase II and phase III cancer prevention

(including screening and early detection) and treatment trials. Additional information is available in the NCI fact sheet *TRICARE Beneficiaries Can Enter Clinical Trials for Cancer Prevention and Treatment Through a Department of Defense and National Cancer Institute Agreement*. This fact sheet can be found at <http://www.cancer.gov/cancertopics/factsheet/NCI/TRICARE> on the Internet.

- The Department of Veterans Affairs (VA) allows eligible veterans to participate in NCI-sponsored prevention, diagnosis, and treatment studies nationwide. All phases and types of NCI-sponsored trials are included. The NCI fact sheet *The NCI/VA Agreement on Clinical Trials: Questions and Answers* has more information. It is available at <http://www.cancer.gov/cancertopics/factsheet/NCI/VA-clinical-trials> on the Internet.

12. What are some questions people might ask their health care provider before entering a clinical trial?

It is important for people to ask questions before deciding to enter a clinical trial. Questions people might want to ask their doctor or nurse include the following:

The Study

- What is the purpose of the study?
- Why do the researchers think the approach being tested may be effective? Has it been tested before?
- Who is sponsoring the study?
- Who has reviewed and approved the study?
- What are the medical credentials and experience of the researchers and other study personnel?
- How are the study results and safety of participants being monitored?
- How long will the study last?
- How will the results be shared?

Possible Risks and Benefits

- What are the possible short-term benefits?
- What are the possible long-term benefits?
- What are the short-term risks, such as side effects?
- What are the possible long-term risks?
- What other treatment options are available?
- How do the possible risks and benefits of the trial compare with those of other options?

Participation and Care

- What kinds of treatment, medical tests, or procedures will the participants have during the study? How often will they receive the treatments, tests, or procedures?
- Will treatments, tests, or procedures be painful? If so, how can the pain be controlled?
- How do the tests in the study compare with what people might receive outside the study?
- Will participants be able to take their regular medications while in the clinical trial?
- Where will the participants receive their medical care? Will they be in a hospital? If so, for how long?
- Who will be in charge of the participants' care? Will they be able to see their own doctors?
- How long will participants need to stay in the study? Will there be follow-up visits after the study?

Personal Issues

- How could being in the study affect the participants' daily lives?
- What support is available for participants and their families?
- Can potential participants talk with people already enrolled in the study?

Cost Issues

- Will participants have to pay for any treatment, tests, or other charges? If so, what will the approximate charges be?
- What is health insurance likely to cover?
- Who can help answer questions from the insurance company or health plan?

13. What happens when a clinical trial is over?

After a clinical trial is completed, the researchers look carefully at the data collected during the trial before making decisions about the meaning of the findings and further testing. After a phase I or II trial, the researchers decide whether to move on to the next phase, or stop testing the agent or intervention because it was not safe or effective. When a phase III trial is completed, the researchers look at the data and decide whether the results have medical importance.

The results of clinical trials are often published in peer-reviewed, scientific journals. Peer review is a process by which experts review the report before it is published to make sure the analysis and conclusions are sound. If the results are particularly important, they may be featured by the media and discussed at scientific meetings and by patient advocacy groups before they are published. Once a new approach has been proven safe and effective in a clinical trial, it may become standard practice. (Standard practice is a currently accepted and widely used approach.)

The National Library of Medicine's Web site offers links to resources for finding the results of clinical trials. It includes information about published and unpublished results. This resource can be found at <http://www.nlm.nih.gov/services/ctresults.html> on the Internet.

14. Where can people find more information about clinical trials?

In addition to the resources described in Question 3, people interested in taking part in a clinical trial should talk with their health care provider. Information about cancer clinical trials is also available from the NCI's [Cancer Information Service \(CIS\)](#). Information specialists at the CIS use PDQ to identify and provide detailed information about specific ongoing clinical trials. PDQ includes all NCI-funded clinical trials and some studies conducted by independent investigators at hospitals and medical centers in the United States and Europe.

People also have the option of searching for clinical trials on their own. The clinical trials page of the NCI's Web site, located at <http://www.cancer.gov/clinicaltrials/> on the Internet, provides information about clinical trials and links to PDQ. Another resource is the NIH's [ClinicalTrials.gov](#) Web site. [ClinicalTrials.gov](#) lists clinical trials sponsored by the NIH, other Federal agencies, and the pharmaceutical industry for a wide range of diseases, including cancer and other conditions. This site can be found at <http://clinicaltrials.gov> on the Internet.

###

Related Resources

Publications (available at <http://www.cancer.gov/publications>)

- National Cancer Institute Fact Sheet 1.2, [The National Cancer Institute Cancer Centers Program](#)
- National Cancer Institute Fact Sheet 1.3, [Community Clinical Oncology Program: Questions and Answers](#)
- National Cancer Institute Fact Sheet 1.4, [NCI's Clinical Trials Cooperative Group Program](#)
- National Cancer Institute Fact Sheet 1.13, [TRICARE Beneficiaries Can Enter Clinical Trials for Cancer Prevention and Treatment Through a Department of Defense and National Cancer Institute Agreement](#)
- National Cancer Institute Fact Sheet 1.17, [The NCI/VA Agreement on Clinical Trials: Questions and Answers](#)
- National Cancer Institute Fact Sheet 1.22, [Cancer Clinical Trials at the National Institutes of Health Clinical Center: Questions and Answers](#)
- National Cancer Institute Fact Sheet 8.14, [More Choices in Cancer Care: Information for Beneficiaries on Medicare Coverage of Cancer Clinical Trials](#)
- [Taking Part in Clinical Trials: What Cancer Patients Need To Know](#)
- [Taking Part in Clinical Trials: Cancer Prevention Studies](#)

National Cancer Institute (NCI) Resources

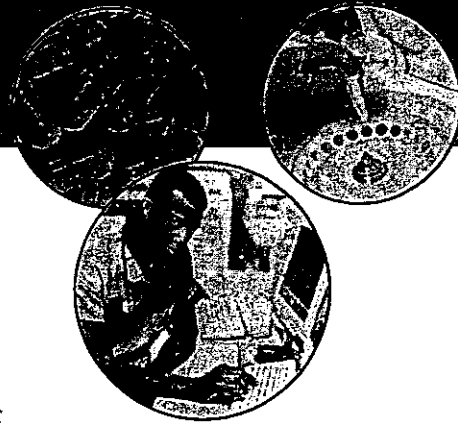
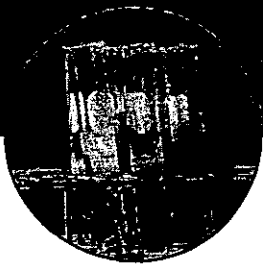
Cancer Information Service (toll-free)
Telephone: 1-800-4-CANCER (1-800-422-6237)
TTY: 1-800-332-8615

Online
NCI's Web site: <http://www.cancer.gov>
[LiveHelp](#), NCI's live online assistance:
<https://cissecure.nci.nih.gov/livehelp/welcome.asp>

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Cancer Facts

Cancer Clinical Trials: Participation by Underrepresented Populations

INTRODUCTION

- Clinical trials are a critical resource for the discovery of new prevention, diagnostic and treatment methods for cancer. Many of today's most effective prevention and treatment modalities are based on previous clinical trial results.
- Only about 3-5% of the 10.1 million adults with cancer in the U.S. participate in cancer clinical trials. This low rate stands in sharp contrast to the

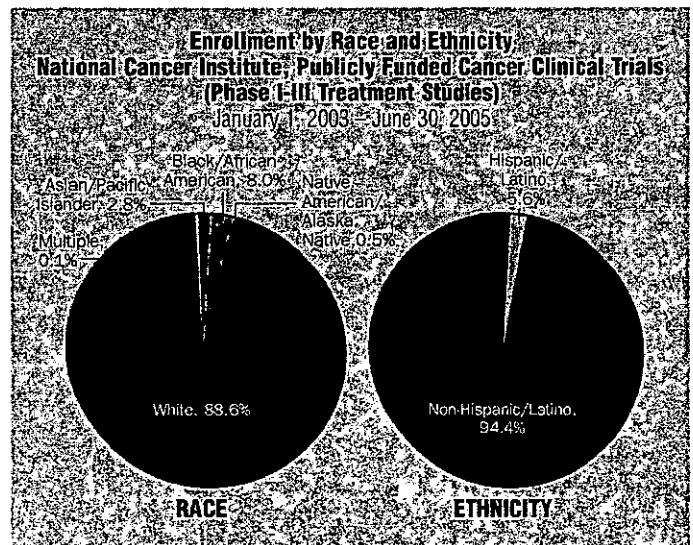
60% participation of children with cancer.

- Certain populations, such as those that are low income, elderly, racial/ethnic minorities or those who live in rural areas have the smallest percentage of clinical trial participants. Unfortunately, these same populations also bear a disproportionate burden of cancer morbidity and mortality.

- Without adequate representation of these populations in clinical trials, researchers cannot learn about potential differences among groups and cannot ensure the generalization of results. In addition, participation in clinical trials increases access to state-of-the-art cancer care, a critical factor in many minority and underrepresented populations that suffer disproportionately from cancer.

Disparities in Clinical Trials

- The National Cancer Institute (NCI) is the largest sponsor of cancer clinical trials in the U.S., with approximately 800 ongoing trials at 3,000 sites. Over 30,000 patients are enrolled in cancer clinical trials annually. From 1998-2001, total enrollment in NCI-sponsored treatment trials increased 22%. However, the number of minority participants during that period remained stable, causing a decrease in the overall percentage of minorities in trials.^{4,11}
- A review of Food and Drug Administration (FDA) approved drugs from 1995-1999 revealed that African Americans, Asian/Pacific Islanders, Hispanics/Latinos and Native Americans collectively represented less than 10% of participants in trials that were testing cancer drugs.¹²
- The rate of participation in U.S. clinical trials is correlated with the demographics of income, educational attainment, employment status, and insurance coverage. Regardless of race or ethnicity, low socioeconomic status has a negative impact on clinical research participation.^{5,13,14}
- The Coalition of Cancer Cooperative Groups evaluated accrual to NCI publicly funded treatment trials from January 2003 through June 2005. The data presented in the figures at right show accrual rates by racial and ethnic status:



Source: Baseline Study of Patient Accrual Onto Publicly Sponsored Trials, Coalition of Cancer Cooperative Groups for the Global Access Project, National Patient Advocate Foundation, April 2006.

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ICC
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Project Director
Nicholas K. Iammarino, PhD, CHES
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This ICC Cancer Fact Sheet was made possible by an unrestricted educational grant from Genentech.



• In 2004, the SELECT prostate cancer prevention trial completed recruiting over 35,000 men of whom 21% were minorities. However, previous NCI-sponsored prevention trials have not recruited significant numbers of minorities or other subpopulations.¹⁵ For example, NCI's Prostate Cancer Prevention Trial, which was conducted in 1993-2003, recruited only 8% minority participants of over 18,000 men enrolled.¹⁶

Underrepresented Populations

- **Adolescents:** Only 10% of 15-to-19 year old adolescent cancer patients are entered into trials, compared to 60% of those under the age of 15.^{17,18}
- **Elderly:** According to Lewis and colleagues, 61% of new cancer cases occurred among the elderly in 2003, but only 25% of participants in national cancer clinical trials were over 65 years of age. Moreover, in Phase II and III clinical trials, the elderly carried 60% of the disease burden but represented only 32% of enrolled patients.¹⁹
- **Racial/Ethnic Groups:** Enrollment in clinical trials is disproportionately low among African Americans/blacks and Hispanics/Latinos in NCI-sponsored surgical trials.^{6,13}
- **Rural:** Among 24,332 patients enrolled in NCI sponsored clinical trials over a one-year period, investigators found marked regional and state variations in patient accrual, and suburban geographic areas had the highest overall accrual.²⁰
- **Women:** An investigation of nonsurgical NCI cancer trials demonstrated that women were less likely than men to be enrolled in colorectal and lung cancer trials.⁸

Patient Barriers to Cancer Clinical Trial Participation

- **Cost/Lack of insurance:** Costs associated with clinical trials are often a concern. A study of NCI-sponsored cancer treatment trials found that uninsured patients represented only 5.4% of all clinical trial participants.²⁰ Even when participants have insurance, some private third-party payers do not cover the full costs associated with participating in the clinical trial.¹¹ Numerous studies have shown that the cost for a patient to take part in a clinical trial is not necessarily any more expensive than it is for the patient to receive standard cancer care.^{11,21-23}
- **Cultural barriers:** Many people from various ethnic and cultural backgrounds may have views that differ from Western medicine. As a result, some beliefs regarding health and disease (e.g., family involvement in decisions about treatment, views regarding traditional healers, religion, prayer, and alternative medicine) may make clinical trials a less desirable option.¹
- **Lack of awareness:** A national survey of cancer patients found that 85% of respondents were unaware that participating in a clinical trial was a treatment option for them.^{21,25}

- **Lack of invitation:** According to a review of enrollment decisions for health research studies, racial and ethnic minorities were less likely to be invited to participate in research studies compared with non-Hispanic/Latino whites.²⁶
- **Language/Linguistic differences:** Many U.S. clinical trials require English proficiency for potential participants, automatically excluding those who do not speak the language.²⁷ Language factors also pose a serious barrier to provider-patient communications and attempts to recruit patients into clinical trials.⁵
- **Low literacy:** The complexity of consent forms and other clinical trials materials may also be a barrier to those patients with low literacy. For example, the initial consent form for the STAR trial, a national breast cancer prevention trial, was over eight pages long and required a 10th grade reading level.²⁸
- **Mistrust:** According to a review conducted by the Agency for Healthcare Research and Quality⁸ and others^{2,29-32} mistrust of research and the medical system is a frequently reported barrier to participating in clinical trials.
- **Practical obstacles:** Transportation to and from a trial, particularly if it is located in a distant location, can be a barrier for many patients. Individuals with low incomes may find it difficult to take time off from work, find childcare or manage other family responsibilities while participating in a trial.^{1,33}
- **Study design eligibility criteria:** Strict inclusion and exclusion eligibility criteria are a commonly reported barrier to trial participation.^{8,34-38} For example, in a study of African American/black cancer patients, only 8.3% were eligible for clinical trial participation due to strict eligibility criteria. Nearly 20% of them were excluded due to the presence of additional health problems.³⁴

Physician/Investigator Barriers to Referring Patients to Cancer Trials

- **Lack of minority investigators:** Increasing the diversity of the investigator pool has been cited as an important strategy to increase recruitment of racial and ethnic populations to clinical trials. Yet, 2005 data show that African Americans/blacks, Hispanics/Latinos, American Indians/Alaska Natives, and Native Hawaiians/Pacific Islanders collectively represent less than 10% of all U.S. medical school faculty who have an M.D. or Ph.D.³⁹

Compared to non-Hispanic/Latino white physicians, Hispanic/Latino physicians were significantly less involved in clinical trials and found less value in them. This in turn, may influence their decision to refer patients to be enrolled in clinical trials.⁴⁰

- **Lack of physician referral:** Although physician referral is one of the most effective means of recruiting patients to cancer clinical trials,⁴¹ some physicians are reluctant to engage in referral. This may be because they believe that

standard therapy is best, or they fear losing control of the patient's care, or that referring or participating in a trial is an excessive administrative or financial burden to their practice. Some community physicians also indicate a mistrust of the academic or research centers conducting the trials.^{1,38,42-44}

- **Physician lack of awareness:** Being unaware that clinical trials are available is one of the most common reasons physicians fail to refer patients to trials.^{45,46} Primary care physicians do not have sufficient information on available clinical trials, and often leave the discussion of clinical research to the patient's oncologist. Yet, many oncologists outside of the academic setting may also not be aware of trials or otherwise choose not to participate in or refer their eligible patients to clinical trials.⁴⁷

Public Attitudes toward Clinical Trials

- Research has shown that the general public is unaware of clinical trials as a treatment/prevention option or is misinformed about the clinical trials process.^{1,25,48}
- Among surveyed U.S. adults who reported having ever participated in a clinical trial, 84% stated they would do so again if given a chance.⁴⁸
- Most U.S. adults agree that clinical research participants are making a significant contribution to science. However, 49% also feel that clinical trial participants are gambling with their health and are treated like "guinea pigs."⁴⁸
- Results from a recent study demonstrated that, in general, the more knowledgeable the respondent, the more likely the respondent was to participate in a clinical trial. However, regardless of their degree of knowledge, racial/ethnic minorities and those aged 18-24 years reported being reluctant to participate.⁴⁹

Clinical Trial Policies and Mandates

- **Center for Medicare and Medicaid Services:** In 2000, Medicare authorized the payment of routine care costs for beneficiaries who are patients in clinical trials.⁵⁰
- **FDA:** The FDA Modernization Act of 1997 provides guidelines on standardization of data collection of racial/ethnic groups in clinical trials, but does not address appropriate racial and ethnic inclusion.⁵¹
- **NIH:** The NIH Revitalization Act of 1993 mandated that women and minorities be included in clinical trials.⁴⁸ However, over a decade later, minorities continue to be underrepresented at varying levels in both cancer prevention and treatment trials.⁸
- **States:** As of 2007, only 20 states in the U.S. ensured the reimbursement of routine medical costs for clinical trial participants by legislative mandates or agreements with large health insurers.⁵²

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SB 280 Testimony 4/3/08

Jeanne E. Anderson, MD
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Anchorage, AK 99508-4627



I am Jeanne Anderson, a Medical Oncologist in practice in Anchorage. On behalf of Alaska cancer physicians and patients, I thank the members of the Labor and Commerce Committee members for considering this bill. It is predicted that 2,650 Alaskans will be diagnosed with cancer in 2008. In the 1970's, only 50% of cancer patients lived 5 years after diagnosis. In 2008, 66% are predicted to survive 5 years. We all know that many Alaskans die of cancer every day and that improvements are desperately needed. The cancer physicians in Alaska are committed to providing the best care possible to our patients, to relieve suffering and reduce death from cancer. In caring for our patients, we often turn to clinical trial as providing the best treatment for our patients. A clinical trial is a formal, scientific way to test whether a new treatment is safe, effective, and superior to existing treatments. The physicians and hospitals in Alaska support clinical trials and there are over 50 trials open in this state for our cancer patients. However, only a small number of our patients enroll on these clinical trials, approximately 40 per year. There are many reasons why enrollment is low. These reasons include lack of knowledge or interest on the part of the patient or physician, lack of availability of an appropriate trial for the patient, and (relevant to this bill) lack of insurance coverage or fear by the patient they will lose coverage if enrolled on a study. Passage of this bill will clearly remove an important barrier to access of a clinical trial. It will result in Alaska physicians providing improved care for our patients, reducing the burden of cancer in our population, and facilitating patients to stay in Alaska for state-of-the-art care.



April 2, 2008

Testimony to Support SB280

To

Senate Labor & Commerce Committee,

I am a medical oncologist-hematologist practicing in Anchorage. Hence I am involved in caring for many, many patients with cancer, which are oftentimes deadly.

As yet, many cancers do not have curative treatments. One of the options I offer to all my patients is to consider treatment under clinical trials- scientifically conducted studies by approved medical organizations to try & improve cancer care.

Unfortunately, due to Insurers denying coverage for routine medical care when patients enter clinical trials, patients very obviously & naturally, decline to participate in clinical trials.

In my opinion, this state of affairs is a major handicap for patients/ individuals in Alaska to receive State of Art Care for Cancer & related problems in Alaska.

Just to give you an example, Herceptin is now used in early breast cancer treatment as the women with breast cancer who participated proved its efficacy in a clinical trial. This trial included at least 2 women in Alaska.

I wholeheartedly support SB280 & sincerely hope your committee members will too for all of our sakes.

Sincerely,

Latha Subramanian MD, FACP

Krista Rangitsch, RN, BSN, OCN, CCRC

523 East 17th Avenue

Anchorage, AK 99504

My name is Krista Rangitsch and I am a Cancer Research Nurse at Providence Alaska Medical Center, however, I am not representing Providence. I am testifying on my own behalf.

First, I'd like to take this opportunity to thank the members of this committee for considering Senate Bill 10 and for allowing me to testify today.

From my perspective, when a clinical trial is recommended to a patient by their physician as the best treatment option, they are referred to our office. Part of my discussion about the study with the patient includes informing them that their insurance company may not cover some or all of the routine costs associated with treating their cancer while on the study. We strongly encourage all patients find out what their policy says about clinical trial coverage. This is the stage where, in my experience, we encounter the majority of barriers to patient enrollment to clinical trials.

Patients go through a lot emotionally and financially when being diagnosed with cancer – the last thing they should have to worry about is finding out if their insurance will cover a clinical trial that their physician thinks is in their best interest.

I've noticed that one of our ever-increasing reasons for patients not enrolling on a clinical trial is because of lack of or fear of lack of insurance coverage. There are many instances, where due to the severity of the cancer and the necessity to start treatment right away, there just isn't reasonable sufficient time to investigate if insurance will cover clinical trial expenses or the insurance company just takes too long to determine coverage.

In closing, if insurance companies were mandated to cover routine care costs associated with a clinical trial, I am confident that many more people would be able to participate in clinical trials, which in turn, would increase the likelihood of improved cancer treatments and maybe someday lead to a cure.

Thank you again for the opportunity and for supporting Senate Bill 10.

March 9, 2009

Senator Bettye Davis
State Capitol
Rm. 30
Juneau, AK 99801-1182



Jack C. McRae
Senior Vice President

Dear Senator Davis:

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our concerns with SB 10 regarding coverage of routine patient care costs during a cancer clinical trial. We would like to work with you and members of the committee to suggest amendments to this bill.

We recognize the importance of cancer clinical trials in identifying effective and safe treatments that are based on evidence and research. To that effect, Premera currently covers the routine costs for our members who are participating in phase 2 or 3 cancer clinical trials.

As drafted, SB 10 is a mandate requiring insurance companies to cover all phases of cancer clinical trials. Mandates have the net effect of increasing the cost of insurance, and we expect that SB 10 will increase the cost of insurance to Alaska consumers. However, if passed and implemented, this requirement would not apply to ERISA or self-funded groups. Since self-funded groups are not regulated under state law, mandates such as this one, will primarily apply to insurance coverage offered to individual policyholders and small groups. As you are well aware, small groups are currently struggling to provide insurance for themselves and their employees, especially during these tough economic times. SB 10 will impact the most vulnerable segment of the insurance market by increasing the cost of their health insurance.


Our concerns with the bill are expanding this coverage to phase 1 and 4 trials for patient safety and treatment effectiveness reasons.

In a phase 1 trial, the drug or treatment is still being evaluated and there is no reasonable expectation of a therapeutic benefit to the patient. Phase 1 trials may be considered close to basic research since they involve testing agents that are not known to have an effect on cancers in the human body. Basic dose mechanisms, drug toxicities, and safety aspects have yet to be validated. We are concerned with requiring coverage for phase 1 clinical trials when the safety and efficacy of the proposed treatment have not been established.

At a phase 4 trial, we would cover the treatment if it is medically necessary. However, there may be other known medical treatments that are available for the patient that are more effective. And, we would like the flexibility to review and pay for these other medical treatments that may be more beneficial to our members.

Thank you for considering our concerns. If health insurance is mandated to cover routine care for members in phase 1 and 4 trials, healthcare costs will increase and add to the rising premiums borne mostly by small groups and individual policyholders. We offer our amendments to encourage participation by Alaska residents in cancer clinical trials to expand research and evidence based medicine, while at the same time balancing patient safety and the rising costs of healthcare insurance.

Sincerely,


Jack C. McRae
Senior Vice President

P.O. Box 327
Seattle, WA 98111

tel 425.918.5767
fax 425.518.5639
jack.mcrae@premera.com

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association



Alaska

January 20, 2009

The Honorable Bettye Davis
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 10

Dear Senator Davis,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 10. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, SB10 mandates specified coverage of medical care coverage during specified clinical trials that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced

The Honorable Betty Davis

January 20, 2009

Page 2

by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

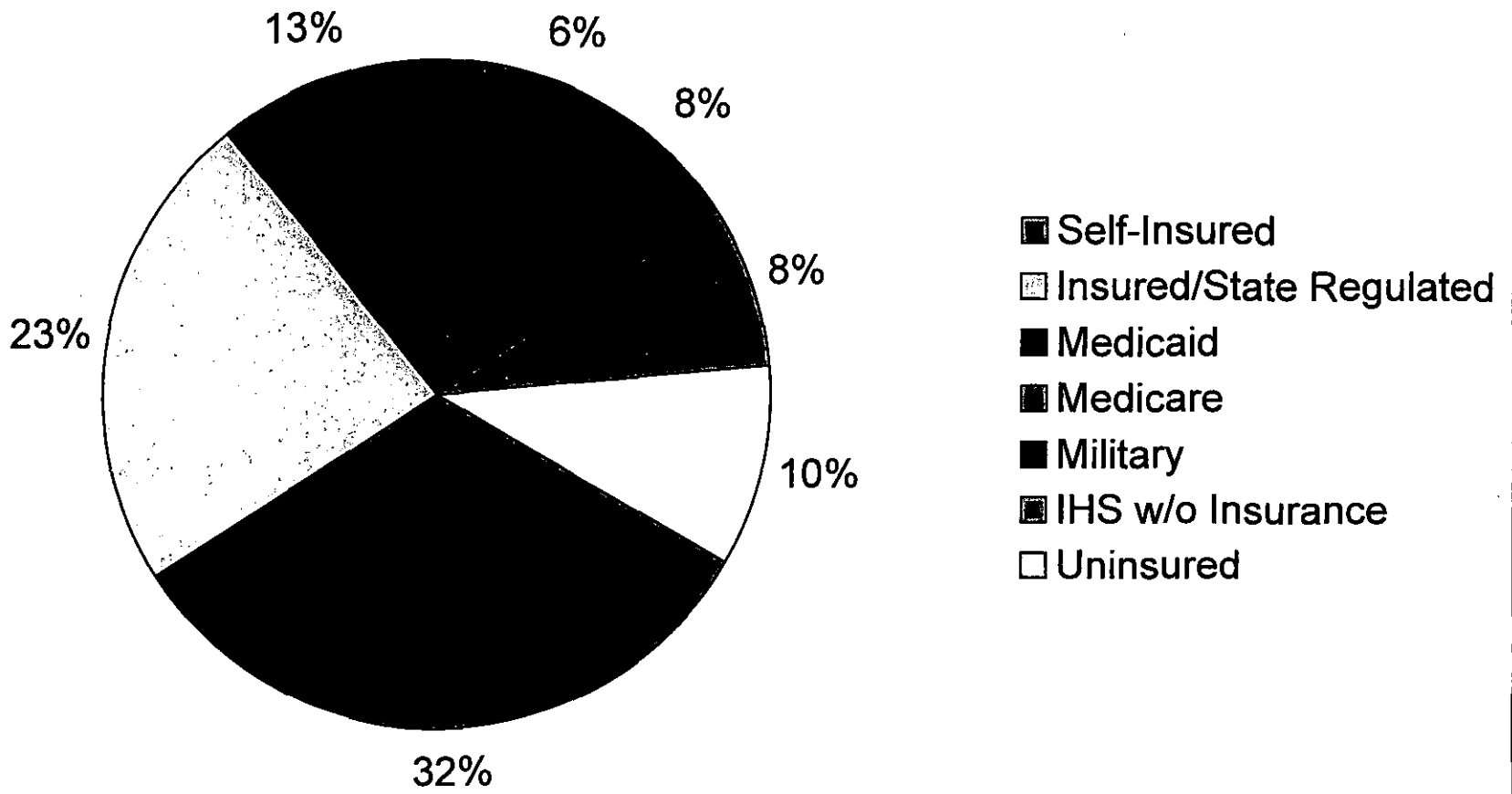
SB 10 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

Health Coverage of Alaska Population





National Surgical Adjuvant Breast and Bowel Project
PARTNERS IN CANCER RESEARCH

Norman Wolmark, MD
Chairman

Operations Center

Medical Affairs
412/330-4600 412/330-4660 Fax
412/330-4661 Fax

Administrative and Fiscal Affairs
412/330-4600 412/330-4662 Fax

Clinical Coordinating Division
1-800/477-7227

TESTIMONY OF D. LAWRENCE WICKERHAM, MD,
ASSOCIATE CHAIRMAN OF THE NSABP, CONCERNING SB280

I am Dr. Lawrence Wickerham, the Associate Chairman of the National Surgical Adjuvant Breast and Bowel Project (NSABP), which is one of the National Cancer Institute's Cooperative Trials Groups.

The NSABP conducts large phase III studies that compare standard treatments with newer innovative therapies in patients with early stage breast or colorectal cancer. The group's mission is to improve the survival and quality of life of these patients. 2008 is the 50th anniversary of the NSABP and over those years we have entered over 130,000 individuals into our trials. Today we have 200 participating centers and 300 satellite centers located throughout the U.S., Canada, Puerto Rico, and Ireland, and we do have centers in Alaska.

Results of previous NSABP studies have had a major impact in improving the care of both breast and bowel cancer. The results of our breast cancer studies have eliminated the use of true radical mastectomies, demonstrated that lumpectomy is an effective alternative, and we have shown that adjuvant treatment (treatment after surgery) can improve survival. Adjuvant therapy for breast cancer includes chemotherapy, hormonal therapy, and newer targeted treatments.

Figures from the American Cancer Society demonstrate that the mortality rate from breast cancer in the U.S. has declined for over a decade. This improvement is thought to be the result of screening mammograms to detect the disease and improvements in treatment. These improvements in care come primarily from clinical

D. Lawrence Wickerham, MD

trials like those conducted by the NSABP. The more patients that enter these studies, the more quickly we get results and the faster we can improve care. Unfortunately, for a variety of reasons, less than 5% of cancer patients choose to enter clinical trials. Cost is a major barrier.

Requiring health care insurers to cover the standard of care costs for individuals participating in cancer clinical trials would remove one significant barrier to increasing participation. Any research trial includes two general categories of costs: 1) research costs – expenses that the patient would not routinely incur if he or she was not a part of the trial (extra lab tests, x-rays, etc.), and 2) standard of care costs – expenses that would occur whether or not the patient entered the trial.

NSABP studies routinely identify the non-standard of care components. We provide the drug(s) being studied and typically provide additional non-federal funding to help defray the costs of trial participation, including the cost of non-standard of care items. The goal is to minimize any additional costs to the patient, improve trial participation and improve cancer care in general.

I and the NSABP strongly urge you to enact this bill so that cancer patients in Alaska can have improved access to state-of-the-art research studies like those available to patients in other states.

Thank you for listening to my testimony and I would be pleased to try to answer your questions.



February 17, 2009

AARP Alaska
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Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 10 (Davis)--Support

Dear Chair Davis,

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 10, authored by you.

SB 10 would require insurance programs, including Medicaid, to provide coverage for cancer victims undergoing clinical trials just as they would if the individual was not in the trial.

Most of our significant advances in cancer treatment that have become standard procedures began as clinical trials.

It makes no sense not to offer health insurance coverage for procedures that may be still considered experimental but offer some hope for the cancer victim. We purchase insurance (or the State provides it through Medicaid) so that we can have help with the costs that accompany a threatening disease. SB 10 is one of those bills that AARP believes makes sense, especially to a cancer victim and his/her family.

AARP recommends an "AYE" vote on SB 10.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Joe Thomas

Senator Fred Dyson
Senator Johnny Ellis

Cancer Clinical Trials CS for SB 10 (HSS)



CS for Senate Bill 10 (HSS) requires state-regulated insurance plans to cover routine care costs associated with cancer clinical trials. SB10 does not require plans to cover the actual costs of the clinical trial.

Why clinical trials:

Clinical trials are essential gateways to developing better tools for cancer prevention, detection, treatment and care. The research conducted through clinical trials helps move scientific discoveries from the laboratory into new therapies that can be used at the bedside to improve the quality of patient care. Yet consistently low enrollment of adults in clinical trials delays our progress.

Routine care defined:

Routine patient care is considered to be those services not specific to the clinical trial, such as infusion, labs, x-rays, and general medical care. **Basically, it means any care that would be provided anyway outside the context of a clinical trial.** SB10 adds the requirement that these routine care costs be covered while participating in a cancer clinical trial.

Costs are comparable:

Numerous studies show that patient care in clinical trials costs approximately the same as care delivered in standard therapy. In most cases, the third-party payer is not billed for the drug or treatment under investigation, therefore, care in a clinical trial can actually cost less than the care delivered in standard therapy.

Other market segments:

State regulated plans are one of the last segments of Alaska's insurance market to provide this coverage. Coverage for routine care costs are currently provided for under Medicare, Medicaid, Military, and a number of self-insured plans such as Providence Health System Alaska.

Why we need the law changed:

- SB10 removes a significant barrier to participation in cancer clinical trials, and
- Opens up treatment options for Alaskans.

Ultimately, increased participation in cancer clinical trials leads to advances that benefit everyone.

American Cancer Society Cancer Action Network / 3851 Piper Street, Suite U240, Anchorage, AK 99508

Alaska Director of Government Relations, Emily Nenon / Emily.Nenon@cancer.org

1.888.NOW.I.CAN / www.acscan.org/alaska



AARP Alaska
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April 5, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 411
Juneau, AK 99801-1182

RE: SB 10 (Davis)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and the members of the House Health and Social Services Committee to support SB 10, authored by Senator Bettye Davis and co-sponsored by Senator Joe Paskvan, your Committee colleague Representative Bob Lynn as well as Representatives Carl Gatto, Cathy Munoz, Pete Peterson, Charisse Millet and Les Gara.

SB 10 would require insurance programs, including Medicaid, to provide coverage for routine costs of cancer victims undergoing clinical trials just as they would if the individual was not in the trial. Research indicates that the costs for patient care in clinical trials are comparable to costs for care delivered in standard practice.

Most of our significant advances in cancer treatment that have become standard procedures began as clinical trials.

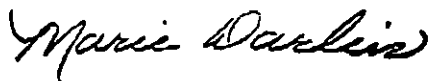
It makes no sense not to offer health insurance coverage for procedures that may be still considered experimental but offer some hope for the cancer victim. We purchase insurance (or the State provides it through Medicaid) so that we can have help with the costs that accompany a threatening disease. SB 10 is one of those bills that AARP believes makes sense, especially to a cancer victim and his/her family.

AARP recommends an "AYE" vote on SB 10.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Representative Tammie Wilson Representative Sharon Cissna
 Representative Bob Lynn Representative Lindsey Holmes
 Representative Paul Seaton Senator Bettye Davis

S B

1 3

HOUSE COMMITTEE REPC 1

(7)

Date Referred to Committee: April 7, 2009

FURTHER REFERRALS: Finance

Date of Committee Action: March 18, 2010

The HEALTH AND SOCIAL SERVICES Committee considered:

SENATE BILL NO. 13

"An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

SB 13 MEDICAL ASSISTANCE ELIGIBILITY

Recommends it be replaced with HCS or CS for _____ (_____)

For Senate Bills with new title: Technical Title New Title: HCR _____ | Same Title | New Title

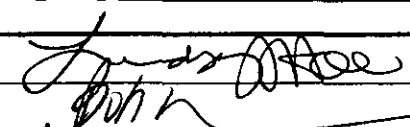
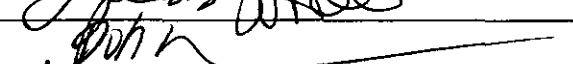
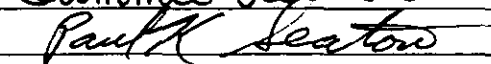
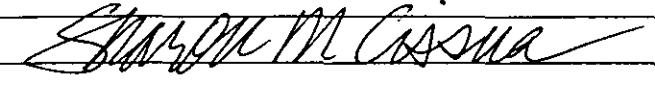
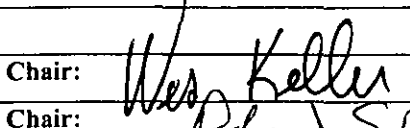
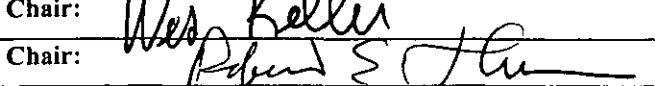
- attach amendments
- add new referral to _____ Committee
- Letter of Intent _____ Committee

List of
Abbrev
for
Depts.:

- ADM
- CED
- COR
- CRT
- EED
- DEC
- DFG
- GOV
- DHS
- LWF
- LAW
- LEG
- MVA
- DNR
- DPS
- REV
- DOT
- UA

NEW FISCAL NOTES				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
DHS		✓		
DHS		✓		
DHS		✓		

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

<u>Signing with recommendations</u>	Printed Last Name	DP	DNP	NR	AM
	Holmes	X			
	LYNN	X			
Jammie Wilson	T. Wilson		X		
	SEATON	X			
	CISSNA	X			
Chair: 	Keller		X		
Chair: 	HERRON	X			

Alaska State Legislature

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Senator [Bettye Davis@legis.state.ak.us](mailto:Bettye.Davis@legis.state.ak.us)
<http://www.akdemocrats.org>

Office of Senator Bettye Davis

January 20, 2010

Representatives Herron and Keller, Co-Chairs, House HSS Committee

RE: Request for Hearing for SB 13- "Denali KidCare" – "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Dear Representatives Herron and Keller,

Senator Davis respectfully requests a hearing concerning SB 13 before the House HSS Committee as soon as possible. SB 13 increases and restores the income eligibility standard for Denali KidCare to 200% of the Federal Poverty Guideline Level (FPL) – the level at which it was established over 10 years ago. Per the Kaiser Commission on Medicaid and the Uninsured in December, 2009 Alaska remains only one of four states below the 200% FPL. Twenty-three states are 200-249% FPL. Twenty-four states are 250% or higher FPL, including DC.

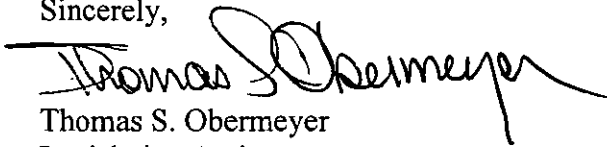
In 2009 over 26 states increased coverage for low income children, parents, and pregnant women. Nineteen states improved children's access to coverage by increasing eligibility, simplifying procedures, and/or eliminating premiums. The enactment of the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the infusion of fiscal relief through the American Recovery and Reinvestment Act (ARRA) in 2009 provided key federal support to help states maintain and expand coverage. Alaska was among nine states rewarded by the federal government for enrolling more uninsured children in Medicaid in 2009. On December 21, 2009 Kathleen Sebelius, Secretary of Health and Social Services, reported Alaska is receiving a \$789,000 bonus for boosting health insurance coverage for children. (See AP article, *Anchorage Daily News* attached).

Governor Parnell indicated to Senator Davis in Fall, 2009 that he supported increasing Denali KidCare to 200% FPL. Prompt action by the House HSS Committee will assure continued federal funding and enhanced matching funds for Denali KidCare through September, 2013.

Attached in order are the following:

1. Original Sponsor Statement
2. The most recent version of the bill
3. Sectional Analysis
4. Fiscal Notes
5. Additional Documentation

Sincerely,



Thomas S. Obermeyer
Legislative Assistant

Alaska State Legislature

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Phone: (907) 269-0144
Fax: (907) 269-0148



Session: (Jan. - May)
State Capitol, Suite 7
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Senator Bettye Davis@legis.state.ak.us
<http://www.akdemocrats.org>

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Sponsor Statement

SB 13 increases and restores to original levels 12 years ago the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL). Alaska as one of the nation's wealthiest states is only one of 5-7 states which funds its SCHIP program below 200% FPL. SB 13 makes health insurance accessible to an estimated 1277 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an "enhanced" reimbursement program with up to 70% matching funds (Alaska currently receives about 66%) under the federal government's State Children's Health Insurance Program (SCHIP), which was created in 1997. Congress reauthorized the SCHIP program for five years and President Obama just signed into law on February 4, 2009 with expanded coverage for 4 million more children.

Consider the following information from the Kaiser Commission on Medicaid and the Uninsured, January, 2009:

- 44 states, including D.C., cover children in families with incomes at 200% FPL or higher.
- 33 states cover children in families with income between 200% and 250% FPL.
- 19 states including D.C., cover children in families with income at 250% or higher. 10 of these states cover children in families with income at 300% FPL or higher.
- 35 states allow premiums or enrollment fees, and 24 states have co-payments for selected services in SCHIP programs on a sliding scale of FPL.
- 46 states do not require asset tests

Denali KidCare serves an estimated 7900 Alaska children and remains one of the least costly medical assistance programs in the state at about \$1,700 per child with full coverage, including dental, which is about 20% of the cost of adult senior coverage.

Early intervention and preventative care under SB 13 will greatly increase Alaska children's health and yield substantial savings to the state and public and private sector hospital emergency rooms which must admit indigent and uninsured patients for non-emergency treatment. It is estimated that

uninsured children with a medical need are five times as likely not to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost.

There are still an estimated 18,000 uninsured children in Alaska, or about 9% of the children age 18 and under. Private health care coverage for children has declined over 30% in the last ten years, and the deepening recession is pulling more children and families into the uninsured ranks. The reauthorized SCHIP program and "Stimulus Package" should help, and Alaska should do its share and take advantage of available federal matching funds by insuring its low income children up to and including 200% FPL under SB 13.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

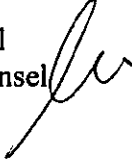
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

January 22, 2009

SUBJECT: Sectional Summary (SB 13; Work Order No. 26-LS0076A)

TO: Senator Betty Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends the medical assistance eligibility provisions for persons under 19 years of age and for pregnant women by increasing the household income limit from 175 to 200 percent of the federal poverty line.

Section 2. Increases the household income limit from 175 to 200 percent of the federal poverty line for requiring premiums and cost-sharing contributions from medical assistance recipients who are under 19 years of age.

Section 3. Provides for an immediate effective date.

JMM:ljw
09-039.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB013
 () Publish Date: _____

Identifier (file name): SB013-DHSS-BHMS-02-01-09 Dept. Affected: Health & Social Services
 Title: Medical Assistance Eligibility RDU: Behavioral Health
 Component: Behavioral Health Medicaid Services
 Sponsor: Davis
 Requester: Unknown Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	430.0	0.0	467.0	507.1	550.7	598.1	649.5
Miscellaneous							
TOTAL OPERATING	430.0	0.0	467.0	507.1	550.7	598.1	649.5

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	284.0		305.7	330.7	359.1	390.0	423.6
1003 GF Match	146.0		161.3	176.4	191.6	208.1	226.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	430.0	0.0	467.0	507.1	550.7	598.1	649.5

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner Phone 907-269-7827
 Division: Health Care Services Date/Time 1/22/08 12:00 AM
 Approved by: Alison Elgee, Assistant Commissioner Date 2/1/2009
Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB013

ANALYSIS CONTINUATION

prevailing federal poverty guideline (FPG) for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility.

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2010 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2010 and 2015. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2010 and 2015; however, the program is currently funded under a continuing resolution. Title XXI funding for the balance of SFY 2009 after March 30, 2009 and for SFY 2010 will not be established until Congress takes additional action to reauthorize and fund the SCHIP program.

Expenditures for the Behavioral Health Medicaid Services component were determined based on the component's share of expenses for the affected eligibility subtypes in 2008. Behavioral Health paid about a quarter of the costs for affected DKC children in 2008. No charges for services for DKC pregnant women were paid by this component in 2008.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB013
() Publish Date: _____

Identifier (file name): SB013-DHSS-MS-02-01-09 Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility RDU: Health Care Services
Component: Medicaid Services
Sponsor: Davis
Requester: Unknown Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8
Miscellaneous							
TOTAL OPERATING	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts	1,448.7	1,561.0	1,689.5	1,834.8	1,992.6	2,164.0
1003 GF Match	656.3	725.1	793.1	861.3	935.4	1,015.8
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other Interagency Receipts						
TOTAL	2,105.0	0.0	2,286.0	2,482.6	2,928.0	3,179.8

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200 percent of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner Phone 907-269-7827
Division: Health Care Services Date/Time 1/22/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 2/1/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB013

ANALYSIS CONTINUATION

prevailing federal poverty guideline (FPG) for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility.

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2010 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2010 and 2015. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2010 and 2015; however, the program is currently funded under a continuing resolution. Title XXI funding for the balance of SFY 2009 after March 30, 2009 and for SFY 2010 will not be established until Congress takes additional action to reauthorize and fund the SCHIP program.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2008. Health Care Services Medicaid paid 100% of the costs for DKC pregnant women and about three quarters of the costs for affected DKC children in 2008.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB013
 () Publish Date: _____

Identifier (file name): SB013-DHSS-PAFS-02-04-09 Dept. Affected: Health & Social Services
 Title: Medical Assistance Eligibility RDU: Public Assistance
 Component: Public Assistance Field Services
 Sponsor: Davis
 Requester: Unknown Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services	134.4		134.4	134.4	134.4	134.4	134.4
Travel							
Contractual	17.6		17.6	17.6	17.6	17.6	17.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0
Equipment	14.4						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	167.4	0.0	153.0	153.0	153.0	153.0	153.0

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	83.7		76.5	76.5	76.5	76.5	76.5
1003 GF Match	83.7		76.5	76.5	76.5	76.5	76.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	167.4	0.0	153.0	153.0	153.0	153.0	153.0

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare(DKC) program was originally created.

This fiscal note represents the additional administrative costs needed to support the increased eligibility determination workload resulting from more pregnant women and children applying for medical assistance, using the assumptions from the companion fiscal notes for the Division of Health Care Services and the Division of Behavioral Health.

(continued on Page 2)

Prepared by: Ellie Fitzjarrald Phone 907-465-5847
 Division: Division of Public Assistance Date/Time 2/4/09 12:00 AM

Approved by: Alison Elgee, Assistant Director Date 2/4/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB 013

ANALYSIS CONTINUATION

The eligibility decision includes verifying information and determining whether a pregnant woman or child qualifies for DKC when they apply, acting on changes, and periodically re-examining a household's eligibility.

We assume that 218 pregnant women and 1,277 children will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and that implementation will begin July 1, 2009. We estimate two additional Eligibility Technician I (Range 13) positions will be needed to manage this additional work in FY2010.

Total Administrative Costs for ET I Positions:

Personal Services: Two Eligibility Technician I Range 13 at a cost of \$134.4, including benefits, for 12 months.

Contractual: Annual cost for office space, phones, etc. will be \$17.6.

Commodities: Annual cost for the office supplies will be \$1.0.

Additional Cost of FY2010:

Equipment/Supply: A one time cost of \$14.4 for desktop computer, software, printer, and work stations will be needed for the new positions.

Alaska State Legislature

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[Senator Bettye Davis@legis.state.ak.us](mailto:Senator_Bettye_Davis@legis.state.ak.us)
<http://www.akdemocrats.org>

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Background of SCHIP/Denali Kid Care

- SCHIP was created in 1997 to reduce the number of uninsured children by providing subsidized insurance to children of those parents who are too poor to afford insurance but make too much to receive Medicaid coverage. About 1/3 of all children in America get health services through Medicaid or the State Children's Health Insurance Program (SCHIP), which is administered in Alaska through the Denali KidCare Program.
- The Denali KidCare Program is 70% funded by the federal government up to the state's allocated funding level. After that, the reimbursement rate declines to slightly over 50%. In fiscal year 2006 the cost of Denali KidCare was \$25.9 million, of which \$18.2 million was paid by the federal government.
- Denali KidCare provides health insurance for children age 18 and pregnant women who meet income guidelines. There is no cost to eligible children, teens and pregnant women. However, youth who are 18 may be required to contribute a limited amount for some services.
- Roughly 7,600 children were covered by Denali KidCare as of December, 2006.
- The cost per child of Denali KidCare is about \$1,700 annually, compared to over \$12,000 for an elderly person who qualifies for federal aid.
- By comparison, private health insurance for a family of three, e.g., a pregnant woman with two children, is estimated at \$8,000-\$17,000 annually. Unlike Denali KidCare, this insurance may require a \$1,000 deductible, 20% co-pay, and no vision, dental or hearing benefits.
- Alaska remains one of the lowest eligibility rates in the nation. Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL. The US and state governments' rationale for higher eligibility for children's health insurance is that it will save huge sums in transfer costs and improve health in the future through early detection and care.

Alaska State Legislature

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Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Repercussions of the unmet health needs of Alaska's uninsured children

- The number of uninsured children in Alaska is estimated to be about 18,000 or 9% of the population age 18 and under (Urban Institute and Kaiser Commission on Medicaid and the Uninsured).
- Over the last 10 years Alaska has seen a 31% decline in the number of children covered by private health insurance (Robert Wood Johnson Foundation).
- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).
- Uninsured children have much higher health risks than do covered children. They receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser, *supra*).
- Uninsured children are more likely to develop throat, eye, and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than five times as likely as insured children to have an unmet need for medical care and nine times more likely not to be examined by a regular doctor. They are also four times more likely to use emergency rooms which are much more costly than care in physicians' offices (*Pediatrics* 105, 113; "Care for Children," *New England Journal of Medicine*, 330).
- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (*Health Affairs* 23, no. 5, September-October 2004).
- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund, Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of \$65-\$130 billion annually.

Why Coverage for Pregnant Women is Important In Alaska

- Alaska has one of the nation's highest documented pregnancy-associated mortality ratios – 58 per 100,000 live births during 1990-1999 (DHSS). National data indicate that women who receive no prenatal care are at increased risk of pregnancy-related death.
- Only 58% of women in Alaska receive adequate prenatal care, compared with 75% nationally.
- Mothers having late or no prenatal care are more likely to have low birth weight or pre-term infants and are at increased risk for pregnancy-related mortality and complications of childbirth (DHSS).
- The average cost of hospital care for a premature baby was \$75,000 in 2001, compared with \$1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about \$13.1 billion annually.

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<http://www.akdemocrats.org>

Office of Senator Bettye Davis

April 7, 2009

Representatives Wes Keller, Co-Chair
House HSS Committee

RE: Request for Hearing for SB 13

"An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Dear Representative Keller,


Senator Davis respectfully requests a hearing concerning SB 13 before the House HSS Committee. SB 13 increases and restores the maximum income eligibility standard for Denali KidCare to 200% of the Federal Poverty Guideline Level (FPL). Denali KidCare, Alaska's federal Medicaid-funded State Children's Insurance Program (SCHIP), was just reauthorized for five years by Congress and signed into law as a priority with expanded coverage by President Obama on February 4, 2009. Continued federal funding should assure enhanced matching funds at 66%-70% for Denali KidCare through FY2015.

Alaska remains only one of five states below the 200% Federal Poverty Level for the SCHIP/Denali KidCare Program. The Alaska Health Care Strategies Planning Council recommended increasing Denali KidCare to 200% FPL in its Final Report on December 23, 2007. It is our understanding that the Governor's office also supports increasing Denali KidCare to 200% FPL.

Attached in order are the following:

1. Sponsor Statement
2. The most recent version of the bill, SB 13
3. Sectional analysis
4. Fiscal Notes
5. Additional Documentation

Sincerely,


Thomas S. Obermeyer,
Legislative Administrative Assistant
465-3762



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Alaska rewarded for kids' health insurance

The Associated Press
(12/21/09 21:40:13)

Alaska is among nine states being rewarded by the federal government for enrolling more uninsured children in Medicaid. Health Secretary Kathleen Sebelius said Alaska is receiving a \$789,000 bonus for boosting health insurance coverage for children.

The payouts were part of the Children's Health Insurance Program reauthorization signed into law by President Barack Obama.

The amounts totaled \$72.6 million in this fiscal year.

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kaiser
commission on

medicaid and the uninsured

A Foundation for Health Reform:

Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost- Sharing Practices in Medicaid and CHIP for Children and Parents During 2009

Executive Summary

Prepared by:

Donna Cohen Ross and Marian Jarlenski
Center on Budget and Policy Priorities

and

Samantha Artiga and Caryn Marks
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

December 2009

THE HENRY J.
KAISER
FAMILY
FOUNDATION

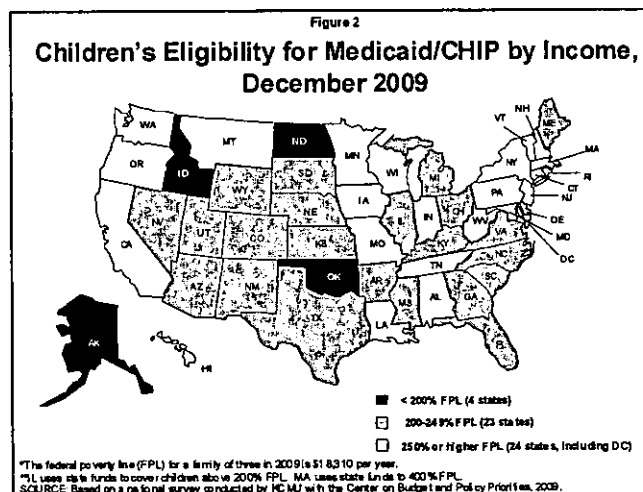
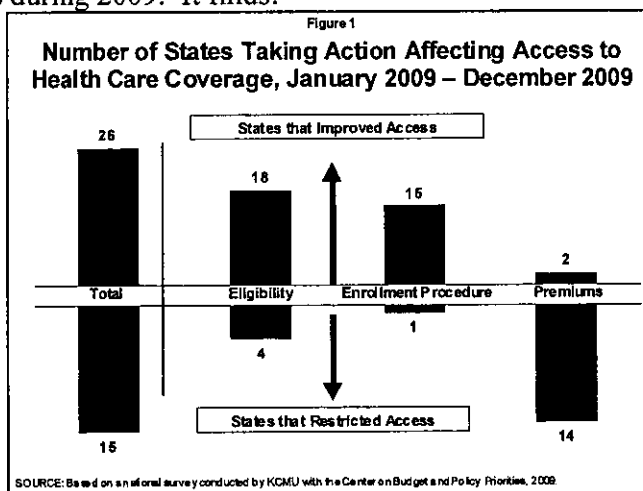
Executive Summary

Over the past decade, substantial progress has been made on covering low-income families through Medicaid and the Children's Health Insurance Program (CHIP). However, states' ability to sustain and advance this coverage faced a difficult test in 2009. As the year began, CHIP still had not been reauthorized and states were facing the bleakest economic picture in years. Then, in early 2009, several developments, including the enactment of the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the infusion of fiscal relief through the American Recovery and Reinvestment Act (ARRA), provided key federal support to help states maintain and expand coverage. ARRA also established important protections to Medicaid eligibility and enrollment procedures that helped preserve coverage (although these did not extend to CHIP).

In 2009, health coverage programs for low-income children and parents managed not only to survive the tumultuous economic environment, but also to expand and improve access. The stabilizing force of ARRA's fiscal relief, along with its stipulations preventing states from reducing eligibility or imposing enrollment barriers in Medicaid, enabled states to avoid cuts to these aspects of their programs and move forward, making use of new resources and opportunities in CHIPRA. Based on a national survey, this report provides an overview of state actions on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and CHIP for children and parents during 2009. It finds:

More than half the states (26 states) advanced health coverage for low-income children, parents, and pregnant women in 2009 (Figure 1). These advancements included eligibility expansions, such as increases in income eligibility limits for children (9 states) and expansions to immigrant children and/or pregnant women who have been legally residing in the U.S. for less than five years under the new CHIPRA option (18 states), as well as enrollment and renewal simplifications and premium reductions.

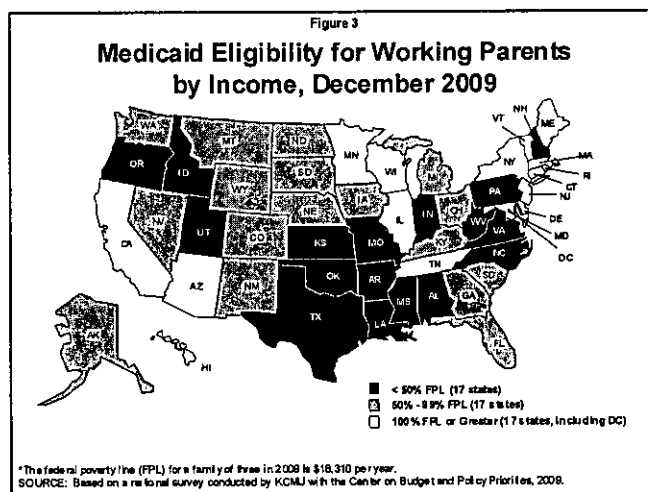
Children were the main beneficiaries of expansions in 2009. Nineteen states improved children's access to coverage by increasing eligibility, simplifying procedures, and/or eliminating premiums. Reflecting this progress, currently, 47 states cover children in families with income at 200 percent of the federal poverty line (\$36,620 for a family of three in 2009) or higher (Figure 2). States also continued to make strides forward in simplifying enrollment and renewal



procedures for children (9 states) and by reducing CHIP premiums (2 states). Overall, of the 34 states that charge premiums for children, most do not charge families with incomes below 150 percent of the federal poverty line and the median charge for two children in a family of three with income at 200 percent of the federal poverty line remains modest at \$480 per year (\$40 per month), or 1.3 percent of family income.

Although most actions were positive, 15 states scaled back coverage due to budget pressures. CHIP programs bore the brunt of reductions since the eligibility and enrollment protections included in ARRA only applied to Medicaid and did not protect CHIP. No state reduced income eligibility for children. However, two states froze CHIP enrollment for some period of time in 2009 and one state reduced eligibility for low-income parents. Other actions included increases in waiting periods for CHIP, retractions in eligibility simplifications, and relatively modest increases in CHIP premiums.

Coverage for parents continues to lag significantly behind children, with disparities growing in 2009. While children's health coverage has grown stronger over time, millions of their parents remain uninsured, since, in most states, eligibility limits for parents remain extremely low. Further, because of the recent advancements for children, the gap between coverage for children and parents has become even more profound. Currently, the median income eligibility limit for children is 235 percent of the federal poverty line, compared to 64 percent of the federal poverty line for working parents. Overall, in 34 states, eligibility for working parents is limited to less than 100 percent of the federal poverty line (\$18,310 for a family of three in 2009) with 17 states limiting eligibility to less than half of poverty (\$9,155 per year for a family of three in 2009) (Figure 3). Additionally, in most states, it remains more difficult to enroll an eligible parent than it does to enroll an eligible child.



States' commitment to provide Medicaid and CHIP coverage to low-income families and hold onto the accomplishments of 2009 will continue to be tested in 2010. States' grim budget situations are projected to persist and the fiscal support and requirements for states to maintain Medicaid eligibility and enrollment practices, which proved instrumental in helping states preserve and continue to advance coverage in 2009, are scheduled to expire. Without additional fiscal relief, states will likely begin to contemplate severe cuts to health coverage programs, which will not only jeopardize coverage for low-income families but weaken the base of coverage upon which broader health reform efforts will seek to build. Current reform proposals would build upon Medicaid to expand coverage to the millions of individuals who remain uninsured. Thus, the status of Medicaid and CHIP programs today and their ability to continue to maintain and advance coverage in the coming year will have important implications for broader reform. Continued actions to strengthen the foundation of Medicaid and CHIP coverage will be key to supporting future reform efforts.



An Overview of the CHIPRA Outreach and Enrollment Grants

On July 6, 2009, HHS Secretary Kathleen Sebelius and Medicaid Director Cindy Mann announced a request for a first round of outreach grant proposals funded through the Children's Health Insurance Program Reauthorization Act (CHIPRA). More information about the long-awaited "Request for Proposals" (RFP) can be found [here](#).

A major goal of CHIPRA is to cover more of the millions of uninsured children who already are eligible for Medicaid or CHIP, but whose families lack information about the programs, face red-tape barriers to enrollment, or encounter unnecessary barriers when seeking to renew their children's coverage. To this end, CHIPRA gave states a range of new tools and incentives to enroll already-eligible children and also created the \$100 million outreach fund.

These outreach grants can help boost awareness and encourage further simplification of the enrollment and renewal processes while targeting areas with high rates of eligible but not enrolled children and minority children who are disproportionately uninsured. Outreach, including community-based assistance, is also critical during a recession, when newly unemployed families may be particularly unlikely to know about the availability of public programs for their children.

The Centers for Medicaid and Medicare (CMS) will administer the grants. In soliciting proposals, CMS emphasizes that a strong connection must exist between outreach efforts and resultant enrollment and retention of eligible children. Data must be collected, reported, and analyzed against performance measures to determine the effectiveness of outreach efforts, and refinements to strategies must be made in real time when outcomes are not achieving the desired gains in enrollment and retention.

Legislative Background

Congress provided \$100 million in CHIPRA for outreach and enrollment activities through September 2013. Of this amount, \$10 million will be used for a national enrollment campaign and \$10 million will be granted directly to Indian health service providers and urban Indian organizations receiving funds under Title V of the Indian Health Care Improvement Act for outreach to and enrollment of Native American children. The remaining \$80 million will be granted to other eligible entities, which may include state, county, and local governments, community-based or faith-based organizations, schools, and federal safety net providers. These grants are the focus of the RFP and up to \$40 million will be awarded in this first round.

As required by CHIPRA, priority for the grant awards will be given to eligible entities that target geographic areas with high rates of:

- eligible but unenrolled children, including children who reside in rural areas; or

- racial and ethnic minorities and populations with health disparities, including proposals that address cultural and linguistic barriers to enrollment.

In applying for outreach grants, eligible entities must establish that they have access to, and credibility with, ethnic or low-income populations in the communities where activities will be conducted. As stipulated in statute and reiterated in the RFP, applicants must also demonstrate the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and other punitive fears associated with receipt of benefits, as well as other cultural barriers to application and enrollment in public programs.

The Request for Proposal Process

CMS announced that it plans to award the \$80 million in outreach grant funds in two or more rounds. This first round will grant up to \$40 million in two-year projects ranging from \$25,000 to \$1,000,000. CMS anticipates awarding about 200 grants in this round.

Prospective grantees have their work cut out for them, with proposals on a fast timeline, due one month after the release of the RFP. CMS will employ a multi-phased review process that includes an objective assessment by a panel that may include private sector experts, beneficiaries, and federal policy staff, based on weighted criteria as defined in the RFP.

Key Dates

July 22, 2009 – Conference Call for Prospective Grant Applicants
July 27, 2009 – Voluntary Letter of Intent Requested (but not required)
August 6, 2009 – Electronic Submission of Application
August 10, 2009 – Mail Submission of Application
On or before September 30, 2009 – Announcement and Commencement of Grants

Grant Principles

In announcing the grants, CMS expressly stated the purpose of providing outreach money is to not only find the children who are eligible but not enrolled in Medicaid and CHIP but to ensure that they are enrolled and that they retain their coverage while eligible. The award of the grants is based on the following principles:

- *Outreach must be results driven and connected to actual enrollment and retention of children in Medicaid and CHIP.*
- *Grantees must provide sound data demonstrating the connection between the proposed outreach efforts and actual enrollment and retention.*
- *Data and systems improvements that are appropriate within the context of the proposed outreach strategies will be considered for funding.*
- *Best practices and lessons learned will be shared among grantees and successful outreach strategies that can be replicated are of particular interest.*

Eligible Entities

By law, a diverse group of entities is eligible to apply for grants. The common thread is that these organizations must have experience serving low-income children and families. Coalitions or eligible entities representing broad community partnerships with evidence of community involvement are allowed. Only one application may be submitted by a single entity in this grant round, but an eligible entity may be a member of multiple coalitions.

Eligible entities include:

- A State;
- A local government;
- An Indian tribe, tribal consortium, Indian Health Service Provider, or other tribal organization receiving funds under title V of the Indian Health Care Improvement Act;
- A federal health safety net organization such as a federally-qualified community health center or disproportionate-share hospital;
- A national, state, local or community-based public or nonprofit private organization, including those that use community health workers or have doula programs;
- A faith-based organization or consortia (subject to section 1955 of the Public Health Service Act); and
- An elementary or secondary school.

Outreach and Enrollment Strategies

Applicants are required to submit an outreach and enrollment plan. It is expected that such plans will have different components depending on the strategies proposed. For example, a proposal to establish or strengthen a community-based application and renewal assistance program will have different elements than a plan aimed at improving notices, processes, or systems to enroll or retain eligible children.

All proposals must include certain components, which include utilizing demographic data in the design of outreach projects for target populations and describing how the applicant will submit and analyze the enrollment and retention data. Also required are descriptions of each vulnerable population to be targeted and estimates of the expected numbers of uninsured children by population to be enrolled through the grant activities. Plans must describe the proposed outreach strategies and the methods that will be used to track and measure the effectiveness of each strategy in enrolling and retaining targeted Medicaid- and CHIP-eligible children. All applicants must demonstrate the ability to refine the strategies in real time based on the assessment of the effectiveness of the strategies.

Target Populations

The design of the outreach projects should target populations with high levels of uninsured children under 200 percent of the Federal Poverty Level (FPL) who may be eligible for Medicaid

or CHIP, but are not enrolled. While *target populations are not limited to the following*, proposals addressing these groups with high rates of uninsurance and issues with access to health care will be viewed favorably:

- Legal immigrants or children living in households with mixed immigration status;
- Cross-border populations;
- Children of migrant farmers;
- Hispanic children;
- Teens;
- Rural children;
- Homeless children; and
- American Indian/Alaska Native children.

Budgets, Match and Sustainability

Grant awards will range from \$25,000 to \$1,000,000 over the two-year period. Funds can be used for a variety of expenses including personnel, equipment, travel, and other direct costs. Applicants are cautioned to use a reasonableness test when determining a cost per new enrollee, as well as the percentage of funds attributable to administrative costs. *The outreach grants do not require a match* from the recipient, but applicants must demonstrate the ability to sustain the outreach, enrollment, and retention efforts beyond the grant period by providing a plan for sustainability. Weight will be given to applications that can show additional funding or in-kind support.

Data Reporting and Evaluation

All proposals must describe how data will be defined, collected, analyzed, and reported to assess the effectiveness of grant activities. Specific outcome measures, which may vary based on the proposed strategies, must be developed as part of the evaluation plan. Applicants must demonstrate the capacity to modify strategies when the data indicate that activities are not achieving the goals of the project. Throughout the RFP, there is a consistent and strong emphasis on data reporting, assessing progress, and redirecting efforts when needed. *The Secretary is also required to submit an annual report to Congress on the outreach and enrollment activities conducted with these funds and make the enrollment data and information collected available publicly.*

Best Practices and Lessons Learned

Applicants must participate in specific program elements to document strategies and outcomes, as well as share and report results. Grantees must commit to sharing policy documents, best practices, and lessons learned with CMS and through peer-to-peer learning and conferences. Grantees must also be willing to coordinate messages and strategies with the national outreach and enrollment campaign.

Specific Requirements for Different Types of Grantees

- ***State Applicants***

By law, a maintenance of effort (MOE) on outreach and enrollment expenditures is required. If funds are granted directly to a state, it must maintain the same level of state funding for outreach and enrollment activities as expended in the prior year. In the proposed grant budget, states must submit the amount of money that was spent on Medicaid and CHIP outreach and enrollment efforts in the preceding fiscal year. This may be challenging to quantify as states have a variety of mechanisms and funding streams for supporting outreach and enrollment. States are also required to submit a certification of maintenance of effort verifying that the grant funds will not supplant existing state expenditures for Medicaid and CHIP outreach and enrollment efforts.

Due to the responsibility that State Medicaid or CHIP agencies have in enrolling eligible children and their possession of critical data, proposals from these agencies or coalitions that include these agencies are subject to additional criteria. Depending on the proposal, such requirements may include:

- Formal agreements with coalition grantees or enrollment facilitators (if proposed in the grant);
- Coordination of coalition grantees for the national outreach and enrollment campaign; and
- Evidence that the state can provide technical assistance to coalition grantees such as providing mapped census demographic data so grantees can target areas of disparities; conducting focus groups or surveys; and broadening partnerships with key entities that can be utilized by grantees.

State applicants must demonstrate a commitment to facilitating enrollment and retention. *Of particular interest are innovative applications of technology* such as web-based applications, telephone enrollment and renewal processes, development of new simplification practices or new methods for premium payments, and other proposals including information technology and systems improvements to support outreach, enrollment, and retention.

- ***Non-State Applicants***

In general, applicants must show that the state is supportive of their application. Non-state applicants must develop a Memorandum of Understanding (MOU) with the State Medicaid and CHIP agencies for the purposes of data collection or alternate plans to demonstrate enrollment or retention results. *In the absence of state collaboration,* applications must demonstrate the efforts will be effective in increasing enrollment among eligible children. No specific guidance is provided on how this might be accomplished.

- ***Tribes or Tribal Entities***

While tribes and tribal organizations are eligible for grants in this solicitation, they are also eligible for the \$10 million in grants targeted to Native American outreach and enrollment. Duplication of funding for activities is not allowed.

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News Release

FOR IMMEDIATE RELEASE
Wednesday, September 30, 2009

Contact: HHS Press Office
(202) 690-6343

Secretary Sebelius Awards \$40 Million to States to Find, Enroll Children in CHIP, Medicaid

HHS Secretary Kathleen Sebelius today announced \$40 million in grants to 69 grantees in 41 states and the District of Columbia to help them find and enroll children who are uninsured but eligible for either Medicaid or the Children's Health Insurance Program (CHIP).

"Today's awards will help fulfill President Obama's pledge to assure the health and well-being of our nation's children," said Secretary Sebelius. "With millions of Americans either out of work or otherwise struggling to make ends meet during this recession, there is an even greater urgency to bring steady, reliable health care to children in these families who may have lost their coverage."

Recognizing that millions of children are eligible for Medicaid or CHIP, but are therefore needlessly uninsured, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) set aside \$100 million for fiscal years 2009-2013 expressly to help find and enroll eligible children. Of the total outreach amount, \$80 million will be given to states and other organizations, \$10 million to Tribal organizations and \$10 million for a national outreach effort. Today's awards are for a two year period ending Dec. 31, 2011, which will then be followed by a second round of \$40 million in new grants.

As called for in CHIPRA, grants were awarded to applicants whose outreach, enrollment and retention efforts will target geographic areas with high rates of eligible but uninsured children, particularly those with racial and ethnic minority groups who are uninsured at higher-than-average rates. For example, 20 percent of the projects to be funded will target Hispanic children, with an emphasis on Hispanic teens, and 11 percent will focus on homeless children and seven percent will be aimed at Native American/Alaska Native children.

The vast majority of grantees will be using multiple, community-based approaches. One grantee in Missouri, for example, will work with a consortium of 35 churches in low-income, minority communities. Those parishioners will go door-to-door to locate potentially eligible children and then help those families apply for CHIP or Medicaid coverage. Another grantee will place self-service kiosks in community centers and Native American Chapter Houses (community halls) where there will also be staff available to help with applications if needed. One state school system will track children who receive free or reduced cost lunches and, with the families' permission, share that information with state health programs, which will, in turn, mail applications for CHIP and Medicaid to those families. The state will also provide one-on-one assistance with those applications.

The grant awards require that recipients be able to show actual increases in enrollment and retention of children already in the programs. Both CHIP and Medicaid state agencies are to report to the Centers for Medicare & Medicare Services (CMS) the number of new enrollees and those who retained coverage that are directly attributable to the grant activities. Grantees are also to report activities they believe were the most effective in finding, enrolling and maintaining children in these benefit programs.

"No child in America should go without decent health care," said Cindy Mann, director of the Center for Medicaid and State Operations -- the group within CMS that will administer the grants. "With the funds we are awarding today we hope to reduce the number of children who do."

A list of grantees by state is below.

State	Grantee	Award
<u>Arizona</u>	Pima Community Access Program	\$982,577
<u>Alabama</u>	Alabama Primary Care Association	\$987,732
	Tombigbee Healthcare Authority	\$141,167
<u>Alaska</u>	Alaska Youth and Family Network	\$198,304
	Norton Sound Health Corporation	\$72,999
<u>Arkansas</u>	St. Francis House NWA Inc., Community Clinic	\$162,965
<u>California</u>	Providence Little Company of Mary Foundation	\$317,144
	Yolo County Children's Alliance (YCCA)	\$399,900
<u>Colorado</u>		

	Colorado Association of School Based Health Care	\$499,835
	Telluride Foundation	\$301,410
<u>Connecticut</u>		
	Community Health Center Association of Connecticut	\$988,177
	Community Health Center, Inc. (CHC)	\$400,584
<u>District of Columbia</u>		
	National Alliance for Hispanic Health	\$984,144
<u>Florida</u>		
	Fann Ayisyen Nan Miyami, Inc. (FANM)	\$69,102
	University of South Florida	\$988,177
<u>Georgia</u>		
	West End Medical Centers Inc.	\$571,135
	Medical College of Georgia Research Institute	\$986,827
<u>Hawaii</u>		
	Bay Clinic, Inc.	\$200,000
	Hawaii Primary Care Association	\$488,187
<u>Illinois</u>		
	Chicago Public Schools	\$235,173
	Beacon Therapeutic School, Inc. of Chicago	\$250,830
<u>Idaho</u>		
	Mountain States Group, Inc.	\$287,896
<u>Indiana</u>		
	St. Vincent Health Inc.	\$864,309
<u>Kansas</u>		
	Inter-Faith Ministries Wichita Inc.	\$523,932
	Keys for Networking	\$866,749
<u>Louisiana</u>		
	Louisiana State Department of Health and Hospitals	\$955,681
	TECHE Action Board	\$234,808
<u>Maine</u>		
	Maine Department of Health and Human Services	\$680,249
	Maine Primary Care Association	\$311,061
<u>Maryland</u>		
	Garrett County Health Department	\$200,000
	MD Department of Health and Mental Hygiene	\$988,177
<u>Massachusetts</u>		
	Health Care for All, Inc.	\$410,815
	South End Community Health Center	\$304,385
<u>Michigan</u>		
	Michigan Primary Care Association	\$915,079
	YMCA of Greater Grand Rapids	\$293,040
<u>Minnesota</u>		
	Portico Healthnet, Inc.	\$988,177
	Vietnamese Social Services of Minnesota	\$280,000
<u>Mississippi</u>		
	Mississippi Primary Health Care Association	\$988,152
<u>Missouri</u>		
	Missouri Coalition for Primary Health Care	\$332,173
	St. Louis Children's Hospital Foundation	\$985,373
<u>Montana</u>		
	Montana Department of Public Health and Human Services	\$971,868

<u>Nebraska</u>	One World Community Health Centers Inc.	\$706,264
<u>New Hampshire</u>	Cheshire Medical Center	\$143,700
<u>New Jersey</u>	Health Research and Educational Trust of New Jersey	\$988,177
	New Jersey Department of Human Services, Division of Medical Assistance and Health Services	\$988,177
<u>New Mexico</u>	First Nations Community Health Source	\$355,000
	New Mexico Human Services Department	\$957,221
<u>New York</u>	The Mary Imogene Bassett Hospital	\$498,718
	Structured Employment Economic Development Corporation	\$988,177
<u>North Carolina</u>	North Carolina Pediatric Society Foundation	\$678,210
<u>Ohio</u>	Dayton Public Schools	\$327,900
	Legal Aid Society of Greater Cincinnati	\$316,418
<u>Oklahoma</u>	Oklahoma Health Care Authority	\$988,177
<u>Oregon</u>	Oregon Department of Health and Human Services	\$988,177
	Northeast Oregon Network of LaGrande	\$465,982
<u>Pennsylvania</u>	Concern for Health Options, Information, Care & Education (CHOICE)	\$200,000
	Consumer Health Coalition	\$299,750
<u>South Carolina</u>	Palmetto Project, Inc.	\$981,009
<u>Texas</u>	Texas Leadership Center	\$988,177
	YWCA of Lubbock, TX, INC.	\$384,680
<u>Utah</u>	Association for Utah Community Health	\$762,580
<u>Virginia</u>	Catholic Charities USA (CCUSA)	\$957,617
	Virginia Health Care Foundation	\$988,154
<u>Washington</u>	HIP of Spokane County/Community Minded Enterprise (CME)	\$299,766
	Puget Sound Neighborhood Health Centers Neighborcare	\$150,000
<u>West Virginia</u>	West Virginia Alliance for Sustainable Families	\$330,700
<u>Wyoming</u>	Wind River Health Systems Inc.	\$381,895
<u>Wisconsin</u>	Wisconsin Department of Health Services	\$988,177
<u>Wyoming</u>	Wyoming Department of Health	\$268,889

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U.S. Department of Health & Human Services - 200 Independence Avenue, S.W. - Washington, D.C. 20201

Setting Income Thresholds in Medicaid/SCHIP: Which Children Should Be Eligible?

Timely Analysis of Immediate Health Policy Issues

January 2009

Genevieve Kenney and Jennifer Pelletier

Summary

As the reauthorization of the State Children's Health Insurance Program (SCHIP) is being considered, important policy questions will include where eligibility thresholds should be set for public coverage and how much latitude states should have in setting their thresholds. The original SCHIP bill targeted children with incomes below 200 percent of the federal poverty level (FPL). For families at that income level in 1996, just before SCHIP was enacted, employer-sponsored insurance (ESI) premiums for family health insurance coverage made up 16 percent of income on average for a family of four. Since then, health insurance costs have risen so much that for families at 300 percent of the FPL, ESI premiums for family coverage now make up 19 percent of income on average for a family of four. Put differently, ESI coverage is less affordable for families at 300 percent of the FPL today than it was for families at 200 percent of the FPL when SCHIP was passed. In addition, the large differences in cost of living that prevail both across and within states mean that imposing a single eligibility threshold nationally would place families in higher-cost areas at a disadvantage.

Background

The United States has experienced sharp growth in health care spending in recent decades. Between 1985 and 2005, health care spending nearly tripled in real terms, reaching \$1.9 trillion in 2005.⁶ Rising health care costs over this time period have numerous root causes, including advances in medical technology and increases in personal income, health sector prices, and administrative costs.⁷ Increases in health care costs exert upward pressure on premiums and cost-sharing.⁸ Between 2001 and 2005 alone, total annual premiums for family coverage increased nearly 30 percent per enrolled employee in private sector firms, or about \$2,500.⁹ Cost-sharing in the form of deductibles and copayments has also been on the rise.¹⁰ Moreover, while no comprehensive data are available to compare cost-of-living differences for families targeted by Medicaid and SCHIP in different areas of the country, the information that is available shows that the cost of living varies substantially across areas, both within and across states.¹¹

Historically, states have had flexibility to set their income eligibility limit in Medicaid/SCHIP.¹² Nationally, seven states have implemented an income limit of less than 200 percent of the FPL, 20 states have implemented an income limit at 200 percent of the FPL, and 24 states cover kids above 200 percent of the FPL. Of the states with higher income limits, 13 cover kids up to 250

Introduction

SCHIP was designed to address gaps in health insurance coverage for children whose family incomes were too high to allow them to qualify for Medicaid but too low to afford private coverage. One of the issues that received considerable attention during the 2007 SCHIP reauthorization debate was the income level at which subsidized public coverage should be available to children through Medicaid and SCHIP.^{1,2} On the one hand, some argued that SCHIP had drifted from its statutory intent by allowing children with incomes above 200 percent of the FPL to be covered in so many states, exposing the programs to an increased

risk that public coverage will substitute for—or crowd out—private coverage.^{3,4} On the other hand, it was argued that private premiums had grown faster than the federal poverty level since the inception of SCHIP, which in turn was placing private insurance out of reach for a growing number of moderate-income families with incomes above 200 percent of the FPL, and that cost-of-living differences across states affect how affordable health insurance premiums are for families.⁵ Where eligibility thresholds are set and the extent to which states have latitude over their thresholds are important because they likely affect how effective SCHIP and Medicaid will be at filling gaps in coverage for children.



Robert Wood Johnson Foundation



percent of the FPL, 10 cover kids up to 300 percent of the FPL, and only one state—New Jersey—covers kids above 300 percent of the FPL with federal funds.¹³ Most states that cover children with incomes above 200 percent of the FPL under Medicaid and SCHIP charge premiums for coverage, but public premiums vary substantially across states and across income levels.¹⁴

Despite the fact that nearly half of all states cover children with incomes above 200 percent of the FPL, the vast majority of children enrolled in these programs appear to be from low-income families. Nationally, 91 percent of children enrolled in SCHIP live in families earning 200 percent of the FPL or less.^{15,16} In addition, legislation passed in 2007 to reauthorize SCHIP (H.R. 3963) would have covered an additional 3.9 million uninsured children, an estimated 80 percent of whom would have had incomes below 200 percent of the FPL; an earlier version of the bill passed by the House was even more targeted, with the share of newly-insured children who would be low-income estimated to be about 85 percent.¹⁷

This brief examines the extent to which increases in the costs of employer-sponsored insurance have outstripped income growth since the time that SCHIP was enacted. The implications of cost-of-living differences are also addressed.

Data and Methods

To assess how the affordability of private health insurance coverage has been changing over the past decade, we use information on the cost of employer-sponsored insurance premiums from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). The MEPS-IC includes survey information for an average of 38,500 private sector establishments per year, going back to 1996. Response rates range from 67 percent to 81 percent, with the early years of the survey experiencing lower response rates.¹⁸ The standard errors on the premium data are small, making the annual estimates of average employer-sponsored insurance premiums very precise. For example, the standard error

associated with the average total family premium in 2006 was less than 0.3 percent as large as the average premium for that year. The survey contains data on the insurance plan offered, including total premiums, employer contributions, cost sharing arrangements and information on the establishment. Data on the average premium cost for single coverage (employee only) and family coverage are available back to 1996.

The FPL for a family of four was obtained for each year from the Department of Health and Human Services (DHHS) Poverty Guidelines for the 48 contiguous states.¹⁹ The poverty guidelines are updated each year by DHHS using the consumer price index. With the exception of Hawaii and Alaska, the same federal poverty thresholds are defined for each state.

We create ratios of average employer-sponsored insurance family premium levels to income for families of four with two different income levels: at 200 percent of the FPL and at 300 percent of the FPL.²⁰ We focus on changes in the average premium relative to family income for ease of presentation. We also examined alternative affordability measures including (1) the average employee premium contribution for family coverage combined with average total out-of-pocket spending on deductibles, coinsurance, and copayments²¹ relative to income (to capture the direct burden on employees); (2) the average premium for family coverage relative to an adjusted income measure that includes the average premium measure (to approximate total compensation), and (3) the average nongroup premium for family coverage relative to income. We found that changes in all three alternative measures tracked closely with changes in the average premium for family coverage relative to income.

We use changes in the average employer premium for family coverage as a proxy for how the costs of private insurance coverage have been changing over time. Fully capturing how the affordability of private coverage has been changing over time would ideally rely on information

on how private nongroup premiums have been changing. However, only limited information is available to estimate changes in nongroup premiums. The MEPS Household Component (MEPS-HC) contains data on nongroup premiums, which are based on small samples of respondents with nongroup family coverage, and even smaller samples that represent a family size of four.²² Studies using the MEPS-HC data found that nongroup premiums for family coverage increased about 25 percent between 2002 and 2005 and by about 67 percent between 1996 and 2005.²³ Using the average premium growth between 2002 and 2005, we estimated the average premium cost for nongroup family coverage in 2006. While the MEPS data suggest that the nongroup premiums have not risen as fast as ESI premiums, we still found substantial growth in nongroup family premiums.²⁴

To assess the implications of the area-variation in the cost of living, we use the Council for Community and Economic Research ACCRA Cost of Living Index data for the third quarter of 2008.²⁵ This index takes into account relative prices for a market basket of consumer goods (including grocery items, housing, utilities, transportation, health care, and miscellaneous goods and services) for a “mid-management standard of living,” which is defined according to spending in the highest quintile in more than 300 urban areas across the country.²⁶

Findings

On average, employer-sponsored insurance premiums for family health insurance coverage rose by 8.7 percent per year between 1996 and 2006, increasing from \$4,954 in 1996 to more than double that at \$11,381 in 2006.²⁷ At the same time, the federal poverty level rose by an average of just 2.4 percent per year. As a consequence, where family employer-sponsored insurance premiums constituted 16 and 11 percent of family income, respectively, for families at 200 and 300 percent of the FPL in 1996, by 2006, those ratios had risen to 28 and 19 percent (figure 1). Overall, the ratio of

total premiums to income rose by about 75 percent for both groups between 1996 and 2006.

Similar growth was found in the ratio of average employee ESI costs (employee contributions to premiums and total out-of-pocket costs) to income over the period, increasing from less than 8 percent of family income in 1996 to 12 percent in 2006 for families at 200 percent of the FPL and from 5 to 8 percent for families at 300 percent of the FPL.²⁹ Because premiums paid by employers are part of an employee's total benefit package, we also examined the share of income spent on premiums after including the value of the employer's premium contribution in the family's income. The trend using this definition of family income tracks very closely to the trend using the simpler definition, increasing from 14 percent in 1996 to 24 percent in 2006 for families at 200 percent of the FPL and from 10 to 17 percent for families at 300 percent of the FPL (data not shown). Regardless of the definition used, the ratio of ESI costs to income was higher for families with incomes at 300 percent of the FPL in 2006 than it was for families with incomes at 200 percent of the FPL in 1996, the year before SCHIP was enacted.

Growth in nongroup premiums, though not as high as that in ESI premiums, was also large. In 1996, the average nongroup premium for family coverage in the nongroup market was \$3,329, representing 11 percent of income for families earning 200 percent of the FPL and 7 percent of income for families at 300 percent of the FPL. In 2006, the average nongroup premium for family coverage rose to an estimated \$6,038, making up 15 percent of income for families at 200 percent of the FPL and 10 percent of income for families at 300 percent of the FPL.²⁹

Another factor determining whether available coverage is affordable for families is the cost of living, which translates into very different effective incomes for families with the same nominal income living in different areas. For example, in 2008, families living in San Francisco and Philadelphia,

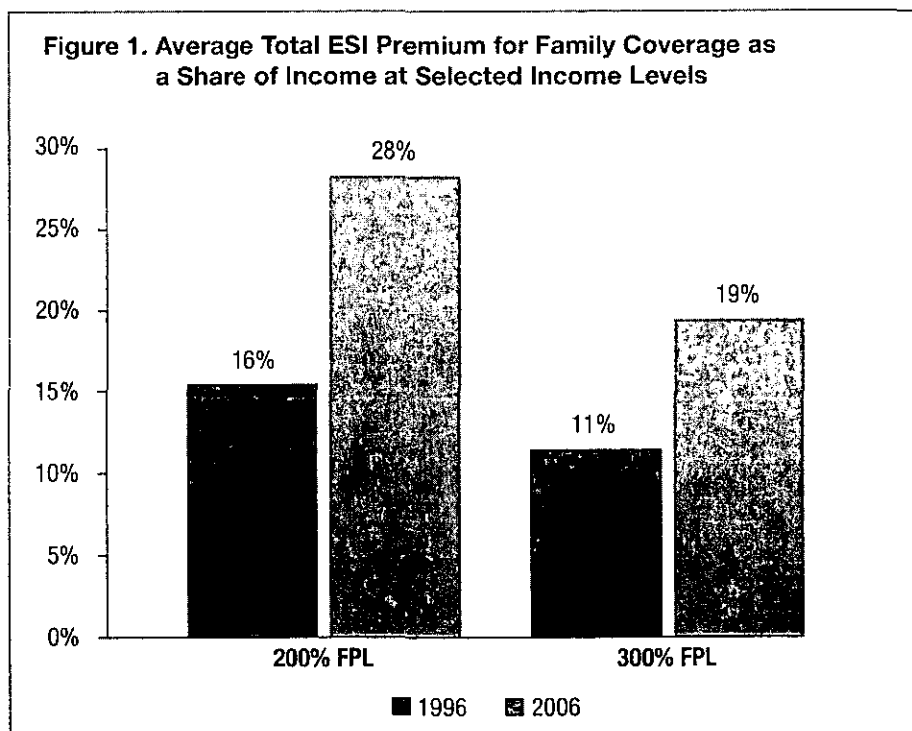
two urban areas with higher than average cost of living than the other areas included in the ACCRA index, would have to earn 2.1 and 1.5 times as much, respectively, to have the same purchasing power as families living in Douglas, Georgia, the lowest cost urban area in the study (figure 2). Consequently, a family living in San Francisco or Philadelphia earning 200 percent of the FPL is much less well-off than a family earning the same income but living in Douglas, Georgia and has fewer resources available to devote to health care. Even within a given state, families face very different costs of living; families living in Philadelphia have to earn 1.4 times as much as those living in Pittsburgh while families living in San Francisco have to earn 1.6 times as much as families living in Bakersfield to have equivalent purchasing power.

Discussion

Given that health care cost growth has historically exceeded general inflation rates, capping eligibility levels for public

coverage at an income level indexed to inflation rather than indexed to changes in the costs of health care premiums will likely mean that more and more moderate-income children are likely to become uninsured as their parents find that they cannot afford the increasingly high costs of private coverage. The effect of the rising premium burdens may have contributed to recent increases in the uninsured rate among children with moderate incomes. Between 2005 and 2006, the number of uninsured children rose by more than 700,000, and fully two-thirds of the increase was composed of children from families earning more than 200 percent of the FPL.³⁰ Over ten states have responded to the declining affordability of private coverage by enacting income eligibility expansions in the past five years.³¹

In addition, imposing a single eligibility threshold nationally, without regard for the substantial variation in purchasing power both across and within states, places families living in higher-cost areas at a disadvantage. Moreover,



Note: Share of income evaluated for families earning exactly 200% and exactly 300% of the FPL.
Source: 1996 and 2006 Medical Expenditure Panel Survey Insurance Component. Premiums reported are for a family of four. Federal poverty level for a family of four from the Department of Health and Human Services available at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>

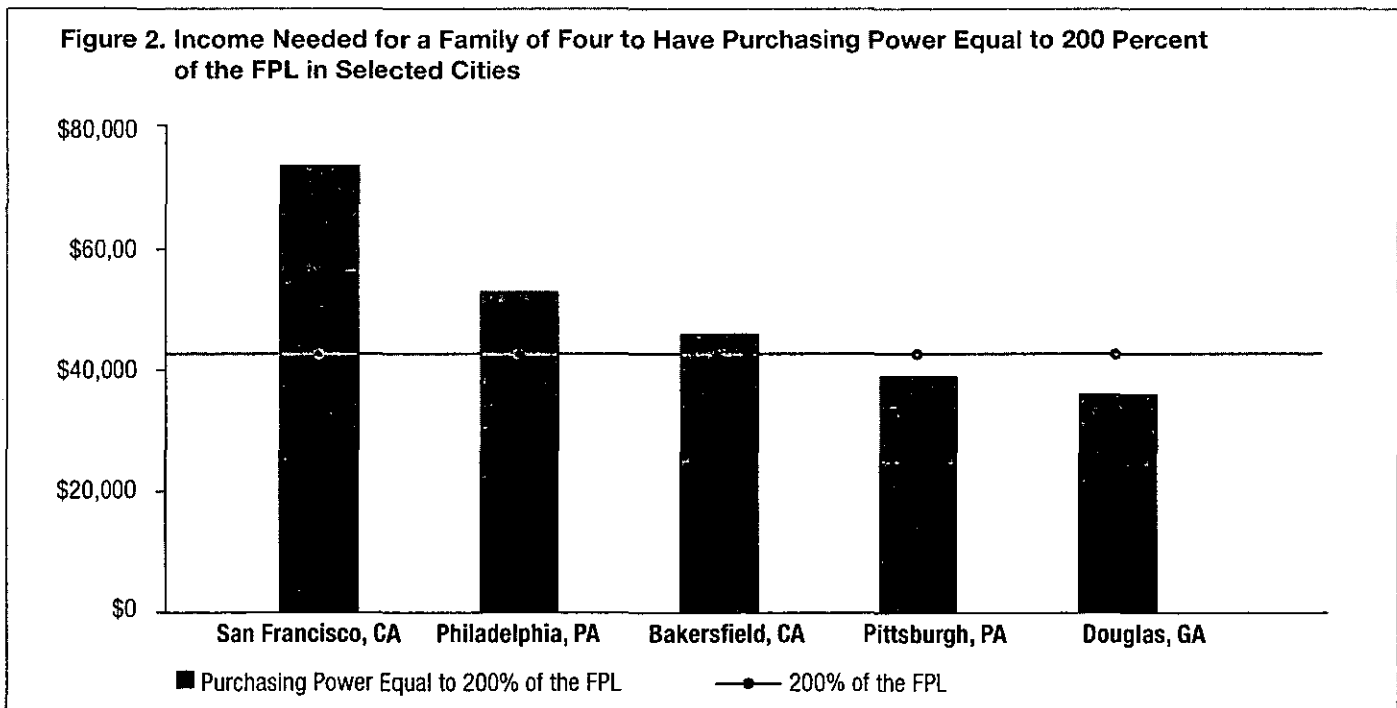
expanding eligibility to higher income levels has been shown to have positive spillover effects on the enrollment of lower-income children who were previously eligible.³² At the same time however, allowing states to expand public eligibility to higher income levels increases the risks that public coverage will substitute for ESI coverage and raises questions about the target efficiency of public subsidies.³³

As states expand coverage to higher incomes, it is also important to consider whether their premium schedules adequately reflect the greater ability of higher-income families to afford coverage. It is important to note that past research has shown that premiums charged in public programs have a negative effect on enrollment, despite being much lower than premiums in the private insurance market, suggesting that even low amounts of cost sharing

can deter families from enrolling their children in coverage.³⁴ At the same time, however, there may be room for some states to raise premium levels, especially for moderate income children, without incurring significant enrollment declines. There is substantial variation in the premiums that states charge in their Medicaid/SCHIP programs to cover families above 200 percent of the FPL—of the eleven states that cover children in SCHIP at 300 percent of the FPL, monthly premiums range from zero in the District of Columbia to over \$100 in New Jersey and Missouri for one child.³⁵ While defining what is Affordable for families of different income levels is analytically difficult because the concept is inherently subjective, it is critical to efforts to achieve and finance universal coverage.³⁶

Whereas 200 percent of the FPL might have been a reasonable eligibility

threshold for coverage in many states when SCHIP was first created, that may not be the case today, particularly in high cost-of-living areas, given the large increases in health care premiums relative to income that have occurred over the past decade. In fact, this analysis suggests that ESI premiums now constitute an even higher share of family income for families at 300 percent of the FPL than they did for families at 200 percent of the FPL in 1996—that is, where health insurance premiums are concerned, 300 percent of the FPL has become what 200 percent of the FPL was over 10 years ago when SCHIP was enacted.³⁷ In addition, this analysis suggests that unless effective cost containment strategies are implemented that reduce the rate of increase of private premiums, pressures on public programs are going to continue to increase.



Source: ACCRA Cost of Living Index, based on the data provided by Kaiser State Health Facts 2008. Income data were adapted to reflect purchasing power at 200% of the FPL by multiplying given income data (for purchasing power at 300% of the FPL) by 2/3. Federal poverty level from the Department of Health and Human Services available at <http://aspe.hhs.gov/poverty/figures-fed-reg.html>

Notes

- ¹ See Kenney, G. "The Failure of SCHIP Reauthorization: What Next?" Washington, DC: The Urban Institute. 2008. <http://www.urban.org/publications/411628.html>.
- ² SCHIP was established over a decade ago as part of the Balanced Budget Act of 1997. Though an optional program, all states expanded coverage under SCHIP, with an estimated 6.7 million children and 700,000 adults having coverage under SCHIP at some point during 2006. State programs vary in terms of their structure and characteristics (e.g., cost sharing arrangements and income eligibility levels), reflecting the flexibility over program design that was built into the SCHIP statute (Kenney 2008).
- ³ Hederman, R. "Expanding SCHIP into AMT Territory: SCHIP Plan Would Extend Welfare to Wealthy Families." Web Memo No. 1546. Washington, DC: The Heritage Foundation. July 10, 2007; Owcharenko, N. "The SCHIP Negotiations: A Backdoor Approach to Expanding Medicaid to the Middle Class?" Web Memo No. 1716. Washington, DC: The Heritage Foundation. December 3, 2007; Winfree, P. and G. D'Angelo. "SCHIP and "Crowd-Out": The High Cost of Expanding Eligibility." Web Memo No. 1627. Washington, DC: The Heritage Foundation. September 20, 2007.
- ⁴ When SCHIP was enacted in 1997, the statute designated children in low-income families (defined as less than 200 percent of the FPL) as the target population for SCHIP, but states had the flexibility to use disregards in setting their thresholds, and an explicit exception was made for states that already were covering children through prior Medicaid expansions above 150 percent of the FPL, who were allowed to cover children in SCHIP up to 50 percentage points greater than their Medicaid eligibility level (The Balanced Budget Act of 1997, PL-105-33).
- ⁵ Mann, C. and M. Odeh. "The Growing Health Insurance Affordability Gap For Children and Families." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007a; Kaiser Family Foundation. "Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level." Snapshots: Health Care Costs. Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. February 2007. <http://www.kff.org/insurance/snapshot/chcm021507oth.cfm>
- ⁶ Congressional Budget Office. "Technological Change and the Growth of Health Care Spending." A CBO Paper. Washington, DC: Congressional Budget Office. January 2008.
- ⁷ Congressional Budget Office 2008.
- ⁸ Seliger Keenan, P. "What's Driving Health Care Costs?" The Commonwealth Fund/John F. Kennedy School of Government 2004 Bipartisan Congressional Health Policy Conference Issue Brief. Washington, DC: The Commonwealth Fund. November 2004.
- ⁹ State Health Access Data Assistance Center (SHADAC). "Squeezed: How Costs for Insuring Families are Outpacing Income." University of Minnesota: State Health Access Data Assistance Center. April 2008.
- ¹⁰ Seliger Keenan 2004; Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits 2008 Annual Survey." Washington, DC: The Kaiser Family Foundation and Health Research and Educational Trust. September 2008. <http://ehbs.kff.org/>
- ¹¹ Kaiser State Health Facts. "Cost of Living Variation." Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. 2008. <http://www.statehealthfacts.kff.org/comparable.jsp?ind=600&cat=1>; Jolliffe, D. "The Cost of Living and the Geographic Distribution of Poverty." Economic Research Service. Washington, DC: US Department of Agriculture. September 2006. <http://www.ers.usda.gov/publications/err26/>
- ¹² Before 2007, states had broad latitude to set their own eligibility levels and to use income disregards to subtract costs of child care or work expenses from a family's gross income, thereby establishing eligibility based on the family's net income; states also applied "blanket" income disregards to reach children at higher income levels, as had long been permitted for Medicaid under Section 1902(r)(2) of the Social Security Act. On August 17, 2007, the Centers for Medicare and Medicaid Services issued a letter to state health officials (SHO-#07-001) restricting states' ability to cover children in families with gross income above 250 percent of the FPL. Specifically, in order to expand income eligibility above 250 percent of the FPL, the letter required states to achieve a coverage rate of 95 percent for low-income children and to ensure that the rate of employer-sponsored coverage for children had not dropped more than two percentage points in the past five years. States were also required to impose a 12-month waiting period for children coming off of other insurance before they could enroll in SCHIP and to charge the maximum amount of cost sharing allowable by law (5 percent of family income) for children in families earning more than 250 percent of the FPL (Mann, C. and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007b). Both SCHIP reauthorization bills that passed Congress but were vetoed by the president in 2007 (H.R. 976 and H.R. 3963) would have overturned the August 17th Directive. The Directive was set to take effect on August 17, 2008 for states already covering children above 250 percent of the FPL; however, CMS has applied the new rules only to states seeking to expand coverage (including New York, Ohio, Oklahoma, Louisiana, Indiana, and Wisconsin) and not to those who had already implemented coverage expansions (Associated Press, "States Won't Be Sanctioned over Kids' Health Insurance." 2008. http://www.usatoday.com/news/health/2008-08-14-children-insurance_N.htm?csp=34).
- ¹³ These income eligibility levels reflect those in effect as of October 2008. Several states have authorized income eligibility increases that have not yet been implemented either because of legislative delays or CMS denials of the increases (see footnote 12). In addition, four states have moved to use state-only funds to increase their income eligibility levels above the limit set in their SCHIP program. Illinois and Wisconsin use state funds to cover kids up to 300 percent of the FPL (Illinois' SCHIP eligibility level is 200 percent of the FPL; Wisconsin's is 250 percent of the FPL); Massachusetts and New York cover kids up to 400 percent of the FPL (Massachusetts' SCHIP eligibility level is 300 percent of the FPL; New York's is 250 percent of the FPL) (Georgetown Center for Children and Families. "Eligibility Levels in Medicaid & SCHIP for Children, by State as of October 1, 2008." Georgetown University Health Policy Institute. October 20, 2008).
- ¹⁴ Selden, T., G. Kenney, M. Pantell, and J. Ruhter. "Cost Sharing Arrangements in Medicaid and SCHIP: Implications for Out-of-Pocket Spending Burdens." Under Review.
- ¹⁵ Congressional Research Service. "REVISED: Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees, 2007." May 30, 2008. This study evaluated low-income families by their net income since that is how SCHIP eligibility is determined in most states. Some children with net income of less than 200 percent of the FPL have gross income above 200 percent of the FPL after adding back in child care and work-related expenses and other disregards.
- ¹⁶ When both Medicaid and SCHIP children are considered together, the proportion of enrollees who are low-income rises to 98 percent (Author's tabulation based on SCHIP enrollment as reported in Congressional Research Service 2008 and Medicaid enrollment from Georgetown Center for Children and Families, "Number of Children Ever Enrolled in Medicaid/SCHIP by Program Type and State, FY 2007." Washington, DC: Georgetown University Health Policy Institute. 2008).
- ¹⁷ Kenney, G., A. Cook, and J. Pelletier. "SCHIP Reauthorization: How Will Low-Income Kids Benefit under House and Senate Bills?" Washington, DC: Urban Institute. 2007. <http://www.urban.org/publications/411545.html>
- ¹⁸ Establishments are pre-screened over the phone, and those that offer health insurance to their employees are mailed a complete questionnaire. Those who do not offer health insurance to their employees are only asked a few questions over the phone. Establishments that do not return the questionnaire are sent a second mailing, and those that do not return the second mailing are called to complete the information over the phone.
- ¹⁹ Available at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>
- ²⁰ Two-hundred percent of the FPL for a family of four translates into \$31,200 in 1996 and \$40,000 in 2006. Three-hundred percent of the FPL translates into \$46,800 in 1996 and \$60,000 in 2006.
- ²¹ Data on out-of-pocket costs are based on Urban Institute tabulations of the Household Component of the 1996 and 2006 Medical Expenditure Panel Survey and include average out-of-pocket costs for families with ESI coverage for the entire survey year.

- ²² Examining nongroup premium growth is also important when considering coverage options for this income group because few low- and moderate-income children have access to ESI coverage. (Kenney, Cook, and Pelletier. "Prospects for Reducing Uninsured Rates Among Children: How Much Can Premium Assistance Programs Help?" Urban Institute. Forthcoming).
- ²³ Bernard, D. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65, 1996 and 2002." Statistical Brief #72. Rockville, MD: Agency for Healthcare Research and Quality. March 2005; Bernard, D. and J. Banthoin. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65: 2002 and 2005." Statistical Brief #202. Rockville, MD: Agency for Healthcare Research and Quality. April 2008.
- ²⁴ Because of the small sample sizes, the nongroup premium estimates in the MEPS have large standard errors associated with them and are therefore much less precise than the ESI premium data. For example, the standard error associated with the mean nongroup family premium for 2005 was close to 10 percent of the mean, compared to a ratio of less than 0.3 percent for the mean ESI family premium in 2006 (MEPS-IC Table I.D.1(2006); Bernard and Banthoin 2008). We also looked at out-of-pocket spending when evaluating the cost of nongroup coverage but chose not to include it because the sample sizes for families of four are very small.
- ²⁵ Kaiser State Health Facts (2008) provides ACCRA data on what a family of four would need to earn in select U.S. cities to have purchasing power equal to 300 percent of the FPL. Because the focus of this brief is on children currently targeted by SCHIP, the income figures were multiplied by 2/3 in order to represent purchasing power equal to 200 percent of the FPL. Mann and Odeh (2007a) used ACCRA data and a similar method to show purchasing power for a family of three at 200 percent of the FPL.
- ²⁶ The index is based on the spending distribution across the six major categories of purchases listed on page 2 for consumers in the top income quintile in the Consumer Expenditure Survey. The distribution is relatively similar to the distribution for the lowest income quintile, which would represent lower-income families. The largest share of expenditures for both quintiles is due to housing costs, which represent 37 and 35 percent of total expenditures in the six categories of goods and services for the top and bottom quintiles, respectively. Because housing costs are highly variable across the country and constitute such a large share of expenditures in the index, the cost of living can vary greatly between cities. Transportation costs make up the second-largest share of expenditures (31 percent for the top quintile and 23 percent for the bottom quintile); groceries and utilities each constitute 10 percent of expenditures for the top quintile and 15 percent for the bottom quintile. Health care costs account for 8 percent of spending in the top quintile and 10 percent of spending in the bottom quintile (Urban Institute tabulations of the 2007 Consumer Expenditure Survey).
- ²⁷ The standard errors associated with these estimates were \$32.33 in 2006 and \$36.06 in 1996 (MEPS-IC Table I.D.1 from 1996 and 2006).
- ²⁸ For firms with large shares of low-wage workers (50 percent or more), the ratio of average employee premium to income is slightly higher than for all firms: For families at 200 percent of the FPL, the ratio is 6 percent in 1996 and 8 percent in 2006, and for families at 300 percent of the FPL, the ratio is 4 percent in 1996 and 5 percent in 2006 (data not shown). Employee contributions remained fairly constant over the period, constituting about a quarter of the total premium (data not shown).
- ²⁹ The premium for 2006 was estimated using the average growth rate in the nongroup premium between 2002 and 2005. The standard errors associated with these estimates are large, \$241 in 1996, or 7.2 percent of the mean, and \$513 in 2005, or 9.2 percent of the mean.
- ³⁰ Holahan, J. and A. Cook. "What Happened to the Insurance Coverage of Children and Adults in 2006?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. September 2007.
- ³¹ Smith, V. and D. Rousseau. "SCHIP Program Enrollment: June 2003 Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. December 2003. <http://www.kff.org/medicaid/upload/SCHIP-Program-Enrollment-June-2003-Update.pdf>; Cohen Ross, D. A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. January 2008. <http://www.kff.org/medicaid/upload/7740.pdf>
- ³² Arjun, L. and J. Guyer. "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children." Georgetown Center for Children and Families. Washington, DC: Georgetown Health Policy Institute. 2008; Kenney, G., L. Blumberg, and J. Pelletier. "State Buy-In Programs: Prospects and Challenges." Washington, DC: Urban Institute. 2008.
- ³³ Winfree and D'Angelo 2007.
- ³⁴ Hadley, J., J. Reschovsky, P. Cunningham, G. Kenney, and L. Dubay. 2007. "Insurance Premiums and Insurance Coverage of Near-Poor Children." *Inquiry* 43, no. 4: 362-377; Kenney, G., J. Hadley, and F. Blavin. 2007. "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* 43, no. 4: 345-361; Kenney, G., R.A. Allison, J. Costich, J. Marton, and J. McFeeters. 2007. "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States." *Inquiry* 43, no. 4: 378-392.
- ³⁵ The cost of enrolling two children in both Missouri and New Jersey is the same as enrolling one child (Selden et al. Under Review).
- ³⁶ Blumberg, L., J. Holahan, J. Hadley, and K. Nordahl. "Setting a Standard of Affordability for Health Insurance Coverage." *Health Affairs* 26(4): w463-w473. 2007.
- ³⁷ These numbers understate the extent to which coverage has become unaffordable at 300 percent of FPL, compared to coverage at 200 percent of FPL when SCHIP was signed into law. The 1996 estimates in the text represent the cost of coverage one year before the 1997 enactment of SCHIP. The 2006 estimates, by contrast, are at least three years before the potential reauthorization of SCHIP; if SCHIP is reauthorized at its earlier possible point (2009), the year most directly analogous to 1996 would be 2008. Between 2006 and 2008, premium growth continued to outstrip increases in the FPL. According to surveys by the Kaiser Family Foundation (KFF) and the Health Research & Educational Trust (HRET), average premiums for family coverage rose by 10.5 percent from 2006 to 2008 (KFF/HRET 2008. Available at <http://ehbs.kff.org/>). During that same period, the FPL rose by 6 percent. Using the recent premium increase reported by KFF/HRET to project ESI premiums for 2008, ESI family coverage in 2008 consumed an average of 30 percent of family income at 200 percent of FPL and 20 percent of family income at 300 percent of FPL. If average nongroup premiums are estimated for 2008 based on the growth rate between 2002 and 2005, nongroup premiums would have constituted 17 percent of income for families at 200 percent of the FPL and 11 percent of income for families at 300 percent of the FPL.

The views expressed are those of the authors and should not be attributed to any campaign or to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgements

Genevieve Kenney is a principal research associate and Jennifer Pelletier is a research associate in the Health Policy Center of the Urban Institute.

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Medicaid & CHIP

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SSI Beneficiaries

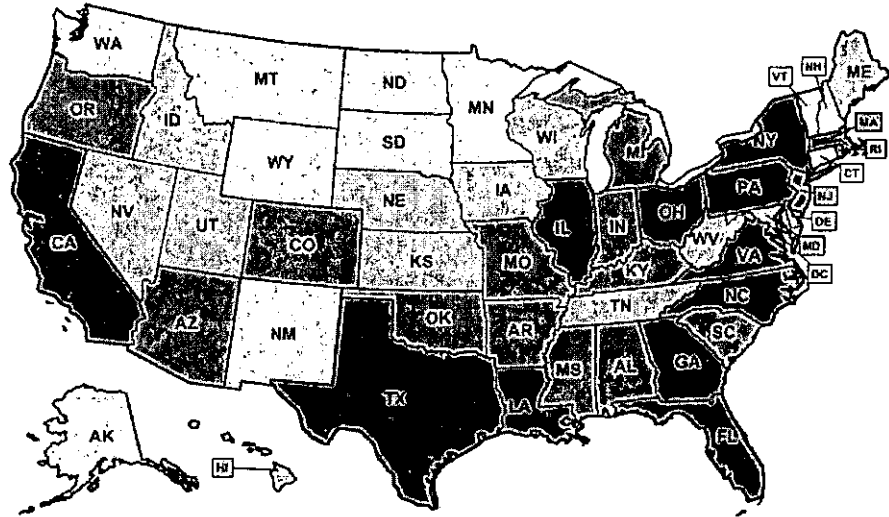
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Estimated Number of Children Enrolled in SCHIP with Family Income at or Below 200% Federal Poverty Level (FPL) and Above 200% FPL, FY2008

Bar Graph | Table | Map | Map & Table

Rank by: View by: # | %
Rank Order: ▲ ▼

At or Below 200% FPL



	At or Below 200% FPL	Above 200% FPL	Total
United States	6,624,419	744,060	7,368,479
Alabama	110,821	NA	110,821
Alaska	18,707	NA	18,707
Arizona	112,072	NA	112,072
Arkansas	93,446	NA	93,446
California	1,371,969	320,118	1,692,087
Colorado	99,555	NA	99,555
Connecticut	4,707	17,563	22,270
Delaware	11,192	NA	11,192
District of Columbia	4,162	4,584	8,746
Florida	354,385	NA	354,385
Georgia	276,820	34,414	311,234
Hawaii	28,803	NA	28,803
Idaho	43,526	NA	43,526
Illinois	356,460	NA	356,460
Indiana	124,954	NA	124,954
Iowa	50,390	NA	50,390
Kansas	51,162	NA	51,162
Kentucky	67,717	NA	67,717

- Aged SSI as % of Population Ages 65+
- SSI with Disabilities
- SSI with Disabilities as % of Population
- Medicaid Medically Needy
 - Total Enrollment
 - Enrollment by Eligibility Category
 - Medically Needy Eligibility
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 - Asset Test: Medicaid & SCHIP
 - Presumptive Eligibility: Medicaid/SCHIP
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 - Aged & Aged/Disabled Participants
 - Aged & Aged/Disabled HCBS Expenditures
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 - Waiting Lists for HCBS Waivers, 2007
 - Home Health Participants
 - Home Health Expenditures
 - Personal Care Participants
 - Personal Care Expenditures
 - Individual Budget-Based Models of LTC
- False Claims Act
 - States With a False Claims Act

Louisiana	146,373	1,490	147,863
Maine	30,947	NA	30,947
Maryland	66,602	66,262	132,864
Massachusetts	142,216	58,734	200,950
Michigan	67,763	NA	67,763
Minnesota	5,534	87	5,621
Mississippi	84,370	NA	84,370
Missouri	110,196	25,939	136,135
Montana	22,679	NA	22,679
Nebraska	48,827	NA	48,827
Nevada	38,592	NA	38,592
New Hampshire	2,891	9,345	12,236
New Jersey	112,909	38,896	151,805
New Mexico	4,270	10,674	14,944
New York	433,047	84,209	517,256
North Carolina	251,647	6	251,653
North Dakota	7,617	NA	7,617
Ohio	251,278	NA	251,278
Oklahoma	117,507	NA	117,507
Oregon	73,686	NA	73,686
Pennsylvania	219,366	37,261	256,627
Rhode Island	23,210	2,821	26,031
South Carolina	73,620	NA	73,620
South Dakota	15,277	NA	15,277
Tennessee	55,320	8,299	63,619
Texas	731,916	NA	731,916
Utah	At or Below 200% FPL	Above 200% FPL	5,492
Vermont	0	6,496	6,496
Virginia	155,289	NA	155,289
Washington	365	16,466	16,831
West Virginia	37,250	395	37,645
Wisconsin	52,940	NA	52,940
Wyoming	8,976	NA	8,976

Notes: The methods used to determine whether a child qualifies for coverage, based on his or her family income, vary from state to state. Under longstanding federal law, states must follow certain rules in determining income-eligibility, but they also have considerable flexibility regarding whether they will count or exempt certain types or amounts of income and whether they allow deductions for certain types or amounts of expenses. Typically, states "disregard" — that is, they do not count — a portion of earnings from a working family's income to reflect that these resources are needed to cover work-related expenses and generally are not available to cover other costs, such as the cost of purchasing health coverage. Estimates presented here reflect *net* income, taking into account each state's income disregard policy, since this is how states provide income information to CMS and is the basis on which enrollees' eligibility is determined.

The SCHIP statute defines low-income children as those at or below 200% of poverty. States use two different types of income disregards in determining eligibility for SCHIP which in turn affects the income levels reported CMS. The first type of disregard is the exclusion of particular dollar amounts or types of income, and the second occurs when a state excludes an entire block of percent-of-poverty income. For more information, see Sources.

Sources: Peterson, Chris, Domestic Social Policy Division, Congressional Research Service (CRS), January 27, 2009 memorandum based on analysis of data from the SCHIP Statistical Enrollment Data System (SEDS) provided by the Centers for Medicare and Medicaid Services (CMS).

Definitions: NA: Children in families with incomes above 200% poverty level were not eligible for the state's SCHIP program as of FY2008.

Federal Poverty Level (FPL) was established to help government agencies determine eligibility levels for public assistance programs such as Medicaid. FPL is represented in this resource as poverty guidelines as opposed to the slightly different poverty thresholds.

Federal Fiscal Year (FY): Unless otherwise noted, years preceded by "FY" on statehealthfacts.org refer to the Federal Fiscal Year, which runs from October 1 through September 30. For example, FY 2009 refers to the period from October 1, 2008 through September 30, 2009.

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To: The Honorable Bettye Davis
Alaska Senate

From: Jennifer Saunders
Health Program
303-856-1440
Jennifer.saunders@ncsl.org

Date: February 11, 2009

Subject: SCHIP Cost Sharing Rules

Senator Davis,

We enjoyed listening to your Health and Social Services committee meeting on Monday. This memo is intended to answer the question posed about the SCHIP cost-sharing rules.

Alaska's SCHIP program is a Medicaid expansion program and therefore must comply with Medicaid's cost-sharing rules as specified under the Deficit Reduction Act of 2005. Under provisions of the Deficit Reduction Act of 2005 (DRA), states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements.

Most children under the age of 18 are exempt from premiums and from cost-sharing on most services. However, the DRA rules allow states to require co-payments for prescription drugs and use of the emergency room for non-emergency care on all children in certain circumstances. The DRA also allows states to assess premiums and cost-sharing charges on some children in families with income above the poverty line. The total amount of premiums and cost-sharing charges cannot exceed a cap of five percent of family income, which is calculated on a monthly or quarterly basis at the option of the state.

Please see the following document by the Center on Budget and Policy Priorities for more detailed information about cost-sharing and premiums in Medicaid:

Cost-sharing and Premiums in Medicaid: What Rules Apply? February 28, 2007

<http://www.cbpp.org/2-28-07health.pdf>

In addition, you may also find the following document by the Congressional Research Service helpful. The table on page 5 compares service-related cost-sharing rules in traditional Medicaid, the DRA options and SCHIP.

Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)

Denver
7700 East First Place
Denver, Colorado 80230-7143
Phone 303.364.7700 Fax 303.364.7800

Washington
444 North Capital Street, N.W. Suite 515
Washington, D.C. 20001
Phone 202.624.5400 Fax 202.737.1069

Website www.ncsl.org

February 11, 2009

p. 2

CRS Report for Congress, January 25, 2007

http://assets.opencrs.com/rpts/RS22578_20070125.pdf

The following document by the Centers for Medicare and Medicaid Services (CMS) also summarizes these Medicaid requirements and you may find the "Important Links" on the bottom of page 2 helpful.

See the CMS document here:

<http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf>

For more general information about cost sharing and SCHIP, please see the following CMS website:

http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp

(Scroll down to see the information under the heading "Cost Sharing.")

To create cost sharing requirements that differ from the Medicaid requirements, states can do so by submitting a waiver to and obtaining approval from the Centers for Medicare and Medicaid Services (CMS) or by creating a stand-alone SCHIP program.

If you have more specific or detailed questions regarding cost-sharing requirements under Alaska's SCHIP program, I would suggest that you contact CMS directly.

Best regards,

Jennifer Saunders



United States Department of
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THE 2009 HHS POVERTY GUIDELINES

One Version of the [U.S.] Federal Poverty Measure

[[Federal Register Notice, January 23, 2009 — Full text](#)]

[[Prior Poverty Guidelines and Federal Register References Since 1982](#)]

[[Frequently Asked Questions \(FAQs\)](#)]

[[Further Resources on Poverty Measurement, Poverty Lines, and Their History](#)]

[[Computations for the 2009 Poverty Guidelines](#)]

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau** (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) Poverty thresholds since 1980 and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "[How the Census Bureau Measures Poverty](#)" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services (HHS)**. The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. The *Federal Register* notice of the 2009 poverty guidelines is available.

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under [Frequently Asked Questions \(FAQs\)](#). See also the [discussion of this topic](#) on the Institute for Research on Poverty's web site.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310

4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add \$3,740 for each additional person.	

2009 Poverty Guidelines for Alaska

Persons in family	Poverty guideline
1	\$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290
For families with more than 8 persons, add \$4,680 for each additional person.	

2009 Poverty Guidelines for Hawaii

Persons in family	Poverty guideline
1	\$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560
For families with more than 8 persons, add \$4,300 for each additional person.	

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding

whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Food Stamp Program, the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility. For a more detailed list of programs that do and don't use the guidelines, see the [Frequently Asked Questions \(FAQs\)](#).

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in January 2009 are designated the 2009 poverty guidelines. However, the 2009 HHS poverty guidelines only reflect price changes through calendar year 2008; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2008. (The 2008 thresholds are expected to be issued in final form in August 2009; a preliminary version of the 2008 thresholds is now available from the Census Bureau.)

The [computations for the 2009 poverty guidelines](#) are available.

The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the *Federal Register* by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Go to [Further Resources](#) on Poverty Measurement, Poverty Lines, and Their History

Go to [Frequently Asked Questions \(FAQs\)](#).

Return to the main [Poverty Guidelines, Research, and Measurement](#) page.

Last Revised: February 27, 2009

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U.S. Department of Health & Human Services · 200 Independence Avenue, S.W. · Washington, D.C. 20201

APPENDIX F

2009 HSS Poverty Guidelines for Alaska

2009 Poverty Guidelines for Alaska	
Persons in family	Poverty guideline
1	\$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290
For families with more than 8 persons, add \$4,680 for each additional person.	

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 8, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 415
Juneau, AK 99801-1182

RE: SB 13 (Davis)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support SB 13, authored by Senator Bettye Davis, and co-sponsored by Senators Paskvan, Ellis, Wielcchowski, and French as well as Representatives Gruenberg and Tuck.

AARP is the world's largest organization of grandparents. We are concerned about health insurance coverage for everyone's grandchildren.

SB 13 will return the Denali KidCare program to the former eligibility levels at 200% of the federal poverty level. We think this is an excellent plan and should provide comprehensive and preventive health coverage for many more young Alaskans and pregnant women.

In addition, we have many retired grandparents who are raising their grandchildren. Currently there are over 5,500 grandparents responsible for raising over 8,200 young Alaskan grandchildren. Very often these grandparents are retired and dependent on Medicare for their health coverage. Denali KidCare, in many cases, is the only health insurance they can secure for their grandchildren. If these grandparents are not able to secure insurance coverage for their grandchildren, some of the children will have to leave this caring family environment and become wards of the state. We hope you realize how important Denali KidCare coverage is to these extended families that are now in one household. These grandparents are trying to provide the best care for their grandchildren. They need Denali KidCare.

Many AARP members have coverage through Medicare or their employer and they understand how important health insurance is to them; we support the efforts of this bill to provide coverage to other Alaskans who need it.

A healthy future for our children should be something everyone can agree on.

AARP requests an "AYE" vote on SB 13.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Tammie Wilson
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes
Senator Bettye Davis

1

| 2121 Starr Avenue | Anchorage, Alaska 99501 | T 907.272.3663 | F 907.277.7368 | www.foodbankofalaska.org |



March 5, 2010

Representative Wes Keller
Alaska State Capital Room 13
Juneau, Alaska 99801

Dear Representative Keller,

I am writing to request your support of SB 13, which will increase the income eligibility guidelines for Denali KidCare from 175% to 200% of Alaska's federal poverty level. This change would make approximately 1,300 children and 225 pregnant women eligible for health care services.

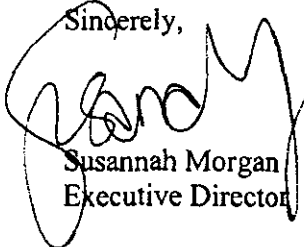
The eligibility level for Denali KidCare is currently set at 175% of federal poverty level. This means that Alaska has one of the most restrictive eligibility criteria for child health insurance programs in the nation. 48 states and the District of Columbia now cover children at or above 200% of the federal poverty level.

Food Bank of Alaska cares about health care for children because our research shows that health care and hunger are inextricably linked. 30% of food assistance clients have no health insurance, and 58% of food assistance clients have unpaid medical bills. 35% of food assistance clients choose between paying for food and paying for health care or medication.

Providing health insurance to more Alaskan children would mean that fewer families face the agonizing choice between feeding their kids and taking them to the doctor. It is also a sound investment; research shows that children and pregnant women with preventive care, such as that received through Denali KidCare, are four times less likely to use expensive emergency room care for medical treatment. Also, the State of Alaska will be able to leverage more federal dollars, since the federal government covers almost 65% of the entire cost of Denali KidCare.

Please help Alaska join the rest of the nation in supporting health care for children and pregnant women by reestablishing Alaska legislature's original level of Denali KidCare at 200% of federal poverty level.

Sincerely,



Susannah Morgan
Executive Director





Mat-Su Health Foundation Resolution in Support of Increased Denali KidCare Income Eligibility Level

WHEREAS the Mat-Su Health Foundation's mission is to enhance the health of Alaskans living in Mat-Su, and where health is in part determined by access to primary, behavioral, and dental care and preventive services;

WHEREAS the provision of health insurance is a key component of healthcare access;

WHEREAS the Mat-Su Borough is the fastest growing area of Alaska, growing from 5,188 in 1960 to 82,515 in 2008 due to both positive birth and in-migration rates; and the AK Department of Labor projects that all Mat-Su age groups will continue to grow through 2020;ⁱ

WHEREAS in 2006, of the 22,868 children in Mat-Su, approximately 12.9% or 2,949 were uninsured;ⁱⁱ

WHEREAS in 2006, approximately 19.5% or 1,530 children in Mat-Su living at or below 200% Federal Poverty Level (FPL) were uninsured;ⁱⁱⁱ

WHEREAS the Average Monthly Medicaid Enrollment *decreased* from 12,073 in 2006 to 11,671 in 2007 in Mat-Su despite a *rising* rate of uninsured coupled with significant population growth;^{iv}

WHEREAS in Mat-Su nearly a quarter (23.5%) of all female headed households fell below the poverty level, 51.9% of those with children under 5 years of age were living in poverty compared to 32% of similar households in AK;^v

WHEREAS 11.3% of families with related children in Mat-Su and 11.2% of families with related children in AK have lived below the poverty level in the last 12 months;^{vi}

WHEREAS 37% of Mat-Su Borough School District students ages five to 17 live in households receiving Public Assistance;^{vii}

WHEREAS Mat-Su Regional Medical Center, the sole community acute care provider in Mat-Su, supplied \$339,554,984 in uncompensated care from 2007 through 2009 and saw uncompensated care rates rise 10% between 2007 and 2008 and 5% between 2008 to 2009;

WHEREAS the rate of uninsured children under age 18 in Alaska is increasing—from 8.4% in 2005 to 10.3% in 2006 to 11.4% in 2007 to 13.2% in 2008;^{viii}

WHEREAS results of the 2007 National Survey of Children's Health 2007 reflect that

- 46% of Alaska's children live at or below 200% FPL as compared to 40.6% nationwide;
- 12.8% of Alaskan children under age 18 were uninsured at the time of the survey versus 9.1% nationwide; and only four states have lower rates than AK
- 18% of Alaskan children under age 18 were currently uninsured or had periods of no coverage during the year versus 15.1% nationwide
- 21% of Alaskan children living at or below 99% FPL were uninsured at the time of the survey versus 15% nationwide
- 28.8% of Alaskan children living at or below 99% FPL had periods of no coverage during the year versus 24.2% nationwide

- 17% of Alaskan children living at or below 199% FPL had no coverage at the time of the survey versus 13.9% nationwide
- 25.1% of Alaskan children living at or below 199% FPL had periods of no coverage during the year versus 24.3% nationwide;^{ix}

WHEREAS approximately 10,000 Alaskan children 18 years or younger and below 200% FPL are uninsured,^x and 36,000 Alaskan children 19 years or younger and below 200% FPL rely on government health insurance to provide access to health care services;^{xi}

WHEREAS Alaska has seen a 31% decline in the number of children covered by private health insurance in the past decade;^{xii}

WHEREAS the cost of caring for uninsured children is passed on to other Alaskans and businesses, raising premiums and out-of-pocket expenses for everyone;^{xiii}

WHEREAS uninsured children are nine times less likely to have a regular doctor, four times more likely to be taken to emergency rooms, and 25% more likely to miss school than insured children;^{xiv}

WHEREAS the Denali KidCare upper income eligibility guideline was decreased in 2007 to 175% FPL from 200% FPL;

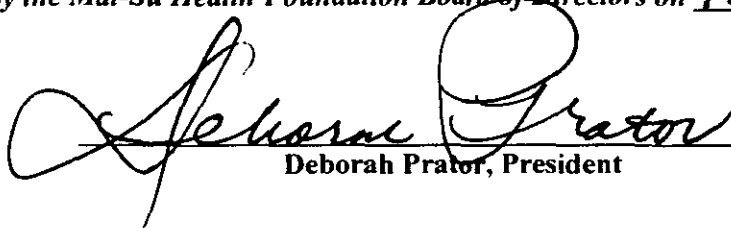
WHEREAS increasing Denali KidCare income eligibility levels to at least 200% FPL will increase health care access for children and families that meet this criterion;

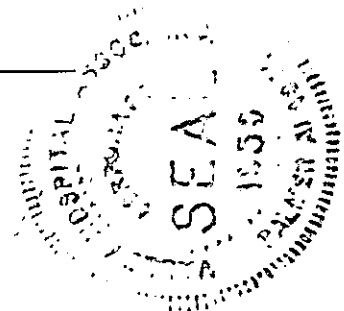
WHEREAS expanding the Denali KidCare income eligibility levels would result in improved public health and overall health outcomes throughout the state for Alaskan children;

WHEREAS the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized and expands the State Children's Health Insurance Program of 1997 to allow states to implement coverage up to 300% FPL and also provides for Performance Bonuses for states enrolling additional children in Medicaid;

BE IT THEREFORE RESOLVED that the Mat-Su Health Foundation supports and advocates for the Denali KidCare income eligibility level to be increased to *at least* 200% FPL and that a cost-sharing option is considered between 200% and 300% FPL.

Approved by the Mat-Su Health Foundation Board of Directors on February 15, 2010 (date)


Deborah Prator, President



ⁱMatanuska-Susitna Borough. Alaska Department of Labor, Division of Research & Analysis.
<http://laborstats.alaska.gov/cgi/databrowsing/localAreaProfileQSResults.asp?geogArea=0204000170&population+census+data=Population&BJ=View+Report>.

ⁱⁱ2006 Small Area Health Insurance Estimates. U.S. Census. <http://www.census.gov/did/www/sahie/data/index.html>

ⁱⁱⁱ Ibid.

^{iv} Alaska Health Care Data Book, page 241. Alaska Department of Health & Social Services. November 2007.

^vIbid.

^{vi} Ibid.

^{vii} Ibid.

^{viii}U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements.
<http://www.census.gov/hhes/www/hlthins/hlthins.html>

^{ix} 2007 National Survey of Children's Health. Data Resource Center. 2007.
<http://nschdata.org/DataQuery/SurveyQuestions.aspx?vid=2&tid=44&geoid=1>

^xU.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements.
<http://www.census.gov/hhes/www/hlthins/hlthins.html>

^{xi} Ibid.

^{xii} Legislative Health Care Initiatives Presentation to the Anchorage Chamber of Commerce, August 27, 2007.

^{xiii} Ibid.

^{xiv} Ibid.



ALASKA ASSOCIATION OF HOMES FOR CHILDREN

February 9, 2010

Alaska Baptist Family Services
Anchorage, AK

Alaska Children's Services
Anchorage, AK

Alaska Family Services
Palmer, AK

Covenant House of Alaska
Anchorage, AK

Fairbanks Native Association
Fairbanks, AK

Family Centered Services of Alaska
Fairbanks, AK

Juneau Youth Services
Juneau, AK

Kenai Peninsula Community Care
Center
Kenai, AK

Maniilaq Association
Kotzebue, AK

Nome Children's Home
Nome, AK

North Slope Borough Children's
Services
Barrow, AK

North Star Behavioral Health
Systems
Anchorage & Palmer, AK

Presbyterian Hospitality House
Fairbanks, AK

Providence Behavioral Health
Systems
Anchorage, AK

Residential Youth Care
Ketchikan, AK

The Salvation Army Booth Memorial
Home
Anchorage, AK

The Boys and Girls Home of Alaska
Fairbanks, AK

Youth Advocates of Sitka
Sitka, AK

Representative Bob Herron
Representative Wes Keller
Co-Chairs, Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

Dear Representatives Herron and Keller:

Please ensure passage of SB 13, Medical Assistance Eligibility, as quickly as possible. The Department of Health and Social Services estimates that raising the income eligibility limit to 200% of the Federal Poverty Level (FPL) can provide health care to 1,277 Alaskan children currently without health insurance.

As you can see from the attached map, Alaska is one of only three states in the country that limit income eligibility for the State Child Health Insurance Program to less than 200% of the FPL. Twenty states have 200% FPL limits and all other states have eligibility above 200% FPL.

As Alaskans who consider our children as our future, we should be leading the nation in providing quality health care to them, not lagging so far behind. Let's join those states that place a greater emphasis on helping working families take care of their children! The clock is ticking. Don't make those 1,277 children wait any longer—pass SB 13 this month!

Sincerely,


Brad Ohs, President

cc.: Representative Tammie Wilson, HSS Vice Chair
Representative Bob Lynn, HSS Member
Representative Paul Seaton, HSS Member
Representative Sharon Cissna, HSS Member
Representative Lindsey Holmes, HSS Member
Representative Mike Chenault, House Speaker

SB 13

Thurs 3/9/10

Testimony in Support of Senate Bill 13

March 8, 2010

Dear Representatives Keller and Herron and other members of the Health and Social Services Committee,

My name is Dr. Monica Gross. I am a board certified pediatrician who has practiced in Alaska since 1993. I am here in support of Senate Bill 13. This bill will strengthen Alaskan families by increasing Denali Kid Care coverage.

When children have medical insurance the entire health care emphasis changes to one that strengthens the family. Medical care is shifted from crisis-oriented care to well child and preventative care. This shift has ramifications not only for children's health, but also for family and community health.

When families don't have medical insurance kids are brought to the doctor when they are very sick and parents are really scared. Doctors respond in emergency mode- tests are ordered, drugs are prescribed and parents admonished for "waiting too long". The role of parents as the primary caregiver for their child is undermined.

When kids have medical insurance they are brought in for well child checkups and preventative care. The whole medical model shifts. Parents and doctors are a team working together to keep children healthy and prevent disease. Parents are empowered, and the important job they are doing is validated. Time is available to answer questions and counsel about age appropriate health promotion and illness prevention. This exchange sets the stage for families where children can develop and grow and become productive and healthy members of their community.

Please support Senate Bill 13.



Monica Gross, M.D.
Fellow, American Academy Pediatrics
524 Main Street
Juneau, Alaska
907-586-6789



Banner Health

Tanana Valley Clinic

1001 Noble Street
Fairbanks, AK 99701
Phone 907-459-3500
Fax 907-459-3583

Representative Keller,

I am writing in support of the Denali Kid Care Funding Increase that is currently being debated in the Alaska Legislature. As a pediatrician in the Fairbanks community for over 25 years, I have seen first-hand the impact of healthcare costs on hard-working families in our state.

Although my primary role as a pediatrician is to care for the health and well-being of children, it is also imminently important that I respect the concerns of parents and consider the welfare of entire families. Many of the exams, procedures and treatments that I provide put a heavy financial burden on families, producing a mountain of medical bills to be paid out of pocket. I am repeatedly faced with this ethical dilemma and must work to reconcile the necessity of treatment with the economic consequences of my decisions. Denali Kid Care alleviates much of the financial burden on families and, in turn, enables me to effectively administer a child's medical care without the added concern of a family's hardship.

Currently, I am caring for an infant who has been producing bloody stools every few days. His parents are understandably concerned, and I have been performing tests to rule out common problems that may cause this reaction. At this point it would be appropriate for the infant to be seen by a Pediatric Gastroenterologist; however, due to the cost of seeing a specialist, the family is unable to move forward.

By increasing the eligibility percentage from 175% to 200%, Senate Bill 13 would give over 1,200 children health insurance coverage. This new eligibility standard would significantly relieve families who must compromise their children's standard of care due to financial constraints. At Tanana Valley Clinic alone, there are at minimum 40 families, in both the pediatric and OB/GYN departments, who would benefit from this increase. For many hard-working men and women who are currently just beyond the income cap to qualify for Denali Kid Care, this new bill would mean the difference between making ER visits only in dire situations and scheduling preventative visits that ultimately create healthier children. Children who receive preventative care are four times less likely to visit the emergency room; this in turn reduces the long-term cost of healthcare to the state.

When I set out to practice medicine, I did not imagine that on a daily basis my conscience would be saddled with financial concerns when caring for a sick child. However, it is the current reality. Denali Kid Care alleviates many of these concerns not only for me as a pediatrician, but more importantly for families who qualify for this service. As the economy continues to struggle and employees are laid off or faced with reduced hours and benefits, it is important that Alaska responds. This is an opportunity to extend care to over 1,200 families who would be otherwise unable to afford the healthcare that their children deserve.

Sincerely,

J. Timothy Foote, MD

kaiser
commission on
medicaid
and the **uninsured**

**Challenges of Providing Health Coverage for Children
and Parents in a Recession:**

**A 50 State Update on Eligibility Rules, Enrollment
and Renewal Procedures, and Cost-Sharing Practices
in Medicaid and SCHIP in 2009**

Prepared by:

Donna Cohen Ross
Center on Budget and Policy Priorities

and

Caryn Marks
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

January 2009



Acknowledgments

The authors would like to extend our deep appreciation to the many Medicaid and SCHIP officials throughout the country who participated in this survey and so generously shared their time and expertise with us. We are grateful for their willingness to explain recent program developments -- from the broadest policy change to the most detailed program rule. Their important contribution to improving the health of children and families deserves recognition and our thanks. We also would like to thank our colleagues at the Center on Budget and Policy Priorities, particularly Matthew Broaddus, for their assistance and helpful suggestions as we prepared this report. We also appreciate the assistance of the Center for Children and Families at Georgetown University's Health Policy Institute.

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Executive Summary

Medicaid and SCHIP have been instrumental in covering more low-income uninsured children over the last decade. While much progress has been made, nine million children remain uninsured. As SCHIP reauthorization approached in 2007, states were poised to move forward with efforts to cover more uninsured children. However, federal obstacles, including the Medicaid citizenship documentation requirements, the issuance of a CMS-directive on August 17th 2007 limiting state expansions, and the failure to reauthorize SCHIP have hampered progress. A temporary extension provided funds for SCHIP through March 31, 2009.

When states adopted their budgets for the fiscal year starting July 1, 2008, many were able to include funding for children's coverage expansions. Later, the severity of the unfolding fiscal crisis became clearer and state budget shortfalls are now expected to total \$350 billion for the remainder of FY 2009 and through 2011. States face mounting pressure to cut Medicaid and SCHIP just as the need for coverage rises due to climbing unemployment and loss of health coverage. In the last downturn, some states implemented restrictive enrollment procedures and reported dramatic declines in children's enrollment as a result. States may soon feel pushed to take such steps. Key findings from the annual KCMU survey of state Medicaid and SCHIP policies for children and parents that were implemented or authorized between January 2008 and January 2009 in the 50 states and D.C. include:

- **States continued to make progress on improving access to health coverage, particularly for children, but several significant setbacks warn about impending problems.** One-third of states (19) increased access to health coverage, while ten states enacted at least one measure to restrict coverage. The most common restriction was imposing new or higher premiums in SCHIP, but two states also restricted eligibility. California increased the frequency of renewal, a change estimated to affect more than 260,000 children as well as large numbers of parents.
- **The economic crisis is widespread and serious healthcare cuts are looming, but the commitment to children is still strong.** States continued to enact eligibility expansions for children, and state officials in several of those states plan to go forward even though they are facing significant budget shortfalls. Federal constraints, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused some states to put expansions on hold temporarily. Others are using state funds to pay for coverage precluded by the directive.
- **Parent coverage is still more difficult to obtain than children's coverage.** The median income at which children qualify for coverage is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. However, for unemployed parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, \$601 per month for a family of three in 2008. Jobless parents who need coverage may find that unemployment payments put them over the income limit for Medicaid.
- **Outreach budgets were increased in a number of states, however, some are beginning to report that these funds are being curtailed.** Outreach, including community-based application assistance, is critical in a recession, since newly eligible families may be unfamiliar with public programs. But in light of budget shortfalls, some states expressed skepticism for conducting aggressive outreach. About half the states are using technology to implement or develop online applications and to develop more efficient enrollment and renewal systems.

As the economic crisis deepens, states will be under major pressure to contain costs. This may lead them to take steps that not only reverse coverage gains, but intensify the hardships that many families are already facing as a result of losing their jobs and their health insurance. Congress is currently considering SCHIP reauthorization and an economic recovery package that would provide additional federal Medicaid matching funds. These would help states to maintain vital coverage for low-income families, support state efforts to enroll more eligible children, and make program improvements. Strengthening Medicaid and SCHIP in these ways is an essential precursor to the larger task of enacting broad health care reform.

I. Introduction

A commitment to providing health coverage for uninsured children has inspired nationwide efforts that began in earnest with enactment of the State Children's Health Insurance Program (SCHIP) in 1997. Like Medicaid, the chief source of health coverage for low-income families, SCHIP finances coverage through a partnership between the federal and state governments. State measures to expand eligibility and adopt streamlined enrollment procedures in Medicaid and SCHIP have strengthened both of these programs, and they have been instrumental in reducing the percentage of low-income uninsured children by one-third over the last decade.¹ Notably, the number of low-income uninsured parents increased over the same period, since eligibility levels and resources for addressing their health coverage needs do not approach those related to children.

While considerable progress has been made, nine million children in the United States remain uninsured, with nearly two-thirds of them eligible for Medicaid and SCHIP. In 2007, with relatively robust state budgets and the reauthorization of SCHIP at hand, across the country, states came forward to reaffirm their commitment to closing this gap. That year, state efforts to expand children's health coverage represented the most aggressive steps forward since the early years of SCHIP. Of the 20 states that expanded eligibility for children, 12 raised or authorized raising SCHIP income limits to 300 percent of the federal poverty line, more than doubling the number of states that previously had eligibility set at this level. States also made progress on adopting simplified enrollment and renewal procedures in both Medicaid and SCHIP, emphasizing strategies that reduce paperwork and jump-start enrollment.²

Despite this burst of activity, efforts to advance children's coverage met unanticipated federal obstacles. The Medicaid citizenship documentation requirement, enacted in 2006 as part of the Deficit Reduction Act, sent state simplification efforts backwards by requiring U.S. citizens applying for Medicaid to present original documents proving their citizenship and identity. States reported that this new rule ushered a deep decline in the enrollment of eligible U.S. citizens, especially children.

The expected reauthorization of SCHIP also encountered roadblocks. Congress passed two versions of legislation to reauthorize SCHIP and President Bush vetoed each of them. And, on August 17, 2007, as SCHIP reauthorization was proceeding, the Centers for Medicare and Medicaid Services (CMS) issued a directive that impeded states' ability to expand coverage.³ The year ended with these problems unresolved, meaning states were without the infusion of funds they were anticipating, and the new tools to bolster outreach and enrollment did not materialize. A temporary extension provided funds for SCHIP through March 31, 2009.

When states adopted their budgets for the state fiscal year starting July 1, 2008, they were able to include funding for children's coverage expansions. Later, the economy began to show signs of trouble, but it was not until September 2008 that the breadth and depth of the unfolding fiscal crisis became clear as financial markets collapsed and unemployment started to rise sharply. States are now facing an extremely threatening fiscal situation, with state budget shortfalls expected to total \$350 billion for the remainder of FY 2009 and through 2010 and 2011.⁴

So far, most states have managed to maintain existing eligibility levels and procedural improvements. For example, despite serious financial pressures, states that enacted earlier children's coverage expansions, such as Iowa and New York, have reiterated their intentions to go forward. But, there are warning signs that this will become more and more difficult.

As in past economic downturns, states will continue to struggle with the mounting pressure to cut health coverage programs just at the time that an increasing number of people need the vital services they provide. Many states have already implemented or announced major cuts to health programs, mainly in the area of provider rates and benefits, which have a significant impact on access and the quality of care. States that have not yet expanded are likely to be deterred from increasing coverage because of the dire economic environment.

Medicaid enrollment and spending growth peaked in 2002 at the same time state revenues dropped sharply. In response, states adopted an array of cost containment strategies to control spending growth. Then federal fiscal relief was made available to states through the Jobs and Growth Tax Relief Reconciliation Act of 2003, increasing the federal share of Medicaid costs, and lifting some of the burden states were carrying. The legislation restricted states from lowering Medicaid eligibility between September 2003 and June 2004, as a condition of receiving relief funds. Thus, no state retracted Medicaid eligibility during this time period. SCHIP eligibility also remained relatively constant, with only a few states cutting back.

However, because they were still grappling with budget shortfalls, nearly half the states put in place enrollment procedures that made it more difficult for children and parents to secure and retain health coverage between April 2003 and July 2004.⁵ Some states reported dramatic declines in children's enrollment as a result of these budget-driven changes, and children who were most likely *eligible* for existing programs became uninsured. For example, in Texas, SCHIP enrollment dropped by more than 149,000 children (a 29 percent decline), in large measure, due to reducing continuous coverage from 12 months to six months. Washington state also repealed the guarantee of 12 months of coverage and required parents to renew their child's eligibility every six months as well as report changes in the interim. This, along with other procedural changes, led to a dramatic caseload reduction of more than 40,000 children. In Wisconsin's BadgerCare program, establishing more rigorous documentation requirements resulted in an enrollment decline of 13,000 children and parents in just the first four months of implementation. Several states also froze SCHIP enrollment. In addition to turning away children who qualified for coverage under SCHIP, this strategy adversely affected Medicaid-eligible children not subject to the freeze. Eligible applicants' path to coverage was limited when states stopped taking joint Medicaid/SCHIP applications or because families mistakenly interpreted news reports to mean that all coverage programs were closed to new applicants.⁶

Coming out of the last economic downturn, states worked to eliminate SCHIP enrollment freezes and reverse some of the enrollment barriers they had imposed. This enabled caseloads to recover somewhat. An important lesson learned, however, is that the problematic effects of changing administrative procedures can endure if such changes send conflicting messages to prospective and current program participants.

As this report goes to press, two major developments are within reach. Congress has taken up SCHIP reauthorization once again and is working towards passing a bill that will likely be one of the first pieces of legislation to be presented to the nation's new president, Barack Obama. Next will come a significant economic recovery package that will contain substantial state fiscal relief in the form of enhanced federal matching funds for Medicaid that will reduce the share of the costs states will have to contribute for the program. Passage of both these bills would provide needed relief, as well as the support to move forward on enrolling more eligible, uninsured children. These measures would also help reinforce the federal/state partnership that is fundamental to the viability of health coverage programs. Strengthening Medicaid and SCHIP by making sure they are in a position to provide coverage to more

low-income uninsured individuals, is also an essential precursor to the larger task of enacting broad health care reform.

II. About this Survey

This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families that were implemented or authorized between January 2008 and January 2009 in the 50 states and the District of Columbia. These policies have a large influence on how effectively Medicaid and SCHIP can deliver health coverage to the eligible children, pregnant women and parents who rely on the vital services these programs provide. They are the driving forces behind efforts to reduce the number of low-income people who lack adequate insurance but cannot afford to pay for it on their own.

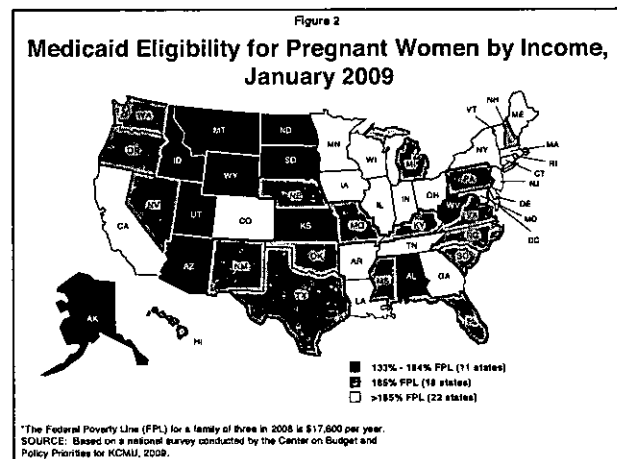
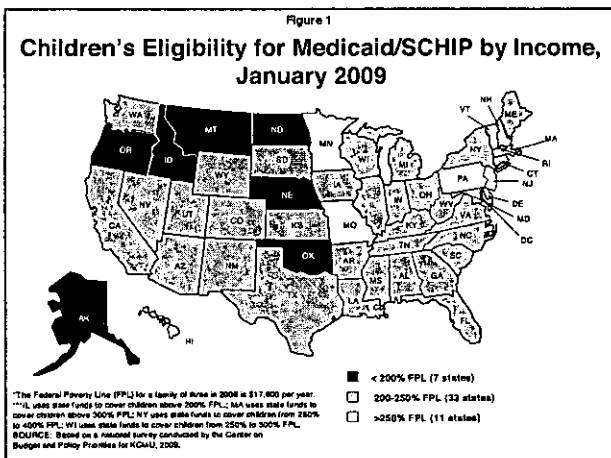
This study, the eighth annual survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, was carried out in the summer and early fall of 2008, through extensive telephone interviews with state Medicaid and SCHIP program administrators. Detailed follow-up interviews proceeded through the end of the year. The findings reflect policies and procedures in effect in the states in January 2009, as well as coverage expansions that were authorized, but were not implemented, by states during the survey period.

III. Key Survey Findings – Current Status of Coverage for Children and Parents

States continue to make progress on improving access to health coverage for low-income families. As of January 2009, income eligibility levels are as follows:

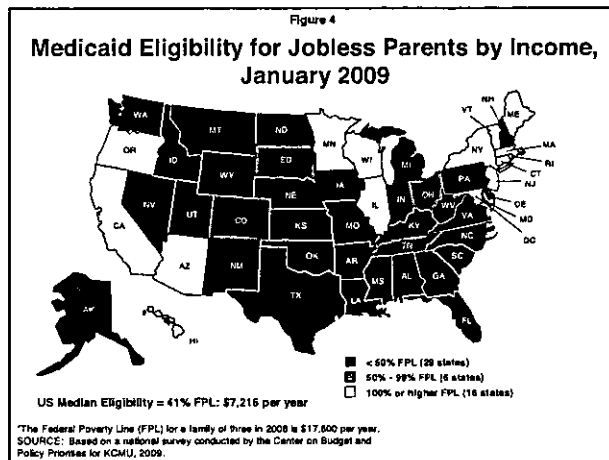
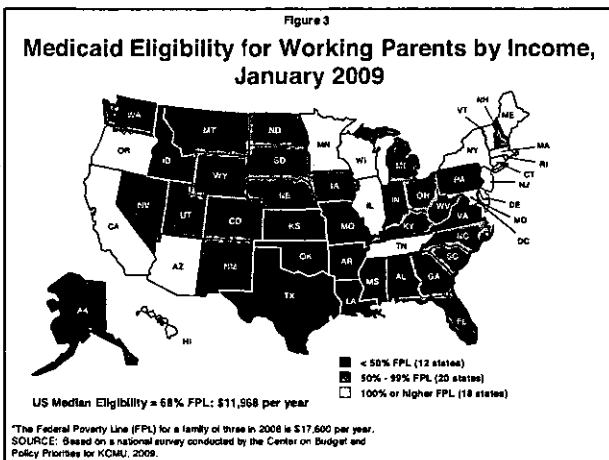
States provide health coverage for children and pregnant women under Medicaid or SCHIP as follows (Figures 1 & 2):

- 44 states, including DC, cover children in families with income at 200% FPL or higher. (\$35,200 for a family of three in 2008).
- 33 states cover children in families with income between 200% and 250% FPL. (200%: \$35,200 for a family of three in 2008; 250% FPL: \$44,000 for a family of three in 2008).
- 19 states, including D.C., cover children in families with income at 250% FPL or higher. 10 of these states cover children in families with income at 300% FPL or higher. (\$52,800 per year for a family of three in 2008).
- 40 states, including DC, cover pregnant women with income 185% FPL or higher. (\$32,560 for a family of three in 2008).

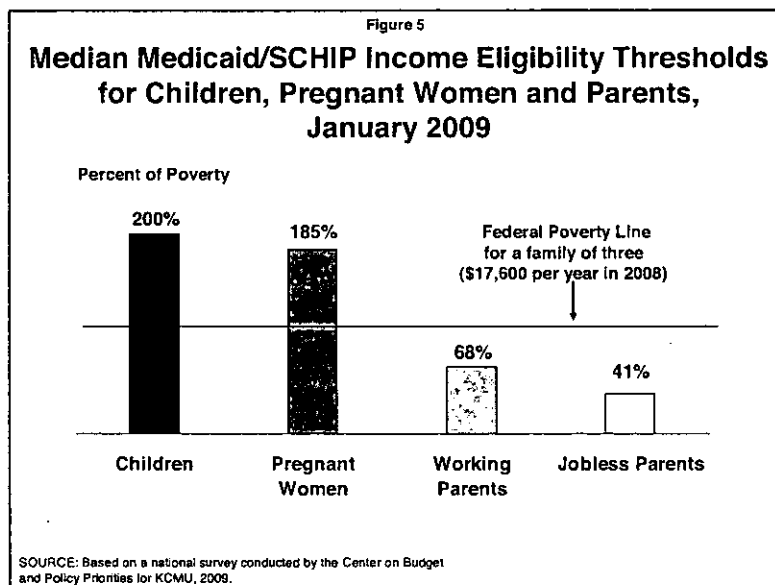


States provide health coverage for parents under Medicaid as follows (Figures 3 & 4):

- In 12 states, family income must be less than half the federal poverty line for a working parent to qualify for Medicaid (\$8,700 per year for a family of three in 2008).
- In 29 states, family income must be less than half the federal poverty line for a jobless parent to qualify for Medicaid (\$8,700 per year for a family of three in 2008).
- 18 states, including the District of Columbia, cover parents in families with income at 100 percent of the federal poverty line or higher (\$17,600 per year for a family of three in 2008).
- In 28 states, a parent in a family of three, working full-time at the minimum wage, earning on average, \$1,092 per month, cannot qualify for Medicaid.



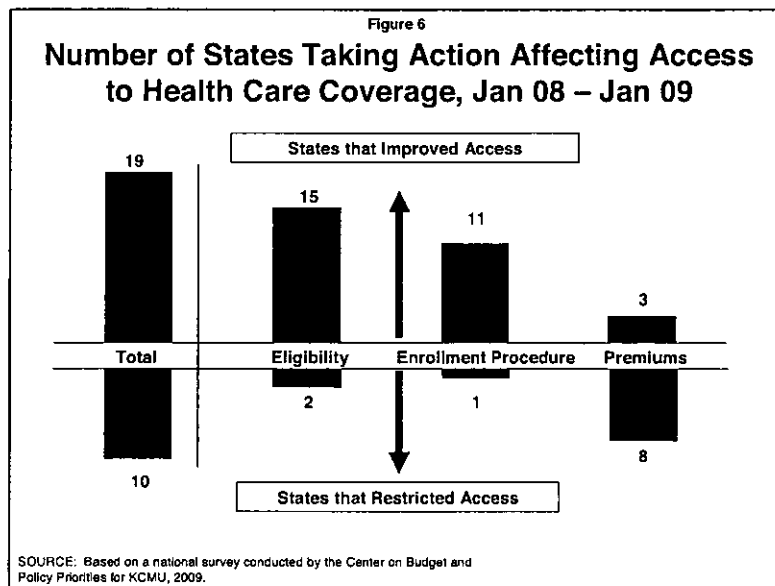
It continues to be more difficult for a low-income parent to qualify for health coverage than for a child (Figure 5). The median income at which children qualify for Medicaid or SCHIP is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. For jobless parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, \$601 per month for a family of three in 2008. In an economic downturn, this low income limit can take a serious toll on families. For many individuals who have lost their jobs and also their health insurance, COBRA coverage is likely to be prohibitively expensive or may not be available, and parents may turn to public programs for coverage. However, they may find that the unemployment compensation payments they receive put them over the income limit for Medicaid. (Since unemployment compensation is unearned income, “earnings disregards” that are designed to help working families qualify do not apply.) Jobless parents may eventually become eligible, but in the interim they are subject to health risks and financial exposure that can have deleterious consequences for themselves and their families.



IV. Key Survey Findings – State Actions During 2008

Overall, states continued to make progress on improving access to health coverage, but a few setbacks warn about impending problems (Figure 6).

- More than one-third of the states (19 states) took steps to increase access to health coverage for low-income children, pregnant women and parents. Fifteen(15) states authorized or implemented coverage expansions (CO, LA, IN, KS, LA, MD, MT, ND, NJ, NY, OK, OR, SC, TN, WI); 11 states reduced procedural barriers (AZ, CO, LA, KY, LA, MD, MT, NV, OR, SC, UT) and three states reduced financial barriers to Medicaid and SCHIP (TN, WA, WI).



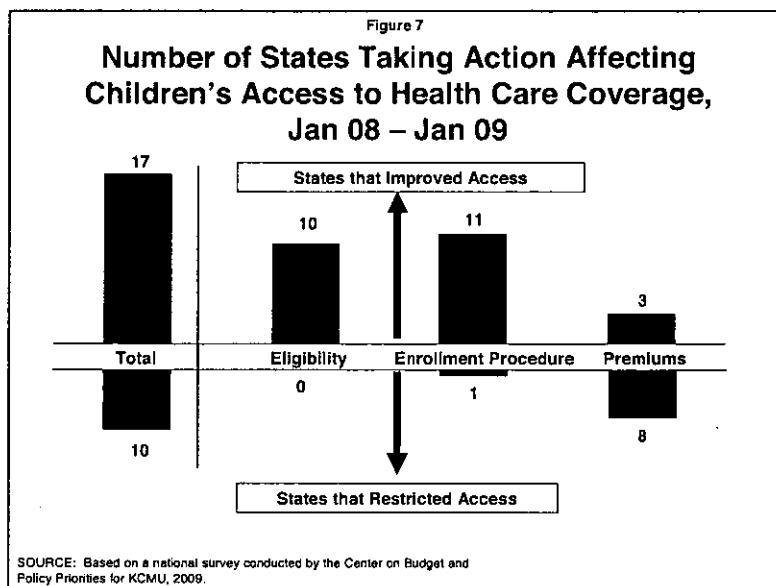
- Ten states (10 states) enacted at least one measure to restrict coverage. The most common restriction was to increase financial barriers such as new or higher premiums in SCHIP programs. Eight states (GA, LA, MN, MO, NJ, NV, PA, RI) went in this direction. Rhode Island and South Carolina restricted eligibility, the former cutting income eligibility for parents, and the latter establishing a three-month waiting period in its new separate SCHIP program, during which children must remain uninsured before they can enroll. California, increased the frequency with which parents and children are required to renew coverage.

The actions taken by Rhode Island and California, among the first states to feel the effects of the economic downturn, raise concerns about where other states could be headed if their fiscal pressures go unaddressed. The premium increases in Rhode Island are steep, coming at a time when families are likely to be financially strapped. Premiums of \$45 per child per month are now required for children in families with incomes as low as 133 percent of the federal poverty line (\$23,467 for a family of three in 2008), as compared to the previous starting point, 150 percent of the federal poverty line. Premiums for other children range from \$86 per month to \$114 per month, representing an increase of up to \$29 per month for some.

California's retraction of 12-month continuous eligibility for children withdraws the guarantee of full-year coverage, which is critical for children with ongoing medical needs. In addition, the state will

now require children and parents on Medicaid to comply with a semi-annual reporting procedure that is likely to cause otherwise avoidable gaps in coverage for eligible families. It will also create unnecessary and costly administrative burdens, since eligible families dropped from the program are likely to reapply within a short period of time. These changes could result in more than 260,000 children losing coverage by 2011. A large number of parents would be affected as well.⁷

The economic crisis is widespread, and serious health care and other cuts are looming, but states are demonstrating a steadfast commitment to covering children (Figure 7). States continued to enact eligibility expansions for children, and state officials in several of those states, such as *Iowa* and *New York*, plan to go forward even though they are facing significant budget shortfalls. Federal constraints that have dampened states' ability to expand, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused several states to put expansions on hold or scale back temporarily. Others, such as *Wisconsin* and *New York*, are using state funds to pay for children whose coverage is precluded by the August 17th directive.



- **One-third of the states (17 states) increased access to coverage for children.** Ten (10) states implemented or authorized eligibility expansions for children. *Iowa* and *Montana* raised children's coverage (scheduled to begin later this year), to 300 percent of the federal poverty line and 250 percent of the federal poverty line, respectively; *Kansas* implemented a children's coverage expansion to 250 percent of the federal poverty line. If the August 17th directive remains in place, these states will be subject to the strict conditions it imposes. Eligibility increases were also implemented, but to more modest levels in *Colorado*, *North Dakota* and *South Carolina*. *New York* adopted the option to allow children leaving foster care upon reaching age 18 to keep their Medicaid coverage.

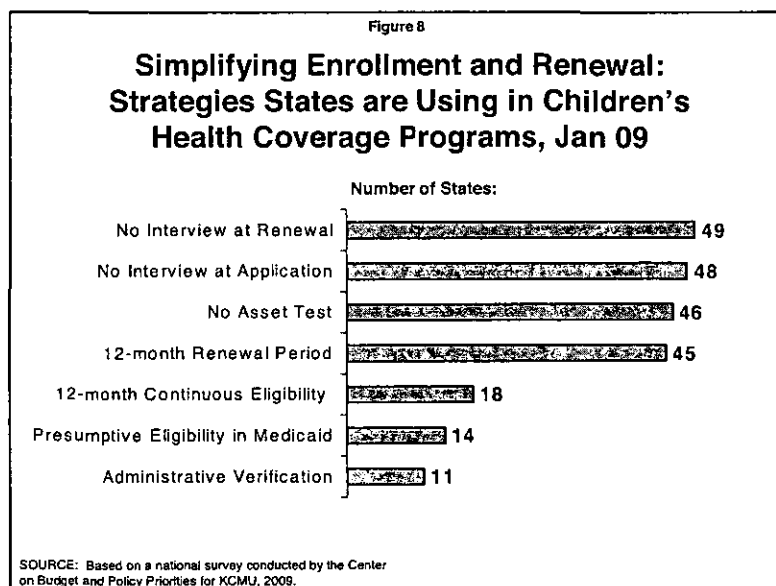
Of the ten states that expanded coverage for children, four were implementing expansions that were authorized last year, but which had been held back by the August 17th directive or by the uncertainty surrounding SCHIP reauthorization. *Louisiana* and *Indiana* increased eligibility to 250 percent of the federal poverty line, rather than 300 percent. *Wisconsin* and *New York* chose to move forward with their full expansions, funding coverage over 250 percent of the federal poverty line with state funds only. *Illinois* has been funding its expansion using state dollars. Planned expansions in five additional states (*NC*, *OH*, *OK*, *WA*, and *WV*) remain stalled.

Iowa Children Get A Coverage Boost

Buoyed by a groundswell of public support for covering children, Iowa Governor Chet Culver, along with state legislators, remain strong in their pledge to expand health insurance to more of the state's uninsured children. In the last legislative session, state legislators passed an expansion of hawk-i, the state's SCHIP program, to 300 percent of the federal poverty line, which will be implemented in July 2009, and cover an estimated 5,000 new children. Program improvements have already proceeded. The state now guarantees children a full 12 months of continuous coverage and is pursuing ways to ease premium payment policies. For example, families new to the program will not have to pay premiums for the first two months of enrollment. Outreach is expected to go forward as well, but may possibly be scaled back. Like many other states, Iowa is in a severe budget crunch, with an expected shortfall of more than \$600 million in the coming year. Major spending cuts are being planned, but it appears that the children's coverage expansion will go forward. Senate Majority Leader, Mike Gronstal (D) stated recently, "We committed to providing access to affordable coverage to every kid in the state of Iowa. I'm not interested in backing up on that commitment."

* "Health Promises Persist: Iowa lawmakers reconcile health care goals, budget" The Hawkeye, January 15, 2009.

- **Eleven (11) states took steps to reduce procedural barriers to coverage for children (Figure 8).** *Arizona, Kentucky, and Utah* no longer require families to participate in face-to-face interviews to obtain health coverage for their children, and *Colorado* adopted "administrative verification and renewal," meaning the state no longer requires families to provide paper documentation of their income and eligibility workers use existing databases to verify the information families provide on the application. *Maryland, Montana, Louisiana, South Carolina and Utah* have revised their applications to allow parents to apply using the same simplified forms that are used for children, a change that benefits both children and parents. *Iowa, North Dakota and Oregon* now guarantee 12 months of continuous eligibility, considered to be one of the most effective tools for keeping children covered for as long as they qualify. One serious setback, the changes to the renewal procedures in *California*, was discussed earlier.



States Explore the Use of Technology to Facilitate Enrollment

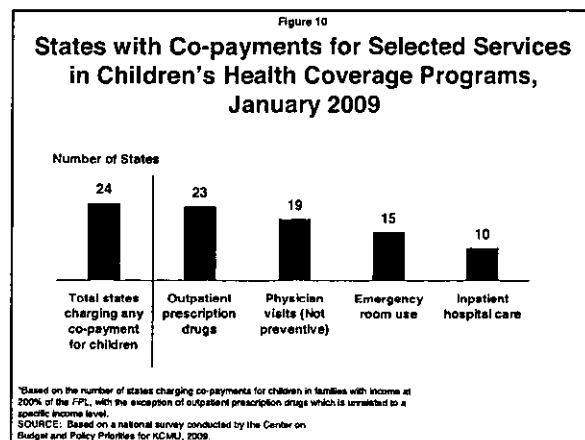
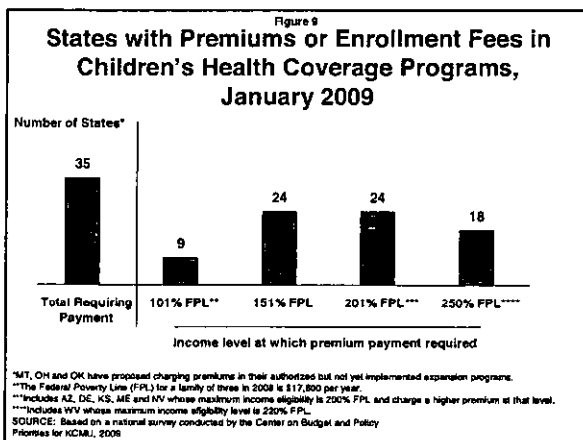
Emergence of Online Applications

About half the states reported that they are implementing, or are in the process of designing, on-line applications. Several of these states also report allowing the use of electronic signatures, so that a follow-up signature page does not have to be printed and mailed in. (Other states appear unsure about the permissibility of electronic signatures and point to the lack of clear federal guidance on this subject.) Some states at the forefront of using on-line applications also report that their applications currently interface with existing eligibility systems (or will in the future), so that information from the on-line application does not have to be re-entered by eligibility workers and an eligibility determination can move forward more rapidly.

Database Usage

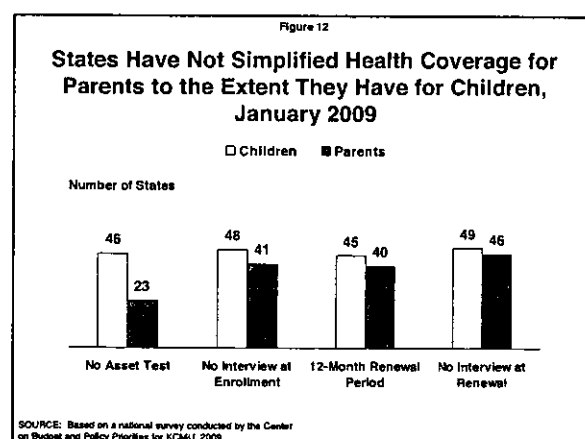
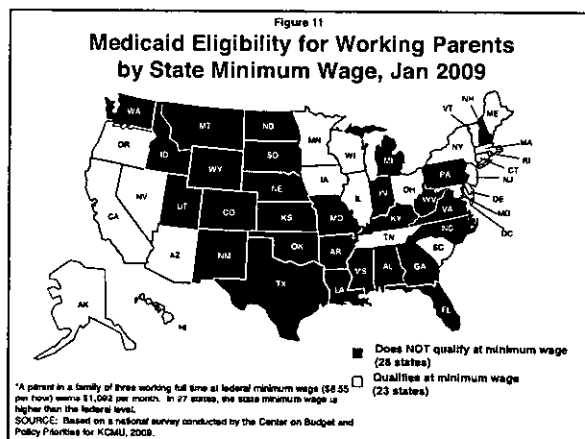
Eleven states (12 states at renewal) report using technology to streamline the enrollment and renewal process. States report conducting matches with existing databases to verify income and other information, as well as eliminating rules requiring families to submit pay stubs or other paper documentation. This procedure is referred to as "administrative verification and renewal." Many states also are conducting data matches with their Vital Records departments to help families comply with the Medicaid citizenship documentation requirement, however, the technological capacity to do this efficiently varies considerably. Finally, states are exploring the use of technology to target outreach, for example, by conducting data matches with existing databases to identify children and parents who are likely to qualify for health coverage but who are not enrolled. States report using matches with food stamp databases for this purpose, and have expressed interest in using state tax system databases.

- **Outreach budgets in a number of states were increased in 2008, however, some states are beginning to report that these funds are being curtailed.** Several states reported increases in outreach funding in 2008, sometimes associated with new expansions, but also for ongoing promotional activities and community-based application assistance. In recent follow-up interviews, some state officials indicated that their outreach budgets have now been cut; others expressed skepticism for conducting aggressive outreach in light of budget shortfalls. Still others said their outreach activities would go forward, with some indicating that activities would emphasize renewal assistance so that already enrolled children do not lose coverage.
- **A few states reduced financial barriers to children's coverage, eliminating or lowering premiums for some children, while other states increased premiums (Figure 9).** *Tennessee, Washington* and *Wisconsin* either reduced premiums or eliminated them for some children. *Georgia, Minnesota, Missouri, Nevada, New Jersey, Pennsylvania* and *Rhode Island* increased premiums for children, with two of these states showing significant increases. *Minnesota* premiums increased by up to \$14 per month for some children. Premium increases in *Rhode Island*, discussed earlier, represented the most severe increases for children this year. New premiums implemented in *Louisiana*, apply to the state's new expansion group (children with incomes between 200 percent and 250 percent of the federal poverty line).
- **Co-payments for health services were adopted in one state and increased in two states (Figure 10).** Currently, 24 states charge co-payments for children's health services. *Wisconsin* adopted new co-payments, and *West Virginia* and *Utah* increased co-payments for prescription drug coverage. Only one state, *Montana* decreased co-payment amounts.



Low-income parents applying for Medicaid coverage continue to face substantially restricted income eligibility and access as compared to their children (Figure 11 and 12).

- A few states took steps to boost coverage and simplify procedures for parents. Three states — *New Jersey, Maryland, and Wisconsin* — implemented parent coverage expansions. Still, in 28 states, parents working full time at minimum wage cannot qualify for Medicaid. One state, *Rhode Island*, cut parent coverage. *Maryland* also stopped counting assets in determining eligibility for parents, a step that fewer than half the states have taken. Given the restrictive income eligibility levels for parents in most states, the majority of parents applying are not likely to have substantial bank accounts, multiple vehicles of significant value, or other resources that would disqualify them. The burdensome and intrusive paperwork associated with proving that one does not exceed the asset limit often deters eligible parents from completing the application process. Other measures were implemented to reduce procedural barriers for parents, including eliminating interviews and reducing the frequency of renewal (*AZ, MD, UT*), but these practices are still more prevalent in children's coverage programs.



Maryland Expands Medicaid Eligibility for Low-Income Parents

Access to health coverage increased measurably for thousands of low-income Maryland parents this year when an income eligibility expansion and a package of procedural improvements were implemented on July 1, 2008. The state boosted parent eligibility from about 30 percent of the federal poverty line to 116 percent. The state also eliminated the asset test and no longer requires parents to have a face-to-face interview at the Medicaid office. This streamlined the process for parents and also aligned procedures for parents and children to a greater extent so that they can apply using the same simplified application form. Since its implementation, 29,682 adults have enrolled as a result of the expansion.

To achieve this early success, a logical first step was to identify children already in Medicaid whose family income is below 116 percent of the federal poverty line and enroll the parents when they renew their child's coverage. Traditional outreach efforts including TV, print and radio publicity, as well as activities with the Baltimore Ravens football team, also have done much to inform families about the new coverage opportunity. In addition, the Medicaid and revenue agencies coordinated on a new initiative that used the tax system to identify 150,000 people who were potentially eligible. They were sent a letter from the state Comptroller inviting them to call a toll-free number for an application. Between December 1 and December 12, 2008, nearly 1,800 hotline callers were sent applications. Others obtained applications on-line and through other avenues.

Enrollment continues to increase and the recession is apparently a driving force: there were more approvals of parents in the expansion group during the first two weeks in December than there have been since it was implemented in July and state officials say they are seeing people who previously had secure jobs and are seeking help, perhaps for the first time. The budget is tight in Maryland, but in two rounds of cuts, the expansion has not been targeted.

*Conversations with Maryland State Officials, January 2009.

- **Income eligibility for pregnant women remained stable with nearly half the states covering pregnant women at 185 percent of the federal poverty line.** Two states, *Tennessee* and *Wisconsin*, increased eligibility for pregnant women to 250 percent and 300 percent of the federal poverty line respectively. *Oklahoma* and *Oregon* both adopted the option to use SCHIP funds to cover unborn children of pregnant women.

V. Discussion

Recession Jeopardizes States' Ability to Maintain and Advance Coverage for Low-Income Children and Parents

States have made substantial progress in reducing barriers to health coverage for low-income children and families. They continued to do so during the first half of 2008 by further expanding eligibility and streamlining enrollment and renewal procedures. Now, as the economic crisis deepens, states will be under major pressure to contain costs. This may lead them to take steps that would not only reverse critical coverage gains, but would intensify the hardships so many families are already facing as a result of losing their jobs and their health insurance. In the last economic downturn, federal fiscal relief was successful in helping states address budget shortfalls, avoid deeper Medicaid cuts, and preserve eligibility, which was a condition of receiving enhanced federal funds. However, to deal with tight budgets, many states made procedural changes to their programs which blocked eligible children and parents from obtaining coverage at a time when they could least afford health care on their own.

Easing Eligibility and Simplifying Procedures Are Especially Important During an Economic Downturn

Individuals who have lost health coverage due to unemployment need a smooth path to Medicaid and SCHIP.⁸ Any period of time without insurance could cause ongoing medical conditions to escalate if it is not possible for families to find or pay for needed medication or other treatment on their own. Parents who are recently unemployed may find that the unemployment compensation payments they receive put them over the income limit for Medicaid. States can choose to disregard these payments or a portion of them in determining eligibility for jobless parents. States can eliminate their SCHIP waiting periods or at least ensure that a job-loss exemption is available. Minimizing documentation requirements and rescinding face-to-face interviews also are important since complicated, burdensome forms and procedures often discourage families from completing the process. Enrolling children for a full 12 months and simplifying renewal helps ensure beneficiaries remain covered for as long as they qualify. In addition to protecting children and families, taking such steps also saves administrative costs by reducing the workload on eligibility workers. Eligibility staff may have been cut at the same time application volume has increased.

Premium Payment Policies Matter

It also is important to ensure that unreasonable out-of-pocket costs do not keep eligible children from obtaining coverage and needed care. When a family has lost income or a job, it will be more difficult to keep up with premium payments on top of regular living expenses. Numerous studies show that premiums for low-income individuals can depress enrollment in health coverage programs.⁹ Similarly, burdensome co-payments can be an obstacle to getting needed care or medication. Programs should also avoid imposing strict payment timeframes after which children are disenrolled from SCHIP, as well as lock-out periods that bar children from returning to SCHIP if the lack of a premium payment forces them to lose coverage.

Outreach Is Critical During Economic Downturns

In tight budget times, it may appear sensible to cut outreach funds as states seek ways to contain the costs associated with expanding caseloads. Conducting outreach may also seem counterintuitive when hiring freezes and lay-offs mean there are fewer eligibility workers to process a larger volume of applications. However, families that previously had stable jobs with health insurance are likely to have little or no experience navigating the public benefits system. They may not know where to turn for help when they become jobless, nor are they likely to know much about Medicaid and SCHIP or realize that they may qualify. Community-based organizations and institutions can play a vital role in alerting families to the availability of free or low-cost coverage and in assisting families with application procedures.

States are attempting to balance these competing pressures. For example, although New Mexico has had to make significant cuts to its Medicaid budget, the state will continue to reach out and enroll more uninsured children, a goal Governor Richardson has prioritized. A state Medicaid official explained that, while available funding will continue to be used for outreach, "the state does not have funds to do anything very aggressive or costly. It's difficult to justify spending on outreach when we're cutting elsewhere, however we will conduct some data matches to identify eligible but unenrolled children."¹⁰ Given the demands that outreach generates and the limitations created by personnel cuts, adopting simplified procedures are more important than ever. Streamlining renewal, in particular, protects the investment in outreach since it guards against eligible children and parents losing coverage unnecessarily.

Federal Legislation May Provide Needed Help for States

Two major pieces of legislation are being considered in Congress as this report is being written. Both are critical to addressing the challenges states are facing as they report mounting deficits and also attempt to assist the growing demand for health coverage among families that are suffering the effects of the weakening economy. The first is reauthorization and extension of SCHIP legislation, which is currently operating with temporary funding through March 2009. This legislation would provide the additional funds to maintain coverage for children currently enrolled and cover additional uninsured children. It would also provide bonus payments designed to encourage states to enroll more eligible children under Medicaid.

The second piece of legislation is the economic recovery package. In this recession, with substantial state deficits, one form of assistance the federal government could provide is an increase in the federal share of financial assistance for the Medicaid program (FMAP). The amount of funding for the enhanced FMAP, the duration of the relief, the distribution of the funds across states, and the conditions or maintenance of effort requirements related to eligibility are critical issues in the design of a recovery package. In 2003, one of the conditions for states receiving an increased FMAP was that they were prohibited from reducing eligibility levels in order to qualify for this financial assistance. Congress could also consider requiring states to maintain enrollment procedures to qualify for federal assistance and additional provisions to extend temporary Medicaid coverage to individuals affected by the economic downturn.

The SCHIP reauthorization and economic recovery plan could provide an essential boost that would enable states to sustain the coverage gains they have achieved and give families hard-hit by the recession the confidence that assistance with health coverage will be available.

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- ¹ Kaiser Commission on Medicaid and the Uninsured analysis of the National Health Interview Survey data.
- ² Donna Cohen Ross, Aleya Horn and Caryn Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.
- ³ Letter from Dennis Smith, Director for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials, August 17, 2007.
- ⁴ Elizabeth McNichol and Iris Lav, *State Budget Troubles Worsen*, Center on Budget and Policy Priorities, Washington, DC, Updated, January 14, 2009.
- ⁵ Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2004.
- ⁶ *Ibid.*
- ⁷ Nicholas Johnson, Phil Oliff and Jeremy Koulisch, "Facing Deficits, Two-Thirds of States Are Imposing Cuts that Hurt Vulnerable Residents," Center on Budget and Policy Priorities, Washington, DC, Updated January 14, 2009.
- ⁸ Michael Perry, Barbara Lyons, Robin Rudowitz and Julia Paradise, "Turning to Medicaid and SCHIP in an Economic Recession: Conversations with Recent Applicants and Enrollees," Kaiser Commission on Medicaid and the Uninsured, December 2009.
- ⁹ Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent States Experiences," Kaiser Commission on Medicaid and the Uninsured, 2005.
- ¹⁰ Conversation with Robert D. Beardsley, Deputy Director, Medical Assistance Division, New Mexico Department of Human Services, January 12, 2009.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

April 15, 2009

Representative Wes Keller, Co-chairman
House Health & Social Services Committee
State Capitol, Room 13
Juneau AK, 99801-1182

Representative Bob Herron, Co-chairman
House Health & Social Services Committee
State Capitol, Room 415
Juneau, AK 99801-1182

Dear Representatives ^{Wes} ~~Keller~~ and ^{Bob} ~~Herron~~:

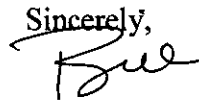
I am writing on behalf of the Governor to respectfully request a hearing for Senate Bill 13 in the House Health & Social Services Committee.

Senate Bill 13 increases the income level for covering children and pregnant women under Denali KidCare to 200 percent of the federal poverty guidelines, up from the current level of 175 percent.

Senate Bill 13 would allow approximately 1,277 more uninsured children and 225 pregnant women to access health insurance. Early intervention and preventative care under SB 13 will significantly improve the health of Alaska children's by addressing problems before they result in more costly conditions that must be treated later in life. Early care can also result in savings to the state and public and private sector hospital emergency rooms by reducing the need to treat indigent and uninsured patients for non-emergencies.

Although we believe there is merit in several other proposals introduced this year to implement cost sharing provisions along with an increase in eligibility, we believe that providing essential care for those up to 200 percent of poverty level is more important than pursuing those options this year.

Thank you for consideration of this request.

Sincerely,


William H. Hogan
Commissioner

cc: Gerald Gallagher, Director Governor's Legislative office
Anna Kim, Governor special assistant
House Health & Social Services committee members

20
Years



**Covenant
House
Alaska**

Crisis Center • Community Services Center • Transitional Living

Governor Sarah Palin
State Capitol
Third Floor
Juneau, AK 99801

April 9, 2009

Dear Governor Palin,

Senator Bettye Davis and Representative Les Gara introduced legislation providing transitional assistance and care for foster care youth leaving the state's care (SB 105 and HB 126). The Alaska State Legislature is currently reviewing these proposed bills.

Covenant House Alaska (CHA) provides shelter, food, healthcare and transitional living assistance to Alaska's homeless youth. CHA strongly supports SB 105 and HB 126.

The proposed legislation provides access to educational, housing and life skills support that is vital for young people to successfully transition to adulthood. Nearly 50% of CHA youth have been involved with the foster care system at some point in their lives. They arrive on our door step with a plastic bag full of a few belongings. Many of these youth survive for a few months after being released from care, but find at the young age of 18 they don't have the resources and life skills required to live completely independently on their own. After living traumatized lives, they are faced with a new trauma and a new set of dangers that homelessness presents.

This legislation is fundamentally about providing to our foster care youth the resources we would naturally provide to our own children. Youth still require assistance with educational, occupational and housing needs past the age of 18. This bill ensures that while we cannot completely erase the trauma endured by foster care children, we can lessen it. We can actively take steps to help them in a responsible, reasonable fashion.

Thank you for your consideration of this letter and the proposed legislation. Please contact me with any questions you may have.

Sincerely,

Deirdre A. Cronin
Executive Director

Opening Doors for Homeless Youth
Celebrating 20 years of service in the State of Alaska

Mailing: P.O. Box 104640, Anchorage, Alaska 99510-4640 • (907) 272-1255 • www.covenanthouseak.org

Janet Ogan

From: doctorem@aol.com
Sent: Wednesday, March 10, 2010 11:24 PM
To: Rep. Wes Keller; Rep. Bob Herron
Subject: in support of SB 13 and Denali Kidcare

March 10, 2010

Dear Representatives Keller and Herron, and members of the House HSS committee,

I am writing in support of SB 13, which has been worked over for 2 years now. SB 13 represents a classic opportunity to demonstrate the wisdom of "a stitch in time, saves nine." Helping children, single mothers and low-income workers get the health care they need BEFORE they land in the emergency department will SAVE money, not to speak of time lost at work, heart-ache, pain and suffering.

This bill is not designed to waste money on those who could actually afford premium health insurance plans. We have all heard about Medicare loopholes in which billionaires get discounted drugs. This bill is about helping people who really need the help. The federal poverty limit for a family of 4 this year is less than \$1000/month per person. This level of income, which represents many hours of hard work in a lower-paying job, may pay rent, cold weather clothing and basic food. It will not allow for opportunities for self-advancement, nor savings, nor debt reduction, in particular if one or more of the family members has health issues. Even at 200% of poverty level, many families will struggle to pay health care insurance premiums, deductibles and co-pays. As you know, the single largest line item for personal debt in the US (Alaska included) is medical bills. Some families lose their homes over choosing to provide needed, yet expensive, care for their cherished children or siblings or parents.

Alaska is the wealthiest state in the nation. Please let us help raise up people in this great country from such a level of struggle. It is shameful to refuse a small part of our \$40 billion bank account to care for our own people. Health, ultimately, is absolutely the most precious resource for every individual. Without health, any amount of money or fame is trivial. Please, invest in the health of all Alaskan people, and let Alaska lead the way in taking care of its own.

Sincerely,

Dr. Emily A. Kane
Juneau AK

SB 13 AMENDMENTS:

It seems to me that its unfair for the chronically disabled to be penalized when they are trying so hard to become productive members of the community. It also seems unfair to penalize working poor families by denying them extra assistance until they are able to solve their financial situation. What I would like to talk to you about is my solutions to these situations:

- Please consider raising the federal poverty rate to 200% across all programs (i.e. Childcare Assistance, Adult Public Assistance, Denali Kid Care). Through this change, not only will it allow more families to qualify for services, but also it might give them the boost they need to stabilize their current situation.
- Create an exemption process for working families that fall slightly over income limits. This would give families the ability to receive assistance and continue working. From personal experience, I know that if my family had had the benefit of just a little extra assistance we would be able to take care of our family and be productive in work, which ultimately helps the State of Alaska.
- Establish a transportation assistance fund for elders and people experiencing disabilities. When I lived in New York, the state ran a program that provided free transportation for elders and people experiencing disabilities through establishing a general transportation assistance fund to the state budget. From my research, I noticed that the Alaska Commission on Aging advocated to get this discussed during the last legislative session. Unfortunately, the proposal did not get passed. As a person who experiences issues with affording public transportation, I strongly urge you to please give their proposal more consideration. If I was able to fully access transportation, I could focus on receiving treatment to help me better handle my symptoms. As I see it, this small change will assist me on my way to achieving my goal of gainful employment and safety/security for my family.

I thank you in advance for your time and consideration in reading my letter. Please know that I welcome the opportunity to speak with you or one of your aides personally about my situation and ways I'm willing to help to create solutions to benefit all Alaskans. My contact information is listed above. Please feel free to contact me at your earliest convenience.

Sincerely,

Michael Markovich

764-5001

MJM7788@GMAIL.COM

SB 13 AMendments :

Ways to decrease spending so that the Federal Poverty Level could be raised to 200%:

- Eliminate 6 - month reviews for people already on Adult Public Assistance. The paperwork so is cumbersome for workers that cases have to be shipped to other offices to be processed. Personally, I live in Anchorage, but my paperwork is processed in the Kenai office. From my research, Alaska is one of a few states that still do 6-month reviews. The majority of other states conduct reviews yearly. Imagine the time and money saved if paperwork was reviewed yearly.
- Limit benefits for people with major criminal offences or history of chronic drug or alcohol use. When applying for benefits, ask people for proof of any criminal or substance abuse history. If they comply, ask them to sign a release so that history can be verified and case managers working with the person can provide feedback on progress. If the person is in a rehabilitation program, they should be allowed on the program as long as they are actively working on staying out of jail or getting clean and sober. People who do not comply with the program or sanctions taken if they have a "bump in the road to recovery" should be removed from the program. The way I see it, if people are actively engaged in trying to get more self-sufficient, funding spent of fighting crime and homelessness would decrease, which will reduce the crime rate, cut spending on policing the State and save the State of Alaska money overall.
- Create a buy in program for Medicaid and Child Care Assistance programs. If a person doesn't quite fit the requirements for assistance due to income (for example if he or she is financially over by a few hundred dollars) allow them the option to partial pay for Medicaid or Child Care assistance based on what they can afford. This would assist people to get medical assistance as well as childcare so that they are healthy and able to find gainful employment, which helps them create a plan for self-sufficiency. A timetable would need to be set in place to ensure that participants work towards coming off the program. People who do not show compliance in working themselves off the program would be removed from the program after a year.

Sincerely,

Michael Markovitch

764-5001

MSM 7788@GMAIL.COM

Fax Written Testimony

269-0229

Alaska State Legislature

Please enter into the record my testimony to the House H&SS
committee name

committee on SB 13 - Increase Denali KidCare dated 3/9/2010
bill/subject

Catholic Social Services provides help & creates hope for nearly 19,000 individuals a year through a variety of social services programs that focus on self sufficiency. Many people seeking assistance at Catholic Social Services are the working poor - people that are just getting by, struggling each day to pay their bills and feed their families.

SB 13 is important legislation because it will increase the income eligibility guidelines for Denali KidCare from 175% to 200% of Alaska's federal poverty level (FPL). As you know, this change would restore eligibility to 1,300 children and 225 pregnant women.

Increasing eligibility to 200% of the federal poverty level is not only a good thing to do for Alaska's low-income families but reflects sound fiscal policy as research shows that preventive care, such as that received through Denali KidCare, has a positive return on investment. For example, children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment. The federal government covers almost 65% of the entire cost of Denali KidCare. Therefore, compared to the long term expenses the State of Alaska will most likely incur if these vulnerable children and pregnant women continue to be denied access to health care, the financial expenditure associated with a return to 200% of FPL is nominal.

Thank you for giving Catholic Social Services an opportunity to speak out on this important issue! We strongly believe that Denali KidCare helps parents raise healthy kids and we are all strengthened by a healthy community.

Signed: Ellen Lawlor Krsnak *Ellen Lawlor Krsnak*
Testifier

Catholic Social Services
Representing (Optional)

3710 East 20th Avenue, Anchorage, AK 99508
Address

907-222-7327
Phone No.



Banner Health

Tanana Valley Clinic

SB 13

1001 Noble Street
Fairbanks, AK 99701
Phone 907-459-3500
Fax 907-459-3583

Representative Keller,

I am writing in support of the Denali Kid Care Funding Increase that is currently being debated in the Alaska Legislature. As a pediatrician in the Fairbanks community for over 25 years, I have seen first-hand the impact of healthcare costs on hard-working families in our state.

Although my primary role as a pediatrician is to care for the health and well-being of children, it is also imminently important that I respect the concerns of parents and consider the welfare of entire families. Many of the exams, procedures and treatments that I provide put a heavy financial burden on families, producing a mountain of medical bills to be paid out of pocket. I am repeatedly faced with this ethical dilemma and must work to reconcile the necessity of treatment with the economic consequences of my decisions. Denali Kid Care alleviates much of the financial burden on families and, in turn, enables me to effectively administer a child's medical care without the added concern of a family's hardship.

Currently, I am caring for an infant who has been producing bloody stools every few days. His parents are understandably concerned, and I have been performing tests to rule out common problems that may cause this reaction. At this point it would be appropriate for the infant to be seen by a Pediatric Gastroenterologist; however, due to the cost of seeing a specialist, the family is unable to move forward.

By increasing the eligibility percentage from 175% to 200%, Senate Bill 13 would give over 1,200 children health insurance coverage. This new eligibility standard would significantly relieve families who must compromise their children's standard of care due to financial constraints. At Tanana Valley Clinic alone, there are at minimum 40 families, in both the pediatric and OB/GYN departments, who would benefit from this increase. For many hard-working men and women who are currently just beyond the income cap to qualify for Denali Kid Care, this new bill would mean the difference between making ER visits only in dire situations and scheduling preventative visits that ultimately create healthier children. Children who receive preventative care are four times less likely to visit the emergency room; this in turn reduces the long-term cost of healthcare to the state.

When I set out to practice medicine, I did not imagine that on a daily basis my conscience would be saddled with financial concerns when caring for a sick child. However, it is the current reality. Denali Kid Care alleviates many of these concerns not only for me as a pediatrician, but more importantly for families who qualify for this service. As the economy continues to struggle and employees are laid off or faced with reduced hours and benefits, it is important that Alaska responds. This is an opportunity to extend care to over 1,200 families who would be otherwise unable to afford the healthcare that their children deserve.

Sincerely,

Timothy Foote, MD



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

April 15, 2010

To: Members of the Alaska House of Representatives

RE: SB 13 (Davis)—Support

On behalf of the members of AARP in Alaska, we encourage you to support SB 13, authored by Senator Bettye Davis, and co-sponsored by Senators Paskvan, Ellis, Wielechowski, and French as well as Representatives Gruenberg, Tuck, Kawasaki, Crawford, Herron, Munoz, Holmes and Kerttula.

AARP is the world's largest organization of grandparents. We are concerned about health insurance coverage for everyone's grandchildren.

SB 13 will return the Denali KidCare program to the former eligibility levels at 200% of the federal poverty level. We think this is an excellent plan and should provide comprehensive and preventive health coverage for many more young Alaskans and pregnant women.

In addition, we have many retired grandparents who are raising their grandchildren. Currently there are over 5,400 grandparents responsible for raising over 8,200 young Alaskan grandchildren. Very often these grandparents are retired and dependent on Medicare for their health coverage. Denali KidCare, in many cases, is the only health insurance they can secure for their grandchildren. If these grandparents are not able to secure insurance coverage for their grandchildren, some of the children will have to leave this caring family environment and become wards of the state. We hope you realize how important Denali KidCare coverage is to these extended families that are now in one household. These grandparents are trying to provide the best care for their grandchildren. They need Denali KidCare.

Many AARP members have coverage through Medicare or their employer and they understand how important health insurance is to them; we support the efforts of this bill to provide coverage to other Alaskans who need it.

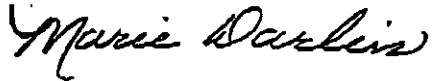
A healthy future for our children should be something everyone can agree on.

AARP requests an "AYE" vote on SB 13.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Bettye Davis

fax

Subject: Denali Kidcare

Date: April 16, 2009

To: *Representative Sharon Cissna*

CC: *Representative Bob Herron, HSS Co-Chair*
Representative Wes Keller, HSS Co-Chair

From: *Various Anchorage Residents*

Fax: 465--4588 (Representative Cissna)
465--4589 (Representative Herron)
465—3818 (Representative Keller)

Comments:

*Dear Representative Cissna:
Please share these letters with your colleagues on the
House HSS Committee. Thank you.*

24 pages plus cover sheet

Letter in Support of Increasing Denali KidCare Income Eligibility Levels

Name: Katrina Letner

Address:

12254 Keystone Place

Eagle River, AK, 99577

Phone Number: 720-7449

During the 2009 State Legislature, Senate Bill 13 and 87 have been introduced to increase the eligibility income level for Denali KidCare. These very important bills would increase Denali KidCare from 175% of Alaska's federal poverty level to 200%. These bills would allow thousands of additional Alaskan children and pregnant women to be eligible for medical assistance. Along with Governor Palin, I support an increase in Denali KidCare and encourage the Alaska State Senate to do the same. Here are my reasons why:

Providing health and dental insurance for more children will prevent major health issues and save money in the long run. Prevention is the key. Uninsured children are 25% more likely to miss school than insured children. Continued illness affects school performance and work force participation.

Thank you for taking my thoughts into consideration. If you have any questions, please call me at the above number. Please do all that you can to support these important pieces of legislation.

Katrina Letner
Signature

03/05/2009
Date

This letter campaign was organized by concerned local citizens and Alaskan non-profit agencies and is not affiliated with any politician, political organization or political action committee.

Letter in Support of Increasing Denali KidCare Income Eligibility Levels

Name: Miriam Verquez Ematio

Address:

241 N Bagrow St.

Anchorage AK, 99508

Phone Number: (907) 277-6358

During the 2009 State Legislature, Senate Bill 13 and 87 have been introduced to increase the eligibility income level for Denali KidCare. These very important bills would increase Denali KidCare from 175% of Alaska's federal poverty level to 200%. These bills would allow thousands of additional Alaskan children and pregnant women to be eligible for medical assistance. Along with Governor Palin, I support an increase in Denali KidCare and encourage the Alaska State Senate to do the same. Here are my reasons why:

I am thinking that is really important for our children

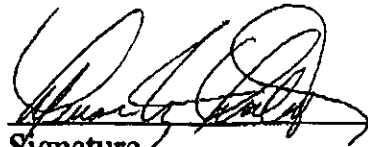
that they have health insurance, with increase of poverty

level at 200% given more chance to other children will

have this benefit. Medical bills in the State of Alaska are

so expensive many families are forced to wait until
the child is very sick to visit a doctor and that puts child in
health risk.

Thank you for taking my thoughts into consideration. If you have any questions, please call me at the above number. Please do all that you can to support these important pieces of legislation.


 Signature

2-27-09
 Date

This letter campaign was organized by concerned local citizens and Alaskan non-profit agencies and is not affiliated with any politician, political organization or political action committee.

Matthew Johnson

From: Rynnieva Moss
Sent: Friday, April 17, 2009 1:34 PM
To: Matthew Johnson
Subject: RE: A SCAN HAS ARRIVED.

The portion spent on minor girls would be Denali Kid Care. Denali Kid Care is a name Knowles gave Medicaid for children. The feds call it CHIP Children's Health Insurance Program. It is Medicaid money.

From: Matthew Johnson
Sent: Friday, April 17, 2009 11:18 AM
To: Rynnieva Moss
Subject: RE: A SCAN HAS ARRIVED.

Would all of these dollars be funded through Denali Kid Care?

From: Rynnieva Moss
Sent: Friday, April 17, 2009 11:02 AM
To: Matthew Johnson
Subject: FW: A SCAN HAS ARRIVED.

Look at page 3 – one-third of the way down on the page is the numbers; \$418,200 dollars for the calendar year of 2008.

From: postmaster@legis.state.ak.us [mailto:postmaster@legis.state.ak.us]
Sent: Friday, April 17, 2009 11:58 AM
To: Rynnieva Moss
Subject: A SCAN HAS ARRIVED.



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Operated by: Planned Parenthood of the Great Northwest

Alaskan Families Can't Wait - Support Denali KidCare Today!

Please call Your Alaska State Senator today!

Take Action on this Issue
Send this message to:

- Senator Con Bunde
Senator Fred Dyson
Senator Thomas Wagoner
Your State Senator (if you live in Alaska)

Tell your Senator to Vote YES on Denali KidCare, Senate Bill 13, this Monday, April 6!

Senate Bill 13 would increase the eligibility rate for Alaska's Denali KidCare program to 200% of the Federal Poverty level and would immediately help support children and pregnant women in these hard economic times.

Health care for children and pregnant women shouldn't be hostage to other bills; there is no time for political games. Senate Bill 13 needs to move to the Senate Floor for a vote - and we need your help to get it there! Alaskan families can't wait.

Send This Message

Complete the following to send this message. If you have participated before, just type in your email address then submit the form.

Email: *
First Name: *
Last Name: *
Suffix:
Address Line 1: *
Address Line 2:
City: *
State: *
ZIP: *
Phone Number:
Fax Number:
Gender:
Email Preference: *
Send me Plain Text
Send me HTML**
Don't Know
Work Phone:

Please take five minutes to take action. Alaska's families are relying on you to speak up!

- 1) Call/write your local district Senator and ask her/him to support Senate Bill 13 because Alaskan Families Can't Wait!
2) Call/write to Senators Wagoner, Dyson and Bunde and urge them to vote YES on Senate Bill 13!

If you have any questions about SB 13 or need support please call the Planned Parenthood public affairs office in Anchorage: (907) 770-9716, or email: ppactionak@ppgnw.org.

Tell me more

Talking Points

Alaskan Families Can't Wait!

Talking Points:

- 1. Even in these hard economic times, a Denali KidCare income eligibility increase is good policy for the health and economics of our state -

An increase in Denali KidCare eligibility to 200% of the federal poverty level reflects sound fiscal policy as research shows that preventive care, such as that received through Denali KidCare, has a positive return on investment. For example, children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment. Since the federal government covers almost 65% of the entire cost of Denali KidCare the additional financial exposure associated with a return to 200% of federal poverty level is nominal compared to the long term expenses the State of Alaska will most likely incur if these vulnerable children and pregnant women continue to be denied access to health care.

- 2. The people of Alaska and Governor Palin support this important increase -

Governor Palin has publicly committed her support of this change which would restore eligibility to 1,300 children and 225 pregnant women.

- 3. Increasing Denali KidCare to 200% of Alaska's federal poverty level simply brings it back up to its original level approved by the legislature in 1999 -

Denali KidCare was authorized by the Alaska Legislature in 1999. The program was modeled after

Political Party:

--Select--

Issue Areas:

Family Planning Funding

Contraceptive Coverage

Abortion Access

Emergency Contraception

Sex Education

Judicial Nominations

Yes, I would like to receive a copy of this letter
 Check this box if you would like to receive periodic updates or action alerts

* Required Field
** Some older email programs may not display HTML correctly.

similar programs around the country with an eligibility level set at 200% of federal poverty level. In 2004, the legislature changed the way Alaska calculated maximum eligibility for Denali KidCare; instead of basing eligibility on a percentage of federal poverty level, maximum eligibility was changed to a fixed income limit that essentially froze eligibility rates at the 2003 level. Over time, this approach has cut children of working families and pregnant women out of the program. By 2007, the maximum Denali KidCare eligibility level had essentially fallen to 153% of the federal poverty level.

Subject: -
Please Vote YES on SB 13 - Alaskan Fa

Dear [Decision Maker],

(Edit Letter Below)

Alaskan families can't wait. Please vote YES on SB 13!

As an Alaskan resident and voter, I think it is critical to increase the income eligibility guidelines for Denali KidCare from 175% to 200% of Alaska's federal poverty level.

Please do not play politics with the health of Alaska's children! Vote YES on Senate Bill 13.

In these hard economic times, a Denali KidCare income eligibility increase is good policy for the health and economics of our state. Children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment.

Sincerely,
[Your name]
[Your address]

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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER
FINANCE AND MANAGEMENT SERVICES

SARAH PALIN, GOVERNOR

P.O. Box 110601
Juneau, AK 99811-0601
Phone: (907) 465-1630
Fax: (907) 465-2499

February 24, 2009

The Honorable Reggie Joule, Chair
House Finance Sub-Committee
State Capitol, Room 502
Juneau, AK 99801-1182

Dear Representative Joule:

In response to your questions on February 23, 2009 from the House Finance Sub-committee closeout hearing, please see our response below:

➤ *What does the childhood obesity initiative buy? Is it possible to do something for less?*

See Attachment A for an overview of the childhood obesity initiative and five major program components:

- community coalitions, \$42,600
- obesity prevention media campaign, \$190,000
- development and training, \$235,500
- data gathering and evaluation pilot program, \$69,000
- program management and staff, \$386,000

➤ *Describe the program impact of reducing the subsidized adoption and guardian assistance increment by 50%?*

The OCS incremental request is to increase existing adoption subsidy levels using the foster care base rates that went into effect July 1, 2008 as the cap for negotiated rates. The request included retroactive adjustments back to FY 2006 which captures most of the adoptions in the pipeline. While this is the approach that provides the majority of adoptive parents equitable subsidies, statute does not require retroactive adjustments. The statute does, however, require departmental review of the appropriateness of subsidy amounts upon request of the person caring for the child.

If a 50% general fund reduction is required, retroactive adjustments would begin January 1, 2007 rather than July 1, 2005. All subsidies negotiated from January 1, 2007 through June 30, 2008 would be retroactively adjusted. This results in a 703.6 GFM reduction to the current request.

- ***Sexual Offender increment added by the Sub-committee – What information does the department have to show that the McLaughlin Youth facility program actually works?***

Evidence that the McLaughlin Youth Center (MYC) Sex Offender Treatment program is effective was recently provided in a study of the program conducted by Tonie Quaintance, a PhD candidate in the Clinical-Community Psychology Program at the University of Alaska-Anchorage. In her 2008 report (see Attachment b) Ms. Quaintance found that the overall recidivism rate for 107 juvenile sex offenders released over the past 9 years was 17.8%--significantly lower than the state average of 29% recidivism for all juvenile offenders released from juvenile institutions statewide in FY05. Most significantly, 0 of the 107 juveniles had committed another sex offense. Recidivism was defined as offenses that resulted in a new juvenile adjudication or adult conviction, or a probation violation resulting in a new institutional order.

While there may be elements of the MYC program that could be used to inform and improve sex offender management around the state, it would be difficult to replicate the MYC Sex Offender Treatment program in rural areas. A more effective approach would be to deploy the "Village-based Sex Offender Treatment Program" that served the small, remote communities around Nome between 1997-2005 and was recognized by the National Partnership for Juvenile Services as a "Promising Practice" (see Attachment C). In this culturally sensitive and community-based approach to juvenile sex offender management, a team of 8-20 people in a community agree to support a juvenile while a clinician would provide on-site, intensive sex offender management every 3 weeks. The juvenile is expected to complete a curriculum in sex offender treatment while also learning social skills, respect, and empathy from local team members. The youth's juvenile probation officer facilitates meetings, reviews progress, and works with the team to determine consequences for any violations the youth commits while on probation supervision.

This program demonstrated preliminary success in the Norton Sound region but ended when the local clinician position was not funded due to budget constraints. The first step in returning this program to rural areas would be to enlist the services of a mental health clinician skilled in juvenile sex offender management and consistently available to rural areas. Such individuals could be employed by the Division of Juvenile Justice, local or regional health providers, or could work on a contractual basis as needed.

- ***Please clarify DJJ's front line staffing needs from last year to this year. Why are they being presented differently than in the past, what has changed? What is the impact of no new staffing increments in FY2010?***

The division's front-line staffing request has shifted as planning has moved from a 4-year period to a 10-year period. In FY09 DJJ was presenting their 2nd year staffing needs within a 4-year plan, as requested by Representative Hawker. In FY2010, while DJJ was preparing its 3rd-year requests in this 4-year plan, the department was directed to develop a 10-year plan. This required the division to adjust its 4-year plan to fit a much longer framework, which may explain why the request is being presented differently from the past. Several DJJ facilities are still staffed at levels below what is recommended both nationally and by the state's own calculation to ensure safety and security for both workers and residents. The staffing shortfall has been temporarily covered by using overtime and non-perms. Funding for these expenses has only been made possibly due

to the vacancy factor built into the budget, and delaying recruitment by a minimum of 30 days to cover those expenses.

When overtime and non-perms are used to cover shifts on a regular basis an unsafe situation is created by having either overworked or tired staff monitor the youth activities. Inexperienced individuals there are basically tasked with maintaining order, similar to a substitute teacher; little work in rehabilitation and restoration can be accomplished by these temporary, fill-in workers. Having an adequate number of permanent staff ensure that we are able to provide a safe and consistent environment that has a well developed structure and plan for these youth that ensures that they learn to behave safely around others, learn the discipline and self-control needed to complete school work and resist negative peer influences, and ultimately take responsibility for themselves so that they are able to succeed once they are released back to the community.

- *Please provide information on the number of abortions and amount paid by state and those paid by Medicaid for the second half of FY08 and first half of FY09.*

The state paid \$418.2 general funds for abortions or abortion-related Medicaid services incurred in the last half of FY2008 and the first half of FY2009 for 783 individuals based on claims paid in calendar year 2008. This isn't necessarily the number of abortions performed, but rather the number of individuals receiving abortions or abortion-related services. There were no abortions paid by federal Medicaid during that period.

- *A significant portion of DPA's General Relief Assistance (GRA) funds go to funeral and burial expenses of indignant deceased persons in Alaska. Please provide detailed information about these costs. For instance, what exactly does the state pay for in this regard?*

Expense	Annual Total	Monthly Average	Percent of Total	Average Pmt
Rent	\$115.1	\$9.6	8.0%	\$160.90
Burial	\$1,266.4	\$105.5	88.1%	\$2,125.22
Utilities	\$44.2	\$3.7	3.1%	\$288.75
Misc.	\$11.0	\$.9	0.8%	\$315.64

The GRA program pays for limited assistance for the burial of indigent persons. A maximum of \$1,250 can be paid for basic funeral and burial services which include:

- preparation and embalming,
- an inexpensive casket,
- a chapel service at the funeral providers place of business,
- use of a hearse, and
- use of funeral provider's facilities and equipment.

Payment of other burial related services (above the \$1,250 allowed for basic services) may also be allowed. These include:

- a cemetery plot where the deceased is going to be buried,
- the cost of opening and closing the grave,
- the cost of cremation if requested by next of kin,
- the cost of hermetic sealer, oversized casket, clothing, extraordinarily lengthy storage,

- the cost of transporting the deceased from the place of death to the place of burial payment,
- a processing fee of 10% for a funeral provider pays directly to a cemetery or a transportation vendor for any of the items listed above.

The chart below shows the 10 year history of burial costs only of the General Relief Assistance.

Burial Costs - 10 Year History

Fiscal Year	Annual Total	Monthly Average	Total FY Caseload	Average Payment
FY1996	\$541,782	\$45,149	353	\$1,534.79
FY1997	\$563,428	\$46,952	361	\$1,560.74
FY1998	\$578,691	\$48,224	354	\$1,634.72
FY1999	\$593,177	\$49,431	347	\$1,709.44
FY2000	\$645,067	\$53,756	387	\$1,666.84
FY2001	\$707,820	\$58,985	402	\$1,760.75
FY2002	\$832,412	\$69,368	448	\$1,858.06
FY2003	\$907,686	\$75,641	508	\$1,786.78
FY2004	\$969,390	\$80,783	475	\$2,040.82
FY2005	\$1,041,913	\$86,826	524	\$1,988.38
FY2006	\$1,029,992	\$85,833	505	\$2,039.59

The GRA program is a last resort. Assistance is granted only if there are not other resources available (including relatives) to meet the persons need for burial costs, or when the court has ordered the burial of an unclaimed body. The department advises families of the obligation to repay funeral and burial costs and sometimes receives payment from the family or estate. The applicable statute is AS 47.25.230.

- *The Legislature has assumed a lower case load for the senior benefits program in FY2010 and reduced funding an additional (\$933.0). Please review projections and let us know the impact of this reduction.*

The Senior Benefits Program component request of \$19,859.4 for FY2010 includes the total costs to administer this program. Unlike many of our other budget components, it includes the personnel costs to determine eligibility and provide benefits (\$697.1), as well as the cost for the benefit payments (\$19,162.3). The benefit cost reflects the \$500.0 decrement already proposed by the Department. We project benefits for FY2010 will total an estimated \$18,926.4, which leaves a small balance to cover unanticipated increases to benefit costs. The projection for FY2010 provides for an estimated 6% increase in the caseload from FY2009, which will result from increased program outreach and growth in the population age 65 and over.

We assume that a reduction in funding of an additional \$933.0 would need to be taken from the program benefits line, so that staff could be retained to administer the program. Such a reduction would result in our inability to pay benefits for all of FY2010. Following is a chart illustrating the effect on benefits if this reduction were to occur:

Benefit projections with additional
proposed decrement of (\$933.0)

	Monthly Cost	Running Balance
	Beginning Balance	\$18,229.3
July	\$1,553.3	\$16,676.0
Aug	\$1,562.7	\$15,113.3
Sep	\$1,570.5	\$13,542.8
Oct	\$1,576.8	\$11,966.1
Nov	\$1,583.1	\$10,383.0
Dec	\$1,589.4	\$8,793.6
Jan	\$1,594.2	\$7,199.4
Feb	\$1,597.4	\$5,602.1
Mar	\$1,599.0	\$4,003.1
Apr	\$1,600.6	\$2,402.6
May	\$1,602.2	\$800.4
Jun	\$1,603.8	(\$803.4)

- *For the Bring The Kids Home program, what is the impact of postponing increments? What is the base level funding already in the budget?*

BTKH has implemented performance measures to monitor progress. These measures verify the decreasing utilization and cost of out-of-state RPTC care. Between FY 2007 and 2008 Out-of-State Medicaid expenditures for Residential Psychiatric Treatment Centers decreased by \$9.89 million. In-State RPTC Medicaid expenditures essentially remained at 2007 levels. However, Alaska still spent a total of \$47.7 M on RPTC care (in-state + out-of-state) for 847 children. A large amount of Medicaid resources continue to support the most restrictive level of treatment for a small number of children with severe emotional disturbances. The BTKH goal is to serve children and families earlier, and in less intensive programs.

The BTKH funding strategy relies on investing Alaska Mental Health Trust funds and State General funds into the in-state services and supports needed to keep children from moving into out-of-state residential psychiatric treatment centers. This will reduce the cost of out-of-state residential care and allow those resources to support an in-state continuum of care. This moves funding from intensive services for a few children to less intensive services for a larger number of children and families.

BTKH success to date reflects the development of some of the required in-state services: enough for *some* kids and in *some* locations. It also reflects the development of in-state RPTC care. However, BTKH has not yet established the basic building blocks needed to make the system sustainable, to serve children statewide, and to build the services to keep children out of RPTC care. The additional BTKH funding requested for FY2010 is for basic building blocks required for a system that serves fewer children in residential care.

Funding these BTKH increments will develop:

- Flexible services that reach into the home first to keep kids and families intact
- Immediate access to services – or treatment on demand - when the child and family reach out
- Strong families and healthy communities
- Resilient children

I. BTKH Community BH Outpatient Services

FY09 base GF =

\$1,000,000	“BTKH Outpx & Emergency Services & Training”
\$250,000	“BTKH Home & Community-Based Start-Up Grants”

This funding is developing community-based and in-home service capacity in new areas of the State and is addressing gaps that result in children moving into residential care. As noted above, this goal is only partially accomplished. Without additional funding we anticipate increased use of residential care resources, for the children who are remaining in Alaska. While in-state RPTC may help to address this issue, long-term success depends upon our ability to divert more children from residential placements.

Remaining gaps include services for children with severe emotional disturbances who have difficult presentations: children who are suicidal, aggressive, psychotic, or are frequent runaways. These children require programs with specific training and expertise to be stabilized in a home or community setting. Many agencies in Alaska still have limited capacity to serve children with these presentations. BTKH data continues to show that children with these challenges move into out-of-state care.

Another gap is in training and expertise for children with both a developmental disability and a severe emotional disturbance (SED): children with autism disorders, traumatic brain injury, fetal alcohol spectrum disorders, and an SED. These children may not benefit from traditional mental health counseling and lack of appropriate services often precipitates a negative spiral resulting in movement into acute or residential care. Unless the residential care is specifically tailored to their needs, it may also fail.

DHSS can remediate some of these gaps through technical assistance, training and support (see BTKH Technical Assistance, below), however new programs require start-up funding to hire and train staff, ramp up service delivery, implement Medicaid billing, and implement new programs. Between FY06 and FY009 BTKH outpatient grants went to 22 agencies working in the following communities/regions:

- Anchorage
- Fairbanks - Interior
- MatSu - Wasilla
- Juneau - Southeast
- Seward
- Kenai Peninsula
- Bethel Area
- Kotzebue
- Prince of Wales Island
- Sitka

- Ketchikan
- Metlakatla

These agencies developed expertise and expanded services to additional children and families or to children with more challenging needs. BTKH grants are all targeted towards children with severe emotional disturbance and towards those children who will move from a community setting into a more restrictive level of care.

Each year, the BTKH solicitation is targeted toward specific geographic areas, towards the populations of children who continue to be underserved, and towards best practices to maintain children in-state. Below are examples of activities that BTKH Community BH outpatient funds support:

- Metlakatla Indian Community developed mental health services and Medicaid billing capacity. MIC was able to serve more than 40 children with severe emotional disturbances in FY08 rather than having those children leave the village to seek care elsewhere.
- Central Peninsula General Hospital developed mental health services and Medicaid billing capacity in a new outpatient support program for adolescents with co-occurring SA and MH disorders. The target population was youth at highest risk of movement into more restrictive care. In FY08 the program served more than 36 children, at least three of these children would otherwise have moved into an RPTC.
- Family Centered Services of Alaska developed respite and crisis respite care in Fairbanks in order to support children to remain in community placements. In FY08 the program served 100 children. At least two of these children were diverted from an acute care setting. Movement into an acute setting generally requires that the child be flown from Fairbanks to the Alaska Psychiatric Institute or Northstar Hospital in Anchorage. Most children who move into out-of-state care do so from acute care settings.
- Denali Family Services in Anchorage developed intensive wraparound services for sexually reactive children. The program started in March of FY08 and served 4 children in its first quarter of operation. It will serve more children per quarter in FY09. This is a population of children for whom in-state services are extremely limited.
- DHSS has applied for a FY2010 Federal grant that will provide up to \$1.5 M in Federal dollars per year for six years. If the federal funding is awarded, we intend to use BTKH grant funding to match it and to sustain the system that is developed through the grant. The project would target families involved in multiple systems (juvenile justice, developmental disabilities, children's services), with children who experience both severe emotional disturbances AND problems at school. These are families who will otherwise impact multiple state systems and funding streams.

II. BTKH Individualized Services Agreements (ISA) FY09 base GF = \$950K

The individualized services funding is used to divert children from moving into residential care, and to help children to move out of residential care. Without additional funding, the ISA funding can only be used to divert children within the fairly narrow existing parameters, and at the current level of service.

During FY08, individualized service agreements supported 196 recipients to remain in community placements. This general funding is only used for services for which there is no other funding source and which are identified in a treatment plan developed by the child's individualized treatment team and signed off on by a master's level clinician. During FY08 and FY09 several areas were identified for which additional funding is required. These include:

- Immediate need - Expanding to additional MH providers: As the resource becomes better understood, its use is expanding. Some providers are using ISA funding appropriately to divert children from residential care, others are not. For FY08, 23 providers signed on to coordinate ISA services.
- However, during the first and second quarters of FY09 there were no ISA used in the entire Northern Region. Unfortunately, this was not because children from the Northern Region were not moving into residential care. During the same time period there were only 17 children from the entire Interior Region who used ISA. There is a continued need for outreach and training around use of ISA which will expand the need for funding. In addition, DHSS continues to develop management strategies to make ISA funding accessible and easy for providers to use but to also ensure that the funding is appropriately used when other funds are not available and when it will help create/salvage a non-residential placement for a child with a severe emotional disturbance.
- Immediate need - Diverting children in the services of the Office of Children's Services or Division of Juvenile Justice: During FY08 and FY09 DHSS began piloting use of ISA for children with a severe emotional disturbance at risk of movement into residential care or moving out of residential care who involved with juvenile justice or protective services. This strategy has been highly effective at building transitions for children with mental health disorders moving back into the community from a juvenile justice setting. These children are at very high risk for recidivism to residential care or a justice setting. The strategy has also been effective to maintain foster care placements and to help children with severe emotional disturbances remain in their homes/communities.
- Immediate need - Diverting children with a primary diagnosis of substance abuse: Currently, ISA can only be used for children with a primary diagnosis of severe emotional disturbance. However, children with primary diagnoses of substance abuse often have a co-occurring severe emotional/behavioral disorder and also move into residential mental health services. It would be strategic to expand ISA funding to this population in order to reduce the use of residential care.
- Possible strategy - Diverting additional populations of children: Several other populations of children also move into MH residential care when a co-occurring severe emotional/behavioral disorder is identified and when community-based services fail. These include children with a primary diagnosis of an autistic disorder, a fetal alcohol spectrum disorder or a traumatic brain injury. It may be strategic to identify when an ISA could stop this progression.

III. BTKH Technical Assistance

No current funding

This funding is necessary to help in-state providers improve business practices (such as expanding Medicaid billing) and to train in and implement clinical best practices in order to improve outcomes. In-state providers must expand their capacity to treat children with complex

needs. There continue to be populations of children for whom in-state services are still extremely scarce. These include services for very difficult presentations such as suicidal ideation/attempts, extreme aggressiveness or psychotic symptoms. There also continue to be significant differences in the capacity of providers to use Medicaid effectively to deliver in-home and community services. Without these services children cannot be safely diverted from RPTC.

During FY2009, DHSS used BTKH funding to begin training for children's mental health workers in Brief Strategic Family Therapy, wraparound and other best practices for serving children in their family setting. This FY2010 funding request will support continued training for practices such as BSFT. It will also support training and support to providers to improve business practices and become sustainable via Medicaid and existing grant funding. To date, DHSS has not requested a single additional position to oversee the BTKH grant program (described below). To date, this grant program has been absorbed by existing staff. The funding capacity within DHSS to provide or contract technical assistance MUST be increased in order to support providers to expand capacity.

IV. BTKH EARLY CHILDHOOD MENTAL HEALTH

We need a qualified early childhood mental health workforce and early childhood professionals who can support positive social emotional development.

Alaska is plagued by a lack of mental health practitioners experienced in early childhood mental health (ECMH) issues and intervention. Parents, teachers, child care providers, mental health clinicians, health providers and others often lack the training necessary to meet the needs of young children with mental health and social emotional concerns.

Two of the approaches we are taking to bring up workforce expertise in this area are:

- 1) A "Learning Network" for mental health clinicians and early interventionists, and
- 2) ECMH Consultation for wider array of professionals working with young children

The budget request was to continue and expand the work of both of these approaches.

Early Childhood MH Learning Network:

No current funding through BTKH – limited funding through Federal ECCS and Title V.

The budget request was to enhance a training and support network for early childhood mental health clinicians and other ECMH specialists. It included a position for an ECMH Leader/Coordinator with a high level of expertise in early childhood mental health, a statewide network of part-time early childhood mental health trainers, travel, training costs, monthly "Learning Network" conference calls and the annual Early Childhood Mental Health Institute.

If this cannot be funded in its entirety, at a minimum it would be helpful to support continuation of the monthly "Learning Network" conference calls (\$15,000) and the Early Childhood Mental Health Institute (\$27,700).

ECCS Grant - Mental Health Consultation:

FY09 base GF = \$0

FY09 MHTAAR = \$75K "Early Childhood Comprehensive Systems Grant" (MH Consultation)

This budget request was to continue and expand ECMH consultation to early care and learning providers, Infant Learning Providers, and others who work with young children. Specific skills are needed to identify mental health problems and to serve children with these issues in their natural environments. The goal is to help young children remain in stable settings with qualified

and nurturing caregivers and prevent the development of serious emotional disturbance (SED). The current funding (\$75,000) is being used to support two ECMH consultation projects. The expanded funding request for FY' 10 was to bring on additional projects in other areas of the state.

If this cannot be fully funded, we request minimum funding to continue the FY09 projects (\$75,000).

FROM THE EXPERTS:

The following points are taken from: *Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life, Working Paper 6*, developed by the National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University,

- The foundations of many mental health problems that endure through adulthood are established early in life. Early mental health problems disrupt the typical pattern of developing brain architecture and impair emerging capacity for learning and relating to others.
- There are indications that early intervention can have a profound positive effect on the trajectory of emotional or behavioral problems as well as improve outcomes for children with serious disorders, be they psychological or genetic in origin.
- Persistent poverty, threatening neighborhoods, and very poor child care conditions elevate the risk of serious mental health problems

WHAT SCIENCE TELLS US:

- Significant adversity early in life can damage the architecture of the developing brain and increase the likelihood of significant mental health problems that may emerge either early or years later.
- Much impairment in mental health arises as a result of the interaction between a child's genetic predisposition and his or her exposure to significant environmental adversity.
- **The behaviors and characteristics associated with mental health problems in the earliest years of life are often different from those seen in older children and adults with psychological difficulties.**
- **If young children are not provided appropriate help, emotional difficulties that emerge early in life can become more serious disorders over time.**
- Some individuals demonstrate remarkable resilience in the face of early, persistent maltreatment, trauma, and emotional harm, but there are limits to the capacity of young children to recover psychologically from such adversity.
- Serious developmental disabilities can also be associated with significant mental health impairments that are affected by experience and amenable to intervention.
- The powerful influences of early relationship illustrate how much the emotional well-being of young children is directly tied to the emotional functioning of their caregivers and the families in which they live.

- For many providers of child health services and early care and education who are faced with children who present problematic behavior, the question of "when to worry" is paramount, yet little evidence exists to answer that question definitively.

POPULAR MISREPRESENTATIONS OF SCIENCE:

- **Contrary to popular belief, young children can and do experience serious emotional problems that are comparable in severity to what we observe in older children and adults, and can have lasting effects.**
- Contrary to popular belief, young children living in highly disadvantaged environments can be protected from serious emotional or behavioral consequences.

THE SCIENCE-POLICY GAP:

- **Professionals who are regularly involved in the lives of infants, toddlers, and preschoolers often lack the knowledge and skills that would help them identify the early signs of mental health problems as well as fully understand the consequences of family difficulties and parent mental health problems for young children's development.**
- In most communities, mental health services for young children and their families are often limited, of uneven quality, and difficult to access, and there are few well-trained professionals with expertise in early childhood mental health.
- There has been a dramatic increase in the use of psychoactive drugs for young children with behavioral or mental health problems, despite the fact that neither the efficacy nor safety or many of these medications has been studied specifically in children at these early ages.

IMPLICATIONS FOR POLICY AND PROGRAMS:

- Because young children's emotional well-being is tied so closely to the emotional status of their parents and non-family caregivers, the emotional and behavioral needs of infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships.
- Therapeutic help for a young child with emotional or behavioral problems can be provided through a combination of home- and center-based services involving parents, extended family members, home visitors, providers of early care and education, and/or mental health professionals
- Mental health services for adults who are parents of young children would have broader impact if they routinely included attention to the needs of the children as well.
- **Physicians and providers of early care and education would be better equipped to understand and manage the behavioral problems of young children if they had more appropriate professional training in this area and easier access to child mental health professionals when they are needed.**
- A better coordinated infrastructure for funding mental health services for young children could provide a more stable and efficient vehicle for assuring access to effective prevention and treatment programs.
- Cultural differences in attitudes and beliefs about behavior and mental health require sensitivity and respect for diversity as well as specialized intervention skills.

- *For the therapeutic court increment of \$653.0 GF, exactly what is being maintained and what is being enhanced? What services would be eliminated if this increment is not received?*

This increment will continue funding the Anchorage Alcohol Safety Action Program (ASAP) at its current level of service, providing direct services to clients for screening, referral, monitoring and supervision of Anchorage-based clients. All clients are referred to ASAP through the Anchorage court system; referrals are made to both the misdemeanor ASAP program and the felony Therapeutic Court ASAP program. All adult ASAP services in the Anchorage area are provided by DHSS, Behavioral Health staff, housed at the Boney Court House (space is provided free of charge by the Alaska Court System, in support of the ASAP program). ASAP services are identified as a critical component of a comprehensive program for treatment of alcohol and other drugs as defined in AS 47.37.045(210); AS 47.37.130 (5) and as a critical court referral for services as identified in AS 28.035.028(f) and AS 28.035.030(h).

Background

In FY07 and FY08, Behavioral Health received \$750,000 per year in grant funds from the Alaska Highway Traffic Safety Office (AHTSO) at the Department of Transportation. Among other things, these funds supported 3.5 Adult Probation Officer positions and 4 administrative positions in the Anchorage ASAP office.

In FY09, we were informed by DOT that we would not receive an award because they had changed their focus for the use of the federal funds. After much discussion and negotiation, we eventually received a reduced award of \$400,000 with the understanding that these grant funds will end effective September 30, 2009.

Prior to Fiscal year 2007 when we first received these DOT grant funds, all ASAP positions were covered by state alcohol tax funds, receipt supported services (generated by ASAP fees) and limited state general funds. In an effort to maintain our ASAP program at full staffing, DOT grant funds were applied for to provide more stability than receipt supported services funds, which fluctuate depending on client payments. At the time we applied for funding, there was no indication the focus of these funds would change in the next three years.

Program Overview

The Alcohol Safety Action Program (ASAP) including the Therapeutic Courts operate as neutral links between the justice and the health care delivery systems and are responsible for service to Adult, Juvenile and all of the different Therapeutic Court's program participants who have alcohol or drug related offenses. The ASAP program operates in eleven communities (Anchorage, Kenai, Homer, Wasilla, Dillingham, Fairbanks, Ketchikan, Kotzebue, Juneau, Kodiak, and Seward). All programs except for the Anchorage Adult ASAP program are offered by community-based agencies with funding from Behavioral Health. Due to the size of the Anchorage Court, referral and education/treatment system, the Anchorage Adult program is operated by Behavioral Health with a coordinated, cross-discipline service system in place to meet the large volume of referrals to ASAP. The FY10 increment of \$653,000 is to maintain Adult ASAP services in the Anchorage community.

Individuals referred for ASAP services include both first time offenders (most often misdemeanants) and repeat offenders (more often felony-level offenses). As an example the Alaska Division of Motor Vehicles reported 5888 Drinking Under the Influence (DUI) offenses in 2008. Of the 5888 DUI offenders, 4047 were first time offenders and had not yet participated in an ASAP program. Most first time offenders are referred to ASAP for services as are many repeat offenders. In 2008, 44% or 2,582 of these DUI offenses were committed in Anchorage.

Impact

The requested increment enables the ASAP Probation Officers to screen, refer, monitor and supervise 5,552 new Adult ASAP cases, 8,000 open and ongoing cases, and the over 200 Therapeutic Court participants that require a much higher level of management and supervision each year. Without this increment to support 3.5 ASAP Probation Officers we will lose the ability to screen, refer, monitor and supervise 60% or 3,331 of our 5552 new Adult cases per quarter and about 4,800 of our 8,000 other open cases per year. Of the 2,582 Anchorage DUI offenders reported by DMV, the ASAP office would only be able to serve 1,032 of those DUI offenders, leaving 1,549 DUI offenders without the intervention that ASAP offers, leaving them ill-equipped to make the informed choices and behavioral changes that might prevent further contact with the justice system, the treatment system, and damage to the offender, their family and their community (e.g. continued driving under the influence of alcohol, alcohol-related violence, alcohol-related accidents, etc.). Without these funds the Anchorage Adult ASAP office will be left with two (2) ASAP Probation Officer, 2.5 ASAP Therapeutic Court Probation Officers and one (1) administrative support staff person.

Without the requested increment about 40 of our most vulnerable offenders with mental health disabilities or substance addictions would not have the opportunity to participate in the Therapeutic Courts, a proven effective and cost saving program. According to a recent study, researchers found that the Therapeutic Court participants were 13% less likely to be re-arrested, 34% less likely to be re-convicted and 24% less likely to be re-incarcerated than those offenders with substance abuse or mental health issues that were not afforded the opportunity to participate in a Therapeutic Court (Rhodes et al., 2006)¹. Because each Therapeutic Court is staffed by a single Probation Officer, without the requested increment we lose the ability to serve one Therapeutic Court project such as the Mental Health, Felony DUI or Felony Drug Courts entirely, decreasing that population's opportunity for a proven and effective intervention.

Without this increment four (4) of the five (5) ASAP administrative positions will be eliminated, further impacting our ability to provide timely and adequate client services. Our support staff assist all ASAP and the Therapeutic Courts activities; the loss of these funds will immediately decrease by 80% our ability to bill clients and generate revenue that helps sustain our programming. This loss will decrease by 80% our ability to research prior client offenses through local and national databases to inform and help direct the client's optimum intervention. It will decrease our ability to send assessment and treatment assignment information to clients, request client's treatment status reports from providers, communicate client's treatment status with the courts, and maintain records of clients, all of which must be done in a timely manner for the program to be effective and successful. In reality, the one remaining administrative support staff would only be available for reception duties—answering the phone and greeting clients who

¹ Rhodes, W., Kling, R., & Shively, M. (2006). *Suffolk County Court Evaluation*. Cambridge, MA: Abt Associates.

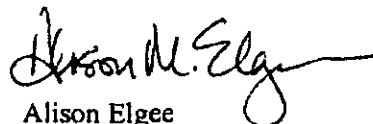
come for appointments. All support activities identified above would become the responsibility of the remaining Adult Probation Officers, in addition to their direct client services.

Currently Anchorage ASAP clients are screened and referred to an education or treatment program within 30-60 days after their offense, depending on how quickly they come into the ASAP office. With the projected reduction in Probation Officers and support staff, services for offenders would be delayed to 240-360 days from the time they come to the ASAP office. Clients would be placed on a "wait list" until staff could process their paperwork and schedule appointments for assessment and referrals. Without the assistance of the administrative staff to inform, gather and disburse the client's past criminal and treatment history to providers and the courts, create and maintain files, answer questions for clients and family members, this process will be greatly hampered, less effective, and greatly decrease the number of clients served.

Substance use, abuse and dependency is a critical social problem in Alaska, with heavy and binge drinking responsible for much of the criminal behavior, health care emergencies, preventable accidents, injuries and deaths that we experience. ASAP provides an opportunity to reach referred individuals early, before the addiction and disease of alcoholism have taken control. ASAP provides early intervention, education, treatment and consequences for adults who are in the early stages of alcohol dependency. Without this program, many of these individuals will continue to enter and re-enter the criminal justice revolving door, ever increasing the damage of alcohol use to themselves, their families and their communities. Data indicates that participating in the ASAP and Therapeutic Court programs reduce both criminal and substance use recidivism. In a 2007 legislative audit of the ASAP program 9% of ASAP clients were reported receiving a new alcohol/drug criminal offense within 42 months after their initial offense compared to the 1999 study that report 35% of ASAP clients received new alcohol/drug criminal offenses within 36 months of their initial offense. It is clear this program works and increases the health and well-being on our citizens and our communities.

If you have additional questions regarding this issue, please contact me at 465-1630.

Sincerely,



Alison Elgee
Assistant Commissioner

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COMMENTARY

Expanding SCHIP Beyond Poor Is Wrong Approach

By Grace-Marie Turner

Few issues generate more political emotion than the need to provide health insurance for children.

It is much less expensive to cover children than adults, and healthy children have the best chance of becoming healthy adults. But that does not mean the government must provide the insurance.

Nonetheless, the new Congress is poised to act on President Barack Obama's campaign promise to provide government-run coverage for children. With the State Children's Health Insurance Program (SCHIP) due to expire March 31, Congress is expected to use renewal of the program as a vehicle to require all children have health insurance.

Pushing Past the Poor

But expanding SCHIP to cover all children would be a mistake, for four reasons.

First, Congress should make sure poorer, uninsured children are covered first. At least two-thirds of the nation's uninsured children already are eligible for SCHIP or Medicaid but aren't enrolled. If SCHIP were expanded to cover children in higher-income families, their parents would rush to the head of the line to get the taxpayer-subsidized coverage. When a "free" government plan is offered, it's nearly impossible to resist. Poorer children would be left behind as states focused on enrolling higher-income kids.

Second, expanding the program would "crowd out" the private insurance many higher-income kids already have. Hawaii offers proof. Earlier this year, the state created a new taxpayer-financed program to fill the gap between private and public insurance in an effort to provide universal coverage for children. But state officials found families were dropping private coverage to enroll their children in the government plan.

When Gov. Linda Lingle saw the data, she pulled the plug on funding. With Hawaii facing budget shortfalls, she said it was unwise to spend public money to replace private coverage children already had.

Third, putting many millions of children on a government program will quickly lead to restrictions on access to care. A young boy died in Baltimore not long ago from an untreated tooth infection, even though he was enrolled in SCHIP. The boy's mother couldn't find

a dentist to see him. Situations like that happen because the program's reimbursement rates are so low that few dentists can afford to take SCHIP patients.

In Massachusetts's move toward universal health coverage, more people have insurance, but they are finding physicians' practices are often filled, with waits for a new patient appointment.



"If SCHIP were expanded to cover children in higher-income families, ... [p]oorer children would be left behind as states focused on enrolling higher-income kids."

ment at 100 days and counting. Putting more children on SCHIP will add to the program's financial pressures, making it harder for poorer kids to get care.

Finally, government insurance means politicians and bureaucrats, not parents, make decisions about the care children receive and what services will or won't be covered.

A Better Way

There is a better way to help the uninsured become insured.

Lower- and moderate-income uninsured families, not just children, need help to afford health insurance. But right now, the deck is stacked against them. They make too much money to qualify for public programs, such as Medicaid, but don't have good, higher-paying jobs that come with health insurance.

"A young boy died in Baltimore not long ago from an untreated tooth infection, even though he was enrolled in SCHIP. The boy's mother couldn't find a dentist to see him. ...

[T]he program's reimbursement rates are so low that few dentists can afford to take SCHIP patients."

They need help in purchasing policies, and that help could be provided through refundable tax credits, which enable people to get the money even if they owe little or nothing in taxes.

Also, 12 million more people would be able to buy affordable health insurance if Congress were to allow people to buy insurance across state lines. And market fixes could help people with preexisting conditions get private insurance.

Providing Powerful Incentives

None of these reforms requires turning our health care system upside down or turning it over to the government, and all would provide powerful incentives for families with children to get health insurance they can own and keep with them.

So when the debate over universal coverage for children begins tugging at the nation's heartstrings this year, it will be wise to consider the costs and consequences and look at alternatives that put parents, instead of politicians, in charge of choosing the right health care for children.

Grace-Marie Turner (galen@galen.org) is president of the Galen Institute.

U.S. House Votes to Expand SCHIP Program

Continued from page 1

the maximum income allowed for enrollment, and more than 10 percent of the 6 million enrollees nationwide were over the age of 18, according to the Department of Health and Human Services (HHS). SCHIP and Medicaid together now insure 45 percent of all children in America, according to HHS.

Funding in Doubt

"This coverage is critical [and] it is fully paid for," said then-President-elect Barack Obama in a statement. Congressional estimates put the cost of the program's expansion at \$32.3 billion, but others say it will be higher and the expansion, funded by an increase of 61 cents per pack in the federal cigarette tax, is not "fully paid for."

Supporters of the legislation are overlooking the problem created by using a tobacco tax increase as the sole funding source, said Rep. Dave Camp (R-MI), ranking Republican on the House Ways and Means Committee.

"The problem is that the percentage of Americans who smoke has been dropping for decades. Research and logic both show that raising the prices of cigarettes will lead to less smoking, and less smoking will lead to less and less money being collected by the federal government to pay for an expansion of SCHIP," Camp said.

A study conducted by The Heritage Foundation concluded 22.4 million non-smoking Americans will have to begin consuming tobacco products in order for the SCHIP expansion to maintain its funding level.

Hurting the Working Poor

Experts say the use of a tobacco tax to fund the SCHIP expansion will place a greater burden on those the program was designed to help.

According to the Centers for Disease Control and Prevention, undereducated and lower-income Americans are more likely to smoke than their better-paid, more highly educated peers. "Given such data," said Camp, "it is hard to imagine a more regressive policy, disproportionately targeting such disadvantaged groups for higher taxes."

"At a time when the last thing we need is an even weaker small business community," said Grover Norquist, president of Americans for Tax Reform, "a tax increase on tobacco products will not only hurt consumers and scapegoat a segment of the American population for using a legal product, but will also hurt small businesses, many of which often lean on tobacco sales to stay in business. "Furthermore," said Norquist, "such

"Research and logic both show that raising the prices of cigarettes will lead to less smoking, and less smoking will lead to less and less money being collected by the federal government to pay for an expansion of SCHIP."

DAVE CAMP, U.S. REPRESENTATIVE - MICHIGAN



a tax increase follows the absurd rationale of discouraging a behavior on the one hand while at the same time relying on its continuance as a revenue stream. Funding an expansion of SCHIP on an already-declining revenue stream is irresponsible and dangerous policy."

State-Level Failures

Experts say legislators should have paid

INTERNET INFO

House Resolution 2: <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.2>

closer attention to recent state-level attempts to expand taxpayer-funded programs, which have been derailed by soaring costs and a "crowding-out" of private health insurers.

Grace-Marie Turner, president of the Galen Institute, cited "Hawaii's hard-learned lesson in health care economics," referring to the Aloha State's Keiki Care program established in 2008 to provide coverage to children whose parents couldn't afford private insurance but whose income was too great to qualify for other public programs.

"Hawaii officials learned that, if you offer people insurance for free, they'll quickly drop other coverage to enroll.

After seven months of operation, during which 85 percent of Keiki enrollees were former private policyholders, [Gov. Linda Lingle (R)] was forced to eliminate the program altogether," Turner noted.

"People who were already able to afford health care began to stop paying for it so they could get it for free," said Dr. Kenny Fink of Hawaii's Department of Human Services in a release.

Unpopular Program

Congress attempted to expand SCHIP in 2007, but legislation was twice vetoed by then-President George W. Bush, who objected to relaxing the program's eligibility requirements when nearly two-thirds of the nation's uninsured children were already eligible to enroll.

In addition, according to the Centers for Medicare and Medicaid Services (CMS), 42 percent of that eligible uninsured population were actually enrolled in a state SCHIP or Medicaid program in 2007, but declined to renew their enrollment—an indication that SCHIP and other taxpayer-funded programs were not as popular as their proponents claim.

Reform Efforts Rebuffed

In 2008 CMS, at Bush's behest, issued a directive tightening SCHIP eligibility requirements, forcing states to limit the program to children whose family income was 2.5 times the federal poverty level or less. Families making \$44,000 per year or more were to be removed from the SCHIP rolls and held out of the program until their state had enrolled 95 percent of its eligible uninsured in the program.

Bush rescinded the directive after pressure from state governments wishing to continue offering SCHIP benefits to people ineligible under federal guidelines.

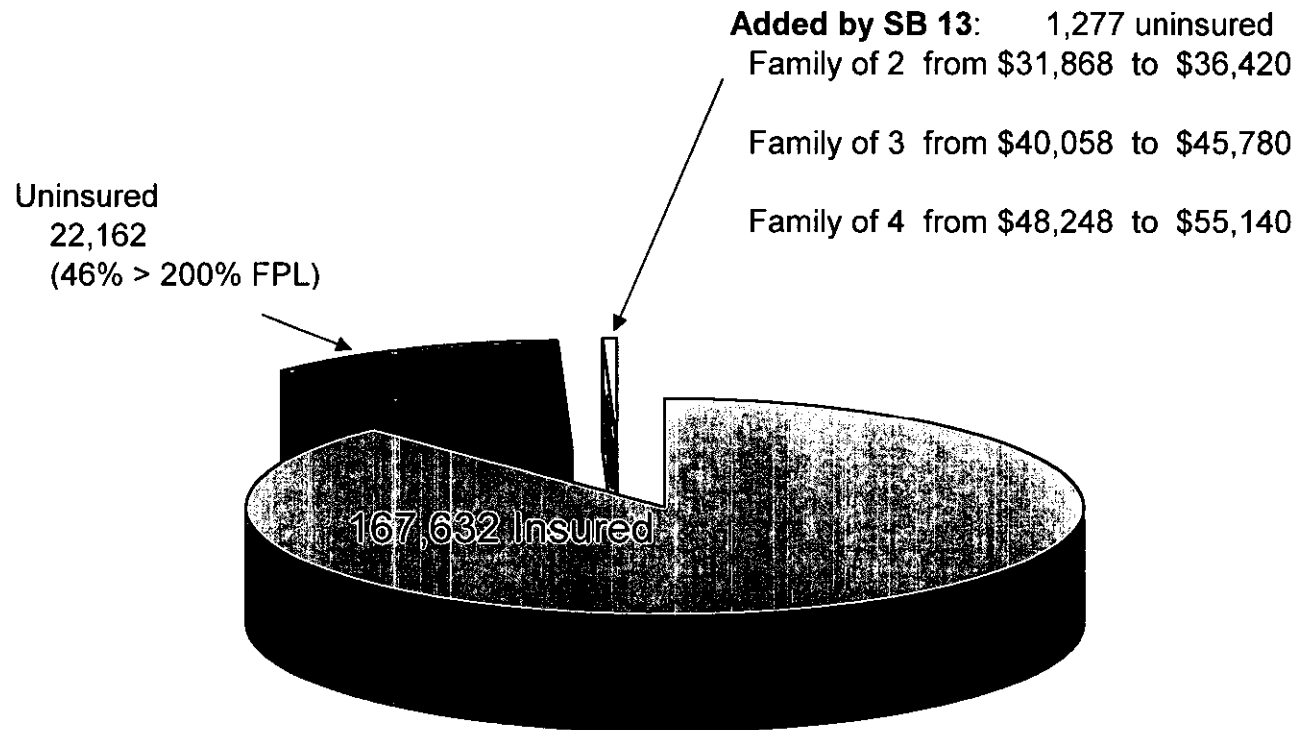
At press time, the SCHIP resolution was still pending in the Senate. Congressional observers expect the House version of the measure ultimately to be signed into law by President Obama.

Jeff Emanuel (jmanuel@heartland.org) is research fellow for health care policy at The Heartland Institute and managing editor of Health Care News.

INTERNET INFO

"22 Million New Smokers Needed: Funding SCHIP With a Tobacco Tax," The Heritage Foundation: <http://www.heritage.org/Research/HealthCare/wm1548.cfm>

Children in Alaska



Income Guidelines (effective March 2009)



Household Size	Children with other Health Insurance	Children with no Health Insurance and Pregnant Women with or without Health Insurance
	Monthly Income (150% FPG)*	Monthly Income (175% FPG)*
1	1,692	1,974
2	2,277	2,656
3	2,862	3,339
4	3,447	4,021
5	4,032	4,704
6	4,617	5,386
7	5,202	6,069
8	5,787	6,751
each additional	585	683

Note: An unborn child of a pregnant woman is counted in the household size for pregnant woman coverage.

Key Points

- » Income figures are gross income (before taxes are taken out).
 - » Income eligibility is determined based on biological or adoptive parent income.
 - » Permanent Fund dividends are not counted as income.
 - » A standard deduction per month for expenses related to employment may apply.
 - » A standard deduction per month for dependent care expense may apply.
 - » Child support payments may be allowed as a deduction.
 - » Income records and proof of deductions must be submitted with application.
 - » Anyone may apply for her/himself or on behalf of a child or teen.
 - » Children with other health insurance may still be eligible.
 - » Children, teens and pregnant women covered by Indian Health Service benefits may be eligible.
- » ***Not sure if you're eligible?
The only way to know for sure is to apply!***

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

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ANSWERS TO HOUSE HSS COMMITTEE QUESTIONS ON SB 13 Prepared by: Dept. of Health and Social Services 3-16-2010

Answers to 3/10/10 email from Rep. Keller:

How many of the projected 1300 children projected to be qualified with SB 13 are already insured?

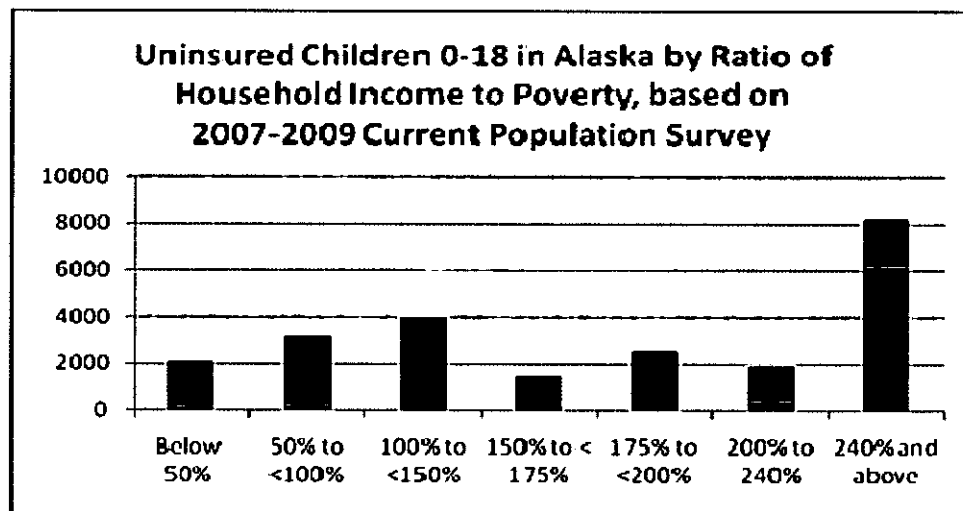
All 1300 children covered under SB13 would be uninsured at the time of application. A child cannot be insured under another plan as a condition of eligibility for Denali KidCare. It is possible that a child could obtain insurance at some point during his/her year of eligibility, but the child would be found ineligible at the annual renewal.

Can you put together a "bell curve" that puts number of Alaska children on the vertical axis and the income level (before dividends) on the horizontal? If that cannot be done, please replace the number of children with the number of Alaska households and provide the average number of children per household in Alaska. I would like to provide a 'visual' to the committee of the children addressed by SB 13 including a vertical line at 175% and a vertical line at 200%. Please include the table that is used to build the graph --- or just send us the table so we can build the bell curve.

We are unable to provide the specific information that you requested, although we do have information that addresses the questions you raise. Below is a table of insured and uninsured children through age 18 broken out by income as a percentage of poverty. The income measured includes the PFD. It should also be noted that the source survey does not use the same income calculation and household composition rules that Medicaid uses in determining eligibility. We have also provided two graphic representations of the data.

Uninsured and Insured Alaska Children through age 18, estimates based on U.S. Bureau of the Census Current Population Survey administered in 2007, 2008 and 2009 (Note: PFD amounts are included in household income)

Income-to-Poverty Ratio in 2006 to 2008 (using the federal poverty guidelines for Alaska)	Insured	Uninsured
Below 50%	8498	2101
50% to <100%	12509	3172
100% to <150%	23477	3971
150% to < 175%	6615	1461
175% to <200%	11217	2598
200% to 240%	13083	1894
240% and above	92233	8242



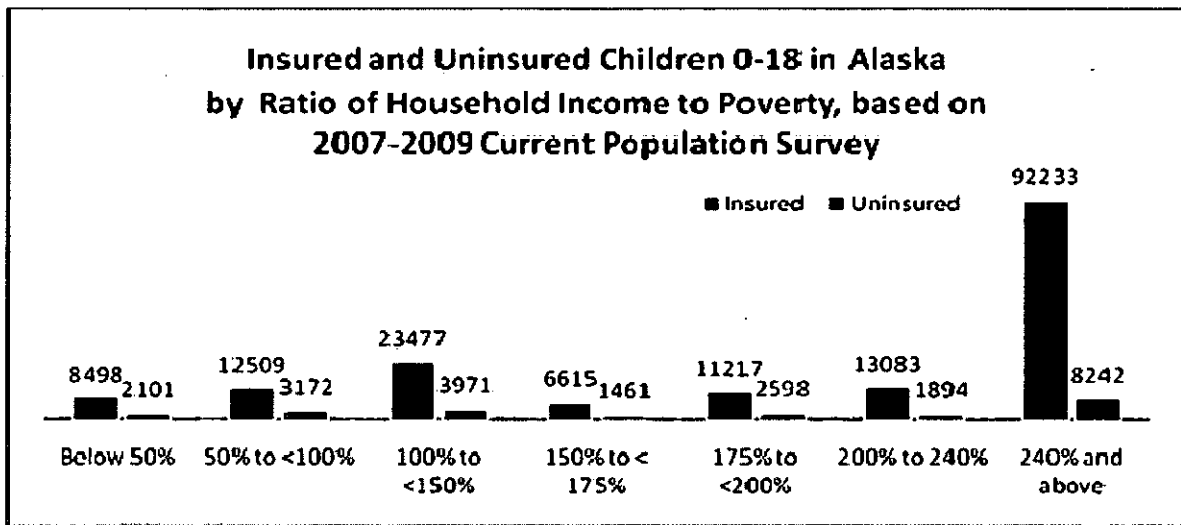


Table and Charts prepared by Health Planning & Systems Development, Div. of Health Care Services, AKDHSS ajr 3/10/2010

Matt Johnson's questions:

1. Of the 1,277 kids who would be eligible for DKC under an increase to 200%, how many are currently on regular Medicaid?

The fiscal note represents our expectations for the net impacts on the program. All of the kids we project adding under SB 13 would be net increases to the CHIP categories. We always have people coming and going and moving between regular Medicaid and CHIP. We do not assume that we would see a net decrease in the regular Medicaid categories, though there may be individual cases where children move from one category to another. We don't anticipate reducing any spending under regular Medicaid categories, so there would be no net savings.

2. Is the ADN article reporting 11,000 more children enrolled in Medicaid in the last 18 months accurate?

Children's enrollment from July 2008 to January 2010 went from 58,028 to 69,117, for a total increase of 11,089. It changes from month to month.

FAX COVER SHEET

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TO: Matt Johnson / Rep Keller

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NUMBER OF PAGES 3
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NOTES/INSTRUCTIONS:

*Please deliver to Matt @ HHSS asap.
Re SB 13 / A.S*

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1 of 10 DOCUMENTS

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*** CURRENT THROUGH PL 111-144, APPROVED 3/2/2010 ***

TITLE 42. THE PUBLIC HEALTH AND WELFARE
 CHAPTER 7. SOCIAL SECURITY ACT
 TITLE XXI. STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Go to the United States Code Service Archive Directory

42 USCS § 1397cc

§ 1397cc. Coverage requirements for children's health insurance

(a) Required scope of health insurance coverage. The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) [42 USCS § 1397aa(a)] shall consist, consistent with paragraphs (5), (6), and (7) of subsection (c), of any of the following:

(1) Benchmark coverage. Health benefits coverage that is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b). ?

(2) Benchmark-equivalent coverage. Health benefits coverage that meets the following requirements:

(A) Inclusion of basic services. The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

(B) Aggregate actuarial value equivalent to benchmark package. The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

(C) Substantial actuarial value for additional services included in benchmark package. With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

(3) Existing comprehensive State-based coverage. Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

(4) Secretary-approved coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

(b) Benchmark benefit packages. The benchmark benefit packages are as follows:

(1) FEHBP-equivalent children's health insurance coverage. The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

(2) State employee coverage. A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(3) Coverage offered through HMO. The health insurance coverage plan that--

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act [42 USCS § 300gg-91(b)(3)]), and

(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

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(c) Categories of services; determination of actuarial value of coverage.

(1) Categories of basic services. For purposes of this section, the categories of basic services described in this paragraph are as follows:

- (A) Inpatient and outpatient hospital services.
- (B) Physicians' surgical and medical services.
- (C) Laboratory an-ray services.
- (D) Well-baby and well-child care, including age-appropriate immunizations.

(2) Categories of additional services. For purposes of this section, the categories of additional services described in this paragraph are as follows:

- (A) Coverage of prescription drugs.
- (B) Vision services.
- (C) Hearing services.
- (D) [Redesignated]

(3) Treatment of other categories. Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

(4) Determination of actuarial value. The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

- (A) by an individual who is a member of the American Academy of Actuaries;
- (B) using generally accepted actuarial principles and methodologies;
- (C) using a standardized set of utilization and price factors;
- (D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;
- (E) applying the same principles and factors in comparing the value of different coverage (or categories of services);
- (F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- (G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(5) Dental benefits.

(A) In general. The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

(B) Permitting use of dental benchmark plans by certain states. A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

(C) Benchmark dental benefit packages. The benchmark dental benefit packages are as follows:

(i) FEHBP children's dental coverage. A dental benefits plan under chapter 89A of title 5, United States Code [5 USCS §§ 895] et seq., that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(ii) State employee dependent dental coverage. A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(iii) Coverage offered through commercial dental plan. A dental benefits plan that has the largest insured commercial, non-medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.

(6) Mental health services parity.

(A) In general. In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of

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the Public Health Service Act [42 USCS § 300gg-5(a)] in the same manner as such requirements apply to a group health plan.

(B) Deemed compliance. To the extent that a State child health plan includes coverage with respect to an individual described in section 1905(a)(4)(B) [42 USCS § 1396d(a)(4)(B)] and covered under the State plan under section 1902(a)(10)(A) [42 USCS § 1396(a)(10)(A)] of the services described in section 1905(a)(4)(B) [42 USCS § 1396d(a)(4)(B)] (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r) [42 USCS § 1396d(r)]) and provided in accordance with section 1902(a)(43) [42 USCS § 1396(a)(43)], such plan shall be deemed to satisfy the requirements of subparagraph (A).

(7) Construction on prohibited coverage. Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title [42 USCS §§ 1397aa et seq.], notwithstanding that any benchmark benefit package includes coverage for such an item or service.

(8) Availability of coverage for items and services furnished through school-based health centers. Nothing in this title [42 USCS §§ 1397aa et seq.] shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers (as defined in section 2110(c)(9) [42 USCS § 1397j(c)(9)]).

(d) Description of existing comprehensive State-based coverage.

(1) In general. A program described in this paragraph is a child health coverage program that--

- (A) includes coverage of a range of benefits;
- (B) is administered or overseen by the State and receives funds from the State;
- (C) is offered in New York, Florida, or Pennsylvania; and
- (D) was offered as of the date of the enactment of this title [enacted Aug. 5, 1997].

(2) Modifications. A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of--

- (A) the actuarial value of the coverage under the program as of the date of the enactment of this title [enacted Aug. 5, 1997], or
- (B) the actuarial value described in subsection (a)(2)(B), evaluated as of the time of the modification.

(c) Cost-sharing.

(1) Description; general conditions.

(A) Description. A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) Protection for lower income children. The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) No cost sharing on benefits for preventive services or pregnancy-related assistance. The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D) or for pregnancy-related assistance.

(3) Limitations on premiums and cost-sharing.

(A) Children in families with income below 150 percent of poverty line. In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose--

- (i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) [42 USCS § 1396o(b)(1)] (with respect to individuals described in such section); and
- (ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3) [42 USCS § 1396o(a)(3)], with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

(B) Other children. For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted

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low-income children in a family under this title [42 USCS §§ 1397aa et seq.] may not exceed 5 percent of such family's income for the year involved.

(C) Premium grace period. The State child health plan--

(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice--

(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term "new coverage period" means the month immediately following the last month for which the premium has been paid.

(4) Relation to medicaid requirements. Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2) [42 USCS § 1397aa(a)(2)].

(f) Application of certain requirements.

(1) Restriction on application of preexisting condition exclusions.

(A) In general. Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

(B) Group health plans and group health insurance coverage. If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 USCS §§ 1181 et seq.] and title XXVII of the Public Health Service Act [42 USCS §§ 300gg et seq.].

(2) Compliance with other requirements. Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act [42 USCS § 300gg-51] insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(3) Compliance with managed care requirements. The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 [42 USCS § 1396u-2] (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX [42 USCS §§ 1396 et seq.].

HISTORY:

(Aug. 14, 1935, ch 531, Title XXI, § 2103, as added Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle J, Ch 1, § 4901(a), 111 Stat. 554.)

(As amended Feb. 4, 2009, P.L. 111-3, Title I, Subtitle B, § 111(b)(1), Title IV, § 403(a), Title V, §§ 501(a)(1), 502, 504(a), 505(a), 123 Stat. 28, 84, 85, 89, 90.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES**Amendments:**

2009. Act Feb. 4, 2009 (effective on 4/1/2009, and applicable to child health assistance and medical assistance provided on or after that date, as provided by § 3(a) of such Act, which appears as 42 USCS § 1396 note), in subsec. (a), in the introductory matter, inserted ", (6)."; and, in subsec. (c), in para. (2), deleted subpara. (B) which read: "(B) Mental health services.", and redesignated subparas. (C) and (D) as subparas. (B) and (C), respectively, and added paras. (6) and (8); in subsec. (e)(2), in the heading, inserted "or pregnancy-related assistance", and, in the text, inserted "or for pregnancy-related assistance".

Compilation of the Social Security Laws

Social Security Online

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STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING



Sec. 1916A. [42 U.S.C. 1396o-1] (a)(1) In general.— Notwithstanding sections 1916 and 1902 (a)(10)(B), but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) subsection (g) or (i) of section 1916.

(2) Exemption for individuals with family income not exceeding 100 percent of the poverty line.—

(A) In general.—Paragraph (1) and subsection (d) shall not apply, and sections 1916 and 1902 (a)(10)(B) shall continue to apply, in the case of an individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved.

(B) Limit on aggregate cost sharing.—To the extent cost sharing under subsections (c) and (e) or under section 1916 is imposed against individuals described in subparagraph (A), the limitation under subsection (b)(1)(B)(ii) on the total aggregate amount of cost sharing shall apply to such cost sharing for all individuals in a family described in subparagraph (A) in the same manner as such limitations apply to cost sharing and families described in subsection (b)(1)(B)(ii).

(3) Definitions.—In this section:

(A) Premium.—The term “premium” includes any enrollment fee or similar charge.

(B) Cost sharing.—The term “cost sharing” includes any deduction, copayment, or similar charge.

(b) Limitations on Exercise of Authority.—

(1) Individuals with family income between 100 and 150 percent of the poverty line.—In the

case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved—

(A) no premium may be imposed under the plan; and

(B) with respect to cost sharing—

(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(2) Individuals with family income above 150 percent of the poverty line.—In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved—

(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

(3) Additional limitations.—

(A) Premiums.—No premiums shall be imposed under this section with respect to the following:

(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom child welfare services are being made available under part B of title IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

(ii) Pregnant women.

(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(v) Women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

(vi) Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc).

(B) Cost sharing.—Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom child welfare services are being made available under part B of title IV on the basis of being a child in foster care or and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

(vii) Family planning services and supplies described in section 1905(a)(4)(C).

(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

(ix) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc).

(C) Construction.—Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

(4) Determinations of family income.—In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this title.

(5) Poverty line defined.—For purposes of this section, the term "poverty line" has the meaning given such term in section 673(2) of the Community Services Block Grant Act^[109] (42 U.S.C.

9902(2)), including any revision required by such section.

(6) Construction.—Nothing in this section shall be construed—

(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

(C) as affecting any such waiver of requirements in effect under this title before the date of the enactment of this section with regard to the imposition of premiums and cost sharing.

(c) Special Rules for Cost Sharing for Prescription Drugs.—

(1) In general.—In order to encourage beneficiaries to use drugs (in this subsection referred to as “preferred drugs”) identified by the State as the most (or more) cost effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may—

(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under section 1916, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not be imposed under subsection (a) due to the application of subsection (b) (3)(B).

(2) Limitations.—

(A) By income group.—In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed—

(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1916); or

(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

(B) Limitation to nominal for exempt populations.—In the case of an individual who is not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1916).

(C) Continued application of aggregate cap.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing under subsection (a)(2)(B) or applied under paragraph (1) or (2) of subsection (b), as the case may be.

(3) Waiver.—In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

(4) Exclusion authority.—Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).

(d) Enforceability of Premiums and Other Cost Sharing.—

(1) Premiums.—Notwithstanding section 1916(c)(3) and section 1902(a)(10)(B), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(2) Cost sharing.—Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this title for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.

(e) State Option for Permitting Hospitals To Impose Cost Sharing for Non-Emergency Care Furnished in an Emergency Department.—

(1) In general.—Notwithstanding section 1916 and section 1902(a)(1) or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this title, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

(A) Access to non-emergency room provider.—The individual has actually available and accessible (as such terms are applied by the Secretary under section 1916(b)(3)) an alternate non-emergency services provider with respect to such services.

(B) Notice.—The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1867 and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

(2) Limitations.—

(A) Individuals with family income between 100 and 150 percent of the poverty line.—In the case of an individual described in subsection (b)(1) who is not described in subparagraph (B), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under section 1916, subject to the percent of income limitation otherwise applicable under subsection (b)(1)(B)(ii).

(B) Application to exempt populations.—In the case of an individual described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in paragraph (1), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1916) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

(C) Continued application of aggregate cap; relation to other cost sharing.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing under subsection (a)(2)(B) or applied under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a) or section 1916.

(3) Construction.—Nothing in this section shall be construed—

(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867; or

(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

(4) Definitions.—For purposes of this subsection:

(A) Non-emergency services.—The term “non-emergency services” means any care or services furnished in an emergency department of a hospital that do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1867.

(B) Alternate non-emergency services provider.—The term “alternative non-emergency services provider” means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this title.

[109] See Vol. II, P.L. 97-35, §673(2).

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ALASKA STATE LEGISLATURE

State Representative Bob Herron

Official Business



State Capitol
Juneau, Alaska
99801-1182

MEMORANDUM

TO: House Health & Social Services Committee

FROM: Representative Herron

DATE: March 10, 2009

RE: SB 13 – Medical Assistance Eligibility

A handwritten signature in black ink, appearing to read "Bob Herron".

For your reference, I have attached the report "Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations." Mathematica Policy Research, Inc completed this report in 2003 as background for Congress.

There are a range of different methods used by States when implementing SCHIP programs including: premiums, copayments, deductibles, and enrollment fees. According to this report, Alaska utilized copayments to charge 18 year olds 5% of the outpatient hospital visit.

I want to emphasize that Table IV.1 is an old snapshot of the various ways states have used cost sharing as a way to control the cost and utilization of services provided under the SCHIP program.

Contract No.: 500-96-0016(03)
MPR Reference No.: 8644-100

MATHEMATICA
Policy Research, Inc.

**Implementation of the
State Children's
Health Insurance
Program:
Synthesis of State
Evaluations**

*Background for the
Report to Congress*

March 2003

*Margo Rosenbach
Marilyn Ellwood
Carol Irvin
Cheryl Young
Wendy Conroy
Brian Quinn
Megan Kell*

Submitted to:

Centers for Medicare & Medicaid Services
Office of Research, Development,
and Information
7500 Security Boulevard
Baltimore, MD 21244

Project Officer:

Rosemarie Hakim

Submitted by:

Mathematica Policy Research, Inc.
50 Church Street, 4th Floor
Cambridge, MA 02138
(617) 491-7900

Project Director:

Margo Rosenbach

TABLE IV.1
COST-SHARING FEATURES OF SCHIP PROGRAMS

States	Type of Program	Cost Sharing				
		No Cost Sharing	Premium ^a	Copayments	Deductibles	Enrollment Fee
TOTAL		22	21	22	1	3
Alabama	COMBO		✓	✓ ^b		
Alaska ^c	M-SCHIP			✓		
Arizona ^f	S-SCHIP			✓		
Arkansas	M-SCHIP	✓				
California ^g	COMBO		✓ ^c	✓ ^c		
Colorado ^h	S-SCHIP		✓	✓		
Connecticut	COMBO		✓ ^c	✓ ^c		
Delaware	S-SCHIP		✓	✓		
District of Columbia	M-SCHIP	✓				
Florida ⁱ	COMBO		✓ ^c	✓		
Georgia	S-SCHIP		✓			
Hawaii	M-SCHIP	✓				
Idaho	M-SCHIP	✓				
Illinois ^j	COMBO		✓ ^c	✓		
Indiana	COMBO	✓				
Iowa	COMBO		✓ ^c	✓		
Kansas	S-SCHIP		✓			
Kentucky	COMBO	✓				
Louisiana	M-SCHIP	✓				
Maine	COMBO		✓ ^c			
Maryland	M-SCHIP	✓				
Massachusetts ^k	COMBO		✓ ^c	✓	✓	
Michigan	COMBO		✓ ^c			
Minnesota	M-SCHIP	✓				
Mississippi ^l	COMBO			✓		
Missouri ^m	M-SCHIP		✓	✓		
Montana ⁿ	S-SCHIP			✓		✓
Nebraska	M-SCHIP	✓				
Nevada	S-SCHIP		✓			
New Hampshire	COMBO		✓ ^c	✓		
New Jersey ^o	COMBO		✓ ^c	✓		
New Mexico ^p	M-SCHIP			✓		
New York	COMBO		✓ ^c			
North Carolina ^q	S-SCHIP			✓		✓
North Dakota	COMBO	✓				
Ohio	M-SCHIP	✓				
Oklahoma	M-SCHIP	✓				
Oregon	S-SCHIP	✓				
Pennsylvania	S-SCHIP	✓				
Rhode Island ^r	M-SCHIP		✓	✓		

only applies to 18 year olds and they are charged 5% of the outpatient hospital visit

Table IV.1 (Continued)

States	Type of Program	Cost Sharing				
		No Cost Sharing	Premium ^a	Copayments	Deductibles	Enrollment Fee
South Carolina	M-SCHIP	✓				
South Dakota	COMBO	✓				
Tennessee	M-SCHIP	✓				
Texas	COMBO	✓				
Utah ^a	S-SCHIP			✓		
Vermont	S-SCHIP					✓
Virginia	S-SCHIP	✓				
Washington ^b	S-SCHIP		✓	✓		
West Virginia	S-SCHIP	✓				
Wisconsin ^c	M-SCHIP		✓	✓		
Wyoming	S-SCHIP	✓				

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Sections 3.2.1, 3.3.1, and 3.3.7 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

^a For detailed premium information, see Table IV.2.

^b In the Alabama S-SCHIP program, children between 100 and 150 percent of poverty have no cost sharing. For children between 151 and 200 percent of poverty there is no deductible and a \$5 copay on some services in addition to a \$50 per year premium with a premium maximum of \$150 per family per year. In the M-SCHIP program, only 18 year olds are subject to copayments.

^c Applies only to S-SCHIP program.

^d Applies to both S-SCHIP and M-SCHIP program.

^e In Alaska, only 18 year olds are subject to copayments.

^f Arizona applies copays only to emergency room use.

^g California's S-SCHIP program has a cap on copays of \$250 per family per year.

^h In Colorado's S-SCHIP program, copayments vary by income. There are no copayments for families with income under 101 percent of poverty. Families between 101 and 150 percent of poverty pay a smaller copay than families between 151 and 185 percent of poverty.

ⁱ Florida has three S-SCHIP programs: Healthy Kids, CMS, and MediKids. Healthy Kids is the only program with copayments.

^j In Illinois, the annual copayment maximum per family is \$100. Families with children who are American Indian or Alaska Natives do not pay premiums or copays. S-SCHIP cost sharing varies based on program: KidCare Share covers children greater than 133 to 150 percent of poverty; KidCare Premium covers children between 151 and 185 percent of poverty. Copayments vary by service and income level; premiums vary by income level.

^k Massachusetts has three S-SCHIP programs: Family Assistance Direct Coverage (FADC), Family Assistance Premium Assistance (FAPA), and CommonHealth (CH). CH has no cost sharing. FADC has no copayments, although it does have premiums. FAPA has premiums; copayments are in accordance with the individual ESI policy, subject to limitations under title XXI.

^l In Mississippi, there are no cost-sharing requirements for families with income below 150 percent of poverty or for American Indian/Native Alaskan children. Families in the S-SCHIP program, with incomes between 150 and 175 percent of poverty have copays on certain services and pay a maximum out of pocket of \$800 per calendar year. Families with incomes between 176 percent and 200 percent of poverty have higher copays on certain services and pay a maximum out of pocket of \$950 per calendar year. There is no copay for preventive services.

^m Families with incomes between 226 and 300 percent of poverty must pay a premium for the Missouri M-SCHIP program. Copayments also vary by income: families with incomes between 186 and 225 percent pay smaller copayments than families with incomes between 226 and 300 percent of poverty.

ⁿ Montana S-SCHIP has copayments for those with family incomes greater than 100 percent of poverty.

^o New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150 percent of poverty; Plan C covers children between 151 and 200 percent of poverty; and Plan D covers children between 201 and 350 percent of poverty. Only Plans C and D have any form of cost sharing.

^p In New Mexico M-SCHIP, copayments only apply to those between 185 and 235 percent of poverty.

^q In North Carolina, copayments only apply to those with incomes greater than 151 percent of poverty.

^r In Rhode Island, cost sharing is only for families with income in excess of 185 percent of poverty if they elected a coinsurance rather than a premium option.

^s In Utah, cost sharing varies by plan. Plan A applies to enrollees at or below 150 percent of poverty. Plan B enrollees have family incomes between 151 and 200 percent of poverty. Plan B has higher copayments than Plan A (although Plan A cost sharing applies only to those between 101 and 150 percent of poverty).

^t Washington has no cost sharing for American Indians/Native Alaskans. Annual maximum out-of-pocket costs are \$300 for one child, \$600 for two children, and \$900 for three or more children.

^u Wisconsin copayments are only for non-pregnant adults in Medicaid FFS.

To: Mr. WES KILLER 465-3818

FROM: [unclear] [unclear]
[unclear] [unclear]

URGENT - Before you proceed -
please call - we suspect
[unclear] [unclear] at
at least 2000 FPL!

Page 7 - includes this cover.

To the Member of the House, Health and Social Services Comm.

Please pass SB 13 out of your committee so that it might pass the full House and Senate and become law. I'm fortunate enough to have health insurance through my job so that my three kids can receive adequate health care without putting me into debt. I have friends, families that are on the fringe of the current income requirement of 175% of the poverty line. By providing Seneca KidCare health insurance to kids whose parents earn up to 200% of the poverty line, the state will allow families of moderate means the ability to see that their kids receive adequate health care. We will join 46 other states that have an income threshold of 200% or higher, and we will provide health care to kids at a very reasonable cost to their state. After all, the federal government matches ^{every} around 20 cents of state monies with 70 cents.

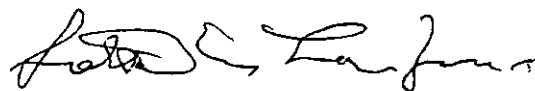
In these rough economic times, please help more working families provide health care to their children.

Sincerely, Greg Bidwell of Anchorage Alaska
3301 Paradise Street 99508

To the Members of the House Health and Social Services
Comm.,

I ask you to pass SB13, funding for children, for
the benefit of Alaskan children, and Alaska people,
~~our~~ our children are our investment of our past.

Sincerely,
RICHARD LYNKY JUNIOR
3722 PARSONS AVE
ANCHORAGE, AK. 99508



4/19/09

To the Members of the House Health and Social Services Comm

Please support the Denali KidCare Program
to 200% of the Federal Poverty Line.

Health insurance is a basic human
right to which I believe all, especially
children, are entitled.

Sincerely,

CLIFFORD MARVIN

201 EAST 16th AVENUE

ANCHORAGE AK 99501



House Health and Social Services Committee
Juneau, AK.

Dear Committee Members:

1. I urge you to pass the bill which covers health care for Alaskan Children. We must restore the standard which existed Twelve years ago when the Denali Kid Care Program was based at 200% of the Federal Poverty Level.
2. It is distressing that Alaska is one of our wealthiest states but we are one of only five states which funds this program below this level.
3. Early intervention and preventive care are essential for the well being of our children and will yield substantial savings to state, and private sector health based institutions.
4. Thank you for your cooperation and I look forward to seeing your support of this bill.

Lane M. Garrett
3701 Winterset Dr
Anchorage, 99508

4/19/09.

Dear Members of the House Health +
Social Services Committee —

I am writing to urge you to please pass
House Bill 61 - which covers health care for
Alaskan children whose families are at the
200% of federal poverty level.

It amazes me that our state is one
of the most wealthy, yet 45 states
do better than we do re: covering children's
health care needs.

Families at this level of poverty are
stretched, stressed + vulnerable; if health
care takes a back seat - family fall
apart. It is crazy to think we cannot
help support a basic need as this.

Again I urge you to support this
house bill - our state needs a
better future for ~~you~~ our children to
be a part of.

Thank you,

Sincerely,

Maureen Johnson, OT

CONCEPTIONAL AMENDMENT #

OFFERED IN THE HOUSE
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 4, line 23

2 Delete all material and insert:

3 **** Sec .3.** This Act takes effect immediately under AS 01.10.070 (d) provided the uncodified
4 law of the State of Alaska is amended by adding a new section to read:

5 CONTINGENT EFFECT; PAYMENT INTO CONSTITUTIONAL BUDGET

6 RESERVE FUND. AS 47.07.030(b)(13) and (14), as amended by sec, 1 of this Act, and AS
7 47.07.042(d), as amended by sec. 2 of this Act, take effect only if

8 (1) on June 30, 2010, money is not owed to the budget reserve fund (art. IX, sec.
9 17, Constitution of the State of Alaska); or

10 (2) money is owed to the constitutional budget reserve fund on June 30, 2010 and
11 the following provision or a substantially similar provision becomes law before January 1,
12 2011:

13 The amount necessary for full repayment of the amounts owed the budget reserve
14 fund (art. IX, sec. 17, Constitution of the State of Alaska) as of June 30, 2010, estimated
15 to be \$401,617,000, is appropriated from the general fund to the budget reserve fund (art.
16 IX, sec. 17, Constitution of the State of Alaska)."

ALASKA STATE LEGISLATURE

Interim:

600 East Railroad Avenue
Wasilla, Alaska 99654
Phone: (907) 373-1842
Fax: (907) 373-4729



Session:

State Capitol Building
Juneau, Alaska 99801-1182
Phone: (907) 465-2186
Fax: (907) 465-3818

REPRESENTATIVE WES KELLER DISTRICT 14

Fax

To: Legis. Legal

Fax #: 465-2029

Number of pages including cover: 3

Fm: Jim Pound

Cc:

Date: February 23, 2010, 8:23 AM

Re: Amendments to SB 13 (26-LS0076\A)

Please prepare the attached amendments for the above referenced bill. Representative Keller will introduce them in the House Health and Social Services Committee.

Thank you

The information contained in this fax is **CONFIDENTIAL** and/or privileged. This fax is intended to be reviewed initially by only the individual named above. If the reader of this transmittal page is not the intended recipient or a representative of the intended recipient, you are hereby notified that any **review, dissemination, or copying** of this fax or the information contained herein is **prohibited**. If you have received this fax in error, please immediately notify the sender by telephone and return this fax to the sender at the above address.

Thank you

E-Mail: [Representative Wes Keller@legis.state.ak.us](mailto:Representative_Wes_Keller@legis.state.ak.us)
Call Juneau Toll free: (800) 468-2186
Website: www.akrepublicans.org/keller/

BILL VERSION: SB 13

CURRENT STATUS: (H) HSS

THEN FIN

SPONSOR(s): SENATOR(S) DAVIS, Ellis, Paskvan, Wielechowski, French REPRESENTATIVE(S) Gruenberg

SHORT TITLE: MEDICAL ASSISTANCE
ELIGIBILITY

STATUS DATE: 04/07/09

Conceptional Amendment 1

AS 47.07.020(b) is amended to read:

02 (13) persons under 19 years of age who are not covered under (a) of
03 this section and whose household income does not exceed 210 [200] [175] percent of the
04 federal poverty line as defined by the United States Department of Health and Human
05 Services and revised under 42 U.S.C. 9902(2);

06 (14) pregnant women who are not covered under (a) of this section and
07 whose household income does not exceed 210 [200] [175] percent of the federal poverty line
08 as defined by the United States Department of Health and Human Services and revised
09 under 42 U.S.C. 9902(2);

10 (15) persons who have been diagnosed with breast or cervical cancer
11 and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII).

12 * **Sec. 2.** AS 47.07.042(d) is amended to read:

13 (d) In addition to the requirements established under (a) and (b) of this section,
14 the department may require premiums or cost-sharing contributions from recipients
15 who are eligible for benefits under AS 47.07.020(b)(13) and whose household income
16 is between [150] 185 and 210 [175] percent of the federal poverty line. If the department
17 requires premiums or cost-sharing contributions under this subsection, the department

18 (1) shall adopt in regulation a sliding scale for those premiums, [or]
19 contributions, or co-pay based on household income;

20 (a) 185.1% to 190% co-pay of 10%

21 (b) 190.1% to 195% co-pay of 20%

22 (c) 195.1% to 200% co-pay of 30%

23 (d) 200.1% to 205% co-pay of 40%

24 (e) 205.1% to 210% co-pay of 50%

25 (2) may not exceed the maximums allowed under federal law; and

26 (3) shall implement a system by which the department or its designee
27 collects those premiums, [or] contributions, or co-pays.

Conceptional Amendment 2

01 * **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

02 CONTINGENT EFFECT. AS 47.07.020(b)(13 & 14), and 47.07.042(d),
03 added in secs. 2, of this Act, take effect only if, before July 1, 2011, the United States
04 Department of Health and Human Services has approved the changes and provided sufficient
05 funding for the changes.

06 * **Sec. 6.** If AS 47.07.020(b)(16), 47.07.020(o), and 47.07.042(g), added in secs. 2, 3, and 4
07 of this Act, take effect, they take effect on the date that the revisor of statutes receives notice
08 from the commissioner of health and social services that the United States Department of
09 Health and Human Services has approved the changes and provided sufficient funding for the
10 additions.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

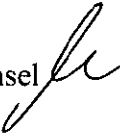
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 16, 2010

SUBJECT: Title change necessitated by adding co-payment provisions
(SB 13; Work Order No. 26-LS0076\A.9)

TO: Representative Wes Keller
Chair of the House Health and Social Services Committee
Attn: Matthew Johnson

FROM: Jean M. Mischel
Legislative Counsel 

As in amendment A.5 of the above bill, the addition of copayment provisions modifies the Senate-passed bill to add new material that necessitates a change in the bill title. This is a bill title change in the measure's second ("other") house. The limitation of Uniform Rule 41(b) applies:

(b) An amendment to a bill introduced in the other house is not in order if the amendment requires a change of the bill title other than a clerical or technical change.

In submitting the committee report for SB 13, the House Finance Committee should also introduce a companion concurrent resolution waiving the application of the appropriate uniform rules in order to accommodate the amendments and the related bill title addition.

If I may be of further assistance, please advise.

JMM:lmb
10-007.lmb

Enclosure

AMENDMENT

OFFERED IN THE HOUSE
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 1, line 1, following "requirements":

2 Insert "**and cost-sharing**"

3

4 Page 4, line 3:

5 Delete "**200**"

6 Insert "**210**"

7

8 Page 4, line 7:

9 Delete "**200**"

10 Insert "**210**"

11

12 Page 4, line 16:

13 Delete "150 and **200**"

14 Insert "**185** [150] and **210**"

15

16 Page 4, lines 18 - 19:

17 Delete "those premiums or contributions based on household income"

18 Insert "**copayments based on household income as follows:**

19 **(A) at least 185 percent but not more than 190 percent, a**
20 **copayment of 10 percent of the cost of services;**

21 **(B) more than 190 percent but not more than 195 percent, a**
22 **copayment of 20 percent of the cost of services;**

23 **(C) more than 195 percent but not more than 200 percent, a**

1 copayment of 30 percent of the cost of services;

2 (D) more than 200 percent but not more than 205 percent, a
3 copayment of 40 percent of the cost of services;

4 (E) more than 205 percent but not more than 210 percent, a
5 copayment of 50 percent of the cost of services

6 [THOSE PREMIUMS OR CONTRIBUTIONS BASED ON HOUSEHOLD
7 INCOME]"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: SB 13

1 Page 4, line 23:

2 Delete all material and insert:

3 **** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to
4 read:

5 CONTINGENT EFFECT; NOTIFICATION OF FEDERAL APPROVAL. (a)
6 AS 47.07.020(b)(13), as amended by sec. 1 of this Act, takes effect only if, before July 1,
7 2011, the United States Department of Health and Human Services has approved the change
8 and included sufficient funding in the federal budget to provide for the change in the fiscal
9 year immediately following the passage of this Act by the Alaska State Legislature.

10 (b) AS 47.07.020(b)(14), as amended by sec. 1 of this Act, takes effect only if, before
11 July 1, 2011, the United States Department of Health and Human Services has approved the
12 change and included sufficient funding in the federal budget to provide for the change in the
13 fiscal year immediately following the passage of this Act by the Alaska State Legislature.

14 (c) AS 47.07.042(d), as amended by sec. 2 of this Act, takes effect only if, before
15 July 1, 2011, the United States Department of Health and Human Services has approved the
16 change and included sufficient funding in the federal budget to provide for the change in the
17 fiscal year immediately following the passage of this Act by the Alaska State Legislature.

18 (d) The commissioner of health and social services shall notify the revisor of statutes
19 of the federal approval and funding provided for in (a) - (c) of this section.

20 *** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:

22 CONTINGENT EFFECTIVE DATES. (a) If AS 47.07.020(b)(13), as amended by
23 sec. 1 of this Act, takes effect under sec. 3(a) of this Act, it takes effect on the day after the

1 day that the revisor of statutes receives notice from the commissioner of health and social
2 services that the United States Department of Health and Human Services has approved the
3 change and provided sufficient federal funding to provide for the change as provided in sec.
4 3(a) of this Act.

5 (b) If AS 47.07.020(b)(14), as amended by sec. 1 of this Act, takes effect under sec.
6 3(b) of this Act, it takes effect on the day after the day that the revisor of statutes receives
7 notice from the commissioner of health and social services that the United States Department
8 of Health and Human Services has approved the change and provided sufficient federal
9 funding to provide for the change as provided in sec. 3(b) of this Act.

10 (c) If AS 47.07.042(d), as amended by sec. 2 of this Act, takes effect under sec. 3(c)
11 of this Act, it takes effect on the day after the day that the revisor of statutes receives notice
12 from the commissioner of health and social services that the United States Department of
13 Health and Human Services has approved the change and provided sufficient federal funding
14 to provide for the change as provided in sec. 3(c) of this Act."

AMENDMENT

OFFERED IN THE HOUSE
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 1, line 1, following "requirements":

2 Insert "and cost-sharing"

3

4 Page 4, line 3:

5 Delete "200"

6 Insert "185"

7

8 Page 4, line 11, following "42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII)":

9 Insert ";

10 (16) persons under 19 years of age who are not covered under (a)
11 of this section

12 (A) who pay a premium under AS 47.07.042(g);

13 (B) whose household income is more than 185 and not more
14 than 210 percent of the federal poverty line as defined by the United
15 States Department of Health and Human Services and revised under 42
16 U.S.C. 9902(2);

17 (C) whose assets do not exceed the maximum value
18 established by the United States Department of Health and Human
19 Services under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act);
20 and

21 (D) who apply annually on a form approved by the
22 department"

23

1 Page 4, line 16:

2 Delete "200"

3 Insert "185"

4

5 Page 4, following line 22:

6 Insert new bill sections to read:

7 **** Sec. 3.** AS 47.07.042 is amended by adding a new subsection to read:

8 (g) In addition to the requirements established under (a) and (b) of this section,
9 the department shall require annual premiums from recipients who are eligible for
10 benefits under AS 47.07.020(b)(16) and whose household income is more than 185
11 and not more than 210 percent of the federal poverty line. The department shall

12 (1) adopt in regulation a sliding scale, providing for a premium that

13 (A) is not less than two percent of the recipient's household
14 income; and

15 (B) meets the maximums allowed under federal law; and

16 (2) implement a system for collection of the premium.

17 *** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to
18 read:

19 CONTINGENT EFFECT. AS 47.07.020(b)(16), added by sec. 1 of this Act, and
20 AS 47.07.042(g), added by sec. 3 of this Act, take effect only if, before July 1, 2011, the
21 United States Department of Health and Human Services has approved the changes and
22 provided sufficient funding for the changes.

23 *** Sec. 5.** If AS 47.07.020(b)(16), added by sec. 1 of this Act, and AS 47.07.042(g), added
24 by sec. 3 of this Act, take effect, they take effect on the date that the revisor of statutes
25 receives notice from the commissioner of health and social services that the United States
26 Department of Health and Human Services has approved the changes and provided sufficient
27 funding for the additions."

28

29 Renumber the following bill section accordingly.

30

31 Page 4, line 23:

- 1 Delete "This"
- 2 Insert "Except as provided in secs. 4 and 5 of this Act, this"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: SB 13

1 Page 1, line 1, following "**requirements**":

2 Insert "**and cost-sharing**"

3

4 Page 4, line 3:

5 Delete "200"

6 Insert "210"

7

8 Page 4, line 14:

9 Delete "may"

10 Insert "**shall** [MAY]"

11

12 Page 4, line 16:

13 Delete "150 and 200"

14 Insert "185 [150] and 210"

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 17, 2010

SUBJECT: Descriptive Title (SB 13; Work Order No. 26-LS0076\A.11)

TO: Representative Wes Keller
Co-chair of the House Health and Social Services Committee
Attn: Matthew Johnson

FROM: Jean M. Mischel
Legislative Counsel 

As we discussed by telephone and as presented in a previous memorandum on this subject, the addition of specific cost-sharing requirements for medical assistance recipients by the above-referenced amendment may not be clear from the title of the bill, which only refers to eligibility requirements. Sec. 3, added by this amendment, requires the addition of premium payments by some medical assistance recipients. While the amendment at page one inserts a new category of eligibility relating to those recipients and the premium requirement is linked to eligibility, the payment of the premium may not be made until eligibility is first determined on the basis of income.

The bill title without the amendment may also be misleading in the sense that the cost sharing limits are amended by sec. 2 on the basis of the income adjustments made for eligibility.

If I may be of further assistance, please advise.

JMM:lmb
10-008.lmb

Enclosure

AMENDMENT

OFFERED IN THE HOUSE
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 4, line 3:

2 Delete "200"

3 Insert "185"

4

5 Page 4, line 11, following "42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)":

6 Insert ";

7

(16) persons under 19 years of age who are not covered under (a)

8

of this section

9

(A) who pay a premium under AS 47.07.042(g);

10

(B) whose household income is more than 185 and not more

11

than 210 percent of the federal poverty line as defined by the United

12

States Department of Health and Human Services and revised under 42

13

U.S.C. 9902(2); and

14

(C) who apply annually on a form approved by the

15

department"

16

17 Page 4, line 16:

18 Delete "200"

19 Insert "185"

20

21 Page 4, following line 22:

22 Insert new bill sections to read:

23 "* **Sec. 3.** AS 47.07.042 is amended by adding a new subsection to read:

1 (g) In addition to the requirements established under (a) and (b) of this section,
 2 the department shall require annual premiums from recipients who are eligible for
 3 benefits under AS 47.07.020(b)(16) and whose household income is more than 185
 4 and not more than 210 percent of the federal poverty line. The department shall

5 (1) adopt in regulation a sliding scale, providing for a premium that

6 (A) is not less than two percent of the recipient's household
 7 income; and

8 (B) meets the maximums allowed under federal law; and

9 (2) implement a system for collection of the premium.

10 * Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section to
 11 read:

12 CONTINGENT EFFECT. AS 47.07.020(b)(16), added by sec. 1 of this Act, and
 13 AS 47.07.042(g), added by sec. 3 of this Act, take effect only if, before July 1, 2011, the
 14 United States Department of Health and Human Services has approved the changes and
 15 provided sufficient funding for the changes.

16 * Sec. 5. If AS 47.07.020(b)(16), added by sec. 1 of this Act, and AS 47.07.042(g), added
 17 by sec. 3 of this Act, take effect, they take effect on the date that the revisor of statutes
 18 receives notice from the commissioner of health and social services that the United States
 19 Department of Health and Human Services has approved the changes and provided sufficient
 20 funding for the additions."

21
 22 Renumber the following bill section accordingly.

23
 24 Page 4, line 23:

25 Delete "This"

26 Insert "Except as provided in secs. 4 and 5 of this Act, this"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: SB 13

1 Page 4, line 3:

2 Delete "200"

3 Insert "210"

4

5 Page 4, line 14:

6 Delete "may"

7 Insert "shall [MAY]"

8

9 Page 4, line 16:

10 Delete "150 and 200"

11 Insert "185 [150] and 210"

12

13 Page 4, lines 16 - 17:

14 Delete "if the department requires premiums or cost-sharing contributions under this
15 subsection, the"

16 Insert "The [IF THE DEPARTMENT REQUIRES PREMIUMS OR COST-
17 SHARING CONTRIBUTIONS UNDER THIS SUBSECTION, THE]"

26-LS0076\S
Mischel
4/13/09

HOUSE CS FOR SENATE BILL NO. 13(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis, Paskvan, Wielechowski, French
REPRESENTATIVE Gruenberg

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to eligibility requirements for medical assistance for certain children**
2 **and pregnant women; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1. AS 47.07.020(b) is amended to read:**

5 (b) In addition to the persons specified in (a) of this section, the following
6 optional groups of persons for whom the state may claim federal financial
7 participation are eligible for medical assistance:

8 (1) persons eligible for but not receiving assistance under any plan of
9 the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act,
10 Supplemental Security Income) or a federal program designated as the successor to the
11 aid to families with dependent children program;

12 (2) persons in a general hospital, skilled nursing facility, or
13 intermediate care facility, who, if they left the facility, would be eligible for assistance
14 under one of the federal programs specified in (1) of this subsection;

15 (3) persons under 21 years of age who are under supervision of the
16 department, for whom maintenance is being paid in whole or in part from public

1 funds, and who are in foster homes or private child-care institutions;

2 (4) aged, blind, or disabled persons, who, because they do not meet
3 income and resources requirements, do not receive supplemental security income
4 under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not
5 receive a mandatory state supplement, but who are eligible, or would be eligible if
6 they were not in a skilled nursing facility or intermediate care facility to receive an
7 optional state supplementary payment;

8 (5) persons under 21 years of age who are in an institution designated
9 as an intermediate care facility for the mentally retarded and who are financially
10 eligible as determined by the standards of the federal program designated as the
11 successor to the aid to families with dependent children program;

12 (6) persons in a medical or intermediate care facility whose income
13 while in the facility does not exceed \$1,656 a month but who would not be eligible for
14 an optional state supplementary payment if they left the hospital or other facility;

15 (7) persons under 21 years of age who are receiving active treatment in
16 a psychiatric hospital and who are financially eligible as determined by the standards
17 of the federal program designated as the successor to the aid to families with
18 dependent children program;

19 (8) persons under 21 years of age and not covered under (a) of this
20 section, who would be eligible for benefits under the federal program designated as
21 the successor to the aid to families with dependent children program, except that they
22 have the care and support of both their natural and adoptive parents;

23 (9) pregnant women not covered under (a) of this section and who
24 meet the income and resource requirements of the federal program designated as the
25 successor to the aid to families with dependent children program;

26 (10) persons under 21 years of age not covered under (a) of this section
27 who the department has determined cannot be placed for adoption without medical
28 assistance because of a special need for medical or rehabilitative care and who the
29 department has determined are hard-to-place children eligible for subsidy under
30 AS 25.23.190 - 25.23.210;

31 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title

1 XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom
2 a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title
3 XVI, Social Security Act) because they meet all of the following criteria:

4 (A) they are 18 years of age or younger and qualify as disabled
5 individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

6 (B) the department has determined that

7 (i) they require a level of care provided in a hospital,
8 nursing facility, or intermediate care facility for the mentally retarded;

9 (ii) it is appropriate to provide their care outside of an
10 institution; and

11 (iii) the estimated amount that would be spent for
12 medical assistance for their individual care outside an institution is not
13 greater than the estimated amount that would otherwise be expended
14 individually for medical assistance within an appropriate institution;

15 (C) if they were in a medical institution, they would be eligible
16 for medical assistance under other provisions of this chapter; and

17 (D) home and community-based services under a waiver
18 approved by the federal government are either not available to them under this
19 chapter or would be inappropriate for them;

20 (12) disabled persons, as described in 42 U.S.C.
21 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under
22 applicable federal regulations or guidelines, is less than 250 percent of the official
23 poverty line applicable to a family of that size according to the United States
24 Department of Health and Human Services, and who, but for earnings in excess of the
25 limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be
26 individuals with respect to whom a supplemental security income is being paid under
27 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is
28 not eligible under another provision of this section shall pay a premium or other cost-
29 sharing charges according to a sliding fee scale that is based on income as established
30 by the department in regulations;

31 (13) persons under 19 years of age who are not covered under (a) of

1 this section and whose household income does not exceed 200 [175] percent of the
2 federal poverty line as defined by the United States Department of Health and Human
3 Services and revised under 42 U.S.C. 9902(2);

4 (14) pregnant women who are not covered under (a) of this section and
5 whose household income does not exceed 200 [175] percent of the federal poverty line
6 as defined by the United States Department of Health and Human Services and revised
7 under 42 U.S.C. 9902(2);

8 (15) persons who have been diagnosed with breast or cervical cancer
9 and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII).

10 * Sec. 2. AS 47.07.042 is amended by adding a new subsection to read:

11 (g) In addition to the requirements established under (a) and (b) of this section,
12 the department shall require annual premiums from recipients who are eligible for
13 benefits under AS 47.07.020(b)(13) and (14) and whose household income is more
14 than 175 percent of the federal poverty line. The department shall

15 (1) adopt in regulation a sliding scale, providing for a premium that

16 (A) is not less than two percent of the recipient's household
17 income; and

18 (B) meets the maximums allowed under federal law; and

19 (2) implement a system for collection of the premium.

20 * Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

26-LS0076\R
Mischel
4/9/09

HOUSE CS FOR SENATE BILL NO. 13(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - FIRST SESSION.

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis, Paskvan, Wielechowski, French
REPRESENTATIVE Gruenberg

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to eligibility requirements for medical assistance for certain children**
2 **and pregnant women; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.07.020(b) is amended to read:

5 (b) In addition to the persons specified in (a) of this section, the following
6 optional groups of persons for whom the state may claim federal financial
7 participation are eligible for medical assistance:

8 (1) persons eligible for but not receiving assistance under any plan of
9 the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act,
10 Supplemental Security Income) or a federal program designated as the successor to the
11 aid to families with dependent children program;

12 (2) persons in a general hospital, skilled nursing facility, or
13 intermediate care facility, who, if they left the facility, would be eligible for assistance
14 under one of the federal programs specified in (1) of this subsection;

15 (3) persons under 21 years of age who are under supervision of the
16 department, for whom maintenance is being paid in whole or in part from public

1 funds, and who are in foster homes or private child-care institutions;

2 (4) aged, blind, or disabled persons, who, because they do not meet
3 income and resources requirements, do not receive supplemental security income
4 under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not
5 receive a mandatory state supplement, but who are eligible, or would be eligible if
6 they were not in a skilled nursing facility or intermediate care facility to receive an
7 optional state supplementary payment;

8 (5) persons under 21 years of age who are in an institution designated
9 as an intermediate care facility for the mentally retarded and who are financially
10 eligible as determined by the standards of the federal program designated as the
11 successor to the aid to families with dependent children program;

12 (6) persons in a medical or intermediate care facility whose income
13 while in the facility does not exceed \$1,656 a month but who would not be eligible for
14 an optional state supplementary payment if they left the hospital or other facility;

15 (7) persons under 21 years of age who are receiving active treatment in
16 a psychiatric hospital and who are financially eligible as determined by the standards
17 of the federal program designated as the successor to the aid to families with
18 dependent children program;

19 (8) persons under 21 years of age and not covered under (a) of this
20 section, who would be eligible for benefits under the federal program designated as
21 the successor to the aid to families with dependent children program, except that they
22 have the care and support of both their natural and adoptive parents;

23 (9) pregnant women not covered under (a) of this section and who
24 meet the income and resource requirements of the federal program designated as the
25 successor to the aid to families with dependent children program;

26 (10) persons under 21 years of age not covered under (a) of this section
27 who the department has determined cannot be placed for adoption without medical
28 assistance because of a special need for medical or rehabilitative care and who the
29 department has determined are hard-to-place children eligible for subsidy under
30 AS 25.23.190 - 25.23.210;

31 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title

1 XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom
2 a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title
3 XVI, Social Security Act) because they meet all of the following criteria:

4 (A) they are 18 years of age or younger and qualify as disabled
5 individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

6 (B) the department has determined that

7 (i) they require a level of care provided in a hospital,
8 nursing facility, or intermediate care facility for the mentally retarded;

9 (ii) it is appropriate to provide their care outside of an
10 institution; and

11 (iii) the estimated amount that would be spent for
12 medical assistance for their individual care outside an institution is not
13 greater than the estimated amount that would otherwise be expended
14 individually for medical assistance within an appropriate institution;

15 (C) if they were in a medical institution, they would be eligible
16 for medical assistance under other provisions of this chapter; and

17 (D) home and community-based services under a waiver
18 approved by the federal government are either not available to them under this
19 chapter or would be inappropriate for them;

20 (12) disabled persons, as described in 42 U.S.C.
21 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under
22 applicable federal regulations or guidelines, is less than 250 percent of the official
23 poverty line applicable to a family of that size according to the United States
24 Department of Health and Human Services, and who, but for earnings in excess of the
25 limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be
26 individuals with respect to whom a supplemental security income is being paid under
27 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is
28 not eligible under another provision of this section shall pay a premium or other cost-
29 sharing charges according to a sliding fee scale that is based on income as established
30 by the department in regulations;

31 (13) persons under 19 years of age who are not covered under (a) of

1 this section and whose household income does not exceed 200 [175] percent of the
2 federal poverty line as defined by the United States Department of Health and Human
3 Services and revised under 42 U.S.C. 9902(2);

4 (14) pregnant women who are not covered under (a) of this section and
5 whose household income does not exceed 200 [175] percent of the federal poverty line
6 as defined by the United States Department of Health and Human Services and revised
7 under 42 U.S.C. 9902(2);

8 (15) persons who have been diagnosed with breast or cervical cancer
9 and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII).

10 * **Sec. 2.** AS 47.07.042(d) is amended to read:

11 (d) In addition to the requirements established under (a) and (b) of this section,
12 the department shall [MAY] require premiums or cost-sharing contributions from
13 recipients who are eligible for benefits under AS 47.07.020(b)(13) and (14) and
14 whose household income is between 150 and 200 [175] percent of the federal poverty
15 line. The department shall [IF THE DEPARTMENT REQUIRES PREMIUMS OR
16 COST-SHARING CONTRIBUTIONS UNDER THIS SUBSECTION, THE
17 DEPARTMENT]

18 (1) [SHALL] adopt in regulation a sliding scale for those premiums or
19 contributions based on household income that [;]

20 (i) [(2)] may not exceed the maximums allowed under
21 federal law; and

22 (ii) may not be less than two percent of the
23 recipient's household income; and

24 (2) [(3) SHALL] implement a system by which the department or its
25 designee collects those premiums or contributions.

26 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

S B

3 2

ALASKA STATE LEGISLATURE

Senate Labor and Commerce
Committee, Chair
•
Legislative Budget and Audit
Committee
•
Senate Rules Committee
•
Committee on Committees



While in Session
State Capitol, Rm. 9
Juneau, AK 99801
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Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave, Ste. 440
Anchorage, AK 99501
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Fax: (907) 269-0172

SENATOR JOHNNY ELLIS
SENATE MAJORITY LEADER

MEMORANDUM

DATE: April 6, 2009

TO: Representative Bob Herron
Representative Wes Keller
Co-Chairs, House Health and Social Services Committee

FROM: Senator Johnny Ellis

RE: Hearing Request for SB 32 – Medicaid: Home/Community Based Services

I am requesting that Senate Bill 32, "An Act relating to medical assistance payments for home- and community-based services and provision of personal care services in a recipient's home; and providing for an effective date" be scheduled for a hearing in the Senate Finance Committee at your earliest convenience. The bill passed the Senate on a unanimous vote, and I am joined by nine co-sponsors from both parties and all regions of the state.

This bill includes the providers of home- and community-based services to Alaska's senior and developmentally disabled populations in the regular rate review process afforded to providers of institutional care. Alaska has made great strides in reforming our network of support for seniors as well as for children and adults with developmental disabilities. Our long-standing state policy is to promote the least restrictive and most cost-effective forms of care, and SB32 does that by providing an equitable review process to home- and community-based service providers.

Included in this packet:

- A current version of CSSB 32 (FIN) – 26-LS0218\M
- Fiscal Notes
- Sponsor Statement
- Letters of Support
- Background Information

Thank you for your consideration. Please contact my staff Max Hensley with any questions.

ALASKA STATE LEGISLATURE

Finance Committee
•
Health & Social Services Committee
•
Legislative Council
•
Committee on Committees



While in Session
State Capitol, Rm. 103
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave
Anchorage, AK 99501
(907) 269-0169
Fax: (907) 269-0172

SENATE MAJORITY LEADER
JOHNNY ELLIS

SPONSOR STATEMENT – SENATE BILL 32

AN ACT RELATING TO MEDICAL ASSISTANCE PAYMENTS FOR HOME- AND COMMUNITY-BASED SERVICES

Senate Bill 32 creates a mechanism for regular Medicaid rate review for providers of home- and community-based services to Alaska's elderly and developmentally disabled citizens. Institutional service providers receive regular reviews in order to bring rates in line with costs.

However, home and community-based services (HCBS) have been conclusively proven to lower overall long-term Medicaid costs. One recent study in the academic journal *Health Affairs* found that states with long-established high proportions of HCBS spending saw a 3% overall decrease in long-term care spending between 1995 and 2005 as opposed to a 14.5% increase in low-HCBS states. The study concluded:

“Justifications based on financial constraints can no longer be credibly offered as reasons for forcing such people [seniors and persons with developmental disabilities] into nursing homes and other institutions. HCBS programs may be one instance in which offering people greater choice also helps reduce costs.”¹

Over the last few years, however, rates for home- and community-based services have been frozen. During that time, not only have costs increased, the medical environment – including regulations, technology, and client expectations – has shifted dramatically. These shifts threaten the continued viability of the hundreds of HCBS providers, primarily private businesses that employ thousands of Alaskans in every region of the state.

Home and community based services are the key to helping our seniors and those living with developmental disabilities live their lives as productive members of our communities while controlling the growth of health care costs. Without the regular review process in Senate Bill 32, many providers will be forced out of business and HCBS services will be taken away from thousands of Alaskans across the state.

¹ *Health Affairs* 28, no. 1 (2009): 262-272.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 3
 Bill Version: CSSB 32(FIN)
 (S) Publish Date: 3/30/09

Identifier (file name): SB032CS(FIN)-DHSS-RR-03-19-09 Dept. Affected: Health & Social Services
 Title: Medicaid: Home/Community Based Services RDU: Department Support Services
 Component: Rate Review
 Sponsor: Ellis
 Requester: Senate Finance Component Number: 2696

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services	309.3		309.3	309.3	309.3	309.3	309.3
Travel	15.0		15.0	15.0	15.0	15.0	15.0
Contractual	38.4		38.4	38.4	38.4	38.4	38.4
Supplies	1.8		1.8	1.8	1.8	1.8	1.8
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	364.5	0.0	364.5	364.5	364.5	364.5	364.5

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	182.3		182.3	182.3	182.3	182.3	182.3
1003 GF Match	182.2		182.2	182.2	182.2	182.2	182.2
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	364.5	0.0	364.5	364.5	364.5	364.5	364.5

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time	3.0		3.0	3.0	3.0	3.0	3.0
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The proposed legislation amends AS 47.07 to add payment rate provisions for Medicaid providers of personal care services and home and community-based services. This legislation would require the Department to review rates annually and set rates considering periodic cost surveys and the Centers for Medicare and Medicaid Services' home health agency inflation rate. The effective date is July 1, 2011.

(Continued on next page)

Prepared by: William J. Streur, Deputy Commissioner Phone 907-334-2520
 Division: Health Care Services Date/Time 3/19/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 3/19/2009
DHSS Finance & Management Services

FISCAL NOTE # 3

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. CSSB 32(FIN)

ANALYSIS CONTINUATION

Under this legislation, the Department would periodically survey providers to obtain cost information. There are approximately 350 home and community-based service providers , including assisted living homes, and an additional 50 personal care providers. Beginning in FY2010, the Department would need to begin developing cost surveys and providing training and technical assistance to providers as they modify their accounting systems to be able to respond to the surveys. The department needs to be able to provide this assistance to providers, so there is clear understanding of the information needed and clear definitions of cost centers; otherwise, it is likely that providers will be unable to provide accurate survey responses.

The Department would also perform some review and inspection of survey information to ensure accuracy before using survey data to set rates. Staff positions would be necessary to oversee the surveys and conduct rate setting operations. The department requires one of these position to be a supervisory level auditor to supervise staff in carrying out, and ensuring the integrity and accuracy of the new processes required by statute.

The legislation would also require the Department to prepare an annual report on the medical assistance rate payments under the new rate setting methodology through FY2014. This report would be prepared by the new rate setting staff at no additional cost.

Assumption:

Annual Personal Services:

2 Internal Auditor III positions and 1 Internal Auditor IV in the Office of Rate Review for cost surveys and rate setting - \$309.3

Annual Travel for audit staff to provide technical assistance and training to providers and receive training required by Government Auditing Standards - \$5.0 per FTE

Annual Contractual:

Office space, phones, etc. - \$12.8 per FTE

Annual Supplies - \$0.6 per FTE

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 4
 Bill Version: CSSB 32(FIN)
 (S) Publish Date: 3/30/09

Identifier (file name): SB032CS(FIN)-DHSS-SDMS-03-19-09 Dept. Affected: Health & Social Services
 Title: Medicaid: Home/Community Based Services RDU: Senior & Disabilities Services
 Component: Senior & Disabilities Medicaid Services
 Sponsor: Ellis
 Requester: Senate Finance Component Number: 2662

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	0.0*		0.0*	6,152.6	12,477.5	18,979.5	25,663.6
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	6,152.6	12,477.5	18,979.5	25,663.6

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts			3,076.3	6,238.8	9,489.8	12,831.8
1003 GF Match			3,076.3	6,238.8	9,489.8	12,831.8
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other Interagency Receipts						
TOTAL	0.0	0.0	6,152.6	12,477.5	18,979.5	25,663.6

Estimate of any current year (FY2009) cost: _____

POSITIONS

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The proposed legislation amends AS 47.07 to add payment rate provisions for Medicaid providers of personal care services and home and community-based services. This legislation would require the Department to review rates annually and set rates considering periodic cost surveys and the Centers for Medicare and Medicaid Services' home health agency inflation rate. The effective date is July 1, 2011.

Passage of this bill would likely increase Medicaid benefit costs by \$6.2 million in FY2012. Annual inflation of 2.8% each subsequent year would increase benefit costs to a projected \$25.7 by FY2015.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner Phone 907-269-7827
 Division: Health Care Services Date/Time 3/19/09 12:00 AM
 Approved by: Alison Elgee, Assistant Commissioner Date 3/19/2009
DHSS Finance & Management Services

FISCAL NOTE # 4

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. CSSB 32(FIN)

ANALYSIS CONTINUATION

This statute would affect approximately 350 businesses who are providers of home and community based services (HCBS), including residential living services. These services are delivered under four Medicaid waivers: Adults with Disabilities, Children with Complex Medical Conditions, Mental Retardation/Developmental Disabilities, and Older Alaskans. Expenditures for these waivers in FY2008 were \$141.5 million. This bill would also affect an estimated 52 businesses not included above that provide personal care services. Expenditures for personal care services in FY2008 were \$72.3 million. Total costs in FY2008 that would be subject to the rates is \$213.8 million.

HCBS and personal care providers currently have their rates or rate methodologies established in regulation. Since FY2004 all of those rates have been frozen (some longer), up until Y2009, when the legislature approved a 4-6% increase. This statute will require the Department to adjust Medicaid payment rates to HCBS and personal care providers to consider data from periodic cost surveys and the home health agency inflation rate.

ESTIMATED RATE ADJUSTMENT

This fiscal note assumes that rates are set under section 47.07.069(b)(3) applying the home health agency inflation rate (2.8%). FY2009 projected benefits of \$219.7 million (FY2008 actual costs plus 2.8%) are the baseline used to calculate the incremental costs in the fiscal note. Annual inflation adjustments of 2.8%, beginning in FY 2012, increase benefit costs by \$6.2 million the first year of implementation. By FY2015, costs increase \$25.7.

The Department has no way of estimating the impact of considering the periodic cost survey data on rates set under this bill as it does not have reliable cost survey data from providers upon which to base such an estimate. Therefore, this fiscal note does not reflect any increased or decreased cost from factoring in the cost survey data.

FUND SOURCE

Costs are eligible for the federal medical assistance percentage which is projected to be 50% in FY2012 and beyond.

* -- The legislation would not require rates increases in FY2010 or FY2011; however, any rate increases funded in those years could reduce the amount of new expenditures required to implement the bill.

Palmer Senior Citizens' Center, Inc.

Seniors helping Seniors

February 11, 2009

The Honorable Senator Johnny Ellis
Alaska State Legislature
State Capitol Building, Room #103
Juneau, Alaska 99801-1182

Dear Senator Ellis:

The Palmer Senior Citizens Center, Inc. (PSCC) wanted to express our sincere appreciation for your support and commitment to the seniors in the state of Alaska. PSCC supports your efforts to pass SB32 which will put into statute a regular review of home and community based waiver rates.

Thank you for making the time to meet with Kenneth Anderson, PSCC Board President, and Rachel Greenberg, Office Manager, on Tuesday, January 10th at 2:00.

The Palmer Senior Citizens Center, Inc. hopes that your busy schedule will allow time for you or your staff to visit us. Thank you again.

With Best Regards,

Kenneth A. Anderson

Kenneth A. Anderson
Board President

Richard G. Tubbs

Richard G. Tubbs
Executive Director





The Honorable Senator Johnny Ellis
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Ellis;

I am writing in support of SB 32 on behalf of the membership of the Alaska Behavioral Health Association. The issues of rates and the mechanism and frequency of adjusting those rates are the primary issue for our membership this year.

We support the effort to put into place rate setting mechanisms for the home and community based services and that this model will be applied to the other providers that contract with the State of Alaska to deliver services. It is difficult to manage a business that is focused on delivering health care services when the cost for reimbursement does not keep pace with inflation and cost of living. Fixed costs don't go away and agencies have been trying to meet their grant obligations while keeping the business solvent. Employers are not able to offer competitive wage and benefit packages because of insufficient reimbursement rates.

Please let me know what else our members can do to support your legislation.
Thank you.

In Health,

Steve Horn
Executive Director

Attachment



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

February 3, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 32-Ellis--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 32, authored by your Committee colleague Senator Johnny Ellis and co-sponsored by you.

SB 32 would allow annual rate reviews of all home and community based services similar to the process for hospitals. Rates for HCBS services under Medicaid have remained the same for several years, discouraging needed providers from entering the field and forcing current providers to reduce their services and cut back on clients.

As we age, many of us would prefer to stay at home or with our families but sometimes we need extra help to do so. With the growing numbers of older people who need support to live on their own, private and public organizations now offer many different options to allow us to "age in place" in our homes and communities. These options form the continuum of home and community based services, ranging from meals on wheels to adult day care. In addition to meeting our personal preferences to remain home and in our communities, HCBS services are much less expensive than institutional care.

Younger persons with disabilities are also primary users of HCBS services to allow them to continue their education, work and participate as full citizens in their communities and with their families.

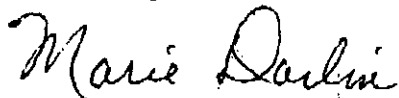
We cannot expect the providers of HCBS to continue to operate on rates often set years ago. It makes sense to review HCBS rates every year just as we do with hospitals.

AARP requests an "AYE" vote on SB 32.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-752-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson



Establish a Regular and Periodic Schedule of Rate Reviews for Home and Community-Based Services

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse and the Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority, the Alaska Brain Injury Network and the Alaska Suicide Council, have identified the establishment of a regular and periodic schedule of rate reviews for home and community based services one of their four legislative priorities for 2009. Regular and periodic rate reviews, for both Medicaid and grant-funded services, are imperative to maintaining the systems of care that serve Alaska's most vulnerable populations. The provisions for this legislation are in SB 32, sponsored by Senator Ellis.

- Before last year's rate rebasing for FY09, most home and community-based services providers had been over a decade without a rate review or increase. This resulted in an erosion of the system, as frozen rates resulted in a diminishing pool of resources – reducing the quality and availability of services.
- In FY07, home and community based services were provided to nearly 57,000 people who would have otherwise been served by costly institutional or nursing home care.
- In order for the Department of Health and Social Services (DHSS) and the State of Alaska to create and maintain a 10-year fiscal plan that adequately budgets for the costs of home and community-based services, a schedule of rate reviews is necessary.
- Our system of care for Alaskans with special needs is based on a network of non-profit providers. Without adequate funding, our providers cannot continue to provide quality services. Without our providers, we have no system of care.

Overview

Home and community-based services include a wide range of Medicaid and grant-funded services for Trust beneficiaries and other vulnerable Alaskans. Mental health care, infant learning, personal care attendant services, assisted living services, senior care, substance abuse counseling, and services for Alaskans with developmental disabilities are all examples of services provided at home or in our communities. These services maintain individuals' quality of life and reduce the need for more costly institutional, emergency and nursing home care.

For more that 10 years, providers have struggled to meet the demand for services while maintaining an acceptable quality of service because there has been no structure for reviewing the rates paid for those



February 23, 2009

Senator Bettye Davis
Chair, Senate Health and Social Services Committee

Senator Johnny Ellis
Sponsor, SB32

Senator Hoffman, Co-Chair – Senate Finance Committee
Senator Stedman, Co-Chair – Senate Finance Committee
Senator Elton, member - Senate Finance Committee
Senator Huggins, member - Senate Finance Committee
Senator Olson, member - Senate Finance Committee
Senator Thomas, member - Senate Finance Committee

I am writing this letter in support of SB32, a bill which I believe will strengthen Home and Community Based (HCB) Providers like Access Alaska and many others. We HCB providers form the backbone of Alaska's long-term care system. We HCB providers are not only the current backbone, but given our cost-effectiveness and desirability – consumers want to age in place – we are the state's answer to the long-term care dilemma.

Like hospitals and nursing homes, we are businesses with actual costs – we pay rent or mortgages, insurance, and personnel. As these costs have grown while reimbursement rates stay flat, our ability to pay workers a living wage has decreased to the point that in many communities, direct service workers can earn more working at a fast food restaurant than they can helping to care for our elders. This has limited our ability to attract workers and in some cases is creating a crisis in the long-term care system.

This is but one example of the ravages of the current rate-setting regime.

In the larger view, it is important to keep in mind that a strong HCB provider system is critical to the state's ability to meet the coming wave of long-term care users. Policy groups from the National Conference of State Legislatures to the AARP have all recommended states rebalance their Medicaid spending in favor of HCB and take advantage of new waiver and partnership opportunities, in order to meet the growing demand for Medicaid long-term care services. In many cases, Alaska has not taken advantage of these opportunities.

Alaska has the enviable position of being one of the top states in the nation in terms of balanced spending between institutional (nursing home) care and HCB care. However, the system has been strained to the point of breaking over the last several years, primarily because of the inattention to Medicaid reimbursement rates. Therefore, it makes sense that the state should do everything it can to strengthen the system.

I believe SB32 goes a long way toward doing just that. We greatly appreciate your leadership on this issue and stand ready to support its passage and implementation.

Sincerely,

Jim Beck
Executive Director
Access Alaska, Inc.

121 W. Fireweed, Suite 105
Anchorage, Alaska 99501
907-248-4777
Fax 907-248-0639
Toll free 800-770-4488
TTY 907-248-8799

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Mat Su
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Kenai
10807 Kenai Spur Highway
Kenai, Alaska 99611
907-283-7224
Fax 907-283-5993
Toll free 888-260-9336

Opening Doors to Independence
www.accessalaska.org
info@accessalaska.org



6311 DeBarr Road Suite L-2 Anchorage, AK 99504
Phone: (907) 336-3365 and Fax: (907) 336-3397

February 3, 2009

Senator John Ellis
Senator Bettye Davis
via email

Dear Senator Ellis and Senator Davis,

I am writing to support SB 32, which establishes periodic rate reviews for home and community-based services. Ensuring consistent rate increases for providers enables less expensive care for the elderly and develops a workforce aimed at the medical field.

As the second largest provider of in-home care services, we are intimately familiar with the associated challenges. The cost of doing business has increased while rates have been flat. Without entrepreneurial incentive, providing direct care may rest on the more expensive option; state-managed assisted living facilities and state-managed skilled nursing facilities

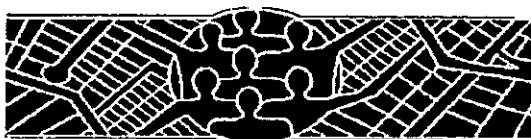
Workforce development for the medical field starts with our in-home care staff. Our Personal Care Assistants (PCA's) can receive certification and provide low level care for the elderly. Many family members and college-age PCA's get their first glimpse at the medical field.

Thank you for your support of SB 32. Please contact me with any questions. My direct line is extension 104 at (907) 336-3365.

Best regards,

A handwritten signature in black ink, appearing to be "BR", written over a circular scribble.

Brian Richardson
Chief Executive Officer



CENTER FOR COMMUNITY

700 Katlian Street, Suite B

Sitka, AK 99835

Phone: 907-747-6960

Senator Johnny Ellis
Alaska State Legislature
P.O. Box
Juneau, AK 99811

RE: Support on behalf of constituents in Sitka, Yakutat, Hoonah, Kake, Angoon, Wrangell, and Ketchikan, for SB 32, "An act relating to medical assistance payments for home and community-based services."

Center for Community is a non-profit organization that provides personal care and home and community based services throughout the services throughout South East Alaska: with clients and employees in nearly every community from Yakutat to Metlakatla. In these communities, we employ a total of 71 Southeast residents and serve 113 Southeast clients at the current time (not counting Juneau).

Senate Bill 32 will cure a long-standing problem in Alaska's Medicaid system for long term care of our seniors and other children and adults with disabilities of all kinds. SB 32 will finally ensure that the Legislature and the Administration regularly receive information about the true cost of providing care to Alaskans--at home--who are trying to avoid more expensive institutionalized long term care. SB 32 gives everyone the information necessary to make both short term budgetary and long term policy choices.

Thank you for your introduction of Senate Bill 32. If we can do anything to further legislative support for passage of SB 32, please call upon us.

Sincerely

Connie J. Sipe, Executive Director
Center for Community

csipe@cfc.org

(Sitka Headquarters Office: 747-6960)

AGENET'S 2009 Legislative Priorities

The Association of Alaska's Providers of Services to Older Alaskans

Contact Information: Marianne Mills (463-6154) or Ken Duff (262-6331)

1. Support legislation, such as SB 32, which would put into statute a regular review of Home and Community-Based Medicaid Waiver rates similar to the process for institutions (hospitals, nursing homes).

- Services available to persons eligible for the Home and Community-Based (HCB) waiver program include meals, transportation, chore, respite, care coordination, adult day services, specialized medical supplies/equipment and home modifications.
- These services are provided for a fraction of the cost of institutionalized care to older Alaskans in their own homes and traditional communities.
- Investing in home and community-based care is the most cost effective way to provide long-term care while supporting local communities throughout the state.
- Regular rate reviews will provide parity with hospitals and nursing homes which have had a similar statute in place since 1999.
- Regular rate reviews will provide a good management tool for the Department of Health and Social Services to determine program costs, budget adequately, and create a 10-year fiscal plan.

2. Work with the legislature to adjust grant rates with a \$2 million increment for Family Caregivers, Nutrition, Transportation & Support Services grants.

- Senior grants help pay for home and community-based services for senior citizens who are not eligible for the HCB Medicaid Waiver program, services such as meals, rides, adult day, chore, respite, care coordination, and health promotion.
- Investing in senior grants upfront save millions of dollars the State would otherwise pay for expensive institutional care (nursing homes). In Alaska, the cost of one month's stay in a nursing home is \$10,000-\$20,000 per senior (compare this to a package of grant services for only \$61 to \$83 per month).
- Alaska's long term care policy is aimed at allowing Older Alaskans to remain at home for as long as possible; these grants help them remain at home, saving the state money, and also support the unpaid work of their family caregivers, work which has been valued at \$534 million in Alaska.
- In July 2009, a regional funding formula will shift senior grant monies out of seven (of nine) regions of the State, jeopardizing local communities from providing much-needed services; this shift will happen even though senior populations in all regions are still increasing and as the costs for food, fuel and workers increase.
- The proposed \$2 million increase in senior grants will help ensure that all regions of the State receive adequate funding to continue senior grant services so that seniors may remain in their traditional communities.



Alzheimer's
Resource of Alaska

Senator Bert Stedman
Senator Lyman Hoffman
Co-Chairs Senate Finance Committee
Alaska State Legislature
Capitol Building
Juneau, Alaska 99801

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fax 907-561-3315
Toll-free in Alaska
800-478-1080

Fairbanks Services
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Fairbanks, AK 99707
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fax 907-457-3376

Juneau Services
3100 Channel Drive
Suite 19
Juneau, AK 99801
phone 907-586-6044
fax 907-586-6084

Mat-Su Valley Services
Trinity Barn Plaza
P.O. Box 4406
Palmer, AK 99645
phone 907-746-3413
fax 907-746-3412

www.alzaska.org

March 2, 2009

Senators Stedman & Hoffman,

The Alzheimer's Disease Resource Agency of Alaska (ADRAA) formally requests your support of the CS for Senate Bill 32 which has just been referred to the Senate Finance Committee and is currently awaiting a hearing date. As you are aware, CSSB 32 would regulate rate review for medical assistance payments for home and community based (HCB) personal care services for providers working in personal and assisted living homes. Currently, no such review is regularly mandated for HCB or Assisted Living Care, although facility based providers such as nursing homes are reviewed regularly to keep up with the growing population served and accurate information regarding cost of care.

The Alzheimer's Resource of Alaska provides in home care services for individuals affected by Alzheimer's disease and related dementias and for frail elders. In FY08, we provided 57,452 hours of services statewide. The services provided include personal care, respite for family caregivers, and household chores such as meal preparation, snow shoveling, and chopping wood. It is the work of unpaid family caregivers as well as professional in home workers that allows elders to remain in their homes, and their communities rather than being placed in full time nursing care at great cost to the state.

ADRAA thanks the bill's sponsor and co-sponsors for their foresight on this issue and for their continued support of seniors across Alaska. We enthusiastically support SB 32 which would strengthen the existing infrastructure of home and community based services and would allow for the best possible outcome for both our clients and employees.

Sincerely,

Dulce Nobre
Executive Director

cc: Senator Johnny Ellis
Senator Charlie Huggins
Senator Bettye Davis
Senator Donald Olsen

cc: Senator Joe Thomas
Senator Kim Elton
Senator Joe Paskvan

The least among us

Alaska's developmental disabilities providers look for allies in the state government

By Brendan Joel Kelley

THIS COMING SATURDAY, on his Fox News program *Geraldo at Large*, Geraldo Rivera is devoting the show to the long waiting lists where people with developmental disabilities languish while waiting to receive services.

"The waiting list is, in essence, the new institution," Rivera told a Pennsylvania blogger associated with The Arc, a national network of service providers for the developmentally disabled. "It's imprisoning in some ways, handicapping the families of the developmentally disabled, really handcuffing them in ways that put tremendous stress and strain on their lives."

Though it's doubtful that Alaska will be mentioned on the show, our state also maintains a list of developmentally disabled people who are eligible for services but aren't receiving them due to inadequate funding. Each year the Department of Health and Social Services prepares a report on this list, and the report for 2008 is due any day now. When the last annual report was released last December, there were 943 individuals on the waiting list. They've been waiting for services an average of 3.7 years.

At the beginning of December, a couple of weeks before Republican Governor Sarah Palin released her budget, state Senator Johnny Ellis (D-Anchorage) wrote Palin a letter asking her to address the waiting list, known officially as the Developmental Disabilities Registry.

"During your time on the campaign trail with Senator John McCain as the Vice Presidential nominee, I was very pleased to hear you speak on multiple occasions about the problems faced by special needs children in our country," Ellis wrote. He then pointed out that as of October 1, the registry contained 993 individuals, mostly between the ages of 4 and 17. "I respectfully request that you do your very best to provide the funding necessary to fully eliminate the Waitlist," Ellis continued, before asking Palin to include funding recommended by the governor's Ad

Hoc Committee, on the DD Registry in her budget.

But that money wasn't included in the budget that Palin released on December 15. And for service providers in the developmental disabilities community, the waiting list is far from the only problem. Organizations like The Arc of Anchorage, Hope Community Resources, and many other home and community-based service providers are barely afloat financially, because the rates at which they're reimbursed aren't commensurate with the actual costs.

Ellis is hoping to change that with a bill he'll introduce in the next legislative session. The bill would evaluate reimbursement rates for home and community-based service providers annually.

"THE NUMBER ONE THING we want [the legislature] to do is establish a regular rate review process for how they pay us," says Gwendolyn Lee, executive director of The Arc of Anchorage. "The current system is not equitable."

Even if the waiting list were eradicated by sufficient funding from the state, Lee says, it would bring those people to a service provider system "that's weakened in its ability to deliver high quality services, and can't find the workers to meet the needs of the existing people."

At The Arc, which offers a large variety of services to those with developmental disabilities, under-funding has resulted in high turnover despite cost-cutting measures. "We have deferred maintenance; we have cut health insurance; we do not give raises; we ask people to do more," Lee says. "We are stretched; the rubber band is truly stretched."

Simply put, The Arc can only afford to hire workers at the lowest possible wages, making for high turnover and training costs. This means that the person with a disability has a constant revolving door of people coming and going from their life, each one having to learn the individual's critical issues, health issues, and personality nuances. "It's really depressing for the staff who are trying to deliver quality if they're constantly hiring and retraining people to do the very basics," Lee says.

There's a real danger to not addressing the financial concerns of home and community-based

"... this would be a real opportunity for Sarah Palin and myself and other legislators from both sides of the aisle to work together and put our money and our commitment where our mouths are. And I expect that she will, I just hope that we do enough to help those people that need the help the most."

—State Senator Johnny Ellis

rates were as low as 9 percent, while only a couple categories gathered responses from over 50 percent of the providers, due to the complexity of the audits.

Meanwhile, hospitals and nursing homes are reimbursed for their costs based on an annual rate review, which is what the home and community-based developmental disabilities providers are asking for. The difference between the two groups, Ellis says, is that "frankly, hospitals and nursing homes have powerful lobbyists in Juneau. These community-based services have never been joined together in a really organized group and have never really had effective lobbyists to get what they need.

"I'm going to put this bill in to the legislature, but it's a really difficult bill to get through, to do what the service providers want—regular rate review and adjustment. I've said to them that they need to create a coalition of people all over the state, clients and service providers and workers to say, 'we need the same thing that the hospitals and nursing homes have.' I think maybe the time has come."

IT'S NOT JUST GERALDO RIVERA that's put the spotlight on the issues the developmental disabilities community faces.



Gwendolyn Lee, Executive Director of The Arc of Anchorage: "It all comes down to how we think about our fellow human beings."

these community services no longer provide these services because they can't afford to, based on the poor reimbursement from the state and/or the feds under Medicaid, then there will be people without services in the community who will have to be institutionalized at greater public expense and more human tragedy."

"It all comes down to how we think about our fellow human beings," Lee says. "Do we have an attitude that the least of these is the most important, and everyone is entitled to fair access to basic community life?"

SIX YEARS AGO, THE STATE realized that the system for reimbursing service providers was flawed and froze the reimbursement rates while studying the issue. Last year, for the first time, the legislature granted an increase in rates, which varied according to the type of services provided. But there is still no mechanism in place for rates to keep up with inflation and cost of living increases.

To study the problem, the state hired an auditing firm, Myers and Stauffer, which attempted to analyze the service providers' costs versus reimbursements. The technique that the firm used, however, was unwieldy for many of the smaller sized organizations that provide services for the developmentally disabled.

"I don't think they got great participation," Ellis says. Indeed, some of the provider response

president, telling families with special needs children that they would find an ally in her, while she held her baby boy Trig, who has Down syndrome.

"I understand that statement," Lee says. "As a parent of a new child with disabilities, it's easy to say 'I feel your pain, I understand your situation, I'll work to improve it.' It's easier said than done to really be an advocate. She is in a very different position than a lot of our families that may not have the circle of support that she has. I think that every family that heard that statement is watching now. We are now anxious to work with her to make that her legacy. It's an incredible opportunity for her, but she has to be willing to do it."

"This morning I heard Governor Palin say that we need to tighten our belts," says Ann WingQuest, The Arc of Anchorage's director of public affairs. "We're beyond tightened anymore. It frightens me when I hear her say that, because we have been so weakened and so stretched. She did say that we're not supposed to look to the government to make us healthy; the problem with our population is that their health care needs are not something that they elected. It wasn't like they were smoking and drinking and becoming obese. These are genetic or birth defects or whatever, and they need help."

Ellis is also looking to the governor to stand by what she campaigned on. "[Palin] got a lot of acclaim on the campaign trail as an advocate for kids with disabilities, not just kids with Down syndrome, but kids with disabilities. Now it's time to live up to that, and I'm hoping and inviting the governor to work with me to pare down the waiting list for DD services, to consider the bill on rate adjustment for DD providers and other community-based service providers. So this would be a real opportunity for Sarah Palin and myself and other legislators from both sides of the aisle to work together and put our money and our commitment where our mouths are. And I expect that she will, I just hope that we do enough to help those people that need the help the most."

There's still a chance that agencies such as The Arc and their advocates in the legislature might get their wishes. Governor Palin's communications director Bill McAllister says, "all of this is pending. The Department of Law is evaluating the rate re-basing issue. And the wait list is under review in the [Department of Health and Social Services] commissioner's office." ♦

bjk@anchoragepress.com

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

December 8, 2009

Representative Wes Keller
600 East Railroad, Suite 1
Wasilla, AK 99654

Dear Representative Keller:

The Alaska Commission on Aging (ACoA) is pleased to present to you our FY2011 legislative priorities for the upcoming session. These top issues were identified with input from older Alaskans, family caregivers, providers, and senior advocates statewide. The ACoA is a state agency under the Department of Health and Social Services, established in 1982. Our charge is to plan, educate and advocate on behalf of all older Alaskans (persons aged 60 years and older) through inter-agency collaboration so that Alaska seniors/elders may lead useful and meaningful lives with dignity and independence and have access to quality services when seniors need them to remain safely in their homes and chosen communities for as long as possible.

- 1. Establish a regular and periodic schedule of rate reviews for home- and community-based services** that serve persons who are Medicaid-eligible and meet nursing home level of care. This measure will promote ongoing awareness of the true costs of providing services. SB 32, sponsored by Senator Johnny Ellis, passed the Senate and the House Health and Social Services Committee last session and waits to be scheduled for a hearing in House Finance. ACoA encourages passage of this legislation.
- 2. Eliminate, or alternatively, adjust the cap on adult dental services reimbursed by Medicaid** to provide program benefits that keep pace with higher health care costs due to inflation, and **allow Medicaid patients access to two-years program benefits in a single year** to permit scheduling of treatment around the oral health care needs of the patient. The current law places a statutory \$1,150 limit on dental health care expenditures per eligible client. When the Medicaid Adult Dental program was created in 2005, this amount was sufficient to pay for one half of a set of dentures, either an upper or lower, with the idea that a patient who needed dentures could have both sets if the treatment was scheduled around the turn of the fiscal year. Although health care costs continue to rise, the cap has not been increased in three years. Allowing Medicaid patients access to two years of program benefits in a single year furnishes Alaskans and their dentists the flexibility needed to provide treatment addressing oral health emergencies that can occur at any time.
- 3. Provide increased operating and capital funding to establish an Alaskan Public Transportation Fund for operations of local coordinated transportation systems** which the State can use to leverage additional federal funds to improve accessible, affordable transportation for older Alaskans, persons with disabilities, low-income individuals, youth and others without access to transportation so that Alaskans with special needs may have greater access to employment and community participation opportunities. According to the Governor's Coordinated Transportation Task Force Report (2009), Alaska is one of only three states in the nation that does not provide any specific state funding for public transportation.
- 4. Provide operating funding to enhance the Aging and Disability Resource Centers**, administered under the Division of Senior and Disabilities Services, to streamline access to more efficient information and referral services by providing eligibility screening, options counseling, and assessments so that Alaskans can make informed decisions and have access to long-term care services through a "one-stop shop," reducing confusion and program fragmentation.

SEAN PARNELL, GOVERNOR

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Mat
Keep in file
SB 32
HSS hearings

5. Return to the original wording of AS 47.07.020 (b) (6), the Medicaid statute establishing income eligibility for persons requiring nursing home level of care, referencing 300% of the maximum Supplemental Security Income (SSI) benefit rate rather than the current frozen dollar amount (\$1,656 a month) to reflect changes in cost of living so that seniors and other Medicaid-eligible persons will not be disqualified for services, including home- and community-based waiver services, due to small increases to their Social Security and other benefits. The amount of \$1,656 is the monthly amount of 300% of SSI in 2003. The 2009 income equivalent is \$2,022 monthly.

We also want to take this opportunity to share with you highlights from the Alaska Elder/Senior Community Forums that we hosted in Kotzebue (August) and Anchorage (December) to increase understanding about the issues that are of most importance to older Alaskans and to identify unmet needs. These forums, to be held in other locations statewide in the coming year, are being conducted to gather public input that will be used to develop the next Alaska State Plan for Senior Services, FY2012-2016. This document, prepared every four years, provides the State with a guide for delivering senior services and meets the requirement of the U.S. Administration on Aging for the state to access funding from the Older Americans Act which provides federal funding for a range of senior programs. Although these forums will be ongoing, Anchorage and Kotzebue participants identified the following issues as the most important:

- Provide improved access to quality and affordable health care, long-term supports that include home- and community-based services in communities where older Alaskans live, and promote disease prevention and wellness programs;
- Promote financial security, increase affordable senior housing, and improve elder safety;
- Provide safe, dependable, and affordable coordinated community transportation services so that seniors/elders can get to medical appointments and remain actively engaged in their communities;
- Enhance information and assistance services to help individuals access long-term support services and make informed decisions regarding their care.

Upon retirement, more seniors are choosing Alaska as their lifelong home to be close to family, friends and the unique Alaskan lifestyle. For the first time, Alaska is now the state with the fastest growing senior population, according to the U.S. Administration on Aging (2008), replacing Nevada, which held that position for many years. Alaska is home to approximately 80,000 persons aged 60 years and older who comprise about 12% of the state's population (Alaska Department of Labor). Alaska's senior population is expected to increase by four to six percent each year through 2020, as baby boomers become of age, by which time the total number of seniors will grow by almost 64 percent. The oldest Alaska seniors, 85 and older, are expected to triple during the next 25 years, vastly increasing the number of Alaskans living with Alzheimer's disease and related disorders.

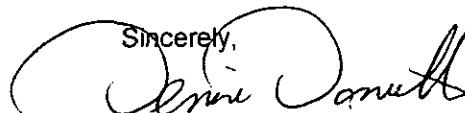
Please feel free to contact Denise Daniello, ACoA's executive director (465-4879 or denise.daniello@alaska.gov) for additional information about these issues or with any questions concerning Alaska's senior population.

The Alaska Commission on Aging will be meeting in Juneau February 10th-12th, 2010 and hopes to schedule a meeting with you to discuss our priorities in person. We look forward to working with you this legislative session. We appreciate your consideration of these advocacy priorities and thank you for your support of services for older Alaskans.

Sincerely,


Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,


Denise Daniello
ACoA Executive Director



*Matt
file SB 13/32*

Alaska Native Health Board
1840 Bragaw Street, Suite 220 | Anchorage, AK 99508
www.anhb.org

The Alaska Native Health Board (ANHB) represents 25 tribal health organizations serving approximately 130,000 Alaska Native and American Indian individuals. These priorities will be the focus of ANHB state advocacy for Fiscal Year 2011.

EXECUTIVE SUMMARY OF ANHB 2011 STATE PRIORITIES

- Full funding for Village Safe Water (VSW) projects.
 - More than 6,000 homes in rural Alaska don't have safe drinking water.
 - Lack of safe water and sanitation creates major health problems, including higher rates of respiratory tract infections, meningitis, pneumonia, and serious ear and blood infections.
 - The State should fund its share of VSW projects at last year's budgeted level.
- Strengthen Medicaid, Denali Kidcare and related programs.
 - Tribal long-term care and behavioral health projects will serve Alaska Native Medicaid beneficiaries at the 100% federal payment percentage. It makes financial sense for the State to invest in these tribal projects and to set reasonable payment rates for them.
 - S.B.13 will raise Denali Kidcare eligibility to 200% of federal poverty level (FPL) for certain children and pregnant women. Alaska is one of only five states with SCHIP eligibility levels below 200% of the FPL. This will bring Alaska in line with national standards.
 - S.B. 32 will require annual review of Medicaid Home & Community Based Services (HCBS) and Personal Care Attendant (PCA) rates. Medicaid rates for services to Alaska Native Elders and vulnerable persons should be at a level that covers actual costs.
- Strengthen domestic violence, sexual assault, and child abuse/neglect programs. Alaska Natives suffer high rates of domestic violence, sexual assault and child abuse/neglect.
 - Alaska's reported rate of forcible rape is over two and a half times the national average.
 - The rate of sexual assaults against Alaska Native women in Anchorage for 2000-2003 was over 7 times greater than for White women.
 - In Alaska State Trooper cases, predominantly in rural areas with a high percentage of Alaska Natives, 94% of all sexual assault victims are 15 years of age or younger.
- Strengthen behavioral health and substance abuse programs.
 - Alaska's suicide death rate is nearly twice the national average. The suicide death rate for Alaska Natives is over three times greater than for Alaska Whites.
 - Alaska's binge and heavy drinking rates are among the highest in the nation. However, there is no statistical difference between the rates for Alaska Natives and non-Natives.
 - Over 40% of Alaska Natives smoke, which is twice the rate for non-Natives, and Alaska Natives are disproportionately represented among the 600 Alaskans who die each year from the effects of tobacco use or secondhand smoke, e.g. lung cancer and heart disease. Thus there is a great need for tobacco program and funding support for tribal health providers.
- Strengthen healthcare workforce development initiatives.
 - S.B. 139 will create a healthcare loan repayment & employment incentives program.
 - Other health workforce initiatives are needed, including strengthening WWAMI, the State visa waiver program, and the Nat'l Health Service Corp loan repayment program.



SUMMARY OF ALASKA TRIBAL HEALTH CHALLENGES

WATER AND SANITATION.

- Over 6,000 (mostly Alaska Native) homes in rural Alaska don't have safe drinking water.
- Infants in Alaska Native villages with limited water service are hospitalized for pneumonia at 11 times the rate for all U.S. infants.
- Southwest Alaska suffers some of the highest rates of meningitis, pneumonia and serious ear and blood infections in the world, primarily associated with lack of in-home water.

VILLAGE BUILT CLINICS.

- The IHS' Village Built Clinic (VBC) Lease Program is designed to fund rent, utilities, insurance, janitorial, and maintenance costs of healthcare facilities in over 150 rural Alaska communities. Despite the dramatic increase in the costs of providing fuel, utilities and other necessities, funding has not materially increased since 1996.
- In 2007, VBC lease payments covered less than 60% of village clinic operating costs, which have continued to skyrocket in rural Alaska, mostly due to heating and utility costs.
- Without adequate funding, Tribes have had to cannibalize funding from critical health programs, defer maintenance and repairs, reduce clinic operations and lay off health staff.

DOMESTIC VIOLENCE, SEXUAL ASSAULT, AND CHILD ABUSE AND NEGLECT.

- 75% of Alaska Native women are physically and/or sexually assaulted during their lifetime.
- Alaska has the highest reported rate of sexual assault in the United States. Within Alaska, Alaska Natives are victimized 3 to 4 times more frequently than others.
- Alaska's child sexual assault rate is 6 times the national average.
- In Alaska State Trooper cases, which are mostly in rural areas with a high percentage of Alaska Natives, 94% of sexual assault victims are 15 years of age or younger.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE.

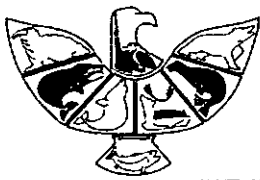
- Alaska's statewide suicide death rate is nearly twice the national average.
- Within Alaska, the Alaska Native suicide death rate is three times greater than for Whites.
- Alaska's binge and heavy drinking rates are among the highest in the nation. Alaska's rate of alcohol-related deaths is three times the national average.
- Alaska ranks second in the nation in use of illicit drugs for those 12 years of age and older.

HEALTH WORKFORCE RECRUITMENT AND RETENTION.

- The Alaska health workforce vacancy rate is over 10% and growing, particularly for hard-to-fill positions in rural areas, almost all of whom are "safety net" providers that deliver care primarily to Medicaid, CHIP, and Medicare beneficiaries, and to the uninsured.
- Tribal health program vacancy rates exceed statewide rates across the board, typically by 150-200%. The average time it takes for a Tribal health provider to fill a physician vacancy is 14 months, at an average cost \$131,000 (including locum tenens costs).

CANCER.

- Cancer is the leading cause of death among Alaska Natives.
- Contributing factors are late diagnosis and poor access to both screening and treatment.
- The Alaska Native five-year cancer survival rate is just over half the overall U.S. survival rate.
- Alaska Native women have the highest cancer death rate of all U.S. racial and ethnic groups.



The Alaska Native Health Board (ANHB) represents 24 Tribes and tribal health organizations, which serve approximately 130,000 Alaska Native customer-owners.

**Alaska Tribal Health Talking Points for the November 5, 2009
WHITE HOUSE TRIBAL NATIONS CONFERENCE**

INDIAN HEALTH CARE IMPROVEMENT ACT. The best way to strengthen tribal health is to reauthorize the Indian Health Care Improvement Act (H.R. 2706 and S. 1790). We urge the Administration to fully support IHCIA reauthorization. The new bills contain the tools needed by tribal health programs to narrow Alaska Native health disparities gaps through improvements or authorization in the areas of:

- Access to Medicaid, SCHIP and Medicare resources
- Long-term care, elder care and chronic disease care
- Health facility and water & sanitation projects
- Domestic violence, sexual assault, and child abuse prevention
- Behavioral health and substance abuse prevention
- Health profession and health workforce development

HEALTHCARE REFORM. First and foremost, the Administration should honor the trust responsibility to Tribes. In healthcare reform, this means (1) assuring that reform legislation fully supports and protects the Indian health delivery system; (2) assuring that tribal health programs have full opportunity to participate in and benefit from reform; and (3) acknowledging and respecting Tribes as sovereign governments. We urge the Administration's support for:

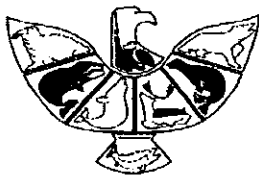
- The Indian-specific provisions contained in the Senate Finance Committee bill
- The Indian-specific provisions prepared by the House Natural Resources Committee Chair
- General provisions in both the House and Senate bills that will benefit tribal health with regard to improving sustainability, strengthening public health and preventive services, and strengthening the tribal health workforce

INDIAN HEALTH SERVICE APPROPRIATIONS. We urge the Administration's continued support for critical tribal health needs, including:

- The Indian Health Service Village-Built Clinic lease program
- The Alaska Dental Health Aide Therapy (DHAT) program
- Tribal Self-Governance contract support cost shortfalls
- Construction of basic water & sanitation infrastructure and healthcare facilities
- Domestic violence, sexual assault, and child abuse & neglect programs
- Behavioral health and substance abuse programs
- Staffing packages for the new Nome and Barrow hospitals

NON-INDIAN HEALTH APPROPRIATIONS THAT IMPACT TRIBAL HEALTH. Because of years of inadequate IHS funding, tribal health programs have had to seek support for basic programs from non-IHS agencies, for which we urge the Administration's full support:

- Denali Commission partners with Tribes on sanitation, energy, and facility projects
- HRSA Community Health Center programs support many village health clinics
- Department of Agriculture Rural Water & Waste Disposal and High Energy Cost programs support basic water and sanitation and energy needs in many Alaska Native villages
- EPA American Indian Environmental Office supports many tribal environmental projects



The Alaska Native Health Board (ANHB) represents 25 tribal health organizations serving approximately 130,000 Alaska Native and American Indian individuals. These priorities will be the focus of ANHB federal advocacy for Fiscal Year 2011.

EXECUTIVE SUMMARY OF ANHB 2011 FEDERAL PRIORITIES

- Permanent reauthorization of the Indian Health Care Improvement Act. We urge the Administration and Congress to support permanent IHCA reauthorization, which will empower and advance tribal health programs in the following areas:
 - Alternate resource systems, including payor of last resort provisions; Medicaid and SCHIP enrollment, coverage and payment; and Veterans Affairs support for tribal health providers.
 - Authorization for tribal long-term care, elder care and chronic disease programs.
 - Workforce development programs and Indian health professions.
 - Long-term care, Elder care, and chronic disease programs.
 - Facilities and sanitation programs, including maintenance & improvement.
 - Domestic violence, sexual assault, and child abuse & neglect programs.
 - Behavioral health and substance abuse and prevention programs.
- Healthcare reform. We urge the Administration and Congress to support the provisions in the House and Senate reform bills that will help tribal health programs narrow the Alaska Native/American Indian health disparities gaps. First and foremost, the government should honor the trust responsibility to Tribes. In the context of healthcare reform, this means:
 - Assuring that reform legislation fully supports and protects the Indian health system.
 - Assuring that tribal health programs fully participate in and benefit from reform.
 - Acknowledging and respecting Tribes as sovereign governments.
- Full funding for Indian Health Service appropriations. We urge the Administration and Congress to use Self-Governance as the preferred tribal funding mechanism for the following critical needs:
 - The Indian Health Service Village-Built Clinic lease program.
 - The Dental Health Aide Therapy (DHAT) program.
 - Tribal Self-Governance contract support costs.
 - Construction of basic water & sanitation infrastructure and healthcare facilities.
 - Behavioral health and substance abuse programs.
 - Domestic violence, sexual assault, and child abuse & neglect programs.
 - Staffing packages for the new Nome and Barrow hospitals.
- Non-Indian Health Service appropriations that greatly impact tribal health. Because of inadequate IHS funding, tribal health programs have sought support from certain non-IHS programs. We urge the Administration and Congress to fully support the:
 - Denali Commission, which partners with Tribes on sanitation, energy, and facility projects.
 - HRSA Community Health Center program, which supports tribally-operated village clinics.
 - Department of Agriculture Rural Water & Waste Disposal and High Energy Cost programs, which support basic water, sanitation and energy needs for Tribes.
 - EPA American Indian Environmental Office, which supports tribal environmental projects.
- "Title VI" legislation will extend the efficiencies and flexibilities of Tribal Self-Governance to all of Department of Health & Human Services. We urge support for Title VI legislation.

SB

101

Alaska State Legislature

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Senator Bettye Davis

Senate Bill 101, 26-LS0524\A

"An Act relating to questionnaires and surveys administered in the public schools."

Sponsor Statement

SB 101 will provide for more student participation in school questionnaires and surveys administered or required by Alaska school districts and the Department of Education and Early Development, while at the same time constitutionally protecting the privacy rights of parents and students and also complying with the federal Protection of Pupil Rights Amendment (PPRA), 20 U.S.C., section 1322h.

With the exception the anonymous Youth Risk Behavior Survey noted in new subsection AS 14.03.110(g) which has been administered biennially since 1991 by the United States Centers for Disease Control and Prevention, SB 101 provides that a school district may not administer a survey, anonymous or not, that inquires into personal or private family affairs of the student not a matter of public record or subject to public observation unless written permission is first obtained from the student's parent or legal guardian. SB 101 provides in AS 14.03.110(e) that a student may still "refuse to answer specific questions" or to participate in the survey.

SB 101 changes subsection AS 14.03.110(e) by requiring that parents who do not want their children to participate in an anonymous survey, must "opt out" or "actively dissent" to participation with written denial of permission submitted to the teacher or principal. SB 101 effectively changes parental consent to anonymous surveys under the current statute from "active" to "passive" consent, *i.e.*, implied consent without written objection. Notice, however, is still required and permission for anonymous surveys can be obtained by school districts annually under the unchanged provision of AS 14.03.110(b).

The 2-week notice requirements under AS 14.03.110(b),(c) remain unchanged, but revised subsection AS 14.03.110(d) under SB 101 requires more information in the notice than current provisions in recognition of the need for more attention to constitutional due process in matters of student privacy. Changes require more information about the nature and content of the survey, the date, sponsor, school contacts, and opportunity to refuse participation in a questionnaire or survey.

Changes under SB 101 comport with the original legislative intent of the school survey statute before it was changed in 1999. The current statute, which requires "active" parental consent for youth to participate in anonymous school surveys requires that parents must acknowledge both permission and denial in writing. SB 101 requires only that parents deny permission in writing to anonymous surveys. Surveys which are not anonymous or that delve into personal or private matters still require parental written consent for permission for students to participate with the exception of AS 14.03.110(g) regarding the Youth at Risk Behavior Survey noted above. The need for statutory changes under SB 101 follow:

It has been found that "active" parental consent overburdens the public school system and drastically increases the costs and labor involved in conducting student surveys. Moreover, "active" consent greatly reduces overall participation by students, because many parents simply are non-responsive. While studies have found that the vast majority of parents would consent to students participating in school surveys, non-response is more often due to apathy, oversight, and student omission or error, rather than parental refusal. Many districts are unable to use the data they collect because there are not enough participants for statistical validation. Some surveys such as the Youth Risk Behavior Survey cannot be validated with less than 60% participation, as occurred in Alaska in 2005. Lack of participation may also reduce federal funding.

School surveys provide reliable and valuable measures of population-based information on youth which helps policy makers, educators, program planners, and parents to better understand health and social issues that affect students' prospects for program success. Standardized surveys such as the Youth Risk Behavior Survey track trends over time and help guide and evaluate important health and prevention programs. State and federal grant programs which rely on these surveys include tobacco prevention and control, obesity prevention, diabetes, heart disease and stroke, safe and drug free schools and other substance abuse prevention, injury prevention, including violence and suicide prevention, HIV and STD prevention, and more.

AMENDMENT

OFFERED IN THE HOUSE
TO: SB 101

BY REPRESENTATIVE SEATON

- 1 Page 2, lines 23 - 24:
- 2 Delete "guardian notice of the survey"
- 3 Insert "legal guardian notice of the survey as provided under (d) of this section at least
- 4 two weeks before the survey is administered"

Alaska State Legislature

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Senator_Betty_Davis@legis.state.ak.us
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Senator Betty Davis

Senate Bill 101, 26-LS0524A

"An Act relating to questionnaires and surveys administered in the public schools."

Sectional Summary

Note: this sectional summary should not be considered an authoritative interpretation of the bill, as the bill itself is the best statement of its contents.

Section 1. Amends AS 14.03.110(a) to require a school district to obtain written permission to administer a questionnaire or survey, anonymous or not, with the exception of the Youth Risk Behavior Survey, as provided in Section 4 in new subsection AS 14.03.110(g).

Section 2. Repeals and reenacts AS 14.03.110(d) to require a school district provide to a student's parent or legal guardian written notice of a questionnaire or survey with detailed information as to the date, contents, sponsor, contacts at the school district, opportunity to review the questionnaire or survey, description of how to submit written permission or denial of permission to participate, including an anonymous or specific questionnaire or survey.

Section 3. Amends AS 14.03.110(e) to allow a student to participate but to refuse to "answer specific questions." Subsection (e) also requires that a parent or legal guardian may refuse to allow the student to participate in a specific questionnaire or survey "by submitting to the teacher or school principal a written denial of permission for the student's participation."

Section 4. Adds a new subsection AS 14.03.110(g) which provides that if a school district administers the Youth Risk Behavior Survey provided by the United States Centers for Disease Control and Prevention, written permission of the student's parent or legal guardian is not required, but the school district shall provide parents notice of the survey and the opportunity to submit to the teacher or school principal a written denial of permission to take the survey.

Note: Subsections AS 14.03.110(b) and (c) remain unchanged as to annual permission and two weeks notice for anonymous surveys under (b), and written permission and two weeks notice for surveys which are not anonymous under (c).

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB101
() Publish Date: _____

Identifier (file name): SB101-EED-TLS-3-15-10 Dept. Affected: Education & Early Develo
Title "An Act relating to questionnaires and surveys administered RDU Teaching & Learning Support
in public schools." Component School & Student Achievement
Sponsor Senator Davis
Requester House Health & Social Services Component Number 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This legislation has no fiscal impact on the Department of Education and Early Development

Prepared by: Paul Prussing, Deputy Director
Division: Teaching & Learning Support
Approved by: Larry LeDoux
Commissioner

Phone 465-8721
Date/Time 3/15/10 12:00 AM
Date 3/15/2010

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB 101
 Bill Version: _____
 () Publish Date: _____

Identifier (file name): SB101-EED-ESS-3-06-09 Dept. Affected: EED
 Title "An Act relating to questionnaires and surveys administered in the public schools." RDU Teaching & Learning Support
 Component School & Student Achievement
 Sponsor Sen. Davis
 Requester Senate Education Committee Component Number 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

There is no fiscal impact on the Department of Education and Early Development.

Prepared by: Paul Prussing, Deputy Director
 Division Teaching & Learning Support
 Approved by: Larry LeDoux
Commissioner

Phone 465-8721
 Date/Time 3/6/09 12:00 AM
 Date 3/6/2009

Sec. ▶14.03.110◀. Questionnaires and surveys administered in public schools.

(a) A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into personal or private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or legal guardian.

(b) For an anonymous questionnaire or survey, written permission required under (a) of this section may be obtained annually and is valid until the commencement of the subsequent school year or until the parent or legal guardian who gave permission submits a written withdrawal of permission to the school principal. The school shall provide each student's parent or legal guardian at least two weeks' notice before administering a questionnaire or survey described under this subsection.

(c) If a school administers to a student a questionnaire or survey that is not anonymous, the school shall obtain the written permission required under (a) of this section from the student's parent or legal guardian at least two weeks before the questionnaire or survey is administered.

(d) The school shall give a student's parent or guardian an opportunity to review the questionnaire or survey described under (b) or (c) of this section and shall give the parent or guardian written notice regarding

- (1) how the questionnaire or survey will be administered to the student;
- (2) how the results of the survey or questionnaire will be used; and
- (3) who will have access to the questionnaire or survey.

(e) A student may refuse to participate in a questionnaire or survey administered in a public school. A student's parent or legal guardian may refuse to allow the student to participate in a specified questionnaire or survey.

(f) In this section, "questionnaire or survey" means a list of questions to, or information collected from, a class or group of students.

Bill Hogan
Commissioner
P.O. Box 110601
Juneau, AK 99811-0601
www.hss.state.ak.us



Fact Sheet

COMMISSIONER'S OFFICE

January 7, 2010

FOR IMMEDIATE RELEASE:

Fact Sheet: 2009 Alaska Youth Risk Behavior Surveys

What is the Youth Risk Behavior Survey (YRBS)?

The Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system that was established in 1990 by the federal Centers for Disease Control and Prevention (CDC). It was developed to monitor health risk behaviors among youth that contribute markedly to the leading causes of death, disability, and social problems of youth and adults in the United States. These behaviors are often established during childhood and early adolescence:

- Tobacco use;
- Unhealthy dietary behaviors;
- Inadequate physical activity;
- Alcohol and other drug use;
- Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; and
- Behaviors that contribute to unintentional injuries and violence.

What is the purpose of the YRBS?

- Determine the prevalence of health-risk behaviors;
- Assess whether health-risk behaviors increase, decrease, or stay the same over time;
- Provide comparable national, state and local data;
- Provide comparable data among subpopulations of youth; and
- Monitor progress toward achieving national and state health goals and other program indicators.

How long has Alaska participated in the YRBS?

The YRBS high school survey was first implemented at the national level in 1990. Since that time, the CDC has sponsored national surveys from 1991 to the present on an every-other-year basis. Alaska first participated in the YRBS in 1995 and obtained representative statewide data. Due to external factors, the YRBS was not administered in 1997. It was administered in 1999; however the Anchorage School District did not participate. Without Anchorage the data were not representative of the state as a whole. The survey was administered in 2001, but unfortunately low student response rates rendered the data unusable. Districts indicated that the new requirement for signed (active) parental permission in 2001 was the primary reason for the low response rate. In 2003 the survey was administered statewide with active parental consent and representative data were obtained,

making this the first statewide YRBS representative sample since 1995. The survey was again administered in 2005, however the response rate fell just below the target and the data was not used. In 2007 and in 2009, the survey was administered and achieved an adequate response rate, yielding important survey results.

What is the difference between active and passive consent?

Alaska's active parental consent law, AS 14.03.110, prohibits public schools from administering surveys or questionnaires that ask about personal or family affairs, or anything else that is not a matter of public record or readily observable in public, without first getting written permission from all participating students' parents or legal guardians (opt in). This law holds regardless of whether a survey is anonymous or not. Alaska is one of a few states in the nation that has a school survey law requiring active parental consent for surveys of this type. Most states employ passive parental consent when administering such anonymous surveys. Passive parental consent involves notifying and informing the parents about the survey and assuming that students will participate unless the parent provides a written refusal to opt out of the survey.

Two statewide surveys were conducted in 2009:

Traditional High Schools - The YRBS survey of regular (traditional) public high schools (excluding private schools, boarding schools, alternative schools and correctional facilities) was conducted as usual. A two-stage sample design was used to select the actual students for participation. The first stage consisted of selecting schools. Schools were selected with probability proportional to the size of their enrollment. Once a school was selected, classes were selected as the second stage. Eligible classes were those where a student would be enrolled in one and only one class at a time – second period or required English, for example. This gave each student an equal opportunity of being selected. A school district, individual school, student, or student's parent could decline participation at any time.

This YRBS survey was completed by 1,373 students from 43 traditional high schools that were scientifically selected to be included in the survey. The school response rate was 91 percent and the student response rate was 64 percent, resulting in an **overall response rate of 62 percent**. The CDC has determined that the overall response rate must be 60 percent or greater in order for the data to represent the high school population of the state. Therefore, these survey results represent 33,271 students from grades 9 through 12 in traditional public high schools.

Alternative High Schools - For the first time, a statewide YRBS survey of high school students in Alaska's alternative schools was conducted. Fifteen alternative schools were chosen to be included in the survey and 1,020 students completed the survey. The school response rate was 100 percent and the student response rate was 71 percent, resulting in an overall response rate of 71 percent.

Alternative schools serving at-risk students are excluded from traditional statewide YRBS surveys per CDC guidelines. Although one national Alternative School YRBS was conducted in 1998, revealing significantly elevated risk behavior among this population, no further national YRBS surveys of alternative schools have been conducted. Since Alaska's Department of Education and Early Development (EED) presently manages several federal grants that require it to direct services and resources to Alaska's most at-risk student/youth populations, it became essential to conduct a statewide alternative schools YRBS to determine if our state's alternative schools profiled consistently with the national alternative schools. Our data indicates Alaska alternative schools report similar levels of risk behavior to the National Alternative Schools Survey of 1998. The results

of this survey provides EED with the credible data it needs to best direct its at-risk initiatives, to determine the level of risk behaviors present in this student population, to advocate for needed supports, and to measure any progress made in decreasing student risk behaviors as a result of its interventions. It is anticipated these data will also be invaluable to Alaska's alternative schools on a local level as they seek to provide empirical evidence for any needed additional resources.

How was the survey administered?

The YRBS survey is voluntary and anonymous. For all classes, teachers or proctors were given a script to read to students that established guidelines for student privacy and anonymity and the importance of the survey. Each student was given an unmarked envelope in which to seal his or her survey before turning it in. These survey envelopes remained sealed until received at a central state collection site. The CDC and a CDC contractor analyzed the state survey data for both the traditional high schools and the alternative high schools.

A national YRBS is also conducted every other year. The 2009 national results will not be available until early summer 2010. As a result, 2007 National YRBS results are being used for comparison purposes.

How are the data used?

The results of the YRBS are used to detect changes in risk behaviors over time and provide an important piece of program planning and evaluation, curriculum development and decision-making regarding the use of available resources. The information from the YRBS can be used to help schools and communities identify strengths and weaknesses in current programs and services. Additionally, the results can be used by schools and communities when applying for grant funding to initiate or maintain programs that serve youth.

Who supported the YRBS in Alaska?

The YRBS in Alaska is a cooperative effort between the state departments of Health and Social Services and Education and Early Development. The survey is also endorsed by the following groups and boards:

- Association of Alaska School Boards
- Alaska Parent Teacher Association (PTA)
- Alaska Action for Healthy Kids
- All Alaska Pediatric Partnership
- American Heart Association, Pacific/Mountain Affiliate
- American Lung Association of Alaska
- American Cancer Society, Alaska
- Alaska Health Education Consortium
- Alaska Tobacco Control Alliance
- Alaska Native Tribal Health Consortium

Contacts: Greg Wilkinson, DHSS, (907) 269-7285, Cell (907) 382-7032
Ann Potempa, DHSS, (907) 269-7957, Cell (907) 240-9158
Terri Campbell, DEED, (907) 465-8719
Todd Brocious, DEED, (907) 465-2887

###

Response to questions during HHSS hearing 2/11/10 on SB 101 – Questionnaires and Surveys in Public Schools.

1. Copy of 1995 YRBS Survey (See attached) *(in back of packet)*

2. Cost to School Districts to reach the minimum of 60% validity threshold for representative data.

There is no direct cost to school districts to reach the validity threshold, other than contribution of staff time and often copying and postage. School districts receive incentive funding, depending on their size, between \$800 and \$30,000 per district. The total state expenditure in 2009 was approximately \$90,000 (which included the special Alternative School Survey). In addition, some districts receive supplemental money from their community coalitions. The \$90,000 was made up of a combination of federal funding from the YRBS grant and a special contribution of \$20,000 from the Division of Behavioral Health and \$50,000 as a one-time contribution from the Alaska Mental Health Trust.

3. Impact on grants of failure to meet the minimum of 60% statistical validity.

We do not have evidence of loss of federal funding for inadequate response rate to YRBS. What we can provide is examples of the program and grant dollar amounts used at the state level that rely on YRBS data.

- DHSS/Division of Public Health/CDC Tobacco Program funding : approximately \$1.6 million per year
- Dept. of Education & Early Development (DEED)/CDC HIV Prevention funding: \$275,000 per year
- DEED/Federal funding: Up until recently, the Title IV Safe and Drug-Free Schools and Community Program funds (formerly \$1.7 million) relied on YRBS – however, this program has been eliminated. It is anticipated that it will be replaced with a new program (focusing on Positive School Climate) which will likely be competitive and it would be difficult to compete with other states without YRBS data with the majority of states that do have YRBS data.
- DHSS/Division of Behavioral Health Programs/Federal Funding:
 - Federal Substance Abuse Prevention and Treatment Block Grant (\$4.8 million approx. per year) has required national outcome measures using YRBS
 - Alaska Youth Suicide Prevention Project, US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). \$500,000 per year x 3 years (1.5 million)
 - SAMHSA's Strategic Prevention Framework State Incentive Grant, five-year, \$11.5 million grant
- Comprehensive Mental Health Plan: \$106,000 from the Alaska Mental Health Trust

Other programs/efforts that rely on the YRBS data:

- Overall tracking progress on State Health Plan (Healthy Alaskans 2010) – approximately 16 measures.
- DEED/No Child Left Behind (NCLB) requirements to collect data captured in the YRBS remain in place and DEED has no other established mechanism to gather this data. Building a new instrument would be costly and labor intensive, and DEED presently lacks the infrastructure to accomplish this and would no doubt run in to the same challenges as YRBS faces.
- Alaska’s Plan to Reduce and Prevent Underage Drinking - without the YRBS data we will lose our baseline data to show we are making change.
- DHSS State Epidemiological Outcomes Workgroup contract deliverables relies heavily on YRBS data.
- Alaska Obesity Prevention Plan

Other large community grants:

- 7 SAMSHA grants directly to community coalitions

District level grants:

- One of the eligibility requirements for school districts to apply for state Tobacco Prevention Grants (\$800,000) is to collect local YRBS data.
- A query is in process to determine how else school districts have used the data to leverage additional funding. Responses so far have mentioned being able to get grant funding for school counselors to address the needs identified by YRBS.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 12, 2009

SUBJECT: Written denial of permission (SB 101;
Work Order No. 26-LS0524\A)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel 

Eddy Jeans asked about the necessity of sec. 3 in the above referenced bill. Section 3 amends existing law in AS 14.03.110(e) to require written denial of permission by a parent or guardian for a student survey. Without the addition of written denial in subsection (e), existing law would be inconsistent with the new subsection (g) that requires written denial of permission for the Youth Risk Behavior Survey (YRBS) contained in sec. 4.

If I may be of further assistance, please advise.

JMM:ljw
09-153.ljw

(c) Nothing in this section limits the ability of a peace officer, chief administrative officer, or other appropriate person, acting in compliance with local, state, or federal laws, to search a locker or other container provided in a public or private school by the school district. (§ 5 ch 33 SLA 1995)

Sec. 14.03.110. Questionnaires and surveys administered in public schools.

(a) A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into personal or private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or legal guardian.

(b) For an anonymous questionnaire or survey, written permission required under (a) of this section may be obtained annually and is valid until the commencement of the subsequent school year or until the parent or legal guardian who gave permission submits a written withdrawal of permission to the school principal. The school shall provide each student's parent or legal guardian at least two weeks' notice before administering a questionnaire or survey described under this subsection.

(c) If a school administers to a student a questionnaire or survey that is not anonymous, the school shall obtain the written permission required under (a) of this section from the student's parent or legal guardian at least two weeks before the questionnaire or survey is administered.

(d) The school shall give a student's parent or guardian an opportunity to review the questionnaire or survey described under (b) or (c) of this section and shall give the parent or guardian written notice regarding

- (1) how the questionnaire or survey will be administered to the student;
- (2) how the results of the survey or questionnaire will be used; and
- (3) who will have access to the questionnaire or survey.

(e) A student may refuse to participate in a questionnaire or survey administered in a public school. A student's parent or legal guardian may refuse to allow the student to participate in a specified questionnaire or survey.

(f) In this section, "questionnaire or survey" means a list of questions to, or information collected from, a class or group of students. (§ 1 ch 23 SLA 1979; am §§ 1, 2 ch 63 SLA 1999)

Opinions of attorney general. — AS 14.03.110 — Behavior Risk Survey does not impermissibly invade the domain of the student's private 'family' affairs. September 28, 1998 Op. Att'y Gen. (Issued before 1999 amendment to this section.)

Sec. 14.03.115. Access to school records by parent, foster parent, or guardian.

Upon request of a parent, foster parent, or guardian of a child under 18 years of age who is currently or was previously enrolled in a municipal school district or a school district that is a regional educational attendance area, the school district shall provide a copy of the child's record. This section does not apply to

- (1) a record of a child who is an emancipated minor; or
- (2) record information that consists of the child's address if the school district determines that the release of the child's address poses a threat to the health or safety of the child. (§ 1 ch 36 SLA 1999)

Sec. 14.03.120. Education planning; reports. (a) A district shall annually file with the department, and make available to the public, a report that

- (1) establishes district goals and priorities for improving education in the district;
- (2) includes a plan for achieving district goals and priorities; and

From: Jeans, Eddy (EED) [mailto:eddy.jeans@alaska.gov]
Sent: Wednesday, March 11, 2009 11:49 AM
To: Thomas Obermeyer
Cc: Herman, Marcy J (EED)
Subject: FW: SB 101

Here is our question for SB102. 101

What is the intent of section 3? Since the ability for students to refuse is already covered in section 2 (8) and families to opt out/opt in to other surveys is covered in section 2 (7) we think it is unnecessary. (Written denial is also covered in section 4 which is specific to YRBS.)

Here are the responses to the questions at the hearing.

Statistics on parental consent for YRBS:

Data from the statewide survey from the last time the YRBS was administered (2007) showed that (after intense efforts to collect forms), in general 69-70% of parents provided written permission, 10-11% of parents declined permission, the remaining 20% of parents did not respond. (It is the non-responders that affect the survey the most). These rates vary by school and district – contact individual school districts for more information on their local YRBS survey experience.

How is the student identity protected?

The YRBS survey is an anonymous and voluntary survey. The survey has been designed to protect each student's privacy. Students do not put their name or any other identifier, or the name of their class or school on the survey. The teacher or proctor is given special instructions and a script to follow and are also required to sign an *Assurance of Confidentiality Form* which is returned to the Department of Health and Social Services.

When students finish the survey, they place their answer sheet in a privacy envelope and seal it shut. The envelopes are then placed in a big box or envelope for returning to the state.

Just another FYI:

The Protection of Pupil Rights Amendment only applies to "required" surveys. (See CDC Parental Permission and the YRBS, 2006)

Let me know if you need any more information.

Patty Owen
School Health/YRBS Coordinator

PO Box 110614
Juneau, AK 99811-0614
phone 907-465-2768 fax 907-465-2770
Toll Free 1-888-465-3140
email: Patricia.Owen@alaska.gov

These risk behaviors among high school students¹ ...

Unintentional Injuries and Violence

- 12% Rarely or never wore a seat belt
- 21% Rode with a driver who had been drinking alcohol, during the past month
- 20% Carried a weapon during the past month
- 28% Were in a physical fight during the past year
- 9% Attempted suicide during the past year

Alcohol and Other Drug Use

- 33% Drank alcohol during the past month
- 22% Reported episodic heavy drinking during the past month²
- 23% Used marijuana during the past month
- 7% Ever used cocaine
- 10% Ever used inhalants
- 21% Ever used prescription drugs without prescription

Sexual Behaviors

- 44% Ever had sexual intercourse
- 11% Had sexual intercourse with ≥ 4 people
- 30% Had sexual intercourse during the past three months
- 5% Did not use a condom during last sexual intercourse³

Tobacco Use

- 48% Ever tried cigarette smoking
- 16% Smoked cigarettes during the past month
- 5% Smoked cigarettes on ≥ 20 days during the past month
- 14% Used smokeless tobacco during the past month
- 10% Smoked cigars during the past month

Dietary Behaviors

- 83% Ate fruits and vegetables < 5 times/day during the past 7 days
- 20% Drank soda or pop one or more times a day during the past 7 days (not including diet soda or pop)

Physical Activity

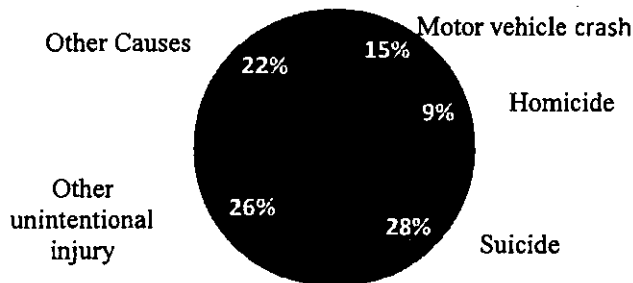
- 58% Did not meet currently recommended levels of physical activity⁴
- 54% Did not attend physical education class
- 82% Did not attend physical education class daily

Overweight

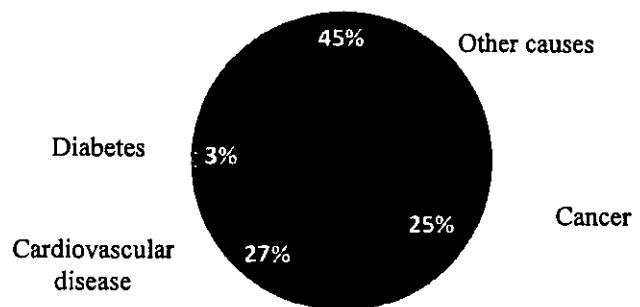
- 14% Were overweight⁵
- 12% Were obese⁵

... contribute to these leading causes of death⁷

Youth Aged 10-24 Years



Adults Aged 25 Years and Older



- ¹ High school students grades 9-12 in Alaska excluding alternative schools and boarding schools, weighted data.
- ² Students who had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the past 30 days
- ³ Among students who had sexual intercourse during the past 3 months.
- ⁴ Students who were not physically active for a total of at least 60 minutes per day on 5 or more days of the past 7 days.

- ⁵ Students who were at or above the 85th percentile but below the 95th percentile for body mass index by age and sex.
- ⁶ Students who were at or above the 95th percentile for body mass index by age and sex.
- ⁷ 2004-2006 Alaska mortality data, Centers for Disease Control and Prevention.

For more information visit www.hss.state.ak.us/dph/chronic

Or call 1-888-465-3140

The Alaska Youth Risk Behavior Survey is a joint project between the Department of Health and Social Services and the Department of Education & Early Development in cooperation with the Centers for Disease Control and Prevention



2009 Youth Risk Behavior Survey (YRBS) Results

These risk behaviors among alternative high school students¹ ...

Unintentional Injuries and Violence

- 14% Rarely or never wore a seat belt
- 30% Rode with a driver who had been drinking alcohol, during the past month
- 28% Carried a weapon during the past month
- 46% Were in a physical fight during the past year
- 11% Attempted suicide during the past year

Alcohol and Other Drug Use

- 57% Drank alcohol during the past month
- 43% Reported episodic heavy drinking during the past month²
- 51% Used marijuana during the past month
- 29% Ever used cocaine
- 20% Ever used inhalants
- 49% Ever used prescription drugs without prescription

Sexual Behaviors

- 82% Ever had sexual intercourse
- 43% Had sexual intercourse with ≥ 4 people
- 66% Had sexual intercourse during the past three months
- 79% Did not use a condom during last sexual intercourse³

Tobacco Use

- 87% Ever tried cigarette smoking
- 58% Smoked cigarettes during the past month
- 34% Smoked cigarettes on ≥ 20 days during the past month
- 18% Used smokeless tobacco during the past month
- 28% Smoked cigars during the past month

Dietary Behaviors

- 80% Ate fruits and vegetables < 5 times/day during the past 7 days
- 31% Drank soda or pop one or more times a day during the past 7 days (not including diet soda or pop)

Physical Activity

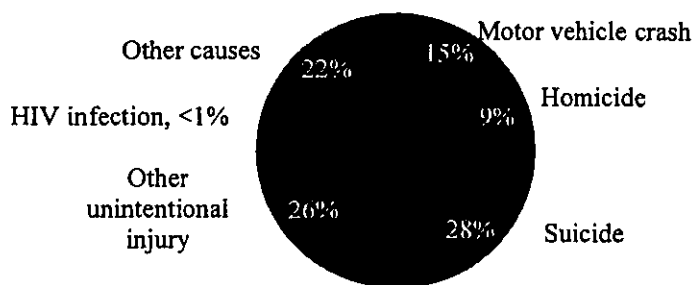
- 80% Did not meet currently recommended levels of physical activity⁴
- 71% Did not attend physical education class
- 87% Did not attend physical education class daily

Overweight

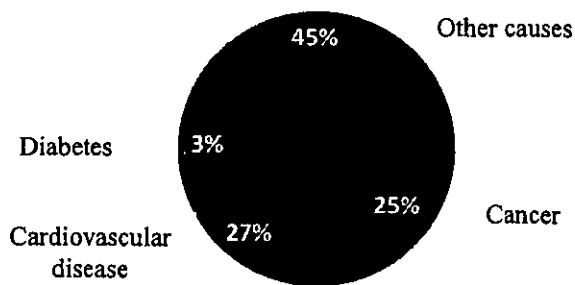
- 18% Were overweight⁵
- 19% Were obese⁶

... contribute to these leading causes of death⁷

Youth Aged 10-24 Years



Adults Aged 25 Years and Older



¹ Alternative high school students grades 9-12 in Alaska, weighted data.
² Students who had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the past 30 days
³ Among students who had sexual intercourse during the past 3 months.
⁴ Students who were not physically active for a total of at least 60 minutes per day on 5 or more days of the past 7 days.

⁵ Students who were at or above the 85th percentile but below the 95th percentile for body mass index by age and sex.
⁶ Students who were at or above the 95th percentile for body mass index by age and sex.
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For more information visit www.hss.state.ak.us/dph/chronic

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The Alaska Youth Risk Behavior Survey is a joint project between the Department of Health and Social Services and the Department of Education & Early Development in cooperation with the Centers for Disease Control and Prevention



Sample-Questions

2009 Alaska Youth Risk Behavior Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to develop better health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

8. During the past 12 months, how would you describe your grades in school?
- A. Mostly A's
 - B. Mostly B's
 - C. Mostly C's
 - D. Mostly D's
 - E. Mostly F's
 - F. None of these grades
 - G. Not sure

E. 6 or more times

The next 4 questions ask about safety.

9. **When you rode a bicycle during the past 12 months, how often did you wear a helmet?**
- A. I did not ride a bicycle during the past 12 months
 - B. Never wore a helmet
 - C. Rarely wore a helmet
 - D. Sometimes wore a helmet
 - E. Most of the time wore a helmet
 - F. Always wore a helmet
10. How often do you wear a seat belt when riding in a car driven by someone else?
- A. Never
 - B. Rarely
 - C. Sometimes
 - D. Most of the time
 - E. Always
11. During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times
12. During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times

18. During the past 12 months, how many times were you in a physical fight?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or 7 times
 - F. 8 or 9 times
 - G. 10 or 11 times
 - H. 12 or more times
19. During the past 12 months, how many times were you in a physical fight in which you were injured and had to be treated by a doctor or nurse?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times
20. During the past 12 months, how many times were you in a physical fight on school property?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or 7 times
 - F. 8 or 9 times
 - G. 10 or 11 times
 - H. 12 or more times
21. During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?
- A. Yes
 - B. No
22. Have you ever been physically forced to have sexual intercourse when you did not want to?
- A. Yes
 - B. No

The next question asks about bullying. **Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.**

23. During the past 12 months, have you ever been bullied on school property?
- A. Yes
 - B. No

The next 5 questions ask about sad feelings and attempted suicide. **Sometimes people feel so depressed about the future that they may consider attempting suicide, that is, taking some action to end their own life.**

24. During the past 12 months, did you ever feel so sad or hopeless almost every day for **two weeks or more in a row** that you stopped doing some usual activities?
- A. Yes
 - B. No
25. During the past 12 months, did you ever **seriously** consider attempting suicide?
- A. Yes
 - B. No
26. During the past 12 months, did you make a plan about how you would attempt suicide?
- A. Yes
 - B. No
27. During the past 12 months, how many times did you actually attempt suicide?
- A. 0 times
 - B. 1 time
 - C. 2 or 3 times
 - D. 4 or 5 times
 - E. 6 or more times

33. During the past 30 days, how did you usually get your own cigarettes? (Select only one response.)
- A. I did not smoke cigarettes during the past 30 days
 - B. I bought them in a store such as a convenience store, supermarket, discount store, or gas station
 - C. I bought them from a vending machine
 - D. I gave someone else money to buy them for me
 - E. I borrowed (or bummed) them from someone else
 - F. A person 18 years old or older gave them to me
 - G. I took them from a store or family member
 - H. I got them some other way
34. During the past 30 days, on how many days did you smoke cigarettes on school property?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
35. Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?
- A. Yes
 - B. No
36. During the past 12 months, did you ever try to quit smoking cigarettes?
- A. I did not smoke during the past 12 months
 - B. Yes
 - C. No
37. During the past 30 days, on how many days did you use chewing tobacco, snuff, or dip, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
38. During the past 30 days, on how many days did you use chewing tobacco, snuff, or dip on school property?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
39. During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?
- A. 0 days
 - B. 1 or 2 days
 - C. 3 to 5 days
 - D. 6 to 9 days
 - E. 10 to 19 days
 - F. 20 to 29 days
 - G. All 30 days
40. During the past 7 days, on how many days were you in the same room with someone who was smoking cigarettes?
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
 - G. 6 days
 - H. 7 days

- B. Slight risk
- C. Moderate risk
- D. Great risk

The next 5 questions ask about marijuana use. Marijuana also is called grass or pot.

- 49. During your life, how many times have you used marijuana?
 - A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 to 99 times
 - G. 100 or more times

- 50. How old were you when you tried marijuana for the first time?
 - A. I have never tried marijuana
 - B. 8 years old or younger
 - C. 9 or 10 years old
 - D. 11 or 12 years old
 - E. 13 or 14 years old
 - F. 15 or 16 years old
 - G. 17 years old or older

- 51. During the past 30 days, how many times did you use marijuana?
 - A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times

- 52. During the past 30 days, how many times did you use marijuana on school property?
 - A. 0 times
 - B. 1 or 2 times
 - C. 3 to 9 times
 - D. 10 to 19 times
 - E. 20 to 39 times
 - F. 40 or more times

- 53. How much do you think people risk harming themselves (physically or in other ways), if they smoke marijuana regularly?
 - A. No risk
 - B. Slight risk
 - C. Moderate risk
 - D. Great risk

- A. Yes
- B. No

- 64. How old were you when you had sexual intercourse for the first time?
 - A. I have never had sexual intercourse
 - B. 11 years old or younger
 - C. 12 years old
 - D. 13 years old
 - E. 14 years old
 - F. 15 years old
 - G. 16 years old
 - H. 17 years old or older

- 65. During your life, with how many people have you had sexual intercourse?
 - A. I have never had sexual intercourse
 - B. 1 person
 - C. 2 people
 - D. 3 people
 - E. 4 people
 - F. 5 people
 - G. 6 or more people

- 66. During the past 3 months, with how many people did you have sexual intercourse?
 - A. I have never had sexual intercourse
 - B. I have had sexual intercourse, but not during the past 3 months
 - C. 1 person
 - D. 2 people
 - E. 3 people
 - F. 4 people
 - G. 5 people
 - H. 6 or more people

- 67. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
 - A. I have never had sexual intercourse
 - B. Yes
 - C. No

- 68. The last time you had sexual intercourse, did you or your partner use a condom?

The next 9 questions ask about food you ate or drank during the past 7 days. Think about all the meals and snacks you had from the time you got up until you went to bed. Be sure to include food you ate at home, at school, at restaurants, or anywhere else.

74. During the past 7 days, how many times did you drink **100% fruit juices** such as orange juice, apple juice, or grape juice? (Do not count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)
- A. I did not drink 100% fruit juice during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
75. During the past 7 days, how many times did you eat **fruit**? (Do not count fruit juice.)
- A. I did not eat fruit during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
76. During the past 7 days, how many times did you eat **green salad**?
- A. I did not eat green salad during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
77. During the past 7 days, how many times did you eat **potatoes**? (Do not count french fries, fried potatoes, or potato chips.)
- A. I did not eat potatoes during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
78. During the past 7 days, how many times did you eat **carrots**?
- A. I did not eat carrots during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day
79. During the past 7 days, how many times did you eat **other vegetables**? (Do not count green salad, potatoes, or carrots.)
- A. I did not eat other vegetables during the past 7 days
 - B. 1 to 3 times during the past 7 days
 - C. 4 to 6 times during the past 7 days
 - D. 1 time per day
 - E. 2 times per day
 - F. 3 times per day
 - G. 4 or more times per day

The next 6 questions ask about physical activity.

83. During the past 7 days, on how many days were you physically active for a total of **at least 60 minutes per day**? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.)
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
 - G. 6 days
 - H. 7 days
84. On an average school day, how many hours do you watch TV?
- A. I do not watch TV on an average school day
 - B. Less than 1 hour per day
 - C. 1 hour per day
 - D. 2 hours per day
 - E. 3 hours per day
 - F. 4 hours per day
 - G. 5 or more hours per day
85. On an average school day, how many hours do you play video or computer games or use a computer for something that is not school work? (Include activities such as Nintendo, Game Boy, PlayStation, Xbox, computer games, and the Internet.)
- A. I do not play video or computer games or use a computer for something that is not school work
 - B. Less than 1 hour per day
 - C. 1 hour per day
 - D. 2 hours per day
 - E. 3 hours per day
 - F. 4 hours per day
 - G. 5 or more hours per day

86. In an average week when you are in school, on how many days do you go to physical education (PE) classes?
- A. 0 days
 - B. 1 day
 - C. 2 days
 - D. 3 days
 - E. 4 days
 - F. 5 days
87. During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?
- A. I do not take PE
 - B. Less than 10 minutes
 - C. 10 to 20 minutes
 - D. 21 to 30 minutes
 - E. 31 to 40 minutes
 - F. 41 to 50 minutes
 - G. 51 to 60 minutes
 - H. More than 60 minutes
88. During the past 12 months, on how many sports teams did you play? (Include any teams run by your school or community groups.)
- A. 0 teams
 - B. 1 team
 - C. 2 teams
 - D. 3 or more teams

The next 3 questions ask about other health-related topics.

89. Have you ever been taught about AIDS or HIV infection in school?
- A. Yes
 - B. No
 - C. Not sure
90. Has a doctor or nurse ever told you that you have asthma?
- A. Yes
 - B. No
 - C. Not sure
91. Do you still have asthma?

96. During an average week, on how many days do you take part in organized after school, evening, or weekend activities (such as school clubs; community center groups; music, art, or dance lessons; drama; church; or cultural or other supervised activities)?

- A. 0 days
- B. 1 day
- C. 2 days
- D. 3 days
- E. 4 days
- F. 5 days
- G. 6 days
- H. 7 days

97. Do you agree or disagree that you feel alone in your life?

- A. Strongly agree
- B. Agree
- C. Not sure
- D. Disagree
- E. Strongly disagree

98. Do you agree or disagree that in your community you feel like you matter to people?

- A. Strongly agree
- B. Agree
- C. Not sure
- D. Disagree
- E. Strongly disagree

99. Do you agree or disagree that your school has clear rules and consequences for behavior?

- A. Strongly agree
- B. Agree
- C. Not sure
- D. Disagree
- E. Strongly disagree

**This is the end of the survey.
Thank you very much for your help.**



Planned Parenthood[®] of the Great Northwest

March 9, 2009

The Honorable Bettye Davis
Alaska State Senate
State Capitol, Rm 30
Juneau, AK 99801-1182

Dear Senator Davis:

On behalf of Planned Parenthood of the Great Northwest (PPGNW), I'm writing in support of Senate Bill 101, "*An Act relating to questionnaires and surveys administered in the public schools.*"

Planned Parenthood relies on the results of the school-based Alaska Youth Behavior Risk Survey to determine where our efforts should be in terms of education and STI prevention programs. For accurate survey results it's critical to get as many survey responses as possible. Planned Parenthood recognizes that the current regulations of active parental consent for anonymous surveys decrease the response rate significantly.

Senate Bill 101 will increase the accuracy of the vital information Planned Parenthood and many other organizations rely on to serve Alaska's young people. Thank you for addressing this issue.

Sincerely,

Clover Simon
Vice President of Alaska
Planned Parenthood of the Great Northwest
(907) 770-9705
clover.simon@ppgnw.org

Planned Parenthood of the Great Northwest
Alaska Administrative Office - 4001 Lake Otis Pkwy
Anchorage, AK 99508



**Position Statement on SB 101
Relating to Questionnaires and Surveys in Public Schools**

AASB member districts need school-by-school data to increase student achievement and accurately assess the effectiveness of current programs. Since passage of HB 70 in 1999, schools have been unable to obtain an adequate sample of student information to provide reliable information. AASB supports modifying the requirements for parental or legal guardian permission for a student to participate in a questionnaire or survey administered in a public school.



Healthy Alaska

Youth Risk Behavior Survey (YRBS) Nationally and in Alaska

January 2007

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YRBS - Nationally

The Youth Risk Behavior Survey (YRBS) is the largest and most respected source of data on the youth risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems in the US. The YRBS was created by the Division of Adolescent School Health, Center for Disease Control, and representatives from more than 800 local, state, and federal health agencies in 1990. The YRBS measures behaviors that fall into the following 6 categories: Behaviors that result in unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors that result in HIV infection, other STDs, and unintended pregnancies, dietary behaviors, physical activity.

YRBS - How Can This Short Survey Collect the Vital Behavioral Information We Need?

Amazingly, nationally 71% of all deaths for persons 10-24 years of age are due to only 4 causes: motor vehicle crashes, other unintentional injuries, homicide, and suicide. In addition, 800,000-900,000 teenaged girls become pregnant each year and an estimated 3 million STDs occur among persons ages 10-19. A limited number of behaviors usually established during youth contribute substantially to these causes of mortality and morbidity. These behaviors include: carrying a weapon, physical fighting, attempting suicide, drinking or using drugs while operating a motor vehicle, lack of seatbelt use while riding in a motor vehicle, lack of helmet use while riding a bicycle, and unprotected sexual intercourse that results in HIV infection, other STDs, or unintended pregnancies.

The Youth Risk Behavior Survey also surveys youth on the leading causes of adult morbidity and mortality as many individuals initiate the risk behaviors that lead to problems as adults in their adolescence. Among adults in the US aged 25 and older, 63% of deaths are due to only 2 causes: cardiovascular disease and cancer. A limited number of causes contribute to these health problems. These behaviors include: use of tobacco, unhealthy dietary behaviors, and physical inactivity.

YRBS - How it Works

The YRBS is administered in a collection of randomly drawn sample schools from nearly every state every other year. The survey is administered to high school aged students in a single class period and is completely anonymous. Some school districts choose to survey all of their high school students to better understand and measure risk behaviors in their communities. Strict precautions are in place to absolutely insure student confidentiality and participation in the survey is completely voluntary. Students answer the multiple choice questions about their current and past risk behaviors, which are collected and sent to the state for processing. State results are then shared federally with CDC.

YRBS - The Value

The YRBS results have tremendous value at the national, state, and local level. Results allow health and educational professionals to track the prevalence of youth risk behaviors over time, to compare their state to other states or to the nation, and even to empower local communities to measure themselves compared to the rest of the state. Understanding the extent to which youth practice health risk behaviors is critical for developing programs that address risk behaviors practiced in their jurisdiction and for measuring progress toward program goals. YRBS results also help with focusing school health education teacher training and instructional programs, supporting health-related legislation, and seeking funding for school health programs.

Alaska's YRBS

Alaska managed to collect enough student responses to the YRBS to get usable data twice since it began administering the survey in 1995. CDC determined that at least 60% of students in the selected sample must complete the survey for it to accurately represent student behavior across the entire state. Alaska was able to get 60% or more responses in 1995 and in 2003. In 2005, Alaska missed achieving an adequate response rate and was unable to use the data. Every effort is being made for a successful survey in 2007.

Here is a sample of Alaska 2003 YRBS data:

- 11.8% of high school boys reported carrying a weapon to school in the last 30 days
- 38.7% of high school students reported drinking alcohol in the last 30 days
- 47.5% of high school students reported having ever used marijuana
- 1 in 4 high school students reporting driving in a vehicle with a driver who drank alcohol in the last 30 days
- 1 in 5 high school girls reported seriously considering suicide in the last 12 months

For more information visit <http://www.hss.state.ak.us/dph/chronic/school/pubs/YRBSreport2003.pdf>.

DEAR PAT,

I am a health teacher who recently heard that Alaska has a law that requires parental consent for youth health surveys at school. I occasionally utilize classroom surveys with my students and now am concerned if I am following protocol. Is this true, and if so, what should I do?
Signed, Alarmed in ABC School

Dear Alarmed in ABC School,

Alaska has had a law, AS 14.03.110, since 1999 that prohibits schools from administering surveys or questionnaires at public schools that inquire into personal or family affairs, or anything else that is not a matter of public record or readily observable in public (regardless of whether or not the surveys are anonymous and voluntary) without first getting written permission from all participating students' parents or legal guardians. This type of requirement is known as active parental consent.

According to the Centers for Disease Control Alaska is one of two or three states in the nation that has a school survey law requiring active parental consent for surveys that are anonymous and voluntary. Most states employ passive parental consent when administering such surveys. Under this system, written notice is sent out to parents informing them of the upcoming survey and the types of questions it will ask, and then permission to participate is assumed unless parents or students indicate otherwise. With passive parental consent all students and parents can decline to participate at any point in the process.

Classroom teachers need to be aware of this law as it applies to small informal surveys teachers may want to include in their instruction as well as to national surveys like the YRBS. Many teachers are surprised to learn of this law and its requirements, and are forced to revisit some of their current instructional assignments and practices to avoid violations. Teachers should check with their school administrators for further guidance.

Addressing active consent is a controversial topic. Advantages to active parental consent are greater parental involvement and less risk of students being included in surveys without parental approval. Disadvantages of active parental consent include the drastically increased costs and labor involved in conducting student surveys, the high failure rates for getting enough student responses to get usable data for larger surveys, the potential for leading to inaccurate/misrepresentative data, the research suggesting that the vast majority of parents consent to their students participating in such surveys, and that most parental failures to provide written permission are driven by apathy, oversight, or student error, not by refusal.

As a health teacher you can do several things to support collections of important health data for local, state and national use. First you can communicate with your site administrator to see if consent for surveys is built into your school's annual parental enrollment packet. Second, you can incorporate lessons on the YRBS into your curriculum, highlighting its findings and its importance. Student health projects could focus on raising community awareness and support for the YRBS and other youth risk behavior surveys. Finally, some students could choose to research Alaska's law around surveys in schools and its current effects on Alaska's youth risk behavior data collection efforts.

***Much of the information in this edition comes from CDC's 2005 Handbook for Conducting YRBS Surveys.

Brain Booster
Answers
Economic
Education Inside
Answers
Fundamentals of HIV
Prevention Council
Alaska
February 12, 13, 2005
Anchorage, Alaska
The training is sponsored
by HIV/AIDS Council of
Substance Abuse
Council, Mental Health
Outlets, and other
responsible for HIV
prevention and control
Council, many other
public health organizations
and community groups
are working together
to reduce the impact of
HIV/AIDS in Alaska.

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will find it helpful to see more
how to use the information
contained in the new
bulletin board on the State
of Alaska
mailto:dba@ced.edu

School Health Partners:



www.ced.state.ak.us/lj/schoolhealth/



www.hss.state.ak.us/dph/chronic/school/default.htm

Thomas Obermeyer

From: Friedman_Jeff [Friedman_Jeff@asdk12.org]
nt: Monday, March 09, 2009 8:43 AM
o: Sen. Bettye Davis
Cc: Sen. Charlie Huggins; Sen. Donny Olson; Sen. Gary Stevens; Comeau_Carol; Siegfried_Robin; Steiner_John
Subject: SB 101

Dear Vice Chair Davis and Education Committee Members:

I am writing to urge your support for SB 101 which relates to questionnaires and surveys.

SB 101 returns Alaska Schools to an opt out procedure for conducting the Youth Risk Behavior Survey from the United States Centers for Disease Control and Prevention. This is a completely anonymous survey that helps asses the emotional and physical health of our children. Parents are still informed of the survey and may choose not to allow their children to participate. Students who take the survey are notified of their right to refuse to answer any question they don't want to answer.

Under current law, school districts can not permit the administration of this survey without specific parent consent. Many parents don't object, they just don't follow through with ensuring that their child gets the permission form back to school. The Anchorage School District has gone to great expense and effort to obtain returned permission forms and most of the returned forms do give permission. With the opt out system proposed by the amendments in SB 101, parents who do object will be given lots of notice of their right to object and plenty of opportunity to do so. This is a good compromise between the need to get adequate data about the health of our children and the interests of those parents who believe this anonymous survey is detrimental in some way.

: Anchorage School Board supports making the changes proposed in SB 101.

Jeff Friedman
Anchorage School Board
1534 D Street
Anchorage, AK 99501
907-742-4699 (Home)



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Protection of Pupil Rights Amendment (PPRA)

The Protection of Pupil Rights Amendment (PPRA) (20 U.S.C. § 1232h; 34 CFR Part 98) applies to programs that receive funding from the U.S. Department of Education (ED). PPRA is intended to protect the rights of parents and students in two ways:

- It seeks to ensure that schools and contractors make instructional materials available for inspection by parents if those materials will be used in connection with an ED-funded survey, analysis, or evaluation in which their children participate; and
- It seeks to ensure that schools and contractors obtain written parental consent before minor students are required to participate in any ED-funded survey, analysis, or evaluation that reveals information concerning:
 1. Political affiliations;
 2. Mental and psychological problems potentially embarrassing to the student and his/her family;
 3. Sex behavior and attitudes;
 4. Illegal, anti-social, self-incriminating and demeaning behavior;
 5. Critical appraisals of other individuals with whom respondents have close family relationships;
 6. Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers; or
 7. Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).

Parents or students who believe their rights under PPRA may have been violated may file a complaint with ED by writing the Family Policy Compliance Office. Complaints must contain specific allegations of fact giving reasonable cause to believe that a violation of PPRA occurred.

For additional information or technical assistance, you may call (202) 260-3887 (voice). Individuals who use TDD may call the Federal Information Relay Service at 1-800-877-8339. Or you may contact us at the following address:

**Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5920**

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Last Modified: 02/17/2005

Model Notification of Rights Under the Protection of Pupil Rights Amendment (PPRA)

PPRA affords parents certain rights regarding our conduct of surveys, collection and use of information for marketing purposes, and certain physical exams. These include the right to:

• *Consent* before students are required to submit to a survey that concerns one or more of the following protected areas ("protected information survey") if the survey is funded in whole or in part by a program of the U.S.

Department of Education (ED)–

1. Political affiliations or beliefs of the student or student's parent;
2. Mental or psychological problems of the student or student's family;
3. Sex behavior or attitudes;
4. Illegal, anti-social, self-incriminating, or demeaning behavior;
5. Critical appraisals of others with whom respondents have close family relationships;
6. Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
7. Religious practices, affiliations, or beliefs of the student or parents; or
8. Income, other than as required by law to determine program eligibility.

• *Receive notice and an opportunity to opt a student out of–*

1. Any other protected information survey, regardless of funding;
2. Any non-emergency, invasive physical exam or screening required as a condition of attendance, administered by the school or its agent, and not necessary to protect the immediate health and safety of a student, except for hearing, vision, or scoliosis screenings, or any physical exam or screening permitted or required under State law; and
3. Activities involving collection, disclosure, or use of personal information obtained from students for marketing or to sell or otherwise distribute the information to others.

• *Inspect*, upon request and before administration or use –

1. Protected information surveys of students;
2. Instruments used to collect personal information from students for any of the above marketing, sales, or other distribution purposes; and
3. Instructional material used as part of the educational curriculum.

These rights transfer to from the parents to a student who is 18 years old or an emancipated minor under State law.

[School District will/has develop[ed] and adopt[ed]] policies, in consultation with parents, regarding these rights, as well as arrangements to protect student privacy in the administration of protected information surveys and the collection, disclosure, or use of personal information for marketing, sales, or other distribution purposes. [School District] will directly notify parents of these policies at least annually at the start of each school year and after any substantive changes. [School District] will also directly notify, such as through U.S. Mail or email, parents of students who are scheduled to participate in the specific activities or surveys noted below and will provide an opportunity for the parent to opt his or her child out of participation of the specific activity or survey. [School District] will make this notification to parents at the beginning of the school year if the District has identified the specific or approximate dates of the activities or surveys at that time. For surveys and activities scheduled after the school year starts, parents will be provided reasonable notification of the planned activities and surveys listed below and be provided an opportunity to opt their child out of such activities and surveys. Parents will also be provided an opportunity to review any pertinent surveys. Following is a list of the specific activities and surveys covered under this requirement:

- Collection, disclosure, or use of personal information for marketing, sales or other distribution.
- Administration of any protected information survey not funded in whole or in part by ED.
- Any non-emergency, invasive physical examination or screening as described above.

Parents who believe their rights have been violated may file a complaint with:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5901

OR CALL 800-CDC-INFO (800-232-4636).
VISIT WWW.CDC.GOV/HEALTHYOUTH
WHERE CAN I GET MORE INFORMATION?

DASH

Division of Adolescent and School Health

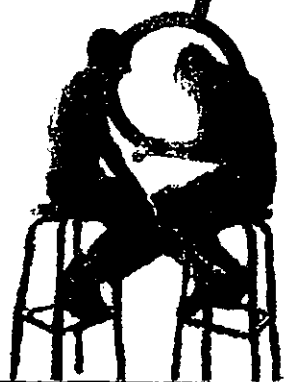


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



Summary of

Surveillance Activities



**DIVISION OF ADOLESCENT
AND SCHOOL HEALTH (DASH)**

Summary of Surveillance* Activities

Division of Adolescent and School Health

Youth Risk Behavior Surveillance System (YRBSS)

National State/Territorial/
Tribal/District Other

	National	State/Territorial/ Tribal/District	Other	State	District
Purpose	<ul style="list-style-type: none"> To determine the prevalence of health-risk behaviors among students To assess trends in these behaviors To examine the co-occurrence of health-risk behaviors 			To provide national data on eight components of a school health program at the state, school district, school, and classroom levels	
Content	<ul style="list-style-type: none"> Unintentional injuries and violence Tobacco use Alcohol and other drug use Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection Unhealthy dietary behaviors Physical inactivity 			<ul style="list-style-type: none"> Health education Physical education and activity Health services Mental health and social services Nutrition services Healthy and safe school environment Faculty and staff health promotion Family and community involvement 	
Sample	Nationally representative sample of public and private high school students	Representative sample of public high school students in each jurisdiction	Representative sample of students in: <ul style="list-style-type: none"> Middle schools Alternative schools Juvenile justice facilities 	<ul style="list-style-type: none"> All states Nationally representative sample of school districts Nationally representative sample of public and private elementary schools, middle schools and high schools 	Representative sample of public middle schools and high schools in a state, territory, tribal government, or school district
Methods	Self-administered paper-and-pencil questionnaire, conducted in classrooms			Computer-assisted telephone and personal interviews and self-administered, mailed questionnaires	
Timing	Biennially, since 1991		Varied	Every 6 years, since 1994	
Example Statements	In 2007, 57.3% of Hispanic female high school students in the U.S. attended physical education classes on 1 or more days in an average week when they were in school.	In 2007, 24.4% of female high school students in Kentucky attended physical education classes on 1 or more days in an average week when they were in school.	In 2007, 87.4% of middle school students in Wyoming attended physical education classes on 1 or more days in an average week when they were in school.	State: In 2006, 70.5% of states required districts or schools to follow national or state physical education standards or guidelines. District: In 2006, 68.9% of districts had someone oversee or coordinate physical education. School: In 2006, 78.3% of schools required students to take some physical education.	In 2006, 60.1% of secondary schools in Alabama required students to take 2 or more physical education courses.
Ownership of Data	CDC	States, territories, tribal governments, and districts	Varied	CDC	States, territories, tribal governments, and districts
Contractor	ORC Macro	Westat, Inc., plus companies hired by states, territories, tribal governments, and districts	Varied	ORC Macro	Westat, Inc., plus companies hired by states, territories, tribal governments, and districts
Web Site	www.cdc.gov/yrbss			www.cdc.gov/shpps	www.cdc.gov/healthyyouth/profiles

*Surveillance is the ongoing collection, analysis, and interpretation of data from generalizable samples.

The Protection of Pupil Rights Amendment (PPRA)

This federal law provides parents with important rights relative to surveys and certain nonemergency physical examinations conducted by schools that receive federal funds from the Dept. of Education.

The Protection of Pupil Rights Amendment (PPRA) is a statute originally enacted in 1978 that provides parents with important rights regarding surveys performed by schools. Such surveys may be overly intrusive and personal or may collect information for purposes other than those represented. The PPRA and a second federal law known as FERPA are enforced by the Family Policy Compliance Office (FPCO) of the US Dept. of Education. Complaints regarding PPRA violations, including non-notification (failing to annually notify parents of their rights under the PPRA), must be filed by mail to the FPCO. Questions regarding the PPRA can be addressed to the FPCO by phone at (202) 260-3887 or by e-mail at ppra@ed.gov (we have found them to be very friendly, helpful and responsive).

The PPRA applies to any school that receives funds from the US Dept. of Education.

A summary of the PPRA is located here. In 2002, Phyllis Schlafly of the Eagle Forum made the observation that compliance with the law has been spotty ever since its inception.

The PPRA statute as it existed prior to January 2002 is available here.

The law as amended in January 2002 (the No Child Left Behind Act of 2001) has significantly strengthened the rights of parents, as follows:

- It now requires written parental consent prior to administering ED-funded surveys that include questions falling into any of the following eight categories:
 1. political affiliations or beliefs of the student or the student's parent;
 2. mental and psychological problems of the student or the student's family;
 3. sex behavior or attitudes;
 4. illegal, anti-social, self-incriminating, or demeaning behavior;
 5. critical appraisals of other individuals with whom respondents have close family relationships;
 6. legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers;
 7. religious practices, affiliations, or beliefs of the student or student's parent; or
 8. income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).
- It now provides for the first time rights regarding surveys *not funded by the US Dept. of Education*. Schools are required to develop and adopt policies - *in conjunction with parents* - regarding the following -

1. The right of parents to inspect, upon request, a survey created by a third party before the survey is administered or distributed by a school to students.
 2. Arrangements to protect student privacy in the event of the administration of a survey to students, including the right of parents to inspect, upon request, the survey, if the survey contains one or more of the same eight items of information noted above.
 3. The right of parents to inspect, upon request, any instructional material used as part of the educational curriculum for students.
 4. The administration of physical examinations or screenings that the school may administer to students.
 5. The collection, disclosure, or use of personal information collected from students for the purpose of marketing or selling, or otherwise providing the information to others for that purpose.
 6. The right of parents to inspect, upon request, any instrument used in the collection of information, as described in number 5.
- Local educational agencies (LEAs) must "directly" notify parents of these policies and, at a minimum, shall provide the notice at least annually, at the beginning of the school year--a sample notification and consent/opt-out examples are provided here. The LEA must also notify parents within a reasonable period of time if any substantive change is made to the policies.
 - In the notification, the LEA shall offer an opportunity for parents to opt out of (remove their child) from participation in the following activities:
 1. Activities involving the collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information, or otherwise providing that information to others for that purpose.
 2. The administration of any third party (non-Department of Education funded) survey containing one or more of the above described eight items of information.
 3. Any non-emergency, invasive physical examination or screening that is: 1) required as a condition of attendance; 2) administered by the school and scheduled by the school in advance; and not necessary to protect the immediate health and safety of the student, or of other students.
 - In the notification, the LEA shall notify parents the specific or approximate dates during the school year when these activities are scheduled.

The Wisconsin Dept. of Public Instruction prepared these instructions/guidelines on surveys and the PPRA for school officials in January 2003.

Surveys in Public Schools--Application of the PPRA

To better understand what might constitute a violation of PPRA, here are several recent examples where surveys have been given or are planned to be given in public schools:

School Survey in Virginia--2003 This site discusses a survey to be given to Fairfax County, Virginia high school students in April 2003. Although Fairfax County Attorney David Bobzien ruled that no federal funds are involved in the survey and that it is therefore "a local initiative not requiring

informed parental consent," the survey would likely violate the PPRA as amended in January 2002 if students were not allowed to opt out of taking it.

Alleged Violation of PPRA in Minnesota--2002 This site describes what appears to be a recent violation of the PPRA that occurred at the Mahtomedi, Minnesota High School in September 2002. Freshmen were shown two videos on homosexuality, then assigned to complete an "assessment" (translation--survey) to determine if they "harbored hidden biases toward straight people, or against gay people." The survey is posted at tolerance.org.

Alleged Violation of PPRA in Ohio--2000 Parents sued an Ohio school district after their children were given an intrusive survey--although their original PPRA complaint was dismissed because the survey in question was not federally funded, the parents and the school board reached a settlement while the case was on appeal. Note that since passage of the NCLB Act, the PPRA now applies to *all surveys*, not just those performed using DOE funds.

Intrusive Survey in Connecticut--2000 The New Milford, Connecticut, school district gave students as young as 11 the "Youth Risk Behavior Survey". Administrators claim they complied with the PPRA (which requires parental consent for federally-funded surveys) by sending a letter home advising parents that they could opt their children out of the survey, but the letter gave no warning that some questions would be explicit and many parents claim they never saw it. Under the new provisions of the NCLB Act, the schools would now require "active consent" from parents prior to administering such a survey.

Survey in New York State This site details the chronology of events during 1999 and 2000 after it was decided that a "Youth Risk Behavior Survey" would be given to local students in grades 7 through 12. The survey included questions related to sex, drugs and alcohol.

Violation of PPRA in New Jersey--1999 This rather extensive site documents what happened after an intrusive anonymous survey was given in the Ridgewood, NJ School District in 1999 using Dept. of Education funds. The FPCO ruled that the PPRA had been violated and the incident ultimately resulted in the passage of a NJ state law that provides even more protection for the rights of NJ students than guaranteed by the PPRA. In June 2004 a Federal District Court held that students' and parents' rights were not violated because the survey was "voluntary and anonymous", but an appeal was filed in September 2004 claiming the survey was not in fact administered in a strictly voluntary and anonymous manner.

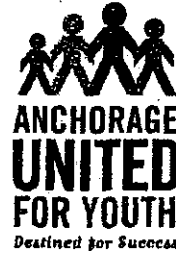
Violation of PPRA in Texas--1999 This site summarizes a case brought against the San Antonio School District for violation of the PPRA that occurred when high school students were given an intrusive psychological survey that asked personal questions such as "Do you ever wish you were a boy or girl instead of what you are?"

What You Should Do

Parents--talk to your kids, and find out if they are being given surveys that ask questions that fall into any of the categories listed above. Students--if you're given surveys, even anonymous ones, that you feel are too personal or intrusive, tell your parents. Let's keep the schools focused on education!

Last updated October 2004

Legal Disclaimer



February 11, 2010

The Honorable Wes Keller
Alaska State House Representative
State Capitol Room 13
Juneau, Alaska 99801

Dear Representative Keller:

The Leadership Team of Anchorage United for Youth is writing again to request your support for Senate Bill 101, *"An act relating to questionnaires and surveys administered in the public schools."*

Over the past three years, we have been able to energize an entire community around supporting our youth to help them graduate from high school and transition to a healthy and successful adulthood. To guide the planning process for this initiative, and to track its progress in order to remain accountable to ourselves, our community, our funders, and our young people, Anchorage United for Youth has drawn upon the vital information gleaned from the YRBS. When our community saw that almost 20% of our youth reported being physically hurt on purpose by a boyfriend or girlfriend in 2005, it was clear that this was a number we could not accept or allow to continue. Alaska already has one of the highest rates of domestic violence per capita in the nation. Our collaborative effort and our partners are determined to provide a better future for our children.

When our community saw that over 40% of our youth were drinking alcohol and almost 30% were binge drinking, we knew that we must come together to help our kids reject alcohol use in order to keep them safe. Tracking this data over time tells us if we are succeeding and where there is more to be done to bolster our youth.

One of the programs borne of this community effort was the Mountain View Photovoice project that provided the opportunity for at-risk youth to come together in a safe environment, learn a form of artistic expression, think critically about their surroundings, and talk with their peers and supportive adults about issues that were important in their lives. An excerpt from the narrative report at the culmination of this project is below:

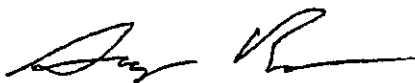
"A 17-year-old, 300-pound young Samoan man, who had spoken earlier about fighting as a regular activity and who tended to sit in the back and disengage, related [his] photo to the colorlessness and emptiness of life in his adolescence and began to speak of his pain, his loss, his nightly drinking. His eyes got wet as he spoke of the deaths he has suffered. And as we listened and spoke, his eyes grew wider open and he sat closer to us...Even as they shared, and even as the 17-year-old young man was desperately asking for help, we could tell that he was reticent about getting professional help. He spoke of cruelty, of fighting, of drinking, and I knew I couldn't push too hard but had to respond. So I found out about treatment services for teens and spoke to him about them quietly. He came back on Wednesday saying that he and his sister had quit drinking, and on Friday that they are going to AA meetings together. Over a month later, he is still clean even though his sister has begun drinking again and even after suffering the murder of his 15-year-old cousin. This young man even wrote that we should stop violence in Mountain View....[The photographer] has since then gone to hang out and shoot photos with him, keeping him engaged through this art form for which he shows almost a preternatural ability, and keeping him connected to a non-violent adult who cares for him."

This is but one of many projects and programs being conducted in our community in an effort to strengthen and support our youth and their families. We measure the success of this combined effort through the data collected from the YRBS.

We recognize and support the important role of parents in choosing what's best for their children. We support Senate Bill 101 because it maintains and strengthens current parent notification provisions. It ensures that parents are informed that the survey will be given, provides for the opportunity to review survey content, and allows parents to choose not to allow their children to participate. This bill supports both parental involvement and the ability to better serve our youth.

We thank you for your commitment to youth in the state of Alaska and ask for your support of Senate Bill 101.

Sincerely,



Greg Razo, CIRI Corporation
Chair, Anchorage United for Youth Leadership Team

Anchorage United for Youth Leadership Team

cc: House Health and Social Services Committee Members (Tammie Wilson, Bob Lynn, Paul Seaton, Sharon Classna, Lindsey Holmes)

Distributed by Representative Bob Lynn – from legislative Blog written 5/3/2007

THURSDAY, MAY 03, 2007

ALASKA YOUTH RISK BEHAVIOR SURVEY ANOTHER "THAT'S INCREDIBLE AWARD"



I harbor a dated concept that schools should teach reading, writing, arithmetic, history and geography (now morphed into “social studies”), music, art and yes, even vocational education. There may be other subjects (dare I say “home economics?”) worthy of curriculum inclusion, but surely you get my point. Please notice I didn’t mention “behavior surveys.”

Question: So why am I bringing up this up in today’s blog? Answer: House Bill 207, entitled “An Act relating to Questionnaires and Surveys Administered in Public Schools,” came before a committee this week. I voted “Do Not Pass.”

According to the bill’s Sponsor Statement, HB 207 changes parental consent requirements for “anonymous” school surveys from an active to passive consent. That means an opt-out instead of opt-in for your parental permission to conduct an “Anonymous” School Surveys on your kid. And what survey does the bill contemplate? – I hear you cry. It’s the invasive 99 question “Anonymous” School Survey called “The Alaska Youth Risk Behavior Survey (hereinafter in the blog to be called AYBS).”

Currently the AYBS cannot be given to students without signed parental consent. Good. That means a consent form to the parent via the child, returned to the school by the child: that’s called “active consent.” Unfortunately, HB207 would change it so “consent” occurs if the school doesn’t receive back a non-consent form from the parent. Come on now . . . I can tell you, both as a parent and retired teacher, that notes don’t always make it home, and all notes from home don’t make it back to school. This isn’t rocket science.

So what's included in the 99 question invasive "Anonymous" Survey? If you want to see for yourself, check out www.asd.k12.ak.us/surveys/YRBS/2005/2005_YRBS.pdf. I don't make this stuff up.

Let me report some of the more salacious questions (If I heard someone ask some of these questions to a kid selling lemonade from a sidewalk stand, I'd call the cops).

Question 1: How old are you? Response A is 12 years old or younger. Response F is 17 years old. Comment: If a child taking the survey wasn't 12 years old or younger, pray tell what would be the purpose of Question 1?

Question 25: During the last 12 months, did you ever seriously consider attempting suicide?

Question 26: . . . did you make a plan about how you would attempt suicide?

Question 27: . . . how many times did you actually attempt suicide?

Possible answers are: 0, 1,2 or 3, 4 or 5, 6 or more times.

Comment: Well, if a kid hadn't thought of suicide already, the survey takes care of that.

Question 47: Have you ever used marijuana? Answers range from 0 to 100 or more.

Questions 48 through 58 ask the same question about a plethora of other drugs the kids may not have even known about.

Comment: Hopefully, a kid who answers 0 on questions 47 to 58 doesn't think of themselves an under-achiever. That would be bad for self-concept.

Now, the questions blog readers have been waiting for:

Question 60: Have you ever had sexual intercourse? Answer: Yes or No.

Question 61: How old were you when you had sexual intercourse for the first time?

Answers: I have never had sexual intercourse, 11 years old or younger, 12, 13, 14, 15, 16, 17.

Question 62: . . . with how many people have you had sexual intercourse? Answers range

from 0, to 6 or more.

Question 65: . . . did you or your partner use a condom?

Question 66: The last time you had sexual intercourse what method did you or your partner use to prevent pregnancy (select only one response) Answers: none, birth control pills, condoms, Depo-Provera, withdrawal, some other method, not sure.

Suggestion: How about adding a possible response to questions 60-66 of "None of your flipping (to use Governor Murkowski's innocent word) business" after Yes or No?

Question 92: How often does one of your parents talk with you about what you're doing in school? Comment: Here's another opportunity for the answer "none of your flipping business."

After taking this survey, it would be logical for a student to conclude that illegal and immoral conduct is normal and, if they answered with "low scores" on sexual activity, etc., think they are "abnormal," or at least a nerd. No kid (or adult) wants to be abnormal. The ABYS is almost like peer pressure by survey.

It's amazing to me that so many folks stridently call the Patriot Act and the Real ID Act "invasions of privacy," but think nothing about assaults on privacy of our children and parents with surveys like the AYBS.

There are also other dangers to the ABYS. If parents refuse permission for the survey, what happens to the excused kids? Do they sit in a corner of the room, go to a study hall? Whatever, I'm sure kids who don't take the survey will be singled out. Knowing kids like I do, the excluded children will suffer cruel ridicule from the other kids. Shouldn't happen. But it will.

The survey is supposed to be "anonymous." Good. But anonmunity is easily subverted by anyone who would want to. If the survey is administered in a small class – maybe one to five – it's even easier to discover identities.

Consider this: would you take a similar "anonymous" survey from your employer? Now here's an interesting thought: would legislators submit themselves to an "anonymous"

ABYS type "at risk" survey, if constituents approved?

Why do the schools want to give such surveys? Let's be positive. Many good teachers and school administrators want to help "at risk" kids, and envision the ABYS survey as one way to do it. There's probably no bad intent. They mean well, but they simply haven't thought it through. Can some good come from such surveys? Sure. But, like most things, there can be both intended and unintended consequences. For me, the surveys are (as one commentator put it) "a sociological strip search" of children, and whatever good may result could be outweighed by the bad.

There's also another reason schools want to change permission for the surveys from active to passive. Some state and federal grant programs require a certain percentage of surveys to be conducted to qualify. Grants can seduce districts into using surveys to interrogate students just to get the money. As we say in politics, "Follow the money."

HB207 passed out of the committee today (but not with my vote), and continues its journey through the legislature. Win Some. Lose some.

Anchorage School District

IMPORTANT RIGHTS FOR PARENTS CONCERNING STUDENT SURVEYS

The Federal Protection of Pupil Rights Amendment (PPRA), 20 U.S.C § 1232h, requires the Anchorage School District to notify you and obtain consent to allow your child to participate in certain school activities. These activities include a student survey, analysis or evaluation that concerns one or more of the following eight areas ("protected information surveys"):

1. Political affiliations or beliefs of the student or student's parent;
2. Mental or psychological problems of the student or student's family;
3. Sex behavior or attitudes;
4. Illegal, anti-social, self-incriminating, or demeaning behavior;
5. Critical appraisals of others with whom respondents have close family relationships;
6. Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
7. Religious practices, affiliations, or beliefs of the student or parents; or
8. Income, other than as required by law to determine program eligibility.

The Alaska State Statute and Anchorage School District Board policy also have requirements regarding surveys that require parental consent.

By Alaska State Statute, AS 14.03.110:

Parental permission is required for surveys that inquire into personal or private family affairs of the student not a matter of public record or subject to public observation.

- Parents/guardians may provide "blanket" permission, once per year, for their student to participate in anonymous surveys requiring parental consent.
- For any survey that is not anonymous and requires parental consent, the District will obtain the written permission from the student's parent or guardian at least two weeks before the survey is administered.
- In addition, for all surveys requiring permission, parents will be provided notice and an opportunity to review the survey at least two weeks in advance of the administration of the survey.

By District Board policy:

1. Each year, the District may seek the annual permission of each parent/guardian for their child to participate in anonymous surveys.
2. For those surveys that are not anonymous and require parental permission, the District shall provide a permission form to be returned by the parents/guardians and the permission form must be returned at least two weeks before the administration of the survey.

2009-2010 Surveys

For surveys that require notice to parents/guardians, the notice will be provided through your school newsletter, school Web site, emails, and/or other methods. At this time, one survey is planned that requires parental permission: the Aggressors, Victims and Bystanders Survey. This survey is anonymous.

1. Aggressors, Victims and Bystanders Survey (AVB)
Dates: August – December, 2009
Grade: Seven

By signing the following Annual Survey Permission Form, your student may participate in this survey. For surveys scheduled after the school year starts, the Anchorage School District will provide parents/guardians at least two weeks notice prior to the administration of the surveys. Notification will come to you through your school newsletter, school Web site, emails, and/or other methods and will advise you of your opportunity to review the surveys.

The following surveys do not require parental permission. The District will provide notice through your school newsletter, school Web site, emails, and/or other methods at least two weeks prior to the administration of the surveys.

1. Climate and Connectedness Student Survey
Dates: January 19 – February 10, 2010
Grades: Three through Twelve

2. OCR – Athletic Interest Survey
Dates: October 5 – 29, 2009
Grades: Eight through Twelve

ANNUAL SURVEY PERMISSION FORM
2009-2010 School Year

I understand that the Anchorage School District may administer, or be permitted to administer, anonymous surveys that require parental permission. I understand that as the parent or legal guardian of this student, I may review any of the survey instruments and determine the appropriateness of the survey in relation to my student. I can remove my student from the survey administration.

Printed name of student: _____

School: _____

Student ID: _____

Grade for 2009-2010 school year: _____

Printed name of parent/legal guardian: _____

Signature of parent/legal guardian: _____

I give my approval to administer anonymous surveys to my child this year. I understand that anonymous surveys may inquire into private matters, as explained in the Important Rights for Parents Concerning Student Surveys. I understand that I may review the survey to be given no less than two weeks prior to administration, and I may remove my child at that time if I wish. I further understand that I may revoke this annual permission at any time.

I do not give my approval to administer any anonymous survey that inquires into personal or private family affairs of the student to my child during the 2009-2010 school year.

Policy

BOARD OF EDUCATION JUNEAU SCHOOL DISTRICT

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STUDENT ATHLETE MANDATORY DRUG TESTING

The Board of Education recognizes that drug abuse is a serious concern in the District's schools and in our community. Drug use by students is physically and emotionally harmful, interferes with the learning process and is detrimental to the welfare of all members of the school community. Further, drug use by students who participate in District athletic programs poses a direct threat to the health and safety of those students and the students with whom they compete.

Participation in extracurricular athletic activities is a privilege available to those students who are willing and able to comply with the requirements for participation in the activity. Some students have abused that privilege by using drugs while participating in athletic activities and by encouraging other students to use drugs. The measures the District has previously taken to prevent student drug abuse have not proven effective to stop that abuse. Consequently, the Board has decided to implement a random drug testing program as a condition of participation in competitive extracurricular athletic activities at the high school level.

The purposes of the program are to 1) help protect the health and safety of all students, 2) help counteract negative peer pressure by providing students with a reason to refuse drugs, and 3) encourage and assist students with drug problems to seek help in overcoming those problems.

As used in this policy and the accompanying regulations, the terms "drugs," "prohibited drugs" and "illegal drugs" include any controlled substance the use of which is prohibited by AS 11.71 in the absence of a valid prescription, tobacco and alcohol, to the extent that students have consumed any of these substances illegally.

Students who desire to participate in high school competitive extracurricular athletic activities shall be required to complete a form signed by the student, and by the student's parent or guardian if the student is a minor, authorizing the District to conduct drug testing on a random basis. The completed form must be submitted before the student may participate in any aspect of a covered activity.

The District's drug testing program shall incorporate procedures for drug testing consistent with applicable legal standards. The program shall include procedures that ensure the confidentiality of student test results and shall require all persons having access to those results to abide by those procedures.

The drug testing program shall also include appropriate consequences in the event of a positive test. Consequences shall be confined to exclusion from covered athletic activities and any applicable periods of exclusion required by the citizenship rules of the Alaska School Activities Association (ASAA); students shall not otherwise be excluded from activities. A positive test in response to random drug testing shall not result in suspension from school or any other academic consequence, nor shall positive test results be reported to law enforcement authorities.

Policy

BOARD OF EDUCATION JUNEAU SCHOOL DISTRICT

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The Superintendent shall develop administrative regulations to implement the District's drug testing program. The District shall provide educational events for parents, guardians, students and the community on alcohol and other drug abuse and the district's policies, rules and regulations relating to drug testing and drug abuse, including the use of suspicion-based drug testing and when and why students may be referred for assessment.

The District will implement evidence-based, comprehensive K-12 educational programs and curricula to assist students in building skills to prevent alcohol and drug use/abuse in accordance with Board Policy # 5530, Drug Abuse. The Superintendent shall direct staff to work with other agencies to improve local support systems for students who are identified as needing intervention and assistance, and shall provide for the training of staff in the District's drug prevention, testing and intervention programs as outlined in Board Policy #5530, Drug Abuse and its accompanying regulations. In addition, the Superintendent shall provide for the periodic assessment of the effectiveness of the District's drug testing, prevention and educational programs.

Adopted 10/5/09

Rules & Regulations

BOARD OF EDUCATION
JUNEAU SCHOOL DISTRICT

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STUDENT ATHLETE MANDATORY DRUG TESTING

Drug testing, including testing for the presence of illegal drugs, tobacco and alcohol, will be required during the term of the athletic activity for students who participate in competitive high school extracurricular athletic activities. The term of the activity in which a student is subject to testing shall be determined as provided in Administrative Regulation 1430R, Student Activities. A complete list of covered activities is set out in Appendix A.

Consent

Prior to participating in any activity covered by this policy, a student and, if the student is a minor (under the age of eighteen), his or her parent will be required to complete and sign the District's Informed Consent Agreement. The agreement will state that the student, and his or her parent, if applicable, understands that by participation in the extra-curricular activity the student agrees to subject himself/herself to the district's drug testing policy. No student will be allowed to participate in practice or competition until this form is completed, signed and on file with the district. One signed form will be sufficient to authorize testing for all covered athletic activities a student participates in during a given school year.

Testing Procedure

Random testing will be conducted weekly during the term of each covered activity. Approximately 15% of the students participating at each school in each sports program that is in season will be tested each week. For purposes of calculating the number of students to be tested, boys' and girls' teams constitute separate programs. Co-ed teams constitute single programs. A program consists of all the teams (varsity, junior varsity, "C" teams, etc.) competing in a particular sport. Students shall be selected for testing by lottery drawing or other random means from a pool of all students participating in a given sport at the time of the drawing. The individual or agency in charge of selecting students for testing shall take all reasonable steps to assure the integrity, confidentiality and random nature of the selection process including, but not necessarily limited to, assuring that the names of all students currently participating in covered activities are included in the pool, assuring that the person drawing names has no way of knowingly choosing or failing to choose particular students for testing, assuring that the identity of students drawn for testing is not known to those involved in the selection process and assuring direct observation of the selection process by at least two adults.

Scope of Testing

Prohibited drugs include any controlled substance the use of which is prohibited by AS 11.71 in the absence of a valid prescription, alcohol and tobacco, to the extent that students have consumed any of these substances illegally. Testing will be performed for one or more prohibited drugs and/or their metabolites. A list of the substances for which testing may be performed is set out in Appendix B. Students shall not be tested for the presence of any substance other than a prohibited drug, nor shall they be tested for the existence of any physical condition other than drug intoxication and/or the presence of prohibited drugs in their systems.

Rules & Regulations

BOARD OF EDUCATION
JUNEAU SCHOOL DISTRICT

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Testing Protocol

The District will schedule all testing. District personnel shall designate a certain area in each high school building as the collection site. Initial screening tests will be conducted by personnel provided by an outside testing agency. Those personnel or "test administrators" shall be trained in appropriate procedures for administering the test, recognizing adulteration of samples and evaluating test results.

Specimen Collection

Students to be tested shall present verification of their identities to the test administrator, if the test administrator does not personally know them. In the absence of other verification, a school administrator may verify a student's identity to the test administrator.

1. Urine Collection

Students shall be asked to remove any jackets or coats and to wash and dry their hands prior to collection of the specimen. Students must leave their purses, packs, wallets and similar items outside the collection site to prevent access to adulterants. These procedures must be completed in the presence of the test administrator.

A student shall be given a choice of at least two sealed drug-testing kits. The student's selected kit shall be opened in full view of the student. The student shall then be directed to a private area for production of a urine specimen. All students providing urine samples shall be given the option of doing so alone in an individual stall with the door closed. The collection and testing process shall be performed in a manner that protects student privacy to the maximum extent consistent with ensuring the validity and accuracy of the test results.

After testing, the student must present the specimen to the test administrator prior to washing his/her hands or flushing the toilet. The specimen shall remain in the student's visual field while the test administrator conducts the following procedures. The test administrator shall measure the specimen and record its temperature. The test administrator shall then divide the specimen in half and shall conduct initial screening using one of the halves. If that screening yields a negative result, the entire specimen will be discarded. If the screening yields an inconclusive or presumptively positive result, the remaining half of the specimen shall be sealed and transmitted as a split specimen to a testing laboratory that has been certified or approved by the federal Substance Abuse and Mental Health Services Administration for confirmatory testing. The student shall be requested to initial and date a form identifying the specimen.

If a student is unable to produce a urine specimen at the time for testing, the student will be allowed to return to provide a specimen later that same day.

Rules & Regulations

BOARD OF EDUCATION
JUNEAU SCHOOL DISTRICT

PROGRAM
1432R/Page 3

Confirmatory Testing

The testing laboratory shall conduct confirmatory testing using gas chromatography/mass spectrometry (GC/MS) techniques or other techniques that produce equally reliable results.

For substances other than alcohol or nicotine, tests shall not be considered positive unless the substance to be tested or its metabolite is present at a level equal to or greater than the cutoff level established by the United States Department of Health and Human Services for that substance in connection with federally-mandated workplace drug testing programs. For tobacco and alcohol, cutoff levels shall be set to exclude positive tests due to environmental exposure or incidental ingestion of those substances. See Appendix C for tobacco and alcohol cutoff levels.

A licensed physician or osteopath shall review all positive confirmatory test results. The physician or osteopath shall contact the student and a parent, if the student is a minor, within 48 hours of receiving a confirmatory positive test/result from the laboratory and offer an opportunity to discuss the test results. Students may be requested to provide verification of prescriptions or other relevant medical information. Test results that the physician or osteopath concludes are caused by medicine prescribed for the student or by the legal ingestion of any substance, including alcohol or tobacco, shall be reported as negative.

Notification of Testing

District personnel will make every reasonable effort to notify a parent of any minor student who has been tested that the student has been tested and the results of the initial screening within one school day following the initial screening. District personnel will also make every reasonable effort to notify students and at least one parent, if the student is a minor, of the results of confirmatory testing within one school day following the District's receipt of the results. If the confirmatory test is positive, then the consequences stipulated by these regulations will be enforced, except as provided below.

Requests for Re-test

An opportunity for re-test of a specimen following a confirmatory positive test shall be provided when it is technologically practicable and economically reasonable to do so. The student may request a re-test, using the split specimen initially provided to the lab, within three calendar days following notification of positive confirmatory testing results. The student will be required to pay the associated costs of re-testing in advance unless excused from the obligation to pay due to financial inability to pay, but the costs will be reimbursed if the result of the re-test is negative.

Rules & Regulations

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JUNEAU SCHOOL DISTRICT

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Appeal

Regardless of whether a student requests that a specimen be retested, the District shall provide an opportunity for the student and a parent, if the student is a minor, to comment on or explain a positive test result to the principal or designee in a confidential setting prior to taking any action to exclude the student from participation in an extra-curricular activity. A student shall have the right to appeal the principal's decision regarding an exclusion based on random drug testing results in accordance with the procedures established in Board Policy 5710, Student Grievance. Consequences for positive testing shall not be held in abeyance pending appeals past the principal's level unless the principal or Superintendent determines that unusual circumstances justify holding them in abeyance.

Right to Review Test Results

Students and the parents of minor or dependent students have the right to review any records the district maintains related to the student's testing. Written test results will be maintained for at least six months following testing. Students and the parents of minor or dependent students shall have the right to obtain a copy of the written results of the student's tests if they make a written request to the principal for those results within six months after the date of the test. If a student or parent requests written test results in connection with an appeal, the principal shall make every reasonable effort to provide the results within one school day of receiving the request, and shall provide them before the principal's meeting with the student and parent. Otherwise, the principal shall provide the written results to the student or parent within five working days of receiving a timely written request for test results.

Refusal to be Tested

Should a student and/or minor student's parent refuse to permit testing of the student when the student has been selected for random testing under this regulation, the student will be excluded from participation in covered athletic activities to the same extent the student would have been if the student had tested positive, and shall not be permitted to participate in covered athletic activities until the applicable period of exclusion has expired and the student has produced at least one negative drug test.

Alteration or Manipulation of Specimens

The use of substances and methods to alter the integrity of specimens or the validity of test results is prohibited. Examples of prohibited alteration or manipulation include catheterization, urine substitution or adulteration, and modification of renal excretion by the use of diuretics or masking substances or agents.

Rules & Regulations

BOARD OF EDUCATION
JUNEAU SCHOOL DISTRICT

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Violations

The following constitute violations for purposes of imposing consequences on students pursuant to these regulations:

- a. Positive test results;
- b. Refusal to take a drug test, unjustified delay in reporting for testing, or unjustified failure to produce a specimen for screening;
- c. Violation of testing protocols by student;
- d. Manipulating, altering or attempting to alter or manipulate the integrity of a specimen or the validity of the collection and testing process.

Positive test results will lead to consequences under both these regulations and the Alaska Student Activities Association's rules, where applicable, as provided below. The violations described in b. through d. above will lead to consequences only under these regulations.

Consequences for Violation

Students who test positive shall be required to complete a substance abuse assessment by a trained substance abuse counselor, and to provide a doctor's or osteopath's certification that the student has successfully completed a course of treatment or otherwise resolved any concerns relating to the student's use of prohibited drugs, in order to be eligible to participate in any future covered athletic activity. Students who violate the requirements of these regulations shall be excluded from participation in the athletic activity in which they are currently participating for the remainder of the season, and shall be excluded from all other athletic activities covered by this policy for a period of thirty days. The 30-day period of exclusion shall run from the first day of exclusion from the student's current activity. For example, a student who commenced serving a term of exclusion during one activity and 20 days prior to the start of another activity would be excluded from participation in the subsequent activity for the first 10 days of that activity. The period of exclusion may be reduced to ten days for athletic activities that have not yet commenced if the student completes a substance abuse assessment and provides medical certification of the student's successful participation in any needed intervention, as provided above. Regardless of whether a student's exclusion is due to a positive test, a refusal to submit to a test after being selected for random testing, or to a violation of the testing protocols, the student must produce at least one negative drug test prior to participating in future covered athletic activities. In addition, positive test results shall be reported to the Alaska School Activities Association (ASAA) as a violation of ASAA's citizenship rules and students who test positive shall be subject to any applicable period of exclusion required by ASAA rules, but shall not otherwise be excluded from activities. Students shall not be subject to any other form of discipline or penalized academically as a result of a violation of these regulations, nor shall positive test results be reported to law enforcement authorities.

Rules & Regulations

BOARD OF EDUCATION
JUNEAU SCHOOL DISTRICT

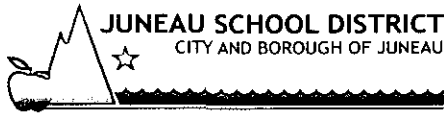
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1432R/Page 6

Confidentiality of Test Results

The District will limit disclosure of information acquired through drug testing to the student, the parent of a minor or dependent student, the test administrator, laboratory and medical review personnel, and district officials with a need to know, typically including the student's coach, principal, any counselor assisting the student in connection with intervention or rehabilitation services and any school official considering the student's appeal of consequences imposed for a violation of these regulations. The information reported to ASAA shall be restricted to the information required by ASAA for reporting violations of ASAA citizenship rules. Test results and other personal and confidential information regarding a student acquired as a result of the testing process shall not otherwise be released without the student's or minor student's parent's written consent, except where disclosure is compelled by law.

Adopted 10/5/09

10/14/09



**PROGRAM
FORM #1432A**

STUDENT ATHLETE MANDATORY DRUG TESTING

Student Athlete, Parent/Guardian Informed Consent Agreement for the _____ School Year

I have read the attached Board Policy 1432 and Administrative Regulation 1432R on Student Athlete Mandatory Drug Testing for high school participants.

I understand that submission to drug testing is a condition of my participation in school sponsored competitive extra-curricular athletic activities. I understand the terms used in the policy and regulations and the process for conducting mandatory drug testing, including the penalties for violations.

I authorize Juneau School District and the individuals they contract with to conduct a test on a urine and/or saliva specimen that I provide to detect the presence of alcohol, tobacco or illegal drugs. I also authorize release of information concerning the results of such a test to school officials and to the individuals contracted with by the Juneau School District for drug testing and medical review of the testing results, as provided in Juneau School District Administrative Regulation 1432R.

This agreement shall be deemed consent pursuant to the Family Educational Rights and Privacy Act for the release of above information to the parties named above.

Student Signature

Date

Student Printed Name

I understand that submission to drug testing is a condition of my student's participation in school sponsored competitive extra-curricular athletic activities. I hereby consent to the testing of my child for the Student Athlete Mandatory Drug Testing and to the release of information concerning the testing as provided above.

Parent Signature

Date

Parent Printed Name



February 2, 2010

The Honorable Bob Herron
 Alaska State House Representative
 State Capitol Room 411
 Juneau, AK 99801

Dear Representative Herron,

I am writing to you as the Executive Director of Anchorage's Promise – the Alliance for Youth in support of Senate Bill 101, "An Act relating to questionnaires and surveys administered in the public schools."

The Youth Risk Behavior Survey (YRBS) is a tool used by multiple community-serving organizations, including Anchorage's Promise to monitor the health and well-being of Alaskan youth. YRBS data is a critical resource used by our organization to set and monitor performance measures that our agency is actively engaged in addressing. Additionally, the findings presented provide additional help in seeking funding for program services that focus on reducing health risk behaviors among youth.

Anchorage's Promise works to mobilize all sectors of our community to build the character and competence of Anchorage's children and youth by fulfilling *Five Promises; caring adults, safe places, healthy start, effective education, opportunities to help others.*

To successfully do this successfully, we require reliable and statistically valid community data. Routine standardized surveys such as the YRBS allows us to track trends over time and help guide and evaluate the important youth programs we implement to keep our youth on track to graduate from high school, avoid delinquency and reject substance use.

When determining your vote, please consider the following:

- The YRBS has a required response rate of 60% to make it statistically valid.
- Current legislation requires active parental consent which presents significant obstacles and costs to achieving this response rate.
- Approximately \$90,000 is spent for just one survey cycle in order to provide the incentives necessary to simply get permission slips returned. However, failure to return permission slips is primarily linked to apathy, oversight, and student error, not parental refusal of permission, which averages around 10%.
- SB 101 protects previously legislated parental rights to consent, parental rights to notification, and children's right to refuse participation.

We support SB 101 because it continues to provide these protections and respects the privacy of families, while removing the obstacles to obtaining this vital data that allows us to track and improve conditions for our youth. We ask for your support of this very important legislation.

Please contact me if I can provide any additional information about how critical this data is to our community's youth.


 Debbie Bogart

Building Caring Communities with Five Promises

- 1** Caring Adults **2** Safe Places **3** Healthy Start **4** Effective Education **5** Opportunities to Help Others

Anchorage's Promise – the Alliance for Youth
 6011 - Zeno Suite 202 Anchorage, AK 99503
 P: (907) 465-4589 Fax: (907) 472-1798

<http://www.anchoragespromise.org/> www.anchoragespromise.org T: 1-800-465-4589

701 West 8th Avenue, Suite 230
Anchorage, Alaska 99501
tel 907.263.3800
fax 907.263.3801
www.unitedwayofanchorage.org

February 1, 2010



To Representatives Wes Keller and Bob Herron, co-chairs of the House Health and Humans Services Committee; and committee members:

I am writing to ask for your full support of SB101, legislation to change the Youth Risk Behavior Survey, to passive parental consent.

This may be a larger issue than you realize. The YRBS provides community level data that is absolutely critical to our community's ability to provide the services and support our youth need in order to be successful.

This data makes it possible for us to hold ourselves and the community ACCOUNTABLE for accomplishing what we say we want to accomplish. We use many points of data from the YRBS, such as substance use rates, weight, youth perception of sufficient supportive adults in their lives, youth perception of opportunities to engage in the community, and more. We actually have strategic community plans, with cross-sector participation and aligned planning and reporting to improve these community indicators – and we are measuring our work against these indicators from the YRBS.

It is therefore critical that this data be valid and reliable. But the active consent legislation that passed several years ago jeopardized that. And not only was the validity and reliability jeopardized, but the legislative action made it MUCH more expensive (approximately \$90,000 additional per year) to implement the survey. It's more expensive because the school districts have to turn back flips to get sufficient participation. And the irony of that is – the vast majority of the non-participation has nothing to do with parents wanting active consent. It's mostly apathy or paperwork hurdles.

I fully support parents' right to full consent, and parents have that with the passive consent legislation, whereby any parent can deny their child's participation, and in addition, any student can him/herself refuse to participate as well.

So, I ask that the committee support this legislation, which will cause a significant savings and enable communities to work in a "results accountability" manner. I am available if the committee would like more information about how Anchorage partners are using YRBS data to drive action plans that are accountable for results.

Sincerely,

A handwritten signature in cursive script that reads "June Sobocinski".

June Sobocinski
Vice President, Community Action
United Way of Anchorage

cc: Senator Bettye Davis, sponsor, SB 101 Student Questionnaires and Surveys

LIVE UNITED.



February 2, 2010

To: Representative Bob Herron
State Capitol Rm 411
Juneau, Ak 99801

Dear Representative Herron,

On the behalf of the Alaska Red Ribbon Coalition, I am writing in support of SB 101, "An Act relating to questionnaires and surveys administered in the public schools."

The Red Ribbon Coalition relies on data retrieved from the Youth Risk Behavior Survey to secure funding for prevention efforts. The information provided by the YRBS is imperative to understanding health and social issues of Alaska's youth. Accurate YRBS data enables the Coalition to implement youth substance abuse prevention strategies in the Anchorage community.

Senate Bill 101 will continue to protect the anonymity of survey participants, the right of parents to dissent permission, and require advance written notice of survey administration in schools. It will increase participation in the YRBS, increasing the accuracy of the data. This will also allow more cost-effective implementation for the school district.

This information is important to many local and statewide groups, who are actively supporting youth and families in Alaska. Thank you for taking the time to consider our support.

Sincerely,

A handwritten signature in black ink that reads "Sara Clark". The signature is written in a cursive style.

Sara Clark
Red Ribbon Coalition Coordinator
Boys & Girls Clubs Alaska
2300 West 36th Ave
Anchorage, Ak 99517
sclark@bgcalaska.org
(907) 770-7330

701 West 8th Avenue, Suite 230
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tel 907.263.3800
fax 907.263.3801
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February 2, 2010

The Honorable Bob Herron
Alaska State House Representative
State Capitol Room 411
Juneau, AK 99801



Dear Representative Herron:

United Way of Anchorage and its 20-member business and community leader Board of Directors requests your support for Senate Bill 101, *"An Act relating to questionnaires and surveys administered in the public schools."*

United Way of Anchorage's mission is to advance the common good by making lasting, measurable changes in community conditions that improve lives. We have set a community goal to increase high school graduation rates through a series of proven strategies. Two critical strategies are to decrease youth delinquency and substance use. To do this, we rely on valid community data to help us understand where our youth need additional services and support. It is also critical that we remain accountable for our work by measuring many points of data to see where we are succeeding and where we have more work to do.

The Youth Risk Behavior Survey (YRBS) provides community level data that is central to the ongoing measurement of our work and the work of many of our service partners. Vital data collected through this tool include youth substance use rates, youth engagement in meaningful activities, youth perception of sufficient supportive adult relationships in their lives, and several risk factors including access to alcohol and engagement in risky behavior. This data informs the planning, implementation, investment in, and evaluation of a community-wide youth plan that serves tens of thousands Anchorage youth.

United Way of Anchorage supports Senate Bill 101 because passive parental consent removes the obstacles to acquiring statistically valid and reliable data about our youth while keeping safeguards in place for both parents and their children. Current legislation that requires active parental consent places an enormous logistical and financial burden on our schools and the state simply to get permission slips returned. Approximately \$90,000 is spent for just one survey cycle in order to provide the incentives necessary to simply get permission slips returned. However, failure to return permission slips is primarily linked to apathy, oversight, and student error, not parental refusal of permission, which averages around 10%.

We thank you for your commitment to our state and its youth and ask that you support SB101.

Sincerely,

Michele Brown
President and CEO
United Way of Anchorage

cc: Representative Wes Keller; Senator Bettye Davis

LIVE UNITED.



Alaska State Legislature

Please enter into the record my testimony to the House Health & Social Services
committee name

Committee on SB 101 Student questionnaires, dated 2-11-10
bill # / subject public hearing date

Dear HHSS Committee Members,

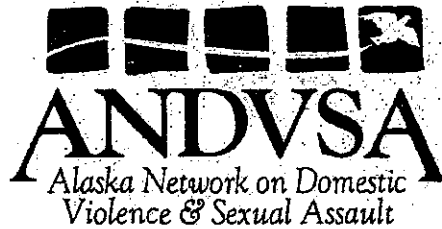
I support SB 101 for the following reasons:

1. It has an opt out provision for parents AND students as well as an opportunity for parents to read the survey ahead of time. It is difficult to get students to return forms. They are kids and don't always do what we want. Many forms end up in the bottom of backpacks or washed in the laundry. The administrative costs to have an opt in are high. As school board members we want to spend our money in classrooms, not on administrative costs. Students in individual classrooms certainly do return field trip forms but most field trips are sponsored by an individual teacher in an elementary classroom. This survey applies to high school students.
2. As school board members we prefer to supplement our programs with grants. The Youth Risk Behavior Survey requires a 60% participation state level.
3. School districts need this information for the safety of all children. This gives us data on obesity, diabetes, suicide prevention, violence/bullying as well as substance abuse. We need to know how students perceive these issues to better serve their needs. We want to provide the best and safest learning environment possible.

Thank you for your service.

Signed: Sammy Crawford
Testifier
Kenai Peninsula Borough School Board Past President, Association of Alaska School Boards
Representing (optional)
36615 Chinulna Ave Kenai, AK 99611
Address
283-9271
Phone number

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Phone: (907) 586-3650
Fax: (907) 463-4493
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Pro Bono Office
PO Box 6631
Sitka, Alaska 99835
Phone: (907) 747-7545
Fax: (907) 747-7547

February 11, 2010 -

Senator Bettye Davis
State Capitol, Room 30
Juneau, AK 99801

Re: Letter of Support - SB 101

Dear Senator Davis:

Thank you for introducing SB 101, an Act relating to questionnaires and surveys in the public schools. The Alaska Network on Domestic Violence and Sexual Assault is committed to prevention efforts and serving victims of violence. This bill can help: SB 101 would provide an invaluable tool for domestic violence, teen dating violence and sexual violence prevention efforts to understand the prevalence and shared risks of youth experiencing violence.

The Centers for Disease Control and Prevention (CDC) Youth Risk Behavioral Survey (YRBS) is used nationally, and within Alaska, to determine risk behaviors among the Alaska high school student population. CDC-developed YRBS data is a credible data source that can be compared to national data. This survey covers a broad range of risk behaviors and streamlines information gathering/surveys in the schools. However, currently with our active consent YRBS policies, many communities, and sometimes our state, have struggled to have enough responses to consider the data as valid.

This information and data is essential to help educators, health workers, social services, victim service programs, and others better serve their communities. This data helps teachers working on prevention education to determine the best age to teach various skills and health topics in their classrooms. This data also helps organizations seeking resources to advocate for real needs in their communities as well as assisting health practitioners and others to determine how to best approach students with co-occurring risk behaviors.

Within the field of domestic and sexual violence prevention, current YRBS data indicates that in traditional high schools, more than 17% of 12th grade students have experienced physical violence in a dating relationship and more than 11.5% have been forced to have sexual intercourse. We also, know that in alternative schools these numbers are 22.6% and 21.9%. While these numbers are staggering they are incomplete. Many of our most vulnerable students are unlikely to turn in their parental permission forms and therefore will be unable to participate in this survey.

Member Programs

Anchorage AWAIC, STAR Barrow AWIC Bethel TWC Cordova CFRC Dillingham SAFE
Fairbanks LAC Homer SPHH Juneau AWARE Kenai LeeShore Center Ketchikan WISH Kodiak KWRCC
Kotzebue MFCC Nome BSWG Seward SCS Sitka SAFV Unalaska USAFV Valdez AVV



Alaska State Legislature

Please enter into the record my testimony to the House Health & Social Services
committee name

Committee on SB 101 Student questionnaires, dated 2-11-10
bill # / subject public hearing date

Dear HHSS Committee Members,

I support SB 101 for the following reasons:

1. It has an opt out provision for parents AND students as well as an opportunity for parents to read the survey ahead of time. It is difficult to get students to return forms. They are kids and don't always do what we want. Many forms end up in the bottom of backpacks or washed in the laundry. The administrative costs to have an opt in are high. As school board members we want to spend our money in classrooms, not on administrative costs. Students in individual classrooms certainly do return field trip forms but most field trips are sponsored by an individual teacher in an elementary classroom. This survey applies to high school students.
2. As school board members we prefer to supplement our programs with grants. The Youth Risk Behavior Survey requires a 60% participation state level.
3. School districts need this information for the safety of all children. This gives us data on obesity, diabetes, suicide prevention, violence/bullying as well as substance abuse. We need to know how students perceive these issues to better serve their needs. We want to provide the best and safest learning environment possible.

Thank you for your service.

Signed: Sammy Crawford
Testifier
Kenai Peninsula Borough School Board Past President, Association of Alaska School Boards
Representing (optional)
36615 Chinulna Ave Kenai, AK 99611
Address
283-9271
Phone number

February 4, 2010

House Health and Social Services Committee
State Capitol, Room 106
Juneau, AK 99801

RE: SB101—Student Questionnaires and Surveys

Dear House HSS Committee:

The Mat-Su Substance Abuse Prevention Coalition is pleased to provide its support for SB 101, an Act relating to questionnaires and surveys administered in the public schools.

The Youth Risk Behavior Survey (YRBS) is vitally important for tracking the behaviors that affect health and well-being of our nation's youth. In addition, the YRBS data are an invaluable resource used by public and private organizations to set and monitor goals, develop health education programs and to seek funding for programs that focus on reducing the health risk behaviors among youth.

The Mat-Su Substance Abuse Prevention Coalition has committed to develop and implement a comprehensive multi-faceted plan leading to measurable per capita reductions in one or more substance abuse problems. Our work is a coordinated effort to maximize community resources and provide a more integrated approach to reduce substance abuse among youth and, over time, among adults by addressing the factors in our community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

Our Coalition members have agreed to participate at the agency level in the collection and assessment of data and to share that data with coalition members in order to define the problems, resources and readiness within the Matanuska-Susitna Borough to address needs and gaps with regard to the substance abuse issue. Our coalition is committed to developing a comprehensive, strategic and data-driven plan that includes policies, programs and practices to address problems identified through the assessment process.

The Alaska Youth Risk Behavior Survey is an important tool in understanding how many youth are engaged in substance abuse, what substances they are using, at what age they started and how they obtained the substance. Due to current State statute AS 14.03.110, the response rate of the 2005 YRBS was so low that the results could not be tallied or released to Mat-Su Borough school district officials. Our coalition could not examine the data or adjust our goals and objectives to implement evidence-based prevention programs, policies and practices in our community. We can't combat what we don't thoroughly understand or know.

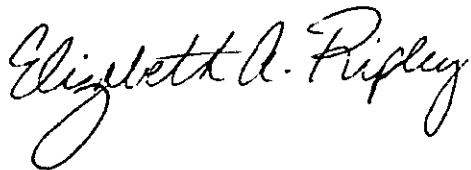
The current law, requiring signed permission slips for any student to participate, unnecessarily hinders data collection needed to design and evaluate risk prevention programs and services to protect our youth. The state spent about \$90,000 last year on incentives to support getting permission slips returned. This is in addition to extra staff time and costs incurred by local school districts. Over the last decade, the survey has had years of not meeting the necessary sample size to have valid data or has barely made the cut off for valid data, but with a higher margin of error than a larger sample size would have provided.

SB101 recognizes the need to keep parents informed and given opportunities for engagement. It balances this with the need to keep administrative burden to a minimum, resulting in a bill that supports both parental involvement and the ability to better serve our youth.

The language in SB 101 allows parents to opt out of the survey for their children, thereby providing those who object a fair and equitable way to prevent their children from participating in the survey. The Mat-Su Substance Abuse Prevention Coalition acknowledges that this opportunity to object is necessary and supports this measure. However, most of the research indicates that parental failures to provide a written permission are driven by apathy, oversight or student error, not by refusal. The current statute results in extremely low response by parents, an inadequate response rate for the survey, and therefore a statistically significant margin of error.

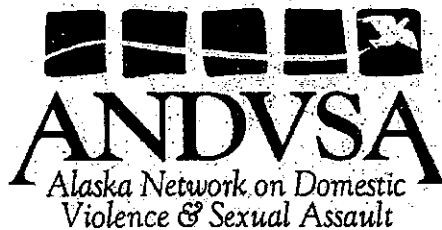
If the Mat-Su Substance Abuse Prevention Coalition succeeds in reducing substance abuse by youth in our community, everyone wins: every parent, child, school, business, neighborhood, and provider. To build this healthier community, we need access to valid and reliable anonymous data about our youth. We fully endorse SB 101 to this end. Many thanks for your efforts!

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth A. Ripley". The signature is written in black ink and is positioned above the typed name and title.

Elizabeth Ripley
Chair, Mat-Su Substance Abuse Prevention Coalition

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Phone: (907) 747-7545
Fax: (907) 747-7547

February 11, 2010

Senator Bettye Davis
State Capitol, Room 30
Juneau, AK 99801

Re: Letter of Support – SB 101

Dear Senator Davis:

Thank you for introducing SB 101, an Act relating to questionnaires and surveys in the public schools. The Alaska Network on Domestic Violence and Sexual Assault is committed to prevention efforts and serving victims of violence. This bill can help. SB 101 would provide an invaluable tool for domestic violence, teen dating violence and sexual violence prevention efforts to understand the prevalence and shared risks of youth experiencing violence.

The Centers for Disease Control and Prevention (CDC) Youth Risk Behavioral Survey (YRBS) is used nationally, and within Alaska, to determine risk behaviors among the Alaska high school student population. CDC-developed YRBS data is a credible data source that can be compared to national data. This survey covers a broad range of risk behaviors and streamlines information gathering/surveys in the schools. However, currently with our active consent YRBS policies, many communities, and sometimes our state, have struggled to have enough responses to consider the data as valid.

This information and data is essential to help educators, health workers, social services, victim service programs, and others better serve their communities. This data helps teachers working on prevention education to determine the best age to teach various skills and health topics in their classrooms. This data also helps organizations seeking resources to advocate for real needs in their communities as well as assisting health practitioners and others to determine how to best approach students with co-occurring risk behaviors.

Within the field of domestic and sexual violence prevention, current YRBS data indicates that in traditional high schools, more than 17% of 12th grade students have experienced physical violence in a dating relationship and more than 11.5% have been forced to have sexual intercourse. We also, know that in alternative schools these numbers are 22.6% and 21.9%. While these numbers are staggering they are incomplete. Many of our most vulnerable students are unlikely to turn in their parental permission forms and therefore will be unable to participate in this survey.

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Fairbanks IAC Homer SPHH Juneau AWARE Kenai LeeShore Center Ketchikan WISH Kodiak KWRCC
Kotzebue MFCC Nome BSWG Seward SCS Sitka SAFV Unalaska USAFV Valdez AVV

Appendix A High School Questions and Responses

High School Questions and Responses

	Unweighted (N)	Weighted (Percent)
1. How old are you?		
12 years or younger	2	0.1
13 years	2	0.1
14 years	160	9.6
15 years	433	26.7
16 years	432	25.8
17 years	389	22.3
18 years or older	215	15.3
Total	1633	100.0
2. What is your sex?		
Female	807	47.6
Male	821	52.4
Total	1628	100.0
3. In what grade are you?		
9th grade	497	29.8
10th grade	383	25.8
11th grade	477	23.0
12th grade	269	21.0
Ungraded or Other	6	0.4
Total	1632	100.0
4. How do you describe yourself?		
White - not Hispanic	1147	68.3
Black - not Hispanic	87	5.2
Hispanic or Latino	53	3.3
Asian or Pacific Islander	75	4.3
American Indian or Alaskan Native	184	15.0
Other	62	3.9
Total	1608	100.0
5. How often do you wear a seat belt when riding in a car driven by someone else?		
Never	95	6.3
Rarely	196	13.2
Sometimes	271	17.6
Most of the time	497	29.4
Always	571	33.5
Total	1630	100.0
6. During the past 12 months, how many times did you ride a motorcycle?		
0 times	1191	73.8
1 to 10 times	291	17.9
11 to 20 times	51	3.2
21 to 39 times	16	0.9
40 or more times	69	4.2
Total	1618	10.0

	Unweighted (N)	Weighted (Percent)
7. When you rode a motorcycle during the past 12 months, how often did you wear a helmet?		
I did not ride a motorcycle during the past 12 months	1167	73.3
Never wore a helmet	129	8.5
Rarely wore a helmet	38	2.4
Sometimes wore a helmet	27	1.7
Most of the time wore a helmet	51	2.9
Always wore a helmet	183	11.1
Total	1595	100.0
8. During the past 12 months, how many times did you ride a bicycle?		
0 times	243	15.8
1 to 10 times	480	30.0
11 to 20 times	238	14.5
21 to 39 times	167	10.1
40 or more times	480	29.6
Total	1608	100.0
9. When you rode a bicycle during the past 12 months, how often did you wear a helmet?		
I did not ride a bicycle during the past 12 months	238	15.5
Never wore a helmet	1125	70.2
Rarely wore a helmet	77	4.5
Sometimes wore a helmet	58	3.5
Most of the time wore a helmet	49	2.8
Always wore a helmet	59	3.5
Total	1606	100.0
10. During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?		
0 times	1100	68.1
1 time	176	11.1
2 or 3 times	199	11.6
4 or 5 times	49	2.7
6 or more times	105	6.5
Total	1629	100.0
11. During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol?		
0 times	1413	87.7
1 time	107	6.4
2 or 3 times	45	2.7
4 or 5 times	25	1.6
6 or more times	26	1.5
Total	1616	100.0

	Unweighted (N)	Weighted (Percent)
12. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club?		
0 days	1234	76.5
1 day	80	5.0
2 or 3 days	80	4.9
4 or 5 days	34	2.1
6 or more days	182	11.4
Total	1610	100.0
13. During the past 30 days, on how many days did you carry a gun?		
0 days	1475	90.9
1 day	63	3.9
2 or 3 days	34	2.1
4 or 5 days	13	0.8
6 or more days	34	2.2
Total	1619	100.0
14. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property?		
0 days	1428	87.7
1 day	47	3.1
2 or 3 days	37	2.3
4 or 5 days	11	0.7
6 or more days	98	6.1
Total	1621	100.0
15. During the past 30 days, how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?		
0 days	1570	96.4
1 day	26	1.5
2 or 3 days	20	1.3
4 or 5 days	6	0.4
6 or more days	7	0.4
Total	1629	100.0
16. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club on school property?		
0 times	1496	90.6
1 time	57	3.3
2 or 3 times	61	3.5
4 or 5 times	11	0.7
6 or 7 times	7	0.5
8 or 9 times	4	0.2
10 or 11 times	4	0.2
12 or more times	18	1.0
Total	1631	100.0

	Unweighted (N)	Weighted (Percent)
17. During the past 12 months, how many times has someone stolen or deliberately damaged your property such as your car, clothing, or books on school property?		
0 times	1032	64.2
1 time	243	14.7
2 or 3 times	240	14.5
4 or 5 times	54	3.3
6 or 7 times	23	1.3
8 or 9 times	9	0.5
10 or 11 times	6	0.4
12 or more times	19	1.1
Total	1626	100.0
18. During the past 12 months, how many times were you in a physical fight?		
0 times	1038	64.2
1 time	249	15.7
2 or 3 times	174	10.9
4 or 5 times	65	4.3
6 or 7 times	21	1.4
8 or 9 times	8	0.6
10 or 11 times	8	0.4
12 or more times	43	2.5
Total	1606	100.0
19. During the past 12 months, how many times were you in a physical fight in which you were injured and had to be treated by a doctor or nurse?		
0 times	1545	95.3
1 time	56	3.5
2 or 3 times	10	0.7
4 or 5 times	3	0.3
6 or more times	6	0.3
Total	1620	100.0
20. During the past 12 months, how many times were you in a physical fight on school property?		
0 times	1351	83.4
1 time	166	10.5
2 or 3 times	62	4.0
4 or 5 times	14	0.8
6 or 7 times	7	0.4
8 or 9 times	0	0.0
10 or 11 times	6	0.4
12 or more times	10	0.5
Total	1616	100.0

	Unweighted (N)	Weighted (Percent)
21. The last time you were in a physical fight, with whom did you fight?		
I have never been in a physical fight	671	41.5
A total stranger	137	8.6
A friend or someone I know	398	25.5
A boyfriend, girlfriend, or date	16	1.0
A parent, brother, sister, or other family member	167	9.8
Someone not listed above	135	8.1
More than one of the persons listed above	92	5.5
Total	1616	100.0
22. During the past 12 months, did you ever seriously consider attempting suicide?		
Yes	392	23.9
No	1237	76.1
Total	1629	100.0
23. During the past 12 months, did you make a plan about how you would attempt suicide?		
Yes	308	18.7
No	1320	81.3
Total	1628	100.0
24. During the past 12 months, how many times did you actually attempt suicide?		
0 times	1394	90.6
1 time	79	5.3
2 or 3 times	41	2.7
4 or 5 times	10	0.8
6 or more times	9	0.6
Total	1533	100.0
25. If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?		
I did not attempt suicide during the past 12 months	1389	90.6
Yes	41	2.9
No	98	6.6
Total	1528	100.0
26. Have you ever tried cigarette smoking, even one or two puffs?		
Yes	1142	72.1
No	467	27.9
Total	1609	100.0
27. How old were you when you smoked a whole cigarette for the first time?		
I have never smoked a whole cigarette	664	39.5
8 years or younger	119	7.8
9 or 10 years	123	7.7
11 or 12 years	239	15.2
13 or 14 years	287	18.0
15 or 16 years	159	9.8
17 years or older	30	1.9
Total	1621	100.0

	Unweighted (N)	Weighted (Percent)
28. During the past 30 days, on how many days did you smoke cigarettes?		
0 days	1041	63.5
1 or 2 days	94	5.8
3 to 5 days	51	3.2
6 to 9 days	43	2.7
10 to 19 days	59	3.7
20 to 29 days	79	5.1
All 30 days	235	16.0
Total	1602	100.0
29. During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?		
I did not smoke cigarettes during the past 30 days	1039	63.2
Less than 1 cigarette per day	78	5.0
1 cigarette per day	96	6.0
2 to 5 cigarettes per day	241	15.6
6 to 10 cigarettes per day	88	6.2
11 to 20 cigarettes per day	46	2.9
More than 20 cigarettes per day	18	1.1
Total	1606	100.0
30. During the past 30 days, how did you usually get your own cigarettes? (Select only one response.)		
I did not smoke cigarettes during the past 30 days	1032	62.9
I bought them in a store such as a convenience store, supermarket, or gas station	152	9.8
I bought them from a vending machine	11	0.7
I gave someone else money to buy them for me	142	9.7
I borrowed them from someone else	170	10.4
I stole them	32	1.9
I got them some other way	71	4.7
Total	1610	100.0
31. When you bought cigarettes in a store during the past 30 days, were you ever asked to show proof of age?		
I did not smoke cigarettes during the past 30 days	1013	61.6
I did not buy cigarettes in a store during the past 30 days	313	20.2
Yes, I was asked to show proof of age	85	5.7
No, I was not asked to show proof of age	191	12.5
Total	1602	100.0

	Unweighted (N)	Weighted (Percent)
32. During the past 30 days, on how many days did you smoke cigarettes on school property?		
0 days	1325	81.2
1 or 2 days	81	5.3
3 to 5 days	39	2.6
6 to 9 days	17	0.9
10 to 19 days	34	2.2
20 to 29 days	45	2.8
All 30 days	75	5.0
Total	1616	100.0
33. Have you ever tried to quit smoking cigarettes?		
Yes	571	40.0
No	904	60.0
Total	1475	100.0
34. During the past 30 days, on how many days did you use chewing tobacco or snuff, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?		
0 days	1377	84.4
1 or 2 days	87	5.6
3 to 5 days	39	2.3
6 to 9 days	27	1.7
10 to 19 days	25	1.6
20 to 29 days	26	1.7
All 30 days	41	2.7
Total	1622	100.0
35. During the past 30 days, on how many days did you use chewing tobacco or snuff on school property?		
0 days	1470	90.5
1 or 2 days	55	3.4
3 to 5 days	27	1.6
6 to 9 days	14	0.9
10 to 19 days	12	0.7
20 to 29 days	16	0.9
All 30 days	30	1.9
Total	1624	100.0
36. How old were you when you had your first drink of alcohol other than a few sips?		
I have never had a drink of alcohol other than a few sips	300	19.5
8 years or younger	222	14.5
9 or 10 years	117	7.4
11 or 12 years	232	14.8
13 or 14 years	404	26.2
15 or 16 years	229	14.8
17 years or older	35	2.8
Total	1539	100.0

	Unweighted (N)	Weighted (Percent)
37. During your life, on how many days have you had at least one drink of alcohol?		
0 days	304	19.9
1 or 2 days	193	13.6
3 to 9 days	247	15.7
10 to 19 days	190	12.3
20 to 39 days	198	12.6
40 to 99 days	192	12.2
100 or more days	208	13.7
Total	1532	100.0
38. During the past 30 days, on how many days did you have at least on drink of alcohol?		
0 days	824	52.5
1 or 2 days	348	22.7
3 to 5 days	188	11.7
6 to 9 days	108	6.7
10 to 19 days	73	4.5
20 to 29 days	23	1.5
All 30 days	8	0.4
Total	1572	100.0
39. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?		
0 days	1096	68.7
1 day	177	11.4
2 days	114	7.1
3 to 5 days	112	6.6
6 to 9 days	64	3.8
10 to 19 days	33	2.0
20 or more days	7	0.4
Total	1603	100.0
40. During the past 30 days, on how many days did you have at least one drink of alcohol on school property?		
0 days	1524	94.1
1 or 2 days	71	4.3
3 to 5 days	8	0.6
6 to 9 days	10	0.6
10 to 19 days	3	0.1
20 to 29 days	2	0.1
All 30 days	4	0.2
Total	1622	100.0

	Unweighted (N)	Weighted (Percent)
51. During your life, how many times have you used any other type of illegal drug, such as LSD, PCP, ecstasy, mushrooms, speed, ice, or heroin?		
0 times	1321	81.2
1 or 2 times	125	7.7
3 to 9 times	82	4.9
10 to 19 times	44	2.6
20 to 39 times	18	0.9
40 or more times	41	2.7
Total	1631	100.0
52. During your life, how many times have you used a needle to inject any illegal drug into your body?		
0 times	1599	98.0
1 time	12	0.7
2 or more times	21	1.3
Total	1632	100.0
53. During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property?		
Yes	570	34.1
No	1059	65.9
Total	1629	100.0
54. Have you ever been taught about AIDS or HIV infection in school?		
Yes	1500	92.1
No	74	4.6
Not Sure	53	3.4
Total	1627	100.0
55. Have you ever talked about AIDS or HIV infection with your parents or other adults in your family?		
Yes	1070	64.0
No	447	28.9
Not Sure	110	7.1
Total	1627	100.0
56. Have you ever had sexual intercourse?		
Yes	741	47.2
No	851	52.8
Total	1592	100.0
57. How old were you when you had sexual intercourse for the first time?		
I have never had sexual intercourse	851	52.8
11 years or younger	75	4.8
12 years	56	3.6
13 years	109	7.0
14 years	170	10.9
15 years	158	10.0
16 years	113	6.9
17 years or older	59	4.0
Total	1591	100.0

	Unweighted (N)	Weighted (Percent)
58. During your life, with how many people have you had sexual intercourse?		
I have never had sexual intercourse	851	52.8
1 person	260	16.7
2 people	122	7.5
3 people	98	5.9
4 people	60	4.0
5 people	42	2.5
6 or more people	158	10.5
Total	1591	100.0
59. During the past 3 months, with how many people did you have sexual intercourse?		
I have never had sexual intercourse	852	52.9
I have had sexual intercourse, but not during the past 3 months	253	16.6
1 person	341	21.0
2 people	73	4.7
3 people	34	2.3
4 people	10	0.7
5 people	5	0.3
6 or more people	24	1.5
Total	1592	100.0
60. Did you drink alcohol or use drugs before you had sexual intercourse the last time?		
I have never had sexual intercourse	849	52.7
Yes	188	12.0
No	554	35.3
Total	1591	100.0
61. The last time you had sexual intercourse, did you or your partner use a condom?		
I have never had sexual intercourse	849	52.9
Yes	416	26.7
No	321	20.4
Total	1586	100.0
62. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.)		
I have never had sexual intercourse	853	53.4
No method was used to prevent pregnancy	125	8.2
Birth control pills	91	5.6
Condoms	363	23.4
Withdrawal	91	5.8
Some other method	34	2.2
Not sure	20	1.4
Total	1577	100.0
63. How many times have you been pregnant or gotten someone pregnant?		
0 times	1527	93.9
1 time	61	3.9
2 or more times	19	1.2
Not sure	14	1.0
Total	1621	100.0

	Unweighted (N)	Weighted (Percent)
64. How do you describe your weight?		
Very underweight	17	1.0
Slightly underweight	225	13.5
About the right weight	913	56.8
Slightly overweight	414	25.2
Very overweight	56	3.5
Total	1625	100.0
65. Which of the following are you trying to do about your weight?		
Lose weight	675	40.7
Gain weight	287	17.7
Stay the same weight	277	17.8
I am not trying to do anything about my weight	388	23.8
Total	1627	100.0
66. During the past 30 days, did you diet to lose weight or keep from gaining weight?		
Yes	465	27.4
No	1159	72.6
Total	1624	100.0
67. During the past 30 days, did you exercise to lose weight or to keep from gaining weight?		
Yes	930	55.9
No	696	44.1
Total	1626	100.0
68. During the past 30 days, did you vomit or take laxatives to lose weight or to keep from gaining weight?		
Yes	77	4.9
No	1549	95.1
Total	1626	100.0
69. During the past 30 days, did you take diet pills to lose weight or to keep from gaining weight?		
Yes	68	4.1
No	1559	95.9
Total	1627	100.0
70. Yesterday, how many times did you eat fruit?		
0 times	511	30.9
1 time	495	31.0
2 times	388	23.5
3 or more times	230	14.6
Total	1624	100.0
71. Yesterday, how many times did you drink fruit juice?		
0 times	479	29.4
1 time	459	28.3
2 times	342	21.2
3 or more times	343	21.1
Total	1623	100.0

	Unweighted (N)	Weighted (Percent)
72. Yesterday, how many times did you eat green salad?		
0 times	1079	67.2
1 time	449	26.8
2 times	71	4.4
3 or more times	25	1.6
Total	1624	100.0
73. Yesterday, how many times did you eat cooked vegetables?		
0 times	794	48.6
1 time	634	38.9
2 times	151	9.6
3 or more times	45	2.9
Total	1624	100.0
74. Yesterday, how many times did you eat hamburger, hot dogs, or sausage?		
0 times	922	55.9
1 time	497	31.2
2 times	154	9.5
3 or more times	51	3.4
Total	1624	100.0
75. Yesterday, how many times did you eat french fries or potato chips?		
0 times	820	49.9
1 time	591	36.7
2 times	146	9.1
3 or more times	66	4.3
Total	1623	100.0
76. Yesterday, how many times did you eat cookies, doughnuts, pie, or cake?		
0 times	734	45.0
1 time	558	34.5
2 times	221	13.9
3 or more times	106	6.6
Total	1619	100.0
77. On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes that made you sweat and breathe hard, such as basketball, jogging, swimming laps, tennis, fast bicycling, or similar aerobic activities?		
0 days	169	11.0
1 day	124	7.9
2 days	151	9.2
3 days	201	12.5
4 days	178	11.1
5 days	273	16.6
6 days	155	9.5
7 days	366	22.2
Total	1617	100.0

	Unweighted (N)	Weighted (Percent)
78. On how many of the past 7 days did you do stretching exercises, such as toe touching, knee bending, or leg stretching?		
0 days	378	24.5
1 day	151	9.6
2 days	165	10.5
3 days	177	11.0
4 days	141	8.1
5 days	237	14.2
6 days	107	6.3
7 days	266	15.7
Total	1622	100.0
79. On how many of the past 7 days did you do exercises to strengthen or tone your muscles, such as push-ups, sit-ups, or weight lifting?		
0 days	404	26.3
1 day	131	8.3
2 days	165	10.2
3 days	197	12.1
4 days	178	10.7
5 days	204	12.1
6 days	90	5.0
7 days	252	15.5
Total	1621	100.0
80. On how many of the past 7 days did you walk or bicycle for at least 30 minutes at a time? (Include walking or bicycling to or from school.)		
0 days	494	31.3
1 day	221	13.0
2 days	205	12.9
3 days	166	10.3
4 days	125	7.4
5 days	112	6.9
6 days	60	3.6
7 days	235	14.6
Total	1618	100.0
81. In an average week when you are in school, on how many days do you go to physical education (PE) classes?		
0 days	782	48.9
1 day	20	1.3
2 days	18	1.4
3 days	113	7.3
4 days	236	14.8
5 days	448	26.4
Total	1617	100.0

	Unweighted (N)	Weighted (Percent)
82. During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?		
I do not take PE	737	46.0
Less than 10 minutes	41	2.7
10 to 20 minutes	98	5.6
21 to 30 minutes	188	10.9
More than 30 minutes	552	34.8
Total	1616	100.0
83. During the past 12 months, on how many sports teams run by your school, did you play? (Do not include PE classes.)		
0 teams	796	48.8
1 team	407	24.9
2 teams	242	15.0
3 or more teams	174	11.3
Total	1619	100.0
84. During the past 12 months, on how many sports teams run by organizations outside of your school, did you play?		
0 teams	949	59.0
1 team	398	24.4
2 teams	158	9.9
3 or more teams	113	6.7
Total	1618	100.0

AMENDMENT

OFFERED IN THE HOUSE
TO: SB 101

BY REPRESENTATIVE SEATON

- 1 Page 2, lines 23 - 24:
- 2 Delete "guardian notice of the survey"
- 3 Insert "legal guardian notice of the survey as provided under (d) of this section at least
- 4 two weeks before the survey is administered"

SB

172

**HOUSE CS FOR CS FOR SENATE BILL NO. 172(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): SENATORS OLSON, Davis, French, Kookesh, Paskvan, Ellis, Egan, Meyer, Thomas

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing the Alaska Health Care Commission in the Department of Health**
2 **and Social Services; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 18.05.010(b) is amended to read:

5 (b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 -
6 18.15.395, the department may

7 (1) flexibly use the broad range of powers set out in this title assigned
8 to the department to protect and promote the public health;

9 (2) provide public health information programs or messages to the
10 public that promote healthy behaviors or lifestyles or educate individuals about health
11 issues;

12 (3) promote efforts among public and private sector partners to
13 develop and finance programs or initiatives that identify and ameliorate health
14 problems;

1 (4) establish, finance, provide, or endorse performance management
2 standards for the public health system;

3 (5) develop, adopt, and implement

4 (A) a statewide health plan under AS 18.09 based on
5 recommendations of the Alaska Health Care Commission established in
6 AS 18.09.010; and

7 (B) public health plans and formal policies through regulations
8 adopted under AS 44.62 or collaborative recommendations that guide or
9 support individual and community public health efforts;

10 (6) establish formal or informal relationships with public or private
11 sector partners within the public health system;

12 (7) identify, assess, prevent, and ameliorate conditions of public health
13 importance through surveillance; epidemiological tracking, program evaluation, and
14 monitoring; testing and screening programs; treatment; administrative inspections; or
15 other techniques;

16 (8) promote the availability and accessibility of quality health care
17 services through health care facilities or providers;

18 (9) promote availability of and access to preventive and primary health
19 care when not otherwise available through the private sector, including acute and
20 episodic care, prenatal and postpartum care, child health, family planning, school
21 health, chronic disease prevention, child and adult immunization, testing and screening
22 services, dental health, nutrition, and health education and promotion services;

23 (10) systematically and regularly review the public health system and
24 recommend modifications in its structure or other features to improve public health
25 outcomes; and

26 (11) collaborate with public and private sector partners, including
27 municipalities, Alaska Native organizations, health care providers, and health insurers,
28 within the public health system to achieve the mission of public health.

29 * Sec. 2. AS 18 is amended by adding a new chapter to read:

30 **Chapter 09. Statewide Health Care.**

31 **Article 1. Alaska Health Care Commission.**

1 **Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care
2 Commission is established in the Department of Health and Social Services. The
3 purpose of the commission is to provide recommendations for and foster the
4 development of a statewide plan to address the quality, accessibility, and availability
5 of health care for all citizens of the state.

6 **Sec. 18.09.020. Composition; chair.** The commission consists of 13 members
7 as follows:

8 (1) 10 voting members appointed by the governor as follows:

9 (A) the state officer assigned the duties of medical director for
10 the department, who shall serve as chair;

11 (B) one member who represents the tribal health community in
12 the state;

13 (C) one member who represents a statewide chamber of
14 commerce who is not financially associated with the health care industry;

15 (D) one member who represents the Alaska State Hospital and
16 Nursing Home Association;

17 (E) one member who is a health care provider and

18 (i) engaged in the active practice of the health care
19 provider's profession in the state;

20 (ii) licensed to practice in the state;

21 (iii) not affiliated with the Alaska State Hospital and
22 Nursing Home Association;

23 (F) one member who represents the health insurance industry in
24 the state;

25 (G) one member who is a

26 (i) health care consumer;

27 (ii) resident of the state; and

28 (iii) not employed by and does not have a business
29 interest in the health care industry;

30 (H) one member who is a licensed primary care physician in
31 the state and who is in the active practice of family medicine, primary care

1 internal medicine, or pediatric medicine;

2 (I) one member who represents the Alaska Mental Health Trust
3 Authority;

4 (J) one member who represents community health centers in
5 the state; and

6 (2) three nonvoting members appointed as follows:

7 (A) one ex officio member from the house of representatives,
8 appointed by the speaker of the house of representatives;

9 (B) one ex officio member from the senate, appointed by the
10 president of the senate;

11 (C) an ex officio member representing the Office of the
12 Governor.

13 **Sec. 18.09.030. Public members' terms of office.** (a) Public members of the
14 commission serve for staggered terms of three years or until a successor is appointed.

15 (b) If a vacancy occurs in a public member's seat on the commission, the
16 governor shall make an appointment for the unexpired portion of that member's term.

17 (c) A public member may serve not more than two consecutive terms.

18 (d) In this section, "public member" means those members appointed under
19 AS 18.09.020(1)(B) - (J).

20 **Sec. 18.09.040. Executive director.** The commission may employ an
21 executive director, who may not be a member of the commission and who may be
22 current staff of the department. The executive director serves at the pleasure of the
23 commission. The commission shall establish the duties of the executive director. The
24 executive director is in the partially exempt service under AS 39.25 (State Personnel
25 Act).

26 **Sec. 18.09.050. Staff.** The department may assign employees of the
27 department to serve as staff to the commission. The commission shall prescribe the
28 duties of the commission staff.

29 **Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its
30 membership and consistent with state law, shall adopt and amend bylaws governing
31 proceedings and other activities, including provisions concerning

1 (1) a quorum to transact commission business and other aspects of
2 procedure;

3 (2) frequency and location of meetings;

4 (3) establishment, functions, and membership of committees; and

5 (4) conflicts of interest that require

6 (A) a member to declare a substantial financial interest in an
7 official action and to request to be excused from voting in that instance;

8 (B) a ruling by the chair on a request by a member to be
9 excused from voting;

10 (C) an opportunity to override a ruling by the chair on a
11 majority vote;

12 (D) filing of a written disclosure form with the department that
13 lists all potential conflicts of interest of a member valued at more than \$5,000
14 annually if the interest is related to health care system income affecting the
15 member or a member of the member's immediate family.

16 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
17 the state health planning and coordinating body. Consistent with state and federal law,
18 the commission shall provide recommendations for and foster the development of a
19 statewide health plan containing the following:

20 (1) a comprehensive statewide health care policy;

21 (2) a strategy for improving the health of all residents of the state that

22 (A) encourages personal responsibility for disease prevention,
23 healthy living, and acquisition of health insurance;

24 (B) reduces health care costs by using savings from

25 (i) enhanced market forces;

26 (ii) fraud reduction;

27 (iii) health information technology;

28 (iv) management efficiency;

29 (v) preventative medicine;

30 (vi) successful innovations identified by other states;

31 and

1 (vii) other cost-saving measures;

2 (C) eliminates known health risks, including unsafe water and
3 wastewater systems;

4 (D) develops a sustainable health care workforce;

5 (E) improves access to quality health care; and

6 (F) increases the number of insurance options for health care
7 services.

8 (b) The commission may hold public hearings to gather information and
9 opinions from health care consumers on matters before the commission. Hearings
10 shall be conducted under AS 44.62.210, except that the commission shall provide
11 public notice of hearings not less than 15 days before the conduct of the hearing and
12 include not fewer than three notices published in the statewide news media.

13 (c) The commission shall submit to the governor and the legislature by
14 January 15 of each year an annual report regarding the commission's
15 recommendations and activities. The report shall include voting records, copies of
16 financial disclosures, and conflicts of interest statements.

17 **Sec. 18.09.080. Compensation, per diem, and expenses.** A member
18 appointed to the commission under AS 18.09.020(1) is entitled to per diem,
19 reimbursement for travel, and other expenses authorized by law for boards and
20 commissions under AS 39.20.180.

21 **Article 2. General Provisions.**

22 **Sec. 18.09.900. Regulations.** The department may adopt regulations under
23 AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

24 **Sec. 18.09.990. Definitions.** In this chapter,

25 (1) "commission" means the Alaska Health Care Commission
26 established in AS 18.09.010;

27 (2) "department" means the Department of Health and Social Services.

28 * **Sec. 3.** AS 39.25.120(c)(7) is amended to read:

29 (7) the principal executive officer of the following boards, councils, or
30 commissions:

31 (A) Alaska Public Broadcasting Commission;

- 1 (B) Professional Teaching Practices Commission;
 2 (C) Parole Board;
 3 (D) Board of Nursing;
 4 (E) Real Estate Commission;
 5 (F) Alaska Royalty Oil and Gas Development Advisory Board;
 6 (G) Alaska State Council on the Arts;
 7 (H) Alaska Police Standards Council;
 8 (I) Alaska Commission on Aging;
 9 (J) Alaska Mental Health Board;
 10 (K) State Medical Board;
 11 (L) Governor's Council on Disabilities and Special Education;
 12 (M) Advisory Board on Alcoholism and Drug Abuse;
 13 (N) Statewide Suicide Prevention Council;
 14 (O) the State Board of Registration for Architect, Engineers,
 15 and Land Surveyors;

16 **(P) Alaska Health Care Commission;**

17 * Sec. 4. AS 44.66.010(a) is amended to read:

18 (a) Boards and commissions listed in this subsection expire on the date set out
 19 after each:

- 20 (1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;
 21 (2) Board of Parole (AS 33.16.020) - June 30, 2016;
 22 (3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;
 23 (4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;
 24 (5) Council on Domestic Violence and Sexual Assault (AS 18.66.010)
 25 - June 30, 2014;
 26 (6) special education service agency (AS 14.30.600) - June 30, 2013;
 27 (7) [REPEALED
 28 (8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30,
 29 2013;
 30 **(8)** [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) -
 31 June 30, 2012;

(9) Alaska Health Care Commission (AS 18.09.010) - June 30,1
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16**2014.**

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed to the Alaska Health Care Commission, established by Administrative Order No. 246 dated December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms as determined by the governor according to AS 39.05.055.

* **Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON



ALASKA
STATE CAPITOL
ROOM 508
JUNEAU, ALASKA 99801-1182

(907) 465-3707
FAX (907) 465-4821

SPONSOR STATEMENT

Senate Bill 172 Alaska Health Care Commission

Alaska is currently facing serious healthcare cost, access and quality issues. Between 1991 and 2005, health care expenditures in our state more than tripled from \$1.6 billion to \$5.3 billion. Costs are expected to double again by 2013 to over \$10 billion. All levels of government – state, local, and federal – are affected, and Alaska's economy cannot sustain this inflationary growth. The purpose of SB 172 is to establish in statute the Alaska Health Care Commission to address the need for health care reform in our state. This issue is complex and broad in scope, and cannot be dealt with adequately unless we have a permanent body to plan and follow through for long range comprehensive health care reform.

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007) both recommended that a permanent body be established to address the problem of health care reform. The Roundtable (which met for 2 years) and the Planning Council (which met for 6 months) recognized that the problem is too great to be effectively addressed through a short-term, ad-hoc body.

The Alaska Health Care Commission would be established in the Department of Health and Social Services, and would consist of a thirteen member body including public officials and private citizens. Representatives from both the executive and legislative branches of state government are included, as well as citizens representing the private business sector, the health care community, and consumers. Three members are to be ex officio appointees from the legislature and the governor's office. The composition and small size would enable efficient and effective teamwork and decision-making, while bringing a balance of viewpoints and perspectives.

The commission would provide its recommendations and support the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the State. A plan for reform will be based on education, sustainability, management efficiency, health care effectiveness, private-public partnerships, research, personal responsibility and individual choice.

Alaska's need for healthcare reform is pressing and must be dealt with thoroughly and efficiently, with a long range view towards meaningful and lasting change. The Alaska Health Care Commission would play an important role in this process, and it is essential that we make it a permanent component of the Department of Health and Social Services, so that present as well as future issues with Alaska's healthcare systems can be better anticipated, understood and addressed.

Sectional analysis: Alaska Health Care Commission Bill

Section 1

AS 18.05.010(b)- Establishes the Alaska Health Care Commission in the Department of Health and Social Services that will work toward recommendations for a statewide health plan under AS 18.09.

Statewide Health Care Section 2

Sec 18.09.010-This section is the basic language to establish the Commission and outline the commission's primary objectives.

Sec 18.09.020-Creates a 10 member Commission made up of Health Professionals and the public including three ex officio appointees from the legislature and the governors office.

Sec. 18.09.030- Members will serve three year staggered terms. Should an opening occur prior to the completion of the term the governor shall appoint a replacement.

Sec. 18.09.040- Creates the position of executive director as a partially exempt position appointed by the commission.

Sec. 18.09.050- Permits the Department to assign employees to work with the Commission as support staff.

Sec. 18.09.060- The commission shall submit internally by-laws for consideration by the full Commission. By laws will establish quorum requirements, time and locations for meetings, etc. The section also defines conflicts of interests when voting and annual reporting requirements

Sec. 18.09.070- This section defines the duties of the Commission, to include goals and language for input from the public through the public hearing process.

Sec. 18.09.080- Standard language that allows members to receive per diem and travel but no salary for serving on the commission.

Sec. 18.09.900- Authorizes the Department to promulgate the necessary regulations to maintain the commission

Sec 18.09.990- Defines the use of the words commission and department.

Section 3

AS 39.25.120 (c)(7)- adds the commissions executive director position to the list of existing executive directors serving other boards and commissions.

Section 4

AS 44.66.010 (a)- Sunset- the commission expires unless renewed by the legislature on June 30, 2014

Section 5

Uncodified language- Permits the department to begin the regulatory process which can not take effect until this bill is singed into law.

Section 6

Uncodified language- The members already serving on the commission shall continue in their positions based on the staggering of their terms.

Section 7

Effective date- Immediate effective date clause.

CS FOR SENATE BILL NO. 172(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered: 4/10/10

Referred: Rules

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing the Alaska Health Care Commission in the Department of Health**
2 **and Social Services; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 18.05.010(b) is amended to read:

5 (b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 -
6 18.15.395, the department may

7 (1) flexibly use the broad range of powers set out in this title assigned
8 to the department to protect and promote the public health;

9 (2) provide public health information programs or messages to the
10 public that promote healthy behaviors or lifestyles or educate individuals about health
11 issues;

12 (3) promote efforts among public and private sector partners to
13 develop and finance programs or initiatives that identify and ameliorate health
14 problems;

1 (4) establish, finance, provide, or endorse performance management
2 standards for the public health system;

3 (5) develop, adopt, and implement

4 (A) a statewide health plan under AS 18.09 based on
5 recommendations of the Alaska Health Care Commission established in
6 AS 18.09.010; and

7 (B) public health plans and formal policies through regulations
8 adopted under AS 44.62 or collaborative recommendations that guide or
9 support individual and community public health efforts;

10 (6) establish formal or informal relationships with public or private
11 sector partners within the public health system;

12 (7) identify, assess, prevent, and ameliorate conditions of public health
13 importance through surveillance; epidemiological tracking, program evaluation, and
14 monitoring; testing and screening programs; treatment; administrative inspections; or
15 other techniques;

16 (8) promote the availability and accessibility of quality health care
17 services through health care facilities or providers;

18 (9) promote availability of and access to preventive and primary health
19 care when not otherwise available through the private sector, including acute and
20 episodic care, prenatal and postpartum care, child health, family planning, school
21 health, chronic disease prevention, child and adult immunization, testing and screening
22 services, dental health, nutrition, and health education and promotion services;

23 (10) systematically and regularly review the public health system and
24 recommend modifications in its structure or other features to improve public health
25 outcomes; and

26 (11) collaborate with public and private sector partners, including
27 municipalities, Alaska Native organizations, health care providers, and health insurers,
28 within the public health system to achieve the mission of public health.

29 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:

30 **Chapter 09. Statewide Health Care.**

31 **Article 1. Alaska Health Care Commission.**

1 **Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care
 2 Commission is established in the Department of Health and Social Services. The
 3 purpose of the commission is to provide recommendations for and foster the
 4 development of a statewide plan to address the quality, accessibility, and availability
 5 of health care for all citizens of the state.

6 **Sec. 18.09.020. Composition; chair.** The commission consists of 13 members
 7 as follows:

8 (1) 10 voting members appointed by the governor as follows:

9 (A) the state officer assigned the duties of medical director for
 10 the department, who shall serve as chair;

11 (B) one member who represents the tribal health community in
 12 the state;

13 (C) one member who represents a statewide chamber of
 14 commerce who is not financially associated with the health care industry;

15 (D) one member who represents the Alaska State Hospital and
 16 Nursing Home Association;

17 (E) one member who is a health care provider and

18 (i) engaged in the active practice of the health care
 19 provider's profession in the state;

20 (ii) licensed to practice in the state;

21 (iii) not affiliated with the Alaska State Hospital and
 22 Nursing Home Association;

23 (F) one member who represents the health care industry in the
 24 state;

25 (G) one member who is a

26 (i) health care consumer;

27 (ii) resident of the state; and

28 (iii) not employed by and does not have a business
 29 interest in the health care industry;

30 (H) one member who is a licensed primary care physician in
 31 the state and who is in the active practice of family medicine, primary care

1 internal medicine, or pediatric medicine;

2 (I) one member who represents the Alaska Mental Health Trust
3 Authority;

4 (J) one member who represents community health centers in
5 the state; and

6 (2) three nonvoting members appointed as follows:

7 (A) one ex officio member from the house of representatives,
8 appointed by the speaker of the house of representatives;

9 (B) one ex officio member from the senate, appointed by the
10 president of the senate;

11 (C) an ex officio member representing the Office of the
12 Governor.

13 **Sec. 18.09.030. Public members' terms of office.** (a) Public members of the
14 commission serve for staggered terms of three years or until a successor is appointed.

15 (b) If a vacancy occurs in a public member's seat on the commission, the
16 governor shall make an appointment for the unexpired portion of that member's term.

17 (c) A public member may serve not more than two consecutive terms.

18 (d) In this section, "public member" means those members appointed under
19 AS 18.09.020(1)(B) - (J).

20 **Sec. 18.09.040. Executive director.** The commission shall employ an
21 executive director, who may not be a member of the commission. The executive
22 director serves at the pleasure of the commission. The commission shall establish the
23 duties of the executive director. The executive director is in the partially exempt
24 service under AS 39.25 (State Personnel Act).

25 **Sec. 18.09.050. Staff.** The department may assign employees of the
26 department to serve as staff to the commission. The commission shall prescribe the
27 duties of the commission staff.

28 **Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its
29 membership and consistent with state law, shall adopt and amend bylaws governing
30 proceedings and other activities, including provisions concerning

31 (1) a quorum to transact commission business and other aspects of

1 procedure;

2 (2) frequency and location of meetings;

3 (3) establishment, functions, and membership of committees; and

4 (4) conflicts of interest that require

5 (A) a member to declare a substantial financial interest in an
6 official action and to request to be excused from voting in that instance;

7 (B) a ruling by the chair on a request by a member to be
8 excused from voting;

9 (C) an opportunity to override a ruling by the chair on a
10 majority vote;

11 (D) filing of a written disclosure form with the department that
12 lists all potential conflicts of interest of a member valued at more than \$5,000
13 annually if the interest is related to health care system income affecting the
14 member or a member of the member's immediate family.

15 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
16 the state health planning and coordinating body. Consistent with state and federal law,
17 the commission shall provide recommendations for and foster the development of a
18 statewide health plan containing the following:

19 (1) a comprehensive statewide health care policy;

20 (2) a strategy for improving the health of all residents of the state that

21 (A) encourages personal responsibility for disease prevention,
22 healthy living, and acquisition of health insurance;

23 (B) reduces health care costs by using savings from

24 (i) enhanced market forces;

25 (ii) fraud reduction;

26 (iii) health information technology;

27 (iv) management efficiency;

28 (v) preventative medicine;

29 (vi) successful innovations identified by other states;

30 and

31 (vii) other cost-saving measures;

1 (C) eliminates known health risks, including unsafe water and
2 wastewater systems;

3 (D) develops a sustainable health care workforce;

4 (E) improves access to quality health care; and

5 (F) increases the number of insurance options for health care
6 services.

7 (b) The commission may hold public hearings to gather information and
8 opinions from health care consumers on matters before the commission. Hearings
9 shall be conducted under AS 44.62.210, except that the commission shall provide
10 public notice of hearings not less than 15 days before the conduct of the hearing and
11 include not fewer than three notices published in the statewide news media.

12 (c) The commission shall submit to the governor and the legislature by
13 January 15 of each year an annual report regarding the commission's
14 recommendations and activities. The report shall include voting records, copies of
15 financial disclosures, and conflicts of interest statements.

16 **Sec. 18.09.080. Compensation, per diem, and expenses.** A member
17 appointed to the commission under AS 18.09.020(1) is entitled to per diem,
18 reimbursement for travel, and other expenses authorized by law for boards and
19 commissions under AS 39.20.180.

20 **Article 2. General Provisions.**

21 **Sec. 18.09.900. Regulations.** The department may adopt regulations under
22 AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

23 **Sec. 18.09.990. Definitions.** In this chapter,

24 (1) "commission" means the Alaska Health Care Commission
25 established in AS 18.09.010;

26 (2) "department" means the Department of Health and Social Services.

27 * **Sec. 3.** AS 39.25.120(c)(7) is amended to read:

28 (7) the principal executive officer of the following boards, councils, or
29 commissions:

30 (A) Alaska Public Broadcasting Commission;

31 (B) Professional Teaching Practices Commission;

- 1 (C) Parole Board;
 2 (D) Board of Nursing;
 3 (E) Real Estate Commission;
 4 (F) Alaska Royalty Oil and Gas Development Advisory Board;
 5 (G) Alaska State Council on the Arts;
 6 (H) Alaska Police Standards Council;
 7 (I) Alaska Commission on Aging;
 8 (J) Alaska Mental Health Board;
 9 (K) State Medical Board;
 10 (L) Governor's Council on Disabilities and Special Education;
 11 (M) Advisory Board on Alcoholism and Drug Abuse;
 12 (N) Statewide Suicide Prevention Council;
 13 (O) the State Board of Registration for Architect, Engineers,
 14 and Land Surveyors;

15 **(P) Alaska Health Care Commission;**

16 * Sec. 4. AS 44.66.010(a) is amended to read:

17 (a) Boards and commissions listed in this subsection expire on the date set out
 18 after each:

- 19 (1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;
 20 (2) Board of Parole (AS 33.16.020) - June 30, 2016;
 21 (3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;
 22 (4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;
 23 (5) Council on Domestic Violence and Sexual Assault (AS 18.66.010)
 24 - June 30, 2014;
 25 (6) special education service agency (AS 14.30.600) - June 30, 2013;
 26 (7) [REPEALED
 27 (8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30,
 28 2013;
 29 **(8) [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) -**
 30 **June 30, 2012;**
 31 **(9) Alaska Health Care Commission (AS 18.09.010) - June 30,**

1 **2014.**

2 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 TRANSITION: REGULATIONS. The Department of Health and Social Services may
5 proceed to adopt regulations necessary to implement the changes made by this Act. The
6 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the
7 effective date of the statutory change.

8 * **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to
9 read:

10 TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed
11 to the Alaska Health Care Commission, established by Administrative Order No. 246 dated
12 December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission
13 under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms
14 as determined by the governor according to AS 39.05.055.

15 * **Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB172
 () Publish Date: _____

Identifier (file name): SB172-DHSS-PHA-02-01-10 Dept. Affected: Health & Social Services
 Title Alaska Health Care Commission RDU Public Health
 Component Public Health Administration
 Sponsor Olson
 Requester Senate HSS Component Number 292

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services	134.5		134.5	134.5	134.5	134.5	134.5	134.5
Travel	35.0		35.0	35.0	35.0	35.0	35.0	35.0
Contractual	300.0		320.5	320.5	320.5	320.5	320.5	320.5
Supplies	20.5		10.0	10.0	10.0	10.0	10.0	10.0
Equipment	10.0		0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	500.0	0.0	500.0	500.0	500.0	500.0	500.0	500.0

CAPITAL EXPENDITURE								
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CHANGE IN REVENUES								
---------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF	500.0		500.0	500.0	500.0	500.0	500.0	500.0
1005 GF/Program Receipt								
1037 GF/Mental Health								
Other Interagency Receipt								
TOTAL	500.0	0.0	500.0	500.0	500.0	500.0	500.0	500.0

Estimate of any current year (FY2010) c 500.0

POSITIONS

Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if nece:

SB 172 establishes the Alaska Health Care Commission in DHSS to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The commission would be composed of 10 members. SB 172 closely parallels Administrative Order #246 of December 2008 establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission recently adopted a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska. The

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
 Division Public Health

Phone 269-8126
 Date/Time 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 2/1/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. SB172

ANALYSIS CONTINUATION

(Continued from Page 1)

The commission based this recommendation on the finding that the need for a plan to address health care cost, access and quality issues is greater than ever before. Health care expenditures in Alaska more than tripled between 1991 and 2005 from \$1.6 billion to \$5.3 billion. Costs are expected to double again, to over \$10 billion, by 2013. The Alaska economy cannot sustain this inflationary growth, and government (all levels - local, state, and fed) carries 64% of this cost burden between the cost for government health care programs and provision of health care insurance for government employees. (Data cited from "Alaska's \$5 Billion Health Care Bill - Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.)

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007), both recommended that a permanent body be established to address the problem of health care reform. The problem is too great in scope and too complex to be able to plan and follow-through in just one or two years time through an ad-hoc body.

\$500.0 in state general funds is required for operations of the health care commission, as follows:

71000 Personal Services: The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal services costs of \$134.5 is Range 23, Step F.

72000 Travel Travel and per diem for Commission staff and for 8 Commission members to conduct quarterly face-to-face public meetings. The two other members are legislators and would have per diem and travel covered.

73000 Contractual Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies

In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment

FY11 includes purchase of a server; in subsequent fiscal years provide technology upgrades and maintenance will be covered through the contractual line.

The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

Testimony List for SB 172, Alaska Health Care Commission

By Denise Liccioli, Staff to Senator Olson, 465-3880

These folks were asked to testify:

Ward Hurlburt, MD, Chair, Alaska Health Care Commission; Chief Medical Officer, DHSS; Director, Division of Public Health/DHSS 465-3090

Jeff Jessee, CEO, Ak Mental Health Trust Authority, 269-7963, cell 632-2561

Note: Deb Erickson had a family funeral and I'm not sure if she will be back and able to be able to testify, but just in case, here is her information:

Deborah Erickson, Executive Director, Alaska Health Care Commission 334-2474 or cell 602-0242

Note: Dr Stinson is sometimes scheduled for surgery at the time of the hearing, but just in case he is able, here is his information since we also asked him to testify:

Dr. Lawrence Stinson, MD, private physician (represented Alaska health care providers on the Commission) 278-2741 or cell 250-4607

I believe some or all of these people may sign up to testify:

Linda Hall, Director, Division of Insurance, DCCED (ex-officio member of Commission) 269-7900

Ryan Smith, CEO of Central Peninsula General Hospital (represented ASHNHA on the Commission) 714-4718

Wayne Stevens, CEO and President, Alaska State Chamber of Commerce (represented small business) 586-2010 or cell 486-6036

Keith Campbell, retired CEO of hospital in Seward and former AARP national chairperson (represented consumers) 362-1624 (cell)

Valerie Davidson, JD, Director of Legal and Intergovernmental Affairs for the Alaska Native Tribal Health Consortium (represented the tribal health system) 729-1908 or cell 350-0572

Jeff Davis, President, Premera Alaska (represented the health insurance industry) 677-2404 or cell 223-7950

Brian Saylor, PhD, currently a member of the Anchorage Health & Human Services Commission, recently retired UAA health policy professor, former official with state DHSS and Anchorage DHHS, also former health facility administrator. 258-1176 or cell 952-5478

Shelly Hughes, Govt Affairs Director, Ak Primary Care Assn. 929-2728, cell 841-1634

Rod Betit, ASHNA, 586-1790, cell 321-2461 (his plane will be landing at about the time Finance starts, but he plans to call in to the teleconference number when he lands)

In addition, there is likely to be interest from other groups who might like to call in for public testimony.

Principles, Elements and Specific Steps

Draft 8 August 29, 2007

Proposal by the Alaska Health Care Roundtable to help the Council achieve the goals it identified at its first meeting:

Health Care Strategies Planning Council Mission Statement (Approved at the June 11, 2007 meeting)

Develop strategies, including performance measures, to provide health care access for all Alaskans by 2014 with the goal of making Alaskans the healthiest population in the nation.

The definition of "access" includes: coverage, affordability, timely service, quality of care, prevention, managing chronic conditions, workforce issues and cost.

Roundtable recommendations are as follows:

Principles of reform — Guidelines for creating effective specific action steps

- Creating healthier people who consume less medical services is the only major sustainable strategy to slow growth of health care costs.
- Plans, programs and policies must encourage and support the principle of individual responsibility to maintain and protect each person's health.
- Dramatically improve value for every health care dollar.
 - Health services that effectively educate and motivate individuals underpin an effective, efficient health care system. Prevention and timely appropriate levels of care earn strong return on investment (ROI) for both employer and public programs. Examples are immunization programs, hypertension or HIV screening, promoting prenatal care, etc.
 - Organizational wellness programs, government or private, are starting to prove that improving employee health is a win/win for both employees and employers.
- Financially support carefully planned experimentation with different types of health delivery models and payment models. Alaska is a highly diverse state. The wide variety of community sizes, many in remote areas, with differing access to care and different prevailing payment systems argues towards creating a variety of solutions from which to choose. Employers are particularly concerned about quality.

- All Alaskans need quality, affordable health care that provides:
 - Physical access
 - Financial access
 - Information access

- Facilitate universal participation in the most appropriate fashion for each individual. Forms of coverage or care include:
 - Employer-based
 - Individual-based
 - Federal programs
 - Military programs
 - Alaska Native programs

- Rely on and develop the private insurance market in sectors where it is currently working and other sectors where it can be logically employed. Avoid creating costly state bureaucracies that duplicate private sector capabilities.

- “Grow our own” health care practitioners at all levels as much as possible.
 - In-state education and clinical training increases the likelihood of keeping graduates in Alaska.
 - In-state education stems the flow of education dollars Outside and helps generate a sustainable economy.
 - Create specialized programs to meet the needs of rural Alaska.

- Collaboration and cooperation is essential. The problem is larger than any one part of the system can solve. Areas to address are financing and insurance, workforce development, facilities and citizen education. Private, state, federal and Native resources will need to be coordinated so all can contribute to the solution.

- Generate sufficient information and research, both in Alaska and from best practices Outside, to support sound fact-based decision making.

- Provide sufficient and appropriate facilities where necessary around the state. Emphasize regional planning, coordination, cooperation and efficiency.

- Develop a statewide electronic health record network that is secure and interoperable with existing systems to improve quality of care and reduce waste by providing necessary medical information to providers.

Elements of reform — Building blocks for a better system

- The problem is huge and complex. Businesses, individuals and governments all must contribute to managing and financing a new Alaskan health care system for it to be sustainable.
- We must stem erosion of employer-sponsored insurance. Keep what works and reshape or fill in as necessary. Reform plans should build on and improve existing parts of the system that work without harming those who are already well served.
- Information to evaluate costs and alternatives before and after treatment is an essential building block of individual financial responsibility. Information access and transparency seems like a basic need, but is elusive. Technology and disclosure requirements will help.
- Encourage adequate federal Medicare reimbursement of provider's costs, but cobble together work-arounds until that happens. This can include creative use of Medicare and Medicaid waivers. Keep track of the changing federal health care environment to uncover opportunities and influence needed change.
- Electronic health records are the cornerstone to modernizing Alaska's health care. Build on existing private and state-level initiatives.
- Develop navigation aids and fail-safe systems to help people gain access to and deal with complexities of the system. Navigation aids must take into account the human, as well as the technological networks, which build healthy lives.
- Alaska has information gaps that need to be filled to chart an optimum path to progress. Fundamental research will enable policy-makers to make sound decisions based on facts: 1. Quantify and identify the source of Alaska cost differentials vs. Outside. 2. Understand who is not covered or insufficiently covered. 3. Continue to define work force development challenges across the full job spectrum.
- Build on the many Alaskan programs that have proven effective or show promise in the areas of quality, access and cost control.
- Monitor and learn from other state's experience in coverage and cost control.
- ★ Alaska will need an ongoing official state-wide group to monitor the ever-changing health care scene and find appropriate synergies.

Specific immediate steps to consider



- Establish an ongoing Alaska health care council/commission/board to coordinate public policy.
- Support and coordinate Alaska research and monitor national research and developments.
- Develop a variety of Alaska health care reform plans based on research to be able to compare and contrast their benefits, costs and impacts.
- Support the next step in development of Alaska electronic health records.
- Develop and monitor quantifiable health care goals for Alaska.
- Support workforce development capable of filling current and anticipated needs.
- Encourage primary care capability based on the “Medical Home” model which provides an ongoing health care point of contact. Examples are family physicians or community health centers.
- Monitor and improve liability and tort laws to help reduce malpractice insurance costs, encourage quality improvements and make Alaska a more attractive place to practice medicine.
- Encourage schools at all levels to foster healthy life styles and offer sports and exercise programs that build life long healthy habits.
- Work with the federal delegation and authorities to maximize federal support of Alaska projects and programs and to support national health care reform efforts that will benefit Alaskans.
 - E.g. Develop stand-alone Medicare clinics in major Alaska hubs via an open RFP process
- Identify pseudo-reform “myths”—things to avoid.

Pseudo-reform “myths” — Things to avoid

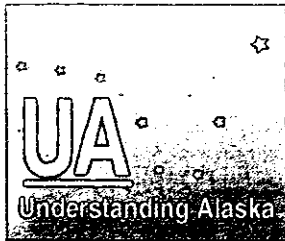
- Continued employer transfer of health care costs to employees.
- Assuming that “market forces” alone will make health care better and more efficient. Health Savings Accounts (HSAs) may be part of a total solution, but not the only solution. Even enlightened health care consumers do not have access to information they need to “shop around” for best value.
- Freezing or reducing state funding. The State of Alaska will need to make additional financial and programmatic investments as a full partner in a comprehensive solution.
- Reliance on the federal government to solve the problem. National solutions are necessary and hopefully will be forthcoming. However, in the interim, Alaska needs to do what it can to help itself.
- ✱ • Assuming, hoping or praying that the problem will solve itself and go away. Effective, creative coordination of every tool available within Alaska is the only chance for success. An ongoing, adequately resourced council, commission or board will need to continue the work of the Alaska Health Care Strategies Planning Council.

Why we need to act now

- As a small state with significant resources, Alaska has the elements it needs to improve the health of its citizens in the long-term.
- Guiding principles will focus the creativity and coordination needed to achieve this lofty, but basic human goal.
- Unchecked, current health trends will create the first generation in 100 years that can expect a shorter life span than their parents.
- Insufficient federal reimbursements are transferring a huge financial burden to the private sector which in turn is passing costs on to employees.
- A mandatory rational system based on the strongest elements already in place can provide basic care for all Alaskans enabling a shift of emphasis towards prevention.
- Investing in prevention and individual responsibility offer high “bang for the buck.” Healthy people feel better and place less financial demands on the system.
- The aging population will increase per capita costs of health. These increases can be mitigated by effective primary prevention and health promotion.
- Everyone and all parts of society need to be part of the solution—businesses, individuals and all levels of government.
- The health care system is not a goal in and of itself. The real goal is healthy Alaskans who know they will be properly cared for if they do get sick.

Background — An unsustainable deteriorating situation

- Many thanks to the Alaska Health Care Strategies Planning Council and key legislators for beginning a formal state dialogue.
- Businesses face annual double-digit increases in health care costs. This necessitates:
 - Cutting back coverage
 - Increasing employee financial contributions
 - Educating and empowering employees to develop healthier lifestyles
- The situation is bad and getting worse.
 - According to a July 2007 Commonwealth Fund report comparing states, Alaska ranks 26th overall, 36th for access and 49th in quality.
 - Medicare and Medicaid do not reimburse providers for their cost of doing business. This “pinch” is being passed on to businesses and insurers, creating an ever-escalating financial burden on them. Health care costs for businesses are a financial ball and chain not shared by international competitors.
 - Many Alaskans are without any health care coverage, or have inadequate coverage.
 - Over 90,000 Alaskans have no health care coverage—if living together, they would be the second largest city in Alaska.
 - Many more are under-insured.
 - Everyone has nominal access to some form of health care at the emergency room, but it is after-the-fact and expensive.
 - Many people in need do not know where to turn because of:
 - Lack of knowledge
 - Lack of money
 - Linguistic and cultural barriers
 - Crushing work and family schedules
 - Alaska is short 300 doctors today, with more needed to replace an aging work force. Similar shortages exist for nurses and other health practitioners.
 - Potential gas pipeline construction will further strain an already challenged Alaska health care system.
- The unhappy net result:
 - Alaska has the highest per capita state expenditures on health care in America (\$8,000 per person).
 - America has the highest per capital health care expenditures in the world (\$7,000 per person).
 - Alaska and America have poor health compared to other industrialized nations despite having greater expenditures on health care.
 - Alaskan and American businesses are becoming less competitive compared to international businesses in countries with public health care systems.
- A caring, humane and financially efficient society cannot continue this downward spiral. Serious national conversations and major state-level reform efforts are under way. Fortunately, Alaska has potential building blocks for a better system and guidelines to help use them.



ALASKA'S \$5 BILLION HEALTH CARE BILL— WHO'S PAYING?

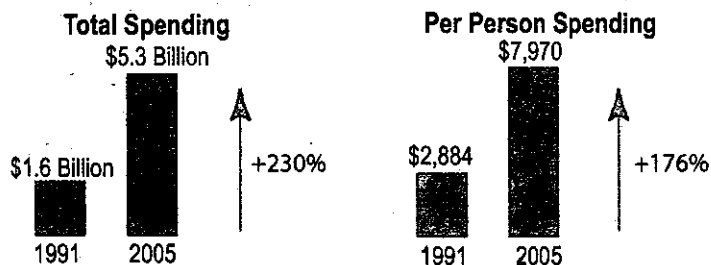
By Mark Foster and Scott Goldsmith

March 2006

UA Research Summary No. 6

Institute of Social and Economic Research • University of Alaska Anchorage

Figure 1. Growth in Alaska Health-Care Spending, 1991-2005



Source: Authors' estimates



Spending for health care in Alaska topped \$5 billion in 2005. Just how big is \$5 billion? It is, for perspective, one-third the value of North Slope oil exports in 2005—a year of high oil prices. It's nearly one-sixth the value of everything Alaska's economy produced last year.

In 1991, health-care spending in Alaska was about \$1.6 billion. Even after we take population growth into account, spending for health care increased 176% per Alaskan in 15 years. These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage.

The \$5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 80%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

What does health-care spending buy? Stays in the hospital, visits to doctors and dentists, prescription drugs, and more, as well as program administration and public health programs. Our estimates don't include capital expenditures.¹

Who pays the bills, and how has that burden shifted as spending increased?

- *Private and government employers spent about \$2 billion for employee health-care coverage in 2005. For comparison, they paid \$11.8 billion in wages in 2005. With rising costs, businesses and governments have become increasingly likely to pay health-care bills themselves—"self-insure"—rather than pay through insurance premiums.*

- *Alaska households spent just over \$1 billion for health care in 2005, up from \$361 million in 1991. That includes everything individual Alaskans spent—not only their out-of-pocket costs, but also what was deducted from their paychecks to help pay for health coverage through their employers.*

- *Governments spent \$2.2 billion for health care programs in 2005, up from \$736 million in 1991. Medicaid spending was almost \$1 billion.*

Health-care spending could double again by 2013, if current trends continue. Why are costs of medical care so high, and why are they increasing faster than everything else? Why have health-care costs in Alaska stayed higher than U.S. averages, even as other costs moved closer to national levels? Are we getting better care now? Who can't afford care?

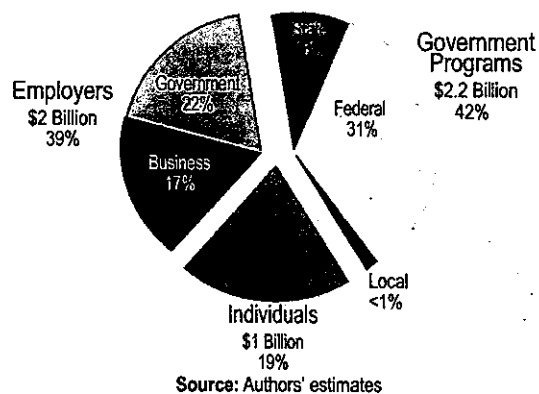
We're starting to assemble data to help answer those questions. Alaskans face some hard choices about how to control costs but still have a health-care system that provides good care and is accessible to everyone. We hope to provide some useful insights.

This publication is the first step in ISER's research on the health-care industry. It starts with our new estimates of spending and of changes since 1991, when we last looked at health-care spending.² But cost alone is only one part of the complicated health-care story, and here we also begin looking at:

- Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.
- Who is more likely to have health insurance provided through their jobs at a reasonable cost? Single people working for big companies.
- How does use of the health care system in the U.S. compare with use in other countries? Canadians and Australians seem to use their systems about as much.
- What is driving costs? Despite what many people think, there are no simple explanations: it's a puzzle with many pieces.

Figure 2. Who Pays The Bills?

(Total 2005 Spending: \$5.3 Billion)



Source: Authors' estimates

Understanding Alaska (UA) is a special series of ISER research studies examining Alaska economic development issues. The studies are paid for by the University of Alaska Foundation. UA reports are available from ISER's offices and at: www.alaskaneconomy.uaa.alaska.edu



ORGANIZATION OF SUMMARY

We first describe what health-care dollars buy—what shares go to doctors, hospitals, drugs, and other expenses. Then we look in more detail at our estimates of health-care spending in 2005 and the changes since 1991. We think our estimates are a good effort to update our previous work. But the health-care industry is complex, and tracking all the spending is difficult.

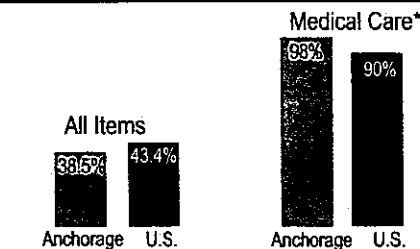
After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

Pages 4, 5, and 6 discuss access to, use of, and benefits from the health-care system: who is uninsured; who has health-care coverage and how that coverage is provided; which patients get the costliest care; how Americans' use of medical care compares with use by people in other industrialized countries; and whether we've gotten healthier in exchange for more spending.

Page 7 summarizes what we know about how medical costs in Alaska differ from the U.S. average, and page 8 concludes with a discussion about the many things that may be driving health-care costs.

Keep in mind that population growth and general inflation account for part of the increase in health-care spending since 1991. Alaska's population increased from about 570,000 in 1991 to 665,000 by 2005. Also, prices for everything Americans buy also went up, by about 43% nationwide and 39% in Anchorage. But prices of medical care nearly doubled (Figure 3).

Figure 3. Increase in Consumer Price Index Anchorage and U.S., 1991-2005



*Measures price increases in a specific "market basket" that includes hospital care, visits to doctors and dentists, nursing home care, and medical supplies; also indirectly measures increases in health insurance premiums.

Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Anchorage and U.S. City Average

WHAT ARE WE BUYING?

Figure 4 shows that as of 2000, more than 70% of Alaska's health-care spending was for hospital care and visits to doctors. Prescription drugs accounted for about 9% and dental care 7%. The "other" category includes medical products, health care provided on the job and in schools, and Medicaid payments for in-home care.

Nursing home and home health care made up only 2% of health-care spending in 2000, far short of the U.S. average of 11%—and that share actually dropped between 1990 and 2000, despite fast growth in the number of Alaskans over 65. There has been a shift in how long-term care is provided in Alaska. A change in Medicaid allowed payment for in-home and assisted-living care for people who would otherwise have been cared for in nursing homes.

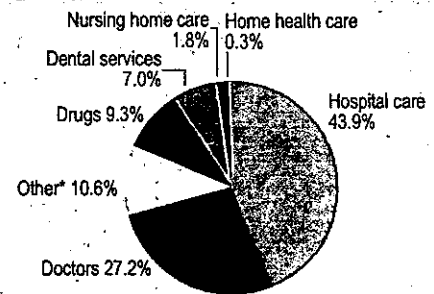
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

HOW HAS SPENDING CHANGED?

Table 1 details who paid for health-care in 2005. Figures 5 and 6 show changes in levels and shares of spending from 1991 to 2005.

- Growth in government spending wasn't uniform. The federal government's share of spending increased (Figure 5). Costs for Medicare and Medicaid more than quadrupled and costs for the Indian Health Service doubled.

Figure 4. What Are We Buying?
(Alaska Health Care Spending, 2000)



*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.

Source: Center for Medicare and Medicaid Services

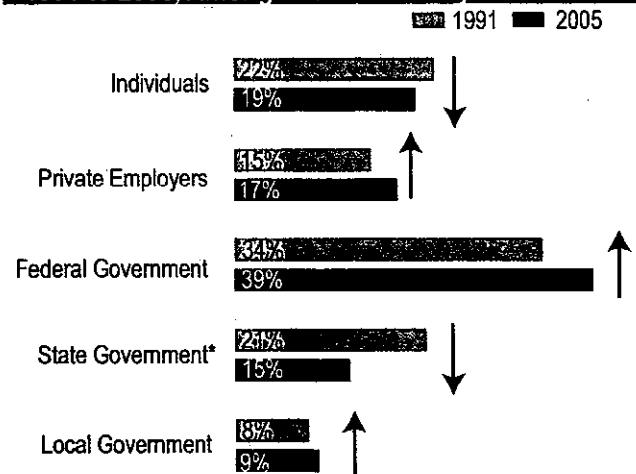
- State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.³

- Local government is the smallest government spender, but the local share of spending increased, mostly because of growing costs for employee health coverage.

- Employers saw the fastest growth. Combined spending by private and government employers increased about 290% (Figure 6).

- Spending by individual Alaskans didn't go up as much—184%—but the \$1 billion they spent in 2005 was still more than the \$922 million businesses spent.

Figure 5. How Did Shares of Spending Change From 1991 to 2005, Among Those Who Buy Health Care?



*See endnote 3, page 8. Note: Totals may not add to 100% because of rounding.

Source: Authors' estimates



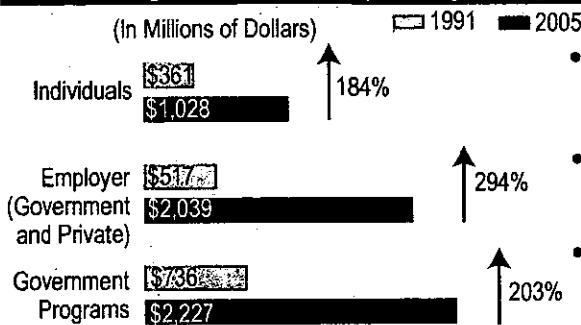
Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: \$5.3 Billion)

Who Provides the Coverage?	Who Buys the Care? (In Million of Dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total
Individuals	\$1,028					\$1,028
Out-of-pocket costs	\$431					
Individual policies	\$276					
Payments for employer-based insurance	\$320					
Employers (Including retiree coverage)		\$922	\$454	\$252	\$411	\$2,039
Insurance Premiums		\$303	\$103	\$72	\$75	
Self-Insured Costs ^a		\$485	\$352	\$180	\$115	
Military Medical Costs					\$221	
Worker's Compensation (medical benefits)		\$134				
Government Health Programs			\$38	\$535	\$1,654	\$2,227
Medicare					\$419	
Medicaid				\$303	\$667	
Other Public Programs						
Federal						
Indian Health Service Contracts					\$401	
Veterans' Affairs					\$105	
Community Health Centers					\$29	
State						
Grant to local governments, private groups				\$116		
API, Pioneers' Homes				\$55		
Other State-Administered				\$31		
Elementary and Secondary Schools			\$3	\$8	\$33	
WAMI Medical Education				\$2		
Department of Corrections				\$21		
Local						
Health and hospital spending			\$35			
Total Spending	\$1,028	\$922	\$492	\$787	\$1,950	\$5,294

^a Many organizations that self-insure—that is, they pay some of their bills themselves—also still carry some insurance to help cover extraordinary risks.

Source: Authors' estimates. Note: Totals may not sum because of rounding.

Figure 6. How Did Spending Change From 1991 to 2005, Among Those Who Provide Coverage?



Source: Authors' estimates

Biggest Kinds of Changes

- Individual Alaskans have seen big increases not only in costs they notice most—how much they have to pay out of their own pockets—but also in less obvious costs: deductions from their paychecks to pay their share of employer-based insurance.
- Both private and government employers became much more likely to self-insure. Self-insurance costs made up about two-thirds of combined employer spending for insurance premiums and self-insurance in 2005, up from about one-third in 1991.
- Spending for Medicaid more than quadrupled (from \$215 million to \$970 million), so that in 2005 it alone made up nearly \$1 in every \$5 of health-care spending. Analysts attribute the fast growth of Medicaid nationwide to growing numbers of eligible Americans, including low-paid workers whose employers don't provide coverage and low-income seniors; to program expansion; to increasing prices of medical care; and to treatment of medical conditions at lower thresholds.



HEALTH-CARE COVERAGE

Most Alaskans—an estimated 87%—have some form of health-care coverage, either through private insurance or government programs.⁴ Some people have more than one kind of coverage, so the percentages in Figure 7 add to more than 100%.

Around 64% of Alaskans are covered by private insurance, 38% by government programs, and nearly 13% have no coverage. Nationwide, 68% of people are covered by private insurance, 30% by government programs, and close to 16% have no coverage.

Alaskans are more likely to have coverage through the military (reflecting the state's large number of active-duty and retired military); the Indian Health Service (because Alaska Natives make up 20% of the population); and Medicaid (the joint federal-state program mainly for low-income and disabled people). Fewer Alaskans are covered by Medicare, because fewer are over 65.

We don't know characteristics of the 13% of Alaskans with no health-care coverage, but we know that nationwide the uninsured are most likely to be young adults and to have annual incomes below \$25,000 (Figure 8).

Children in Alaska are more likely to have coverage than both adults in Alaska and children nationwide. Figure 9 shows that about 8% of children in Alaska had no coverage in 2003, compared with the U.S. average of nearly 12%.⁵ The smaller share of uninsured children in Alaska is probably due to the fact that Alaska Native children are eligible for care through the Indian Health Service, and also to the Denali KidCare program, an extension of Medicaid that provides coverage for low-income children without other coverage.

It's outside the scope of this summary to describe all the ways that families, communities, and governments are affected because millions of Americans lack health insurance. But a recent report by the National Academy of Sciences broadly summarized those effects. It found that the uninsured are in worse health; that uninsured children are more likely to have development delays; that the direct costs of caring for uninsured Americans fall heavily on local communities; and that governments pay hospitals large public subsidies to offset their costs for uncompensated care.⁶

The 64% of Alaskans with private insurance either pay for that coverage themselves (through individual policies) or are covered through their jobs and share the costs with their employers. Figures 10, 11, and 12 show how the rising costs of medical care have affected health-insurance coverage for Alaskans working for private industry.

- Health insurance in Alaska was already more expensive in the 1990s and still is. In 2003, insurance premiums for family coverage at private firms were about \$10,500 in Alaska and \$9,200 nationwide. By 2005, those premiums had jumped to an average of \$11,268 nationally (Figure 10).

- Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. But employers, especially at small firms, have been shifting more insurance costs to workers. The 2005 UBA-Ingenix Health Plan Survey found that employees of businesses nationwide paid 43% of the premiums for family coverage.

Figure 7. Health-Care Coverage, Alaska and U.S., 2004

	Private Insurance	Medicaid	Medicare	Military	IHS only*	None
Alaska	63.5%	15.3%	7.3%	11.6%	4.2%	12.8%
U.S.	68.1%	12.9%	13.7%	3.7%	N/A	15.7%

Authors' adjustment. See endnote 4, page 8.

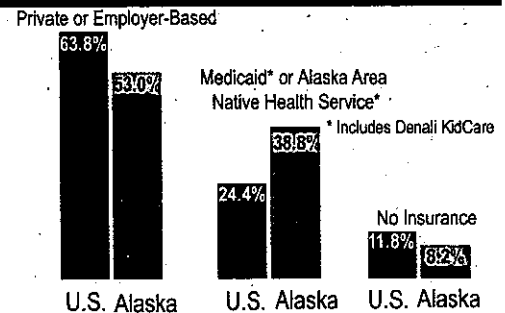
Note: Totals are more than 100% because some people have more than one coverage.
Source: U.S. Census Bureau, Current Population Survey, 2004

Figure 8. Who Is Most Likely To Be Uninsured in U.S.?

By Age	Percent Uninsured
18-24	31%
65+	1%
By Annual Income	
Less than \$25,000	24%
\$75,000+	8.4%

Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the U.S.*, 2004

Figure 9. Health-Care Coverage for Children (18 and Under), Average 2001-2003



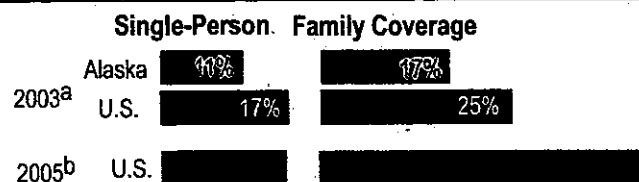
Source: American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

Figure 10. Health Insurance Premiums For Family Coverage^a, Private Firms

Alaska	1993	\$6,175
	2003	\$10,564
U.S.	1993	\$4,786
	2003	\$9,249
	2005 ^b	\$11,268

^aTotal costs shared by employer and employee. ^bAlaska figures for 2005 not available.
Sources: Medical Expenditure Panel Survey, U.S. Agency For Health Care Research and Quality, 2003; 2005 UBA/Ingenix Health Plan Survey

Figure 11. Share of Health Insurance Premiums Employees Pay (At Private Firms Offering Health Insurance)

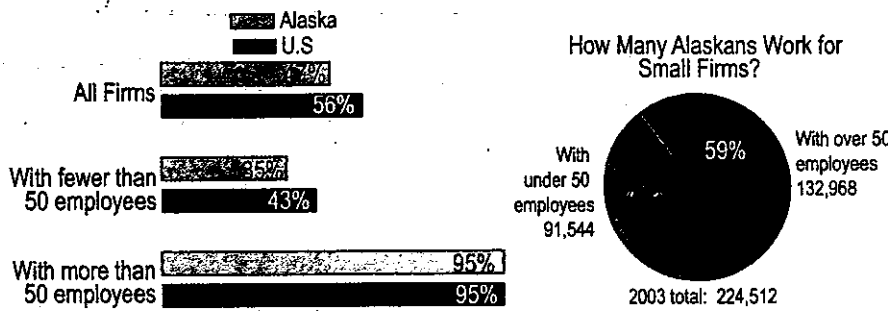


^aReported in Medical Expenditure Panel Survey, 2003

^bAlaska 2005 figures not available; national figures from 2005 UBA/Ingenix Health Plan Survey



Figure 12. Private Firms Offering Health Insurance,* Alaska and U.S., 2003



* Not all workers at firms that offer insurance carry that insurance. Source: Medical Expenditure Panel Survey, 2003

• Small Alaska businesses are less likely to offer insurance coverage. Only about a third of those with fewer than 50 employees offer coverage, compared with 43% nationwide (Figure 12).

A lot of Alaskans work for small businesses. In 2003, about 91,500 of the state's 224,500 private-industry employees worked for businesses with fewer than 50 employees. That's more than 40% of all those with jobs in private industry.

WHO COSTS THE MOST AND THE LEAST?

We've talked about the costs of health care and of health-care coverage. Now we turn to the other side of the equation: who's getting the benefits of the spending?

Health-care spending in Alaska was close to \$8,000 per person in 2005. But not everyone is average. The cost of care for a few is significantly higher than average, but for many it's only a few hundred dollars a year.

As a first step toward understanding who gets the benefits of health-care spending, ISER analyzed national data on the characteristics of high- and low-cost patients. That data is from a federal panel survey—that is, a survey that follows households over time.

As Figure 13 shows, just 5% of patients nationwide account for almost half of all health-care spending in any given year, while at the other extreme 50% of patients account for just 3% of spending in a year.

A lot of Americans tend to think that the most expensive patients are probably very

old, or suffering from some catastrophic illness or injury, and are possibly uninsured.

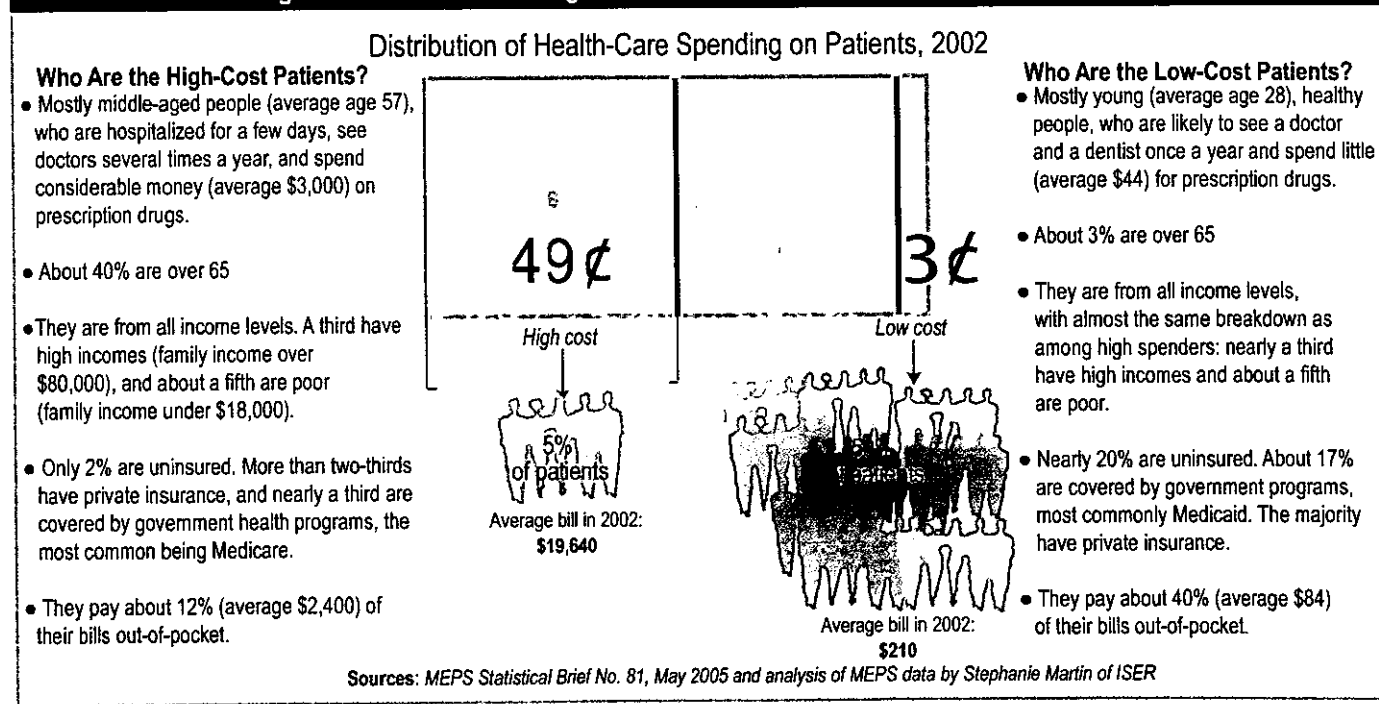
The high-cost patients are older; health-care costs do go up as people age.⁷ But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under \$20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital for surgery, several visits to doctors, and significant spending for prescription drugs. Few of the high-cost patients—2%—are uninsured.

The low-cost patients are mostly young, averaging 28 years old. They may see a doctor or a dentist once a year, and they pay almost half their modest medicals bills out of their pockets.

Many of the low-cost group—nearly 20%—are uninsured. The share of uninsured patients in this group tracks with what the National Academy of Sciences has reported: that the uninsured often don't have any medical costs at all in a year, and among those who do, their expenses are less than half the average for people under 65.⁸

Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

Figure 13. Who Are the High-Cost and the Low-Cost Patients in the U.S.?





DO WE USE MORE MEDICAL CARE?

Americans spend more on health care than anybody else. Do Americans increase health-care costs by getting more medical care than people in other developed countries? Or conversely, do countries with national health-care systems hold down costs by rationing care?

Figure 14 compares Americans with the British, Canadians, New Zealanders, and Australians on use of, access to, and satisfaction with their health-care systems. The comparison countries all have some form of national health-care system.

Overall, the comparisons show that residents of all four countries are almost equally likely to see doctors and have diagnostic tests, and that Americans are slightly more likely to take prescription drugs.

Americans are, however, more likely to skip medical tests because of cost and less likely to get appointments the same day they call. They also seem to be somewhat less satisfied with care they get from their doctors and in the emergency room.

ARE WE HEALTHIER?

Another important aspect of the health-care story is what we're getting in return for the high spending. Are Alaskans healthier than in 1990?

The answer seems mixed. In 2005 the United Health Foundation ranked Alaska as among the most improved states in health outcomes since 1990. Despite that improvement, the foundation still ranks Alaska somewhere in the mid-range of states on health measures—because 15 years ago Alaska was ranked toward the bottom.⁹ Figure 15 illustrates some of the improvements Alaska has made since 1990.

Rates of infectious disease (which include hepatitis, tuberculosis, and many more) went from far above the U.S.

Figure 14. Use of Medical Care, U.S. and Selected Countries, 2004
(Percent of Survey Respondents)

	U.S.	Great Britain	New Zealand	Canada	Australia
Saw at least one doctor in previous 2 years	97%	95%	97%	95%	98%
Regularly take prescription drugs	46%	44%	39%	43%	39%
Had blood tests, x-rays, or other diagnostic tests in past 2 years	84%	71%	82%	84%	83%
Able to get doctor's appointment same day when sick	33%	41%	60%	27%	54%
Skipped medical tests, treatment or follow-up because of cost	27%	2%	20%	8%	18%
Rate regular doctor's care excellent or very good	61%	64%	74%	68%	71%
Among those who used emergency room, share who rate emergency services fair or poor	34%	23%	27%	27%	23%

Source: Commonwealth Fund International Health Policy Survey, 2004

average in 1990 to significantly below by 2005. Infant mortality dropped in Alaska and throughout the country.

Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.¹⁰ In Alaska and nationwide, advances in treatment and technology have also reduced infant deaths.

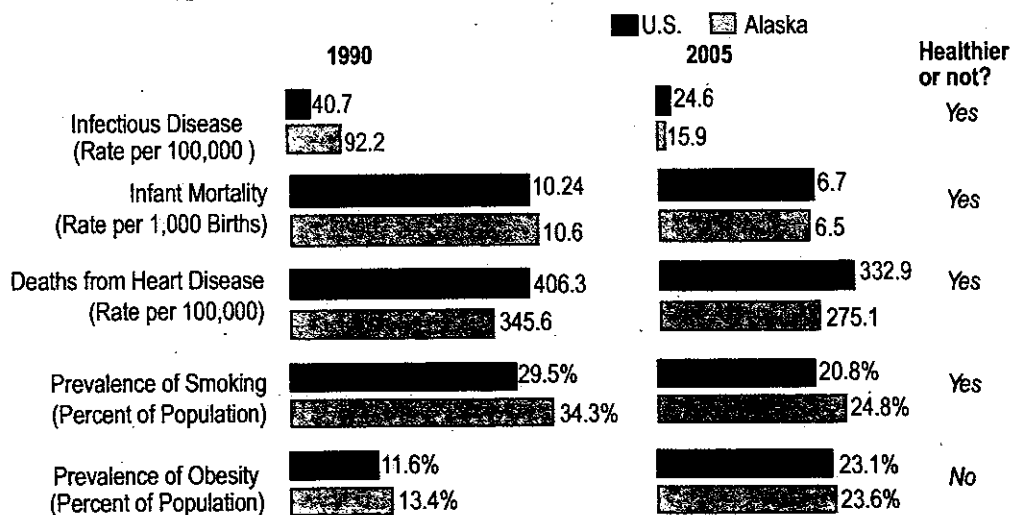
With improved treatments for heart disease, the rate of death from heart disease

declined by 20% in Alaska since 1990, dropping slightly faster than the national rate.

Rates of smoking among Alaskans fell also, but Alaskans are still more likely to smoke than other Americans. Again, public-health campaigns to fight smoking likely contributed to the decline.

On the down side, Alaskans and other Americans are far more likely to be obese now than in 1990—and obese people are more likely to require treatment for diabetes and high blood pressure.

Figure 15. Are Alaskans Healthier Now Than in 1990?



Source: United Health Foundation, *America's Health Rankings 2005*



ALASKA AND U.S. COSTS

Years ago, everything cost more in Alaska, and costs still remain high in remote areas. But in Anchorage and other urban places, the historically high costs of many things have moved closer to U.S. averages in recent times, as the population grew, local markets got bigger, and infrastructure and transportation improved.

But costs of medical care haven't declined relative to U.S. averages. Overall medical costs are probably somewhere in the range of 25% higher in Alaska, but that cost difference varies quite a bit among services and procedures, and prices don't always reflect cost.

Alaska has fewer practicing doctors per capita than the nation as a whole, but somewhat more dentists—so how the supply of medical professionals may affect costs is not clear (Figure 16).

Figures 17 through 20 show some examples of cost differences, but it isn't a comprehensive picture.

- Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).

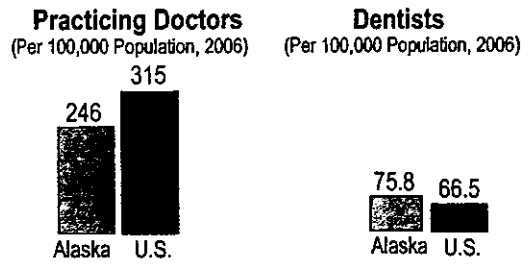
- Average costs of a visit to a doctor's office were 30% higher in Alaska in 2001. But the average is a mix of private insurance

and government payments. A private insurer in Anchorage and Fairbanks paid nearly twice as much as Medicare for an office visit in 2001, as Figure 18 shows.

- Alaskans don't use as many prescription drugs as other Americans—mostly because there are fewer Alaskans over 65—but we pay more. In 2003, the average price of retail prescriptions was 25% higher in Alaska.

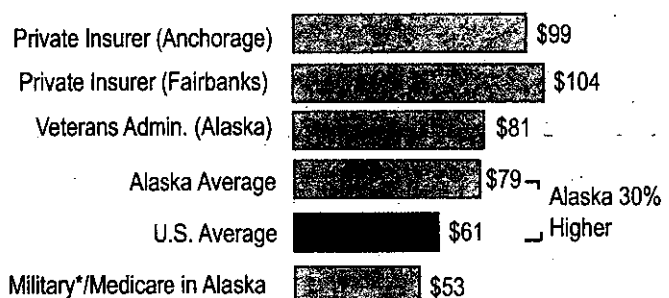
- Costs of hospital care went up faster in Alaska than nationwide from 2000 to 2003—so in 2003 average expenses for a day in an Alaska hospital were 42% above the U.S. average, compared with 30% in 2000.

Figure 16. How Do Numbers of Alaska Doctors and Dentists Compare with U.S. Averages?



Note: Figures updated and corrected March 2007; see endnote 11. Sources: American Medical Association; American Dental Association; U.S. Census Bureau

Figure 18. Costs of An Office Visit, Alaska and U.S., 2001
(Established Patient, 15 minutes)



*Insurance coverage for active-duty and retired military personnel for medical care not available from military facilities. Source: GAO Report GAO-01-620, May 2001

Figure 17. How Much Higher are Medical Costs in Alaska?
(Costs Paid by Private Insurer, 2000)

Category	Percent Above U.S. Average
Medical/Surgical Procedures	18.1%
Dental Procedures	37.7%

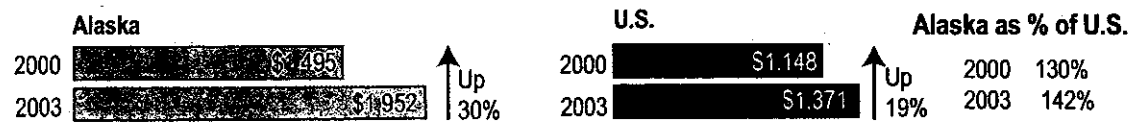
Source: Ingenix data base; cited in Alaska Division of Medical Assistance, HealthCare Cost Analysis, 2001

Figure 19. Prescription Use and Cost, Alaska and U.S., 2003

	Prescriptions Per Capita	Average Price of Retail Prescriptions	Average Cost Per Capita
United States	10.7	\$52.97	\$566.78
Alaska	6.3	\$66.89	\$421.41

Source: Kaiser Family Foundation, based on data from Verispan, L.L.C.: Special Data Request, 2004; and U.S. Census Bureau, State Population Datasets for six Race Groups

Figure 20. Hospital Costs, Alaska and U.S., 2000 and 2003
(Expenses per In-Patient Day)

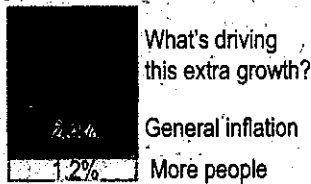


Source: 2003 American Hospital Association, Annual Survey



Figure 21. What's Driving Health-Care Spending In Alaska?

Annual Growth, 1990-2005*
8.9%



*Authors' estimate

WHAT'S DRIVING COSTS? IT'S A PUZZLE

Spending for health care in Alaska increased an average of nearly 9% a year from 1990 to 2005—and that figure doesn't reflect the big capital costs for building hospitals and clinics in the state since 1990.

More people and general inflation together account for only about 40% of that growth. So what's driving the rest?

Just about everybody has an opinion about what's pushing up medical costs, here and nationwide. Alaska has some special conditions—mostly small markets and high costs in rural areas—but other possible contributors to high costs are common to Alaska and the rest of the country.

Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

Other arguments related to the delivery system are that Americans get more medical care than they need, because most of the bills are still paid by health insurance. Others believe, by contrast, that costs of caring for uninsured people are responsible.

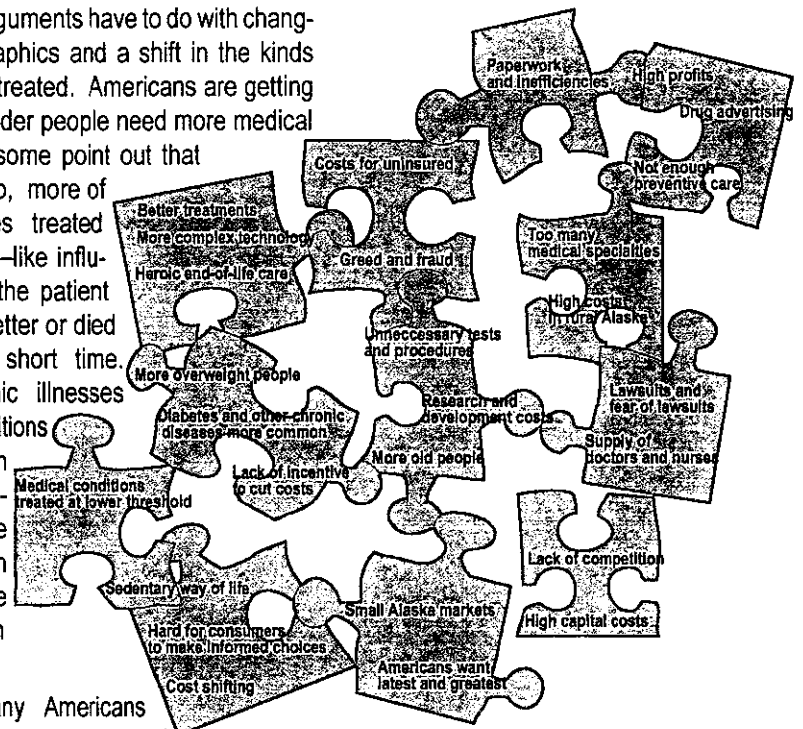
Others blame environmental factors, especially Americans eating too much and not exercising—leading to the spread of diabetes and other conditions requiring more care.

Still others say the growth has to do with changes in treatments and technology—treating conditions at lower thresholds (like the recent drop in the cholesterol level at which doctors recommend treatment); more effective but costlier treatments and prescription drugs; and more complex technology.

Other arguments have to do with changing demographics and a shift in the kinds of illnesses treated. Americans are getting older, and older people need more medical care. Also, some point out that decades ago, more of the illnesses treated were acute—like influenza—and the patient either got better or died in a fairly short time. Now, chronic illnesses and conditions—like high blood pressure—are common and require long-term treatment.

And many Americans link high costs to behavior of drug companies, the insurance industry, the medical and legal professions, and individual Americans. Such behavior would include, for instance, insurance and drug companies making high profits; doctors overbilling government programs; and patients filing lawsuits—causing doctors to practice "defensive medicine."

Probably there are other opinions we haven't discussed here. We're not endorsing any of them, but merely pointing out that many things could be contributing to rising costs—and it's a puzzle how all the pieces fit together. We will learn more as we study Alaska's health-care system. But for now, we want to emphasize that the answer to what is driving health-care costs is not simple, and finding solutions won't be simple either.



ENDNOTES

1. Our estimates are based on the Center for Medicare and Medicaid Services' definitions of personal health care spending. See http://www.cms.hhs.gov/NationalHealthExpend-Data/01_Overview.asp#TopOfPage. We have also included insurance costs, to capture the expenses paid by employers and employees.
2. ISER Research Summary No. 53, "The Cost of Health Care in Alaska," December 1992.

3. The decline in state share is expected to ameliorate somewhat beginning in FY 2006, due to a decision by the 9th District Appellate Court to disallow the Fair Share program that enabled tribal hospitals to receive a higher reimbursement than non-tribal hospitals for uncompensated care.
4. U.S. Census Bureau figures from the Current Population Survey classify Alaskans with coverage only through the Indian Health Service as "uninsured." We have adjusted those figures, separating those with IHS-only coverage from the uninsured. The adjustment is based on methods of the University of Minnesota's School of Medicine, State Health Access Data Center.
5. American Academy of Pediatrics figures for uninsured Alaska children are adjusted U.S. Census figures, separating children with IHS-coverage only from the "uninsured" category.
6. National Academy of Sciences, *Hidden Costs. Value Lost: Uninsurance in America*. Available at: <http://www.nap.edu/catalog/10719.html>. Public subsidies for uncompensated care are illustrated in the State of Alaska's FY 2007 budget request, which includes \$27 million to help Alaska hospitals pay for uncompensated care.
7. In 1999, for example, health-care spending for Americans 75 to 84 was seven times higher than for those 18 and under.
8. See note 6.
9. United Health Foundation, *America's Health Rankings*, 2005 edition.
10. See Chapter 3 in ISER report, *Status of Alaska Natives 2004*, May 2005.
11. Our original figure for number of dentists per 100,000 in Alaska was incorrect. We thank researchers at Health Planning and Systems Development in the Alaska Department of Social Services for helping us identify that error. A separate addendum, *Dentists in Alaska*, prepared in March 2007, provides more information about the source of the error and the correction. See: http://www.iser.uaa.alaska.edu/Publications/researchsumm/A_RS6_addendum03_07.pdf

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COMMONWEALTH NORTH

Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

Approved by the Board of Directors on June 7, 2005
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EXECUTIVE SUMMARY

Why Alaska health care issues must be addressed and solved

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

ACCESS

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

QUALITY

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care.
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

COST

- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over \$1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

What can we do?

There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

These drivers are currently interacting in a "cost spiral" that is creating a very serious situation nationally and in Alaska. The rate of increase in the cost of health care is unsustainable—if unchecked health care increases will price employers out of the market. Already industries such as automobiles are threatened. We need to avoid similar impacts in Alaska.

We believe that with focus and coordination Alaskans can impact this "cost spiral" positively through specific actions in the four areas mentioned above:

1. Lifestyle and prevention: Raise public awareness and increase personal responsibility for wellness
2. Access: Make services and insurance more widely available
3. Quality: Continue improving quality of care that is delivered
4. Costs: Reduce costs of service delivery and insurance to make them more affordable

There are many health care initiatives already underway in these areas by various governmental and non-governmental entities. Some have proven to be effective and cost-efficient. Others show significant promise. Health care reform is complex and controversial, with multiple players and competing interests. Inconsistent tracking and trending create significant factual disputes about healthcare systems. Any major reform has potential to create both winners and losers.

Given this environment, the Study Group came to three overarching conclusions:

1. The Study Group process itself has been enlightening, educational and productive.
2. Every aspect of health care is complex. Understanding the system and improving it is beyond the capacity of any one element within the system.
3. The Study Group recommends that an ongoing body be established to continue and deepen this Group's work.

The time to act is now. Involvement of Alaskans in the health care debate is vital. Reform of some sort is inevitable, and Alaskans should control it as much as possible to our own benefit. Since there is no single forum today where the disparate players can come together to agree on facts, share solutions and craft a win-win for our unique Alaskan conditions, this Study Group recommend formation of—

The Alaska Health Care Roundtable ("Roundtable")

The goals of the Roundtable are to continue communication and foster action among parties that have a long-term vested interest in health care reform. It must set a standard of credibility and create timely actionable ideas that can gather bipartisan support, get quick approval and become part of a long-term fiscal plan for Alaska. It would be a sounding board and facilitator for ideas and recommendations, with a focus on lifestyle and prevention, access, quality and cost.

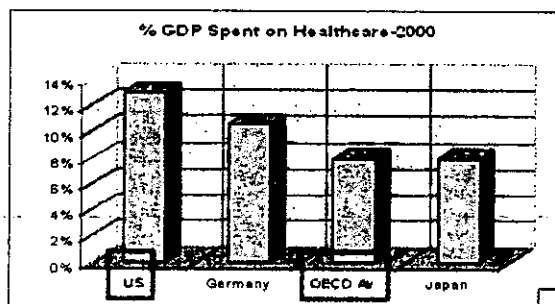
The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential members, resources and ad hoc participants could be included as needed. Funding would be by voluntary contributions by the participants and the community.

INTRODUCTION

The big picture: National background issues and the state of health in the U.S.

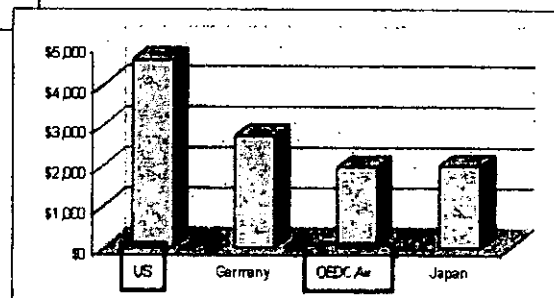
While the focus of this study is factors controllable in Alaska, it is important to understand the national context in which we operate. The United States spends more on health care than any other country, measured either as a percentage of gross domestic product, or in terms of money spent per person. The OECD, or Organization for Economic Cooperation and Development, is a group of industrialized nations that are an appropriate benchmark for U.S. expenditures and performance.

The National Situation - Spending



OECD—Organization for Economic Cooperation and Development

Per capita health care expenditures by country



Source: Commonwealth Fund

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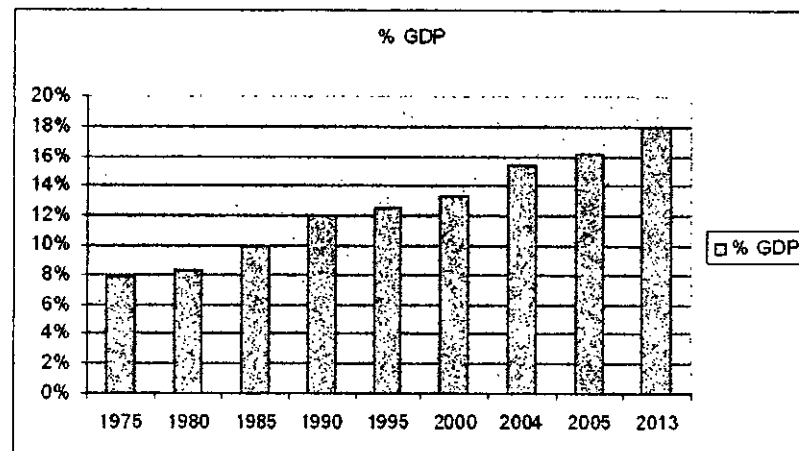
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Health care spending has risen dramatically in recent years, increasing from about 8 % of the gross domestic product in 1975 to over 16% today. The Commonwealth Fund, a private nonpartisan foundation that supports independent research on health and social issues, projects that by 2013 the U.S. will be spending 18% of GDP on health care.

Many factors contribute to these increases. Often cited are huge costs caring for the last three months of life, advertising driven consumerism, high cost of technology, defensive medicine practiced to avoid malpractice suits, malpractice insurance, a fractionated payment system and massive cost shifting to those able to pay caused by inadequate or no health insurance for many Americans (and Alaskans). The crushing cost of health care threatens whole industries and affects our worldwide ability to compete economically.

The National Spending Situation: Trend in Healthcare Costs as a % of GDP



Source: Commonwealth Fund

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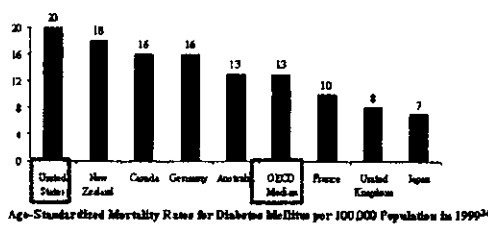
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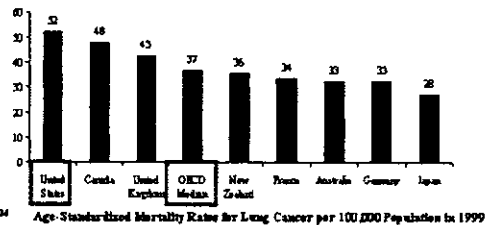
The Commonwealth Fund is a foundation specializing in health care issues.

In terms of outcomes, the United States has obtained poor results from the massive amounts invested. By many measures, the U.S. trails other industrialized nations, as represented by Organization of Economic Cooperation and Development averages. We also have a higher percentage of uninsured than most advanced countries, which tend to have centralized health care systems.

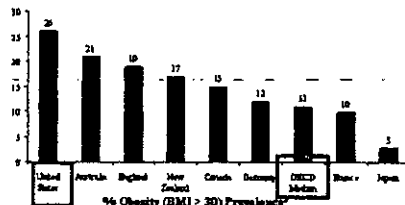
The National Situation: Outcomes



DIABETES



LUNG CANCER



OBESITY

And, the U.S. ranks only

- 28 overall in infant mortality
- 24 in life expectancy

Sources: OECD Health Data 2002,
 March of Dimes Data Center 2002
 World Health Organization 2000

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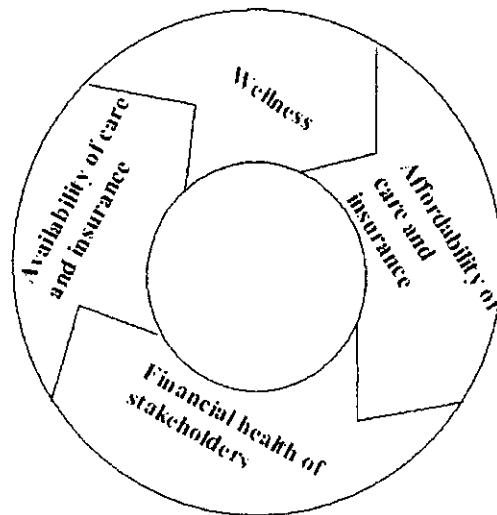
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A conceptual framework of four primary healthcare factors can help us understand how all the different factors are interrelated.



Four Primary Healthcare Factors and how they are interrelated



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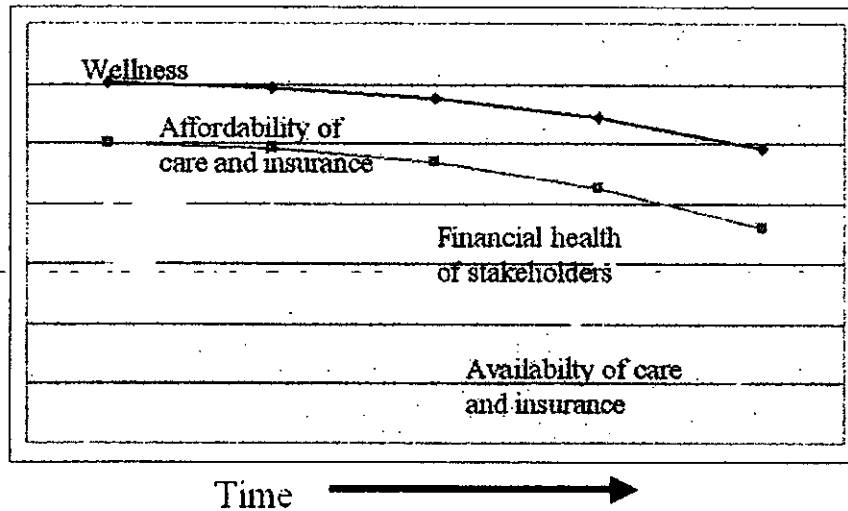
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- Wellness of the population
- Affordability, coordination and quality of care and insurance
- Availability of care and insurance
- Financial health of stakeholders including:
 - Health care providers (physicians, clinics, hospitals)
 - Companies, institutions and government

These factors are all part of a complete cycle. Each factor affects the other. Therefore they are portrayed in a circle.

As time goes on, each of these factors influences the others, with the ultimate result of either undermining or improving the health and wellness of our people.

The conceptual crux of the problem



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A significant problem is a de facto dynamic in our current U.S. health care policy.

The motto of a popular Alaska establishment embodies this unintended and unwanted de facto policy, to wit—



“We cheat the other guy and pass the savings on to you!”

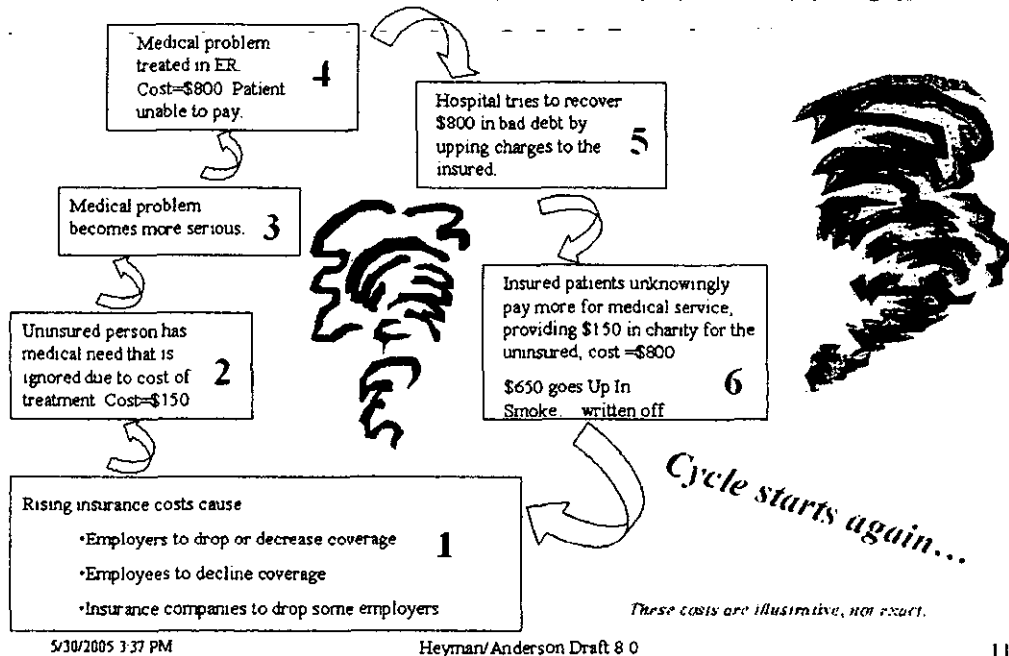
This phenomenon has impacts both nationally and in Alaska, and Alaskans are not always the beneficiary, creating serious cost shifting and economic dislocations.

A SIGNIFICANT ISSUE FOR HEALTH CARE IN ALASKA

The focus of this study is what can be done in Alaska. It does not address national issues such as a single payer system, rationing of health care or national structural issues. However, the following conceptual illustration is both a national and Alaska problem.

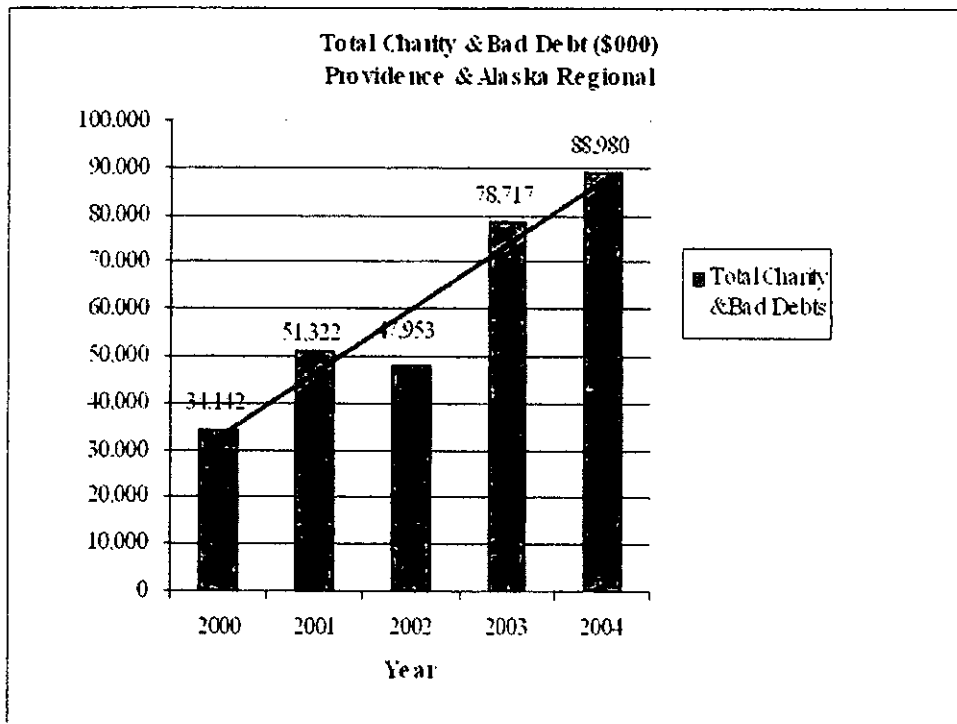
It shows how the high cost of health care causes people to postpone needed care, which increases ultimate costs of treatment, frequently and reluctantly performed by practitioners at unneeded and inappropriate levels. Often the emergency room of a hospital becomes a highly expensive primary care facility. If treated earlier, medical conditions could have better outcomes at a lower cost.

Why even a non-compassionate insured should care about the uninsured



A federal law, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that hospital emergency rooms treat and not turn away any patients who show up, regardless of ability to pay.

Emergency rooms are becoming primary care treatment centers for those without access to, or awareness of, alternatives. Current waits can be up to two hours, especially during high traffic times like early evenings or weekends. This creates inefficient use of specially trained staff and is enormously expensive. Many ER patients have no insurance coverage or other means to pay their bill. The financial burden then falls on the hospital to write off uncollectible accounts.

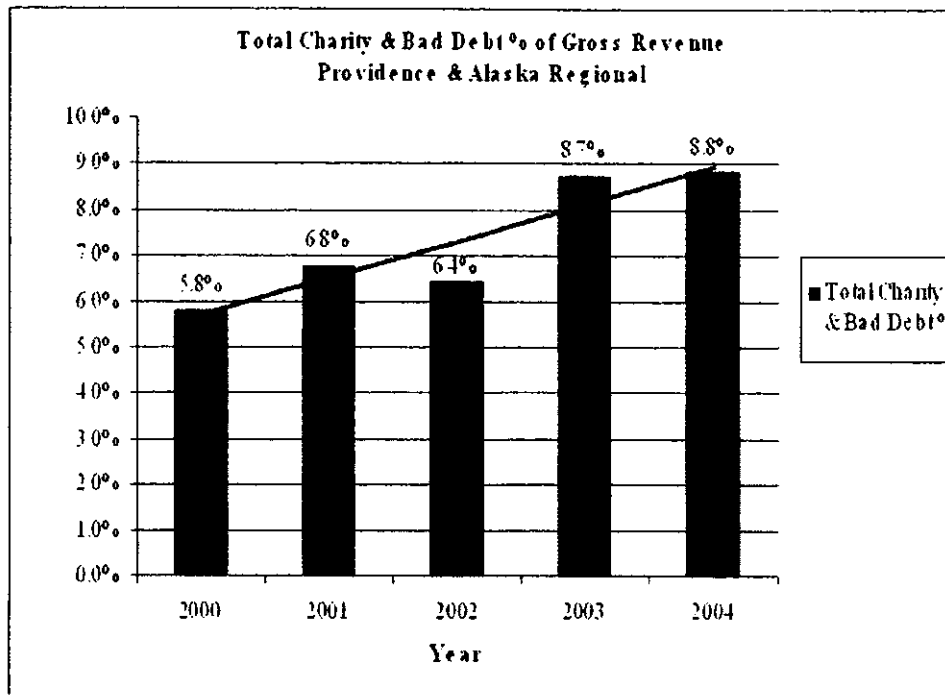


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Note: the numbers above are in thousands of dollars. E.g. 88,980 = \$88,980,000



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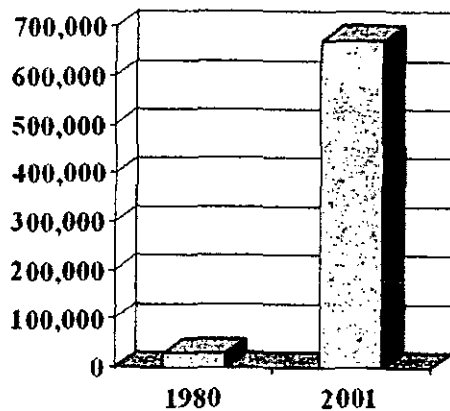
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The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less than the gross revenue billings used in the chart above.

Hospitals are not the only ones affected. Individuals unable to pay medical expenses are filing for bankruptcy at staggering rates. Although Alaska data are not available, national data are noted below.

Personal Bankruptcies due to Health Care Costs-U.S.



- Between 1980 and 2001 medically driven bankruptcies increased 23 times
- 60% skipped doctors visits
- 47% skipped prescription medicines

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Source: American Medical Association 2/05 and a Harvard Law School/Medical School 2/05 studies.

70% of these debtors had some form of health insurance at the start.

Main factors cited for declaring bankruptcy were:

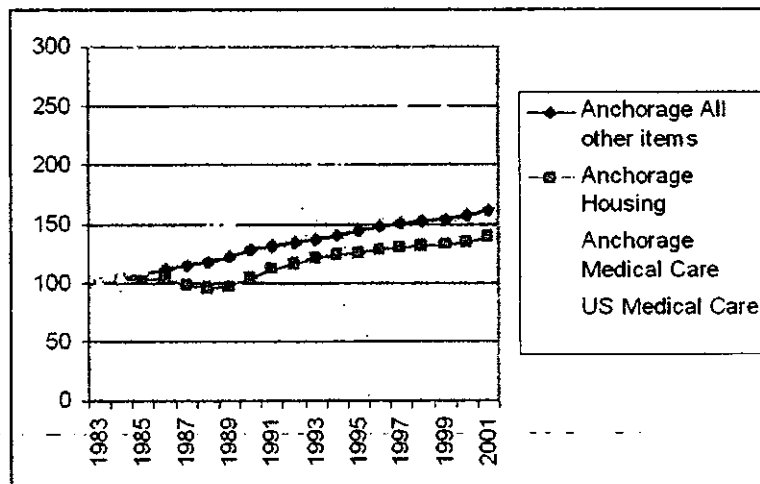
Hospital costs	42%
Prescription drug costs	21%
Doctor bills	20%

Cost: What do Alaskans pay? Why?

The impact of **bad debt** on the health care system has been clearly illustrated in the preceding charts.

Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001



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Source: Alaska Economic Trends June 2004

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Premera, Alaska's largest health care insurer, reports that their **Alaska costs are about 40% higher than Seattle**. General observations by resource people have referenced a 40% differential overall, more in some specialties, less in others. Local hospitals have corroborated this differential. Other information points to even larger discrepancies on reimbursement rates for physicians. The Alaska Division of Medical Assistance Health Care Cost Analysis Report placed Alaska in the top five states in terms of the cost of medical and surgical procedures.

Small practices and increasing personnel costs contribute to the high cost of medicine in Alaska. Also there is general, but not substantiated, belief that the **Alaska population is too small to support HMOs**. Any discussion of managed care has been resisted by medical providers.

Dependence on "Fair Share" and other sources of federal dollars place about \$800 million potentially at risk, an important share of current health care funding to Alaska. Alaska also faces **competition from other states** for willing providers. Furthermore, **reimbursement**

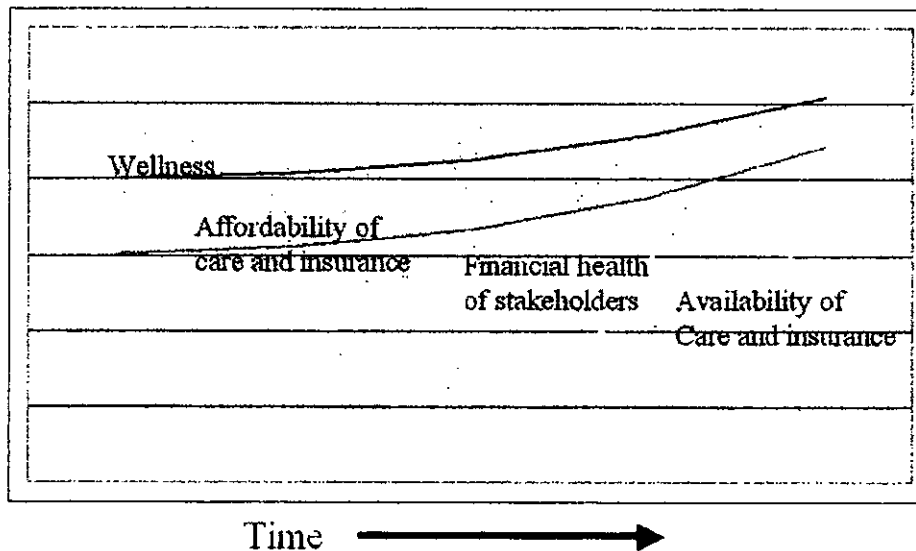
formulas are going down. The state is now paying over one billion dollars annually to pay Medicaid expenses.

Cost of health insurance—there is no public oversight of health care insurance rates by the Division of Insurance as there is in some other states. They are a result of negotiations between insurance companies and large groups.

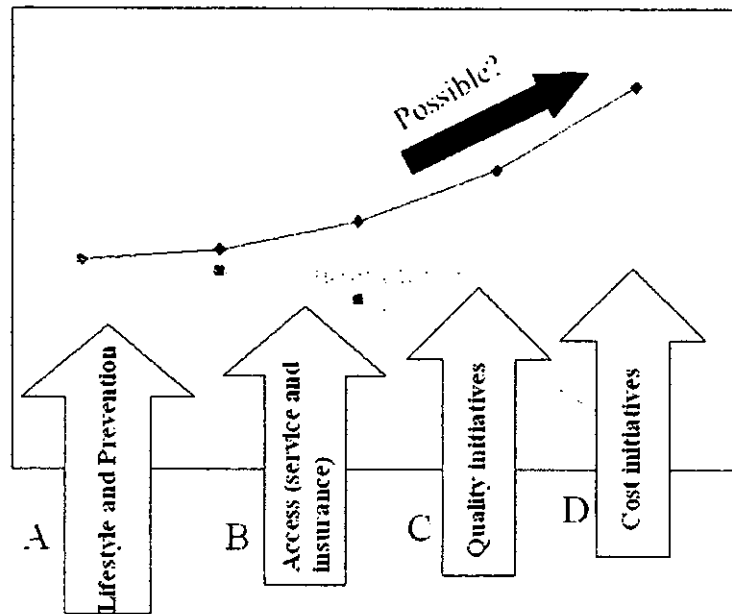
The **Certificate of Need** situation needs to be objectively analyzed and considered as a component in a comprehensive statewide health care plan. Critics of the Certificate of Need claim the process stifles competition and innovation. Supporters claim it prevents unnecessary duplication of facilities and allows more rational allocation of assets.

The impact of tort issues on health care. The cost of malpractice insurance and defensive medicine is hard to quantify, but is deemed to be substantial. OB/GYN liability insurance is \$60-65k/year. SB 67 puts a 250k cap on non-economic suffering. The California experience with a similar cap since 1975 has been positive. Alaska has only two traditional liability carriers. However, compared to U.S. averages, malpractice insurance costs in Alaska are middle of the pack.

Is a trend reversal possible in Alaska?



Perhaps, with coordinated and focused effort



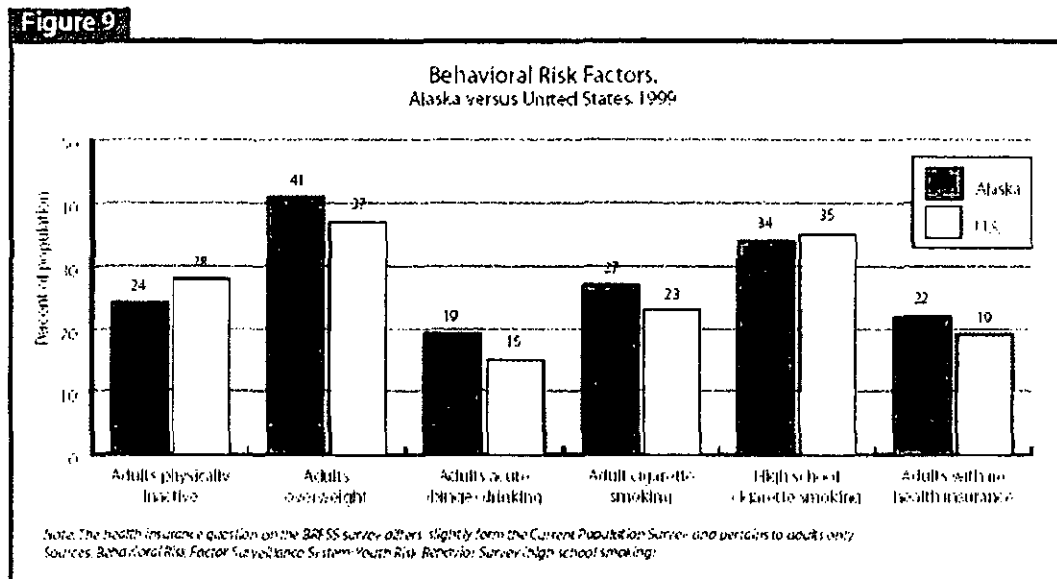
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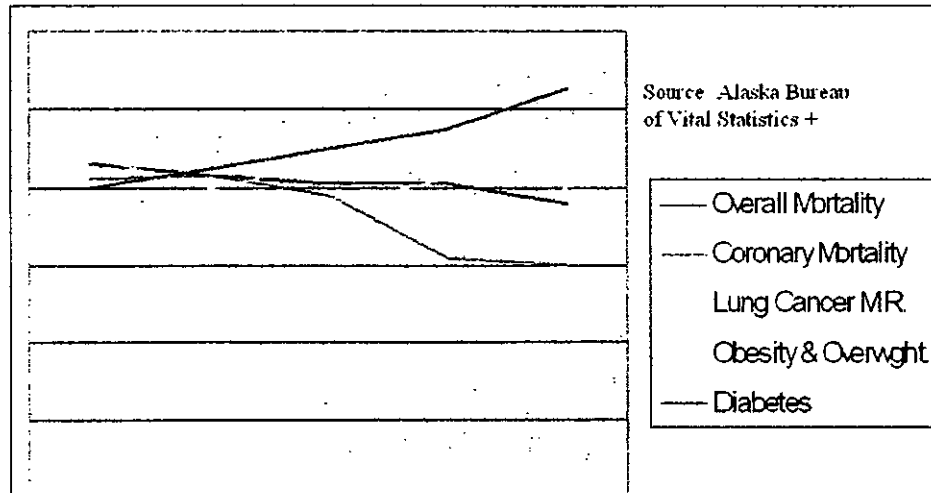
Quality of Alaska's health: Based on the 2004 National Health Care Quality Report of 100 measures of health care quality, Alaska is about average for the U.S. However, as the charts on page 7 indicate, the U.S. trails many other industrialized nations.

Unfortunately, Alaska mirrors poor National behavioral risk factors





Alaska Trends in major disease



Trends only—not incidence rates

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(Vertical axis is rates of disease, horizontal axis is time)

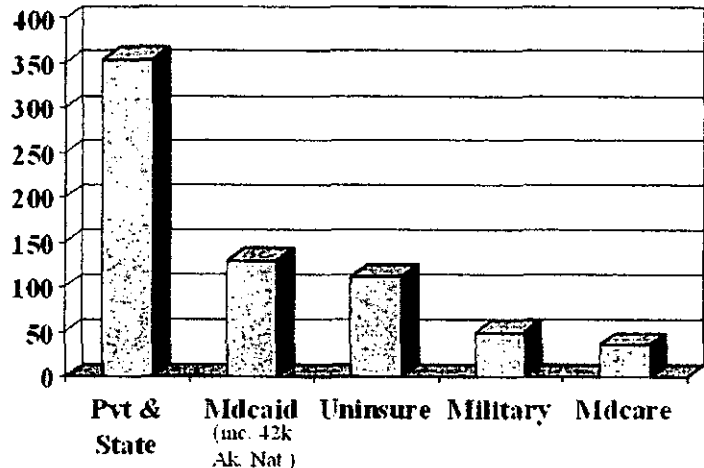
While progress has been made in heart and lung disease, obesity and diabetes have negative trends.

How is Alaska's health care being paid? What about those without coverage?

Currently about 110,000 Alaskans do not have health care insurance. Approximately 82% of Alaskans have some type of insurance coverage, as illustrated by the chart below. The column for private and state coverage includes state employees. Medicaid covers over 40,000 Alaska Natives, the remainder of which are covered under federal programs. Military and Medicare coverage rounds out the picture. However, an unquantified, but suspected to be substantial, number of people have inadequate insurance coverage.



Alaska's Insurance Coverage



Source Navigant Consulting, Ak Journal of Commerce

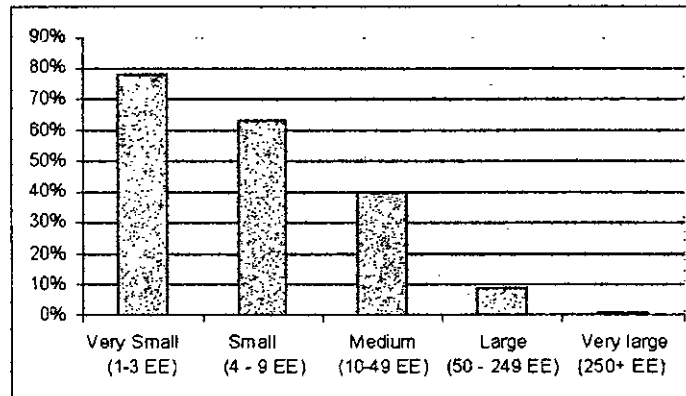
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The majority of Alaskans without insurance work for smaller businesses.

Alaskan firms NOT offering health insurance



And only 2% of Alaskans were employed in firms with over 50 employees

Source: Alaska Dept. of Labor and Workforce Development, 2002-

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Safety net providers

There are 34 federally sponsored Community Health Centers (CHCs) in Alaska. They see all patients and charge a sliding fee schedule based upon income. Although there are the Neighborhood Health Center in Anchorage and the Interior Community Health Center in Fairbanks (both federally sponsored CHCs), a large number of uninsured patients receive their care in the city's emergency rooms.

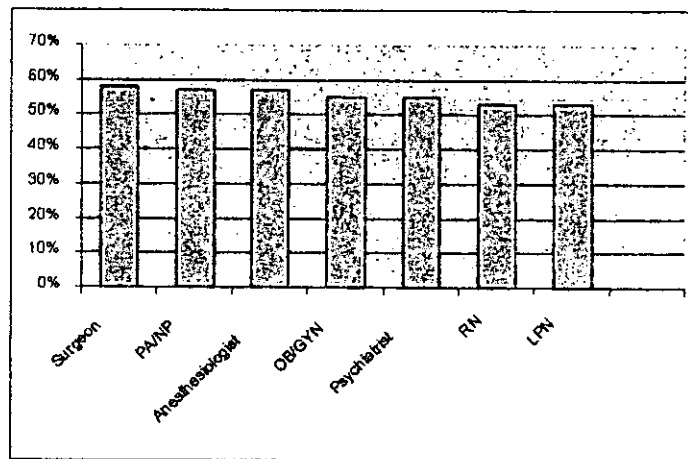
Under federal law, patients who visit the emergency rooms must be seen regardless of their ability to pay. This results in the uncompensated care that was referenced previously.

Although not safety net providers, the Alaska Native Health system provides care to an estimated 125,000 Alaska Natives through an extensive network of community health aid clinics, regional hospitals and a major referral center.

Healthcare Provider Shortages are Projected for Alaska



PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE



Sources: AK Department of Labor

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Shortage of doctors: ½ doctors in Alaska are over 50. Fewer doctors are practicing than are licensed. Compared to the rest of the U.S., Alaska has 17-30% fewer doctors per capita, partly because we have a relatively younger population. However Alaskans are aging, and the need will increase. Today Alaska needs 472 more doctors than it has. The shortage will increase in the future. Statewide Alaska has a 25-30% shortage of physicians. Physicians are practicing fewer hours and retiring younger than in past decades. As a result it may require more than one new physician to replace a retiring one. 70% of doctors in the lower 48 practice near where they did their residency. The rate of return on a medical education is diminishing compared to other professions. Medical students average \$100,000 of debt; specialties can be \$250,000 with an average of 8 years post-graduate education. Similarly, graduating dentists average nearly \$200,000 in debt. In contrast, graduating attorneys and MBA's begin earning money faster and with less debt.

Nurse Practitioners and Physician Assistants provide care to Alaskans in a wide variety of settings, including rural and urban primary care clinics, urban specialty practices, and remote critical access hospitals that were historically difficult to staff with other providers. There are over 200 physician assistants and 420 nurse practitioners working in Alaska. This gives Alaska one of the highest ratios of nurse practitioners per capita in the nation.

As in 25 other states nurse practitioners are licensed to practice autonomously. A recent Columbia University study (JAMA, 2000) and another from Yale University (1992), compared physician and nurse practitioner practice. They found that patients expressed a high degree of satisfaction with the care they received, that accuracy of diagnosis and health outcomes were equivalent, and that Nurse Practitioners provide quality, cost-effective care to their patients.

The role and extent of coverage of complementary and alternative medicine (chiropractic, acupuncture, etc.) in Alaska is undefined, but substantial. As of May 25, 2005, the Alaska Division of Occupational licensing listed the following numbers of active licenses for the following types of doctors:

Allopathic doctors (M.D.)	2,377
Chiropractic doctors (D.C.)	227
Osteopathic doctors (D.O.)	183
Podiatrist (D.P.M.)	20

SPECIFIC ALASKAN RECOMMENDATIONS FOR IMPROVEMENT

This Study Group has identified a continuum of challenges, many of which are interrelated to each other. While they may all be part of a whole, the Study Group identified discrete categories to more readily focus on how each recommendation may be best implemented. A chart below summarizes the recommendations and identifies which parties are affected by, or responsible for, each recommendation.

However, in the process of assessing health care in Alaska, and looking for improvements, the Study Group developed consensus on three overarching conclusions:

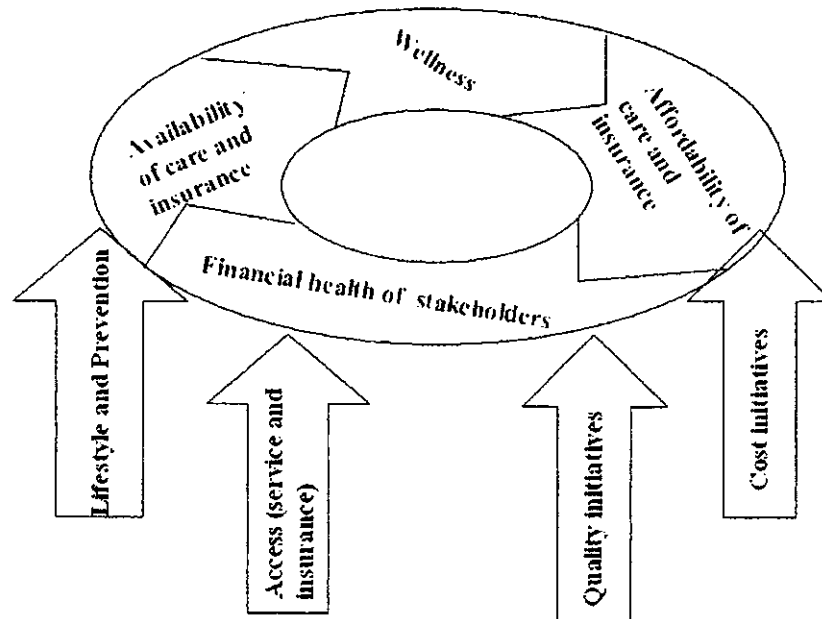
- 1. The Study Group process itself, which includes representatives of all key components of the health care system in Alaska, has been enlightening, educational and productive. For the first time in recent years, key players have been able to share experiences and ideas in a supportive and cooperative environment.**
- 2. Every aspect of health care is complex. Education, technology, funding, social and demographic factors, economics, federal and state laws and regulations all have many interrelated facets. Understanding the health care system, and improving it, are beyond the capacity of any one element within the system.**



- 3. Therefore, a fundamental recommendation of the Study Group is that an ongoing body be established to achieve multiple goals:**
 - a. Continue the communication process started by this Study Group among the key elements in the Alaska health care system and the broader Alaska community.**
 - b. Create a body that will have a long-term vested interest in understanding and improving the system. Some solutions are immediate, others will take generations. But without consistent advocacy, the system is unlikely to make needed fundamental changes.**
 - c. Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations.**

In that spirit, this Study Group offers the “Yarmon Plan” as a starting point for structuring such a body.

The Roundtable Proposal (The Yarmon Plan)



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The Alaska Health Care Roundtable

Goals: a, b, c on the previous page. Create a timely, actionable package that will gather bipartisan political support, get quick approval, and become a significant part of a long-term fiscal plan for Alaska.

Focus: Access, quality and cost. Function as both a sounding board and facilitator for ideas and recommendations.

Structure: Create the "Alaska Health Care Roundtable"

Membership in the Roundtable: Self-selecting. Must have a core of members who have a long-term compelling interest in improving access, quality and cost of health care in Alaska. Examples of potential members would be:

- a. Major employers
- b. Providers
- c. Foundations
- d. Other participants as invited by the Roundtable

Funding: Voluntary contributions by the participants.

Strategic relationships: Form a research relationship with the **University of Alaska/Institute of Social and Economic Research (ISER)**. The Roundtable itself could focus on strategic policy and political analysis. UA would provide in-depth research as needed on a contract basis.

Tactics: Secure the support of major employers and secure their interest in funding such a Roundtable. There is no point in CWN issuing a major recommendation that will fall flat on its face. Get seven or more CEOs of major employers to make a financial commitment to the project and be present at its unveiling.

Create a package of recommendations that will be dynamic, compelling and politically impossible not to accept. Create a "win-win" atmosphere so all participants can claim victory.

Local or regional Roundtables can address "nuts and bolts" issues of cooperation, implementation, sharing and efficiency.

Potential resources, ad hoc participants or additional members: Business leaders of large businesses, business leaders of small businesses, Alaska Natives, labor, non-profit (Foraker Group), education, military, insurance industry, state government (legislature, administration), health care providers, Medicare, Medicaid

Summary table of recommendations with affected and responsible parties

The following chart summarizes various recommendations that were suggested in the course of our study. They are a starting point of menu items for the Roundtable to analyze and prioritize.

A = Parties affected by or benefiting from the listed Recommendation

R = Parties responsible for implementing the listed recommendation

Recommendation	Individuals	Legislature	Governor	Local Governments	Private Sector	Health Care Professionals & Institutions	Universities (or schools)	Insurance Companies
Lifestyle & Prevention								
1. Walkable community	AR			AR	AR	AR	AR	AR
2. Public Health role	A	R	R	AR	A	A	AR	A
3. School phys ed	A	R	R	AR	A	AR	R	A
4. Schools nix bad foods	AR	R	R	AR	A	AR	AR	A
5. Incentivize behaviors	AR	AR	AR	AR	AR	A	AR	AR
7. Rural dentistry	A	A	A	AR	A	AR	AR	AR
8. Drug/psych facilities	A	AR	AR	AR	A	AR	A	AR
9. U.S. preventive health recommendations	AR	AR	AR	AR	AR	AR	AR	AR
10. Circumpolar health studies	A	AR	AR	AR	A	A	A	A

Access	Indiv.	Legis.	Gov.	Loc Gv	Private	HC	Univ/Sc	Ins. Cos
1a. Expand WWAMI	A	R	R	A	A	AR	AR	AR
1b. Market AK To MDs	A	R	R	AR	AR	AR	A	AR
2. Cut liability ins. Cost factors	A	R	R	A	A	AR		AR
3. Cover uninsured	AR	AR	AR	AR	AR	AR	AR	AR
4. Pool small cos.	A	R	R	AR	AR	A		AR
5. Promote lower cost centers	A	AR	AR	AR	AR	AR	A	A
6. Same day non ER alternatives	A	R	R	AR	A	AR	A	AR
7. Examine other state models e.g. UT, ME	A	R	R	A		R	R	AR
8. More GME \$ for family practice	A	R	R	A	A	AR	AR	A
9. Improve MD reimbursements	A	R	R	A	A	AR		AR
10. Medicare licensing requirement	A	R	R	A	A	A	A	A
11. Public insurance hearings	A	R	R	A	A	A	A	AR
Quality								
1. Evidence based prevention, Intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Use benchmarks	A	R	R	AR	AR	AR	AR	AR
3. Measure, disclose quality info	AR	AR	AR	AR	AR	AR	AR	AR
Costs								
1. Prevention education, intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Electronic medical records	A	AR	AR	AR	AR	AR	AR	AR
3. Drug formularies	AR	AR	AR	AR	AR	AR	A	AR
4. Health care < State fiscal plan	A	AR	AR	AR	AR	AR	AR	AR
5. Disclose fees clearly	A	R	R	A	A	AR	A	AR
6. Community duplication dialogue	A			AR	AR	AR		AR
7. Joint purchasing	A			AR	AR	AR		A
8. Allocation & rationing	A	AR	AR	AR	A	AR	AR	AR
9. Fee transparency legislation	A	R	R	AR	A	AR	AR	AR
10. Legislative ins., reimbursement, tort solutions	A	R	R	AR	AR	AR	AR	AR

The impact of lifestyle and prevention

First and foremost, this is an issue of individual responsibility. This means that each of us is ultimately responsible for our own health, how we eat, exercise and live. Nevertheless, many collective societal educational and social efforts can help further acceptance of this individual responsibility through application of sound health maintenance principles.

Our society is not used to facing the facts of collective issues. They are not part of the national or state non-Native psyche. Currently, the health care industry plugs holes in the dike that are the result of unhealthy lifestyles. We need to go way upstream and focus on prevention.

Fortunately, we can learn from the positive example of reduction of smoking in America. Much remains to be done. Today's limited but meaningful success is the result of a long-term effort that lasted over a generation. Extensive public education, warning labels, laws banning smoking in public places and a consistent message from the health care community ultimately resulted in societal changes that now appear to have gained a self-reinforcing life of their own.

1. Plan a "walkable community."

- a. Land use designed to facilitate walking and biking can encourage cardiovascular health. Maintaining safe municipal trail systems, seasonal bike paths, and cleared wintertime walkways permit citizens to practice healthful life habits year around.
- b. Enlightened city planning and architecture can promote a more active lifestyle.
- c. As public demand for exercise opportunities grow, their inclusion in real estate development and city planning can improve property values.

2. The role of public health as community educator and provider. Municipal health departments need to serve many more people than those who seek care at the clinic. Promoting wellness and healthful living habits to the entire community is an essential part of the public health mission. This portion of the mission needs to be funded adequately in the budget.

3. The importance of physical education in the schools— (not a "frill") It is important to teach children about the relationship between health, diet and exercise. Not every child will want to join a sports team, but learning to be responsible for their own health by incorporating physical activity into their daily lives is an important health lesson that cannot be ignored.

4. Eliminate internal inconsistencies and conflicts between programs and objectives. For example, eliminate financial incentives in schools to promote unhealthy foods. Provide a financial alternative to schools that have come to rely upon income from selling junk foods in the schools.

5. **Incentivize healthy behaviors through workplace activities.** Convince the Top 49 Alaska businesses to educate their employees on healthy lifestyles and offer healthful workplace activities. The Top 49 businesses would represent a large percentage of the Alaska population not already covered by Federal or Alaska Native health care systems. Encourage a **Top 49 Health Summit** to facilitate understanding and participation of these large Alaska businesses.
6. Develop intervention programs for **promoting the traditional rural diet.**
7. **Reconsider rural access to dentistry as part of the study.** Many rural communities lack a sufficient population to support construction of a simple dental facility to house a full time dental practice. The investment required to maintain a facility for use by an itinerant dentist would likely need to be made by the community, possibly partnering with the state. Lack of roads prevents the use of mobile dental clinics that are used in other remote locations worldwide.
8. **Reduce the critical shortage of facilities for alcohol and drug detox, and psychiatric facilities. The lack of services these facilities provide can increase costs in the long run.** Persons affected by alcohol and drug use, and the accidents they cause, account for a significant portion of the population needing care in hospital emergency rooms and psychiatric facilities. Yet Alaska has too few beds to treat those in need of drug and alcohol recovery. As a result we are forced to tolerate that burden of higher healthcare costs. Detox beds make good economic and health policy sense.
9. Find ways to incorporate **U.S Task Force on Preventive Health** recommendations into medical practices, schools, work environments and homes.
10. **Continue the Institute of Circumpolar Health Studies** to analyze common problems and look for solutions that will work for all circumpolar peoples. Similar environments and cultures may result in shared knowledge that can benefit those in northern latitudes. Many health issues in Alaska relate to weather, the environment, subsistence food quantity and quality, potable water and sanitation issues. These are issues shared by other circumpolar peoples. Alliances with other circumpolar countries, and organizations like the Institute for Circumpolar Health Studies may provide new insights in resolving some of these issues.

Access improvement recommendations

1. **Workforce development issues**
 - a. **Expand the WWAMI program.** Improve the supply of primary care providers (family practice physicians, internists, nurse practitioners, physician's assistants), especially outside of Anchorage. Current or potential shortages can be identified in specific specialties.
 - b. **Market the Alaska lifestyle to Outside doctors.** JV with tourism, the State Medical Board, ASMA. Create a dog and pony show.

2. **Investigate and modify the factors that influence the cost of professional liability insurance**
3. **Reduce the number of uninsured Alaskans**— A non-government designed system is probably preferable to a government-operated system.
4. **Investigate pooling smaller companies a la the Foraker Group in an effort to reduce premium costs.**
5. **Promote lower cost models such as neighborhood health centers where appropriate**
6. **Educate the public and promote same day access to alternatives other than hospital emergency rooms.** This involves creation of more readily available and timely access to primary care. Alternatives could include increasing the number of primary care providers and clinics, establishing a variety of disincentives for visits for minor complaints, and establishing a system for care for the uninsured. Emergency rooms themselves may need to be reorganized and redesigned to separate life-threatening emergencies from routine medical needs.
7. **Examine uninsured models elsewhere; e.g. Utah, Maine and Florida.**
8. **Adjust the Medicare (GME) reimbursement formula for Family Practice Residency programs.**

9. **Ensure adequate government reimbursement to doctors, hospitals, community health centers, mid-level practitioners and community health aides without unreasonable bureaucratic burdens.**
10. **Consider making accepting Medicare patients a condition of licensure in Alaska. This has been done in Massachusetts.** Weigh the advantages of increased access for Medicare patients against the negative effect of attracting practitioners to Alaska.
11. **Consider public hearings for health care insurance and professional liability insurance rates** to facilitate price transparency. Currently insurance rates are largely negotiated between large institutional users and insurance carriers. As private contracts, the resulting rates are not disclosed. Individuals have little or no negotiating power and either have to accept or reject rates offered to them. The thought is that greater transparency could result in more favorable, or at least understandable, rates for individual consumers.

Quality improvement recommendations

1. **Promote and encourage primary prevention, early intervention, and evidence based practices by providers and payers of health care.**
2. **Use meaningful benchmarks; e.g. the Alaska 20/20 example.**
3. **Measure quality of service and make the information publicly available.**

Cost reduction recommendations

1. **Prevention through Public health education, and early intervention** Preventing illness will save more lives, more lost work time and more healthcare dollars than any other option available to us as a community. Consider the adage “the cheapest health insurance is healthcare you don’t need.” Measures include flu shots when they are recommended and vaccinations against common diseases. Encourage the following behaviors: weight control, regular exercise, avoiding cigarettes and excessive alcohol, fat, salt, and sugar, adequate water consumption, and controlling blood pressure.
2. Encourage and promote the establishment of an **Electronic Medical Record** with a common interface as a means to improved safety and efficiency of health care.
3. **Drug formularies**—utilize where appropriate and effective.
4. **Promote the strong interrelationship between cost of health care and a state fiscal plan** as a means of putting health and budget decisions in perspective.
5. **Fee and billing transparency.** Mandatory disclosure of fees in advance of treatment and “understandability” standards for medical billing.
6. Encourage **local cooperation and sharing of services and facilities.** Promote community by community dialogue on the cost of duplication
7. Analyze the possibility of saving money by **joint purchasing** by appropriate parties.
8. **Allocation and rationing** might be considered if other measures fail to stabilize health care costs.
9. **Suggest legislation to mandate fee transparency**
10. **Consider legislative solutions to tort and liability issues.** Quantify professional liability insurance, patient reimbursement and tort issues—are there legislative solutions? Look at tort reform experiences Outside, such as MICRA, for ideas that might apply to Alaska.

SUCCESS STORIES AND PROMISING PROGRAMS

Alaska has a number of programs that have proven to be successful:

Lifestyle and prevention

- The South Central Foundation Primary Care Clinics place great emphasis on prevention. This results in some of the best state data for immunization rates, colorectal screening, mammograms and other standard preventive health interventions.

Access

- Anchorage Neighborhood Health Center
- Other community health centers
- Health aides in rural Alaska
- South Central Foundation has programs that have established same day access. Utilization rates for emergency room use and specialty services have fallen dramatically. Utilization rates of primary care services have also had a modest decrease.

Quality

- Hospital quality control programs have been established in all the major hospitals in Alaska with excellent results. For example, Providence Hospital received national recognition for reducing surgical site infections after joining a national collaborative focus on this issue. Alaska Regional Hospital was recognized for reducing pneumonias after intubations. The Alaska Native Medical Center has developed a national reputation for quality improvement activities working in close association with the Institute for Health Care Improvement. All of our major hospitals have joined the national initiative known as the "100,000 Lives Campaign" to save this many lives in U.S. hospitals by June 2006.

Costs

- The Alaska Federal Health Care Partnership, consisting of the DOD, VA, Coast Guard and the Alaska Native Health System, have been able to reduce costs by bulk purchasing and the sharing of clinical resources.

Other programs show promise:

- The State of Alaska has developed benchmarks for population health improvement targets in a document called "Healthy Alaskans 2010."

Lifestyle and prevention

- The Anchorage Daily News and a growing number of businesses are discussing wellness incentives in an effort to reduce health care costs. Generally all of these approaches are similar. Employees who agree to join this effort receive personal health care improvement plans and personalized coaching on a regular basis. Some companies offer health care premium discounts as an incentive to participate.

Access

- Anchorage Project Access is a developing physician initiative in Anchorage (adopting a national model) to provide free care to uninsured individuals who meet certain low-income criteria. Almost all physicians and hospitals currently provide uncompensated care. By organizing this effort, other communities with this program have been able to efficiently provide more care to the uninsured.

Quality

- A new initiative in the U.S., public reporting of quality indicators in hospitals and nursing homes, is being required by the Center for Medicaid/Medicare Services (CMS). Hospital quality reports are now available on the Web under the title of "Hospital Compare." Both the federal government and insurance companies are instituting "pay for performance" programs to improve service quality by hospitals and doctors. Countries like Great Britain have already introduced these programs.

APPENDIX

Key ideas in the 1994 CWN study "Health Care: Finding an Alaskan Solution"

1. The health care reform debate is complex and controversial, with multiple players with competing interests.
2. There are significant factual disputes about the health care system.
3. Health care reform creates winners and losers.
4. The most important conclusion for Alaskans: Involvement of Alaskans in the health care debate is vital. Some type of reform is inevitable and Alaskans must work to ensure that reform is responsive to our unique Alaskan conditions.

Study Group Participants

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Duane Heyman Executive Director, Commonwealth North

The Charge

Alaska Primary Health Care – Opportunities & Challenges

Approved by the Commonwealth North Board on July 20, 2004

1. Questions to be addressed:

- a) How is primary health care currently being delivered to Alaskans?
- b) Are Alaskans receiving quality health care under the current scenario?
- c) What does the future hold for health care in Alaska?
- d) Are there ways to do a better job, such as by bridging the current multiple systems?

2. Scope of study:

The intention of this study is to focus on primary care – the need for Alaskans to receive basic health care. Recognizing there are a number of health care areas which merit similar attention such as long-term care, behavioral health, dental care, etc., the focus of this particular study is to address the past, present and future of primary health care in Alaska. The study will include an update/compilation of previous reports to provide a context.

- The study will briefly explore the historical delivery of health care and how that history impacts the present challenges Alaska faces. In providing this background, the study will also look at the health status of Alaskans – is it above/below that of other states or are we keeping pace?
- The study will explore the “drivers” behind the cost of health care in Alaska and will assess its impact, if any, upon economic development in the State. Access and quality of care/services are a critical determinant of cost within the various health systems in Alaska.
- This study will identify principal health care entities and look at the current multiple health systems – what are the benefits and challenges? Are they sustainable? What impact, if any, do these multiple systems have on the cost and quality of health care?
- There are a number of challenges facing health care providers and recipients: This study will identify those challenges and where possible, potential solutions.
- There are a number of examples where health care entities are collaborating. The study will highlight the best practices and identify additional areas of collaboration. The study will also take into account lessons learned from other states.

3. Nature of report to be issued (Technical, Analytical, or Opinion):

This report will analyze issues, identify a process for addressing them and suggest guiding principles. The report will provide background, current status and recommendations for change or further study. While the report will largely express opinions, it will address technical issues that are necessary aspects of the larger picture.

4. Conflict of interest standards:

The intent of the study is to represent a balance between the geographic, demographic, ethnic and economic interests in Alaska. It is expected that persons with interests in the outcome of the study will be members of the study group and will participate in its deliberations. Study group leaders should request that study group members identify their interests relative to specific points they advocate.

5. Measure of success:

This study will succeed by generating a greater understanding of and insight into health care issues in Alaska and areas in which health providers can work together for the mutual benefit of all Alaskans.

Resource People Interviewed

- 9.23.04 Ed Lamb, Al Parrish—Hospital perspectives
- 9.30.04 Barbara Russell—Premera
- 10.07.04 Alex Spector—VA, Lt. Col. Vic Rosenbaum—Elmendorf Hospital, Maj. Ward Hinger-
-TRICARE
- 10.14.04 Commissioner Joel Gilbertson
- 10.21.04 Paul Sherry—Alaska Native Tribal Health Consortium
- 10.28.04 Tessa Rinner—Denali Commission
- 10.28.04 The Maine Plan (Sergei Bogojavlensky, MD)
- 11.11.04 Norman Wilder MD, MBA (Regional), Roy Davis MD (Providence)—Quality and cost
control initiatives
- 11.18.04 Rod Betit—State Hospital & Nursing Home Association
- 12.02.04 Catherine Schumacher MD—Access to health care in Anchorage
- 12.09.04 Cathy Giessel, MS, FNP-CS—The role of nurse practitioners
- 12.09.04 Harold Johnston, MD—Program Director, Alaska family Practice Residency
- 1.06.05 Joan Fisher – Executive Director, Anchorage Neighborhood Health Center and Medical
Director, Dr. Tom Hunt and Beverly Wooley, Director, Anchorage Municipal Health
Department
- 1.27.05 Janet Trautwein – VP Government Affairs, National Assn of Health Underwriters
- 1.28.05 (Forum) panel discussion with Commissioner Joel Gilbertson, Al Parrish, Randall
Burns—Alaska Small Hospital Performance Improvement Network, Dr. David Snyder—
Alaska Native Medical Center
- 2.03.05 James Jordan, Executive Director, Alaska State Medical Association
- 3.10.05 Ann Conway, Maine Center for Public Health
- 3.25.05 Joseph Ditte, Executive Director, Consumers for Affordable Health Care Foundation
(Maine)

Alaska Health Care Strategies Planning Council

Final Report: Summary and Recommendations

*Making Alaskans the healthiest people in
the nation...*

December 23, 2007

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**The Alaska Health Care Strategies Planning Council
Final Report: Summary and Recommendations
December 23, 2007**

Executive Summary

On February 15, 2007, Governor Sarah Palin issued Administrative Order #232 establishing the Alaska Health Care Strategies Planning Council in the Office of the Governor. The purpose of the Council was to build the foundation for developing a statewide plan to identify both short-term and long-term strategies that effectively address issues related to access, cost and quality of health care for Alaskans. Members of the Council, all appointed by Governor Palin, are listed in Appendix C.

The Council interpreted its charge from Governor Palin broadly, to focus on the overall goal of improving the health of Alaskans. Within that broad charge, the Council considered health care to be an important component in improving the health of Alaskans. According to the Council, health care is a broadly defined term, relating to the prevention, treatment and management of illness, preserving mental, behavioral, physical health, and dealing with chemical dependency.

In accordance with the order, the Council reviewed and synthesized the extensive body of existing research on the subject, agreed upon the most salient facts, and identified the most significant health care issues in the state. Based on seven overarching healthcare challenges identified by the Council, members articulated the following seven comprehensive health care policy goals:

- *Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals;*
- *Health care costs for all Alaskans will consistently be below the national average;*
- *Alaska will have a sustainable health care workforce;*
- *All Alaskan communities will have access to clean and safe water and wastewater systems;*
- *Quality health care will be accessible to all Alaskans to meet their health care needs;*
- *Develop and foster the statewide leadership necessary to support a comprehensive statewide health care policy;*
- *Increase the number of Alaskans covered by health insurance and encourage employers to offer a range of health insurance options.*

Because of its short time frame, the Council was unable to address the Administrative Order's directive to present fiscal information to accompany each of the short- and long-term strategies. Unfortunately, with only 24 hours of face-to-face meeting time, identifying the fiscal impact of recommendations remains unaddressed, and must be a top priority in future consideration by this or subsequent bodies.

The Council's Vision and Long-term Goal

At its inaugural meeting on June 11, 2007, Council members articulated an overall vision of health care in Alaska – that *“Alaskans are the healthiest people in the nation.”* This vision led to development of a concrete mission statement describing the ultimate

outcome of the Council's work: *"To develop strategies, including performance measures, to provide health care access to all Alaskans by 2014."*

The "Fact-Based Process"

The work of the Council was facilitated through a "fact-based" process by Mr. Dennis McMillian, President and CEO of The Foraker Group, an Alaskan-based nonprofit corporation. Members were asked to review existing research and initiatives, and hear from subject-matter experts on the major issues in Alaska's health care system. Only those facts garnered from existing sources and/or presented to the Council at its meetings, and which were widely recognized by Council member as salient to the process, were allowed to remain in the conversation.

While time-consuming, the fact-based process allowed the development of a solid basis for discussing the issue of health care in Alaska, highlighting the major challenges with that system, and identifying realistic solutions to address those challenges.

Alaska's Health Care Challenges: A Strategic Plan for the Future

In the opinion of the Council, there are seven challenges requiring immediate and comprehensive attention in Alaska's health care system:

- *Prevention and personal responsibility don't play big enough roles in the health and health care of Alaskans;*
- *Receiving quality health care in Alaska is expensive, well above the national average, and increasing;*
- *There are significant shortages in the health care workforce across the state;*
- *Water and wastewater systems in many rural communities lead to health problems;*
- *Quality health care is difficult to access for many Alaskans, urban and rural;*
- *There must be consistent and focused state and local leadership to improve the health of Alaskans, and build a comprehensive health care system in Alaska;*
- *Health insurance is an important if as yet misunderstood part of comprehensive health and health care.*

Based on the vision of a healthy Alaska, a one-page "Alaska Health Care Action Plan" was developed by the Council. The plan appears in the following section, and includes a combination of long-term and short-term goals. Where applicable, the short-term strategies appear at the beginning of the relevant goals.

During its work the Council was able to generate dozens of possible solutions to address the challenges, much of that the result of "brain-storming." The identified solutions are presented in Appendix A. Most require development of implementation plans, which was considered beyond the scope of the Council's work, especially given the short window for completion of its tasks. Although they are not developed fully, the articulated solutions in the plan, and within Appendix A, present a real and actionable foundation for helping to meet the goals in the "Alaska Health Care Action Plan."

**Alaska's Health Care Action Plan: "Making Alaskans the healthiest people in the nation."
Long-Term Goals and Strategic Directions (2008 – 2014)**

Goal One: Health costs for all Alaskans will consistently be below the national average.

- Increase the place of consumerism in health care purchasing by giving people control over their health care dollar – the foundations are accessible, transparent, evidence-based price/quality information about providers and services (short-term)
- Create an easily accessible and constantly updated website containing evidence-based price and quality information about health care providers and services (short-term)
- Increase community-based health care services, both public and private sector
- Stabilize the costs of health care by reducing the rate of increase relative to other states (national increase is 6%, decrease Alaskan rate to 4% annual increase)

Goal Two: Alaska will have a sustainable health care workforce.

- Increase WWAMI seats to 50 per year, and increase seats in UA Nursing and Nurse Practitioner programs (short-term)
- Develop policies and systems to alleviate the health care worker shortage, and prevent it from recurring
- Implement a doctoral-level nursing program at the University of Alaska to meet the 2015 deadline for Nurse Practitioner education requirements

Goal Three: All Alaskan communities will have clean and safe water and wastewater systems.

- Improve adherence to the state's existing water and wastewater treatment "plan," through the Village Safe Water Program

Goal Four: Quality health care will be accessible to all Alaskans to meet their health care needs.

- Expand tele-health and electronic health record systems, taking the lead in pursuing matching FCC grant funds (short-term)
- Increase presence of the public health system, particularly public health nurses, especially in rural communities (short-term)
- Increase access of Alaskans to a primary care provider and behavioral health provider when they are needed
- Decrease the likelihood that Alaskans will use emergency rooms for primary care
- Reduce the impact of existing barriers to health care accessibility by exploring private enterprise incentives
- Improve primary and long-term health care options for elders, particularly with regard to Medicaid and Medicare

Goal Five: Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals.

- Decrease the impact of obesity, smoking, substance abuse and other lifestyle factors on the health of Alaskans, through intense public education with public and private partners (short-term)
- Improve the likelihood that every Alaskan will choose to live a healthy lifestyle and make healthy lifestyle choices
- Increase the place of personal responsibility in health care decision making for all Alaskans

Goal Six: Develop and foster the statewide leadership necessary to develop and support a comprehensive statewide health and health care policy.

- Create an ongoing, quasi-independent, non-partisan, volunteer "Alaska Health Care Commission" in statute (short-term)
- Elevate the discussion of health care to a statewide audience

Goal Seven: Increase the number of Alaskans covered by health insurance

- Raise the eligibility criteria for Denali KidCare from the current 175% to 200% of federal poverty limits (short-term)
- Reduce potential for financial impact from catastrophic loss by supporting new and innovative approaches to insurance for individuals, which would be consumer-owned, portable, and purchased with pre-tax dollars
- All Alaskans have at least a catastrophic, incentive-based insurance option (i.e., high deductible coverage)
- Encourage employers, through varied incentives, to offer a range of insurance options/choices to employees – to include at a minimum, high deductible plans

Alaska's Health Care Challenges: Discussion and Recommendations

The Council engaged in lengthy discussion of the seven main challenges facing Alaska's health care system, and generated the following discussion points related to each.

- *Defining the specific problem or problems*
- *Why addressing them through comprehensive state action is important*
- *What should be done about it – in other words, identifying desired outcomes*

In addition to discussing what should be done to address each problem, the Council generated possible solutions and solicited public comment on the Health Care Action Plan. A Strategic Implementation Table (Appendix A) list the many solutions generated by the Council, and sets the foundation for implementation of selected short and long-term strategies. The full text of public comment will be presented to Governor Palin under separate cover, but the overriding themes contained within those comments are summarized in Appendix B.

Goal One: The High Cost of Health Care in Alaska

What's the problem? *The costs of producing quality health care are high, and therefore it is quite expensive to be a consumer of that care. The costs of health care in Alaska are already well above the national average, and like the rest of the nation, are increasing.*

Why this is important: *A new approach to this problem must be embraced if there is to be long-term, positive reform in Alaska's health care system. If Alaska continues along the same path, the results will remain unchanged. Reducing the rate of increase in the costs of health care is a "must do" priority, and Alaskans need to get the best value for health care dollars spent. Every health care dollar must be spent wisely. Broadly stated, the high cost of health care is a barrier to many Alaskans getting the health care they need. The present system supports the high and increasing costs of health care and inefficient utilization of health care dollars.*

What should be done about it: *Decreasing the rate of growth in health care costs in Alaska will require development of a high-quality health care system that is evidence-based, consumer driven and market-responsive. With respect to lowering costs, insurance that is portable and consumer-owned plays a central role, and requires much more discussion at the state level. Overall, giving people more control over their health care dollar is a central component, as is providing appropriate, accessible, transparent, and evidence-based cost and quality information about health care providers and services. In the short-term, one of the most important goals should be state creation of an easily accessible and up-to-date website providing health care cost and quality information to Alaskans. These strategies alone are not sufficient to reduce the overall cost of health care in Alaska, nor to reduce the rate of growth. Closely related are the subjects of personal responsibility, access to health care, increasing the number of health care providers, and insurance.*

Goal Two: The Health Care Workforce

What's the problem? *There are significant shortages in the health care workforce across the state. Alaska needs more health care workers throughout the system, at all levels.*

Why this is important: *Without ample health care workers, the system will continue to falter – it is already showing signs of strain. Lack of a sustainable health care workforce is a primary factor in the increasing costs of health care, and also in the decreasing access of health care for Alaskans. In addition, significant access issues exist in both urban and rural areas, which will likely require expansion of the health care workforce.*

What should be done: *Statewide policy should enable the creation of a sustainable health care workforce that alleviates the current shortage and prevents it from recurring. A good start is to “grow more of our own” within Alaska, by presenting health care professions more prominently as viable career options, with students continually encouraged to build the skills and the interests necessary to pursue health care careers. In the short-term, to increase primary care providers in the state, the number of WWAMI seats should be increased to meet the projected need of 50 per year in the next decade. In concert with that, the University of Alaska nursing doctorate degree should be implemented as well. The number of resident positions in the Family Practice Residency Program should be increased, as should the number of graduates in both the UA Nursing and-Nurse-Practitioner-Programs.*

Goal Three: Sustainable Rural Water and Wastewater Systems

What's the problem: *Water and wastewater systems in many rural communities are inadequate, unsafe, or non-existent, and can be a major cause of health problems within those communities.*

Why this is important: *There is a strong correlation between the health of Alaska's rural residents, and water and wastewater safety. Building and operating clean drinking water and wastewater disposal systems is one of the most effective means for improving the health and wellness of rural Alaskans and rural communities.*

What should be done: *There is an active state program in place to bring sustainable and safe drinking water and wastewater disposal systems to all of Alaska's rural communities – the Village Safe Water Program. However, the real success of that program depends on the recognition by state policy makers that there is no “one size fits all” approach to bringing those systems to rural Alaska. What works in one community may not work in another. Efforts to provide infrastructure that the community can support in the future should continue. The state's long-term health care policy, therefore, should improve and ensure the state's adherence to the “plan” for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community.*

Goal Four: Access to Health Care

What's the problem? *Accessing quality health care is difficult for many Alaskans, both urban and rural. There is little consistency of access to health care for all Alaskans – some have it all the time, some have it some times, and some have it hardly at all. In Alaska's urban areas there is a lack of access to necessary specialized care and efficient "same-day" primary care. In rural communities, there is often no access at all to health care because of a variety of barriers, including costs, geography, transportation challenges, lack of providers and much more.*

Why this is important? *The lack of access to quality health care contributes to Alaskans' wellness challenges. Being able to guarantee timely access to primary care, in particular, presents significant challenges; but appropriate primary care is one of the most effective means for keeping Alaskans healthy. There was considerable discussion among members about the positive impact of Community Health Centers, and the state's public health nurses, in providing greater access to health and health care opportunities.*

There was agreement among Council members on two major points relevant to health care access. First, Community Health Centers (CHCs) are a valuable part of the "health care safety net" for Alaskans. Second, the state's public health nursing structure is one of the most important mechanisms for affording greater access to a wider range of health care. The problem with CHCs and public health nursing is that both programs are under-funded. Community Health Centers are federally funded, and most states provide supplemental financial assistance because CHCs are viewed as an important part of the overall health care system in those states. Partly due to the provision of health care services to the under-insured and uninsured, CHCs consistently face budgetary challenges. In Alaska, CHCs receive virtually no funding from the state. Similarly, the state's public health nursing system has been chronically under-funded for years. Ever-decreasing state dollars for the Public Health Division has meant that fewer and fewer public health nurses are able to do their important work improving the health of Alaskans.

What should be done: *Accessing health care should not be difficult for Alaskans, and broad policies that improve access to primary care and behavioral health care should be the focus of any state health care policy. Strategies should include: 1) the state becoming more actively engaged as an active investor in the Community Health Center system through supplemental funding and regulatory relief; 2) appropriate funding for and utilization of the state's Public Health Division, in particular the Public Health Nursing program; 3) building monetary and other incentives into the health care system which encourage Alaskans to more effectively utilize primary care opportunities; 4) leveraging information technologies such as tele-health and electronic health record systems which can improve access while reducing costs; and 5) reducing barriers to private clinicians practicing in underserved areas. In the very short term, the state could take the lead in guaranteeing that the required "match" associated with the current \$10 million Federal Communications Commission tele-health grant is made.*

Goal Five: Prevention and Personal Responsibility

What's the problem: *Prevention and personal responsibility play too small a role in health care, including maintaining and improving health. While Alaskans may understand the connection between their lifestyle choices and their individual health, for the most part they do not make a connection between personal choices, having a personal stake in their health, and the cost of their health care. Alaskans are not optimally encouraged and equipped to make the kinds of choices that improve health and subsequently decrease health care costs.*

Why this is important: *More healthy Alaskans translates into fewer sick Alaskans, and improved quality of life with resultant cost savings. A clear understanding of the role of personal choice in individual health status and the impact on health care costs, as well as the central role of government in supporting health choices, are critical components in developing long-term strategic health and health care policies.*

What should be done about it: *Solving this problem requires a two-pronged approach. First, Alaskans must be encouraged to play a much greater role in their own wellness by having both a personal and financial "stake" in their own health. Having a "stake" in their own health is the product of a personal investment in wellness, and realizing the financial benefits of saved dollars by maintaining healthy lifestyles. In the opinion of the Council, the most effective mechanism for increasing the personal health investment of Alaskans is incentivizing and supporting positive change.*

Second, governments, school districts, tribal entities and other employers are uniquely situated to be catalysts for positive change. These entities have the influence to help Alaskans understand and make healthy choices, while at the same time avoiding those lifestyle decisions that contribute to poor health.

Goal Six: Statewide Leadership

What's the problem: *A lack of consistent statewide leadership makes development of comprehensive statewide health and health care policy challenging.*

Why this is important: *Public leaders have a pivotal role as catalysts for positive change. Commitment at the executive and legislative levels to comprehensive and lasting change will effect health and health care in Alaska.*

What should be done about it: *The Council believes that government has an obligation to "jump start" healthy choices through incentives, and in addition build the necessary incentive structures for the future. Positive change will be the result of a concerted effort by the governor and the legislature, through partnering with local communities, in a long-term commitment to maintain positive momentum. The key is elevating the discussion of health and health care to the statewide level.*

One of the most effective mechanisms for solidifying that long-term commitment to bringing positive change to Alaska's health care system is to establish through statute a quasi-independent "Alaska Health Care Commission," which would seek to provide advice on innovative solutions, and act as a catalyst for positive change. The Commission would be responsible for advising state leaders on incentivizing positive lifestyle choices; fostering ongoing research; controlling health care costs; improving access, and ensuring a sustainable health care workforce.

Goal Seven: Health Insurance

What's the problem: *Over 100,000 Alaskans – including more than 14,000 children – are without health insurance at some time during any given year. When insurance is made available, there is often a misconception that it should cover everything, from routine and predictable events to catastrophic occurrences and long-term care; this misconception increases the cost of health insurance beyond the reach of many Alaskans.*

Why this is important: *Having access to health insurance coverage is one of the most significant determinants of access to appropriate health care. Alaskans who do not have health insurance are often unable to get the services they need to become healthy, and to maintain wellness.*

When uninsured Alaskans do seek health and health care services, it is often for expensive chronic conditions which could possibly have been avoided if they had had health insurance coverage, or access to appropriate primary care. When Alaskans who may not be eligible for Medicaid and Denali KidCare do access health care, they are often unable to pay and often seek care in a hospital emergency room, which is the most expensive and inefficient mechanism for receiving primary care. The costs of such access are borne across the whole health care system, which raises the overall costs of health care in Alaska. When the uninsured who are not eligible for Medicaid and Denali KidCare do pay for health and health care services, they often do so at significant personal and family financial impact.

Not having insurance is only part of the problem, and simply providing insurance under the current structure is not the answer. With the exception of preventative health services, comprehensive health insurance is not an efficient way to pay for routine and predictable care, such as the common cold, ear infections, hang nails, and sprained ankles. Whereas health insurance IS the most important tool for protecting people from unplanned catastrophic health events, it is an inefficient way to pay for routine expenditures. Therefore, the current system, which relies on insurance to pay for routine and predictable health care expenses, raises the costs of premiums above the reach of many Alaskans.

What should be done about it: *More Alaskans need to be covered by efficient health insurance plans. Increasing the number of Alaskans covered by efficient health insurance will be the result of several specific actions. In the short-term, the Council recommends that the state immediately pursue and support change in the Denali KidCare program to make Alaskan children in families at 200% of the federal poverty level eligible for coverage. While there was a majority vote among Council members regarding this expansion of Denali KidCare coverage, the role of that program within an efficient and effective system of health care coverage is worthy of continued debate at the statewide level, through the recommended "Alaska Health Care Commission."*

To most effectively cover the adults and remaining children without health insurance, bringing consumerism to the forefront of Alaska's health insurance structure is important. Alaskans should have access to choices, through a wide range of health insurance options, including at the very least high deductible coverage with a strong prevention component. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. Whereas some uninsured Alaskans are not working, most are working for employers who would like to, but cannot necessarily afford to, provide health insurance coverage for their employees. Therefore, through incentives, Alaskan employers should be encouraged to offer a wide range of coverage choices, to include at a minimum, high deductible coverage.

Consumerism is an essential component of bringing rationality to the health insurance structure in Alaska, and extending coverage to as many Alaskans as possible. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. In addition, insurance must be consumer-owned, market-responsive and portable; this recommendation has received attention elsewhere in this report. Coverage options debated in the Council's discussions, which are by no means exhaustive, include Health Savings Accounts, Health Opportunity Accounts, and high-deductible plans with a strong prevention component. This list provides a solid foundation from which to continue the ongoing discussion about expanding health care coverage for all Alaskans.

Summary and Conclusions

Resolving the health and health care issues in Alaska will not be the result of a single solution. Instead, bringing real and lasting change means working together in partnership. Many of the solutions presented within this report fall squarely within the purview of state government. But no matter how committed state government is, solutions will not be forthcoming without involving all stakeholders as partners for change – from individual Alaskans to families, nonprofit organizations and private sector employers and employees, communities and local governments, tribal entities, state government, the governor, the legislature, and the federal government.

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The Council has deliberately not prioritized solutions for solving the problems it has identified with the health and health care system in Alaska. Indeed, all of the problems must be addressed concurrently if real, long-term change is to take place. Having said that, within those identified by the Council, one is definitely the larger-order problem, meaning if we can solve it, many of the other problems will be alleviated. That problem is the lack of prevention and personal responsibility.

By improving the place of prevention and personal responsibility in the health and health care decision-making rubric of Alaskans, costs of health care could be lower than they otherwise would be. With concentration on a wellness model of health care, as well as state support for the Community Health Center system and a robust public nursing program, the current access problems could be significantly reduced. Most Alaskans will have both the motivation and the means to maintain their own wellness. And with greater wellness, the composition of the health care workforce will likely change, decreasing the dependence on health care professionals who are the most difficult and most expensive to attract and retain.

Becoming the healthiest people in the nation is indeed a grand vision – but it is real and achievable.

Respectfully Submitted,

The Alaska Health Care Strategies Planning Council
December 23, 2007

**The Alaska Health Care Strategies Planning Council
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Appendix A: Strategy Implementation Table

2008 / 2009 / 2010 / 2011 / 2012 / 2013 / 2014

Short-Term Strategies <i>(for implementation between 2008 and 2010)</i>	Action Required (Policy, Regulation, Statute)	Expense	Implementation Timeline
<ul style="list-style-type: none"> • Create an ongoing and quasi-independent "Alaska Health Care Commission." • Promote incentives for clinic use, rather than the use of emergency rooms for routine/primary care. • Promote the use and expansion of Community Health Centers throughout the state. • More effectively target recruitment of health care professionals by marketing Alaska to rest of nation/world as a great place to live, work, raise a family, enjoy nature, etc. • Conduct a comprehensive, statewide health care workforce assessment. • Continue to support Alaska Native Tribal Health Consortium's ongoing efforts to develop sustainable, community-specific water and wastewater capacity in all villages. • Increase quality of and access to Telemedicine, Community Health Aides/Practitioners, Community Mental Health Aides and Community Dental Health Aides. • Implement a prevention-focused "Fit for Life" social marketing program that is multigenerational and culturally aware. • Emphasize the role of the public health nurses in prevention and wellness – from well-baby checks on up to flu shots for elders. • Support programs to encourage employers to offer employees "time off" for making healthy lifestyle choices and maintaining wellness. • Institute "Silver Sneakers Programs" – for elders – to keep elders healthy. • Ensure public health immunization funding. • Fund free and/or low-cost clinics, keeping in mind uninsured Alaskans. • Incorporate a "Wellness Certificate" into the PFD program, and give a five percent boost in the dividend for maintaining a healthy lifestyle. • Foster a state culture through policy that rewards schools for wellness. • Provide financial incentives for "healthy schools." • Support the ongoing efforts to establish comprehensive health care insurance options to employees of Alaska's nonprofit sector. 			

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- Pay the tuition – or forgive student loans – for residents from rural Alaska who are willing to practice – after graduation – in their home community.
- Institute student loan forgiveness for medical/health professionals and para-professionals who make a commitment to stay in Alaska.
- Provide grants for low-income vocational/tech students in Certified Nurses Assistant/Pharmacy Tech programs.
- Increase the presence of public health system, particularly public health nurses, especially in rural communities.
- Follow through on existing state plans for safe drinking water and wastewater, through the Village Safe Water Program and other efforts.
- Support and expand telemedicine and tele-behavioral medicine -- include education, maintenance and equipment upgrades.
- Increase behavioral health training and support,
- Increase available slots in Physician Assistant and Nurse Practitioner programs at the University of Alaska and with other academic partners.
- Increase number of Residents in Family Practice Residency Program.
- Create a greater awareness of the distinction between routine and predictable health care costs (less expensive) and unanticipated or catastrophic costs (more expensive).
- Promote Health Savings Accounts and high deductible insurance plans – for individuals and employers.
- Provide incentives for providers and consumers, with performance measures and rewards (for providers), based on evidence-based results.
- Foster better informed consumers through creation of a dynamic (continuously updated) website providing transparent quality and cost information about medical services, prescriptions, etc.
- Build teaching capacity in K-12 schools to excite young Alaskans about the physical sciences generally, and the health care field in particular.
- Increase penalties for selling alcohol to youth.

Long-Term Strategies <i>(for implementation between 2010 - 2014)</i>	Action Required (Policy, Regulation, Statute)	Expense	Implementation Timeline
<ul style="list-style-type: none"> • Support information technology improvements. • Promote insurance that is portable, consumer-focused and consumer owned, purchased with pre-tax dollars. • Increase Alaska WWAMI seats to 50 /year – the projected need to meet demand in the next 10 years. • Institute doctoral NP program at UAA. • Increase the availability of education programs for health care disciplines. 			

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<ul style="list-style-type: none">• Expand State role in direct funding of and improving access to Community Health Centers.• Foster a consumer-directed health care approach to long-term care.• Encourage the implementation of a consumer-directed health care system.• Integrate "consumerism," encouraging people to shop around for the best quality and appropriate cost and consider personal responsibility.• Encourage formation of Tobacco Free communities, businesses and workplaces through Statewide Clean Indoor Air Act.• Institute/Increase Alcohol taxes.• Increase fluoride in drinking water.• Reduce barriers to establishing and running CHCs: (state and federal red tape).• Where establishing a CHC is difficult, encourage creation of public-private partnership in creating primary/urgent care clinics.			
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Appendix B: Summary of Public Comment Received by the Council

- Support the Community Health Centers as a way to improve access and decrease use of the emergency room for primary care.
- Improve e-health
- Increase workforce, specifically mid-level practitioners
- Incorporate incentives to attract and retain necessary health care workers, including loan forgiveness and other repayment incentives
- Make sure to get the mix right of what is needed in the health care workforce
- Recruitment programs are best done in state
- Build interest in the health care field at the middle and high school level
- Develop a statewide group with oversight responsibility for recruitment and retention – because it cost too much for individual organizations to do it
- Eliminate shortage of UA educators in health care professions
- Put fluoride in rural water systems
- Improve the place of preventative dental service in the health care continuum
- Prevention, collaboration and partnerships are the key to improving access
- Building existing programs makes the most sense, versus making new programs and the associated structures
- Remove bureaucratic barriers to effective health care access
- Examine innovative solutions that involve Medicaid reimbursement
- Acknowledge and build upon the work of public health nurses and the public health nursing program
- Include alternative treatments when talking about prevention and personal responsibility
- Improve worksite health as a cost-saver
- Most feel there should be basic, portable insurance coverage for all Alaskans
- Concentrate on preventing sickness rather than curing it
- Should be at least some mechanism to insure a minimum coverage for all Alaskans
- People with disabilities have real trouble finding primary care – the state should close the gap in those services
- Alaskans need a range of services that are affordable – maybe the state should subsidize those services
 - Don't forget the severely disadvantaged – Alaska's working poor
- Funding for substance abuse and mental health are effective preventative services, which lead to increase wellness
- State must support the e-health FCC grant
- State should not be shy about supplementing the loss of federal Medicaid dollars with state support
- Behavioral health in Alaska has taken huge cuts, and the system is on the verge of crisis
- The broadly stated goals of the Council really skip over the importance of behavioral health and substance abuse as preventative factors

**The Alaska Health Care Strategies Planning Council
Final Report: Summary and Recommendations
December 23, 2007**

- Oral health needs to play a more significant role in overall health
- Need more dental techs in the health care workforce
- Realize that turning 65 in Alaska means no more health care for most elders
- Make it easy for people to navigate the health care system – now it is really difficult
- Remove barriers that prevent Alaskans from receiving necessary primary care, and to get Denali KidCare after birth
- There **MUST** be a continued forum for addressing health care issues in the long term

Appendix C: Alaska Health Policy Council Members

The council is composed of 14 Alaskans appointed by the governor:

- Jeff Davis of Anchorage has served as president of Premera Blue Cross Blue Shield of Alaska for nine years, which provides insurance for 180,000 Alaskans statewide.
- Cathy Giessel of Anchorage is a registered nurse and advanced nurse practitioner whose career and experience spans more than 30 years.
- Dr. Derek Hagen of Anchorage is a doctor of osteopathy associated with Primary Care Associates, the largest private family practice in the state.
- Thomas Hendrix, PhD, of Anchorage is an assistant professor at the University of Alaska School of Nursing specializing in the policy, economics, assessment, and fundamentals of health care.
- Don Kashevaroff of Anchorage is the chair and president of the Alaska Native Tribal Health Consortium, and serves as the primary spokesman for the Consortium regarding state and federal funding, legislation, and regulatory issues.
- Brian Slocum of Fairbanks is the administrator at Tanana Valley Clinic, the largest multi-specialty, multi-site practice in Alaska.
- Dr. Michael Carroll of Fairbanks is a private practice physician, specializing in internal medicine and oncology.
- Donna Fenske of Homer served the State of Alaska as a public health nurse from 1979 to 2004 and most recently has provided community health aide services in Port Graham and Nanwalek clinics, and nursing services to K-12 students in rural communities in the Kenai Peninsula Borough School District.
- Steve Horn of Soldotna is the executive director of the Alaska Behavioral Health Association whose members are the businesses that provide direct services to recipients of behavioral health services throughout the state.
- Dr. Cathy Baldwin-Johnson of Wasilla is a private practice family physician and the 2002 National Family Physician of the Year from the American Academy of Family Physicians.
- Karen Rhoades of Wasilla is the owner and operator of Northern Living Centers, a five bed assisted-living home.
- Tim Joyce of Cordova is a three-term mayor of the City of Cordova who has dealt with escalating community medical costs, a constant turnover of medical center administrators and a community medical center that is continually in need of city assistance.
- Rod Betit of Juneau is the president and CEO of the Alaska State Hospital and Nursing Home Association (ASHNA), a not-for-profit association with members representing hospitals, nursing homes, and Native Alaska health care providers.
- Dr. Bob Urata of Juneau has served as a family physician for over 23 years, and has served on the Bartlett Regional Hospital Board of Directors.
- Commissioner Karleen Jackson managed the Health Council. Serving as ex-officio, non-voting members were Senator Bettye Davis and Representative Peggy Wilson, chairs of the Health, Education and Social Services committees in the Alaska State Legislature.



COMMONWEALTH
NORTH

Resolution 2009-3
In support of continuing the Alaska Health Care
Commission as proposed in Senate Bill 172
April 14, 2009

This resolution is based on the 2005 Commonwealth North study entitled "Alaska Primary Health Care: Opportunities and Challenges."

Commonwealth North:

Encourages the Alaska State Legislator to extend the life of the Alaska Health Care Commission

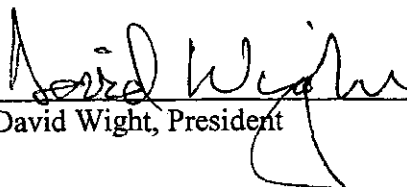
Requests all state legislators to approve authorizing legislation in Senate Bill 172; and

Forwards this resolution to all members of the Alaska State Legislature, Governor Sarah Palin, and Alaska's congressional delegation.

Resolved for the following reasons:

1. A body needs to be vested in the long term interest in understanding and improving the system; consistent advocacy is necessary make needed fundamental changes
2. Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations

Approved by the Commonwealth North Board of Directors
April 14, 2009



David Wight, President

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

February 2, 2010

Senator Donald Olson
Alaska State Capitol, Room 514
Juneau, AK 99801-1182

Subject: Support for SB 172

Dear Senator Olson:

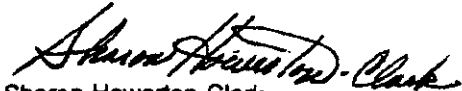
The Alaska Commission on Aging (ACoA) is pleased to offer our support of SB 172 authored by you to extend the life of the Alaska Health Care Commission in the Department of Health and Social Services until 2014 with responsibilities to plan and implement strategies related to health care reform for all Alaskans across the life span.

As you know, the Alaska Health Care Commission was first established by Governor Palin in December 2008 to develop a statewide health plan and provide recommendations to address the quality, accessibility, and availability of health care for all Alaskans. We agree with the Commission's findings that the high cost of health care and access to primary care present serious challenges for our state. ACoA supports establishment of a state commission to comprehensively examine the multitude of issues related to improving health care services including improving access to affordable primary care in addition to promoting strategies for preventative care and chronic disease management.

Older Alaskans represent one of the largest consumer groups of health care services of all age categories. Access to primary care is of utmost concern for many Alaska seniors insured by Medicare who are challenged to find a physician particularly if they live in Anchorage, Fairbanks or the Mat-Su Borough. Limited access to essential health care services for older individuals can put these persons at greater health risk who may postpone going to a provider for the care they need only when their medical conditions become serious. Workforce shortages of health care workers, particularly doctors and nurses, pose a serious problem that affects all Alaskans and has a critical impact on people 65 years and older. The ACoA is pleased that these issues were identified in the Alaska Health Care Commission Report (2009) and look forward to working with the Health Care Commission to implement the Commission's recommendations.

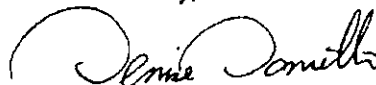
We support SB 172 to extend the Alaska Health Care Commission. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879) should you have questions or need additional information.

Sincerely,



Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director

MUNICIPALITY OF ANCHORAGE

Department of Health and Human Services



907-343-6718

Mayor Dan Sullivan

SENIOR CITIZEN ADVISORY COMMISSION

February 9, 2010

The Honorable Donald Olson
State Capitol Room 506
Juneau AK, 99801

Dear Senator Olson,

RE: Letter of Support for SB 172

The Municipality of Anchorage Senior Citizens Advisory Commission strongly supports the passage of SB 172, which would extend the Alaska Health Care Commission until the year 2014.

Health care reform is an issue at the forefront of our country's executive and legislative agenda. Regardless of what shape national health care reform ultimately takes, Alaska will still have to address health care issues in our own state.

The Alaska Health Care Commission will recommend a statewide plan for addressing the availability, accessibility, and quality of health care for all Alaskans. We need an expert team to plan for long-term health care solutions in our state that is supported by our Legislature.

As Alaskans grow older and live longer, it is imperative that quality health care be available and accessible. The Commission supports SB 172 and urges passage of this important legislation.

Respectfully,

A handwritten signature in cursive script, appearing to read "Dawnia Clements".

Dawnia Clements, Chair
Senior Citizens Advisory Commission
6800 Louise Court
Anchorage, AK 99507

CC: Senator Bettye Davis, Chair, Health and Social Services Committee
Senator Joe Paskvan, Vice-Chair, Health and Social Services Committee

Alaska Physicians & Surgeons, Inc.

4120 Laurel Street, Suite 206

Anchorage, Alaska 99508

Phone: 907-561-7705

Fax: 907-561-7704

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Thomas Vasileff, MD

March 17, 2010

Senator Donald Olson
Alaska State Senate
Room 514 – State Capitol
Juneau, AK 99811

Dear Senator Olson:


Alaska Physicians and Surgeons are appreciative of your efforts to establish a health care commission and would like to offer our support to Senate Bill 172.

Alaska has an aging population and a population that is as diverse culturally as it is geographically. It is difficult to pick up a newspaper or listen to a newscast without learning of Alaskans growing frustration with the health care delivery system. Seniors are having difficulty accessing care, businesses are struggling in their efforts to provide coverage for their workers, some with health insurance coverage believe they are being denied coverage for needed services, the large number of under and un-insured is having a significant impact on the economy and the list goes on. The establishment of a Health Care Reform Commission will allow Alaska's leaders to look at all aspects of health care and prioritize what issues need to be addressed.

In December of 2008, the Alaska Health Care Commission was created by Administrative Order. The Commission was charged to provide recommendations for and to foster the development of a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state. The Commission did report their findings, but given the short existence of the Commission, we view this report as a good 'first step.' However, the establishment of a permanent Health Care Reform Commission, with a more robust stakeholder membership, is needed to continue to address the health care issues in our state.

Again, thank you for introducing this legislation and please let us know if you would like any information from our association.

Sincerely,


Mike Haugen, JD, MBA
Executive Director



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 16, 2010

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 172 (Olson)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 172, authored by Senator Donald Olson.

As you know, Governor Palin appointed a Health Care Commission that took on this enormous responsibility in 2009. Senator Olson serves on that Commission.

SB 172 would basically extend the life of the Alaska Health Care Commission until 2014 and give it responsibility to develop, adopt and implement the recommendations the Commission comes up with.

Alaska and our entire country have entered a period during which many health issues are being and will continue to be considered. Not all decisions will be made in Washington. No matter what the White House and Congress do, it is evident that every state will have to make health care work for its citizens. Indeed, if Congress does not take significant action, Alaska and the other states will have even greater responsibility to determine how we will deal with our own future health care issues.

As we review the responsibilities of the Commission as outlined in SB 172, it is obvious to us that this will be one of the most important teams to address issues that touch every single Alaskan.

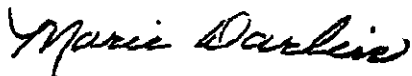
We believe that it is critical that SB 172 passes to allow the Commissioners to take on this responsibility, knowing that they will have the support of the Legislature for an extended period.

AARP requests an "AYE" vote on SB 172.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

April 16, 2010

To: Members of the Alaska House of Representatives

RE: SB 172 (Olson)—Support

On behalf of the members of AARP in Alaska, we encourage you to support SB 172, authored by Senator Donald Olson and co-sponsored by Senators Davis, French, Kookesh, Paskvan, Ellis, Egan, Meyer and Thomas as well as Representatives Kawasaki and Gara.

As you know, Governor Palin appointed a Health Care Commission that took on this enormous responsibility in 2009. Senator Olson serves on that Commission as does Representative Keller.

SB 172 would basically extend the life of the Alaska Health Care Commission until 2014 and give it responsibility to develop, adopt and implement the recommendations the Commission comes up with.

Alaska and our entire country have entered a period during which many health issues are being and will continue to be considered. Not all decisions will be made in Washington. No matter what the White House and Congress have done, it is evident that every state will have to make health care work for its citizens.

As we review the responsibilities of the Commission as outlined in SB 172, it is obvious to us that this will be one of the most important teams to address issues that touch every single Alaskan.

We believe that it is critical that SB 172 passes to allow the Commissioners to take on this responsibility, knowing that they will have the support of the Legislature for an extended period.

AARP requests an "AYE" vote on SB 172.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

April 16, 2010

To: Members of the Alaska House of Representatives

RE: SB 10 (Davis)—Support

On behalf of the members of AARP in Alaska, we encourage you to support SB 10, authored by Senator Bettye Davis and co-sponsored by Senator Joe Paskvan and Representatives Bob Lynn, Bob Buch, Carl Gatto, Cathy Munoz, Pete Peterson, Charisse Millett, Les Gara, Chris Tuck and Lindsey Holmes.

SB 10 would require insurance programs, including Medicaid, to provide coverage for routine costs of cancer victims undergoing clinical trials just as they would if the individual was not in the trial. Research indicates that the costs for patient care in clinical trials are comparable to costs for care delivered in standard practice.

Most of our significant advances in cancer treatment that have become standard procedures began as clinical trials.

It makes no sense not to offer health insurance coverage for procedures that may be still considered experimental but offer some hope for the cancer victim. We purchase insurance (or the State provides it through Medicaid) so that we can have help with the costs that accompany a threatening disease. SB 10 is one of those bills that AARP believes makes sense, especially to a cancer victim and his/her family.

AARP recommends an "AYE" vote on SB 10.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

SB

199

ALASKA STATE LEGISLATURE

Rules Committee
•
Finance Committee
•
Health & Social Services Committee
•
Legislative Council
•
Committee on Committees



While in Session
State Capitol, Rm. 103
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave
Anchorage, AK 99501
(907) 269-0169
Fax: (907) 269-0172

SENATE MAJORITY LEADER
JOHNNY ELLIS

SPONSOR STATEMENT – SENATE BILL 199

SB 199 – An Act relating to a two year funding cycle for medical assistance coverage for dentures.

SB 199 makes a simple change to the Adult Medicaid Dental program that would allow patients who are approved for dentures to receive both the uppers and lowers in a single fiscal year. The bill would let patients access two years of funding in a single year, thereby allowing them and their dentists to schedule treatment around the oral health of the patient, rather than the bureaucratic ease of the state fiscal year.

Current law places a limit on expenditures per eligible client at \$1,150 per year. This number was designed to pay for ½ of a set of dentures, either uppers or lowers, in a single fiscal year. When the program was created, the idea was that a client who needed dentures could receive one set on June 30th, and the second on July 1st. Unfortunately, this has proven to be impractical. Dentists who are forced to pull teeth can't always do so on the state's fiscal calendar, and Alaskans shouldn't suffer needlessly because their medical emergency occurred in the fall rather than the summer.

Adult Medicaid Dental has been recognized across the political spectrum as a successful government health care program. Over the past three years, the state has saved substantial amounts of money – and poorer Alaskans have been saved immense pain and hardship – by allowing Medicaid to pay for exams, cleanings, fillings, root canals, and dentures before painful and expensive surgery became necessary. SB 199 will fix a small flaw in the cost-containment portion of the program and help protect this important state investment.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 2
 Bill Version: SB 199
 (S) Publish Date: 1/27/10

Identifier (file name): SB199-DHSS-ADPMS-01-22-10 Dept. Affected: Health & Social Services
 Title: Medicaid Coverage for Dentures RDU: Health Care Services
 Component: Adult Preventive Dental
 Sponsor: Ellis
 Requester: Senate HSS Component Number: 2839

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	935.0		467.5	0.0	0.0	0.0	0.0	
Miscellaneous								
TOTAL OPERATING	935.0	0.0	467.5	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURE								
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CHANGE IN REVENUES								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	626.5		266.5					
1003 GF Match	308.6		201.0	0.0	0.0	0.0	0.0	
1004 GF								
1005 GF/Program Receipt								
1037 GF/Mental Health								
Other Interagency Receipt								
TOTAL	935.0	0.0	467.5	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) c: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill addresses limitations of coverage for upper and lower dentures within a given state fiscal year with the current \$1,150 annual limit. The annual limit provides for expenditures that would typically cover only an upper or lower denture, thus requiring Medicaid recipients to wait until the subsequent fiscal year to obtain the opposing denture under the Adult Preventive Dental (APD) program. The bill would authorize the department to allow for provision of both an upper and lower denture within the same state fiscal year, however when these services are provided the adult recipient would not be eligible for additional services under the APD program for a 2-year period.

In SFY 2009, the total cost of complete, partial and immediate denture claims was approximately \$1,620.0. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
 Division: Health Care Services

Phone: 269-7827
 Date/Time: 1/20/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Finance & Management Services

Date: 1/22/2010

FISCAL NOTE # 2

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. SB199

ANALYSIS CONTINUATION

We estimate that the cost of denture services in the APD has grown at the same rate as all Health Care Services Medicaid Services costs (forecasted to be 6%) from FY 2009 to 2010. Medicaid growth for APD alone is forecasted to be 8.9% from FY 2010 to 2011 to reach a baseline cost of \$1,868.0 for denture services in FY 2011 with no changes to the program.

With the changes proposed in this bill and an expected effective date of July 1, 2010, we estimate the baseline costs noted above for denture services in FY 2011 will increase by 50%, assuming half of denture services recipients would be completing the denture process from FY2010 and the other half would be getting both their upper and lower dentures in FY 2011 for a total cost of \$2,803.0 (a difference of \$935.0 from baseline). We would still expect some increased costs over baseline in FY2012 as the number of people getting denture services has been growing each year as adults continue to learn about the APD program and this bill allows for them to be paid in one year. For FY2012, we estimate the need for increased funds to be half of the amount needed in FY 2011.

For subsequent years, we would expect the cost of denture services to level out to approximately what we would expect without the changes in this bill, the shift being not in cost but in how many recipients are receiving services.

For FY2011, we estimate 67% of APD services to be federally reimbursable, assuming ARRA FMAP increases are valid through all 4 quarters of FY 2011. For FY2012 we expect a FMAP of 50%. As some ADP services are IHS and reimbursed at 100%, we expect 57% of ADP costs to be federally reimbursable.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 199
(S) Publish Date: 2/24/10

Identifier (file name): _____ Dept. Affected: Health and Social Serv.
Title Medicaid Coverage for Dentures RDU Health Care Services
Component Medical Assistance Administration
Sponsor Ellis
Requester Senate Finance Committee Component Number 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Senate Finance Committee
Co-Chair Bert Stedman/Co-Chair Lyman Hoffman

Phone 465-3873/465-4453
Date/Time _____

Approved by: _____

Date 2/22/2010

SENIOR VOICE

Serving Older Alaskans and Their Families Since 1978

A publication of *Older Persons Action Group, Inc.* 325 E. Third Ave., Suite 300, Anchorage, Alaska 99501

Vol. 32 No. 11 November, 2009

Desperate senior prompts denture legislation

By SEN. JOHNNY ELLIS

Late last summer, an elderly man walked into my office and threatened to commit suicide. Needless to say, it was a very tense and upsetting situation for me and my staff. This gentleman had come from the Medicaid Adult Dental office, where he had been told that he had a choice – he could receive either the upper half or the lower half of the dentures that he needed, but not both, at least not in the same year. Of course, this set of options was really no choice at all, seeing as how he had no teeth at all. The state's wholly inadequate response to this constituent's unfortunate situation set my office in motion, and I am prepared to introduce legislation this session with bipartisan support that will provide a common-sense fix to an otherwise successful and needed program.

Medicaid Adult Dental was created three years ago. Until that time, Medicaid only covered emergency dental services for low income Alaskans. By expanding the program to cover preventative care – exams, cleanings, root canals, fillings and dentures – the state has saved millions of dollars and patients have avoided painful surgeries as the need for emergency care declines. In addition, good dental health

I have worked with the Dept. of Health and Social Services to allow patients who qualify for dentures under the Medicaid Adult Dental program to receive their full set of dentures in one sitting.

is closely linked with decreased risk for diabetes, heart disease, cancer and other serious diseases. Last year, the legislature unanimously made this successful program permanent.

The program limits the care that can be paid for in a single year, which is intended as a cost-control measure, an important feature in these uncertain budgetary times. Unfortunately, these measures go beyond cost control and have impacted the function of the program by limiting patients to half of a set of dentures per year. In public testimony on these limits, it was suggested that a patient could receive the upper dentures on June 30, the final day of the state fiscal year, and the lower dentures on July 1. I don't believe that we should be punishing citizens who happen to require dental care in the fall or winter, and I don't believe that dentists should be forced to schedule the care their patients need to make things more convenient for bureaucrats. This is the kind of frustrating flaw in our

system that drives people crazy and gives government a bad name.

That's why I have worked with the Department of Health and Social Services to develop a way to allow patients who qualify for dentures under the Medicaid Adult Dental program to receive their full set of dentures in one sitting, without destroying the cost-control mechanisms currently in place. The bill will be introduced when the legislature goes back into session in January, and I am pleased to have received bi-partisan support from my colleagues in the Senate.

In fact, as I have continued to work on this issue, I have heard more and more about how much sense this small change makes. A dentist in Juneau told me about the patients he sees from all around Southeast Alaska. The state pays for them to fly to Juneau, pays for their lodging, and pays for one half of their dentures. Then, a little while later, public money is spent to do it all over again for the other half. Allowing him and other

dentists to consolidate the care they are giving into one session will make the program a more efficient use of public money and improve the quality of care received by patients.

State government can be a large and unwieldy bureaucracy, and change is hard to do and often happens slowly. Most of the attention goes to the big issues that attract press coverage or help generate campaign slogans. But sometimes, there are issues that require us to place people over politics and give a direct benefit to the neighbors and constituents we are privileged to serve. It's too late for the gentleman who threatened to kill himself in my office – we worked with him to get his dentures through the existing two-year process – but it's not too late for others in his situation. This may be a small bill, and it won't change the world, but it will improve the lives of a few senior citizens in need – and that's a job I'm glad to do.

Senator Johnny Ellis represents downtown and midtown Anchorage in the Alaska State Senate and serves as the Majority Leader of the Senate Bi-Partisan Working Group.



Alaska Dental Society

9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
info@akdental.org

SB199/HB265 Medicaid Adult Dental Coverage

The Alaska Dental Society urges passage of SB199/HB265.

SB199 and its companion bill HB265 remedy an unintended consequence of the adult dental supplemental Medicaid coverage. Currently, under the maximum allowable benefit, a Medicaid recipient may receive either an upper or lower denture.

Unfortunately many Medicaid recipients need dentures for both the upper and lower jaws or dental arches. SB199/HB265 would allow a Medicaid recipient to combine two years worth of coverage so they could receive a full denture of both upper and lower dentures at the same time.

SB199/HB265 provides a benefit for everyone involved – the patient, the doctor and the Medicaid program:

- Medicaid recipients benefit from receiving both dentures at once, restoring their appearance, their ability to talk and chew, and most importantly their dignity.
- Providers benefit as they are no longer placed in the uncomfortable position of deciding which arch is in the worst condition. They can also work in a more efficient fashion constructing both sets of dentures simultaneously.
- The state benefits economically. The cost for both dentures, which would normally be borne over 2 years are now in one year but Medicaid recipients would still be limited to the same benefit total for 2 years. Denture patients frequently have to use travel benefits to reach a provider and for dentures this can be especially costly as dentures require multiple appointments. Providing both dentures at the same time would reduce the states travel expenses in half. Removing diseased and abscessed teeth would also save on costly ER and oral surgery visits.

L O G A N

D E N T A L

November 10, 2009

Senator Ellis
716 W. 4th Ave. Suite 500
Anchorage AK, 99501-2133

Dear Senator Ellis:

Thank you for sponsoring a bill to allow Medicaid recipients to use two consecutive years of supplemental benefits in the same year to receive upper and lower dentures at the same time. This will greatly help recipients as a single denture when you have no teeth to oppose it is of limited value. I believe it will ultimately lower costs for the Medicaid division, also, when travel benefits are factored in for this multi step procedure that must be repeated twice under the current system.

A case I did earlier this year may illustrate the problem providers' face. Due to HIPAA concerns I am not using names for this story.

I have a dental office in Juneau. Unfortunately, for a variety of reasons, dental offices in other Southeast communities do not usually accept new Medicaid patients. This patient had to travel over from Sitka and needed dentures, both upper and lower. He currently did not have either upper and lowers having lost both sets. The supplemental system for adult Medicaid benefits would cover a single denture, either the upper or lower. The patient, 78 years old and on fixed income, was unable to afford the second set even at reduced Medicaid fees. I wrote a letter Medicaid division, enclosed, outlining the problem and pointing out that travel costs associated with constructing the second set at a later date (when the new year's benefits kicked in) would ultimately cost more than the Medicaid fee for a denture. I received a reply from the division basically saying their hands were tied given the current statutes in place.

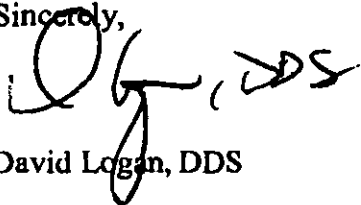
In the case of this patient I did a full set of dentures for the patient and absorbed the cost of construction of the second set. As I write this letter I saw two patients today in the same situation, one who lives here in Juneau that we are constructing an upper denture alone although he has no lower teeth. Currently are plan is construct the lowers after July

2237 N. Jordan Avenue, Juneau, AK 99801

Phone: (907) 780-6066 Fax: (907) 780-4274 info@juneausmiles.com

1, 2010. The second patient traveled here from Angoon and lost both his upper and lower dentures 2 weeks ago. His treatment will be further complicated as his old set was apparently ill fitting and led to a large tissue mass on the lower that will have to be removed prior to denture construction.

Sincerely,

A handwritten signature in black ink, appearing to read "DLG, DDS". The signature is stylized and written over the printed name below.

David Logan, DDS

2237 N. Jordan Avenue, Juneau, AK 99801

Phone: (907) 780-6066 Fax: (907) 780-4274 info@juneausmiles.com

L O G A N
D E N T A L

December 17, 2008

ACS
Preauthorizations
POB 240808
Anchorage, AK 99524-0808

Re: [REDACTED]
Medicaid #: [REDACTED]

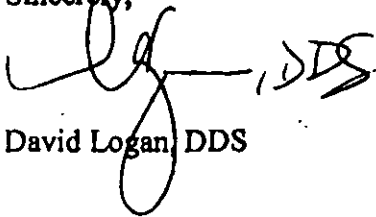
Dear Sirs:

Mr. [REDACTED] is currently edentulous (without teeth) upper and lower. We have previously preauthorized Mr. [REDACTED] for a lower denture (preauth [REDACTED]) - working with a Sitka Clinic we had not previously seen Mr. [REDACTED].

Mr. [REDACTED] has been without teeth for 6 years. One denture, the maximum allowed under the MEDS system, will provide little improvement for him. Mr. [REDACTED] will be traveling to our office from Sitka for completion of the denture. The travel costs will ultimately cost more than the fee for the denture given the number of appointments required to properly construct a denture.

I am requesting preauthorization for upper and lower dentures (included) for Mr. [REDACTED]. This is a case where everyone will benefit: the state will have less overall costs than a second round of travel costs to construct the other denture after July 1, Mr. [REDACTED] will have opposing dentures to eat with, and my overall costs will be less than repeating the same appointments come July 1.

Sincerely,


David Logan, DDS



ALASKA

PRIMARY CARE ASSOCIATION

The Honorable Senator Ellis
Alaska State Senate
State Capitol, Room 103
Juneau, Alaska 99801-1182

Re: Support for Medicaid Coverage for Dentures – SB 199

January 22, 2010

Dear Senator Ellis,

The Alaska Primary Care Association (APCA) represents 26 health care organizations and 142 non-profit Community Health Centers (CHCs), as well as other safety net providers throughout Alaska. In 2009, our sites provided primary healthcare to over 81,000 Alaskans from across the state. According to the Alaska Community Health Center Uniform Data System, Alaska's CHC provided dental services to 16,244 Alaskans and totaled 39,016 dental encounters in 2007.

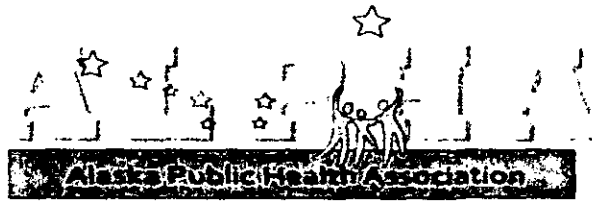
The APCA supports providing a two-year funding cycle for Medicaid assistance coverage for dentures. The APCA knows that access to dental services improves health outcomes and reduces overall health care costs. Oral health is critical for overall health and adults in the Medicaid program receiving access to dental services reduces the likelihood that they will develop more expensive and acute dental problems.

We appreciate your hard work and service to Alaskans and support your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director



November 6, 2009

Senator Johnny Ellis
Senate Majority Leader
Alaska State Legislature
716 W. 4th Ave
Anchorage, AK 99501
Fax: (907) 269-017

Dear Senator Ellis;

I am writing on behalf of the Alaska Public Health Association (ALPHA) to extend our support for and thank you for introducing a Bill that will allow Alaska's adult Medicaid recipients to receive a set of dentures within one fiscal year. This Act will meet the needs of patients and dental providers by providing two-years worth of dental benefits for dentures in a single year.

The ALPHA represents over 150 health professionals in Alaska; the primary mission of ALPHA is the enhancement of the public's health. In fulfilling our mission, we support systems that support patient-oriented health service delivery. ALPHA believes that the "Act providing for a two-year funding cycle for medical assistance coverage for dentures" establishes a system enabling patients to receive patient-oriented care.

Thank you for consulting ALPHA in developing this Bill. Please feel free to contact me if you have further questions.

Sincerely,

Karol Fink, MS, RD
ALPHA Health Policy Chair
Karolfink@yahoo.com
907.227.8178

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 23, 2010

Senator Johnny Ellis
Senate Health and Social Services Committee
Alaska State Capitol, Room 103
Juneau, AK 99801-1182

Subject: Support Letter for SB 199

Dear Senator Ellis:

The Alaska Commission on Aging (ACoA) is pleased to offer support for SB 199, a bill to provide access to Medicaid patients who are approved for dentures using a two-year funding cycle for medical assistance benefits to cover the costs for complete and partial dentures in a single fiscal year. This legislation is authored by you and co-sponsored by Senators Bettye Davis, Dennis Egan, Hollis French, Linda Menard, Donald Olson, Joe Paskvan, Joe Thomas, and Bill Wielechowski.

The Commission believes SB 199 provides a common sense solution that allows patients and their dentists the flexibility to schedule treatment around the oral health needs of the patient, which will improve the quality of care for older Alaskans and other qualifying recipients. Moreover, this legislation enhances the cost-effectiveness of the current Medicaid Adult Dental program by reducing the number of oral surgery visits, medical procedures, and related travel costs required for individuals who need a complete set of dentures but are limited to half of a set of dentures per fiscal year under the existing program. Anecdotally, we have learned that some individuals may even refuse partial extractions in one arch knowing that they could be without teeth for a prolonged period waiting for Medicaid to cover the cost of the other complete denture in the next fiscal year.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain and missing or decaying teeth can affect dietary choices for seniors that may impact overall health and wellness. Vulnerable older Alaskans are at risk of developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease. Restorative dental care can help to prevent the progression of serious dental disease and discomfort which can result in more costly emergency care.

Older Alaskans utilize the Medicaid Adult Dental program. According to data based on Medicaid claims information for persons age 60 years and older for the period April 1, 2007 thru December 31, 2009, there were a total of 3,104 (unduplicated) seniors served by the Medicaid Adult Dental Program. The average cost for partial dentures for seniors ranges between \$1,085 (for a complete maxillary denture) to \$1,125 (for a complete mandibular denture). The approximate cost for a complete set of dentures is \$2,225. The current program cap is \$1,150 per year.

As we move forward, the Commission respectfully asks for your consideration of our recommendations below to enhance SB 199 and the Adult Dental Medicaid program for qualifying older Alaskans and other Medicaid recipients:

- Allow eligible patients access to two years of total funding as determined by the cost cap of the Medicaid Adult Dental program to permit individuals receiving partial dentures through the program the ability to access remaining benefits under the cost cap should they need additional denture services during the two-year period.
- Pending approval of SB 199, begin work with the Department of Health and Social Services to expand the two-year access of services to phase in other preventative and restorative services allowed under the Medicaid Adult Dental program in FY 2012.
- Adjust the annual cost cap for dental services (currently in statute for the last three years) to address the rising costs of dental care and encourage more participation of Medicaid dental providers.

Please accept our sincere appreciation for your efforts to improve the Medicaid Adult Dental program by allowing patients who qualify for dentures under the program to receive their full set of dentures according to a treatment schedule determined by the patient with their dentist. We believe that SB 199 will help to improve health and wellness for many older Alaskans who need dentures and we support passage of this legislation. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information. Thank you.

Sincerely,



Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director

Cc: Senator Bettye Davis
Senator Dennis Egan
Senator Hollis French
Senator Linda Menard

Senator Donald Olson
Senator Joe Paskvan
Senator Joe Thomas
Senator Bill Wielechowski

The TRUST

The Alaska Mental Health
Trust Authority

Alaskan Seniors
Living Longer Growing Stronger
from the Alaska Commission on Aging



**Governor's Council on Disabilities
and Special Education**

**Advisory Board on Alcoholism
and Drug Abuse**



Alaska Mental Health Board

Adjust Cap on Adult Dental Services Reimbursed by Medicaid

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority and the Alaska Brain Injury Network, jointly support the developing a solution that will allow for the adjustment of the current cap on adult dental services reimbursed by Medicaid.

- Currently, the annual cap for dental services – such as cleanings, exams, crowns, root canals and dentures – is \$1,150 per individual. With the rising cost of dental care, this cap is proving not adequate yet the cap is set in statute and has not been increased in over three years.
- The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs, and as former U.S. Surgeon General C. Everett Koop stated, "You're not healthy without good oral health."
- Trust beneficiaries continue to list dental services as a priority unmet health needs.
- The challenge this session is to find a current bill or to introduce a new bill that will create a method for adjusting the adult dental Medicaid cap on a regular basis or will at least increase the cap to cover the increase the cost of living increases over a 4 or five year period.

Therefore, we support a legislative solution that will allow for the adjustment of the current cap on adult dental services reimbursed by Medicaid.



3745 Community Park Loop, Ste. 140
Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

February 2, 2010

Senator Johnny Ellis
Alaska State Capitol, Room 103
Juneau, AK 99801-1182

RE: Support Letter for SB 199

Dear Senator Ellis,

Alaska Brain Injury Network appreciates your leadership in sponsoring SB 199 to provide vulnerable Alaskans who are approved for dentures to use a two-year funding cycle for medical assistance benefits to cover the costs for complete and partial dentures in a single fiscal year. This is a common sense solution for all involved: Medicaid dental patients, dentists, and the state paying for the service.

Alaska has made strides since 2006 in providing Medicaid adult dental services and we appreciate your continued efforts to improve the needed dental benefits for our focus population of adults with traumatic brain injuries and acquired brain injuries. Preventative care we have in place lessens the need for painful surgery, emergency care, and also lowers the risk of dental infections effecting overall health.

Cost control measures are important to consider in good fiscal management. However, there are factors we ask you to please consider to better SB 199 and the Adult Dental Medicaid program as recommended by the Alaska Commission on Aging:

- Allow eligible patients access to two years of total funding as determined by the cost cap of the Medicaid Adult Dental program to permit individuals receiving partial dentures through the program the ability to access remaining benefits under the cost cap should they need additional denture services during the two-year period.
- Pending approval of SB 199, begin work with the Department of Health and Social Services to expand the two-year access of services to phase in other preventative and restorative services allowed under the Medicaid Adult Dental program in FY 2012.
- Adjust the annual cost cap for dental services (currently in stature for the last three years) to address the rising costs of dental care and encourage more participation of Medicaid dental providers.

We appreciate your continued efforts to improve the Medicaid Adult Dental Program and support the passage of SB 199. Thank you for your dedication.

Sincerely,

Jill Hodges, Executive Director

Alaska Brain Injury Network, Inc. mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors for traumatic brain injury and their families.



Mailing Address
P.O. Box 201849
Anchorage, AK 99520

Fairview Center
1217 E. 10th Avenue
(907) 257-4688 appointments
(907) 257-4844 fax

Fairview Dental Clinic
1217 E. 10th Avenue
(907) 257-4661 appointments
(907) 257-4894 fax

Administrative Office
903 W. Northern Lights, #218
(907) 792-8500 billing
(907) 792-6538 phone
(907) 792-6526 fax

www.anhc.org

February 9, 2010

Senator Johnny Ellis
Majority Leader
Alaska Senate
716 W 4th Avenue
Anchorage, AK 99501

Subject: Support Letter for SB 199

Dear Senator Ellis:

The Anchorage Neighborhood Health Centers Dental Department is pleased to offer support for SB 199, a bill to provide eligible Medicaid adult recipients the opportunity to access a two-year funding cycle to cover the cost of a complete set of dentures or partial dentures in a single fiscal benefit year.

Attempting to provide a patient with one half of a needed set of dentures at the end of a fiscal benefit year and the second half at the beginning of the next fiscal year creates difficulty in providing quality care. Moreover it frustrates the patient and overloads the provider and the lab rendering it nearly impossible to meet the demand and is clearly a less than optimal way of providing an individual with dentures.

Passing SB 199 will allow eligible Medicaid adult recipients to receive a full set of dentures or partial dentures at the same time. It will allow providers to make and deliver a complete set of dentures/partial dentures anytime throughout the fiscal year. This will create better flow for both the provider and the labs and allow for improved quality of care to the patients.

Thank you for your efforts to improve the Adult Medicaid Dental program.

Sincerely,

Pamela Hawk, Dental Operations Manager
Anchorage Neighborhood Health Center
1217 E 10th Avenue, Anchorage, AK 99501
907-257-4662 (voice) 907-257-4694 (fax)



Promoting wellness by providing the highest quality care with compassion and accessible care.



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

February 10, 2010

The Honorable Lyman Hoffman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 518
Juneau, AK 99801-1182

The Honorable Bert Stedman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 516
Juneau, AK 99801-1182

RE: SB 199 (Ellis)--Support

Dear Co-Chairs Hoffman and Stedman:

On behalf of the members of AARP in Alaska, we would like to urge your support for SB 199 to establish a two year funding cycle for the adult dental benefit in Medicaid. The bill is sponsored by your Committee colleague, Senator Johnny Ellis, and co-sponsored by twelve other Senators including your Committee members Senators Egan, Thomas, Olson and Huggins as well as Senators Davis, French, Menard, Paskvan, Wielechowski, Kookesh, Wagoner and McGuire.

SB 199 basically changes the benefit for dentures so that an adult Medicaid beneficiary would be able to use the funds available for two years to pay for dentures. This makes sense for both the client and the provider.

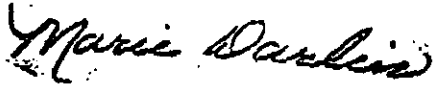
Older persons in need of dentures often have accompanying nutrition problems. These nutrition problems can cause other health issues and create an overall deterioration in health status. For those who need them, dentures are essential to quality health care. Two-year funding for dentures should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent on more serious health care problems resulting from poor oral health status.

AARP recommends an "AYE" vote on SB 199.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas
Senator Charlie Huggins
Senator Dennis Egan
Senator Donald Olson
Senator Johnny Ellis



Sun'aq Tribe of Kodiak

Federally Recognized December, 2000

Ceremonial Bent Wood Hat

February 8, 2010

Senator Johnny Ellis
Senate Health and Social Service committee
Alaska State Capitol, Rm 102
Juneau, AK 99801-1182

Dear Senator Ellis:

Sun'aq Tribe of Kodiak is in full support of SB 199, a bill to provide access to Medicaid patients who are approved for dentures using a 'two-year' funding cycle for medical assistance benefits to cover the costs for complete and partial dentures in a single fiscal year. We believe the bill would be beneficial to the elders among our 1,500 tribal citizens by allowing patients and their dentists the flexibility to schedule treatment around the oral health needs of the patient, while also enhancing the cost-effectiveness of the current Medicate Adult Dental Program by reducing the number of oral surgery visits, medical procedures, and related travel costs.

In addition, we also support the recommendations of the Alaska Commission on Aging, which we believe enhance S.B. 199. Those recommendations include allowing eligible patients access to two years of total funding and the ability to adjust the annual cost cap for dental services to address the rising costs of dental care and encourage more participation of Medicaid dental providers.

We believe that SB 199 will help improve health and wellness for many older Alaskans who need dentures and we whole heartedly support this legislation. We appreciate your efforts and SB 199's co sponsors to improve the Medicaid Adult Dental program.

Sincerely,

Brenda Schwantes
Chairwoman
Sun'aq Tribe of Kodiak

Cc:	Senator Bettye Davis	Senator Donald Olson
	Senator Dennis Egan	Senator Joe Paskvan
	Senator Hollis French	Senator Joe Thomas
	Senator Linda Menard	Senator Bill Wielechowskie

312 W. Marine Way, Kodiak, Alaska 99615 (907) 486-4449

Fax: (907) 486-3361 * E-mail:

Proudly representing the members of the Sun'aq Tribe of Kodiak Island, Alaska

MABEL T. CAVERLY**Senior Center**325 E. Third Avenue
Anchorage, AK 99501

Phone: 907-276-1496 • Fax: 907-258-1356 • e-mail: redhead@pobox.alaska.net

10 February 2010

The Honorable Senator Johnny Ellis
Alaska State Senate
State Capitol, Room 103
Juneau, AK 99801-1182

Re: Support for Medicaid Coverage for Dentures-SB199

Dear Senator Ellis:

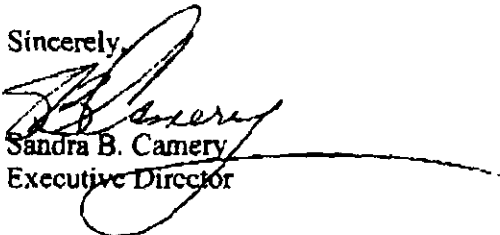
The Mabel T. Caverly Senior (Services) Center has worked with many individuals, ages 55 and over, who needed dental work. For those fortunate seniors who qualify for Medicaid, the additional of dental services to Medicaid was a life saver. Unfortunately, it has been a hardship for seniors and their dentists to schedule one denture in June and one the following month in July. A 2 year cycle for Medicaid dentures would alleviate this problem.

Oral health is now linked to physical health—particularly heart disease, diabetes, osteoporosis, and dementia. These conditions are prevalent in the senior population. A simple administrative change in the way dentures are funded would not only alleviate suffering, it would ultimately reduce Medicaid costs.

For seniors who don't qualify for Medicaid, but aren't able to afford dental work, this agency has had in place for over 10 years a program to issue income qualifying seniors \$900.00 grants for their dental work. This program has been funded by corporate donors, the Municipality of Anchorage, and, until 2008, by the Human Services Matching grant. If the HSMG is re-authorized, we hope our program will once again be chosen for funding by the local review panel. This program alleviates a great deal of suffering and ultimately reduces costs, too.

Thank-you for all your support for senior citizens. We appreciate your understanding and compassion.

Sincerely,



Sandra B. Camery
Executive Director

A Friendly Place Providing Stepping Stones Over Deep Water



April 14, 2010

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

To: Members of the Alaska House of Representatives

RE: SB 199 (Ellis)--Support

On behalf of the members of AARP in Alaska, we would like to urge your support for SB 199 to establish a two year funding cycle for the adult dental benefit in Medicaid. The bill is sponsored by Senator Johnny Ellis, and co-sponsored by twelve other Senators, including four Republicans and eight Democrats. It is also co-sponsored by Representatives Neuman, Stoltze, Herron, Gardner, Austerman, Doogan, Gara, Fairclough, and Hawker.

SB 199 basically changes the benefit for dentures so that an adult Medicaid beneficiary would be able to use the funds available for two years to pay for dentures. This makes sense for both the client and the provider.

Older persons in need of dentures often have accompanying nutrition problems. These nutrition problems can cause other health issues and create an overall deterioration in health status. For those who need them, dentures are essential to quality health care. Two-year funding for dentures should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent on more serious health care problems resulting from poor oral health status.

AARP recommends an "AYE" vote on SB 199.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Johnny Ellis

SB

238

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148



Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator [Bettye Davis@legis.state.ak.us](mailto:Bettye_Davis@legis.state.ak.us)
<http://www.akdemocrats.org>

Senator Bettye Davis

SB 238 - "An Act amending the eligibility threshold for medical assistance for persons in a medical or intermediate care facility."

SPONSOR STATEMENT

This bill amends and restores the Medicaid income eligibility threshold for individuals who reside in a medical or intermediate care facility from a specified monthly income limit to 300% of the Social Security income benefit rate. This threshold is also used for people who receive home and community-based waiver services. In 2003 the Legislature fixed the Medicaid long-term services income eligibility limit for persons in medical or intermediate care facilities at \$1,656 per month which was 300% Supplemental Security Income (SSI) at that time. This change created an income ceiling for waiver eligibility, effectively freezing the eligibility limit for the last seven years, rather than allowing the limit to adjust annually in tandem with the SSI, the income equivalent of which in 2009 was \$2,022. The result was that small Social Security cost of living adjustments have disqualified many needy disabled people from the program.

Alternatives for preserving eligibility, particularly for those requiring lifetime or long-term care, include creation of a Medicaid qualifying income trust, also known as a Miller Trust. Trusts, however, have procedural drawbacks, including numerous responsibilities and restrictions, limited access to income, assistance of an attorney, and a trustee to manage trust assets.

As background, the Supplemental Security Income (SSI) program is a federal needs-based disability program for low income adults over age 65, blind, or disabled. For an adult, the SSI disability requirement is based on the ability to work. An adult is considered disabled if the person cannot do the work that he/she performed before the disability occurred or cannot do alternate work because of a severe physical or mental condition. For a child to be eligible, he/she must suffer from serious physical and/or mental problems. For both adults and children, the disability must last, or be expected to last for at least a year.

Medicaid services are critical to the well-being of Alaska's most vulnerable citizens. Supporting SB 238 will ensure that eligible Alaskans can continue to receive nursing home care and in-home services. It also will save the Legislature from amending statutes every year or two as the Federal Poverty Level guidelines and Supplemental Security Income levels increase with the cost of living.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

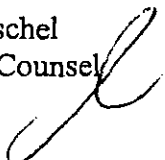
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 4, 2010

SUBJECT: Sectional Summary (SB 238 (Work Order No. 26-LS1362\A))

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends the eligibility threshold for medical assistance applicants who are in a medical or intermediate care facility from a specified monthly income limit to 300 percent of the Social Security income benefit rate.

JMM:ljw
10-060.ljw

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: SB 238
 (S) Publish Date: 2/3/10

Identifier (file name): SB238-DHSS-SDMS-1-29-10 Dept. Affected: Health & Social Services
 Title: Medicaid for Medical & Intermediate Care RDU: Senior and Disability Services
 Component: Senior and Disability Medicaid Services
 Sponsor: Davis
 Requester: Senate HSS Component Number: 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES								
---------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)
 This bill would increase the Medicaid income eligibility standard for individuals who reside in medical institutions, typically nursing facilities. This standard is also used for people who receive home and community-based waiver services. Currently, this standard is fixed at \$1,656 per month. The bill would increase the amount to 300 percent of the federal Supplemental Security Income (SSI) monthly benefit, which is currently \$674, adjusted for cost of living each year. Initially, the new standard for Medicaid nursing facility residents and waiver recipients would be \$2,022 per month.

 DHSS does not anticipate that increasing the monthly standard for this eligibility category will increase the number of Medicaid recipients receiving services. While this is contrary to DHSS expectations when the Legislature fixed the standard at a set dollar amount in 2003, experience shows that as individuals receive cost of living increases in pensions or Social Security payments that raise their incomes over \$1,656 per month, they use Medicaid qualifying income trusts to reduce their countable income below that amount and continue to qualify for Medicaid.
 (Continued on Page 2).

Prepared by: William J. Streur, Deputy Commissioner
 Division: DHSS Health Care Services

Phone: 269-7827
 Date/Time: 1/29/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date: 1/29/2010

ANALYSIS CONTINUATION

Another consideration is that Medicaid recipients who qualify under this institutional income standard are required to make a contribution toward the cost of the Medicaid institutional or waiver services they receive if their countable income exceeds the personal needs allowance established for their living arrangement. The personal needs allowance for people on waivers has historically been set in regulation and the amount varies depending on the person's living situation, and is not linked to the institutional income standard. DHSS has not assumed an increase to the personal needs allowance. Therefore, DHSS does not anticipate an increase in Medicaid spending as a result of this legislation. If DHSS increased the personal needs allowance in conjunction with increasing the income eligibility standard, it would increase Medicaid expenditures.

ALASKA STATUTES 1962

Volume 10

TITLE 45 TO TITLE 47

NOVEMBER 2002

300% SSI

Published by
THE ALASKA LEGISLATIVE COUNCIL

Annotated and Printed by
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Under the Supervision of
JANICE COFFIELD, THOMAS D. CRANFIELD, JR.,
AND BRIAN YOST

Effective Date of Statutes
See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5589. For complete
scope of annotations, see preface. For detailed in-
formation on the use of the Alaska Statutes,
see User's Guide in Volume 1.



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claims under medicaid, medicare, or similar welfare programs providing medical services. 32 ALR4th 671. Criminal liability of pharmacy or pharmacist for welfare fraud in connection with supplying prescription drugs. 16 ALR5th 390.

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

ALASKA STATUTES 1962

2003 SUPPLEMENT

NOVEMBER 2003

\$1,656 / Month

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THE ALASKA LEGISLATIVE COUNCIL

Annotated and Printed by

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Under the Supervision of

TERESA BUCHHOLZ, ANN GRADY, THOMAS D. CRANFIELD, JR., AND BRIAN M. YOST

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5704. For complete scope of annotations, see preface. For detailed information on the use of the Alaska Statutes, see User's Guide in Volume 1 of the 2002 main set.



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- (12) "medical assistance record" means records required to be kept by state or federal law or regulation regarding claims to a medical assistance agency;
- (13) "organization" has the meaning given in AS 11.81.900;
- (14) "person" has the meaning given in AS 11.81.900;
- (15) "property" has the meaning given in AS 11.81.900;
- (16) "reckless disregard" means acting recklessly, as that term is defined in AS 11.81.900;
- (17) "services" or "medical assistance services" means a health care benefit that may qualify for reimbursement under AS 47.07 or AS 47.08, including health care benefits provided, attempted to be provided, or claimed to have been provided to another, by a medical assistance provider, or "services" as defined in AS 11.81.900;
- (18) "unconditional discharge" has the meaning given in AS 12.55.185. (§ 3 ch 66 SLA 2003)

✓ Chapter 07. Medical Assistance for Needy Persons.

Section

- 10. Purpose
- 20. Eligible persons
- 30. Medical services to be provided
- 32. Inpatient psychiatric services for persons under 21 years of age
- 35. [Repealed]
- 36. Cost containment measures authorized

Section

- 42. Recipient cost-sharing
- 70. Payment rates for health facilities
- 73. Uniform accounting, budgeting, and reporting
- 74. Audits and inspections
- 110 — 190. [Repealed]
- 900. Definitions

Sec. 47.07.010. Purpose. It is declared by the legislature as a matter of public concern that the needy persons of this state who are eligible for medical care at public expense under this chapter should seek only uniform and high quality care that is appropriate to their condition and cost-effective to the state and receive that care, regardless of race, age, national origin, or economic standing. It is equally a matter of public concern that providers of services under this chapter should operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients. Accordingly, this chapter authorizes the department to apply for participation in the national medical assistance program as provided for under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act). (§ 1 ch 182 SLA 1972; am § 4 ch 66 SLA 2003)

Effect of amendments. — The 2003 amendment, effective September 9, 2003, rewrote the first sentence, added the second sentence, and in the last sentence substituted "department" for "Department of Health and Social Services."

NOTES TO DECISIONS

Cited in *Garner v. State*, 63 P.3d 264 (Alaska 2003).

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed \$1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and



February 1, 2010

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The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 238 (Davis)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 238, which you authored.

SB 238 corrects a situation which occurred in 2003 when the Legislature changed eligibility for long-term care services in facilities from 300% of the SSI level to \$1,656 per month. Since then, each year some Alaskans would find themselves no longer eligible than when the 300% level was used.

Alaska has a long history of using home and community based services in preference to institutionalized care. SB 238 will allow our most frail and vulnerable citizens to remain in their homes and communities or in institutional settings, when appropriate.

The beneficiaries of SB 238 are not well off financially. They are at risk economically as well as from a health standpoint.

AARP recommends an "AYE" vote on SB 238.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

Senate Finance Committee – Testimony for SB 238
March 15, 2010

- Good Morning. My name is Denise Daniello, executive director for the Alaska Commission on Aging.
- We are pleased to offer our strong support for SB 238.
- This is an important piece of legislation for older Alaskans who receive small cost-of-living increases to their Social Security and other benefit amounts. The impact from this freeze has been that from 2003 forward, a small cost-of-living adjustment to Social Security can put a senior over the \$1,656 limit and in effect disqualifies them from receiving Medicaid long-term support services. These vulnerable individuals are at-risk both financially and with regards to their health.
- Our office became alerted to this issue around Christmastime in 2008 when many individuals on Social Security receiving waiver services were issued notice from the State that they would no longer be eligible for these services after the 2009 Social Security COLA went into effect. They were given the choice of either paying out-of-pocket for these services or establishing a Medicaid qualifying income trust, also known as a Miller Trust, to preserve their income eligibility. They were very distraught and called our office for help. Some called their legislators.
- (As has already been explained...) the Miller Trust reduces one's countable income below the income standard, which is now set at \$1,656, so that a person can continue to qualify for Medicaid.
- The Miller Trust is a useful tool for maintaining income eligibility but has some drawbacks:
 - First, it requires an individual to seek legal assistance from an attorney to establish the Trust and then to find a person they trust to manage their account. Some elderly Medicaid recipients have no friends or family they know who can serve as reliable trustees. They must either trust a stranger to manage their money or forego benefits. Some recipients risk their money by having less-than-trustworthy relatives serve as a trustee. Recently, we learned of a case involving an elder whose granddaughter left the state with the individual's trust account funds.
 - Secondly, trustees have a lot of legal responsibilities that include registering the trust with the court system, arranging for an identification number from the IRS, setting up a special account with the bank, arranging for direct deposits to that account through Social Security, and securing approval from the Division of Public Assistance for the Trust. Trustees are also responsible for properly managing the Trust that includes distributing the correct monthly allowance to the Medicaid recipient, making allowable expenses with Trust funds that are not clearly defined by law (which creates confusion for Trustees), tracking and documenting receipts, and passing an annual audit with Public Assistance.

- Thirdly, it costs money to establish the Trust – \$800 to \$1,200, according to estimates from Alaska Legal Services. This fee is paid for by the senior who is living on a fixed income.
- Fourth, a Miller Trust is irrevocable. In the rare event that a person's health turns around and they are no longer medically eligible for long-term services, they will not have access to the trust funds for their daily expenses.
- Finally, managing one's own expenses is a matter of personal dignity for many older Alaskans. Being forced to give up this right can be stressful and humiliating, as well as financially risky.
- The Alaska Commission on Aging supports SB 238. We believe that this legislation is good public policy that promotes more efficient use of public funds since fewer individuals will have the need to establish Miller Trusts in order to maintain their income eligibility for Medicaid services when they receive COLA adjustments to their Social Security and other public benefits.
- Passage of this legislation will also ensure that eligible Alaskans can continue to receive nursing home care and in-home services, which are critical to an elderly person's health and well-being.
- Thank you.

SB

307

Alaska State Legislature

Interim: (May - Dec.)
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Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148



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Senator Betty Davis @legis.state.ak.us
<http://www.akdemocrats.org>

Senate Health and Social Services Committee

SPONSOR STATEMENT

SENATE BILL 307 *"An Act relating to residential shelters for runaway minors"*

SB307 would allow emergency residential shelters like Covenant House Alaska to continue competing for federal grant funding. Covenant House Alaska has five programs that include emergency shelter, healthcare, job and educational assistance and transitional living. Covenant House Alaska served nearly 3,000 Alaskan youth in FY2009 and has been in Alaska over 20 years – serving literally tens of thousands of youth.

In 2007, Covenant House Alaska was awarded the federal Basic Center Grant (BCG) through the Administration for Children and Families. This competitive federal grant supplied Covenant House Alaska with \$300,000 phased over three years to operate the Crisis Center - \$100,000 per year. Recently, the Administration for Children and Families recently notified Covenant House Alaska the Crisis Center is technically out of compliance with federal grant requirements stated in the Homeless and Runaway Youth Act. Established through the Act, federal regulation 45 CFR 1351.18 (d) states the Basic Center Grant (BCG) may be awarded to facilities with a shelter capacity of 20 beds or less. Covenant House Alaska holds 40 beds.

However, the Act at 42 U.S.C Section 5712(b)(2)(A) states the shelter can have "a maximum capacity of not more than 20 youth, **except where the applicant assures that the State where the center or locally controlled facility is located has a State or local law or regulation that requires a higher maximum to comply with license requirements for child and youth serving facilities.**" The Administration for Children and Families (ACF) concedes that states with statutes requiring them to operate a facility over 20 beds will meet the federal requirements. Supporting SB307 would allow a statutory change which would make it possible for emergency residential shelters like the Covenant House to continue competing for federal grants by operating under the terms of their license.

(3) award nonprofit corporations or municipalities grants for the establishment or operation of licensed programs for runaway minors;

(4) adopt regulations for the administration of AS 47.10.300 — 47.10.390, including regulations providing for the coordination of services to be provided by licensed programs for runaway minors and by the department. (§ 4 ch 144 SLA 1988; am § 35 ch 126 SLA 1994; am § 8 ch 107 SLA 1998)

Collateral references. — 47 Am. Jur. 2d, Juvenile Courts and Delinquent and Dependent Children, § 36.

Sec. 47.10.310. Licensing of programs for runaway minors. (a) A person may not operate a program for runaway minors in the state without a license issued under this section. A person who violates this subsection is guilty of a violation.

(b) The department may license a program for runaway minors under AS 47.10.300 — 47.10.390 only if the program

(1) is operated by a corporation or a municipality; and

(2) meets the requirements of (c) of this section.

(c) A program for runaway minors shall

(1) explain to a minor who seeks assistance from the program the legal rights and responsibilities of runaway minors and the services and assistance provided for runaway minors by the program and by the state or local municipality;

(2) upon admission of a minor to the program, attempt to determine why the minor is a runaway and what services may be necessary or appropriate for reuniting the minor with the minor's family;

(3) provide or help arrange for the provision of services necessary to promote the health and welfare of a minor in the program and, if appropriate, members of the minor's family; services may include, but are not limited to, the provision of food, shelter, clothing, medical care, and individual, group, or family counseling;

(4) within one state working day after admission of a minor to the program inform the department of a minor in the program

(A) who claims to be the victim of child abuse or neglect, as defined in AS 47.17.290;

(B) whom an employee of the program has cause to believe has been a victim of child abuse or neglect; or

(C) whom an employee of the program has reason to believe is evading the supervision of the department, the person to whom the department has entrusted supervision, or the minor's legal guardian;

(5) be operated with the goal of reuniting runaway minors with their families, except in cases in which reunification is clearly contrary to the best interest of the minor; and

(6) maintain adequate staffing and accommodations to ensure physical security and to provide crisis services to minors residing in a facility operated by the program; a program that, as determined by the department, regularly receives state money in an amount that exceeds one-fourth of the program's costs shall maintain semi-secure portions of its facilities in a proportion that meets regulations established by the department; residents under 18 years of age shall be segregated from residents who are 18 years of age or older.

(d) A program for runaway minors may provide services for the protection of the health and welfare of a person under 21 years of age who is in need of the services and who is without a place of shelter in which supervision and care of the person are available. (§ 4 ch 144 SLA 1988; am § 17 ch 33 SLA 1994; am § 8 ch 120 SLA 1996; am § 9 ch 107 SLA 1998)

(e)

NOTES TO DECISIONS

Cited in R.J.M. v. State, 946 P.2d 855 (Alaska 1997).

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB307
 () Publish Date: _____

Identifier (file name): SB307-DHSS-C&L-3-12-10 Dept. Affected: Health & Social Services
 Title: Shelters for Runaway Minors RDU: Public Health
 Component: Certification and Licensing
 Sponsor: Health & Social Services
 Requester: Senate HSS Component Number: 245

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This statutory change is designed to bring Covenant House Alaska (a shelter for homeless youth) into compliance with federal grant requirements in the Homeless Runaway Youth Act. Federal regulations have a capacity cap of 20 beds, and this will allow Covenant House to operate a 40-bed facility under the terms of their license without jeopardizing their grant. It does not create an increased workload for existing staff; therefore, the Department has determined this will have zero fiscal impact to state operations.

Prepared by: Ward B. Hurburt, MD, MPH, Chief Medical Officer / Director Phone 907-269-8126
 Division: Public Health Date/Time 3/11/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 3/12/2010
DHSS Finance & Management Services



Covenant House Alaska

Crisis Center • Community Services Center • Transitional Living

The Honorable Bettye Davis
State Capitol
Juneau, AK 99801

March 1, 2010

Dear Senator Davis,

Thank you for your long-standing support of Covenant House Alaska (CHA). CHA is the only shelter in Alaska specifically designed for homeless youth. Throughout our five programs including emergency shelter, healthcare, job and educational assistance and transitional living, CHA served nearly 3,000 Alaskan youth in FY09. CHA has been in Alaska for over 20 years and served literally tens of thousands of youth.

CHA was awarded the Basic Center Grant (BCG) through the Administration for Children and Families (ACF) in 2007. This competitive, federal grant supplied CHA with \$300,000 phased over 3 years to operate the Crisis Center (\$100,000 per year). ACF recently notified CHA that the Crisis Center is technically out of compliance with federal grant requirements stated in the Homeless and Runaway Youth Act. CHA will not be competitive for the new grant cycle starting in September 2010 if Alaska's state statute is not amended to comply with federal requirements.

Established through the Act, federal regulation 45 CFR 1351.18 (d) states that the BCG will be awarded to facilities with a shelter capacity of 20 beds or less. CHA's Crisis Center holds 40 beds. ACF concedes that states with statute requiring them to operate a facility over 20 beds will override the federal requirements. Through consultation with an attorney, CHA proposes the following change in Alaska statute to satisfy ACF's request.

Amendment to AS 47.10.310 to add a new subsection (e):

- (e) A program for runaway minors, which operates a residential shelter in the State of Alaska for runaway or homeless minors and which is required to obtain a license to operate pursuant to AS 47.10.330 – 47.10.390, is required to provide a shelter with the capacity designated in the approved license.

Since CHA is licensed to operated a shelter with 40 beds, this amendment would effectively require CHA to operate a facility that houses over 20 youth.

As the Chair of the Senate Health, Education and Social Services Committee, CHA is seeking your assistance in changing Alaska's statute. Our goal is to have a committee bill introduced this session in order to comply with the federal regulations by September 2010. Please contact me for additional materials if necessary, including ACF's findings.

Thank you for your consideration. Please contact me with any questions.

Sincerely,

Deirdre A. Cronin

Although a change in regulations may satisfy federal requirements, CHA is pursuing a change in statute as a primary means to satisfy the grant requirements. Through consultation with an attorney, CHA proposes the following change in Alaska statute to satisfy ACF's request.

Amendment to AS 47.10.310 to add a new subsection (e):

- (e) A program for runaway minors, which operates a residential shelter in the State of Alaska for runaway or homeless minors and which is required to obtain a license to operate pursuant to AS 47.10.330 – 47.10.390, is required to provide a shelter with the capacity designated in the approved license.

Since CHA is licensed to operate a shelter with 40 beds, this amendment would effectively require CHA to operate a facility that houses over 20 youth. Our goal is to make this change to statute during the 2010 Legislative Session.

Similarly, CHA will be pursuing a change in regulations simultaneously. Pursuing a change in regulations will both compliment our legislative changes, as well as serve as a back-up if the statutory changes are not completed in the 2010 Legislative Session.

A change in regulation would likely be an addition to 7 AAC 57.030. A new subsection could be added to the end of 7 AAC 57.030 that stated something to the following effect:

Upon issuance of a license to a program for runaway minors authorizing operation of any type of residential shelter in the State of Alaska for runaway or homeless minors within the meaning of AS 47.10.330-47.10.390, the program receiving the license is required to provide a shelter with the capacity designated in the approved license.

As the Commissioner of Health and Social Services, CHA wants to ensure you are adequately briefed on our goals to amend Alaska's statute and/or regulations and actively pursue the BCG next fall. We hope you will be supportive of our efforts.

Thank you for your consideration. Please contact me with any questions.

Sincerely,



Deirdre A. Cronin
Executive Director

HHS publishes annually in the Federal Register a program announcement of grant funds available under the Runaway and Homeless Youth Program Act. The program announcement states the amount of funds available, program priorities for funding, and criteria for evaluating applications in awarding grants. The announcement also describes specific procedures for receipt and review of applications. An applicant should:

- (a) Obtain a program announcement from the Federal Register or from one of HHS's 10 Regional Offices in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco, and Seattle;
- (b) Obtain an application package from one of HHS's Regional Offices; and
- (c) Submit a completed application to the Grants Management Office at the appropriate Regional Office.

[43 FR 55635, Nov. 28, 1978, as amended at 48 FR 29202, June 24, 1983]

§ 1351.18 What criteria has HHS established for deciding which Runaway and Homeless Youth Program grant applications to fund?

 top

in reviewing applications for a Runaway and Homeless Youth Program grant, HHS takes into consideration a number of factors, including:

- (a) Whether the application meets one or more of the program's funding priorities; (see §1351.12)
- (b) The need for Federal support based on the number of runaway or otherwise homeless youth in the area in which the runaway and homeless youth project is or will be located;
- (c) The availability of services to runaway or otherwise homeless youth in the area in which the runaway and homeless youth project is located;
- (d) Whether there is a minimum residential capacity of four and a maximum residential capacity not to exceed 20 youth with a ratio of staff to youth sufficient to assure adequate supervision and treatment;
- (e) Plans for meeting the best interests of the youth involving, when possible, both the youth and the family. These must include contacts with the families. This contact should be made within 24 hours, but must be made no more than 72 hours following the time of the youth's admission into the runaway and homeless youth project. The plans must also include assuring the youth's safe return home or to local government officials or law enforcement officials and indicate efforts to provide appropriate alternative living arrangements.
- (f) Plans for the delivery of aftercare or counseling services to runaway or otherwise homeless youth and their families;
- (g) Whether the estimated cost to the Department for the runaway and homeless youth project is reasonable considering the anticipated results;
- (h) Whether the proposed personnel are well qualified and the applicant agency has adequate facilities and resources;
- (i) Whether the proposed project design, if well executed, is capable of attaining program objectives;
- (j) The consistency of the grant application with the provisions of the Act and these regulations.

§ 1351.19 What additional information should an applicant or grantee have about a Runaway and Homeless Youth Program grant?

 top

(a) Several other HHS rules and regulations apply to applicants for or recipients of Runaway and Homeless Youth Program grants. These include:

- (1) The provisions of 45 CFR part 74 pertaining to the Administration of Grants;
- (2) The provisions of 45 CFR part 16, Departmental Grants Appeal Process, and the provisions of Informal Grant Appeal Procedures (Indirect Costs) in volume 45 CFR part 75;
- (3) The provisions of 45 CFR part 80 and 45 CFR part 81 pertaining to nondiscrimination under programs receiving Federal assistance, and hearing procedures;
- (4) The provisions of 45 CFR part 84 pertaining to discrimination on the basis of handicap;
- (5) The provisions of 45 CFR part 46 pertaining to protection of human subjects.

Westlaw

42 U.S.C.A. § 5712

Page 1

C

Effective: October 8, 2008

United States Code Annotated Currentness

Title 42. The Public Health and Welfare

Chapter 72. Juvenile Justice and Delinquency Prevention (Refs & Annos)

▣ Subchapter III. Runaway and Homeless Youth (Refs & Annos)

▣ Part A. Basic Center Grant Program (Refs & Annos)

→ § 5712. Eligibility; plan requirements

(a) Runaway and homeless youth center; project providing temporary shelter; counseling services

To be eligible for assistance under section 5711(a) of this title, an applicant shall propose to establish, strengthen, or fund an existing or proposed runaway and homeless youth center, a locally controlled project (including a host family home) that provides temporary shelter, and counseling services to youth who have left home without permission of their parents or guardians or to other homeless youth.

(b) Provisions of plan

In order to qualify for assistance under section 5711(a) of this title, an applicant shall submit a plan to the Secretary including assurances that the applicant--

(1) shall operate a runaway and homeless youth center located in an area which is demonstrably frequented by or easily reachable by runaway and homeless youth;

(2) shall use such assistance to establish, to strengthen, or to fund a runaway and homeless youth center, or a locally controlled facility providing temporary shelter, that has--

(A) a maximum capacity of not more than 20 youth, except where the applicant assures that the State where the center or locally controlled facility is located has a State or local law or regulation that requires a higher maximum to comply with licensure requirements for child and youth serving facilities; and

(B) a ratio of staff to youth that is sufficient to ensure adequate supervision and treatment;

(3) shall develop adequate plans for contacting the parents or other relatives of the youth and ensuring the safe return of the youth according to the best interests of the youth, for contacting local government officials pursuant to informal arrangements established with such officials by the runaway and homeless youth center and for providing for other appropriate alternative living arrangements;

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Matthew Johnson

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Tuesday, March 30, 2010 2:47 PM
To: Liz Clement; Matthew Johnson
Cc: joe-user-recover4; Newman, Anthony (HSS); Lesmann, Mike (HSS); Rep. Mike Hawker; Juli Lucky; Rep. Peggy Wilson; Rebecca Rooney; Hurlburt, Ward B (HSS); Streur, William J (HSS)
Subject: HSS hearing plan

This is to let you know the following:

SB 307, shelters for runaways: Wilda Laughlin, HSS Liaison, making a statement on behalf of the administration. Tony Newman, DJJ program officer; and Mike Lesmann, Office of Children's Services Community Relations Manager, available for questions.

HB 25, Health Reform Policy Commission: Health Care Commission Executive Director Deborah Erickson testifying on behalf of the administration. Bill Streur, Deputy Commissioner of Health Care Policy; and Dr. Ward Hurlburt, Director of Public Health and Chief Medical Officer, available for questions.

HB 277, certify emergency use of Epinephrine: Dr. Ward Hurlburt, Director of Public Health and Chief Medical Officer, available for questions.

Sorry so late getting this to you—
w.

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

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SCR

1

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249



Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade,
Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

SENATOR LESIL MCGUIRE

MEMORANDUM

To: Representative Bob Herron
Co-Chair, House Health & Social Services Committee

From: Senator Lesil McGuire *LM*

Date: February 23, 2009

Re: Hearing Request: SCR 1: Brain Injury Awareness Month 2009

I respectfully request that SCR 1: Brain Injury Awareness Month 2009 be scheduled for a hearing *pending referral* in the House Health & Social Services Committee at your earliest convenience. SCR 1 is tentatively scheduled to be read across in the House and referred to HHSS this Friday, February 27th.

SCR 1 would make March of 2009 Brain Injury Awareness Month with the aim of raising awareness about traumatic brain injuries (TBI) and the impact they have on Alaskans and their families. Alaska has more TBIs per capita than any other state in the nation.

Attached you will find the most current version of the resolution, a sponsor statement, fiscal note, and all backup information.

I request that the hearing be teleconferenced so that a representative from the Alaska Brain Injury Network and one or two TBI survivors or survivor family members can give public testimony.

If you have any questions or concerns, please feel free to contact me personally or my staff, Trevor Fulton, at x3579. Thank you for your time and consideration.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249



Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade,
Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SCR 1: BRAIN INJURY AWARENESS MONTH: MARCH 2008

SCR 1 aims to raise awareness about traumatic brain injuries and the impact they have on Alaskans and their families.

A traumatic brain injury (TBI) is when a blow or jolt hits the head hard enough to cause the brain to move within the skull or the skull breaks and the brain is directly hurt. When this happens, the injury disrupts the normal functioning of the brain. A traumatic brain injury can result in both short-term and long-term problems that involve impairment of cognitive abilities, physical functioning, or both.

Brain injury is very complex because no two injuries are the same. How each person may react to the same type of trauma is unknown. The cause, location and severity also are factors in how a person will react to a brain injury.

The State of Alaska is number one per capita for brain injuries and TBI is one of the leading causes of death of young people in the state. Over 800 TBIs are reported annually and an estimated 12,000 Alaskans have suffered a TBI. It is unknown how many people suffer from traumatic brain injuries (TBI) who do not receive medical assistance.

These injuries are often life altering and consequently place a tremendous strain on TBI survivors and their families. Survivors often live with permanent disabilities and the tragedy of TBI is exacerbated by the fact that most TBIs are preventable.

The Brain Injury Association of America recognizes March of each year as Brain Injury Awareness Month. SJR 1 comports with national recognition by making March 2009 Traumatic Brain Injury Awareness Month in Alaska.

Because TBI incidence in Alaska is on the rise, raising TBI awareness is more important now than it has ever been. TBIs are one of the most common injuries incurred in military combat today and as injured military personnel return home to Alaska the rate of TBIs is increasing sharply -- with no signs of slowing.

According to a task force on traumatic brain injury created by the Army Surgeon General, as many as one in five U.S. combat troops who fought in Iraq or Afghanistan leave with signs they may have had a TBI. The Walter Reed Army Medical Center reports that 60% of arriving service members from Iraq have a TBI from blasts, severe falls, and motor vehicle accidents. TBI screening at the National Naval Medical Center shows that 83% of wounded Marines treated at that facility have some form of temporary or permanent brain damage.

Rising TBI rates in Alaska is another reason why it is so important to bring attention to this silent epidemic. So please join us in support of brain injury awareness, prevention, and treatment by supporting SCR 1.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: SCR 1
 (S) Publish Date: 2/13/09

Identifier (file name): SCR1-LEG-COU-2-11-09 Dept. Affected: Legislature
 Title: Relating to establishing March 2009 as Brain Injury Awareness Month. RDU: Legislative Council
 Component: Council and Subcommittees
 Sponsor: Senator Lesil McGuire
 Requester: Senate HESS Committee Component Number: 783

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
-----------------------------	--	--	--	--	--	--	--

CHANGE IN REVENUES ()							
-------------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other Interagency Receipts						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: _____

POSITIONS

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation has zero fiscal impact on the Legislative Affairs Agency.

Prepared by: Karla Schofield, Deputy Director
 Division: Legislative Affairs Agency
 Approved by: Pamela Varni, Executive Director
Legislative Affairs Agency

Phone 465-6626
 Date/Time 2/11/09 12:32 PM
 Date 2/11/2009



Jill Hodges
Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99501
February 10, 2009

Senator Lesil McGuire
Alaska State Legislature
Capitol Building
Juneau, Alaska

Dear The Honorable Lesil McGuire:

Thank you for your continued concern for safety for Alaskans, as well as prevention of injury and death. SCR 1 –Relating to establishing March 2009 as Brain Injury Awareness Month will help raise awareness about injuries to the brain and the effects brain injury has on the survivor, the family, the community and Alaska.

The Alaska Brain Injury Network is a non-profit 501 (c) 3 whose mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for survivors of traumatic brain injury and their families. Our vision begins with prevention.

There are 800 Alaskans each year hospitalized for more than 24 hours with a moderate to severe traumatic brain injury (Alaska Trauma Registry). There is an estimated 3000 Alaskans that visit the Emergency Department each year (CDC). Falls, motor vehicle crashes, assault, ATV/Snowmachine and bicycle crashes are the leading causes of traumatic brain injury in Alaska. The Alaska Brain Injury Network, "10 Year Plan for TBI in Alaska" highlights Prevention, Advocacy, and Public Awareness on pages 49-57 (http://www.alaskabraininjury.org/documents_akbrain/10%20Year%20TBI%20Plan.pdf) with a specific objective "Participate in March Brain Injury Awareness Month activities through resolutions, proclamations, press kits and so forth." (attachment).

Success

In 2003, the Alaska Legislature passed legislation for a primary seatbelt law. The TBI rate due to motor vehicle crashes on the highway has decreased 38% from 2001 to 2005 (attachment). The Alaska Brain Injury Network will continue to study the data to see if TBI-disability among children and adults increases or decreases.

Potential Challenges

It is important to recognize traumatic brain injury, especially since there are service - members returning from Iraq and Afghanistan with brain injury. Highest rates of brain injury in civilians are among rural Alaskans and Alaska Natives. Many national guardsmen/women live in rural Alaska. A risk factor for a brain injury is history of brain injury; i.e. A national guardsperson is in an IED blast in Afghanistan. He/she returns to Alaska and may have challenges with balance, memory, attention, etc. He is riding his snowmachine and crashes, no helmet or maybe even with a helmet, he sustains an additional brain injury. There is potential for an influx of brain injuries in the next 5-20 years; a coordinated TBI prevention program and service delivery system would benefit all Alaskans.

ABIN Activities Promoting March as Brain Injury Awareness Month

The ABIN works closely with the Alaska Native Tribal Health Consortium, State of Alaska -Department of Health and Social Services, and the Alaska Mental Health Trust Authority. We are coordinating press conferences, newspaper advertisements, television commercials, and awareness among youth through internet media. ABIN is also working with the Veterans Clinic in Anchorage to host a public forum on brain injury.

Thank you for your concern and your untiring pursuit of keeping Alaskans healthy. You have our support.

Sincerely,

Jill Hodges

ATTACHMENT 1:

(Alaska Brain Injury Network "10 year plan for TBI in Alaska p. 55
http://www.alaskabraininjury.org/documents_akbrain/10%20Year%20TBI%20Plan.pdf)

Goal I:

Alaskans have knowledge of traumatic brain injury in Alaska.

Objectives

A. To inform Alaskans about TBI, causes, effective prevention, extent and resulting problems through public education campaigns and materials.

B. Strengthen the TBI information sharing network across the state.

Recommendations

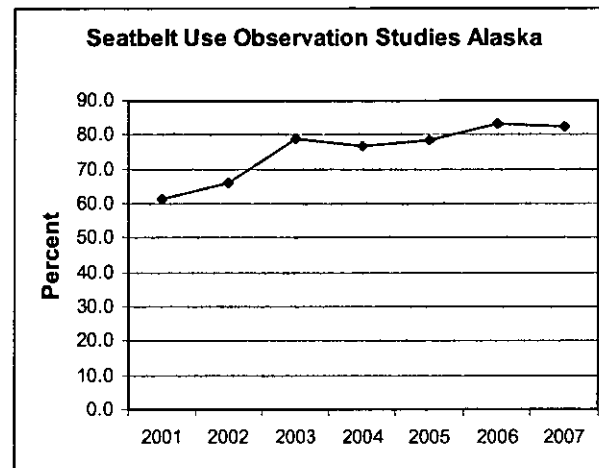
Years One-Ten

- Use injury surveillance data sets to describe TBI in Alaska.
- Provide TBI information through resources library, website, and conferences.
- Raise awareness of TBI through participation in the AMHTA Coordinated Communications Campaign.
- Participate in March Brain Injury Awareness Month activities through resolutions, proclamations, press kits and so forth.
- Recruit a self-advocate to put a face on TBI and serve as spokesperson.

ATTACHMENT 2:

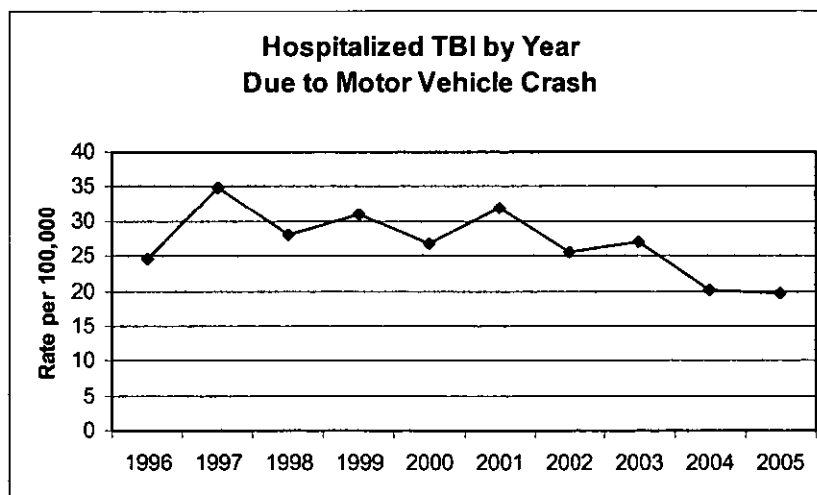
Primary Enforcement Seatbelt Law

On May 1, 2003 Alaska passed a law to change their seat belt law from secondary enforcement to primary enforcement state, ie. a vehicle can be stopped solely for seat belt non-use by an occupant. A study of Alaska has seen a steady increase in seatbelt use in the last decade. In 2007 the percent use as seen in the annual observations study was 82.4%. The national rate is 82%. The NHTSA goal is 95% use.



Source: Alaska Highway Safety Office

States with primary seat belt laws on average had seat belt use rates about 10 percentage points higher than States without primary laws in 2005. Wearing a seat belt is the best defense for an occupant in a motor vehicle crash and the single most effective measure to prevent serious traumatic brain injury. 56% of Alaskans with TBI resulting from a motor vehicle crash on the highway were not wearing seat belts. If every state with a secondary seat belt law upgraded to primary enforcement, about 1,000 lives and \$4 billion in crash costs could be saved each year.



State of Alaska > Governor > News > News Details

The Office of the Governor
SARAH PALIN



Traumatic Brain Injury Awareness Month

WHEREAS, an estimated 5.3 million Americans currently live with disabilities resulting from traumatic brain injury (TBI). Every year, 80,000 individuals experience the onset of long-term disability following a brain injury.

WHEREAS, brain injury can affect a person cognitively, physically, emotionally, and behaviorally. Consequences can include short and long-term memory loss, double or low vision, headaches or migraines, fatigue, increased anxiety, depression and mood swings, and impulsive behavior.

WHEREAS, the three leading causes of brain injury are motor vehicle accidents, violence, and falls.

WHEREAS, the effects of brain injury are devastating emotionally and financially to families.

WHEREAS, the Alaska Department of Health and Social Services, Division of Behavioral Health, the lead state agency for TBI, in close collaboration with the Alaska Traumatic Brain Injury Advisory Network, the Division of Public Health, the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Governor's Council on Disabilities and Special Education, and the Alaska Commission on Aging are all working together toward the prevention, treatment, and rehabilitation of traumatic brain injury in Alaska.

WHEREAS, public awareness of the extent, consequences, and causes of brain injury is critical to the prevention of these injuries and will enhance the recovery process for persons with brain injury.

NOW, THEREFORE, I, Sarah Palin, Governor of the state of Alaska, do hereby proclaim March 2009 as:

Traumatic Brain Injury Awareness Month

in Alaska, and encourage everyone to remember those with brain injuries and to become more informed about traumatic brain injury.

Dated: February 24, 2009

Printed on 3/02/09 at 12:11:33 PM by 146.63.16.195

SCR

12

Alaska State Legislature




Interim:
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0199

Session:
State Capitol Building
Juneau, Alaska 99801-1182
(907) 465-4945

Senator Kevin Meyer
Senate District O

TO: Representative Wes Keller, Co-Chair
Representative Bob Herron, Co-Chair
House HSS Committee

FROM: Senator Kevin Meyer 

DATE: February 16, 2010

RE: House HSS Committee Hearing Request for SCR 12

This is a request for a House HSS Committee hearing for SCR 12, "Proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day."

The following documents are attached:

- Sponsor Statement
- Current version of the bill
- Fiscal Note
- Back up information
 - 10 Facts about FAS from the SOA, Office of Fetal Alcohol Syndrome website
 - Fetal Alcohol Spectrum Disorders, Pages 33-36 of the "Economic Costs of Alcohol and Other Drug Abuse in Alaska" 2005 Update prepared by the McDowell Group.
 - 4 Letters of Support
- Potential witnesses/testifiers (depending on schedule)
 - Michael Baldwin, Behavioral Health Clinician
 - A representative from Stone Soup Group
 - A representative from HSS or the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board
- Staff member assigned to the bill: Christine R. Marasigan, 465-6876

This resolution would observe FASD Awareness Day.

Please contact Christine if you have any questions regarding this legislation.

ALASKA STATE LEGISLATURE

Interim:
716 West 4th Avenue
Anchorage, Alaska 99501-2133
Phone: (907) 269-0199
Fax (907) 269-0197
Senator_Kevin_Meyer@legis.state.ak.us



Session:
Alaska State Capitol
Juneau, Alaska 99801-1182
Phone: (907) 465-4945
Fax: (907) 465-3476
Toll Free: (866) 465-4945

SENATOR KEVIN MEYER
SENATE DISTRICT O

SPONSOR STATEMENT FOR SCR 12

"Proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day."

SCR 12 would proclaim September 9, 2010 as Fetal Alcohol Spectrum Disorders Awareness Day (FASD).

Alaska has the highest known incidence of FASD in the United States. This is a condition caused by prenatal exposure to alcohol, which can result in permanent brain damage, birth defects, learning disabilities, behavioral problems and most tragically, the loss of individual potential.

While FASD affects all racial and socioeconomic groups, it is a 100% preventable condition. FASD Awareness Day is observed internationally on September 9th. This serves as a reminder on the ninth day of the ninth month of the year that during the nine months of pregnancy a woman should abstain from alcohol.

SCR 12 would observe FASD Awareness Day by promoting the awareness of the effects of prenatal exposure to alcohol.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: SCR 12
 (S) Publish Date: 2/10/10

Identifier (file name): _____ Dept. Affected: _____
 Title SCR 12 FETAL ALCOHOL SPECTRUM DISORDERS DAY RDU _____
 Component _____
 Sponsor Senator Meyer _____
 Requester (S) Health and Social Services Committee Component Number _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES ()							
-------------------------------	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Celeste Hodge, Committee Aide
 Division: Senate Health & Social Services Committee
 Approved by: Senator Bettye Davis
Senate Health & Social Services Committee, Chair

Phone 465-4906
 Date/Time _____
 Date 2/8/2010

TEN THINGS YOU SHOULD KNOW ABOUT FAS

1. Drinking during pregnancy can cause permanent damage to a developing fetus.
2. FAS is one of the most common causes of mental retardation, and is the only cause that is entirely preventable.
3. According to recent State of Alaska DHSS surveillance data, more than 126 children are born at risk for FASD each year in Alaska.
4. Prenatal exposure to alcohol can cause brain damage and other permanent birth defects.
5. Obtaining an FAS diagnosis can improve an individual's ability to function in the world, and may reduce secondary disabilities like depression and school failure.
6. FASD is found in all races and all socio-economic groups – wherever women drink alcohol FASD exists.
7. There is no safe level of alcohol consumption during pregnancy.
8. Women should stop drinking prior to trying to conceive – alcohol can cause damage to a developing fetus even before a woman knows she is pregnant.
9. FASD is 100 percent preventable.
10. With the right diagnosis, support and understanding, many individuals with FASD are living happy and full lives.

**ECONOMIC COSTS OF ALCOHOL
AND OTHER DRUG ABUSE IN ALASKA,
2005 UPDATE**

**PREPARED FOR:
THE ADVISORY BOARD ON
ALCOHOLISM AND DRUG ABUSE
DEPARTMENT OF HEALTH
& SOCIAL SERVICES**

PREPARED BY:



JUNEAU • ANCHORAGE

DECEMBER 2005

Full report is available online:

http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

Fetal Alcohol Spectrum Disorders

Prenatal exposure to alcohol can cause specific birth defects which may include physical, mental, behavioral, and learning disabilities. Many children with fetal alcohol disorders are not identified until they reach school age or later. Individuals with alcohol-related effects may have difficulties with attention, memory, and problem solving. Heart, liver, and kidney defects are also common, as well as vision and hearing problems.¹³ Alcohol-related effects that fall within the broad category of fetal alcohol spectrum disorders (FASD) include:

- fetal alcohol syndrome (FAS),
- partial FAS (PFAS),
- fetal alcohol effects (FAE),
- alcohol-related neurodevelopmental disorder (ARND),
- and other alcohol-related birth defects (ARBD).¹⁴

¹³ National Organization on Fetal Alcohol Syndrome, *What is FAS/FASD?*, www.nofas.org/faqs.aspx?id=9

¹⁴ US Department of Health and Human Services, SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence. *The Language of Fetal Alcohol Spectrum Disorders*.

Full report is available online:

http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

During the past ten years, a number of FAS prevalence rates have been established. Studies by the Centers for Disease Control and Prevention indicate a national rate from 0.2 to 1.5 cases per 1,000 births across various populations.¹⁵ Other studies, including those focusing on specific high-risk populations such as Native Americans, other minorities and families living in poverty have indicated rates from 0.5 to 5.0 per 1,000 live births. Clearly, the data is varied and limited.

In establishing a clear number of infants born each year in the United States with Fetal Alcohol Syndrome, the CDC estimates between 1,000 and 6,000 children will be born with FAS each year - a preventable birth defect and disability.

Beginning in 1997, Alaska was one of five states comprising the CDC's Fetal Alcohol Syndrome Surveillance Network (FASSNet), a program established to provide consistent and comparable FAS prevalence rates. Participating states included Arizona, Colorado, New York, Wisconsin and Alaska (however, FAS rates for Wisconsin are not available). At 1.5 per 1,000 live births, Alaska has a significantly higher rate of children born with FAS than other states in the FASSNet program. In addition, Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives. CDC data indicates FAS prevalence rates ranging from 0.3 per 1,000 in Arizona and Colorado to 0.4 in New York.

CDC estimates that other prenatal alcohol-related conditions, such as ARND and ARBD, occur approximately three times as often as FAS.¹⁶ Within the wider category of FASD (which would include individuals with FAS), the US is estimated to have about 10 cases per 1,000 live births.¹⁷

Alaska's estimated rate of all births impacted by prenatal alcohol exposure is 16.3 cases per 1,000 births, based on the 1995 to 1999 birth years. While these alcohol-related effects are closely associated with FASD, these rates are not directly comparable to national FASD rates of 10 per 1,000 live births due to differences in diagnoses and reporting at the state and national levels. Based on 16.3 cases per 1,000 and the number of live births from 1995 to 1999, approximately 160 infants are born each year in Alaska with FAS and other effects from maternal alcohol use during pregnancy. Of those, approximately 15 are born with Fetal Alcohol Syndrome (FAS).

FAS vs. FASD

It is important to remember that the information being used to determine the economic costs of care and service delivery to individuals with Fetal Alcohol Syndrome is only a small portion of the overall impact of prenatal exposure to alcohol and the resulting birth defects and disabilities. Beginning in 2000, the State of Alaska began extensive efforts to improve and expand the ability to appropriately diagnose individuals prenatally exposed to alcohol. In 2005, Alaska has a broad and regionally diverse network of diagnostic teams across the state.¹⁸ Data collected from these teams indicate that from July 2000 through March 2005 teams have conducted

¹⁵ FAS: *Guidelines for Referral and Diagnosis*, CDC, 2004.

¹⁶ CDC, *Tracking Fetal Alcohol Syndrome*, www.cdc.gov/ncbddd/fas/fassurv.htm

¹⁷ National Organization on Fetal Alcohol Syndrome, *What are the Statistics and Facts about FAS and FASD?*, www.nofas.org/faqs.aspx?id=12

¹⁸ For information on available services go to <http://health.hss.state.ak.us/fas/teams/default.htm>.

Full report is available online:

http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

755 FASD diagnostic assessments. Of this number, 76 (10.0 percent) were diagnosed with FAS or atypical FAS; 378 (49.9 percent) were diagnosed with Static Encephalopathy; 251 (32.2 percent) were diagnosed with Neurobehavioral Disorder; and 50 (6.6 percent) were found to have no evidence of organic brain damage.

What this data indicates is that the costs associated with all alcohol-related births are much higher than those estimated just for individuals with FAS. And, as noted in the break-through research of Dr. Ann Streissguth in 1996 (*Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome [FAS] and Fetal Alcohol Effects [FAE]*), individuals with FAE (what is now referred to as FASD) are more likely to develop secondary disabilities and need more services than those with Fetal Alcohol Syndrome and the associated facial dysmorphism. For Alaska and the economic costs associated with all fetal alcohol spectrum disorders, the costs could be as much as 80 percent higher than indicated for FAS alone.

Economic Cost of Fetal Alcohol Syndrome

The cost of caring for and providing appropriate services to a person with FAS can be significant. These costs may include neonatal care for low birth weight to special speech therapy, behavioral management, or residential care for adults with FAS. Lifetime costs for care for children born in 2003 with FAS are estimated below. However, these costs are excluded from the total health care costs for 2003, as the component of that expenditure in 2003 alone cannot be determined.

Methodology

To estimate the economic costs from FAS, the research team first determined the number of live births with FAS in Alaska. The Alaska Department of Health and Social Services has closely monitored incidence of FAS in the state since 1998, as part of a U.S. Centers for Disease Control (CDC) monitoring program called the Fetal Alcohol Syndrome Surveillance Network (FASSNet), the ongoing Alaska FAS Surveillance Project and the Alaska Birth Defects Registry. The development of 13 community-based FASD diagnostic teams across Alaska has also assisted in the collection of data related to both FAS and other alcohol-related disabilities included in the FASD umbrella definition.

The Alaska FAS Surveillance Project data collection system is based on reports to the Alaska Birth Defects Registry, and uses medical chart data points to identify children with FAS or other prenatal alcohol-related conditions. DHSS staff consider the surveillance program to be highly rigorous. Alaska clinicians and case workers use a diagnostic process developed by researchers at the University of Washington Fetal Alcohol Syndrome Diagnostic and Prevention Network. Reporting of birth defects to the state registry is mandated by Alaska law. While Alaska's FAS surveillance system is believed to capture the majority of prenatal alcohol-related cases, it is possible that underreporting could make the incidence rate even higher.

For birth years 1995 to 1999, the incidence rate of FAS in Alaska is 1.5 per 1,000 live births.¹⁹ This was the highest rate of the five states that were involved in developing

¹⁹ Susan Merrick, FAS Surveillance Project Manager, Alaska Department of Health and Social Services, personal communication, July 2005.

Full report is available online:

http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

the CDC FASSNet system. (The lowest rate was 0.3 FAS cases per 1,000 births.) However, the incidence of all prenatal alcohol-related conditions, including such conditions as alcohol-related birth defects (ARBD) and alcohol-related neurodevelopmental disorder (ARND), as well as FAS, is 16.3 per 1,000 live births. This incidence rate is assumed to be consistent in birth year 2003.

To estimate FAS costs in Alaska, the research team relied on data published in Health Professions Education Partnership Act of 1998 (Senate Bill 1754). The cost of treating an individual with FAS over his or her lifetime was estimated to be at least \$1.4 million in 1995. These costs could include neonatal intensive care, medical and surgical services (not related to neonatal care), special speech therapy, behavioral management, and residential care. Medical and surgical service might include rectifying or monitoring hearing loss or cleft palate surgery. Residential services include special education, home care, speech therapy or institutional care. The 1995 data was adjusted for inflation using the Bureau of Labor Statistics Consumer Price Index for medical care. Additionally, costs of providing care were adjusted by the Alaska differential for cost of living (65 percent in 2003). The resulting total lifetime costs (in 2003 dollars) for providing services to an individual with FAS are estimated at \$3.1 million.

The total cost for providing services to an individual with FAS born in Alaska during 2003 was estimated by multiplying the lifetime costs by the number of FAS births during that period.

Results

Table 18 presents estimated costs for FAS births in Alaska during 2003. During that period, Alaska had about 15 FAS births. Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately \$47.0 million.

Table 18
Lifetime Costs of Medical and Residential Services
for Children Born with FAS in 2003

	Incidence and Costs
Alaska births in 2003	10,084
FAS incidence per 1,000 live births	1.5
FAS births	15
Lifetime FAS cost	\$47,037,000

Source: Birth data from the Alaska Bureau of Vital Statistics. McDowell Group, based on FAS data from Alaska Department of Health and Social Services; and Health Professions Education Partnership Act of 1998, S. 1754, 108d Congress (1998).

Senator Kevin Meyer
Alaska State Capitol
Juneau, AK 99801-1182

February 8, 2010

RE: SCR 12 Fetal Alcohol Spectrum Disorders Awareness Day Proclamation

Dear Senator Meyer,

I am writing this letter in support of Senate Concurrent Resolution No. 12 proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day. I was planning to provide testimony by phone, but unfortunately, I am unable to break away from work.

Over the past 22 years as a behavioral health clinician I have witnessed firsthand the devastating consequences of prenatal alcohol and FASD for Alaska's families and communities.

Alaska unfortunately has the highest known rates of FAS/FASD in the United States. As you know, Alaska also ranks high in many other statistics such as domestic violence, sexual assault, and suicide. One of the secondary consequences of prenatal alcohol is that those with an FASD without adequate support often experience significant mental health problems, are at greater risk for suicide, and are frequently exploited and victimized.

Your efforts towards keeping FASD awareness active, and on the forefront of people's minds, will make a difference for Alaska's families and communities. This will happen by communicating the importance of awareness and taking action to prevent future FASD, as well as provide interventions for those who are already impacted.

Thank you for your efforts. If I can answer any questions, or be of help, please let me know.

Respectfully,



Michael Baldwin

5340 Tudor Top Circle
Anchorage, AK 99507
907-250-7736

Anchorage Council on Fetal Alcohol Spectrum Disorders

The Anchorage Council on FASD is a cooperative network of individuals and organizations committed to advocacy for people impacted by prenatal alcohol exposure and to the prevention of FASD.

February 5, 2010,

Members:

Alaska Center for Resource Families

Alaska Injury Prevention Council

Alaska Pacific University

Anchorage School District STRP Center

Covenant House Alaska

Good Samaritan Counseling Center

Nine Star Enterprises

Northern Educational Consulting

Pioneer Consulting

RURAL GAP

Southcentral Foundation Alaska Women's Recovery Project

Southcentral Foundation Dena A Cay Program

Southcentral Foundation FASD Diagnostic Team

State of Alaska Office of Children's Services

Stone Soup Group

Volunteers of America, AK Inc.

To the members of the Alaska State Senate HSS Committee,

I am writing on behalf of the agencies, programs and community members that participate in the Anchorage Council on FASD asking the committee to support passage of SRC 12, relating to FASD Awareness Day, September 12, 2010.

Our council has been involved in FASD prevention, education and support activities for many years. One of our most intensive community outreach activities has been the annual International FASD Awareness Day events taking place each year on September 9 at 9:09 am for the last 10 years.

With Alaska having the highest know rate of Fetal Alcohol Spectrum Disorders in the United States, we believe it is imperative that prevention activities such as that proposed in this resolution be actively encouraged whenever possible.

Each year, members of more Alaskan communities get together to plan and conduct FASD prevention and education events on September 9. It will be wonderful to have the support of our legislature as we continue our work on this serious health issue.

We look forward to joining many other Alaskan communities putting on community - based FASD educational activities next 9/9 and encourage the members of the Senate HSS committee to approve SRC 12.

Sincerely,



Cheri Scott, facilitator

Anchorage Council on FASD

Advisory Board on Alcoholism
and Drug Abuse



Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

February 8, 2010

Senator Kevin Meyer
Alaska State Capitol
Juneau, Alaska 99801

Re: SCR 12 — FASD Day

Dear Senator Meyer,

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board express their appreciation and support for your resolution declaring September 9, 2010 Fetal Alcohol Spectrum Disorders Day. As you know, fetal alcohol spectrum disorders are 100% preventable. Raising awareness and recognition of this fact will help prevent more Alaskan children from being born affected by prenatal alcohol exposure.

Even more importantly, it will raise awareness of the special, and often very individual, needs of individuals diagnosed with fetal spectrum disorders. Too often the services and supports they need to thrive – at home, at school, and in their communities – are not available. By designating a day to focus on the unique issues of fetal alcohol spectrum disorders and their impact on Alaska, we can not only support Alaskans with FASD but also prevent future Alaskans from experiencing FASD.

Thank you for your continued work on this important issue.

Sincerely,

Debi Keith, Chair
AMHB

James Duncan, Chair
ABADA



Supporting families who care for children and youth with special needs

February 8, 2010,

To the members of the Alaska State Senate HSS Committee,

I am writing to ask the members of the Senate HSS committee to support passage of SRC 12, relating to FASD Awareness Day, September 12, 2010.

I manage the FASD Family Support Program housed at Stone Soup Group. This program provides FASD focused training to family members and service providers, information and referral services and support to families of children and adults who experience FASD.

I am also the adoptive parent of a young man who was severely affected by prenatal exposure to alcohol. We are one of the lucky families – our son is so impaired that he qualifies for many services and supports. Many of my friends and the families I work with every day are not so lucky. Their children look typical and so the world expects them to be able to function as if they didn't have organic brain damage from their prenatal alcohol exposure.

Our family has been proud to be part of the annual International FASD Awareness Day events taking place each year in Alaska on September 9 at 9:09 am for the last 10 years. We see it as an excellent opportunity to help educate the community about the needs of individuals living with FASD and the importance of preventing prenatal damage to future members of our community.

As both a service provider that works with families dealing with the issues of FASD everyday and as the parent of a wonderful child with FAS, I want to encourage the members of the Senate HSS committee to approve SRC 12 proclaiming September 9, 2010 Fetal Alcohol Spectrum Disorders Awareness Day, and continue to identify ways to assist our state in combating this terrible disorder that impacts every area of our state budget in one way or another.

Best Wishes,

A handwritten signature in black ink that reads "Cheri Scott".

Cheri Scott, Manager

FASD Family Support Program

Stone Soup Group

Liz Clement

From: Liz Clement
Sent: Thursday, March 11, 2010 12:33 PM
To: 'Kathleenmtil@aol.com'
Subject: RE: (no subject)

Ms. Tilton,

Thank you for the email. I will place a copy of your message on each of the House Health and Social Services Committee members' desks at the hearing this afternoon. That way they will all be able to see it as they listen to testimony and talk about SCR 12.

Sincerely,

Liz Clement
Staff to Rep. Herron
Alaska State House District 38
t: (907) 465-6576
f: (907) 465-4589

From: Kathleenmtil@aol.com [mailto:Kathleenmtil@aol.com]
Sent: Thursday, March 11, 2010 12:26 PM
To: Liz Clement
Subject: (no subject)

Liz,

I would like to be heard. I am currently a Foster Parent with a beautiful Cognitively Disabled 12 year old who has introduced me to FASD. I want to learn as much as I can & being able to attend public functions would be a safe cooperative to do just that. I am hoping this e-mail will be considered a voice as I have an appointment this afternoon and am unable to speak by phone.....

Thank you for your time & efforts involving this very important matter.

Sincerely,

Kathleen M. Tilton

SCR

13

Alaska State Legislature



Senator Con Bunde

Senate District P

Senate Minority Leader / Senate Republican Caucus

Member: Senate Labor & Commerce Committee

Sponsor Statement

SCR 13

"Supporting senior caregivers and encouraging the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers."

Alaska's senior population is growing. The number of Alaskans 65 years of age or older is expected to increase by 155 percent in the next 20 years and the population of those 85 years or older is projected to double by 2050. Per capita, Alaska has the fastest growing 85 and over population in the entire nation.

While advances in medicine, technology, and assisted living practices are enabling seniors to live longer, more productive, and more comfortable lives than ever before, the fact remains that many of our aging loved ones will at some point require some form of caregiving. In fact, more than 25 percent of all seniors need some level of assistance with their daily activities.

It is critical that we as a state are prepared to meet and manage the needs of our aging population.

By supporting senior caregivers and encouraging the Department of Health & Social Services to provide additional education on the effects of aging and the importance of senior caregivers, SCR 13 draws attention to the changing demographics of aging in Alaska and highlights the critical role played by senior caregivers in helping meet the needs of our aging population.

Sen.Con.Bunde@legis.state.ak.us

907-465-4843 Juneau

907-269-0181 Anchorage

1-800-892-4843

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: CSSCR 13(HSS)
 (S) Publish Date: 3/16/10

Identifier (file name): SCR013-DHSS-SDSA-3-12-10 Dept. Affected: Health & Social Services
 Title Supporting Senior Caregivers RDU Senior and Disabilities Services
 Component Administration
 Sponsor Bunde
 Requester Senate HSS Component Number 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES (
-----------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

Senate Concurrent Resolution 13 supports senior caregivers and encourages the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers. There are no foreseeable costs.

Prepared by: Rebecca Hilgendorf, Director Phone 907-269-2083
 Division Division of Senior and Disabilities Services Date/Time 3/10/10 4:36 PM
 Approved by: Alison Elgee, Assistant Commissioner Date 3/12/2010
DHSS Finance & Management Services

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

March 1, 2010

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Subject: Support for SCR 13, Senior Caregivers

Dear Chair Davis:

The Alaska Commission on Aging (ACoA) supports SCR 13, a bill that recognizes the important role of family and professional caregivers who care for older Alaskans, some of whom have Alzheimer's disease and related dementias (ADRD), by providing the assistance they need to remain in their homes and communities for as long as possible. The number of older Alaskans with Alzheimer's disease and related disorders is projected to nearly double within the next decade, based on national age-based prevalence rates, and quadruple by 2030. Fifty-eight percent of residents at the Pioneer Home have ADRD (Pioneer Home, January 2010 report). SCR 13, authored by Senators Con Bunde and Lesil McGuire, also highlights Alaska's demographic aging transition.

For the second year in a row, Alaska is the state with the fastest growing population of older adults age 65 years and older. Between 1998 and 2008, the number of Alaska seniors grew by over 50%, which is more than four times the national average.

The growth of the older Alaskan population is occurring at both ends of the senior age continuum – among the youngest seniors (age 60 to 64 years) many of whom moved to Alaska during the 1970s pipeline era, and the "oldest old," those age 85 years and older who are the most frail, the most prone to Alzheimer's disease and related disorders, and most in need of long-term support services. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors as demand increases and providers are becoming of retirement age.

Alaska's emphasis on caregiving performed by family and professional home- and community-based (HCBS) providers has made a significant difference in seniors' ability to remain at home; this is apparent in the increased average age of admission to the Pioneer Homes from 76 in 1998 to 86 in 2008. As a result of caregiver efforts, older Alaskans are able to continue living at home and in their communities, where they most desire to be, and spend fewer years in nursing homes when this care is most appropriate. Rates for a semi-private room in a nursing home will rise by 192% over the next twenty years, increasing from \$187,815 (in 2008) to \$549,662 by 2030 (Genworth Financial 2008 Cost of Care Study).

The majority of caregiving for persons with ADRD is performed by loved ones. In Alaska, there are approximately 14,539 unpaid ADRD caregivers who have contributed an estimated 12,550,265 hours of unpaid care that is valued at \$139,307,943 (Alzheimer's Association 2009). Without family caregivers, the state would be paying far more for Medicaid long-term support services.

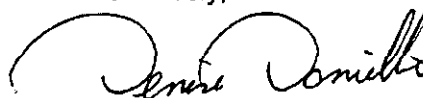
ACoA supports SCR 13 and its recommendations to regularly review state policies and programs to ensure they address the needs of Alaska seniors and their caregivers and for the Department of Health and Social Services to provide education about the aging process and the importance of senior caregivers. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,



Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director

Cc: Senator Joe Paskvan, Vice Chair
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Con Bunde



February 26, 2010

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SCR 13 (Bunde)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SCR 13, authored by Senator Con Bunde and co-sponsored by Senator Lesil McGuire.

SCR 13 puts a spotlight on the changing demographics of aging in Alaska and the critical role played by family caregivers.

The fastest growing age group in America is the eighty-five plus. Per capita, Alaska has the fastest growing eighty-five plus in the entire nation.

The eighty-five plus are the age group most likely to need some assistance with activities of daily living. The majority of this assistance is rendered by family caregivers.

Many Alaskan families will find themselves in a caregiving mode as our population ages. AARP supports the recommendation in SCR 13 that encourages the Department of Health and Social Services to provide education about caregiving to all of us and to support the efforts of family caregivers to take care of older relatives and friends.

Without family caregivers, government would face increasing demands for paid assistance for older citizens. This would significantly impact the Medicaid long term care program as well as the personal care attendant program.

Family caregivers don't "dump" their responsibilities on government. They step up to the plate and provide assistance as they are able. We often find caregivers in their 70's and 80's caring for older parents as well as frail spouses and siblings.

With a little help and support, Alaska can do much to help these caregivers continue to assist their family members. This is a legitimate and appropriate service for state and local government to render to those citizens who give so much of themselves.

We should shine a spotlight on these caregivers, recognize their efforts, and provide whatever education we can to help them maintain the independence of their family members and their own health and well-being.

AARP recommends an "AYE" vote on SCR 13.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Con Bunde



Alzheimer's
Resource of Alaska

February 26, 2010

Senator Con Bunde
State Capitol, Room 423
Juneau, AK 99801

Anchorage &
Statewide Services
1750 Abbott Road
Anchorage, AK 99507
phone 907-561-3313
fax 907-561-3315
Toll-free in Alaska
800-478-1080

Fairbanks Services
565 University Ave.
Suite 2
P.O. Box 72791
Fairbanks, AK 99707
phone 907-452-2277
fax 907-457-3376

Juneau Services
3100 Channel Drive
Suite 19
Juneau, AK 99801
phone 907-586-6044
fax 907-586-6044

Mat-Su Valley Services
Trinity Barn Plaza
P.O. Box 4406
Palmer, AK 99645
phone 907-746-3413
fax 907-746-3413

www.alzaska.org

Dear Senator Bunde,

On behalf of the Alzheimer's Resource of Alaska and the individuals we serve, I would like to thank you for introducing Senate Concurrent Resolution n.13 supporting caregivers of Alaska seniors.

Seniors choose to remain in their home and their community, with help from family, for as long as possible. Family caregivers are honoring their elder's wishes; more than 70% of people with Alzheimer's disease and related dementias (ADRD) live at home where they are cared for by family and friends. However, the demands of caregiving can come at a high cost to the caregiver's own physical and mental wellbeing. Caregiver stress is becoming a major health risk for caregivers.

Education and support services give caregivers tools and skills that enable them to maintain families' independence and are an effective mechanism for families to continue caring for a loved one in their own home and community. Families assume most of the responsibility for the care of the older family member while working, caring for children and holding other responsibilities. In the later stages, when some people with ADRD move to an assisted living facility or nursing home many family caregivers continue to assist with financial and legal affairs, medical care and emotional support. Some even continue to help with bathing, dressing and personal care needs.

Education for caregivers is a key component in the statewide *infrastructure* of senior care. Research shows that education and support services for the family caregivers can maintain this informal care longer and delay placement of the elder by an average of 1 1/2 years. State funding simply leverages the enormous contributions by families making education and support services highly cost-effective. We must increase our support of this informal, unpaid, caregiving network.

Thank you again for introducing SCR N. 13.

Sincerely,

Dulce Nobre
Executive Director

One Hundred Eleventh Congress
of the
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday,
the sixth day of January, two thousand and nine*

Concurrent Resolution

Whereas 8,000 people in the United States turn 60 years old every day;

Whereas an estimated 35,900,000 people, 12.4 percent of the population, are 65 years of age and older;

Whereas the United States population age 65 and older is expected to more than double in the next 50 years to 86,700,000 in 2050;

Whereas the 85 and older population is projected to reach 9,600,000 in 2030 and double again to 20,900,000 in 2050;

Whereas it is estimated that 4,500,000 people in the United States have Alzheimer's disease today;

Whereas it is estimated that number will increase to between 11,300,000 and 16,000,000 by 2050;

Whereas 70 percent of people with Alzheimer's disease and other dementias live at home, and these individuals are examples of individuals who need assistance in their homes with their "activities of daily living";

Whereas currently over 25 percent of all seniors need some level of assistance with their "activities of daily living";

Whereas in order to address the surging population of seniors who have significant needs for in-home care, the field of senior caregiving will continue to grow;

Whereas there are an estimated 44,000,000 adults in the United States providing care to adult relatives or friends and an estimated 725,000 nonfamily private paid senior caregivers;

Whereas both unpaid family caregivers and paid caregivers work together to serve the daily living needs of seniors who live in their own homes;

Whereas the Department of Labor estimated that paid caregivers for the year 2006 worked a total of 835,000,000 hours, and the projected hours of paid senior caregivers are estimated to increase to 4,350,000,000 hours by 2025; and

Whereas the longer a senior is able to provide for his or her own care, the less burden is placed on public payment systems in State and Federal governments: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That Congress—

- (1) recognizes caregiving as a profession;
- (2) supports the private home care industry and the efforts of family caregivers nationwide by encouraging individuals to provide care to family, friends, and neighbors;

H. Con. Res. 59—2

- (3) encourages accessible and affordable care for seniors;
- (4) reviews Federal policies and supports current Federal programs which address the needs of seniors and their family caregivers; and
- (5) encourages the Secretary of Health and Human Services to continue working to educate people in the United States on the impact of aging and the importance of knowing the options available to seniors when they need care to meet their personal needs.

Attest:

Clerk of the House of Representatives.

Attest:

Secretary of the Senate.

Monday Mar 1, 2010

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National Family Caregivers Association

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What is Family Caregiving?

Caregiving Statistics

Surveys and Reports

Who are America's Family Caregivers?

[Suzanne Mintz on YouTube](#)

[Suzanne Mintz Interview on Women's Radio](#)



Rosalyn Carter said it best: "There are only four kinds of people in the world – those who have been caregivers, those who are currently caregivers, those who will be caregivers and those who will need caregivers". Caregivers are needed for family members of all ages. With appropriate information and support, family caregivers can help their loved ones across the lifespan.

So, who are family caregivers ... It's a complicated question and answers may vary depending upon whom you ask. Physicians may give an answer different from social workers and researchers may undoubtedly quote statistics. However, if you really want to know who America's family caregivers are, you need to ask them directly.

America's family caregivers are *family, friends, partners, and neighbors*. To better understand the experience and the meaning of being a family caregiver go to [The National Family Caregiver Story Project](#). The NFCA Story Project is a collection of first-person accounts by family caregivers. It is the gateway to becoming part of a growing group of family caregivers who have reached out to share their thoughts, feelings and find solace in the words of others. As you read the stories of America's family caregivers you may find yourself nodding in recognition and find the answers to [Who are America's Caregivers?](#)

Research and Statistics:

[NFCA Research and Reports](#) have focused largely, but not exclusively, on those family caregivers who provide significant levels of care. One aspect of our research has sought to better understand how to communicate effectively with family caregivers, since so many are uncomfortable with calling themselves anything other than a spouse, a parent, or a loving adult child.

There is an extensive body of family caregiver research available on many different aspects of the caregiving experience. You can find out more about the financial, physical and emotional impact of family caregiving as well as information on family caregivers at work and in the healthcare system in the [Caregiver Statistics](#) section of this site.

Suzanne Mintz on YouTube

Listen to Suzanne Mintz, President/CEO of NFCA, talk about family caregivers. [Click here](#) for the video on YouTube.

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In-Home Care Services

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"I got to a point where I didn't like driving or running errands by myself. Now, thanks to my CAREGiver Susan, I don't put off getting the things I need and I actually enjoy getting out."

- Ruth, Florida

Senior Home Care Services

Everyone shares similar concerns about health care for our parents, grandparents and loved ones as they reach retirement age and beyond. Perhaps your mother gets confused and can't keep her doctor appointments and medications straight. Or your dad seems depressed and doesn't enjoy fishing anymore. Maybe your grandmother suffering from Alzheimer's needs regular attention while you're at work. That's when Home Instead Senior Care can come into the home and be the caregiver for you. [Learn more about how Home Instead Senior Care can help you care for the senior in your life.](#)

Are you seeing that your loved ones need home care as they age? Have you thought about a nursing home or assisted living facility but want to keep them in their home for as long as possible? Are you starting to wear out because of the impact the senior care you're providing is having at work and with your family members? Do you fear for a loved one's safety?

Home Instead Senior Care can help with compassionate, home senior care services delivered right in your loved one's home. Whether a few hours a day or long-term care 24 hours a day, a CAREGiver can assist you. All CAREGivers are thoroughly screened, extensively trained, insured and bonded, matched to your preferences, professional and reliable.



Home Instead Senior Care Means Exactly That



Share Video: [Twitter](#) [Facebook](#) [Email](#) [Embed](#)

Home Instead Senior Care's mission is to enable seniors to live happy, healthy, and independent lives in their homes. As the industry leader for in-home, non-medical care, Home Instead's CAREGivers help turn clients' ordinary days into extraordinary experiences. Hear what actual clients have to say about how Home Instead has improved their lives.

Become a part of
the North American
Home Instead
Senior Care family
of franchises

International
Franchise
Opportunities

Media Room

Home Instead, Inc demonstrates commitment to quality care through our proprietary PEAQ program, -Pursuing Excellence by Advancing Quality. In fact, we commissioned J.D. Power and Associates to routinely survey CAREGivers and clients to ensure consistent delivery of high quality service.

We understand that making the decision to use outside help for caring for an elderly loved one is difficult. That's why we provide a wealth of [senior care resources](#) and [Alzheimer's and dementia care](#) resources for you to consider.

Home Instead Senior Care offers a wide variety of services, which may grow to include activities and support that are unique to you and your elderly loved one's needs.

Senior Services include the following and more - all tailored to meet your needs:

Companionship Services

- Offer elderly companionship and conversation
- Provide respite care
- Monitor diet and eating
- Check food expirations
- Assist with evening and tuck-in
- Stimulate mental awareness
- Assist with entertaining
- Answer the door
- Reminisce about the past
- Assist with clothing selection
- Care for houseplants
- Provide reminders for appointments
- Discuss current and historical events
- Participate in crafts
- Play games and cards
- Supervise home maintenance
- Record and arrange recipes
- Oversee home deliveries
- Prepare grocery lists
- Clip coupons for shopping
- Monitor TV usage
- Mail bills and letters
- Buy magazines, papers and books
- Rent and play movies
- Plan visits, outings and trips
- Visit neighbors and friends
- Read religious materials
- Maintain calendar
- Maintain family scrapbook
- Record family history

Home Helper Services

- Provide Alzheimer's Care
- Assist with laundry and ironing
- Take out garbage
- Aid with morning and wake-up
- Arrange appointments
- Provide medication reminders
- Aid with reading
- Assist with walking
- Write letters and correspondence
- Organize mail
- Change linens
- Plan, prepare and clean up meals
- Make beds
- Dust furniture
- Drop off and pick up dry cleaning
- Pick up prescriptions
- Organize and clean closets
- Assist with pet care
- Shop for groceries and supplies
- Prepare future meals
- Escort to appointments
- Accompany to lunch or dinner
- Escort for shopping and errands
- Attend plays and concerts
- Escort to religious services
- Attend club meetings and sporting events
- Aid with airport tasks

Personal Services

Assistance with:

- Eating
- Grooming
- Dressing
- Bathing
- Incontinence
- Cognitive impairment
- Mobility
- Medication reminders

Services vary by location.

To download and print our brochures, [click here](#).

Senate Concurrent Resolution No. 13

My name is Kevin Turkington. I am the CEO of Senior Care of Alaska Inc, serving senior Alaskans since 2002, the board president of the Older Persons Action Group since 2003 and the newly formed Alaska Chapter of the National Private Duty Association, NPDA. The Alaska Chapter of the NPDA is result of four private, competing companies working together for those we feel a strong passion to serve and protect.

I am testifying in support of SCR13. I believe it can be the vehicle that brings a better balance to our states legislation and support for our ENTIRE senior population. So much of our resources appear to be focused on our low income seniors; and I agree that these senior individuals need that support. However, about 75 percent of the senior population are not eligible for most of these services.

The most profound statement of SCR13 is on line 11 and 12, which states: "*WHEREAS the longer seniors are able to provide for themselves, the less the public payment systems supported by state and federal governments are burdened*" I believe we as a state focus more on providing for low income persons; to the tune of about \$38,500¹ per person of the total 3676² recipients in the Medicaid Waiver program alone. These costs continue to rise as we increasingly throw more money into a system that over time seems to increase and even encourages dependence on it. There are providers³ who flat out tell seniors and their families that they need to get their loved ones into a 'spend-down' situation as soon as possible so as to use their services under Medicaid.

The recent Federal Audit and Moratorium of the Medicaid program in Alaska speaks loud and clear to the problems we as a state face, including the reality that the current system seems to pay for poor management and fraud, making serving the Medicaid system very lucrative for many. Ever wonder why about 90⁴ percent of agencies serving senior and disabled Alaskans are Medicaid providers? Guaranteed income! Add to that, it appears the state is even considering rewarding these organizations with more money through a review process if they find they aren't making enough profit providing services under Medicaid⁵.

I believe that the best way to serve seniors and lower the costs of doing so is by empowering both the senior and their providers whether by a family member or a professional caregiver. I believe that this can be accomplished best by filtering all current regulations and subsequent legislation through SCR13 and the powerful statement it makes on behalf of seniors and their families. I believe it says that we as a state really do care about our seniors, *all of them*.

I think that if we stay on a path we are currently on, throwing more and more of our resources towards a system that can't be sustained, we will not meet the challenge.

However, by recognizing seniors caregiving as a profession, by supporting the private duty home care industry and the efforts of family caregivers to provide care to family, friends and neighbors, by encouraging accessible and affordable care for ALL seniors, and provide the educational support on the effects of aging and the importance and availability of senior caregivers we will meet the challenge Alaska faces with the expected 157 percent⁶ growth of our senior population over the next 20 years.

I believe most of us really do care about those we propose to serve. I know I do. It's why I started my company and it's why I actively serve in the community with several organizations.

I believe that by providing a means, both in education and support for people to do for themselves and encourage less dependence on the State of Alaska will we be able to meet the challenges ahead. Medicaid was designed to help those individuals who just plain fall through the cracks, whether by choice or by no fault of their own. But widening the cracks isn't the answer.

I ask that you recommend passage of Senate Concurrent Resolution 13 and pledge to help support all of our seniors, making safe, affordable and professional care accessible, whether through family, friends or organizations. I can assure you that I will be doing so both through my company as well as through the organizations I serve with.

In service,


Kevin Turkington, CSA

3/15/10

Senior Care of Alaska Inc, Alaska Chapter NPDA, Older Persons Action Group.

Notes:

¹ AKSAS data, Report to Senate Health and Social Services Committee, November 3, 2009, pg 4.

² AKSAS data, Report to Senate Health and Social Services Committee, November 3, 2009, pg 5.

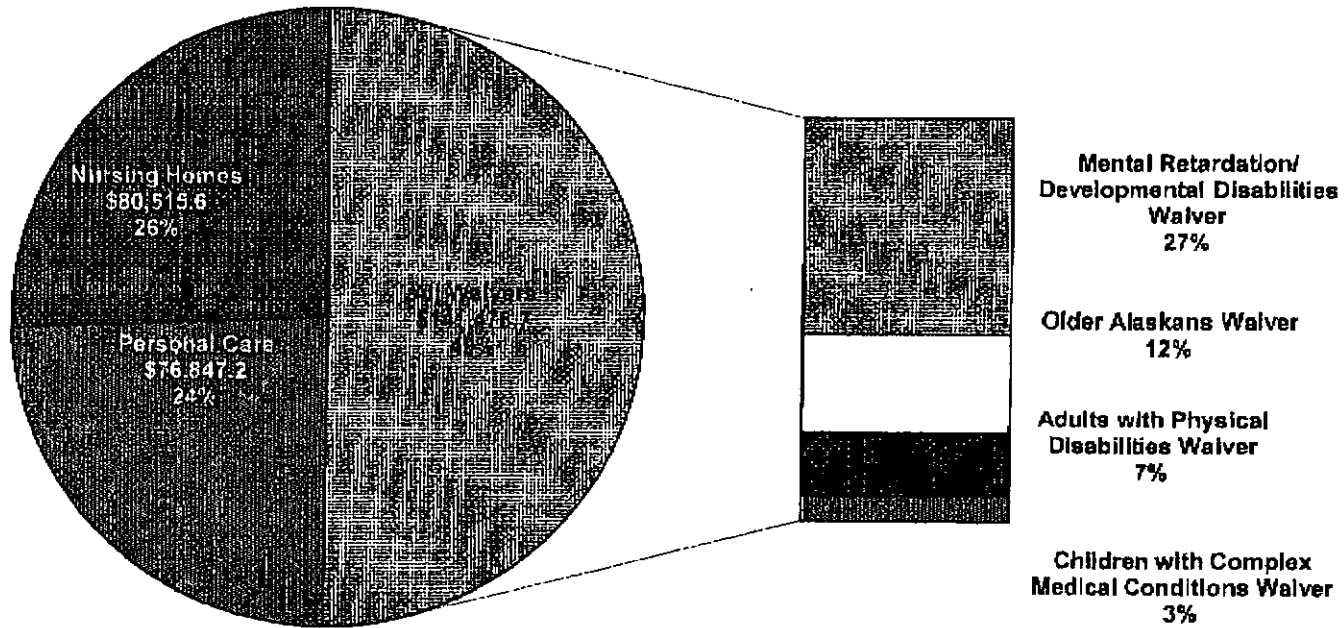
³ From competitor marketing calls made by our staff to other providers in the Anchorage area.

⁴ Based on ACS Yellow Page listing 30 companies and knowledge of which are not serving the Medicaid program.

⁵ refer to Senate Bill 32.

⁶ SCR13, line 9.

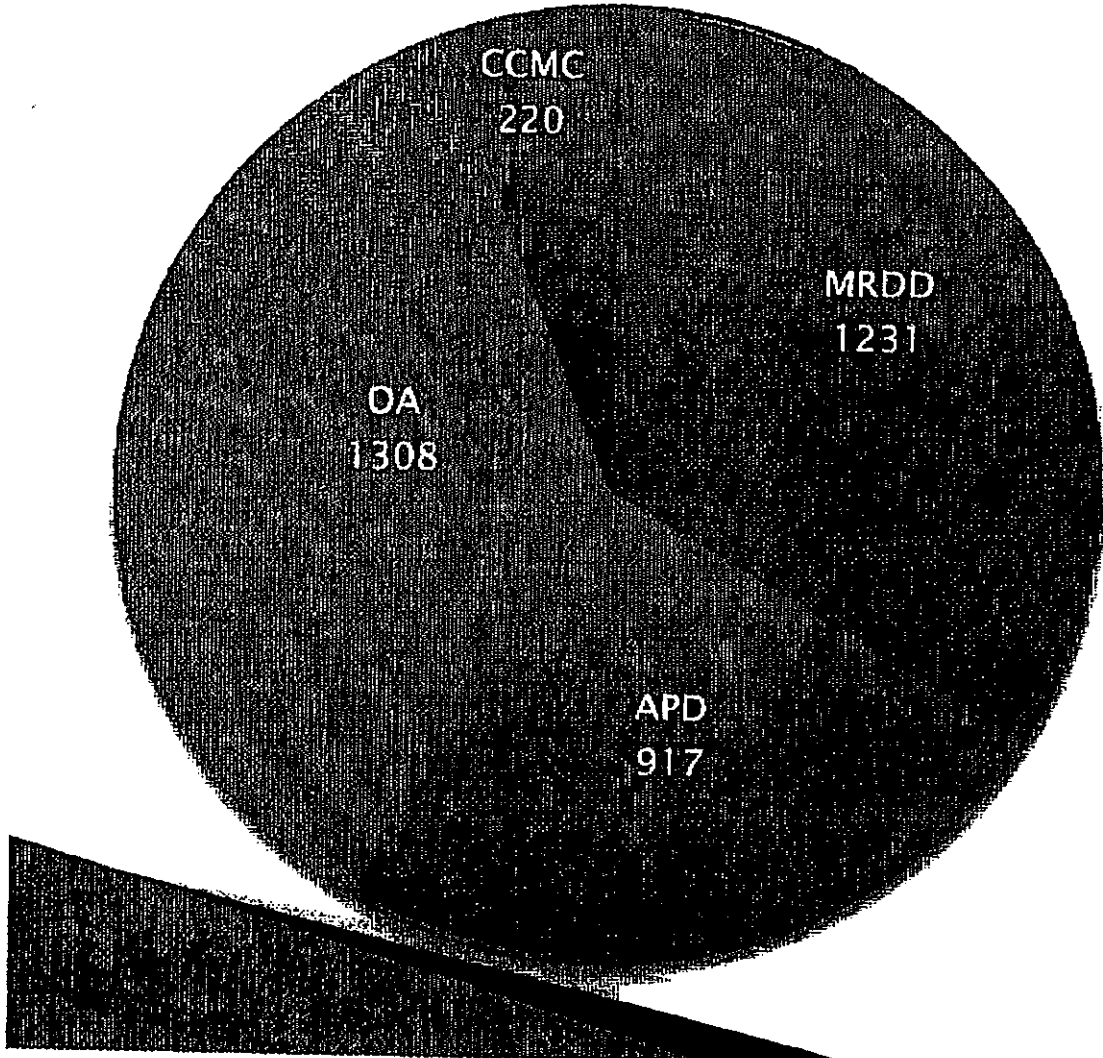
**Senior and Disabilities Medicaid Services
 FY 2009 Expenditures by Service Category
 Total Expenditure = \$298,841,000**



Source: AKSAS data.
 Excludes waiver determinations.

Tuckerington pg 4/6

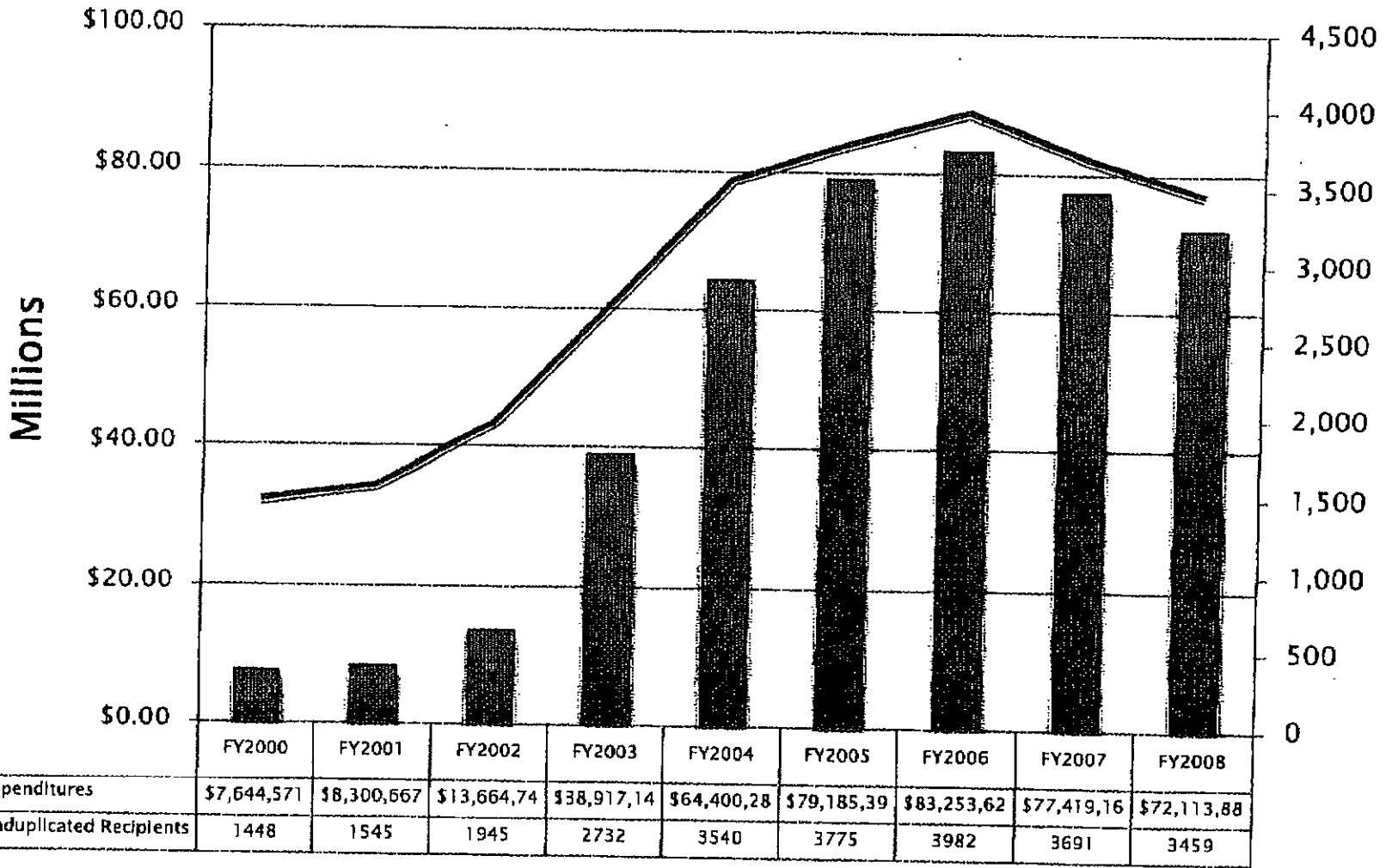
Waiver Recipients September 2009 3,676 - Unduplicated



- Mental Retardation
Developmental Disabilities
Waiver
- Adults with Physical
Disabilities
- Older Alaskans
- Children with Complex
Medical Conditions

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Personal Care Assistance Expenditures and Number of Recipients



Expenditures	\$7,644,571	\$8,300,667	\$13,664,74	\$38,917,14	\$64,400,28	\$79,185,39	\$83,253,62	\$77,419,16	\$72,113,88
Unduplicated Recipients	1448	1545	1945	2732	3540	3775	3982	3691	3459

Tr. Value from pg. 6/6.