AK LEGISLATURE FINANCE COMMITTEES FILES 2007-2008 3136

The Alaska Mental Health Trust Authority

The Trust coordinates planning for a comprehensive mental health program, makes recommendations to fund the program and advocates for funding and policies that support the systems serving its beneficiaries. Trust beneficiaries include people with mental illness, developmental disabilities, chronic alcoholism and Alzheimer's disease and related disorders. Along with its partner advisory boards, the AMHTA works to help Alaskans understand:

Our beneficiaries are families, friends, and neighbors –

They are Alaskans in our schools, churches and workplaces. They deserve the quality of care and level of service that will allow them to live as independently as possible. Healthy people are Alaska's most important natural resource.

Services make a difference –

An individual who receives appropriate services can live a fuller, more dignified life. We have made great strides in understanding the challenges facing Trust beneficiaries and how to better help them. Adequate services allow beneficiaries to become more self-sufficient, improving the quality of life for them, their families and communities.

Investment produces dividends –

Wisely investing resources today in early intervention and prevention helps people build healthy lives and decreases the prospect of more costly services in the future. Individuals, families, communities, and the state reap the dividends.

AMHB Advocacy Issues – how you can help us serve our beneficiaries

- Maintain service capacity and promote service quality, while working toward "no wrong door" service access
- Complete transition and sustainability funding for community services from federal grants to on-going funding
- Find resources to implement the Bring [And Keep] the Kids Home Initiative
- Build support for parity with other illnesses in health insurance coverage for mental health and substance use disorders
- Maintain the integrity of the Alaska Mental Health Trust framework while evaluating possible changes to serve Trust beneficiaries' best interests
- Revise statutes to permit individuals to retain their dignity, rather than submit to involuntary commitment, in cases in which transportation to another community to receive a mental health evaluation is necessary

For more information on AMHTA or its advisory boards, call or check these websites

Alaska Mental Health Trust Authority	907-269-7960 -- www.mhtrust.org
Advisory Board on Alcoholism and Drug Abuse	888-464-8920 -- www.hss.state.ak.us/abada
Alaska Commission on Aging	907-465-3250 -- www.alaskaaging.org
Alaska Mental Health Board	907-465-8920 -- www.hss.state.ak.us/amhb
Governor's Council on Disabilities and Special Education	907-269-8990 -- www.hss.state.ak.us/gcdse

Photo courtesy of Alaska Rainforest Sanctuary
Ketchikan, Alaska

Commercial Tourism Opportunities

Information

Maps and answers to general Mental Health Trust Land questions can be found at the Department of Natural Resources Public Information Offices.

DNR Public Information Offices
Northern Region, Fairbanks, (907) 451-2705
Southcentral Region, Anchorage, (907) 269-8400
Southeast Region, Juneau, (907) 465-3400

More specific questions can be directed to the Trust Land Office at (907) 269-8658, or email at **MHTLO@dnr.state.ak.us**.

Questions about The Trust can be directed to the Alaska Mental Health Trust Authority Office at (907) 269-7960, or *www.mhtrust.org*.

Trust Land Office
718 L Street, Suite 202
Anchorage, AK 99501
Tel: (907) 269-8658; Fax: (907) 269-8905
www.mhtrustland.org

Alaska Mental Health Trust Land Office
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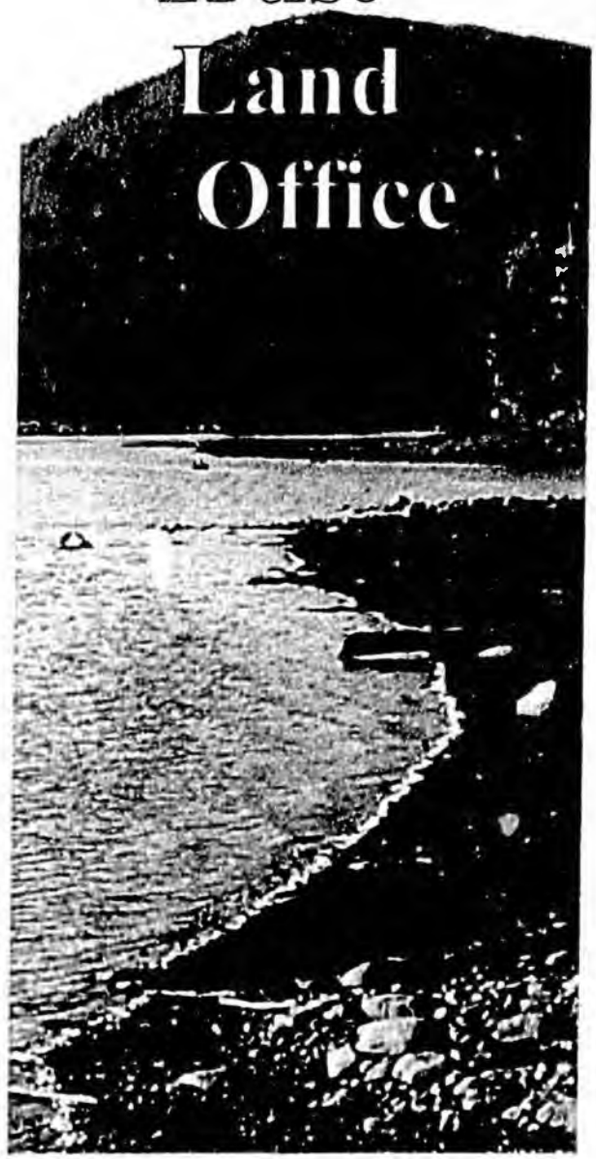
The Alaska Mental Health Trust

Trust Land Office



The Trust

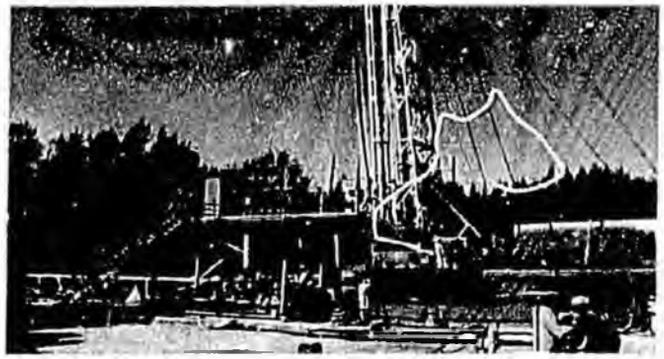
The *Alaska Mental Health Trust* was established by Congress in 1956. The 1956 law included a grant of one million acres of land to be used to generate revenues to meet the expenses of mental health programs in Alaska. In the mid-1980s a citizen lawsuit was filed claiming mismanagement of these lands. In 1994 the Alaska Superior Court and Alaska Legislature took actions that effectively settled the litigation. The settlement created the Alaska Mental Health Trust Authority whose responsibility is to ensure the creation of a comprehensive integrated mental health program for Alaska.

Trust Beneficiaries

Alaska Mental Health Trust beneficiaries include people with mental illness, people with developmental disabilities, people with chronic alcoholism, and people with Alzheimer's disease or related dementia.

Trust Land Office

The 1994 settlement reconstituted the Alaska Mental Health Trust and the related legislation transferred nearly one million acres of land to the Alaska Mental Health Trust Authority. It also required the creation of a separate unit within the Department of Natural Resources, the Trust Land Office. This office was established to manage the lands under contract to the Alaska Mental Health Trust Authority. Trust Land Office activities are funded from Alaska Mental Health Trust income, not the General Fund.



Oil & Gas Exploration

Trust Land Office Mission

The Trust Land Office manages Mental Health Trust Land to generate income that is used by the Alaska Mental Health Trust Authority to improve the lives and circumstances of Trust beneficiaries.

Trust Land Opportunities

- Real estate opportunities uniquely situated for residential and commercial activities, including opportunities for development related to recreation and tourism.
- A wealth of natural resources including: commercial timber, hard rock minerals, coal, oil and natural gas.
- An enthusiastic Trust Land Office staff, dedicated to generating revenues from Mental Health Trust Land.
- A flexible business-oriented decision making process that encourages creative and sensible projects.
- The knowledge that revenues generated from Mental Health Trust Lands go to improving the lives and circumstances of trust beneficiaries.

Real Estate Development

Timber Opportunities

Trust Land Office Management Guiding Principals

- Be loyal and accountable to the Alaska Mental Heath Trust and its beneficiaries.
- Maximize revenues from Trust Land and resource assets over time.
- Protect and enhance the value and productivity of Trust Land.
- Manage Trust Land prudently, efficiently and with accountability to The Trust and its beneficiaries.
- Encourage a diversity of revenue-producing uses of Trust Land.
- Emphasize innovative solutions.

History

Prior to statehood, the Territory of Alaska offered no services for individuals who experienced mental illness or developmental disabilities. Instead, the federal government sent these individuals to live in an institution in Portland, Oregon. During Alaska's transition to a state, Congress passed the Alaska Mental Health Enabling Act of 1956 to help bring these individuals home. This act transferred the responsibility for providing mental health services from the federal government to the Territory of Alaska and ultimately the State of Alaska, by creating the Alaska Mental Health Trust. To fund The Trust, the State selected one million prime acres of land that would generate income to pay for a comprehensive integrated mental health program.

Although the state legislature held a fiduciary responsibility to manage the land on behalf of Alaskans with mental illness, it did not do so. Instead, by 1982, only about 35 percent of the land remained in state ownership. The majority of the land had been transferred to individuals or municipalities, or designated by the legislature as forests, parks, or wildlife areas.

In 1982, Vern Weiss filed a lawsuit on behalf of his son, who required mental health services that were not available in Alaska. Other beneficiary groups joined Weiss v. State of Alaska in a class action suit. The case was ruled on in 1984 by the State Supreme Court, which ordered that the original trust be restored. Ten years later, in 1994, a final settlement reconstructed The Trust with 300,000 acres of original Trust land, 500,000 acres of replacement land and $200 million. The settlement established the independent Board of Trustees and defined Trust beneficiaries as people with mental illness, developmental disabilities, chronic alcoholism and Alzheimer's disease and related disorders.

Trustees

Dr. William Doolittle
Fairbanks
Chair

Laraine Derr
Juneau
Vice Chair; Finance Committee Chair

Margaret Lowe
Anchorage
Secretary Treasurer; Rural Outreach Committee Chair

Tom Hawkins
Anchorage
Resource Management Committee Chair

John Malone
Bethel
Program and Planning Committee Chair

Roy Huhndorf
Anchorage

Paula Easley
Anchorage

Trust Staff

Jeff Jessee	Chief Executive Officer
Delisa Culpepper	Chief Operating Officer
Marie Tinchlood	Chief Financial Officer
Marilyn McMillan	Budget Coordinator
Bill Herman	Program Officer
Nancy Burke	Program Officer
Steve Williams	Program Officer
Lucas Lind	Grants Administrator
Erika Wolter	Grants Program Manager
Jody Thomas	Administrative Manager
Keith Applegarth	IT Manager
Heather Atkinson	Administrative Support Specialist

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The TRUST

The Alaska Mental Health Trust Authority

- Vision and Mission
- Managing Trust Assets
- Advisors
- Comprehensive Integrated Mental Health Plan
- Budget Recommendations
- History
- Trustees / Staff

About The Trust

The Alaska Mental Health Trust Authority administers the Alaska Mental Health Trust, a combination of Alaska real estate and cash assets invested to help Alaska's most vulnerable citizens: people who experience a mental illness; developmental disability; chronic alcoholism; or Alzheimer's disease or related dementia.

The Trust is guided by a seven-member board of trustees appointed by the governor and confirmed by the legislature. Each year, the Trustees spend Trust income and recommend expenditures of state funds to pay for the Comprehensive Integrated Mental Health Program for Trust beneficiaries.

Vision and Mission

The Alaska Mental Health Trust Authority has a fiduciary responsibility to its beneficiaries to enhance and protect The Trust in perpetuity; to provide leadership in advocacy and planning; and in making recommendations for a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries.

The Trust is involved with issues such as affordable, safe housing; the disability justice system; workforce development; and, bringing kids home from out-of-state institutions.

Managing Trust Assets

The Trust employs the expertise of several organizations to manage its assets. The Mental Health Trust Land Office within the Alaska Department of Natural Resources manages its non-cash assets such as timber, minerals, and coal, oil, and gas development. The Alaska Permanent Fund Corporation and the Treasury Division, Alaska Department of Revenue manage the cash assets.

Advisors

Trustees work closely with several advocacy boards that represent Trust beneficiaries: the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Alaska Brain Injury Network and the Suicide Prevention Council. The commissioners of health and social services, natural resources, revenue, and corrections also provide important advice to Trustees.

Comprehensive Integrated Mental Health Plan

The Comprehensive Integrated Mental Health Plan provides policy direction to programs and services that serve beneficiaries of The Trust. The Department of Health and Social Services develops the plan in conjunction with The Trust.

Budget Recommendations

The Trustees approve budgets in two-year cycles, with annual recommendations to the governor and legislature. Trustees review the budget recommendations developed by focus area workgroups, state agencies, and four governor-appointed boards.

The Budget Recommendations Planning Process allocates significant resources each fiscal year. Current budget priorities include:

- Affordable, Appropriate Housing For Trust Beneficiaries
- Bring The Kids Home
- Justice For Persons With Disabilities
- Trust Beneficiary Group Initiatives
- Workforce Development

Budget Recommendations Planning Process (BRPP)

The Budget Recommendations Planning Process (BRPP) allocates significant resources annually. The Trust hopes to bring about significant changes in several focus areas.

- Affordable, Appropriate Housing for Trust Beneficiaries
- Bring The Kids Home
- Justice for Persons with Disabilities
- Trust Beneficiary Group Initiatives
- Workforce Development

The BRPP has been budgeted through FY2007. In January 2006 the BRPP began for FY2008 and FY2009 budgets.

Small projects funding

Three times each year: February 1, June 1, and October 1, The Trust awards small project grants (up to $10,000). These are projects solely administered by the Trust Authority and are funded with Trust income. Applications are available at www.mhtrust.org.

The bottom line - results

In establishing budgets, the Board of Trustees considers programs and services that will deliver results. By using a results-oriented budgeting approach, the Trustees focus funding on programs designed to develop cost savings and/or improved, and sustainable services for beneficiaries. Trustees also require a high level of reporting on projects funded within the GF/MH base, including multiple methods of accountability and performance measurements. This approach ensures cost effective services to improve the lives and circumstances of Trust beneficiaries.

The TRUST

The Alaska Mental Health Trust Authority

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The TRUST

The Alaska Mental Health Trust Authority

- **Our Mission**
- **Budget Recomendation Planning Process**
- **The Budget Process**
- **Small Projects Funding**

Who we are

The Alaska Mental Health Trust Authority (The Trust) occupies a unique niche in state government. The Trust provides leadership in shaping a Comprehensive Integrated Mental Health Program to help Alaska's most vulnerable citizens: people who experience a mental illness; chronic alcoholism; developmental disability; Alzheimer's disease or related dementia.

Our mission and how we operate

The Alaska Mental Health Trust Authority has a fiduciary responsibility to its beneficiaries to enhance and protect The Trust in perpetuity; to provide leadership in advocacy and planning; and in making recommendations for a Comprehensive Integrated Mental Health Program to improve the lives and circumstances of its beneficiaries.

The Trust is lead by a seven-member Board of Trustees, appointed by the Governor subject to legislative approval. To accomplish its mission, The Trust works in partnership with advisory groups, consumers and family members, various state agencies, the Governor's office, the Alaska Legislature, and private nonprofit service providers.

Budget Recommendation Planning Process

The Trustees approve budgets in two-year cycles, with annual recommendations to the governor and legislature. In shaping the Comprehensive Integrated Mental Health Program, the Trustees review the budget recommendations developed by focus area workgroups, state agencies, and four governor-appointed boards:

- Alaska Mental Health Board
- Advisory Board on Alcoholism and Drug Abuse
- Alaska Commission on Aging
- Governor's Council on Disabilities and Special Education

The budget process - a separate appropriation bill

As required by statute, The Trust forwards a proposed annual capital and operating budget to the governor and Legislative Budget and Audit committee for services to beneficiaries within the state Comprehensive Integrated Mental Health Program. The budgets include funds for preventive and early intervention services. The statute requires that this budget be identified in a separate appropriation bill. If the governor or the legislature changes this budget, they must explain the difference to the Trustees in writing.

The separate appropriations bill for the Comprehensive Integrated Mental Health Program includes several components:

1. General Fund/Mental Health Base (GF/MH Base) - This is the amount established by identifying the mental health services funded within the state's general fund budget. General funds are designated as general fund/mental health dollars, or GF/MH Base. The final budget from the previous fiscal year establishes the GF/MH Base.

2. GF/MH Increments - When the Trustees identify better and more cost efficient ways of providing ongoing services or providing for unmet needs, they make recommendations in the form of GF/MH increments, which are new GF/MH funds for the budget year.

3. Mental Health Trust Authority Authorized Receipts (MHTAAR) – The Trustees choose to have existing state agencies administer many projects funded by The Trust. These state agencies must have legislative approval to receive and spend Trust funds.

4. Capital Budget – The separate appropriations bill includes that portion of the state's capital budget that funds mental health projects. This often includes funds from the Alaska Housing Finance Corporation to provide housing for beneficiaries as part of the Comprehensive Integrated Mental Health Program.

Bring The Kids Home Initiative

offering a better outcome for families, the state, and the economy

executive summary

Every year, more than 700 Alaskan children get sent to out-of-state psychiatric institutions at state expense. They are torn from their families and their communities, sent to places that have no meaningful relationship with or understanding of Alaska, and housed for long periods of time at a cost of hundreds of dollars a day.

At any one time, more than 400 Alaska children up to 18 years old are in these institutions. Alaska pays the cost, and the children pay the price of losing touch with their families and communities. And the cost is staggering. In fiscal year 2005, the state paid almost $40 million for out-of-state care.

In theory, the kids who get sent out of state are children with mental health needs that cannot be met in their communities. In practice, there has been very little control over who gets sent where. Individual providers can decide that a child has needs that should be met in an out-of-state institution. Without any state oversight or control, these children can be sent to treatment facilities all over the country from Oregon to Texas.

Most appalling of all is that after one month out of state, these children automatically become eligible for Medicaid assistance. In other words, regardless of financial circumstances or need, the state steps in and pays for the care. Since there has been very little state supervision of these placements, and since the bills are getting paid regularly, it should come as no surprise that there can sometimes be little incentive to treat these children effectively and get them back home as soon as possible. It should also come as no surprise that the costs of treating children out of state has skyrocketed in recent years.

In 2003, Joel Gilbertson, then-commissioner of Health and Social Services, decided that this issue should become a priority. Working with the Alaska Mental Health Trust and tribal organizations, he began what has come to be known as the "Bring the Kids Home" initiative. For the last two years, a coalition of agencies, nonprofit organizations, local governments, parents and the Mental Health Trust has worked to figure out how to keep our children in state while still providing the care they need. This is one of the most complicated efforts The Trust has undertaken. It requires capital infrastructure development and work force development as well as system redesign.

The answer to this problem is not, as some seem to think, to build new inpatient psychiatric beds in Alaska and simply transfer these kids from one institution to

another. To the contrary, as we have analyzed who is getting sent away, we have been appalled to see that many children who are being treated in out-of-state residential facilities should never have been sent in the first place.

What they need is a level of care that can often be provided in their home communities. Instead of only building expensive, new hospitals to institutionalize children unnecessarily, we are building up the whole continuum of services that these children need, from in-home supports to foster and group homes.

Fortunately, the Legislature has also seen this as an area where we can be doing much better. The budget that recently passed includes both capital and operating funding to address this problem in a comprehensive and coherent way. However, creating a sensible program -- one that keeps both our precious children and our scarce state dollars here where they belong -- will take several years of sustained effort.

To replace the present inefficient system with something that works better, we need the involvement of school districts, Native health organizations, state and local government agencies, and both public and private care providers. If we do this correctly, we can save the state government money, create jobs in local communities, reinvest millions of dollars that now leave Alaska every year, and, most importantly, bring our children home, where they belong.

Jeff Jesse, CEO
Nelson Page, former Trustee
Alaska Mental Health Trust Authority

Published in the Anchorage Daily News, June 23, 2006

More Details about Bring the Kids Home

Bring the Kids Home: A focus area of the Mental Health Trust

In 2004, the Alaska Mental Health Trust Authority, in partnership with Governor Murkowski selected the Bring the Kids Home (BTKH) as a focus area for a multiple year effort. Beginning in FY06, the Trust invested about $2 million each year to address the problem.

The Trust is the only organization of its kind in Alaska dedicated to assisting those who experience mental illness; mental retardation or similar disabilities; chronic alcoholism with psychosis; or Alzheimer's disease or related dementia. The duties of The Trust are to:

- provide leadership in advocacy, planning, implementing, and funding of a comprehensive integrated mental health program
- coordinate with state agencies about programs that affect beneficiaries
- propose a budget for the state's comprehensive mental health program
- report to the legislature, governor, and the public about Trust activities

trends: out-of-state placement of severely emotionally disturbed children

Despite acknowledged problems, the practice of sending severely emotionally disturbed children out of Alaska for treatment has grown dramatically during the past several years, both in absolute terms and in relationship to in-state growth. From fiscal year 1998 through fiscal year 2003, in-state residential care grew by 145 percent, but the growth of out-of-state placements of Alaskan children in residential psychiatric treatment centers approached 700 percent. In other words, in recent years the rate of growth of out-of-state placements of severely emotionally disturbed children was well over four times the rate of growth of in-state placements.

The associated Medicaid reimbursement costs reflect an even more extreme overall rate of growth, as well as the imbalance between in-state and out-of-state residential treatment. Between fiscal year 1998 and fiscal year 2004, Medicaid expenditures for residential psychiatric treatment inside Alaska increased about 300 percent, while out-of-state placements experienced an overall increase of 1,300 percent!

However, it is important to point out that acknowledgement of the problem in the last two years, along with initial attempts to control it, appears to have had a positive effect. Between fiscal years 2004 and 2005, **in-state** Medicaid expenditures for residential psychiatric treatment increased by 20 percent, while comparable **out-of-state** Medicaid expenditures increased by only one

percent--the smallest annual increase since 1998. Nevertheless, hundreds of Alaskan children each year are still being shipped out-of-state for treatment, and tens of millions of dollars that could be working hard in Alaska are following the children out of state.

why is this happening?

To date, the processes of determining both the appropriate level of treatment, and determining where to send a child to receive that treatment, have been inconsistent. Any physician can advise a child's family that the child needs to be in any out-of-state residential psychiatric treatment center favored by the physician. Solely on the basis of that recommendation, the parents can put the child on a plane and fly him or her to a facility somewhere in the Lower-48 to be admitted.

There is a provision in Alaska that specifies that after 30 days in a residential psychiatric treatment center, any child can become Medicaid-eligible if the family petitions it and the state considers them seriously emotionally disturbed, regardless of the family's income. On the face of it this regulation may appear to be rather generous, but it was enacted on the basis of bitter and tragic experiences in the past. The rule evolved because there had been parents who were so desperate for residential treatment for their severely emotionally disturbed child and so incapable of paying for it despite not being eligible for Medicaid that they would give up custody of their children just so the child would be considered independent of the family and therefore be eligible for Medicaid. The rule is an expression of the state's desire to strengthen the family as a valuable resource, rather than to provide a bureaucratic impetus to break up the family.

However, the unintended consequence of this important provision is that the state had been, until recent legislation was passed, unable to review these cases prior to the physician's determination of need, prior to the selection of the out-of-state facility, and prior to the transport of the child to that facility. In other words, the state had no opportunity to assess required level of care, modality of care, or determine location of care until the child had arrived out of state. However if the child qualified, Alaska Medicaid is responsible for financial costs generated by the child's out-of-state treatment.

Solution: The Bring The Kids Home Initiative

The Bring The Kids Home initiative began as a partnership formed in 2004 between the Alaska Mental Health Trust Authority, the Alaska Department of Health and Social Services, the Denali Commission, and others. In 2005 the Alaska Mental Health Trust Authority trustees made the Bring The Kids Home initiative a high priority focus area. The goal of the initiative is to develop a continuum of care in Alaska for severely emotionally disturbed children, ranging

from home-based services to residential psychiatric treatment centers, so that the maximum number of children possible will receive services near their homes and families. The following long-term goals have been developed to guide the direction of the the Bring The Kids Home initiative:

- Develop and sustain the in-state community-based and residential capacity to serve children at appropriate levels of care in Alaska.
- Develop an integrated, seamless service system in Alaska that will allow children and youth to be served as close as possible to home in a culturally competent and least restrictive setting.
- Significantly reduce the existing numbers of children and youth in out-of-state care, and ensure that the future use of out-of-state facilities is kept to a minimum.

An important additional benefit of the initiative is that tens of millions of dollars currently spent out of state will be retained in Alaska, following the children who stay in Alaska to be supported in their own communities. The initiative supports the reinvestment of funding--which currently pays for out-of-state care--to in-state services in order to develop the capacity to serve children closer to home. The children and the Alaskan economy benefit from this strategy.

strategies for change

In order to accommodate the complex and interrelated nature of the Bring The Kids Home initiative, seven strategies for change have been identified to facilitate the organization and direction of the initiative:

1. Theoretical foundation - Articulate and communicate a formal theory of change and continue ongoing communication.

In the course of the discussions among the institutional partners and with the public during the last two or three years, core values and guiding principles have been established. The target population has been identified, and strategies to ameliorate the problems have been developed. All of this is reflected in the strategies that follow.

2. Strong family voice - Develop a strong family and youth voice in policy development, advocacy, family education and support, quality assurance, and evaluation.

The Trust has initiated an on-going Bring the Kids Home workgroup, composed of a wide variety of partners, meets quarterly. Part of the Trust's funding is used to transport youth and parents to these meetings. Additionally, the Trust Board meetings are open to the general public and typically reserve public comment opportunities in the agenda. In addition, The Trust has four governor-appointed advisory boards that are integrally involved in the work group and other Trust

planning. Consequently, the Bring The Kids Home initiative has been influenced by families and youth coming to these meetings to talk about what they have been experiencing, and to critically review current services and planned activities.

In acknowledgement of the fact the 40% of seriously emotionally disturbed youth are Alaska Native, the Trust has included Alaska Native behavioral health professionals from across the state in their regular workgroup planning meetings. The Trust pays their associated expenses to maximize participation. The Trust works with them to develop group homes and residential beds in their local communities. This effort has not been easy because everyone involved has multiple responsibilities, but all understand the value of having Native children treated in Native settings.

The collaboration is paying off. For example, Southcentral Foundation in Anchorage is proposing a $20 million, 44 bed facility in Eklutna. Services will be 100% Medicaid reimbursable since Alaska Natives are reimbursed at 100% federal dollars by Medicaid--the State of Alaska will not pay anything for the residential treatment of these children.

3. Policy and accountability - Examine financing and policy issues

Numerous public policies have been analyzed in terms of their current or potential relationship to the Bring The Kids Home initiative. For example Alaska's Certificate of Need facility review process was found to be central to the goals of the Bring The Kids Home initiative:

> The Certificate of Need (CON) program is a review process used to promote responsive health facility and service development, rational health planning, health care quality, access to health care, and health care cost containment. Project reviews help ensure that the public will be able to comment on the project during its development, that it fits well within the continuum of care, and that the project will meet the public need while preventing excessive, unnecessary, or duplicative development of facilities or services.

Out-of-state providers can see the early successes of the initiative, and are increasingly interested in developing new costly in-state residential psychiatric services, or expanding existing facilities. The Certificate of Need review process helps ensure that the system of treatment remains balanced with the right number of appropriate levels of care, and helps keep the focus on community-based and home-based care for these children. The Certificate of Need process helps provide the children with more appropriate care, and keeps costs down for the state.

4. Performance and quality assurance - Ensure that strong performance measurement and continuous quality improvement procedures are in place.

In the Division of Behavioral Health, staff gathers outcome data on a variety of processes that relate directly to the many components of Bring The Kids Home. indicators currently or prospectively include:

- a decrease in the number of children served in out-of-state residential psychiatric treatment centers
- an overall reduction in the residential psychiatric treatment center level of care
- a decrease in the length of stay for children in both residential and acute care settings
- a decrease in the number of children readmitted to residential care facilities
- an increase in the length of time between residential placements

5. Home and community-based services - Develop a wide range of accessible home and community-based services that reduce the need for Alaskan children to enter residential care, and ease transition back into the community for those in out-of-home care.

Using about $1.1 million from The Trust, a request for proposals was issued for home and community based capacity enhancements in summer 2005, to provide operational funding for therapeutic alternatives close to home for youth diagnosed as severely emotionally disturbed. In the first round in 2006 The Trust funded about 20 grantees. It's estimated to provide treatment for 193 new children, and add approximately 50 new beds in the first year. These new facilities are mostly group homes, but include some outpatient services.

Trust money is being used to finance startup costs such as the initial infrastructure and development of group homes. The provision of this startup money is very important because Medicaid will not reimburse until there are children in the facility. This initial funding is applied to facility modifications, the development of operating procedures, initial staff, and training. These startup tasks usually require a few months of support. Moreover, initially when children begin to be admitted into the facility, the admissions are accomplished in stages in order to make certain that the system is working correctly. The Division of Behavioral Health receives and manages these funds from The Trust.

In addition, utilizing Mental Health Trust Authority funding, the Department of Health and Social Services began a planning initiative to define and implement Individualized Service Agreements to ensure youth diagnosed as severely emotionally disturbed are provided services that are sometimes not eligible for Medicaid funding so that they may be served as close to their home and community as possible, providing clinically necessary services to avoid

unnecessary residential psychiatric care.

6. Work force development - Develop the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders.

Workforce development is an important and emerging area of activity for The Trust. The Trust is working closely with the University of Alaska to make sure that people are coming into the field and that they are being appropriately trained. Some of this training targets staffs who are currently working with kids, but whose skills can benefit from upgrading. In FY06, the Trust provided $500,000 to match the University commitment for behavioral health workforce development. A collaborative planning group composed of the various stakeholders periodically meets and keeps the process moving forward.

7. Assessment and Care Coordination - Develop "gate keeping" policies and practices, and implement regional networks to support children who would otherwise be in residential psychiatric care.

In past years there has been a committee that reviewed the case of every severely emotionally disturbed child in the custody of a public agency, for example Juvenile Justice. Because of this review process, the number of out-of-state placements across the years have been pretty level for the kids in custody, but, as explained previously, out-of-state placements of the non-custody children have skyrocketed in recent years.

There are three divisions within the Department Of Health and Social Services that typically have severely emotionally disturbed children in custody. These are the Alaska Division of Juvenile Justice, the Office of Children's Services, and the Division of Behavioral Health. Each of these agencies are responsible for a different group of kids, and each agency has a unique culture and process influencing how the children are reviewed and served. Until recently, these agencies were not efficiently coordinating their efforts regarding the review and disposition of severely emotionally disturbed children. Now with a higher level of collaboration and with the assistance of Trust and state funding, that is all changing.

Trust and state funding is creating Resource Committees that will review non-custody youth regarding their residential placement. This process will parallel the placement committee now in existence for custody youth. The funding has helped create three utilization review positions in the Division of Behavioral Health to assist in ensuring that all in-state resources are used prior to a young person being placed in an out-of-state Residential Psychiatric Treatment Center. The availability of an adequate number of utilization review staff ensures that the decision process happens in a timely manner for the children and the families, who are likely to be in a crisis situation. In addition, the

utilization process directs children who do not need residential care to a lower level of community-based care, or care in the home, which is better for the children, the families, and the state. If parents or practitioner disagree with the utilization review decision, the decision is referred to the resource committee for additional consideration.

the initiative is working

Due to the efforts of the partners in the Bring the Kids Home initiative, and due to the creative collaboration with some urban providers, the numbers of Alaska children placed out-of-state declined in FY05 for the first time. This is significant and clearly demonstrates that the initiative is working.

- After years of steady increases, the number of out-of-state Alaska youth not in state custody who are receiving Medicaid assistance for Residential Psychiatric Treatment decreased 7% between FY04 and FY05. At minimum the referral rate is leveling off. With additional in state service capacity to be implemented in FY07 and FY08 as a result of the initiative, this decline will continue.

- The escalation of costs has declined dramatically. Between FY98 and FY04 out-of-state Residential Psychiatric Treatment Center Medicaid expenditures increased 1,300%. However, between FY04 and FY05 out-of-state Residential Psychiatric Treatment Center Medicaid expenditures increased by only 1 percent — the smallest annual increase since 1998.

summary

"Instead of only building expensive, new hospitals to institutionalize children unnecessarily, we are building up the whole continuum of services that these children need, from in-home supports to foster and group homes." The evidence is in. The Bring The Kids Home initiative is beginning to work.

Bring the Kids Home Focus Area - FY08 State Budget Recommendations

	A	B	C	D	E	F	G
1	FY08 BUDGET RECOMMENDATIONS for Bring the Kids Home (BTKH) Focus Area	Dept./RDU	FY08 MHTAAR	FY08 Authority Grant	FY08 GF/MH	FY08 Denali Commission	FY08 Total
2	Strategy 1: Theory of change: Articulate a formal theory of change & ongoing communication.						
3	No funding for this strategy in FY08						$0
5							
6	Strategy 2: Strong family voice in policy development, peer support, advocacy						
7	BTKH Strong Family Voice: parent & youth involved via AMHB	DHSS/AMHB	$25,000				$0
8	Peer Navigators: funding to non-profits (parent and youth)	DHSS/SEDYth	$150,000		$200,000		$350,000
10							
11	Strategy 3: Examine financing & policy issues						
12	Regulations Planning for Therapeutic Foster Homes & Group Homes	DHSS/BHAdmin			$50,000		$50,000
15							
16	Strategy 4: Performance & QA measures Ensure strong performance measures/quality improvement.						
17	No funding for this strategy in FY08						$0
19							
20	Strategy 5: Home & community-based services Increase service capacity to reduce need for higher level of care						
21	Anchorage Crisis Stabilization - Funding for non-resourced youth (custody & non-custody)	DHSS/SEDYth	$100,000		$184,000		$284,000
22	Home & Comm-based Start Up Grants (continuation)	DHSS/SEDYth	$400,000		$250,000		$650,000
23	Expansion of school-based services capacity via grants	DHSS/SEDYth	$200,000		$250,000		$450,000
24	Tool kit development & expansion of school-based services capacity via contract	DHSS/BHAdmin	$100,000				$100,000
25	Comm Behavioral Health Centers outpatient grants, emergency residential, training	DHSS/SEDYth	$500,000		$2,000,000		$2,500,000
26	Early childhood comprehensive system grants (Birth to 8 yrs)	DHSS/ILPGrnts	$100,000				$100,000
27	BTKH Group Homes Denali Commission Funding (capital, not in state budget)	not in state budget				$2,000,000	$2,000,000
28	BTKH Group Homes GF/MH Match for Denali Commission funding (capital)	DHSS			$1,000,000		$1,000,000
30							
31	Strategy 6: Work force development Build the capacity and core competencies of in-state providers						
32	BTKH Training Academy - ongoing support (RSA to UA)	DHSS/BHAdmin			$200,000		$200,000
33	BTKH Residential Aides Training - ongoing support (RSA to UA)	DHSS/BHAdmin			$105,000		$105,000
34	SCF Eklutna RPTC Training Site in FY09	DHSS/BHAdmin					
36							
37	Strategy 7: Assessment & Care Coordination Develop "gate keeping" policies and practices and implement regional resource committees to divert kids from psychiatric residential care.						
38	Individualized Services	DHSS/SEDYth	$500,000		$700,000		$1,200,000
39	Level of Care Licensing Placeholder	DHSS/BHAdmin			$100,000		$100,000
40	SCF Eklutna RPTC Denali Commission Funding (capital, not in state budget)	not in state budget				$7,000,000	$7,000,000
41	SCF Eklutna RPTC GF/MH Match (capital)	DHSS			$7,000,000		$7,000,000
44							
45	BTKH Administrative Costs						
46	Face to Face Quarterly Meetings & Research (direct Authority grant)	DOR/AMHTA		$60,000			$60,000
48	Total by Fund Source		MHTAAR	Authority Grant	GF/MH	Other (Denali Commission)	Total Budget all Sources
49			$2,075,000	$60,000	$12,039,000	$9,000,000	$23,149,000

MAKING CONNECTIONS TO COMMUNITY

Community Transportation for Alaskans

Alaska Mental Health Trust
January 2007

Contents

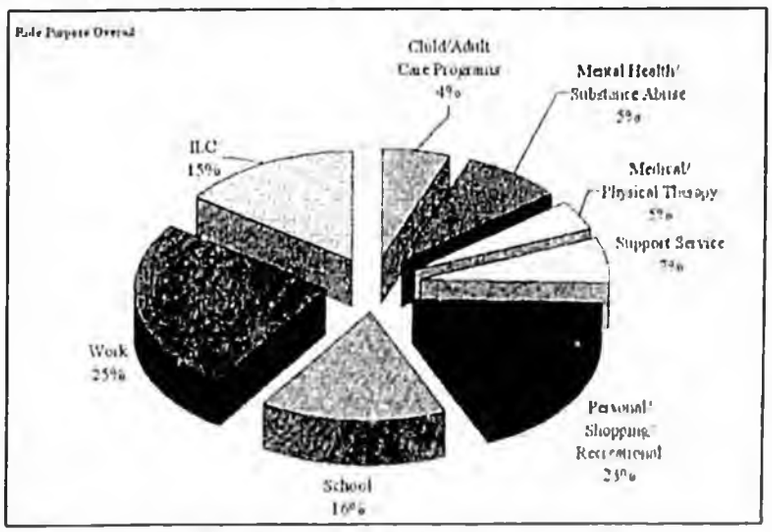
Executive Summary

Trust beneficiaries are among many thousands of Alaskans who struggle to make connections to work and community activities using inadequate or nonexistent public transportation systems.

- A survey by the U.S. Census Bureau estimated that 10 percent of households in Alaska have no vehicle.
- While the major community transportation systems in Alaska provided 6.1 million rides in 2005, few of Alaska's communities have coordinated ride systems that can accommodate the special needs of people with disabilities, the elderly or mentally ill passengers.
- In almost all cases, the limited hours of community transportation systems restrict work and other opportunities for Alaskans who do not drive.

Recent efforts to develop coordinated ride transportation systems have improved both services and the efficiency of door-to-door and point-to-point transportation in grant communities. These systems are saving money. Their experience of rapidly increasing demand indicates unmet need.

- Coordinated systems provide good models for communities in Alaska that are still developing ride services.
- The monthly number of rides provided by four core grant programs increased 180% between January 2001 and January 2004.
- Travel to and from work is one of the main ride purposes of passengers using CARTS, a brokerage model of coordinated transportation serving the Kenai Peninsula.



Source: Carts *See page 13 for more about this chart*

Riders, social service agencies and the community benefit when affordable, accessible point-to-point and door-to-door ride services are available.

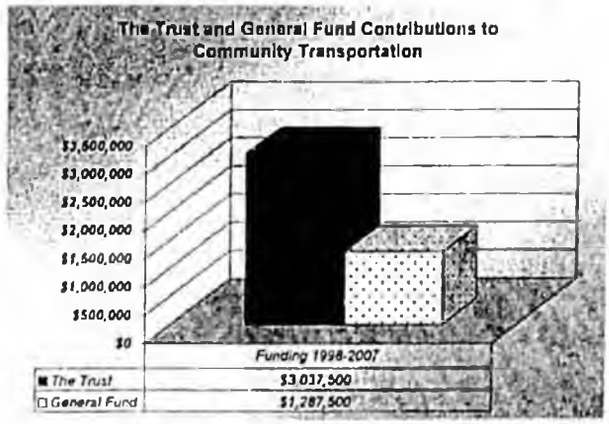
- Riders experience an increase in independence and mobility. Among other things,
  - Low-income riders are able to get to work and hold jobs
  - Beneficiaries make community connections that assist them in their recoveries.
- Senior citizens, people with disabilities, and others can access medical services.

Naomi McCarr, Senior Van Driver in Aleknagik, stands in front of the city's lift-equipped van. The Trust helped fund the van, which is used to transport elders and people with disabilities to medical appointments and other activities.

Photo courtesy of the City of Aleknagik and the Alaska Department of Transportation and Public Facilities

- Social service agencies find that transportation services increase the ability of clients to show up for appointments and stick to required programs.
- These systems save state and federal dollars by improving the efficiency of government programs, getting people into the workforce and coordinating resources of what have previously been separate human service transportation programs.

Community transportation systems need steady funding to meet capital and operating costs in order to provide service. However, they face an annual financial puzzle of shifting funding sources. Federal money requires a local match.



The Alaska Mental Health Trust has provided most of the match money that comes from state funds, though only about half of the riders for systems that receive its grants are beneficiaries. State general fund contributions have varied and have been low in recent years.

RECOMMENDATIONS:

- Establish a formal Community Transportation program at the Alaska Department of Transportation and Public Facilities. This program will provide planning assistance and funding for capital and operations expenses of community transportation programs.

- Provide on-going state funding for community transportation:
  - Seek an increase in federal highway funds received by Alaska that can be directed to community transportation, equivalent to **one percent** of total current federal highway funds received by the state. **(Estimated at $1 million)**
  - Increase state fuel taxes and/or vehicle registration fees, with a percentage to be directed to community transportation.
  - Appropriate General Fund dollars each year to provide ½ of the match funds required by federal programs and encourage completion of local community match funding. **(Recommended at $750,000 annually)**
- **Appropriate $1.8 million in FY 2008** from the state's general fund to assist with both capital and operating costs of the community transportation systems that provide door-to-door, and point-to-point transportation for Alaskans.
- Assist community transportation systems in stabilizing costs:
  - Direct the Division of Insurance to look into the feasibility of setting up a state-backed vehicle insurance pool similar to those in Washington and other states , with recommendations presented to the Alaska Legislature by April 30, 2007
  - As part of a statewide plan to help communities with high energy costs, include funding for community transportation providers, up to 25% of their total fuel budget or $150,000 per recognized provider.
  - Establish a Coordinated Transportation Task Force charged with identifying additional ways to coordinate existing resources and save state and federal dollars.

Community Transportation

Transportation is a basic necessity. We all need ways to get from one point to another in our communities. We need to get to work, to buy groceries or run errands, to get to the doctor's office, enjoy recreation, or participate in church or other community activities. Most of us can simply get in a car and drive to our destination.

"If I did not have CARTS I would not be able to get to work. I would not have a job."
--Bob Baxter, Kasilof

Those who don't drive in Alaska have had few options. Anchorage, Fairbanks and Juneau offer some regular public bus service on fixed routes. These communities and some others offer limited ride services with special vehicles that can accommodate people with disabilities. Still, there are many thousands of Alaskans throughout the state who do not drive and who have little or no access to affordable public transportation options. [1]

Included among these Alaskans are many of the beneficiaries of the Alaska Mental Health Trust Authority. The Trust operates on behalf of thousands of Alaskans with mental illness, a developmental disability, Alzheimer's disease and related dementia, or chronic alcoholism. Many of them are unable to drive but must have transportation to get to services and participate in their communities.

The ability of our beneficiaries to get to treatment, work and community activities is critical to their physical, mental and financial health. This is why The Trust has worked for nearly a decade with the Alaska Department of Transportation and Public Facilities and with dedicated Alaska residents and community organizations to support development of local coordinated community transportation options.

The term community transportation encompasses a variety of publicly-funded transportation options. This variety is necessary to meet different needs:

Public bus service provides transportation between specific stops on a regular schedule for those who are capable of using the service.

Paratransit vehicles are equipped with lifts and are otherwise set up to assist passengers with special physical needs.

Coordinated Transportation provides transportation through a collaboration of non-profit organizations that combine their vehicles, drivers and dispatch functions into a more efficient, collaborative system. In some communities these collaborative efforts may also provide some fixed route service for the general public.

[1] All comments are drawn from materials submitted in support of grant applications.

Paratransit and Coordinated Transportation may provide service as follows:

- **Dispatched point-to-point** small van service provides transportation for passengers between points defined by the passenger.
- In **door-to-door** service, drivers get out of their vehicles and assist passengers in getting to and into the vehicle.

Each community must decide what mix of services will make transportation accessible to riders in its area. The Trust has focused on assisting communities to develop transportation options for those who do not have access to or cannot normally use standard fixed route bus service because of their special needs. In the past individual organizations, such as a senior center or disability or mental health service organization may have offered some sort of point-to-point, or door-to-door ri'e service. The Trust has supported efforts by these organizations in recent years to work together to create coordinated transportation systems. This effort in Alaska is consistent with a federal effort to promote coordinated systems that help people with disabilities, lower income families, and seniors get the transportation they need for their daily activities. The Trust is also aware that there are many transportation needs that cannot be met within a coordinated system and has funded projects that meet specific needs that would be hard to fund given federal funding restrictions.

Who Needs Point-to-Point Public Transportation in Alaska?

There is a concerted effort underway to identify Alaskans who need coordinated transportation services, and the best options available for each community, as part of a federally-funded planning program. The "Coordinated Human Service Transportation Plan" is a new federal requirement that communities applying for funding must meet under the Safe Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users. SAFETEA-LU, as it is called, authorizes federal surface transportation programs for highways, highway safety, and transit for the 5-year period 2005-2009. The required plan must incorporate the following elements:

"Your cab partner with the Juneau Cab Company has served me all winter and without this program I would stay home and not be able to serve on Committees and to volunteer for many organizations." -- Connie Munro, ANS Camp 2 Health Committee Chair, Adult Education Volunteer, JAMHI Advocate (about SAIL program in Juneau)

- An assessment of transportation needs for individuals with disabilities, older adults, and persons with limited incomes;
- An inventory of available services that identifies areas of redundant service and gaps in service;
- Strategies to address the identified gaps in service;
- Identification of coordination actions to eliminate or reduce duplication in services and strategies for more efficient utilization of resources; and,
- Prioritization of implementation strategies.

But we don't need to wait for all of the details to know there is a great and growing need, in Alaska and around the nation. A 2005 report by the National Conference of State Legislators[2] detailed some of the statistics that support the call for ride assistance programs nationwide:

- The National Household Transportation Survey conducted by the U.S. Department of Transportation in 2001 found that more than 50 percent of non-drivers age 65 and older—or 3.6 million Americans—stay home on any given day in part because they lack transportation options.

- A 2002 AARP Survey found that 16 percent of respondents over age 75 reported not having a driver's license in 2001, and 25 percent had not driven at least once in the last month

- A National Organization on Disabilities survey found that 30 percent of respondents with disabilities had trouble accessing transportation, compared to 10 percent of respondents without disabilities.

[2] *Coordinated Human Service Transportation: State Legislative Approaches*, by Matt Sundeen, James B. Reed, and Melissa Savage; National Conference of State Legislatures, January 2005

- For those living at or below the poverty line, the costs to purchase, insure and maintain a car often are prohibitive. It is estimated that 90 percent of public assistance recipients do not own a car.

No one knows exactly how many Alaskans are unable to drive and need some form of community transportation. However, the 2004 American Community Survey by the U.S. Census Bureau found that 22,940 households in Alaska had no vehicle. That's 10 percent of households in Alaska. This high statistic is likely related to rural communities. Nationwide, 8.8 percent of households are without a vehicle. Even residents of households that have vehicles sometimes need to use community transportation.

Seniors are a significant part of the population needing door-to-door ride services. In 2004, more than 41,000 Alaskans were age 65 and older. A September 2006 report by the Institute of Social and Economic Research[3] on the contributions of older Alaskans noted that the percentage of seniors is growing in our population.

Trust beneficiaries make up just one significant population that uses existing transportation services and needs access to new and expanded services.

[1] *$1.5 billion a Year and Growing: Economic Contribution of Older Alaskans*, By Scott Goldsmith and Jane Angvik, September 2006, UA Research Summary No. 7, Institute of Social and Economic Research, University of Alaska Anchorage

Community Transportation Systems in Alaska

Anchorage, Fairbanks, Juneau and Ketchikan have public buses that run fixed routes and also offer limited door-to-door service with lift-equipped vans for special needs passengers. Kodiak, Mat-Su, Central Kenai Peninsula and Sitka have coordinated systems run by nonprofit groups. These four coordinated systems have seen tremendous growth. By January 2004, they were providing 180% more rides in that month – 24,955 individual rides-- than they did in the baseline month of January 2001[2]. The major community transportation systems in Alaska, all types together, provided 6.1 million rides in 2005 (see chart on page 12) . While these systems are providing a tremendous service, the Alaska Mobility Coalition, an advocacy group of providers and consumers working to increase community transportation, has identified many needs that remain unmet. Among these needs are more point-to-point and door-to-door services that can accommodate special needs passengers, and the extension of service hours to include more hours in the evenings and on weekends.

Although churches, senior centers and civic groups may offer some rides in both urban and rural communities in Alaska, the need is far greater than they can meet. Most communities in Alaska are still working on transportation solutions for their residents.

As part of its contribution toward a solution, The Trust has funded more than 90 community transportation projects since 1998. The community leaders who have undertaken these projects have demonstrated innovative thinking and cooperative action. In a number of communities one organization has taken on the primary responsibility of coordinating ride services and the available vehicle resources to meet ride needs. Below is a sampling of some of the approaches taken by organizations focused on coordinating ride services:

Kodiak Area Transit System's (KATS) is run by the Senior Citizens of Kodiak. KATS provides rides to Trust beneficiaries, senior citizens and people with disabilities, and also allows nonprofit groups to purchase rides. Rides are free to those who qualify, but riders are encouraged to contribute $2.00 per ride. The system began providing coordinated transportation in 2000 in a borough that has a population of approximately 13,638. It serves about 719 riders per year and provides about 1256 rides per month. The current KATS schedule does not provide services after 6:30 p.m. and offers only limited trips to locations outside of the city limits.

Mat-Su Community Transportation (MASCOT) serves the Matanuska-Susitna borough area, with a population of 67,473. It provides fixed route transport from point-to-point with stops at local senior centers, medical centers, shopping areas, employment and childcare centers, and social service agencies. It also provides on-demand service to link to its fixed route transportation, door-to-door paratransit services and provides low-cost or shared resource transportation to nonprofit agencies, including The Boys and Girls Club of Mat-Su and Special Olympics.

Southeast Alaska Independent Living (SAIL) provides consumer-directed services to more than 500 people of all ages who experience any significant disability. Sail leases a 2004 lift-equipped Ford to Juneau Taxi and Tours as the only accessible, on-demand transportation available in Juneau. SAIL leases the vehicle at no cost, screens individuals for eligibility and sells tokens for the program.

The Trust has also funded many village projects; these projects are often for specific needs in areas where coordinated transportation is needed but difficult to provide. Many rural communities have an old and a new town site separated by several miles. The community coordinates rides for Trust beneficiaries, elderly and people with disabilities. One example is the purchase of a van that meets accessibility standards of the Americans with Disabilities Act for use in transporting elders and people with disabilities in Aleknagik. Aleknagik is a short boat ride and about 25 road miles from Dillingham where most services are located. The van is operated by the Senior Center. Previously, they used a minivan which was too small, wasn't accessible, and did not have the clearance needed to safely navigate snowy roads.

CARTS – A Successful Brokerage Model

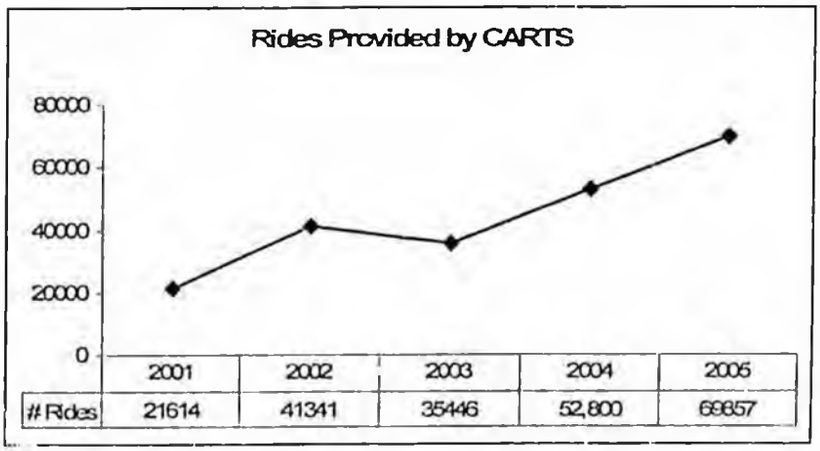
Central Area Rural Transit System, Inc., (CARTS) is a nonprofit that provides a community-based coordinated brokerage system to get rides to the people who need them living in Kenai, Soldotna, Sterling, Nikiski and Kasilof. Total population in the service area is about 38,000.

"I am a single mother and cannot afford a car at this time; the transit system (CARTS) has helped tremendously in being more independent for me and not relying on others to cut their schedule to help me."
--Carol Dawson, Soldotna

Based in Soldotna, CARTS began offering rides in October 2000, but there had already been two years of cooperative community planning for the new organization. The participation of many local organizations and businesses, facilitation of planning efforts by the Alaska Department of Transportation & Public Facilities, and the Community Transportation Association of America, funding from The Trust and $500,000 in earmarked federal funding all helped jumpstart the organization's ride services. The organization grew quickly and continues to grow.

Reflecting the unmet need, the number of rides provided by the CARTS system more than tripled in its first five years of operation and is expected to grow in the years ahead.

Today, CARTS provides the financial, administrative and training coordination necessary to offer more than 50,000 door-to-door rides each year, and has more than 1,600 riders using the service. Riders have included Trust beneficiaries, senior citizens, welfare recipients, students, children traveling to after-schooi programs, and the general public. Rides to get to and from work are available 24 hours a day, seven days a week, and available from 7 a.m. to 11 p.m. during weekdays for other purposes.



Data Source: CARTS

CARTS owns seven vehicles, including lift-equipped wheelchair-accessible vehicles, and contracts with both nonprofit and for-profit companies to deliver rides.

Riders pre-purchase punch cards or have punch cards purchased for them from CARTS and cooperating organizations, so no money exchanges hands with drivers. The organizations save money by not needing vehicles, drivers and dispatchers. Riders pay $2.50 per zone in a thirteen zone area. Riders must reserve their ride the day before and be prepared to leave 15 minutes before or after their reserved time.

"This program provides transportation to those in need...be it, because they have no car, are unable to drive, weather making driving a real hazard for them to be on the roads, they are too young to drive yet have a need to be at school or to an event at a time when parents are working, a need to be at a doctor or dental appointment or some place for therapy ...and the list goes on!"
--Jane Stein, President of the Board of Directors, Bridges Community Resource Network, Inc.

CARTS works closely with other nonprofits to meet ride needs. For instance, The Kenai Independent Living Center (ILC) provides ride services under contract with CARTS by purchasing vouchers from cab companies for discounted rides.

CARTS has been a tremendous success, and continues to develop ways to meet the as-yet unmet needs in its area. It provides one strong model for other communities considering the best way to coordinate rides in their areas. Each community, however, must decide what system of potential services will work best for them.

ALASKA'S MAJOR COMMUNITY TRANSPORTATION SYSTEMS

System	Communities Served	2005 Ride Estimates	Unmet Needs
Anchorage Transportation System, i.e. People Mover, Anchor Rides, and Van Pools†	Anchorage Bowl, Eagle River/ Chugiak	3,975,074 fixed route; 183,590 paratransit; 4,250 van pools; **4,162,914 total**	People Mover - More frequent routes; earlier and later hours; Girdwood; AnchorRIDES – expanded hours; lower fares; consistent service; Vanpools – waiting list; vehicles.
Capital Transit and Care-a-Van†	Juneau, Douglas	1,125,23 fixed route; 33,019 paratransit; **1,158,250 total**	Extended service area for paratransit and deviated route service. Increased capacity for fixed route.
MACS and VanTran†	Fairbanks, North Pole	399,000 fixed route; 22,000 paratransit; **421,000 total**	Extended hours; shorter headway; new routes; Park 'n Ride service
The BUS and Senior Van†	Ketchikan	150,985 fixed route; 13,470 paratransit; **164,455 total**	Extended service area for paratransit and fixed route.
Community RIDE and Senior Van‡	Sitka	22,211 fixed route; 17,712 paratransit; **39,923 total**	Weekend service, evening service, extended route coverage.
MASCOT‡	Wasilla, Palmer	**65,000 total**	Knik, Fairview, Houston, Big Lake, Willow, Talkeetna Sutton, Chickaloon, Butte
CARTS‡	Central Kenai Peninsula	**69,857 total**	Homer, Seward and all points in between
KATS‡	Kodiak	**13,348 total**	Weekend and evening paratransit service; public transit system; vehicles
Total Rides Provided in 2005		**6,094,747**	

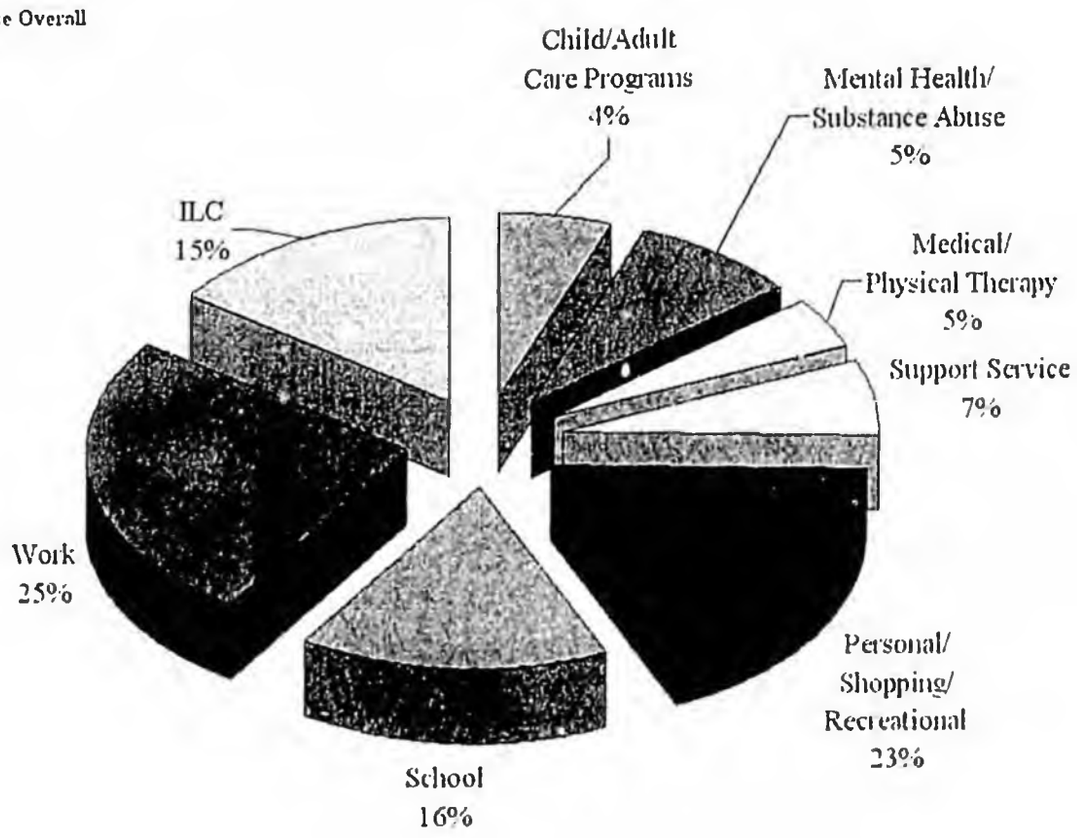
† Traditional government-run bus system with contracted paratransit system.
‡ Community non-profit run system

Source: Alaska Mobility Coalition

Who's Riding and Where are They Going?

According to reporting by the grantees, about half of the riders on community transportation systems that have been funded in part by The Trust are Trust beneficiaries. Senior citizens, people with disabilities, low-income workers, patients, children transported to child care, youth transported to after-school programs and the general public are among the other riders.

Clients of community transportation systems use the ride service for typical daily activities. Key among them is getting to work. The chart below shows the purpose of rides reported by Central Area Rapid Transit, Inc. (CARTS), which serves communities on the Kenai Peninsula.



Source: Central Area Rapid Transit, Inc. (Note: ILC stands for the Independent Living Center. The specific purpose of rides originating from the ILC was not reported, but they likely parallel the other usages listed in this pie chart).

Benefits of Community Transportation

Mobility is a great part of quality of life and productivity. Access to work and health services and participation in the community can prevent illness, poverty, isolation and premature institutionalization. It helps people with disabilities to be more meaningfully engaged, with transportation to jobs, recreational pursuits, health care and recovery support. Making connections within their communities and being able to work improves the health and well-being of Alaska's residents.

Riders experience an increase in independence and mobility. Among other things,

- Low-income riders are able to get to work and hold jobs.
- Beneficiaries make community connections that assist them in their recoveries.
- Senior citizens and other riders are able to better access medical and other services.

But the individuals who receive rides through community transportation systems are not the only ones who benefit. The local economy and the community in general also benefit by the more active participation of these individuals.

- Social service agencies find that transportation services increase the ability of clients to show up for appointments and stick to required programs.
- These systems save state and federal dollars by improving the efficiency of government programs, getting people into the workforce, and coordinating resources of what have previously been separate human service transportation programs.

State and federal programs benefit as community transportation helps to reduce costs of providing services, and makes those services more effective. In the past, some service agencies have had to own their own vehicles and hire drivers or pay high costs for taxi or even ambulance services to transport clients with special needs because coordinated community transportation services were not available. Other agencies are finding that the availability of transportation to their clients improves the delivery of services.

These excerpts from letters of support submitted with grant applications make clear that coordinated transportation benefits a wide range of community interests:

> *"As Homeless Liaison for the school district, I arrange transportation for homeless children and youth to their schools of origin. With situations where bus transportation is not readily available, I rely on CARTS' dependable transit system to transport these students to and from school. I often recommend After the Bell or Boys and Girls Club to assist homeless students with their homework. The availability of CARTS during after school hours has been invaluable to these kids."-- Karen Ruebsamen, Homeless Liaison, Kenai Peninsula Borough School District*

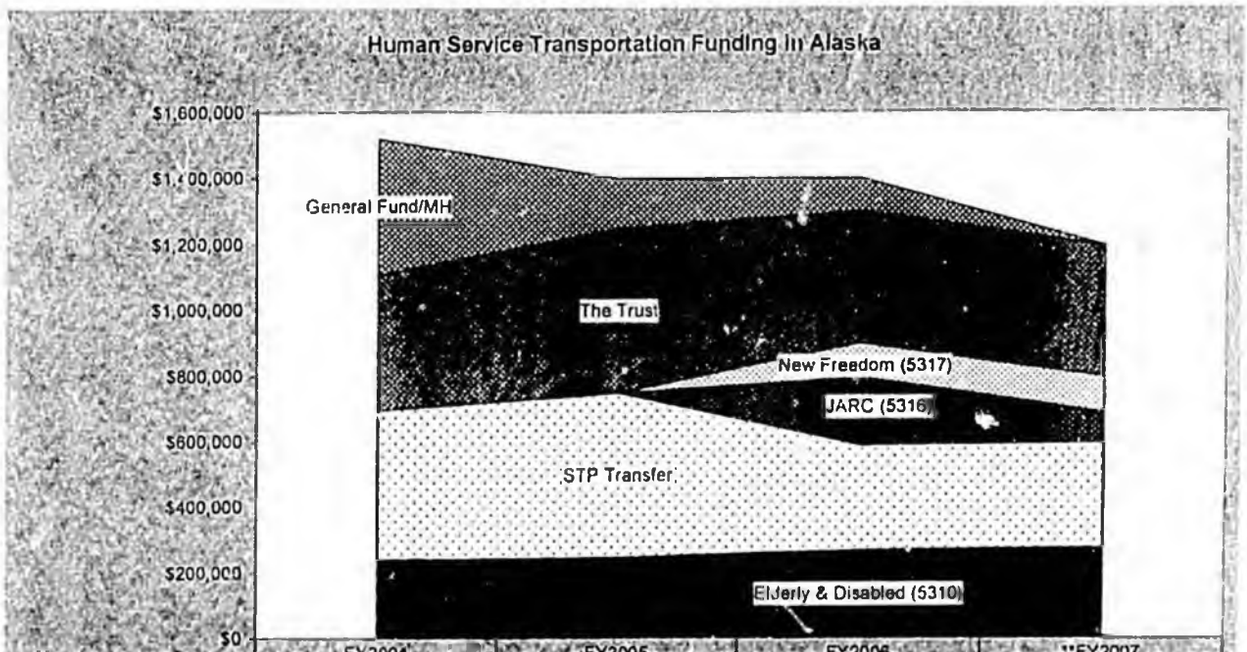
> *"Without CARTS, a large number of our clients would not be able to find cost effective transportation. CARTS is an instrumental factor in more clients being able to seek and find employment. Without CARTS, our clients may not be able to afford rides to work and could ultimately return to the welfare roles." -- Susan Lacey, Work Services Supervisor, State of Alaska Department of Labor & Workforce Development, Employment Security Division, Work Services*

"Senior Citizens of Kodiak, Inc. provides over 90 rides per day to people in our community who need it the most; seniors, nursing home residents, adult day participants, and mental health trust beneficiaries as well as those going to work, doctor's appointments, food bank, physical therapy, shopping, and other appointments that are necessary for people to have a viable income and be healthy. KATS has been in operation as a coordinated system since August 2000. The system is vital for those who have no other means of transportation. More than 14 different local non-profit agencies use KATS for their clients. These services are vital to ensure dignity and independence for those who depend upon this service in Kodiak." -- Jerome M. Selby, Mayor, Kodiak Island Borough

"As the Director of Vocational Rehabilitation for the State, my Counselors work with individuals who experience difficulty in securing meaningful employment because they live outside the Para-transit boundaries. They have also worked with individuals with disabilities who have not been able to consider certain employment opportunities because the proposed shift ends later in the evening than the last mass transit and Para-transit bus. Another situation is the individual who misses the bus on the way to work. On-demand transportation is key in these situations and may be the difference in keeping or losing a job." Gale Sinnott, Director, Division of Vocational Rehabilitation, State of Alaska Department of Labor and Workforce Development (regarding SAIL program in Juneau)

Funding for Community Transportation

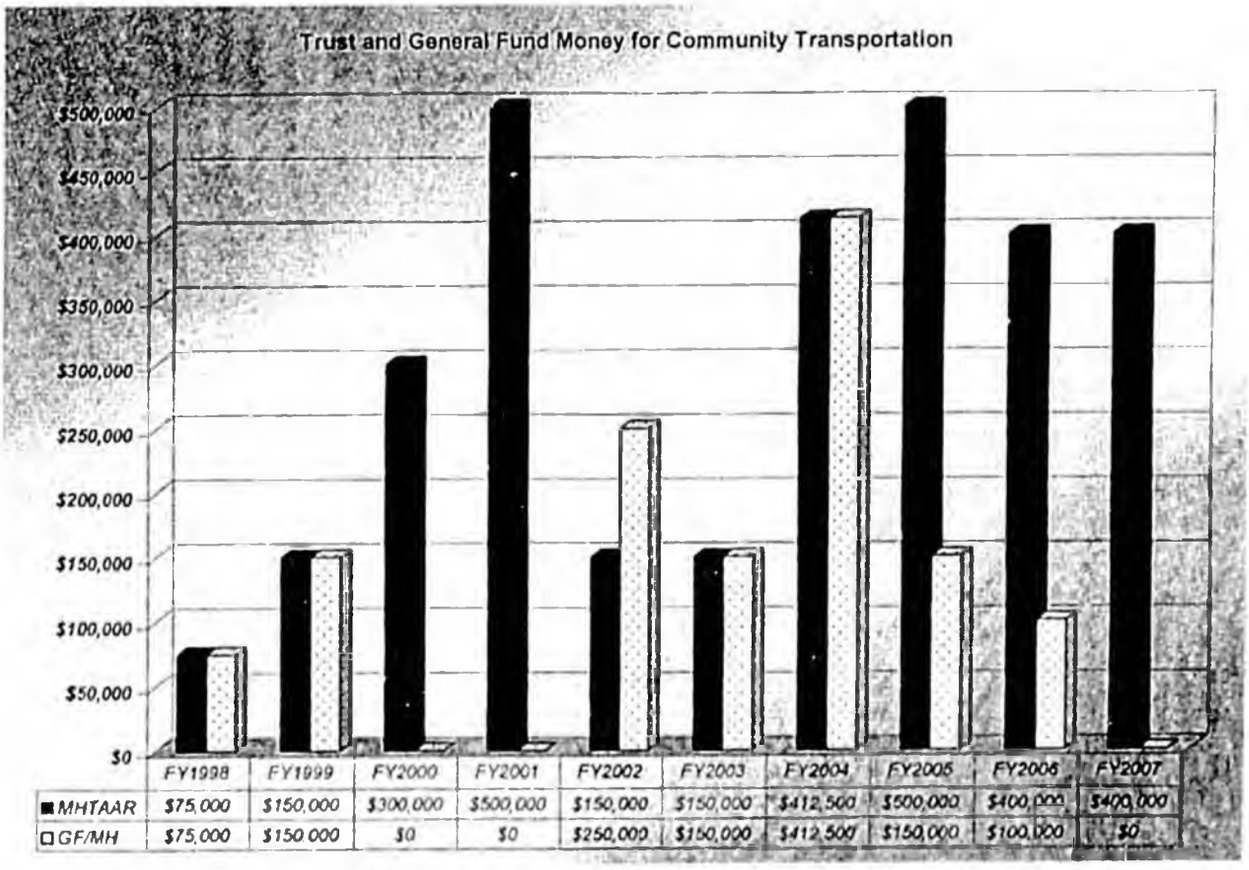
Funding for Alaska's fledgling community transportation systems has come primarily from federal dollars matched with money provided by The Trust and local governments, the Rasmuson Foundation, nonprofits and service programs, and fees paid by riders. Government and Trust funding is coordinated and administered by the Division of Program Development in the Alaska Department of Transportation & Public Facilities (DOT&PF). The federal dollars come with various restrictions and require match money. The shifting funding picture has meant that each year these systems have to put together budgets to fund basic equipment and operations from a shifting funding puzzle. Long-term planning is difficult without a stable funding stream.



	FY2004	FY2005	FY2006	**FY2007
General Fund/MH	$412,500	$150,000	$100,000	$0
The Trust	$412,500	$500,000	$400,000	$400,000
New Freedom (5317)	$0	$0	$104,035	$108,264
JARC (5316)	$0	$0	$207,503	$93,000
STP Transfer	$454,850	$500,300	$318,400	$318,400
Elderly & Disabled (5310)	$239,902	$245,633	267,371	$278,000

** FY2007 numbers are estimated. The New Freedom (5317), Job Access and Reverse Commute (5316), and Elderly and Disabled (5310) are federal human service transportation grant programs. STP Transfer is Alaska Federal Highway Administration Funding transferred from the Surface Transportation Program into the Section 5310 program.. The Trust and General Fund/MH are State of Alaska funding used to match and provide flexibility for funding special needs. This chart does not include funding received under the federal Rural Areas (5311) program. *Data Source: Alaska Department of Transportation and Public Facilities*

Monies from The Trust and the State of Alaska's General Fund/Mental Health budget have been used to provide match funding for the federal program funds. Unfortunately, General Fund money has been low and inconsistent in addressing the community transportation needs in Alaska. Meanwhile, needs go unmet. Alaska communities submitted grant requests for the available human service transportation monies in FY2006 of $3,166,346 but many were not funded because only $1,291,169 was available.



	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
MHTAAR	$75,000	$150,000	$300,000	$500,000	$150,000	$150,000	$412,500	$500,000	$400,000	$400,000
GF/MH	$75,000	$150,000	$0	$0	$250,000	$150,000	$412,500	$150,000	$100,000	$0

Data Source: Alaska Mental Health Trust

More dollars are needed that can be used to fund the unique but appropriate solutions to transportation challenges that face Alaska's communities. Many rural hub communities are considering coordinated systems to meet their transportation needs more efficiently. Rural villages are desiring coordinated vehicles to ensure disadvantaged persons and people with disabilities are not home bound.

Funding shifted in a mostly positive direction in 2005 when Congress passed SAFETEA-LU. Funding has been increased for some program sources that may be used to support coordinated community transportation with fixed route systems, noticeably the Rural Areas (5311) program. However, funding for other programs, including the Job Access and Reverse Commute Program is reduced for Alaska under the SAFETEA-LU legislation.

The shift emphasizes a fundamental challenge that continues to face those trying to develop community transportation systems. These systems need to be able to rely on a steady stream of

funding in order to maintain vehicle fleets and organizational structure. Each year, they have been faced with scrambling to find different puzzle pieces to create a complete financial picture that will cover costs. The funding stream must be stabilized.

The new SAFETEA-LU funding provides an opportunity to stabilize funding for Alaska's community transportation systems, if the State of Alaska is willing to commit General Fund dollars and partner on the required match to develop a statewide community transportation program.

The need to address funding is heightened this year because the Alaska Public Transportation Management System (APTMS) plan is being updated. This plan provides a listing of vehicles used by organizations to transport the public, or for special transportation (private-non-profit organization) needs. The database lists each vehicle, the mileage, condition, expected replacement date, and replacement cost.

The Trust is confident that significant new capital needs will be revealed upon completion of this plan, as they were when the last plan was completed. There are many communities that are just beginning to develop systems. Existing systems need to replace aging vehicles and meet increasing demand for services.

In addition to capital needs, fuel costs have been skyrocketing and insurance and other costs can increase in unpredictable ways. Community transportation administrators are seeking ways to control and offset these costs while maintaining services. Stabilizing costs and funding for these systems is critical to their continued success and to the success of new systems which are being developed in other Alaska communities.

Conclusion and Recommendations

Alaska's community transportation systems are taking on the challenge of meeting an enormous need and are, in the process, creating greater efficiency in the provision of ride services; they are leveraging community resources to enhance a variety of service programs. Amid the shifting funding picture, they are keeping vehicles running, assuring safe transportation for vulnerable riders. These systems have proven their worth. They deserve support from state government in the form of a match to federal and Trust funding for their efforts to meet the needs of tens of thousands of Alaskans. These fledgling systems need assistance with planning and funding that will help to stabilize their financial position.

The Trust and its partners recommend that the Governor of Alaska and Alaska Legislature take the following actions:

Recommendation: Establish a formal Community Transportation program at the Alaska Department of Transportation & Public Facilities. This program will provide planning assistance to communities and funding for capital and operations expenses of community transportation programs.

Explanation: The Department of Transportation and Public Facilities had been engaged in this effort for some time. Naming a formal program will improve the state's focus on developing Alaska's community transportation systems.

- **Recommendation:** Provide on-going state funding for community transportation (Department of Transportation & Public Facilities and the Alaska Legislature).
  - Seek an increase in federal highway funds received by Alaska that can be directed to community transportation, equivalent to one percent of total current federal highway funds received by the state. **(Estimated at about $1 million)**
  - Increase state fuel taxes and/or vehicle registration fees, with a percentage to be directed to community transportation
  - Appropriate General Fund dollars each year to provide ½ of the match funds required by federal programs and encourage completion of local community match funding. **($750,000 annually)**

Explanation: The 10 percent of households in Alaska that do not have a vehicle cannot use the roads that are built unless there is community transportation that gives them access to transportation. It's estimated that 1% of federal highway dollars that come to Alaska would amount to what it would cost to build about 20 miles of road. This seems a small amount to allocate to the transportation needs of those who must rely on community transportation to be able to use roads in Alaska. It will help to provide a solid base for community transportation.

Recommendation: Appropriate $1.8 million in FY 2008 from the state's general fund to assist with both capital costs of the community transportation systems that provide door-to-door and point-to-point transportation for Alaskans.

Explanation: Alaska's community transportation systems have continuing and compelling capital and operating costs. $1.8 million from the general fund in this next fiscal year would provide a catch-up match to contributions made by The Trust to community transportation. Since only about half of the riders of systems funded by The Trust are beneficiaries, it would be fair for the state to contribute this share on behalf of the other riders.

Recommendation: Assist community transportation systems in stabilizing costs.

- Direct the Division of Insurance to look into the feasibility of setting up a state-backed vehicle insurance pool similar to those in Washington and other states, with recommendations presented to the Alaska Legislature by April 30, 2007.

- As part of a statewide plan to help communities with high energy costs, include funding for community transportation providers, up to 25% of their total fuel budget or $150,000 per recognized provider.

- Establish a Coordinated Transportation Task Force charged with identifying additional ways to coordinate existing resources and save state and federal dollars.

Thousands of Alaskans are Homeless.

- 3,500 Alaskans are homeless on any given night, including 1,600 people in families with children.
- 4,000 Alaskan households are on the waiting list for public housing programs—most are families with children.
- 20,000 low-income Alaskan households spend over half their income on housing, placing them at risk of homelessness.

A recent statewide public opinion survey found that 90% of Alaskans agree that "it is only fair that everyone has access to a decent place to live" and 89% agree that "we have a responsibility to help people who need a place to live."

Problem: Lack of Focus

- Federal programs are not adequately focused on housing for the poorest Alaskans; these programs are the primary source of current housing assistance.
- Current housing programs are not well connected to necessary supportive services (e.g. case management, tenant education).

Solution: The Alaska Housing Trust

- Create a fund at the Alaska Housing Finance Corporation (AHFC) using an appropriation of state general funds.
- Leverage the fund to implement our strategic mission: develop housing for homeless Alaskans and those struggling to stay in their homes.
- Invest in permanently affordable housing. Community Land Trust models and other creative approaches can be used to assist Alaskan families.
- Provide supportive services that prevent homelessness and increase housing retention.
- Serve as a catalyst to pull other funding sources together to move families out of homelessness.
- Encourage innovative ideas and entrepreneurial partnerships.

ALASKA HOUSING TRUST

Opportunity
begins with a home

Benefits: Families, Communities and All Alaskans

- A stable home promotes community stability. When families are more invested in their neighborhoods, they increase their civic participation.
- By moving people from homelessness to permanent housing, Alaska can reduce the amount of public funding it would otherwise use.
- Safe, stable and affordable housing promotes strong families:
  - Children become more successful in school
  - Families have a foundation to grow their dreams
  - Seniors and persons with disabilities can live with independence and dignity

Implementation: Accountability and Results

- Alaska Council on the Homeless will develop an annual housing trust fund plan, advise on allocation of fund resources, and report results annually.

For more information about the Alaska Housing Trust visit [illegible]

ALASKA HOUSING TRUST

Opportunity begins with a home

The Alaska Housing Trust: Preventing and ending homelessness in Alaska

Q: How many Alaskans are homeless?

A: Estimates vary; a recent AHFC survey indicated nearly 3,500 Alaskans are homeless on any given night.[1] The Alaska Department of Education and Early Development, which counts children only, reported that more than 3,000 children were homeless or inadequately housed at some time during the 2005-06 school year.[2] Over the last six years, an average of 68 discharges a year from Alaska Psychiatric Institute have led to homeless status.[3] A 2005 Department of Corrections Homeless Offender survey found that 35% of offenders did not know where they would live upon release or planned to live in a shelter or on the street.[4]

Q: How many Alaskans are at risk of homelessness?

A: 20,000 low-income Alaskan households spend more than 50% of their income on housing costs, placing them at risk of homelessness.[5]

Q: Why are so many Alaskans homeless?

A: Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Contributing factors include:

- ***Inadequate income.*** A 2001 study found 57% of Alaska households could not afford a median priced home and 46% could not afford the average rent.[6] Today in Alaska, a person needs to earn $17.05 per hour to afford a modest two-bedroom apartment at the average fair market rent of $905.[7]
- ***Inadequate supply of affordable housing.*** The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is nearly 4,000 households.[8]
- ***Catastrophic events and destabilizing forces.*** A sudden economic downturn caused by illness, injury, divorce or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.
- ***Insufficient supportive services.*** In Alaska, homeless prevention and housing retention services are not generally available.

Opportunity begins with a home

Q: Who is homeless?

A: In Alaska, families with children are the largest sector.[9] Of all homeless Alaskans:

- 45% are persons in families with children
- 15% are victims of domestic violence
- 9% are veterans
- 14% are severely mentally ill
- 24% suffer from chronic substance abuse problems
- 16% are chronically homeless[10]

(Some homeless individuals are counted in more than one category.)

Q: What does homelessness cost Alaska?

A: Data is not available to precisely answer this question. However, the University of California San Diego Medical Center found that, over 18 months, 15 chronically homeless inebriates were treated at the hospital's emergency room 417 times, running up bills that averaged $100,000 each.[11] In Asheville, North Carolina, it was discovered that just 37 homeless men and women generated $278,000 in jail costs over a three-year period.[12]

Q: What is a Housing Trust?

A: A housing trust is a pool of funds earmarked to provide for the housing needs of low-income families and individuals. More than 30 states have housing trusts. Experience shows that state housing trust funds are more innovative and move quicker than federal programs to address local issues. On average, each dollar spent by a state housing trust leverages $9.25 in additional funding for housing.[13]

Q: What will be the mission of Alaska's Housing Trust?

A: To reduce homelessness through the creation and retention of an adequate supply of affordable, long-term housing.

Q: What will be the benefits?

A: Safe, stable and affordable housing promotes strong families:

- Children are more successful in school
- Families have a foundation on which to build their dreams
- Seniors and persons with disabilities can live with independence and dignity

Home ownership promotes community stability—families are more invested in their neighborhoods and increase their civic participation. Moving people from homelessness to permanent housing reduces the amount of public funding they would otherwise use. And investing in housing creates economic opportunity in the private sector, including construction and other housing related industries.

ALASKA HOUSING TRUST

Opportunity begins with a home

Q: What type of projects and activities will the Alaska Housing Trust fund?

A: All projects and activities must reduce homelessness and include (but are not limited to) the following:

- Construct new housing (single-family, multi-family, cooperative)
- Buy existing housing (single-family, multi-family, cooperative)
- Rehabilitate/repair existing housing (single-family, multi-family, cooperative)
- Fund affordable housing component only of mixed-income and mixed-use developments
- Buy land
- Perform accessibility modifications
- Provide down-payment assistance
- Provide rental assistance
- Fund homeless prevention services (e.g. prevent foreclosures and evictions)
- Fund housing retention services or facilitate transition from dependency on subsidized housing
- Support Community Land Trusts
- Fund capacity building in the development and operation of affordable housing and provide support services (operations and technical assistance)
- Fund predevelopment activities for affordable housing

Q: How will the Alaska Housing Trust differ from other housing programs?

A: The Alaska Housing Trust will support and complement existing efforts by working as a catalyst to pull together other funding sources in order to move families out of homelessness and help those at risk of homelessness. The Alaska Housing Trust will:

- Give a priority to those who have the greatest housing affordability gap—people with extremely low income.
- Target those in danger of becoming homeless with homeless prevention and housing retention services.
- Support those transitioning from homelessness who are confronting multiple barriers to becoming self-sufficient.
- Create and retain permanently affordable housing by reinvesting the initial public investment.

Q: Who will administer the Alaska Housing Trust?

A: The Alaska Housing Trust will be a separate capital budget fund within Alaska Housing Finance Corporation (AHFC). The duties of the Alaska Council on the Homeless, which

was established by the Governor in 2004, will be expanded to:

- Develop an annual housing trust plan
- Advise on the allocation of fund resources
- Report results annually to the governor and legislature

Q: Where will the money come from for the Alaska Housing Trust?

A: A legislative appropriation of state general funds will be used to create the Alaska Housing Trust and leverage existing resources.

Q: How will the Alaska Housing Trust work with existing low-income housing programs?

A: The Alaska Housing Trust will seek to maximize the capacity of existing programs by pulling together available resources and addressing the gaps in which the poorest Alaskans fall. The Alaska Housing Trust will not—and cannot—replace the existing service providers who are already stretched to their limits. The federal government has historically provided the lion's share of housing assistance in Alaska, and will likely continue to do so. But for a number of reasons the federal programs are not adequately addressing the homeless problem:

- Federal funds fall far short of needs. HUD estimates that nationally only about 25% of households that qualify for housing assistance are receiving it.[14] In Alaska, 4,000 families are on the waiting list for affordable housing.[15]
- Federal funds are poorly connected to homeless prevention and housing retention services.
- Federal programs do not effectively reach people with extremely low incomes.

Footnotes

The TRUST

The Alaska Mental Health Trust Authority

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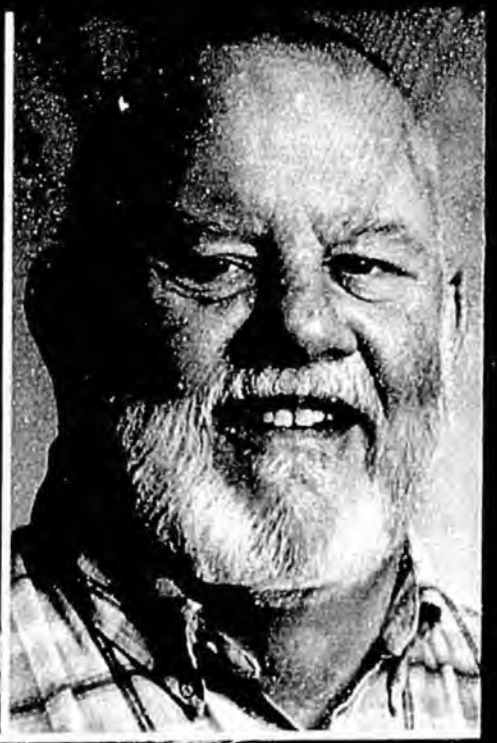
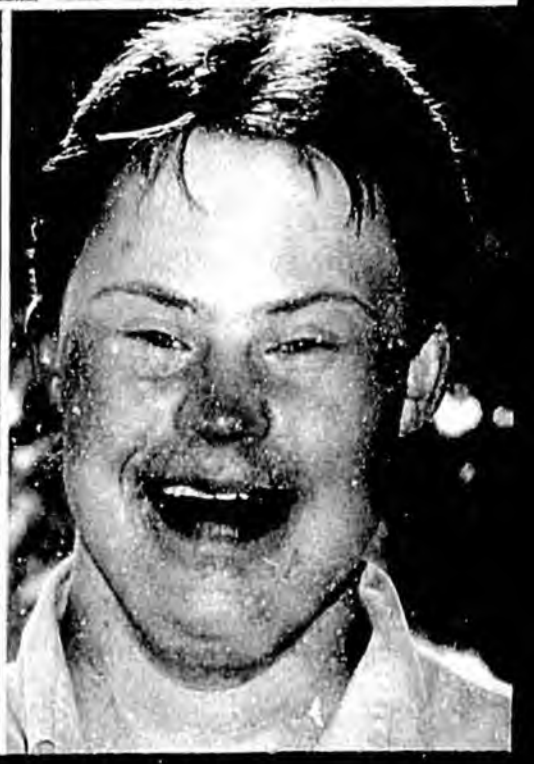
You KNOW us...





The TRUST

The Alaska Mental Health Trust Authority

Annual Report 2006

Vision and Mission

[illegible] administers the [illegible] Alaska Mental Health Trust as [illegible] trust. It has a fiduciary responsibility [illegible] its beneficiaries to enhance and [illegible] Trust and to provide leadership [illegible] planning, implementing and funding [illegible] as a catalyst for change [illegible] a comprehensive Integrated Mental Health Program [illegible] improve the lives [illegible] circumstances [illegible] beneficiaries.

Year In Review

You Know Us - but we are more than the Alaska Mental Health Trust Authority, (The Trust). Perhaps the most important role The Trust has is that of a convener of stakeholders and partners, serving as a catalyst in collaborative efforts to address issues of concern to our beneficiaries. Our primary partners are the four Governor-appointed boards, which represent our beneficiaries, participate in setting the focus of Trust efforts and work with us to achieve tangible results.

Jeff Jessee, Chief Executive Officer

The Governor's Council on Disabilities and Special Education, the Alaska Commission on Aging, the Advisory Board on Alcohol and Drug Abuse, and the Alaska Mental Health Board consist of broad-based memberships including consumers, family members, providers, agency representatives, and the public. With this make up, the boards are uniquely positioned to provide The Trust and state agencies with essential information on the status and needs of the beneficiaries and to evaluate the outcomes achieved by Trust programs. In addition, their planning and advocacy efforts on behalf of the beneficiaries are critical to the success of the state's mental health program.

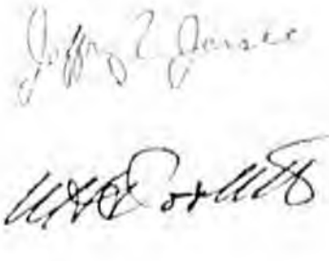
These boards have faced many challenges in recent years. Reductions in state financial support, the increasing needs of the beneficiaries they represent, and demands for closer cooperation and efficiencies in their operations have required new approaches to achieving their missions. They have responded by working closer with each other, securing limited funding from The Trust, and, in the case of the Alaska Mental Health Board and the Governor's Advisory Board on Alcohol and Drug Abuse, sharing staff, office space, and meetings.

You also know our other partners. At the core are the many beneficiaries and their families who take the time and the risk to share their stories and efforts to improve the lives of our beneficiaries. The Suicide Prevention Council and the Alaska Brain Injury Network provide important information and strategies to The Trust. The Departments of Health and Social Services and Corrections, the Alaska Court System, the Alaska Housing Finance Corporation, the Denali Commission, the Rasmuson Foundation and other philanthropies, Housing and Urban Development, Tribal health organizations, housing and social service organizations, local governments, the Trust Land Office, and many others also form our collective identity.

As you read in this report about the results we have achieved in our focus areas of Bring the Kids Home, Disability Justice, Housing, Workforce Development, and Trust Beneficiary Projects Initiatives, keep in mind just who "we" are. As we solidify our gains in these areas and move on to the new challenges that emerge, continued interaction and collaboration will be essential to develop strategies for making the most of the limited funding that is available.

William Doolittle, M.D., Board Chair

You do Know Us. We invite you now to join with us, look at where we have been and help us look to the future.



Disability Justice

Alaska's criminal justice system manages a disproportionate number of cases involving persons with mental disorders. The majority are arrested for minor offenses resulting from behaviors related to an under-treated or untreated mental disorder. Once involved with the criminal justice system, Trust beneficiaries are at greater risk of repeated cycling through the system and increased

Anchorage Mental Health Court Team

risk for financial, physical, and sexual victimization and exploitation.

The Disability Justice Focus Area seeks to:

- Prevent inappropriate or avoidable arrest, prosecution, incarceration, and reduce criminal recidivism.
- Increase the criminal justice system's ability to effectively interact with and accommodate for the needs of victims and offenders who are Trust beneficiaries.
- Ensure a continuum of services to Trust beneficiaries who require emergency intervention and/or protective custody or whose condition or behavior results in their involvement with the criminal justice system.

In 2006, the following occurred towards this end: (1) Anchorage and Fairbanks police officers received 40 hours of intensive training assisting them to interact effectively with people experiencing mental disorders; (2) The Alaska Court System developed a pilot project to expedite comprehensive neuropsychological evaluations; and, (3) The University of Alaska Anchorage – Center for Human Development assessed the nature and scope of Trust beneficiaries who are crime victims and inventoried available services and resources to assist them.

Bring the Kids Home

Each year, almost 700 Alaskan youth with serious emotional disturbances are sent to out-of-state facilities for treatment, an 800% increase since 1998. The state pays $40 million in Medicaid expenditures annually to out-of-state providers. The Bring the Kids Home (BTKH) initiative seeks to counteract this problem.

In FY06 The Trust provided $2.2 million for the BTKH initiative. That same year, and in subsequent years, the Denali Commission designated capital funds for increasing in-state bed capacity. In FY07 state government began to assist with state operating funds. At the end of FY06, 75 new in-state beds were added. Upwards of 200 beds are proposed to be available in FY07 and FY08.

Recent indicators show the increase of out-of-state referrals has stopped; with the projected increase in in-state bed capacity those numbers should decrease significantly in the next several years.

The BTKH Initiative planning and funding efforts focus on increasing lower levels of care. The goal is to ensure a full continuum of care so that each child is treated at the appropriate level as close to home as possible. The initiative also focuses effort on ensuring that youth and their parents are supported as they navigate the system of care. Parents and youth also provide important feedback to the BTKH planning process about the appropriateness of services.

Beneficiary Projects Initiatives

The Beneficiary Projects Initiative places more control in the hands of beneficiaries than any other Trust focus area. The Trust has dedicated $3.5 million annually to programs and services conceived and managed by beneficiaries.

Benificiary Projects Initiatives provides funds to beneficiaries to develop grass-roots projects that focus on peer-to-peer support. The programs emphasize prevention, education, and early intervention to help participants find their own path to recovery and wellness.

The Trust Focus Areas

The Trust dedicates $1 million for grants and provides technical assistance to achieve balance between consumer-run principles and public accountability. Targeted and anticipated outcomes include effective consumer/client-provided services, improved beneficiary input in policy making and planning, and demonstrated positive impact on beneficiary lives.


Alaska Native Youth and Elders experience Tlingit art and culture at Silver Cloud Art Center

Workforce Development

The Trust is working with its partners to develop strategies to address the need for a trained workforce to provide services around mental health, developmental disabilities, alcohol treatment, and Alzheimer's disease and related dementias. Several studies completed in the last year indicate Alaska is already facing workforce shortages in these critical areas and is forecasted to continue to have critical shortages over the next ten years.

The Trust, state, university, native tribal and provider systems are working together to develop strategies to address the workforce issues through training new workers and providing updates for the current workforce. Behavioral health and direct service jobs are some of the fastest growing job sectors. Recruiting and retaining this trained workforce is critical to Alaska's health and economy.

Safe, Affordable Housing

Safe, decent, affordable, and accessible housing is often the key for beneficiaries maintaining a healthy lifestyle and participating in rehabilitation and recovery activities. The statewide shortage of this type of housing disproportionately affects Trust beneficiaries due to the challenges associated with disabling conditions and the lack of opportunities for economic advancement.

In 2006, The Trust participated in the Governor's appointed Interagency Council on Homelessness, a Commissioner-level council charged with focusing on homelessness in Alaska. The council recommended formation of a steering committee to focus on an affordable housing trust fund. The Alaska Housing Trust fund has become a major priority for the Alaska Mental Health Trust Authority. You can read about it elsewhere in this report.

Predevelopment

Predevelopment is the planning and groundwork of a capital project. It is a critical component to the development process and, if not done correctly, can result in higher cost or the failure of a project. In 2003, the Rasmuson Foundation and the Alaska Mental Health Trust Authority created a vision for a program to help non-profits develop sustainable capital projects. The funders recognized that few resources were available at the beginning of the capital development and that many projects floundered in the initial stages of development.

Many partners supported the concept of a standardized, streamlined approach to funding technical assistance and resources in the predevelopment phase, including the Denali Commission, USDA Rural development, Alaska Housing Finance Corporation, municipal governments, and representatives of the not-for-profit sector.

In 2005, the Rasmuson Foundation, the Alaska Mental Health Trust Authority, and the Denali Commission launched the Pooled Predevelopment Fund. The program ensures that selected projects meet a community need and that they are adequately prepared to pursue operations and capital funding to ensure success long into the future. At an average cost of about $40,000 per project, organizations have access to program specialists, architects, engineers, and other specialists they may require to successfully complete the pre-development phase of their project.

The Pooled Pre-Development Program is currently funded by $1.4 million from the Denali Commission, the Rasmuson Foundation, and the Alaska Mental Health Trust Authority.

In 2006, over 300 projects were considered and more than half of the 30 selected to receive help will benefit Trust Authority beneficiaries.

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The Alaska Housing Trust

On any given night in Alaska, there are 3,500 homeless Alaskans. Of these, 24% suffer from chronic substance-abuse problems, and 14% are severely mentally ill. At least 3,000 children were homeless or inadequately housed during the 2005-2006 school year. These children are more likely to experience conditions of anxiety, withdrawal, depression, hunger, asthma, ear infections, stomach problems, and speech problems than their peers.

Homelessness results from a complex set of circumstances that require people to choose among food, shelter, and other basic needs. Contributing factors include:

- Inadequate income. A 2001 study found 57% of Alaska households could not afford a median-priced home and 46% could not afford the average rent. In Anchorage, a person needs to earn $17.05 per hour to afford a modest two-bedroom apartment at the average fair market rent of $905.
- Inadequate supply of affordable housing. The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is nearly 4,000 households.
- Catastrophic events or destabilizing forces. A sudden economic downturn caused by illness, injury, divorce, or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.
- Insufficient supportive services. In Alaska, homeless prevention services (i.e. renter education and broad based financial counseling), after-hours mental health counseling, and other housing retention services are not widely available.

A steering committee was formed in 2006 to develop a workable framework for our state to develop and sustain more affordable housing through a housing trust fund. This steering committee is comprised of representatives from the governor's office, the Alaska Housing Finance Corporation, the Alaska Department of Health and Social Services, Housing Authorities, US Department of Housing and Urban Development, US Department of Agriculture Rural Development, Wells Fargo Bank, the Rasmuson Foundation, service providers and home builders with the Alaska Mental Health Trust Authority serving as facilitator and chair.

The Steering Committee researched the successes of housing trusts in over 30 other states and designed the proposed Alaska Housing Trust to be a source of flexible funding that maximizes the effectiveness of existing low-income housing programs. For example, the funds will allow a stronger link between housing and the supportive and counseling services necessary for many Alaskans to find and retain safe, affordable housing.

The Alaska Housing Trust Coalition has formed in support of the recommendations made by the Steering Committee in order to take

continued on next page...

this concept to the Legislature in the upcoming legislative session. Currently, the Housing Trust Coalition is made up of over 20 different organizations, including several commissions of the Municipality of Anchorage, statewide service providers, private developers, and the Alaska chapter of the American Association of Retired Persons. Additional members are signing on board every day.

With these efforts, obtaining and retaining affordable, safe, and appropriate housing for Alaskans will help us demonstrate that successful outcomes begin with a home.

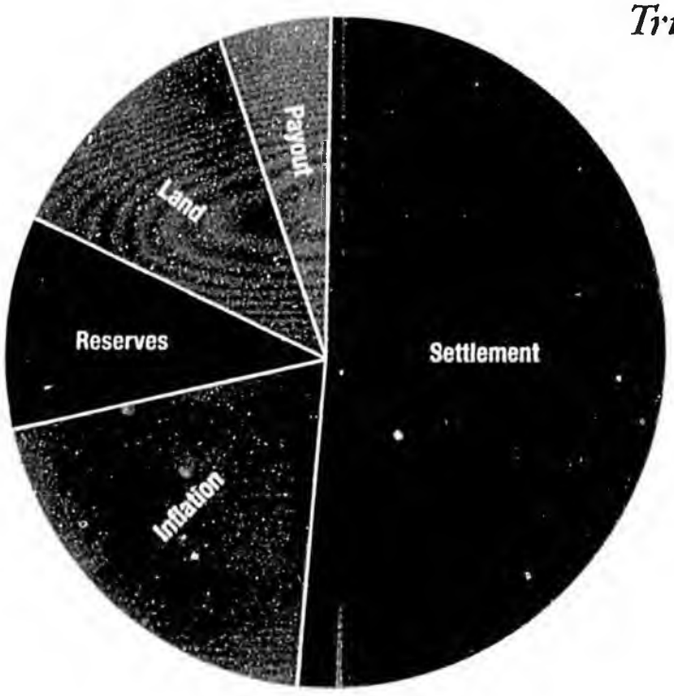
Coordinated Communications

The "You Know Me" campaign continued this year in an effort to reduce the stigma that Trust beneficiaries experience and to highlight reasons to invest in services for our relatives, neighbors, coworkers, and friends. Work by Trust advisory partners from the Governor's Council on Disabilities and Special Education, the Alaska Mental Health Board, the Advisory Board on Alcohol and Drug Abuse, the Alaska Commission on Aging, the Alaska Suicide Prevention Council, and the Alaska Brain Injury Network created a series of print, radio, theater, and television ads that bring to life the contributions and triumphs of Trust beneficiaries. Investment in Trust beneficiaries pays dividends in productive lives and provides a quality and dignity in life that we all deserve.

Ramy Brooks serves as a spokesperson for The Trust and the communications campaign. This veteran musher speaks out on his concerns about alcohol problems in Alaska emphasizing the need for youth to ask for help when they are experiencing problems in their lives. Ramy's own attempt at suicide at age 16 has led him to share his journey to adulthood and the effects of alcohol on families and youth.

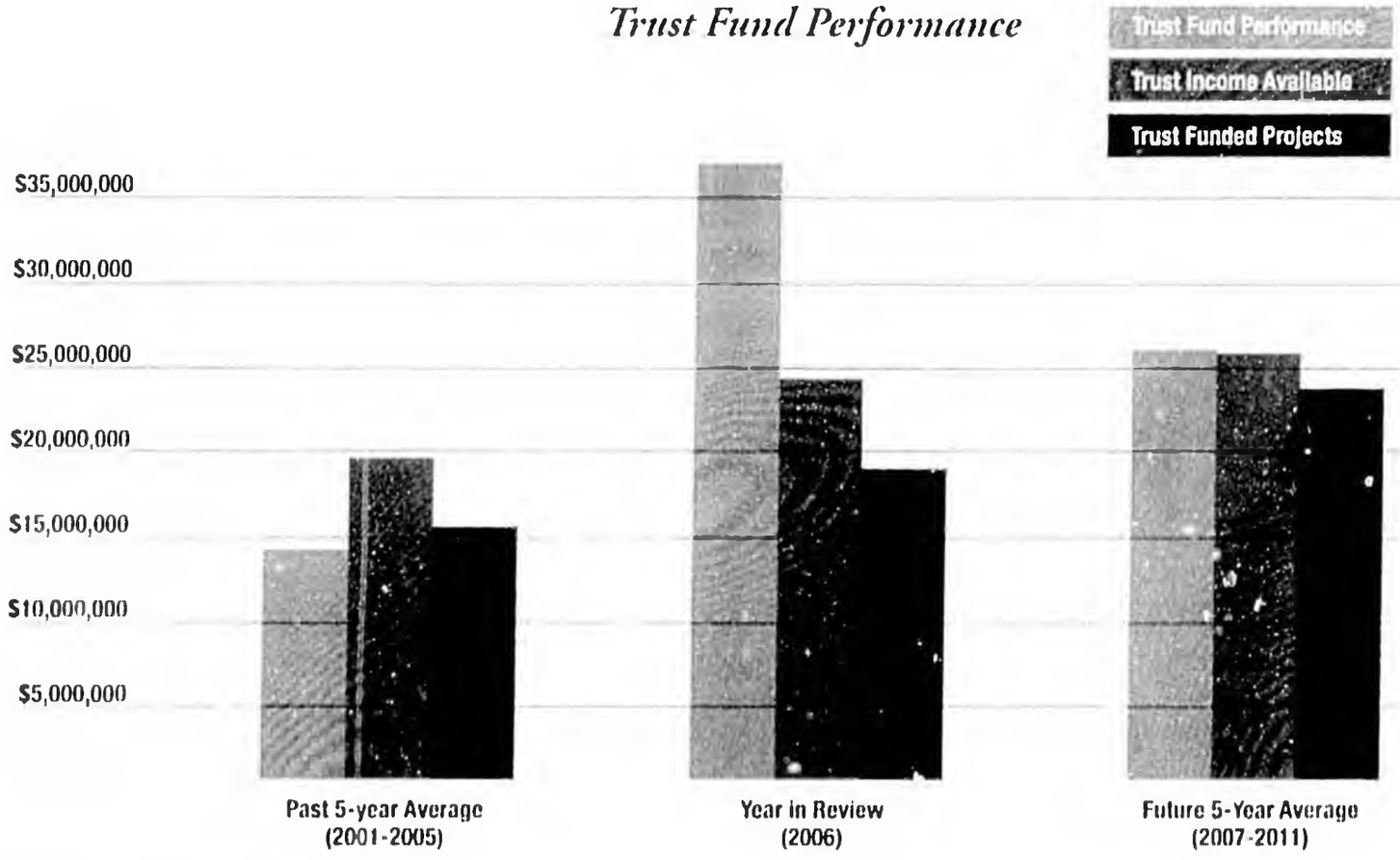
Key Financial Outcomes of The Trust Fund

Trust Cash Assets at End of FY2006



Settlement	51.33%	$ 200,000,000
Inflation	23.46%	$ 91,417,898
Land	14.96%	$ 58,287,126
Reserves	12.67%	$ 49,375,496
Payout	4.00%	$ 16,827,397

Trust Fund Performance



Key Financial Outcomes of The Trust Fund

For the third consecutive year, the cash assets of The Trust benefited from a healthy stock market. Investments with the Alaska Permanent Fund increased from $363,826,000 at the end of FY2005 to $385,366,600 at the end of FY2006.

Income from these investments was $36,046,700 for FY2006 and $30,811,000 for FY2005. Statutory net income determined by APFC (which does not include unrealized gains) was $31,756,200 for FY2006 and $21,008,800 for FY2005. Statutory net income increases the Budget Reserve and can be used as spendable income, while unrealized net income can only be applied to inflation proof our Principal Investment. Because the Alaska Permanent Fund Corporation was realigning its portfolio to allow for more diversified investments, realized gains were higher than usual in FY2006.

The Budget Reserve is set at 400% of the annual payout, to allow for disbursements during market downturns without eroding Trust Principal. The Budget Reserve investment is split between the Alaska Permanent Fund and the Treasury Division of the Alaska Department of Revenue. Callan Associates, Inc. (who set up the financial model initially) reviewed the budget reserve requirements this year to ensure that we have adequate protection from market volatility.

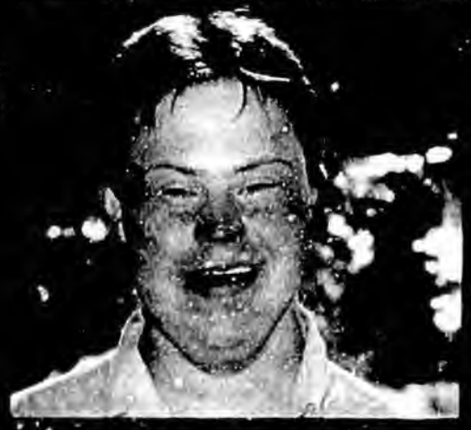
The portion of the Budget Reserve managed by the Treasury Division of the Department of Revenue earned $445,740 in FY2006. Callan Associates Inc. recommended new investment allocations within Treasury as part of its review of the Budget Reserve, which is expected to increase future returns.

The Trust payout rate, which is used to calculate the disbursement (or payout) for spendable income was increased at the end of FY2006 from 3.75% to 4.0% beginning with the FY2007 budget. This rate is applied to the balance in the Trust Fund (Principal and Budget Reserve) at the end of a fiscal year to calculate the payout for the subsequent year.

The following performance from FY2006 is available for spendable income in FY2007:

- Disbursement (payout) rate of 4.0%, for a payout of $16,627,397. This represents an increase of 13.8% over FY2005.
- Resource management revenue allocated as income was $3,543,093.
- Interest on the Income Account at Treasury Division was $967,031.
- Lapsed funds from prior fiscal years were $1,895,152.
- Total funding available for spendable income in FY2007 is $23,032,672. This is a slight decrease from FY2006 availability of $23,761,256 (which was unusually high due to prior-year lapsed funds of $5.2 million).

Trust Beneficiary



Trust spokesperson Ramy Brooks

Trust Beneficiaries

Trust Land Office

General Background

The Trust Land Office (TLO) is a small 11-person unit in the Department of Natural Resources (DNR) that manages approximately one million acres of land throughout the State of Alaska on behalf of the Alaska Mental Health Trust Authority (The Trust). Trust land is managed in accordance with state law (AS 38.05.801) and regulations (11 AAC 99), which provide in part, that Trust land management shall be conducted solely in the best interest of the Alaska Mental Health Trust and its beneficiaries. The regulations also provide that the TLO actions adhere to the following principles:

Oil & Gas Exploration on Trust Land Northern Dancer Wellsite

- Maximize long-term revenue from Trust land
- Protect The Trust corpus
- Protect and enhance the long-term productivity of Trust land
- Encourage a diversity of revenue-producing uses of Trust land
- Manage Trust land in a prudent and efficient manner, with accountability to The Trust and its beneficiaries.

Revenue-generating uses of Trust land include land leasing and sales; commercial timber sales; mineral exploration and production; coal, oil and gas exploration and development; sand, gravel and rock sales; and other general land uses. Rents, fees and 15 percent of timber revenue from Trust land uses are considered "Spendable Income" and are available to The Trust for use in the following year. Land sale revenue, hydrocarbon and mineral royalties, and 85 percent of timber revenue are considered "Principal" and are also forwarded to The Trust for deposit into The Trust corpus which is held and managed by the Alaska Permanent Fund Corporation.

FY06 Financial Outcomes

Gross revenues equaled about $7.2 million. As noted above, the TLO earns two types of revenues: Spendable Income, which equaled about $3.5 million and exceeded revenue projections by about 136 percent, and Principal revenues which equaled about $3.6 million and were somewhat shy of projected earnings. This shortfall can be attributed to several multi-year transactions that were completed ahead of schedule in FY05 and were accounted for in that year.

Trust Land Office

Highlights of the Year

The real estate program accounted for over 49 percent (about $3.5 million) of gross revenue. Successful efforts included completion of our 9th annual land sale which resulted in selling 68 parcels through a sealed bid process for a value of $1,574,868.

Renovation of The Trust Authority Building (located in midtown Anchorage) was completed in June

Timber Production on Trust Land, Log Transfer Facility, Leask Lake

Photo courtesy of Lane Daig, Forest and Management, Inc.

and The Alaska Mental Health Trust Authority relocated to the second floor along with the Alaska Brain Injury Network.

The timber sale program accounted for over 38 percent (about $2.7 million) of gross revenue, with multi-year sales continuing at Leask Lake and Wrangell. A small timber sale program was created with the Department of Natural Resources, Division of Forestry for local log home builders in Haines.

The coal, oil and gas programs accounted for 7 percent (about $512,000) of gross revenue. The annual Cook Inlet Oil and Gas Lease Sale held in November, 2005 resulted in the leasing of two tracts with bonus bids and first year's rentals of nearly $70,000. Two exploratory wells were drilled on Trust land for natural gas. One well was plugged, pending further evaluation, and the other is currently awaiting availability of equipment for testing.

The minerals and materials program accounted for almost 5 percent of gross revenue (about $357,000). This includes royalty from the Fort Knox Mine as well as lease rental payments from existing claims and leases on Trust land.

Future Focus

The TLO will continue efforts to diversify its revenue generating activities with emphasis on improving The Trust's real estate portfolio in the Anchorage and Southcentral areas. Key projects for the upcoming year include:

Subdivide the Trust's Hiland Road parcel into mixed-use commercial and residential tracts;

Remediate the Juneau subport warehouse property and sell the armory parcel to the City & Borough of Juneau for their Centennial Hall expansion project;

Complete the South Fairbanks Subdivision improvements in preparation for construction of the new Fairbanks Detox Center;

Expand the Wrangell 8 Mile Timber sale contract to include an additional five million board feet of timber;

Resolve the proposed Petersburg Timber Sale;

Offer about 80 parcels in The Trust's annual land sale;

Continue to offer Trust land for oil and gas exploration and development;

Northern Dancer Rig Inspection Mike Franger TLO Senior Manager

Complete the Chickaloon coal lease sale and facilitate exploration;

Offer Trust land for mineral development and exploration;

Complete the 1956 Mental Health Enabling Act land entitlement selection; and,

Develop the design for a new system to facilitate assets management.

The TRUST

The Alaska Mental Health Trust Authority

3745 Community Park Loop; Suite 200
Anchorage, AK 99508

www.mhtrust.org

2/15/07

PERS/TRS FUNDING STATUS & REVIEW

PUBLIC POLICY INSTITUTE

#2004-08
July 2004

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by
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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy group at AARP. One of the missions of the Institute is to foster research and analysis on public issues of importance to older Americans. This publication represents part of that effort. The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of AARP.

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Foreword

The likelihood that an employer offers retiree health benefits varies by size of employer, region, and industry. State and local governments continue to offer retirees health coverage at a higher rate than any other industry. While there are some common factors that influence health benefit decisions of employers in both the public and private sectors, there are also factors that distinguish public and private sector employers.

One such distinction is that state and local governments follow accounting standards for financial reporting different from those followed by private companies. State and local governments follow standards set out by the Governmental Accounting Standards Board (GASB), whereas private companies follow those of the Financial Accounting Standards Board (FASB). In the early 1990s, FASB implemented accounting standards for retiree health benefits that changed how a company's costs for retiree health benefits have to be reported. The standards required a change from reporting the expense of retiree health benefits on the basis of the cost of benefits in the period in which they are paid to reporting the cost of benefits as they are earned, which involves estimating and accruing both the future cost of these commitments and current spending for these commitments. This change has been widely cited as one factor, along with rising cost of these benefits, that has led companies to revise their retiree health benefit programs. Although GASB did not implement similar standards at the same time, it is now issuing new standards for state and local governments to report the costs of their Other Postemployment Benefits (OPEB), i.e., benefits other than pensions. The new standards raise the question of how their implementation will affect retiree health benefits in the future.

The AARP Public Policy Institute commissioned Workplace Economics, Inc. to conduct this research on retiree health benefits in state governments. In addition to providing a snapshot of state government retiree health benefits under existing accounting rules, the report gives an overview of current accounting practices for these benefits and of the changes that the new standards require. Based on this information, the report discusses potential issues that the new standards may raise for governments, taxpayers, and retirees. For example, reports based on the new accounting standards will make information on the long-term costs of retiree health benefits to state and local governments more readily available. Such information may focus attention on the challenge of honoring past and future commitments for retiree health benefits.

We hope this report will help inform debates that implementation of the new GASB standards may stimulate.

Gerry Smolka
Senior Policy Advisor
AARP Public Policy Institute

Table of Contents

Executive Summary

Purpose

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft[1] early in 2003, and a revision to the draft in early 2004, detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits. The Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans,* in May 2004 and a related Statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions,* in June 2004. The earliest these will go into effect is for fiscal years starting in December 2006. To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, decision-makers' consideration of the more comprehensive information developed may result in changes in behavior and practices by both providers and users of retiree health benefits. To assess the potential impact of the new GASB standards on public policy, this paper examines retiree health care benefits currently provided in state government employment by the 50 states excluding the District of Columbia and practices employed by state governments to account for and finance their retiree health benefit obligations. The results can be used as a baseline against which to gauge the implications of the changes in accounting standards.

Background

Current practices used by state governments to account for and report their retiree health benefit obligations diverge from private sector practice and are shaped by existing accounting standards such as GASB 12, 25, 26, and 27. The new standards for governmental employer reporting of OPEB are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. For many states, the new OPEB standards will require accrual accounting for such benefits for the first time.

Methodology

To provide a current snapshot of health benefits for retired employees, Workplace Economics, Inc. analyzed information in its proprietary database on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). To provide the overview of current state financial reporting practices, Workplace Economics analyzed state governments' annual financial reports.

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[1] Standards for "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions" and "Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans" can be ordered from GASB at its internet website (www.gasb.org).

Findings

1. Many states play a substantial role in the provision of retiree health benefits. Current retiree health care programs available to state government retirees vary significantly by key plan characteristics such as number and type of plans offered; premium costs; cost-sharing features such as copayments, coinsurance, and deductibles; and prescription drug plan features. For example, total monthly premiums for individual coverage for pre-Medicare retirees range from $159.92 for the lowest-cost plan offering available among the 50 states to $925.42 for the highest-cost plan offered in any state. For Medicare-eligible retirees, total monthly premiums for single coverage range from $46.40 for the lowest-cost available plan to $448.52 for the highest-cost plan offered in any state.

2. State financial statement reports provide some insight into the dimensions of retiree health insurance programs and their aggregate cost. Significantly, 41 states report providing some contribution towards defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees. Of the 41 states that reported providing some contribution towards retiree health insurance, 30 finance the state costs on a pay-as-you-go basis, while only 11 reported a prefunding arrangement. In the aggregate, state spending on OPEB approximated $4.4 billion in FY2001. About $3.8 billion was financed on a pay-as-you-go basis.

3. There are currently four GASB standards that provide guidance for existing state government accounting and reporting for postemployment health insurance benefits. GASB 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, became effective June 15, 1990 and requires that all employers who finance all or some portion of their retiree health insurance should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period. These disclosures are typically accomplished through a note to the governmental entity's financial statement. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed in recognizing and measuring retiree health insurance benefits. Subsequently, three additional GASB standards were implemented which affected the treatment of retiree health care benefits when provided through a public employee retirement system. First, GASB 27, *Accounting for Pensions by State and Local Governmental Employers*, issued in late 1994 but not effective until mid-1997, provides guidance to employers that elect to apply their pension accounting standards to retiree health care. In June 1996, GASB 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, and GASB 26, *Financial Reporting for Postemployment Health care Plans Administered by Defined Benefit Pension Plans*, became effective. GASB 25 and GASB 26 have delineated the applicable standards, not only for retiree health care plans that are advance funded through a public employee retirement system, but, more broadly, for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of whether the health care plan is funded on an actuarially determined basis or by some other mechanism. In its OPEB project, the Board decided to apply the same overall approach adopted in GASB 25 and GASB 27 to the reporting of OPEB by employers and plans, with such modifications as the Board considered necessary to reflect differences between pension benefits and OPEB.

4. While GASB's new OPEB standards are similar to FAS 106 in requiring those government employers to accrue the costs of postretirement health insurance during the years of service of their employees just as private sector employers are required to accrue the costs of such benefits, it appears likely there will be some significant differences in the standards as well as differences in the impact of the standards.

Impact and Implications

Employer-sponsored retiree health care provided by public employers is an important component of our nation's system of health care insurance for retirees. Therefore, any significant changes to state government employer retiree health care insurance resulting from the new OPEB standards or from the impact of underlying cost drivers necessarily will call for a response from policymakers if insurance gaps arise.

1. The private sector experience with FAS 106 provides mixed lessons for trying to anticipate the outcome of the new OPEB standards as formulated by GASB.

2. State government employers are typically large employers, and large employers generally provide postemployment benefit programs that remain relatively stable over time.

3. The financial information produced by the application of the new OPEB standards may encourage state governments to think about reducing retiree health benefit programs in the future in order to avoid liabilities. Yet, while the new OPEB standards may result in the consideration of changes that would minimize adverse accounting effects on public budgets, health benefit program changes seem more likely to be prompted by the availability of a drug benefit through Medicare and the underlying cost drivers, e.g., health care inflation, an expanding retiree population relative to active employees.

4. The new OPEB standards may encourage greater prefunding of retiree health care benefits. Because prefunding typically produces higher short-term costs as compared to pay-as-you-go financing, it may add to state government financial obligations at an inopportune time for those states and may, therefore, prompt a reconsideration of the level of state commitments for future retirees. At the same time, states which do begin prefunding (and those already prefunding) may find that their direct employer costs will be lower in the long run and that their credit rating may be bolstered.

5. To the extent the new OPEB standards may encourage greater prefunding of retiree health care benefits, they may produce greater intergenerational equity for taxpayers. This is because each generation, at least in theory, can assure itself that it is paying only for the personnel costs associated with the services provided by employees active during the taxpayer's lifetime, not previous lifetimes.

Conclusion

Economic and demographic factors are putting upward pressure on the cost of retiree health insurance provided by state public employers and, unless adequately prefunded, increasing

retiree health insurance costs may result in mounting deferred liabilities for state employers with the potential for an adverse impact on credit ratings. The concern over the future potential effect of such liabilities has prompted an examination of current governmental accounting standards for financial reporting to determine if such reporting achieves a sufficient consideration of the impact of providing retiree health care benefits on overall government operations. However, the implementation of new governmental accounting standards concerning retiree health insurance and other postemployment benefits, while adding to short-term pressures on government employees, appears unlikely to change what are typically the stable benefit provision patterns of large state employers, unless coupled with significant health care cost inflation for the foreseeable future and a continued deterioration of the active-to-retiree workforce ratio.

Introduction

It is the widespread practice of state governments to provide health benefits to former employees when they retire. In fact, the share of public sector employers offering retiree health benefits remains high in comparison to private employers.

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft early in 2003 detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits; the Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and a related statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, in June 2004. The new standards for employer reporting of Other Postemployment Benefits (OPEB) are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. Some additional differences from private sector requirements are associated with GASB's simplified alternative measurement method for small plans, e.g., single employer OPEB plans with fewer than 100 members.

To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, the introduction of these new standards may result in changes in behavior and practices by both providers and users of retiree health benefits. Faced with more comprehensive financial information and revised expectations regarding current and future health care costs, it is generally assumed that public employers, retiree health care plans, plan participants (including both retiree participants and actively employed future participants) and policymakers may alter their decision-making regarding the structure and level of postretirement health benefits.

Organization of Paper. This paper begins with a description of how retiree health care benefits are provided in state government employment in fiscal year 2003. This "current" state of retiree health care benefits provided by state government employers then can be used as a baseline against which the impact of any policy changes can be assessed. Next, this paper reviews the current practices used by state governments to account for and finance their retiree health benefit obligations. This involves a review of existing accounting standards, such as GASB 12, 25, 26, and 27, where relevant, and a delineation of how these standards have set the stage for movement to new OPEB standards. Then, this paper examines the potential impact of the new OPEB standards on accounting practices and contrasts the standards' likely effect with the impact of the adoption of FASB 106, highlighting the major similarities and differences between the standards. Finally, this paper concludes with an assessment of the potential impact of the new OPEB

standards on current and future state government retirees, public employers, taxpayers, and policymakers.

Methodology. In order to provide an overview of current state government retiree health insurance benefits, Workplace Economics, Inc. analyzed information in its proprietary database, developed over 15 years, on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). The database is the product of an annual survey of state governments on their employee benefits as well as an analysis of state employee health insurance plan documents; the database includes information on health benefits for retired employees. The information in Appendix A comes from this database. To provide the overview of current state financial reporting practices and the information in Appendix B, Workplace Economics analyzed state governments' annual financial reports.

The discussions of the current and new standards are based on the authors' knowledge of the two sets of standards, and the section on the impact reflects the authors' own assessment of some of the potential effects of the implementation of new GASB accounting standards.

Overview of Current State Government Retiree Health Benefits

In order to properly assess the impact of any new OPEB standard, both the depth and breadth of retiree health care benefits received by state government retirees needs to be determined. That is, it is important to identify the scope of such state programs and to understand the share of the financial burden borne by each state government for such benefits. To shed light on these issues, Workplace Economics, Inc. undertook two data analyses in this paper: (1) an examination of the key plan characteristics of state retiree health care programs and (2) a review of state government annual financial reports on the scope and aggregate annual cost of state OPEB spending.

Key Characteristics of State Retiree Health Care Plans

Fiscal year 2003 data for each state were examined in order to determine: (1) the actual dollar amount of premiums paid for retiree health care coverage by the state and by the retiree, respectively; (2) the deductibles, coinsurance, physician co-payments, and out-of-pocket maximums associated with the plans reviewed; and (3) the key characteristics of any prescription drug plans offered as part of the retiree health care program. When more than two plans were offered, the lowest-cost and the highest-cost plans were included in the analysis.[1] As summarized below, retiree health care programs available to state government retirees varied significantly in design.

Plan Offerings. In fiscal year 2003, all 50 state government employers surveyed offered health care benefits for retirees under the age of 65, and 48 states—all but Indiana and Nebraska—offered health care benefits to retirees age 65 and older. (See Appendix Table A1.) Roughly one in five states offered a single plan statewide, while some others offered as many as 10 or more plans. However, in states with multiple options, generally no more than three or four plans were available statewide, while additional offerings—usually HMOs—were available only in limited service areas. A retiree therefore typically had no more than three or four options available, based on the location of his or her residence.

In a number of cases, health coverage options offered to pre-Medicare retirees were the same as or similar to those available to active employees. In some cases, pre-Medicare and/or Medicare-eligible retirees selected from either additional or different options offered by the state and the retirement system. In Arizona, for example, retirees could

[1] Because some states offer a large number of pre-Medicare and Medicare retiree health care plans that would make a complete inventory of the key characteristics of all such plans unwieldy, this analysis was limited to providing information on the key plan characteristics of the lowest-cost and highest-cost plans offered to retirees, where "lowest-cost" and "highest-cost" refers to the retiree premium cost in dollars for retiree-only coverage. These plans were selected for analysis because they set the lower and upper bounds for the premium costs for all available plans and because such plans often attracted the largest enrollments among available plans. For example, a survey of state plan sponsors revealed that, for 72% of the responding states, the retiree health plan with the largest enrollment was either the "lowest-cost" plan or the "highest-cost" plan that was described for that state in Appendix A.

select from separate sets of plans offered by the retirement system and by the state Department of Administration.

Upon reaching age 65, when retirees become eligible for Medicare, plan payment and/or coverage changed. Retirees of the states of Indiana and Nebraska were no longer covered under the state's health plan after age 65 and had to seek individual coverage elsewhere to supplement Medicare. In the remaining 48 states, many retirees were able to continue coverage in the same health plan that they had while working or as an early retiree, but in 20 states they were also offered options for Medicare supplement plans.[2] A few states offered only Medicare supplement plans to retirees over the age of 65. In either case, Medicare was the primary payer for retirees age 65 and over, so individuals had to sign up for Medicare as soon as they became eligible. Comprehensive plans were not explicitly designed to complement Medicare as were the supplement plans, but they all coordinated coverage with Medicare to avoid duplicate payment for services covered by both plans.[3]

The majority of states offered the two groups of retirees—pre-Medicare and Medicare eligible—the same number of plan options. Nevertheless, 14 states offered fewer options, and seven states offered more options to retirees age 65 and over than their younger counterparts.

Eligibility for Retiree Health Benefits. In most states, individuals eligible for pension based on their years of service could opt for continued health care coverage, although 17 states had additional requirements such as some minimum number of years of active service with the state or prior coverage in the health plan as an active employee. (See Appendix Tables A2 and B1.) States also differed as to when the retiree could opt for coverage. A dozen states required the individual to enroll within a limited time period — usually 30 to 90 days — surrounding the retirement date. A few allowed the retiree to defer enrollment in specific situations, such as when the retiree was already covered as a dependent under a state-sponsored plan but later lost that coverage upon the spouse's death, or when an employee terminated employment prior to retirement but with specified service credit.

Premium Contribution. Eligibility requirements for state subsidization of the premium frequently differed from requirements for participation in the plan, i.e., a retiree who was eligible to participate in the health plan may not have been eligible for a premium

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[2] The Centers for Medicare and Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC) have defined 10 standardized "Medicare supplement" or "Medigap" plans that may be offered to Medicare-eligible retirees. Employers that offer Medicare supplement plans to retirees over age 65 conform to one of these types. The plans (designated "A" through "J") are designed to complement Medicare coverage by paying for varying degrees of deductibles, coinsurance, prescription drugs and other services not covered by Medicare.

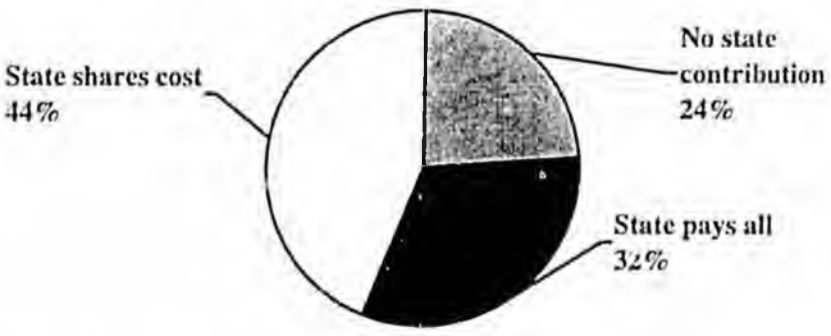
[1] Retirees who do not enroll in Medicare are effectively treated by state government health plans "as if" they were enrolled. Some plans make allowances for individuals not eligible for Medicare because their employer did not pay taxes into the program to retain some level of coverage. See Appendix Table A2.

subsidy. (See Appendix Tables A2 and B1 for details about eligibility for subsidies from health plan documents and financial reports, re.pectively, and also the notes to Tables A3 and A4 o~ premium costs for early retirees and Medicare-eligible retirees.) Almost one-third of states varied the portion of the subsidy based on the individual's years of credited service at retirement, with long-service employees (typically with 20 to 30 years) eligible for the maximum subsidy.

Figure 1 summarizes how states shared premium costs with pre-Medicare retirees for single coverage assuming the individual was eligible for the maximum subsidy.[4] For pre-Medicare retirees, 16 states (32%) paid the full amount of the premium for at least the lowest-cost plan offered and, in 12 states (24%), the retiree paid 100 percent of the premium.

Figure 2 summarizes premium cost-sharing requirements for Medicare-eligible retirees for single coverage assuming the individual was eligible for the maximum subsioy. Seventeen states (34%) paid the full premium for at least the lowest-cost plan offered to eligible retirees over the age of 65, while Medicare-eligible retirees in 11 states (22%) paid the full amount of the premium themselves. Of the remaining states, 20 states (40%) shared premium costs for individual coverage between the state and the retiree (shown in Appendix Tables A3 and A4), and two states (4%) had no plan.

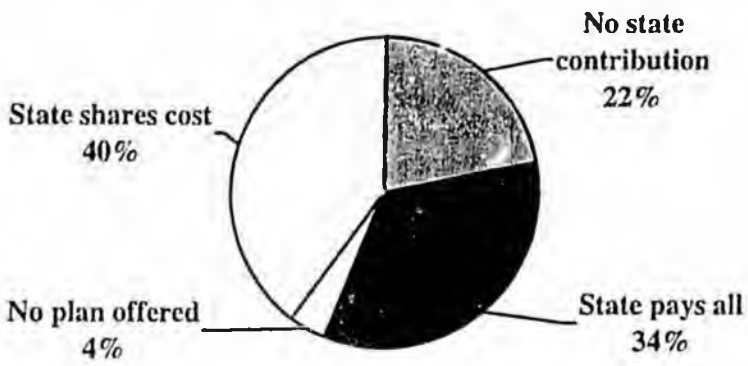
Figure 1. Premium Cost Sharing For Pre-Medicare Retirees, FY 2003



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest-cost plan.
Source: Workplace Economics

[4] The information cited and provided in the Appendix tables applies to individual coverage for the retiree only. States vary in their practices regarding coverage and the extension of subsidies to dependents.

Figure 2. Premium Cost Sharing For Medicare-Eligible Retirees, FY 2003



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest cost plan.
Source: Workplace Economics

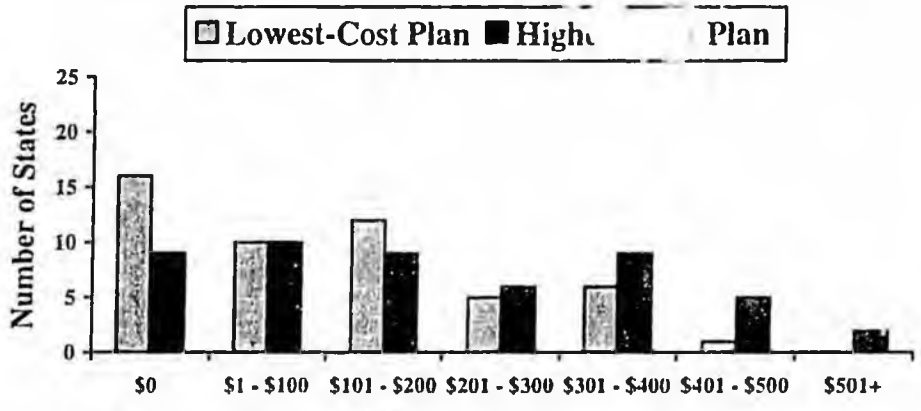
Across all 50 states, total monthly premiums for individual coverage for pre-Medicare retirees ranged from $159.92 in South Dakota for the state's low-option preferred provider plan (PPO) to a high of $925.42 for a PPO plan in Arizona. Among the 34 states where the pre-Medicare retiree paid either all or some portion of the premium costs, the monthly payment varied from $5.01 in Utah for an HMO to $795.40 for an indemnity plan in Wisconsin, assuming the retiree qualifies for the maximum subsidy. Figure 3 shows the distribution of pre-Medicare retiree premium contributions in $100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

For Medicare-eligible retirees, total monthly premiums for single coverage ranged from $46.40 for an HMO in New Mexico to $464.23 for a regional HMO in New York. Among plans requiring retirees to pay all or a portion of premium costs, the monthly premium share for individual coverage paid by Medicare-eligible retirees varied from $10.00 in Georgia for a Medicare HMO to $448.52 for Iowa's open access plan, assuming the retiree qualifies for the maximum subsidy. Figure 4 shows the Medicare-eligible retiree premium contribution within $100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

These findings clearly show the substantial role played by many states in the provision of retiree health care benefits in terms of the dollar amount of premium contributions that they made. It should also be noted that, in many cases, the health insurance premium applicable to pre-Medicare retirees might have been the same premium applicable to active employees. This may have been the case particularly where pre-Medicare retirees continued to be pooled for health insurance together with active employees. As a result, the premiums reported in such cases may have understated the actual claims costs incurred on behalf of the pre-Medicare participants. While such pooling of individuals

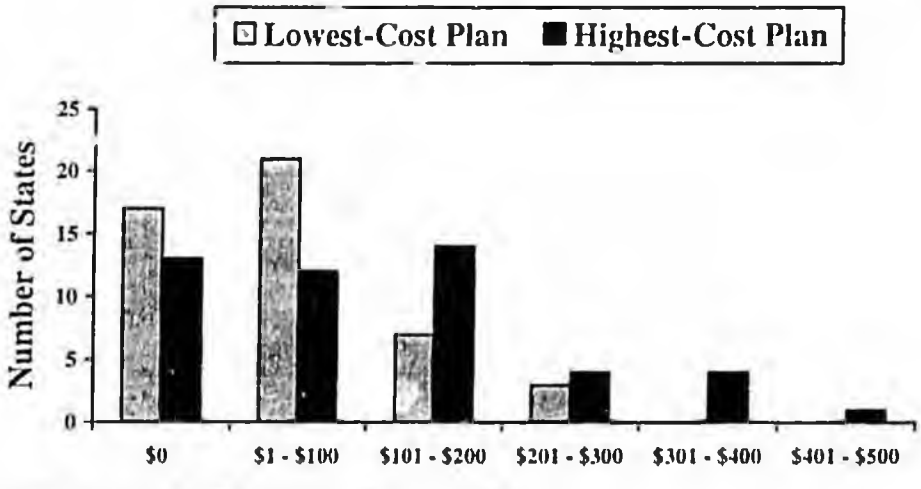
who are offered the same benefits (even though they may have different health or age characteristics) is at the heart of the insurance principle of spreading the risk, a few states took the position in their plan reporting that they were providing an implicit premium subsidy to their pre-Medicare retirees.

Figure 3. Premium Contributions Paid by Pre-Medicare Retirees by State, FY 2003



Note: Data are for single coverage and assumes maximum subsidy.
Source: Workplace Economics

Figure 4. Premium Amounts Paid by Medicare-Eligible Retirees by State, FY 2003



Note: Data are for single coverage and assumes maximum subsidy.
Source: Workplace Economics

Types of Plans and Cost-sharing Features. Key features of the lowest-cost and highest-cost plans available to retirees in each state are detailed in Appendix Tables A5 (pre-Medicare retirees) and A6 (Medicare-eligible retirees). Note that plan types in the tables — for example, HMO, PPO, and point-of-service (POS) — reflect the terminology of the particular state, i.e., the terms are not uniformly defined from state to state. Furthermore, the traditional distinctions between plan types have blurred as providers, plan administrators, and the state employers or retirement systems that offer the plans have altered plan features and added options to both minimize costs and provide alternatives.

Most common among the plans offered to pre-Medicare state retirees were plans that offer a different level of coverage and out-of-pocket payment depending on whether the member chooses to obtain care from in-network providers or out-of-network providers. Deductibles were common in most plans, except plans that only offer benefits when network providers were used. Many plans required copays that vary by the type of service obtained (e.g., specialty physicians, mental health, laboratory, physical therapy). Though not widespread, some plans (such as those that do not have deductibles) required hospital copays, typically from about $100 to $300 per admission, after which the plan paid all or most covered charges. A majority of plans reviewed had out-of-pocket maximums to limit the annual expenses paid by members. The per person maximums (using in-plan services where provider networks are part of the plan design) varied from $400 to $10,000 per year, but typical maximums were $1,000 or $2,000. Nonetheless, nearly a third of plans reviewed had no out-of-pocket maximum. Deductibles, copays, coinsurance and out-of-pocket maximums could vary considerably within a plan depending on whether the individual has obtained care from in-network or out-of-network providers.

Plan options available to Medicare-eligible retirees either were the same or similar in structure and characteristics to the options offered to pre-Medicare retirees, or were Medicare supplement plans (see Appendix Table A6). Yet plans without an out-of-pocket maximum were more likely in offerings to Medicare-eligible retirees. Plans that were not Medicare supplements differed from those described in the preceding paragraph only in how the benefit payment was calculated. Because Medicare was the primary payer, remaining charges were submitted to the insurance plan, which paid in accordance with the features of the plan. Copayments and out-of-pocket limits still applied (and, where applicable, continued to vary depending on whether the provider was part of the plan network). Medicare supplement plans, as noted previously, were explicitly designed to pay certain covered charges that are not paid by Medicare, such as all or part of the deductibles required under Medicare, or the retiree's 20 percent share of coinsurance for physician services.

In general, the lowest-cost plans were those requiring the retiree to pay the greatest share of covered benefits in the form of higher deductibles, copays or out-of-pocket maximums. In addition, plans with the greatest restrictions on where and how a member receives care tended to have lower premium costs.

Prescription Drug Benefits. Almost all of the highest- and lowest-cost state plans reviewed included some level of prescription drug coverage (see Appendix Tables A7 (pre-Medicare) and A8 (Medicare-eligible)). Since Medicare currently does not cover prescription drugs, this benefit was of particular importance to retirees over the age of 65. The majority of states offered the same drug benefit to early retirees and retirees on Medicare. However, in one state (South Dakota), both the lowest-cost and highest-cost Medicare-eligible plans did not include a drug benefit, although this benefit was available for early retirees. In a few other states, a drug benefit may have been available in one, but not both, of the plans examined in this study.

Many states offered a single prescription drug benefit as part of all (or most) of the health plans. Generally, under these plans, the retiree made a payment when purchasing the drug at a participating retail pharmacy. The vast majority of plans required copayments of a certain dollar amount, but a dozen or so plans required retirees to pay coinsurance of a certain percent of the drug price; the plan paid the balance. Some of these plans had a minimum or maximum coinsurance amount. Plans may have had different levels of copayments or coinsurance. The levels typically differed depending on whether the drug was classified as generic, brand name/formulary, or nonformulary. Of state government drug benefits reviewed, a small share had a single copayment level and a slightly larger share had two copayment levels. The majority had three levels of copayment. Among the plans reviewed, typical copayments were $5 or $10 for the lowest level; $15, $20, or $25 for the second level; and $30, $35, or $40 for a third level. The copays typically applied to a 30-34 day supply, and many plans offered further discounts for retirees who purchased maintenance or other medications by mail order (e.g., a requirement of two copays for a 90-day supply is typical). In addition, a few plans required a drug deductible or limit out-of-pocket payments for drugs. Limits on out-of-pocket payments be limited to generic and preferred drugs and drugs purchased in the plan's network. While benefits commonly included a mail order pharmacy option, this option was not included in at least one plan in about a dozen states.

State Retiree Health Care Program Financial Report Data

The analysis of health plan documents in the previous section provides information on the availability of, premiums for, and nature of benefits offered to state retirees. While that is an important part of the picture of current state retiree health benefits, it does not describe the current size, funding, or costs of these benefits to the state. To develop a picture of these aspects of state retiree health benefit plans and because, ultimately, any change in the OPEB accounting standards is most likely to be reflected in the comprehensive annual financial report (CAFR) of the state or the entity through which the benefit is provided (e.g., state retirement plan), each state's most recently available CAFR was reviewed with respect to OPEB reporting.

Each state's relevant annual reports were examined for the following categories of information: (1) the number of eligible retirees reported (generally as of mid-year

2001);[5] (2) the scope or nature of the retiree health care benefit program, particularly in terms of eligibility; (3) the reported percentage of employer contributions; (4) whether the state finances its retiree health care insurance obligations on a pay-as-you-go or prefunded basis; and (5) the most recent annual total cost reported by the state in connection with providing retiree health care insurance (details for items 1-3 and 4-5 are presented in Appendices B1 and B2, respectively).

Generally, the information of interest for each state was included in its CAFR in a note disclosure as required by applicable GASB reporting standards.[6] Some states did not include an OPEB disclosure note, usually indicating —as borne out by the absence of state contributions to retiree health insurance premiums— that the state determined that it had no OPEB impact to report. Of the 50 states, only six states (Arkansas, Indiana, Iowa, Nebraska, South Dakota, and Wyoming) did not include an OPEB disclosure; only one of these states (Arkansas) in fact provided some retiree health care insurance subsidy. On the other hand, Mississippi included an OPEB disclosure note in the CAFR, notwithstanding the fact that the state incurred no expense for retiree health care benefits. Vermont included a note disclosing a retiree health benefit obligation, but not the number of retirees, funding, or cost.

Wisconsin —— whose "contribution" to the financing of retiree health care benefits consisted solely of a program that converts accumulated sick leave to retiree health insurance credits[7]— reported these programs in an OPEB disclosure note. This last reporting approach arguably may have overstated Wisconsin's retiree health care contribution relative to other states that provided accumulated sick leave cash-out programs[8] inasmuch as these states' retirees receiving such lump sum payments at retirement could use the payments to finance some portion of their health insurance costs.[9]

Excluding the nonreporting states and the other exceptions noted above (Mississippi, Vermont, and Wisconsin), 41 states reported providing some contribution towards

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[5] Data reported in state CAFRs typically follow a fiscal year format; not every state or relevant reporting entity follows the same fiscal year.

[6] See *infra* at pp. 13 to 16 for a discussion of currently applicable GASB reporting standards for state postemployment health benefit obligations.

[7] Upon retirement, all or some portion of accumulated sick leave, instead of being paid as cash termination benefit, is converted to credits to pay the retiree's own group health insurance premiums.

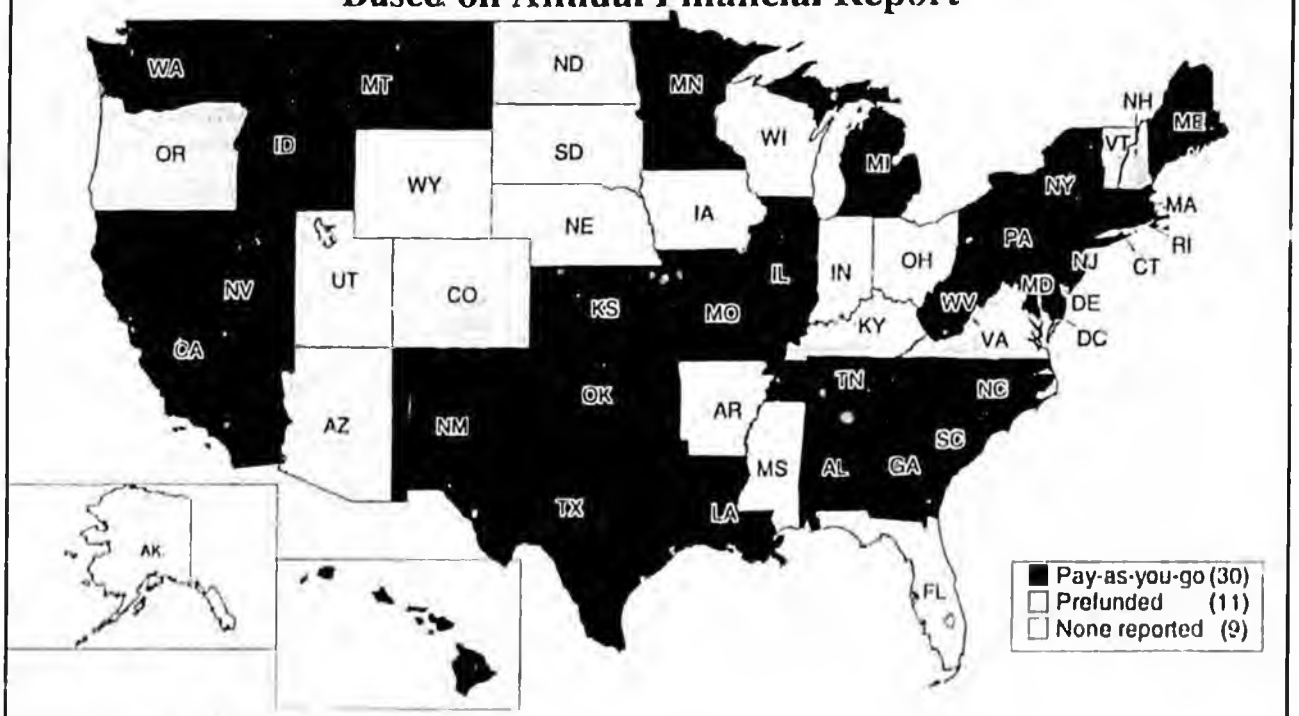
[8] In such programs, upon retirement, accumulated unused sick leave is converted at some rate to cash and paid to the retiring employee in a lump sum (typically, conversion is at a 25% rate, rather than a one-for-one or 100% rate).

[9] More consistent comparisons across states would appear possible in part if the dollar value of such sick leave conversion programs were reported only in the "compensated absences" disclosure note found in most state CAFRs along with lump sum sick leave and annual leave cash out programs. For a discussion of the governmental accounting treatment of sick leave conversion programs, see Governmental Accounting Standards Board Statement No. 16, *Accounting for Compensated Absences*.

defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees (see Figure 5). The OPEB disclosure note in the state CAFR provided some information about the dimensions of their postretirement health care programs.[10] In some cases, when the benefit was provided through a separate retirement system, the information was augmented by additional information presented in the state retirement system's CAFR.

Of the states that reported providing some contribution towards retiree health insurance (other than expenditures for sick leave conversion credits), 30 states financed these costs on a pay-as-you-go basis, while only 11 states percent reported a prefunding arrangement.

Figure 5. State Financing of Retiree Health Benefits, 2001 Based on Annual Financial Report



Source: Workplace Economics

Moreover, in states where retiree health benefits were prefunded separately from pension benefits, the funded levels reported for retiree health benefits often were lower than the funded levels reported for pension benefits. In short, both the predominance of pay-as-you-go financing among state retiree health care programs, as well as the low funded levels of many of those state retiree health care plans which are prefunded, could presage larger future cash outflows for such programs. This may be especially the case if the ratio of retired to active state employees continues to increase and retiree medical cost inflation continues to rise faster than the general rate of inflation.

[10] While providing some information about their programs, three states did not indicate the total fiscal year costs of the benefits provided in their OPEB disclosure notes.

Total annual spending on retiree health care benefits was reported by most of the 41 states that reported OPEB benefits.[11] In the aggregate, state spending on OPEB retiree health benefits approximated $4.4 billion in FY2001.[12] About $3.8 billion was financed on a pay-as-you-go basis. It should be noted that the remainder – roughly $600 million – that was financed on a prefunded basis represented the actual state contributions made to plan assets, rather than total expenditures made by those plans for the current provision of postemployment benefits.

Given the current prevalence of retirement health care benefits provided by state public employers, the substantial cost involved, and the relatively small number of states prefunding to meet their potential liabilities, it is not surprising that OPEB transactions have received GASB attention.

[11] Three states (Tennessee, Vermont and Washington) included an OPEB disclosure note in their 2001 comprehensive annual financial report but did not report an annual cost expense or total dollar amount of annual contribution in their OPEB disclosure notes.

[12] It should also be noted that not every state segregated retiree health care expenses from expenditures on other postemployment benefits provided such as life insurance. Such other expenditures are typically very modest relative to the cost of retiree health insurance. At the same time, some state reporting also included state expenditures for retiree health insurance subsidies provided to public employees other than state employees (e.g., teachers); usually such expenditures were reported as separate amounts from the amounts spent on state employee retirees.

Current Standards Applicable to Accounting for State Retiree Health Insurance Obligations and the Implications of the New OPEB Standards for Accounting Practices

Four GASB standards currently provide guidance regarding existing state government accounting and reporting for postemployment[13] health insurance benefits: GASB No. 12, 27, 25, and 26. This section describes the evolution of these standards which govern the current practices of state governmental entities that provide postemployment health benefits to retirees of various state government agencies. Since 1990, GASB standards have progressed from requiring financial disclosure by entities that finance some portion of retiree health benefits to providing guidance about how different types of entities might adapt pension accounting standards for the purposes of reporting on health benefits for all categories of retirees. Much of the content in the current standards is reflected in the new standards which will be implemented over the several years beginning in fiscal years starting in December 2006.

Not all of the standards apply to all governmental entities providing retiree health benefits. Retiree health benefits are provided through a number of different organizational/administrative arrangements (e.g., as part of the state employee benefit system, through a separate public employees retirement system, under the auspices of a defined benefit pension plan), and some of the standards are particular to the type of organizational arrangement responsible for the plan. Other standards are particular to the methods used to finance the health benefits, e.g., pay-as-you-go vs. prefunded basis.

Governmental Accounting Standards Board Statement No. 12, ***Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers***, became effective June 15, 1990 and requires that all governmental employers who finance all or some portion of their retiree health benefit costs should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period.[14]

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[13] While the focus of this paper is retiree health insurance benefits, it should be noted that the term postemployment as used by GASB is not synonymous with retirement. Rather, the term postemployment has a broader meaning that embraces not only retirement but also any period after termination but before retirement during which benefits may be provided.

[14] GASB 12 permits state government employers to simply state that OPEB expenditures/expenses "cannot be reasonably estimated" if a reasonable approximation of OPEB expenditures/expenses is not possible because OPEB expenditures cannot be separated from similar expenditures for active employees, e.g., where pre-Medicare retirees participate in the same health insurance plans offered to active employees.

These required disclosures are accomplished through a note to the governmental entity's financial statement. A GASB 12 footnote disclosure for OPEB financed on a pay-as-you-go basis might read as follows:

> "In addition to the pension benefits described in NOTE X, the State provides postretirement health care benefits, in accordance with State statutes, to all employees who retire from the State on or after attaining age 60 with at least 15 years of service. Currently, 25,000 retirees meet those eligibility requirements. The State reimburses 75 percent of the amount of validated claims for medical, dental, and hospitalization costs incurred by pre-Medicare retirees and their dependents. The State also reimburses a fixed amount of $25 per month for a Medicare supplement for each retiree eligible for Medicare. Expenditures for postretirement health care benefits are recognized as retirees report claims and include a provision for estimated claims incurred but not yet reported to the State. During the year, expenditures of $30 million were recognized for post-retirement health care. Approximately $500,000 of the $3 million increase in expenditures over the previous year was caused by the addition of dental benefits, effective July 1, 19XX" (Governmental Accounting Standards Board Statement No. 12, 1990, Appendix B).

If the retiree health program is prefunded, a GASB 12 footnote disclosure would include the employer's actuarially required contributions, the amount of net assets available for OPEB, and the actuarial accrued liability and unfunded accrued liability for OPEB according to the actuarial cost method in use.

GASB 12 is an interim standard pending the new OPEB standards. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed when recognizing and measuring retiree health insurance benefits; therefore, when GASB 12 became effective in 1990, state and local government employers were not required to change their accounting for those benefits. In short, GASB 12 addresses only the disclosure of the nature and extent of retiree health insurance benefits, but does not establish recognition and measurement standards applicable to those benefits.

Moreover, GASB 12 permits employers that advance fund their retiree health insurance benefits on an actuarially determined basis through a public employee retirement system to elect to apply alternative disclosure standards applicable to public employee pension plans. Those alternative standards are part of **Governmental Accounting Standards Board Statement No. 5, *Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Government Employers***. The impact of electing this alternative is that: (1) the employer has to disclose its health care cost inflation assumption along with the other actuarial assumptions it is already disclosing for pension purposes; and (2) the employer has to calculate the funded status and funding progress of retiree health care benefits in a manner consistent with the requirements already applicable to pension benefits. While the disclosure of the funded status and

funding progress of retiree health care benefits separate from that of pension benefits is encouraged, such disclosure is not required.

Subsequently, three additional GASB standards were implemented which both move beyond disclosure requirements and affect how retiree health care benefits are to be treated for accounting purposes when provided through a public employee retirement system. First, **Governmental Accounting Standards Board Statement No. 27,** ***Accounting for Pensions by State and Local Governmental Employers***, issued in late 1994 but not effective until mid-1997, supersedes that part of GASB 12 that permits employers the option of reporting under GASB 5 standards if they prefund their retiree health care benefits through a public employee retirement system. GASB 27 provides guidance to employers that elect[15] to apply their pension accounting standards to retiree health care benefits on an interim basis pending the issuance of the OPEB standards. Essentially, employers who elect to apply GASB 27 to retiree health care benefits, are instructed to: (1) apply not only the measurement and recognition requirements of GASB 27 to those retiree health care benefits but also to provide notes to the financial statements required by GASB 27 instead of the note disclosures required by GASB 12; (2) to measure required supplementary information in the same manner as the pension plans if the retiree health benefits are administered through a defined benefit pension plan;[16] (3) to disclose the health care cost inflation assumption used in the valuation; and (4) to provide information on retiree health care benefits separately from information on pension benefits. While this elective standard governs *employer* reporting, other GASB standards address financial reporting by government defined benefit pension plans when such pension plans administer a retiree health care plan.

In June 1996, **Governmental Accounting Standards Board Statement No. 25,** ***Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans***, and **Governmental Accounting Standards Board Statement No. 26,** ***Financial Reporting for Postemployment Health Care Plans Administered by Defined Benefit Pension Plans***, became effective. GASB 25 and GASB 26 delineate the applicable standards, not only for retiree health care plans that are prefunded through a public employee retirement system but also for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of how the health care plan is funded, e.g., on a prefunded, pay-as-you-go, or partially prefunded basis. GASB 26 is an interim standard meant to apply until the new OPEB standards become effective; it basically requires that retiree health care benefit plans administered by defined benefit pension plans apply the reporting standards of GASB 25 which are also applicable to pension plans. Essentially, under GASB 26, retiree health care benefit plans are required to present a statement of plan net assets, a statement of changes in net assets, and note disclosures similar to those required of pension plans (providing for a brief description of benefit eligibility requirements and the required employer

[15] Employers are not required to apply GASB 27 pension accounting rules to retiree health benefits; the application remains an election.

[16] Required supplementary information under GASB 27 includes, among other information, such disclosures as the plan's funded ratio, the unfunded actuarial liability or funding excess as a percentage of covered payroll, and the actuarial methods and assumptions used in the plan valuation.