

AK LEGISLATURE FINANCE COMMITTEES FILES 2007-2008 3356

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	Copayment	Copayment Frequency	Estimated Cost-Offset
*Rationale for Change From Current Cost Estimate			

The HMO Benchmark Model includes a \$10 copayment. Eliminating cost-sharing is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	-	N/A	Children: cost-saving, Adolescents: some cost-effective, some cost-saving in limited populations
The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). If a plan does not currently provide coverage for preventive dental services, including these services with coverage at 100% will increase the employer's plan cost by 2.3%	-	N/A	Early preventive care: cost-saving, Dental sealants: cost-effective in high-risk populations, Fluoride varnish: cost-effective in high-risk populations
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 1.7%.	-	N/A	Probably cost-saving
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's portion of the plan cost by 0.1%.	-	N/A	Cost-effective
The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). If a plan does not currently provide coverage for unintended pregnancy prevention services, including these services with coverage at 100% will increase the employer's plan cost by \$3.07 or 1.1%.	-	N/A	Cost-saving
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to be cost neutral .	-	N/A	Cost-saving
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.6%.	-	N/A	Cost-saving
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Breastfeeding promotion: cost-saving
The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 1.1%.	-	N/A	Cost-saving or cost-effective

The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	1	per visit	N/A
The HMO Benchmark Model includes a copayment of \$25. Reducing the required copayment to \$20 is estimated to increase the employer's plan cost by 0.10%. If an employer's HMO has a maximum of 30 mental health visits per year, removing this maximum will increase the employer's plan cost by \$0.58 or 0.2%, assuming a typical level of managed care.	1	per visit	N/A
The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	1 or 2	per visit	N/A
	1 or 2	per visit	N/A

Figure 2E: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (HMO Plan Design)

HMO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations

HMO Estimate (2007 Year Dollars)	Current Cost Estimate (PMPM) Average 2007 HMO Cost Per Member Per Month ¹			Revised Benefit Cost Estimate			
	Plan Benefit Model Recommendations	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)
III. Emergency Care, Hospitalization, and Other Facility-Based Care							
a. Emergency Room Services	\$17.05	\$1.94	\$15.11	1.56	\$16.67	\$(1.56)	
b. Inpatient Substance Abuse Detoxification	\$0.86	\$0.02	\$0.84	\$-	\$0.84	\$-	
c. Inpatient Hospital Service: General Inpatient / Residential Care (Including Mental Health / Substance Abuse)	\$61.82	\$0.59	\$61.24	\$-	\$61.24	\$-	
d. Inpatient Hospital Service or Birth Center Facilities: Labor / Delivery	\$11.14	\$0.09	\$11.05	\$-	\$11.05	\$-	
e. Ambulatory Surgical Facility or Outpatient Hospital Services	\$69.64	\$0.53	\$69.11	\$-	\$69.11	\$-	
f. Mental Health / Substance Abuse Partial-Day Hospital (or Day Treatment) or Intensive Outpatient Care Services	\$0.19	\$0.00	\$0.19	\$-	\$0.19	\$-	
Category Sub-Total				\$1.56		\$(1.56)	
IV. Therapeutic Services / Ancillary Services							
a. Prescription Drugs	\$45.47	\$14.96	\$30.51	\$-	\$30.51	\$-	
b. Dental Services	\$17.07	\$4.52	\$12.55	\$2.81	\$15.36	\$(2.81)	
c. Vision Services	\$1.01	\$0.17	\$3.93	\$-	\$3.93	\$-	
d. Audiology Services	\$1.86	\$0.62	\$1.24	\$-	\$1.24	\$-	
e. Nutritional Services	\$-	\$-	\$-	\$1.03	\$1.03	\$0.26	
f. Occupational, Physical, and Speech Therapy Services	\$1.23	\$0.31	\$0.92	\$-	\$0.92	\$-	
g. Infertility Services	\$5.12	\$0.30	\$5.82	\$-	\$5.82	\$-	
h. Home Health Services	\$1.23	\$0.21	\$1.02	\$-	\$1.02	\$-	
i. Hospice Care	\$0.03	\$0.01	\$0.08	\$-	\$0.08	\$-	
j. Durable Medical Equipment & Supplies	\$2.33	\$0.40	\$1.93	\$0.56	\$2.49	\$0.02	
- Medical Food				\$0.09	\$0.09	\$0.02	
k. Transportation Services	\$0.61	\$-	\$0.61	\$-	\$0.61	\$-	
Category Sub-Total:				\$4.49		\$(2.51)	

		Copayment	Copayment Frequency	Estimated Cost-Offset
Percent Employer Change from Current Cost Estimate (% of total)*	*Rationale for Change From Current Cost Estimate			
0.5%	The HMO Benchmark Model includes a \$100 copayment for ER services. Reducing the required copayment to \$20 for urgent care services is estimated to increase the employer's plan cost by 0.50%.	3 or 5	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	4	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	4	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	4	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	3	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	3	per episode	N/A
0.5%				
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	Tiered	per fill/refill	N/A
1.0%	The Plan Benefit Model includes member coinsurance for restorative and orthodontic procedures (20% and 50% respectively) will increase the employer's plan cost by 1.00%.	2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	2	per visit	N/A
0.4%	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.40%.	2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral), if a plan does not currently provide coverage for infertility services, including these services with a \$100+ copayment will increase the employer's cost by \$5.62 or 2.0%.	5	per visit/unit/ or per cycle	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	5	one time	N/A
0.2%	The HMO Benchmark Model excludes coverage for hearing aids. Adding coverage for hearing aids will increase the employer's plan cost 0.2%.	1	per unit	Cochlear ear implants: cost-effective
0.0%	The HMO Benchmark Model excludes coverage for medical foods. Adding coverage for medical foods will result in a negligible increase to the employer's plan cost (cost neutral).	1	per unit	Donor breast milk: cost-saving for limited populations
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	2 or 5	per use	N/A
1.6%				

Figure 2E: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (HMO Plan Design)

HMO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations						
HMO Estimate (2007 Year Dollars)	Current Cost Estimate (PMPM) Average 2007 HMO Cost Per Member Per Month ¹			Revised Benefit Cost Estimate		
Plan Benefit Model Recommendations	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)
V. Laboratory Diagnostic, Assessment, and Testing Services						
a. Laboratory Services	\$6.50	\$-	\$6.50	\$-	\$6.50	\$-
b. Diagnostic, Assessment, and Testing (Medical and Psychological) Services	\$8.23	\$-	\$8.23	\$-	\$8.23	\$-
Category Sub-Total:				\$0.00		\$0.00
Plan Design Total						
				\$17.78	\$309.88	\$(4.44)
Estimated Impact of Plan Benefit Model						
Impact of Plan Benefit Model Recommendations (Benefit Additions and Modifications):				\$13.34	4.6%	
Impact From Cost-Shifting to Employer/From Member:				\$1.44	1.5%	\$(1.44)
Total				\$17.78	6.2%	
HMO Benchmark Model Costs						
Total Per Member Per Month (PMPM)	\$322.07	\$29.98	\$292.10	\$17.78		\$(4.44)
Total Per Employee Per Month (PEPM)	\$676.35	\$62.96	\$613.41	\$37.35		\$(9.32)
Total Per Employee Per Year (PEPY)	\$8,116	\$755	\$7,361	\$448		\$(112)

		Copayment	Copayment Frequency	Estimated Cost-Offset
Percent Employer Change from Current Cost Estimate (% of total)*	*Rationale for Change From Current Cost Estimate			
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	1 - 4	per battery	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	1 - 4	per battery	N/A
0.0%				
6.2%				
-14.81%				

Notes

Refer to the Maternal and Child Health Model Plan Benefit Model for a description of recommended benefits.

1. The term "member" represents employees and dependents. The Benchmark Model costs are summarized on a per member per month (PMPM) basis.
 2. The Benchmark Model average costs shown in this table are for a HMO plan with the following member cost-sharing specifications:
 - Medical: office visit copays = \$10 PCP/ \$25 specialist; outpatient surgery = \$50; ER copay = \$100; inpatient = \$100 per admission.
 - Prescription drugs: \$10 generic and \$25 brand copay for prescriptions (mail order = 2 times retail).
 - Dental services: \$50 deductible, 0%/20%/50% coinsurance for preventive/restorative /orthodontic services, with a \$5,000 maximum benefit per year.
 3. A given employer's health plan costs may vary from the rates shown above due to differences in plan design, member demographics, provider payment rates, or level of managed care practices for medical and mental health services.
 4. Unless otherwise noted, changes in coverage to meet the minimum Plan Benefit Model recommendations are applicable to all members.
- *Cost estimates for select Plan Benefit Model recommendations are based on assumptions developed by the Business Group for (a) the degree to which the service is currently covered by large-employer health plans, and (b) the prevalence of the condition the service seeks to address.

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate Average 2007 PPO Cost Per Member Per Month (PMPM)¹			Revised Benefit Cost Estimate			
Plan Benefit Model Recommendations	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	
I. Preventive Services							
a. Well-Child Services	\$2.24	\$0.84	\$1.40	\$0.84	\$2.24	\$(0.84)	
b. Immunizations	\$2.21	\$0.83	\$1.38	\$0.83	\$2.21	\$(0.83)	
c. Preventive Dental Services	\$7.60	\$-	\$7.60	\$-	\$7.60	\$-	
d. Early Intervention Services for Mental Health / Substance Abuse	\$-			\$5.85	\$5.85	\$-	
e. Preventive Vision Services	\$-			\$0.39	\$0.39	\$-	
f. Preventive Audiology Screening Services	\$-			\$0.39	\$0.39	\$-	
g. Unintended Pregnancy Prevention Services	\$3.42	\$1.19	\$2.23	\$1.19	\$3.42	\$(1.19)	
h. Preventive Preconception Care	\$-			\$-	\$-	\$-	
i. Preventive Prenatal Care	\$-			\$1.95	\$1.95	\$-	
j. Preventive Postpartum Care	\$-			\$0.39	\$0.39	\$-	
k. Preventive Services (General)	\$-			\$3.90	\$3.90	\$-	
Category Sub-Total:				\$15.73		\$(2.86)	

		Coinsurance	Coinsurance Frequency	Estimated Cost-Offset
Percent Employer Change From Current Cost Estimate (% of Total)*	*Rationale for Change From Current Cost Estimate			
0.3%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and coinsurance is estimated to increase the employer's plan cost by 0.3%.	-	N/A	Cost-effective
0.3%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and member coinsurance is estimated to increase the employer's plan cost by 0.3%.	-	N/A	Children: cost-saving, Adolescents: some cost-effective, some cost-saving in limited populations
0.0%	The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). If a plan does not currently provide coverage for preventive dental services, including these services with coverage at 100% will increase the employer costs by 2.5%. If the employer's PPO covers these services but requires 20% member coinsurance, eliminating the coinsurance will increase the employer's plan cost by \$1.52 or 0.5%.	-	N/A	Early preventive care: cost-saving, Dental sealants: cost-effective in high-risk populations, Fluoride varnish: cost-effective in high-risk populations
1.9%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 1.9%.	-	N/A	Probably cost-saving
0.1%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
0.1%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
0.4%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and coinsurance will increase the employer's plan cost by \$1.19 or 0.4%. If a plan does not currently provide coverage for unintended pregnancy prevention services, including these services with coverage at 100% will increase the employer's plan cost by \$1.19 or 1.1%.	-	N/A	Cost-saving
0.0%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to be cost neutral .	-	N/A	Cost-saving
0.6%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services and eliminating cost-sharing is estimated to increase the employer's plan cost by 0.6%.	-	N/A	Cost-saving
0.1%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services and eliminating cost-sharing is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Breastfeeding promotion: cost-saving
1.3%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services and eliminating cost-sharing are estimated to increase the employer's cost by 1.3%.	-	N/A	Cost-saving or cost-effective
5.1%				

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate Average 2007 PPO Cost Per Member Per Month (PMPM) ¹			Revised Benefit Cost Estimate			
	Plan Benefit Model Recommendations	Total Costs (PMPM)	Paid by Members (PMPM) ¹	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)
II. Recommended Levels of Care for Physician/Practitioner Services							
a. Services Delivered by a Primary Care Provider	\$26.76	\$10.05	\$16.70	\$2.13	\$18.83	\$(2.13)	
b. Services Delivered by a Mental Health/Substance Abuse Provider	\$5.34	\$1.05	\$4.28	\$0.91	\$5.19	\$(0.13)	
c. Services Delivered by a Specialty Provider or Surgeon	\$74.70	\$14.84	\$59.86	\$2.47	\$62.33	\$(2.47)	
d. E-Visits and Telephonic Visits	N/A	N/A	N/A	N/A	N/A	N/A	
Category Sub-Total:				\$5.51		\$(4.73)	
III. Emergency Care, Hospitalization, and Other Facility-Based Care							
a. Emergency Room Services	\$19.84	\$3.90	\$15.94	\$1.82	\$17.76	\$(1.82)	
b. Inpatient Substance Abuse Detoxification	\$1.17	\$0.12	\$1.05	\$-	\$1.05	\$-	
c. Inpatient Hospital Service: General Inpatient / Residential Care (Including Mental Health / Substance Abuse)	\$84.44	\$9.00	\$75.44	\$0.30	\$75.74	\$(0.30)	
d. Inpatient Hospital Service or Birth Center Facilities: Labor / Delivery	\$15.21	\$1.62	\$13.59	\$-	\$13.59	\$-	
e. Ambulatory Surgical Facility or Outpatient Hospital Services	\$91.02	\$15.93	\$65.09	\$-	\$65.09	\$-	
f. Mental Health / Substance Abuse Partial-Day Hospital (or Day Treatment) or Intensive Outpatient Services	\$0.24	\$0.03	\$0.21	\$-	\$0.21	\$-	
Category Sub-Total:				\$2.12		\$(2.12)	

			Coinsurance	Coinsurance Frequency	Estimated Cost-Offset
Percent Employer Change From Current Cost Estimate (% of Total)*	*Rationale for Change From Current Cost Estimate				
0.7%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Reducing the coinsurance to 10% is estimated to increase the employer's cost by 0.7%.		10%	per visit	N/A
0.3%	The PPO Benchmark Model includes 20% member coinsurance. Reducing the coinsurance to 10% is estimated to increase the employer's cost by 0.1%. If an employer's PPO has a maximum of 30 mental health visits per year, removing this maximum will increase employers cost by \$0.61 or 0.20%, assuming a typical level of managed care.		10%	per visit	N/A
0.8%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Reducing the coinsurance to 15% is estimated to increase the employer's plan cost by 0.8%.		10% or 15%	per visit	N/A
N/A			Left to IPA	per visit	N/A
1.8%					
0.6%	The PPO Benchmark Model includes 20%-25% member coinsurance and this range is consistent with the Plan Benefit Model (cost neutral). Reducing the urgent care coinsurance to 10% is estimated to increase the employer's cost by 0.6%.		20% or 25%	per visit	N/A
0.0%	The PPO Benchmark Model includes a deductible. Eliminating the deductible will result in a negligible increase to the employer's plan cost (cost neutral) .		25%	per episode	N/A
0.1%	The PPO Benchmark Model includes a deductible. Eliminating the deductible is estimated to increase the employer's plan cost by 0.1%.		25%	per episode	N/A
0.0%	The PPO Benchmark Model includes a deductible. Eliminating the deductible will result in a negligible increase to the employer's plan cost (cost neutral) .		25%	per episode	N/A
0.0%	The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		20%	per episode	N/A
0.0%	The PPO Benchmark Model includes a deductible. Eliminating the deductible will result in a negligible increase to the employer's plan cost (cost neutral) . This cost estimate assumes there are no changes in managed care practices.		20%	per episode	N/A
0.7%					

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate Average 2007 PPO Cost Per Member Per Month (PMPM) ¹			Revised Benefit Cost Estimate			
	Plan Benefit Model Recommendations	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)
IV. Therapeutic Services / Ancillary Services							
a. Prescription Drugs	\$58.23	\$21.16	\$37.06	\$-	\$37.06	\$-	0.0%
b. Dental Services	\$18.90	\$5.01	\$13.90	\$3.11	\$17.01	\$-	0.0%
c. Vision Services	\$4.77	\$1.73	\$3.03	\$1.73	\$4.77	\$-	0.6%
d. Audiology Services	\$2.25	\$0.50	\$1.75	\$-	\$1.75	\$-	0.0%
e. Nutritional Services				\$1.22	\$1.22	\$0.35	0.4%
f. Occupational, Physical, and Speech Therapy Services	\$1.43	\$0.31	\$1.12	\$0.23	\$1.35	\$(0.23)	0.1%
g. Infertility Services	\$7.42	\$1.47	\$5.94	\$-	\$5.94	\$-	0.0%
h. Home Health Services	\$1.43	\$0.52	\$0.91	\$-	\$0.91	\$-	0.0%
i. Hospice Care	\$0.11	\$0.02	\$0.08	\$-	\$0.08	\$-	0.0%
j. Durable Medical Equipment & Supplies	\$2.71	\$0.98	\$1.72	\$0.55	\$2.27	\$0.06	0.2%
- Medical Foods				\$0.11	\$0.11	\$0.03	0.0%
k. Transportation Services	\$0.70	\$0.26	\$0.45	\$-	\$0.45	\$-	0.0%
Category Sub-Total:				\$6.95		\$0.21	2.3%
V. Laboratory Diagnostic, Assessment, and Testing Services							
a. Laboratory Services	\$8.71	\$1.93	\$6.78	\$-	\$6.78	\$-	0.0%
b. Diagnostic, Assessment, and Testing (Medical and Psychological) Services	\$10.17	\$2.12	\$8.04	\$-	\$8.04	\$-	0.0%
Category Sub-Total:				\$0.00		\$0.00	0.0%

	Coinsurance	Coinsurance Frequency	Estimated Cost-Offset
*Rationale for Change From Current Cost Estimate			

The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	Tiered	per fill/re-fill	N/A
The PPO Benchmark Model includes member coinsurance for restorative and orthodontic procedures (20% and 50% respectively). Decreasing the coinsurance to 15% and setting the annual maximum benefit at \$5,000 will increase the employer's plan cost by 1.0%.	15%	per visit	N/A
The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and decreasing the coinsurance to 15% will increase the employer's plan cost by 0.6%.	15%	per visit	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	15%	per visit	N/A
The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services will increase the employer's plan cost by 0.4%.	15%	per visit	N/A
The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible, decreasing the coinsurance to 15%, and increasing the annual visit limit from 60 visits to 75 visits will increase the employer's plan cost by 0.1%.	15%	per visit	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) . If a plan does not currently provide coverage for these services, including these services with 25%+ member coinsurance will increase the employer's plan cost by \$5.94 or 2.0%.	25%	per visit/unit or per cycle	N/A
The PPO Benchmark Model includes 20% member coinsurance. Reducing the coinsurance to 10% will result in a negligible increase to the employer's plan cost (cost neutral) .	15%	per visit	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	25%	one-time	N/A
The PPO Benchmark Model excludes coverage for hearing aids. Adding coverage for hearing aids will increase the employer's plan cost 0.2%.	10%	per unit	Cochlear ear implants; cost-effective
The PPO Benchmark Models excludes coverage for medical foods. Adding coverage for medical foods will result in a negligible increase to the employer's plan cost (cost neutral) .	10%	per unit	Donor breast milk; cost-saving for limited populations
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	15% or 25%	per use	N/A

The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	10% - 25%	per battery	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	10% - 25%	per battery	N/A

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate Average 2007 PPO Cost Per Member Per Month (PMPM) ¹			Revised Benefit Cost Estimate			
	Plan Benefit Model Recommendations	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)
Plan Design Total							
				\$30.31	\$334.10	\$(9.50)	10.0%
Estimated Impact of Plan Benefit Model							
Impact of Plan Benefit Model Recommendations (Benefit Additions and Modifications):				\$20.81	6.9%		
Impact From Cost-Shifting to Employer/From Member:				\$9.50	3.1%	\$(9.50)	-11.0%
			Total:	\$30.31	10.0%		
PPO Benchmark Model Costs							
Total Per Member Per Month (PMPM)	\$390.31	\$86.52	\$303.79	\$30.31		\$(9.50)	
Total Per Employee Per Month (PEPM)	\$819.65	\$181.69	\$637.96	\$63.66		\$(19.95)	
Total Per Employee Per Year (PEPY)	\$9835.9	\$2180.33	\$7655.56	\$763.89		\$(239.40)	

Notes

1. The term "member" represents employees and dependents. The Benchmark Model costs are summarized on a per member per month (PMPM) basis.
2. The Benchmark Model average costs shown in this table are for a FPO plan with the following member cost-sharing specifications:
 - Medical services other than prescription drugs: \$250 deductible, 20% coinsurance, subject to a \$2,500 out-of-pocket limit.
 - Prescription drugs: \$10 copay for generic and \$25 copay for brand prescriptions (mail order = 2 times retail).
 - Dental services: \$50 deductible, 0%/20%/50% coinsurance for preventive/restorative/orthodontic services, with a \$2,500 maximum benefit per year.
3. A given employer's health plan costs may vary from the rates shown above due to differences in plan design, member demographics, provider payment rates, or level of managed care practices for medical and mental health services.
4. Unless otherwise noted, changes in coverage to meet the minimum Plan Benefit Model recommendations are applicable to all members.
*Cost estimates for select Plan Benefit Model recommendations are based on assumptions developed by the Business Group for (a) the degree to which the service is currently covered by large-employer health plans, and (b) the prevalence of the condition the service seeks to address.

2

Maternal and Child Health Plan Benefit Model: Evidence-Informed Coverage

Maternal and Child Health Plan Benefit Model

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Maternal and Child Health Plan Benefit Model

Sample Plan Benefit Key

Recommended Plan Benefits: One of Five Types of Service																	
The Specific Type of Benefit																	
Definition of Benefit		Covered Providers															
A summary definition of the type of benefit and/or rationale for including the benefit.		Covered providers and/or related benefit information.															
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions														
Typically expressed as the maximum amount of benefit covered by the plan.	Plan provisions that reflect unique circumstances and allow for exceptions to be made.	Particular benefits that should be covered by the type of benefit.	Particular benefits that should not be covered by the type of benefit.														
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0%-25%)	Out-of-Pocket Maximum															
Recommendation on copayment (HMO model) or coinsurance (PPO model) amount.	<p style="text-align: center;">Recommended copayment and coinsurance (in-network) levels correspond to the key summarized below:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Copayment</td> <td style="width: 50%;">Coinsurance</td> </tr> <tr> <td>0 = \$0</td> <td>= 0%</td> </tr> <tr> <td>1 = \$10 - \$20</td> <td>= 10%</td> </tr> <tr> <td>2 = \$25 - \$40</td> <td>= 15%</td> </tr> <tr> <td>3 = \$45 - \$60</td> <td>= 20%</td> </tr> <tr> <td>4 = \$75 - \$100</td> <td>= 25%</td> </tr> <tr> <td>5 = \$100+</td> <td>= 25%+</td> </tr> </table>	Copayment	Coinsurance	0 = \$0	= 0%	1 = \$10 - \$20	= 10%	2 = \$25 - \$40	= 15%	3 = \$45 - \$60	= 20%	4 = \$75 - \$100	= 25%	5 = \$100+	= 25%+	<p>Denotes whether individual expenses apply to the maximum expense paid per individual or per family in a single calendar year. After that amount is reached, the health plan will pay 100% of covered charges for the remainder of the calendar year.</p> <p>Individual (1): \$1,500 Individual plus one (2): \$3,000 Family (3+): \$4,500</p>	
Copayment	Coinsurance																
0 = \$0	= 0%																
1 = \$10 - \$20	= 10%																
2 = \$25 - \$40	= 15%																
3 = \$45 - \$60	= 20%																
4 = \$75 - \$100	= 25%																
5 = \$100+	= 25%+																
Actuarial Impact	Cost of Recommended Benefits (PMPM)	Cost Impact															
	The per member per month (PMPM) estimate of the total employer cost of the benefit as it is described in this plan.	One of the following: <ul style="list-style-type: none"> • Decrease • Neutral • Increase 	The estimated employer cost impact will be influenced by an individual employer's health plan design and administration rules. If an employer's current health plans were identical to the HMO/PPO Benchmark Model and the employer were to adopt all of the Plan Benefit Model recommendations, the employer's health plan costs would Increase 10% and 6.2%, respectively. Cost-offset values associated with preventive services are excluded from this calculation.														
Citations																	
Source	Actual reference	The strength of the reference, which will be one of the following: <ol style="list-style-type: none"> 1. Evidence-Based Research 2. Recommended Guidance (e.g., Expert Opinion, Expert Consensus, Expert Panel) 3. Federally Vetted 4. Industry Standard 5. Actuarial Analysis 															

I. Recommended Minimum Plan Benefits: Preventive Services

A. WELL-CHILD SERVICES

Definition of Benefit		Covered Providers	
Medical services designed to promote and protect the health of infants, children, and adolescents. These services include comprehensive health assessments; age-appropriate screening, counseling, preventive medication, and preventive treatment; parent and child education; and anticipatory guidance. ¹		Covered services must be furnished by or under the direction of a primary care provider (family physician, pediatrician, nurse practitioner, general practitioner, internal medicine physician).	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
26 visits between birth and 21 years of age. ¹	Include provisions for children with complex case-management needs (e.g., flex benefits).	All appropriate preventive care. Medical necessity supported by the Plan Benefit Model definition.	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 2.24 (HMO) \$ 2.24 (PPO)	The HMO Benchmark Model includes a \$10 copayment. The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating cost-sharing for both plans is estimated to increase the employer's plan cost by: <ul style="list-style-type: none"> • \$0.37 PMPM / 0.1% of total plan costs (HMO) • \$0.84 PMPM / 0.3% of total plan costs (PPO) 	
Citations			
1. Bright Futures Recommendation	Hagan J, Shaw JS, Duncan P, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> , 3rd edition. Elk Grove Village, IL: American Academy of Pediatrics; 2007.		Recommended Guidance: Expert Opinion
2. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: PricewaterhouseCoopers LLP, August 2007.		Actuarial Analysis

Maternal and Child Health Plan Benefit Model

I. Recommended Minimum Plan Benefits: Preventive Services

B. IMMUNIZATIONS

Definition of Benefit		Covered Providers	
Screening for susceptibility to vaccine-preventable diseases, immunizations, and related services. ¹		Covered services must be furnished by or under the direction of a primary care provider (family physician, pediatrician, nurse practitioner, general practitioner, internal medicine physician), physician's assistant, certified nurse midwife, OB-GYN, or other qualified provider.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
No limits for children and adolescents (0 to 21 years); women planning a pregnancy, and women who are pregnant. ^{1,2}	N/A	<ul style="list-style-type: none"> All immunizations and associated care recommended by the Advisory Committee on Immunization Practices (ACIP).¹ Immunizations to address travel, occupational, and other high-risk activities.¹ 	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
No cost-sharing for ACIP recommended routine and high-risk immunizations; minimal cost-sharing for travel immunizations.	0 / 0% (general); 1 / 10% (travel)	Copayment and coinsurance amounts apply toward maximum	
Actuarial Impact ³	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 2.21 (HMO) \$ 2.21 (PPO)	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and coinsurance are estimated to increase the employer's cost by: <ul style="list-style-type: none"> \$ 83 PMPM / 0.3% of total plan costs (PPO) 	
Citations			
1. Advisory Committee on Immunization Practices	Centers for Disease Control and Prevention. General recommendations for immunization: recommendations of the Advisory Committee on Immunization Practices and the American Academy of Family Physicians. <i>MMWR</i> 2006; 55(RR-15):1-18.	Preventive Services Guideline	
2. American Academy of Pediatrics	American Academy of Pediatrics. Pickering LK, Baker CL, Long SS, Mittleman B, et al. <i>Red Book: 2006 Report of the Committee on Infectious Diseases</i> . 27th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2006.	Recommended Guideline Expert Opinion	
3. Fidelity Investments	Fidelity Investments Company LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: Fidelity Investments Company LLP; August 2007.	Actuarial Analysis	

¹ The Advisory Committee on Immunization Practices (ACIP) releases updated recommendations for immunization coverage for children and adolescents. Employers should contact their health plan administrator to provide coverage for newly recommended immunizations and state-specific immunization requirements from ACIP.

I. Recommended Minimum Plan Benefits: Preventive Services

C. PREVENTIVE DENTAL SERVICES

Definition of Benefit		Covered Providers	
Covered preventive services include risk assessments and anticipatory guidance in order to promote oral health, ¹ oral examinations, and diagnostic procedures. ²		Covered services must be furnished by or under the direction of a licensed dentist or licensed dental hygienist. Licensed dental hygienists must be overseen by a dentist or primary care provider or operate in conformance with state regulation for the independent practice of preventive dentistry. Risk assessments, anticipatory guidance, and fluoride varnish may be performed by a primary care provider.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
One preventive visit during the first 12 months of life ^{1,2} ; 2 visits per calendar year for all beneficiaries aged 2 to 21 years ^{2,5} ; 1 visit during the preconception period and 1 visit during pregnancy for all women. ⁵ Additional visits to implement and maintain preventive equipment (e.g., space maintainer) and procedures are covered, as medically necessary.	N/A	<p>All appropriate preventive care, including:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year.^{2,3} • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16).^{2,3} • Space maintainer (primary teeth only).³ • Bitewing x-rays (one set per calendar year).^{2,3} • Complete series x-rays (one complete series every 3 years).^{2,3} • Periapical x-rays.^{2,3} • Routine oral evaluations (limited to 2 per calendar year).^{2,3} • Fluoride varnish or gel applications (1 treatment per calendar year for children under age 16 at low or average risk, 4 treatments per calendar year for children under age 16 at moderate or high risk).⁴ • Fluoride supplementation.^{2,4} 	All others as defined by the health plan. <i>Please refer to the "Dental Services" benefit for additional coverage guidelines.</i>
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ⁷	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 6.86 (HMO) \$ 7.60 (PPO)	The HMO and PPO Benchmark Models are consistent with the Plan Benefit Model (cost neutral)	
Citations			
1. Bright Futures Recommendations	Hogan JF, Shaw JS, Duncan P, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> . 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2007.	Recommended Guidance: Expert Opinion	
2. American Academy of Pediatric Dentistry	American Academy of Pediatric Dentistry. <i>Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children</i> . Revised 2003.	Recommended Guidance: Expert Opinion	
3. Federal Employee Health Benefit Plan	U.S. Office of Personnel Management. <i>Federal Employees Health Benefits Program Survey of Plan Characteristics (Other Individual Practices) with a Consumer-driven health plan option and a high deductible health plan option</i> . Available at: http://www.opm.gov/health/07/teachres/0773-828.pdf . Accessed on January 15, 2007.	In-Situ Study	
4. American Dental Association	Task Force Based Clinical Recommendations: Professionally Assisted Topical Fluoride. Report of the Commission on Preventive Services. ADA May 2006.	Recommended Guidance: Expert Opinion	
5. Maternal and Family Health Benefits Advisory Board	Maternal and Family Health Benefits Advisory Board. Washington, DC: National Business Group on Health; August 2007.	Recommended Guidance: Expert Opinion	
6. U.S. Preventive Services Task Force	U.S. Preventive Services Task Force. <i>Oral cancer screening in preschool children: Summary of recommendations</i> . Rockville, MD: Agency for Healthcare Research and Quality; 2004. Available at: http://www.ahrq.gov/clinic/uspstf04/oralcan.htm . Accessed on June 1, 2007.	Evidence-Based Research	
7. PricewaterCoopers	PricewaterCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: PricewaterCoopers LLP; August 2007.	Actuarial Analysis	

Maternal and Child Health Plan Benefit Model

I. Recommended Minimum Plan Benefits: Preventive Services

D. EARLY INTERVENTION SERVICES FOR MENTAL HEALTH / SUBSTANCE ABUSE

Definition of Benefit		Covered Providers	
Medical services designed to educate and counsel individuals and families about behaviors that facilitate mental health, improve personal resiliency, facilitate early intervention and prevent the escalation of sub-clinical problems, and monitor and treat V-code conditions.		Covered services must be furnished by or under the direction of a primary care provider (family physician, pediatrician, nurse practitioner) or a mental health professional (psychiatrist, clinical psychologist, licensed clinical social worker, licensed professional counselor, psychiatric nurse practitioner) ¹	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
8 visits per calendar year ²	Include provisions for children with complex case-management needs (e.g., flex benefits). Consider extending benefit for multiple providers.	Screening (including family psychosocial screening), monitoring, and treatment of DSM-IV V-code conditions.	All others as defined by the health plan. Please refer to the "Mental Health / Substance Abuse" benefit for additional coverage information.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ³	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 4.83 (HMO) \$ 5.85 (PPO)	The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by: <ul style="list-style-type: none"> • \$4.83 PMPM / 1.7% of total plan costs (HMO) • \$5.43 PMPM / 1.9% of total plan costs (PPO) 	
Citations			
1. U.S. Department of Health and Human Services, Bureau of Health Professions	U.S. Department of Health and Human Services, Bureau of Health Professions, <i>Health Professional Shortage Area Guidelines for Mental Health Care Disparities</i> . Available at http://bhpr.hhs.gov/shortage/hsa-guidelines.htm . Accessed on January 12, 2007.	Recommended Guidance	
2. Maternal and Family Health Benefits Advisory Board	Maternal and Family Health Benefits Advisory Board, Washington, DC: National Business Group on Health, August 2007.	Recommended Guidance: Expert Opinion	
3. PricewaterhouseCoopers	PricewaterhouseCoopers LLP, Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model. Atlanta, GA: PricewaterhouseCoopers LLP, August 2007.	Actuarial Analysis	

I. Recommended Minimum Plan Benefits: Preventive Services

E. PREVENTIVE VISION SERVICES

Definition of Benefit		Covered Providers	
<p>Medical services designed to identify children who may have eye or vision abnormalities, or risk factors for developing eye problems. Examination of the eyes should be performed beginning in the newborn period and at all subsequent well-child care visits. Additional preventive vision screening is recommended for children who are unable to be screened in well-child care due to time or health constraints.¹</p>		<p>Covered services must be furnished by or under the direction of a primary care provider (family physician, pediatrician, nurse practitioner, general practitioner, internal medicine physician).</p>	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
<p>2 visits outside of regular well-child care⁴ between birth and age 5.^{1,3}</p>	<p>Include provisions for children with complex case-management needs (e.g., flex benefits).</p>	<p>Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.²</p> <p>Exams include: visual acuity tests, stereopsis, vision history, external eye inspection, ophthalmoscopic examination, tests for ocular muscle motility and eye muscle imbalances, and monocular distance acuity.¹</p>	<p>All others as defined by the health plan. Please refer to the "Vision Services" benefit for additional coverage information.</p>
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ⁴	Cost of Recommended Benefits (PMPM)	Cost Impact	
	<p>\$ 0.32 (HMO) \$ 0.39 (PPO)</p>	<p>The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by:</p> <ul style="list-style-type: none"> \$0.32 PMPM / 0.1% of total plan costs (HMO) \$0.39 PMPM / 0.1% of total plan costs (PPO) 	
Citations			
1 American Academy of Ophthalmology	American Academy of Ophthalmology. Pediatric eye evaluations. Preferred Practice Pattern. AAO, 2002	Recommended Guidance Practice Guideline	
2 U.S. Preventive Services Task Force	U.S. Preventive Services Task Force. <i>Guide to Clinical Preventive Services</i> . 2nd ed. Rockville, MD: Agency for Healthcare Research and Quality, 2003	Evidence Based Research	
3 American Academy of Pediatrics; American Association of Certified Orthoptists; American Association for Pediatric Ophthalmology and Strabismus; American Association of Ophthalmology	Committee on Practice and Ambulatory Medicine, Section on Ophthalmology. American Association of Certified Orthoptists. American Association for Pediatric Ophthalmology and Strabismus. American Academy of Ophthalmology. Eye examination in infants, children, and young adults by pediatricians. <i>Pediatrics</i> 2003;111(4):1119-27	Recommended Guidance	
4 Procter and Gamble	Procter and Gamble. <i>Actuarial Analysis of the National Business Group on Health's Medical and Child Health Plan Benefit Model</i> . Atlanta, GA: Procter and Gamble LLP, August 2007	Actuarial Analysis	

⁴ Most children and adolescents receive routine vision screening during the course of well-child care. However, young children who are uncooperative or children with special needs and children who are in day well-child care need access to vision screening outside of designated preventive visits. The "Preventive Vision Services" screening benefit is designed to support this need.

Maternal and Child Health Plan Benefit Model

I. Recommended Minimum Plan Benefits: Preventive Services			
F. PREVENTIVE AUDIOLOGY SCREENING SERVICES			
Definition of Benefit		Covered Providers	
Medical services to detect and diagnose speech, hearing, and language disorders.		Covered services must be furnished by or under the direction of a primary care provider (family physician, pediatrician, nurse practitioner, general practitioner, internal medicine physician) or a covered specialist (audiologist or speech pathologist).	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
3 visits between birth and 19 years of age. Services must be rendered during the course of a well-child care visit or with referral from a PCP to a covered specialist. ¹	Include provisions for children with complex case-management needs (e.g., flex benefits).	All appropriate preventive care. Medical necessity supported by the Plan Benefit Model definition.	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 0.32 (HMO) \$ 0.39 (PPO)	The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to Increase the employer's plan cost by: <ul style="list-style-type: none"> • \$0.32 PMPM / 0.1% of total plan costs (HMO) • \$0.39 PMPM / 0.1% of total plan costs (PPO) 	
Citations			
1	Maternal and Family Health Benefits Advisory Board	Maternal and Family Health Benefits Advisory Board, Washington, DC, National Business Group on Health, August 2007	Recommended Guidance, Expert Opinion
2	PricewaterhouseCoopers	PricewaterhouseCoopers LLP, <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> , Atlanta, GA, PricewaterhouseCoopers LLP, August 2007	Actuarial Analysis

Maternal and Child Health Plan Benefit Model

I. Recommended Minimum Plan Benefits: Preventive Services

H. PREVENTIVE PRECONCEPTION CARE

Definition of Benefit		Covered Providers	
Medical services aimed at improving the health outcomes of pregnant women and infants by promoting the health of women of reproductive age prior to conception. ¹		Covered services must be furnished by or under the direction of a primary care physician (family physician, general practitioner, internal medicine physician, OB-GYN ²), nurse practitioner, or a medical professional who is licensed to provide pregnancy-related primary care services (e.g., certified nurse midwife)	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
2 preconception care visits per calendar year ¹	Include provisions for women with complex case-management needs (e.g., flex benefits).	All appropriate preventive care. Medical necessity supported by the Plan Benefit Model definition.	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	N/A (already included in standard office visit estimate)	The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to be cost neutral.	
Citations			
1. Centers for Disease Control and Prevention	Centers for Disease Control and Prevention. <i>Recommendations to Improve Preconception Health and Health Care — United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care.</i> Available at: http://www.cdc.gov/MMWR/preview/mmwrhtml/rr5506a1.htm . Accessed on September 1, 2007.		Recommended Guidance, Expert Opinion
2. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model.</i> Atlanta, GA: PricewaterhouseCoopers LLP, August 2007.		Actuarial Analysis

¹ Obstetricians and gynecologists (OB-GYNs) are considered "primary care providers" only when they are providing preconception, prenatal, and postpartum care. They are considered "medical specialists" when providing all other types of services. Copayment/coinsurance amounts should be adjusted accordingly.

I. Recommended Minimum Plan Benefits: Preventive Services

I. PREVENTIVE PRENATAL CARE

Definition of Benefit		Covered Providers	
<p>Prenatal care: Medical services designed to facilitate the health of a pregnant woman or fetus, or that have become necessary as a result of pregnancy. Covered services may also address conditions that might complicate a pregnancy, threaten a woman's ability to carry the fetus to term, or deliver the fetus safely.¹</p> <p>Prenatal pediatric care: A single visit designed to allow a pediatrician (or other primary care provider) to gather basic information from parents, provide information and advice, and identify high-risk situations in which parents may need to be referred to appropriate resources for help.² This visit is relevant only in situations where the infant's primary care provider did not provide prenatal care to the infant's mother.</p>		<p>Covered services must be furnished by or under the direction of a primary care physician (family physician, general practitioner, internal medicine physician, OB-GYN³), nurse practitioner, or a medical professional who is licensed to provide pregnancy-related primary care services (e.g., certified nurse midwife).</p>	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
<p>20 prenatal care visits¹ 1 prenatal pediatric visit²</p>	<p>Include provisions for women with complex case-management needs (e.g., flex benefits).</p>	<p>All appropriate preventive care including all routine screening and diagnostic tests (e.g., amniocentesis, chorionic villus sampling, etc). Medical necessity supported by the Plan Benefit Model definition.</p>	<p>All others as defined by the health plan.</p>
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ³	Cost of Recommended Benefits (PMPM)	Cost Impact	
	<p>\$ 1.61 (HMO) \$ 1.95 (PPO)</p>	<p>The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by:</p> <ul style="list-style-type: none"> • \$1.61 PMPM / 0.6% of total plan costs (HMO) • \$1.95 PMPM / 0.6% of total plan costs (PPO) 	
Citations			
1. American Academy of Pediatrics & American College of Obstetricians and Gynecologists	American Academy of Pediatrics & American College of Obstetricians and Gynecologists. <i>Guidelines for Perinatal Care</i> , 5th ed. Elk Grove Village, IL: American Academy of Pediatrics & American College of Obstetricians and Gynecologists, October 2002. (Source recommends 15 prenatal care visits, plus one per week after week 40)	Recommended Guidance: Expert Opinion	
2. American Academy of Pediatrics	Committee on Psychosocial Aspects of Child and Family Health. Policy statement: The prenatal visit. <i>Pediatrics</i> 2001; 107(6): 1456-1458. American Academy of Pediatrics. Pickering LK, Bicker CJ, Long SS, M.M. et al. <i>Red Book, 2006 Report of the Committee on Infectious Diseases</i> , 27th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2006	Recommended Guidance: Expert Opinion	
3. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: PricewaterhouseCoopers LLP, August 2007	Actuarial Analysis	

³ Obstetricians and gynecologists (OB-GYNs) are considered "primary care providers" only when they are providing preconception, prenatal, and postpartum care. They are considered "medical specialists" when providing all other types of services. Copayment/coinsurance amounts should be adjusted accordingly.

Maternal and Child Health Plan Benefit Model

I. Recommended Minimum Plan Benefits: Preventive Services

J. PREVENTIVE POSTPARTUM CARE

Definition of Benefit		Covered Providers	
Medical services that are necessary for the health of the woman post-pregnancy and/or the newborn infant. ¹		Covered services must be furnished by or under the direction of a primary care physician (family physician, general practitioner, internal medicine physician, OB-GYN ²), nurse practitioner, or a medical professional who is licensed to provide pregnancy-related primary care services (e.g., certified nurse midwife). In addition, lactation consultants credentialed by the International Board of Lactation Consultant Examiners (IBCLCs) are approved for the provision of breastfeeding counseling, training, and support. ³	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
One postpartum care visit per pregnancy (delivered between 21 and 56 days after delivery). ² 5 lactation consultation visits per pregnancy. ^{3,4}	N/A	All appropriate preventive care. Medical necessity supported by the Plan Benefit Model definition. Lactation benefit supported by medical necessity of mother or infant.	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0%	N/A	
Actuarial Impact ⁴	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 0.32 (HMO) \$ 0.39 (PPO)	The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by: <ul style="list-style-type: none"> \$0.32 PMPM / 0.1% of total plan costs (HMO) \$0.39 PMPM / 0.1% of total plan costs (PPO) 	
Citations			
1. Kaiser Family Foundation	The Henry J. Kaiser Foundation. <i>Medicaid Benefits Online Database, Benefits by Service, Definition/Notes (October, 2004)</i> . Available at: http://www.kff.org/medicaid/benefits/service_main.jsp . Accessed on January 15, 2007.	Industry Standard	
2. American Academy of Pediatrics & American College of Obstetricians and Gynecologists	American Academy of Pediatrics & American College of Obstetricians and Gynecology. <i>Guidelines for Perinatal Care</i> . 5th ed. Elk Grove Village, IL: American Academy of Pediatrics & American College of Obstetricians and Gynecologists, October 2002.	Recommended Guidance: Expert Opinion	
3. United States Breastfeeding Committee	Association of Women's Health, Obstetric and Neonatal Nurses. <i>United States Breastfeeding Committee Recommendations</i> . Available at: http://www.usbreastfeeding.org/press/finding/index.htm . Accessed on February 1, 2007.	Recommended Guidance	
4. Procter & Gamble	Procter & Gamble Coopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: Procter & Gamble Coopers LLP, August 2007.	Actuarial Analysis	

¹ Obstetricians and gynecologists (OB-GYNs) are considered "primary care providers" only when they are providing pre-pregnancy, prenatal, and postpartum care. They are considered "medical specialists" when providing all other types of services. Copayment/coinsurance amounts should be adjusted accordingly.

² Lactation consultation visits may be used at any point during pregnancy and in the year after birth.

Recommended Minimum Plan Benefits: Preventive Services

K. PREVENTIVE SERVICES (GENERAL)			
Definition of Benefit		Covered Providers	
Medical services that are designed to detect the existence of, or risk for, diseases, conditions, and problems in asymptomatic people.		Covered services must be furnished by or under the direction a primary care provider (family physician, general practitioner, internal medicine physician, nurse practitioner, pediatrician), or other qualified provider.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
<p>Coverage for clinical preventive services for at-risk children, adolescents, and women of childbearing-age that are not typically delivered in routine:</p> <ul style="list-style-type: none"> Well-child care Preventive preconception, prenatal, or postpartum care. <p>Frequency as defined by the U.S. Preventive Services Task Force or other cited reference.</p>	N/A	<p>All appropriate preventive care. Screening services for high-risk populations are covered, as deemed medically necessary. Services may include, but are not limited to:</p> <ul style="list-style-type: none"> Alcohol misuse screening and counseling^{1,2} Cervical cancer screening² Chlamydia screening² Depression screening² Diabetes² Gonorrhea screening² HIV screening² Hypertension² Lead screening³ Lipids² Obesity² Sexually transmitted infection (STI) counseling Syphilis² TB screening³ Tobacco use screening and counseling² 	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
None	0 / 0% (office visits and any covered screening services)	N/A	
Actuarial Impact ⁴	Cost of Recommended Benefits (PMPM)	Cost Impact	
	<p>\$ 3.22 (HMO) \$ 3.90 (PPO)</p>	<p>The HMO and PPO Benchmark Model: exclude coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by:</p> <ul style="list-style-type: none"> \$3.22 PMPM / 1.1% of total plan costs (HMO) \$3.90 PMPM / 1.3% of total plan costs (PPO) 	
Citations			
1 American Academy of Pediatrics	<p>American Academy of Pediatrics. Alcohol use and abuse: a pediatric concern. <i>Pediatrics</i>. 2001;108:185-9. Rubin JW. Tobacco, alcohol, and other drugs: the role of the pediatrician in prevention, identification, and management of substance abuse. <i>Pediatrics</i>. 2005;115:816-21.</p> <p>American Academy of Pediatrics. In: Pickering LK, Baker CL, Long SS, McMillan JA, eds. <i>Red Book: 2006</i>. Part of the Committee on Infectious Diseases. 27th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2006.</p>		Recommended Guidance: Expert Consensus

Maternal and Child Health Plan Benefit Model

I. Recommended Minimum Plan Benefits: Preventive Services

K. PREVENTIVE SERVICES (GENERAL) *continued*

Citations		
<p>2. U.S. Preventive Services Task Force</p>	<p>Information on U.S. Preventive Services Task Force (USPSTF) recommendations can be found at http://www.ahrq.gov/clinic/uspstf/uspstf.htm</p> <ul style="list-style-type: none"> • Screening for alcohol misuse. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. Rockville, MD: Agency for Health Care Research and Quality, 2004. <i>Recommended for adults age 18 and older only.</i> • Screening for cervical cancer. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. 2nd ed. Rockville, MD: Agency for Health Care Research and Quality, 2003. • Screening for chlamydial infection. Summary of recommendations / Supporting documents. <i>Guide to Clinical Preventive Services</i>. Rockville, MD: Agency for Healthcare Research and Quality, 2007. • Screening for depression. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. Rockville, MD: Agency for Healthcare Research and Quality, 2002. <i>Recommended for adults age 18 and older only.</i> • Screening for diabetes mellitus, adult type II. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. 2nd ed. Rockville, MD: Agency for Healthcare Research and Quality, 2003. <i>Recommended for high-risk adults age 18 and older.</i> • Screening for gonorrhea. Recommendation Statement. <i>AHRQ Publication No. 05-0579-A</i>, May 2005. Agency for Healthcare Research and Quality, Rockville, MD. <i>Recommended for sexually active women only.</i> • Screening for high blood pressure. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. Rockville, MD: Agency for Healthcare Research and Quality, 2003. <i>Recommended for adults age 18 and older only.</i> • Screening for lipid disorders in adults. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. Rockville, MD: Agency for Health Care Research and Quality, 2001. <i>Recommended for adults age 18 and older only.</i> • Screening for obesity, adult type II. Summary of Recommendations / Supporting Documents. <i>Guide to Clinical Preventive Services</i>. Rockville, MD: Agency for Healthcare Research and Quality, 2003. <i>Recommended for high-risk adults age 18 and older.</i> • Screening for Syphilis Infection. Recommendation Statement. <i>J. 2004</i>. Agency for Healthcare Research and Quality, Rockville, MD. <i>Recommended for high-risk women and all pregnant women.</i> • Tobacco use. Summary of Recommendations / Supporting Documents. Rockville, MD: Agency for Healthcare Research and Quality, 2003. 	<p>Evidence-Based Research</p>
<p>3. Centers for Disease Control and Prevention</p>	<p>Centers for Disease Control and Prevention. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings. <i>MMWR</i> 2006;55 (RR14): 1-17.</p> <p>Centers for Disease Control and Prevention. <i>Screening young children for lead poisoning: guidance for state and local public health officials</i>. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, CDC, 1997. Available at: www.cdc.gov/nceh/lead. Accessed June 1, 2007.</p> <p>Centers for Disease Control and Prevention. Targeted tuberculin testing and treatment of latent tuberculosis infection. <i>MMWR</i> 2000;49 (RR-6): 1-54.</p>	<p>Expert Opinion</p>
<p>4. PricewaterhouseCoopers</p>	<p>PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i>. Atlanta, GA: PricewaterhouseCoopers LLP, August 2007.</p>	<p>Actuarial Analysis</p>

Replaced

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 170(L&C)
(S) Publish Date: 5/10/07

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
Title Insurance Coverage for Well-Baby Exams RDU Insurance (116)
Component Insurance
Sponsor McGuire
Requester Senate Labor & Commerce Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
----------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation would require health care insurers to provide insurance coverage for well baby exams. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director
Division Insurance
Approved by: Emil R. Notti, Commissioner
Agency Commerce, Community, and Economic Development

Phone 907-269-7900
Date/Time 05/08/2007 2:36PM
Date 5/8/2007

ALASKA STATE LEGISLATURE

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Chair
Senate State Affairs
Administrative Regulation Review

Member
Senate Judiciary Committee
Senate Resources Committee

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SB170 – Insurance Coverage for Well Baby Exams

Infancy is perhaps the most critical period in a child's life. Routine medical checkups during this vulnerable stage are necessary in order to monitor and assess a baby's normal, healthy development. These checkups – commonly referred to as "well-baby" exams – not only provide a professional medical assessment of a newborn's health and development, but they also provide the opportunity to educate parents in proper child care.

SB 170 would require health insurance carriers in the State of Alaska to include in their standard coverage for dependents well-baby exams. These exams, considered a part of routine pediatric health supervision, are estimated to cost between \$125 and \$250 per visit. The American Academy of Pediatrics recommends a schedule that includes 10 exams in the first 24 months of a baby's life. A typical well-baby exam includes monitoring development and growth rates, hearing, vision, language skills, motor development, diet, general and preventative health care, immunizations, and infectious diseases.

There is evidence to suggest that preventative healthcare coupled with early detection of health related problems not only improves health outcomes but is also cost-effective over the long run. Although "well-baby" exams may increase short-term costs to insurance providers, they inevitably save money in the long run. By averting severe and more costly health problems, including serious illness and emergency care, "well-baby" exams make sense.



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January 29, 2008

The Honorable Lesil McGuire
State Capitol, Room
Juneau, AK 99801-1182

RE: SB 170 Well Baby Exams

Dear Senator McGuire

I am writing to add support for SB 170 that would require insurance carriers to provide well baby coverage for the first 2 years of life. The American Academy of Pediatrics has long been an advocate of routine well visits. Preventative care has been shown to be very cost effective in that early screening allows for early intervention, when problems are small and easily remedied. Regular visits also improve immunization rates. I have included a link to the AAP's Well Visit Periodicity Schedule below. (If you are not able to access this it can also be found in *Pediatrics* December 2007 page 1376-1377)

<http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1>

Thank you for your continued concern and interest for the well being of Alaska's children

Sincerely yours

Jody Butto MD FAAP
President Alaska Chapter AAP

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 11, 2008

Honorable Bettye Davis, Chair Senate Health, Education and Social Services Committee
State Capitol, Room 30
Juneau, AK 99801-1182

RE: CS SB170 - Well Baby Exams

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

CS SB170 provides for mandatory health insurance coverage for the cost of well-baby exams. Monitoring a child's medical metrics in the first 24 months of life is critical to the preventative healthcare and the early detection of health problems. This is good medicine and ASMA supports the enactment of CS SB170.

ASMA urges you to support the enactment of CS SB170.

Sincerely,



J. Ross Tanner, DC, President



Alaska

February 7, 2007

The Honorable Lesil McGuire
Alaska State Capitol Building
Juneau, Alaska 99801

RE: Senate Bill 170 – Mandatory Health Insurance Coverage for Well Baby Visits

Dear Senator McGuire,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 170. The National Federation of Independent Business is the largest small-business advocacy group in the state.

While we understand the concern with health insurance coverage for well baby visits, we must oppose mandatory benefits, especially when directed to a specific health benefit. Small businesses in Alaska budget a portion of their revenues to employee compensation, which includes the cost of health insurance. The distribution of those funds should be left to discussions between employees and employers, without the interference of the state. Mandating this benefit limits the options of employee health insurance programs.

The design of employee health insurance programs should not be determined by the legislature for private employers. Such action is nothing less than an unfunded mandate on small Alaskan employers and their employees. Such benefit mandates can increase the cost of health insurance and may have the ultimate effect of pricing health insurance out of the reach of small employers and their employees.

I enclosed a report done by NFIB in 2007 on the purchasing of health insurance by small businesses. Among its findings is that a significant number of new small businesses are choosing not to offer health benefits. Also it shows a move to defined benefit approach by offering a fixed payment to reimburse employees who purchase their own coverage. We believe the cost of mandated benefits leads to these strategies to contain added employer costs.

Sincerely,

Dennis L. DeWitt
Alaska State Director
National Federation of Independent Business

cc: Senate Health, Education, and Social Services Committee

Effect of Compliance With Health Supervision Guidelines Among US Infants on Emergency Department Visits

Rosemarie B. Hakim, PhD; Donna S. Ronsaville, PhD

Background: There are few studies that demonstrate the health benefit of compliance with early periodic health supervision.

Objective: To examine the association between emergency department (ED) use and compliance with prevailing guidelines for periodic health supervision for conditions that potentially could be avoided among a national cohort of US children.

Design: This was a historic cohort study that combined maternal and primary care physician reports of the use of preventive care services for infants during the first 7 months of life from the 1988 National Maternal and Infant Health Survey and its 1991 Longitudinal Follow-up study. A preventive care scale used in Cox proportional hazards survival regression predicted the time to the first ED visit for selected diagnoses and all-cause visits controlling for illness severity.

Results: Among children with incomplete well-child care in the first 6 months of life, there was an increased risk of having an ED visit for an upper respiratory tract infection (hazard ratio, 2.3; 95% confidence interval, 1.6-3.2), gastroenteritis (hazard ratio, 1.8; 95% confidence interval, 1.0-3.0), asthma (hazard ratio, 2.1; 95% confidence interval, 1.0-4.3), and all-cause ED visits (hazard ratio, 1.6; 95% confidence interval, 1.4-1.98).

Conclusions: Because of the positive effect compliance with national guidelines for early well-child care has on lowering the risk of experiencing ED use, national efforts to improve the quality of child health services for young children should focus on increasing compliance with periodic preventive care for young children.

Arch Pediatr Adolesc Med. 2002;156:1015-1020

THE SCHEDULE of early pediatric well-child care visits was designed to accommodate the immunization schedule, monitor early development, and provide guidance and counseling to parents about child care.^{1,2} Other than the proven effectiveness of immunizations, efforts to show a direct health benefit to the schedule of well-child care visits have largely been unsuccessful.³ The conviction that these visits are themselves beneficial is reinforced by research that has correlated poor access to ambulatory services among low-income children with more severe childhood illnesses,⁴ higher avoidable hospitalizations rates,^{5,6} and more frequent use of the emergency department (ED).^{7,8} Because of this lack of evidence, we embarked on a study to examine the relationship of compliance with the schedule of visits recommended by the American Academy of Pediatrics on ED visits.

In an earlier analysis of Medicaid claims data, we found that compliance with the American Academy of Pediatrics recommended series of well-child care visits dur-

ing the first 2 years of life among a large cohort of children enrolled in Medicaid from birth was related to fewer avoidable hospitalizations.¹¹ Only limited information is available in the Medicaid claims about ED visits. To examine the relation between compliance and ED visits, we used longitudinal data from the 1988 National Maternal and Infant Health Survey (NMHS) and its 1991 Longitudinal Follow up (LF).

PARTICIPANTS AND METHODS

The NMHS is a representative sample of live births and late fetal and infant deaths that occurred in the United States in 1988.¹² The purpose of the survey was to examine factors related to poor pregnancy outcomes. The infants were sampled by birth weight (<1500 g, 1500-2499 g, and ≥2499 g) and race (African American and all others) strata, oversampling low-birth-weight and African American children. Seven months after the infants were born, the mothers were interviewed about health habits, socioeconomic characteristics, use of health care services, and the child's health and medical care up until that time. Of the 13 417 mothers selected for the live birth survey, 9953 (74%) re-

From the Centers for Medicare & Medicaid Services, Baltimore, Md (Drs Hakim and Ronsaville); and KLVRIQ Company, Inc, Baltimore (Dr Ronsaville). Dr Ronsaville is now with the National Institute of Mental Health, Bethesda, Md.



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doi: 10.1377/hlthaff.23.5.77
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Quality & Access

Access And Quality In Child Health Services: Voltage Drops

Paul J. Chung and Mark A. Schuster

Abstract

Children require a health care system that promotes healthy development for all children while reaching out to the neediest. Barriers to care have been described as "voltage drops"—resistance points at which patients drop from the system like voltage from an electrical current. We examine the size and nature of these drops, ranging from insurance access to service quality, with respect to children. We find critical policy needs (such as expanded insurance opportunities, increased care coordination, and improved quality measurement) at all system levels. Comprehensive access to insurance and services does not guarantee that children will receive high-quality (safe and effective) care.

Childhood is a unique period of rapid growth and development characterized by dependency, vulnerability, and, for a disproportionate number of children, poverty. The U.S. health care system, best suited to acute care for adults, struggles to accommodate vulnerable populations (such as the elderly or mentally ill). Children require a protective, preventive system—one that helps families anticipate upcoming needs, monitors problems as they arise, and coordinates services. Developing such a system is a critical health policy frontier.

It is essential to understand where the current system succeeds and fails for children. John Eisenberg and Elaine Power adopted the term "voltage drops." Just as an electrical system loses voltage when current passes through

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resistance, the health care system loses people as they confront barriers in seven areas: access to insurance coverage, enrollment in available insurance plans, access to covered services/providers, choice of plans/providers, consistent access to primary care, access to referral services, and delivery of high-quality care.¹ For children, evidence is scant regarding one drop, the impact of plan/provider choice. The other six drops, however, clearly have policy implications that are the focus of this paper. How large are these drops for children, and how might they be reduced?

- ▶ Quality Of Care
- ▶ State/Local Issues

Voltage Drop 1: Access To Insurance Coverage

Background. Lack of insurance is a major barrier to receipt of services. Uninsured children are half as likely as privately insured children to have well-child visits, office visits, or hospitalizations.² By contrast, uninsured children are just as likely to visit emergency departments (EDs): Lack of insurance may cause parents to shift care to EDs or wait until emergency care becomes unavoidable.

In 2002, 61 percent of children had private insurance at least part of the year (mostly through parents' employers), 21 percent had public insurance (primarily through Medicaid or the State Children's Health Insurance Program, SCHIP), and 6 percent had both (switched between them).³ Although 12 percent were uninsured all year, more were uninsured at any given time. In 1999, 26 percent were uninsured at least part of the year.⁴ Reasons for being uninsured include lacking access to insurance (voltage drop 1) and not enrolling despite having access (voltage drop 2).

- ▲ Top
- ▼ Voltage Drop 1: Access...
- ▼ Voltage Drop 2: Enrollment...
- ▼ Voltage Drop 3: Access...
- ▼ Voltage Drop 4: Access...
- ▼ Voltage Drop 5: Access...
- ▼ Voltage Drop 6: Delivery...
- ▼ Conclusion
- ▼ Editor's Notes
- ▼ NOTES

For most children, access to insurance depends heavily on parents' ability to obtain employer-based insurance. In 2003, 66 percent of firms offered health benefits to at least some of their employees; 74 percent of employees were eligible for benefits.⁵ Benefits, however, were offered primarily to full-time employees in larger firms. Only 46 percent of part-time employees, 7 percent of temporary employees, and 46 percent of employees in firms with one to nine workers were offered benefits, down from 2000–2001 peaks. Many employees not offered benefits are above typical income limits for Medicaid/SCHIP; others are noncitizens whose children are often ineligible for public insurance.

Even children currently eligible for public insurance are vulnerable. Although federal Medicaid/SCHIP funding remains stable in 2004, budget shortfalls have prompted thirty-four states to drop a half-million children from Medicaid/SCHIP this year through tightened eligibility.⁷ Many of these children will be unable to obtain private insurance.

Policy implications. Immediate policy needs include recouping losses in Medicaid/SCHIP eligibility and protecting against future threats. Because state budgets have proven particularly vulnerable in economic downturns, Medicaid/SCHIP funding appears inherently unstable, placing children's eligibility in jeopardy. SCHIP reauthorization in 2007 may need to include increased federal control of both funding and eligibility standards.

Private insurance access for children might be increased through market-oriented approaches, including (1) creating employer incentives to provide family coverage for part-time, temporary, and small-firm employees; (2) expanding coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to include these employees; (3) helping small firms establish purchasing cooperatives; and (4) regulating insurance markets to limit costs for small firms. Recent experience with these approaches, however, has been disappointing.⁸

Voltage Drop 2: Enrollment In Available Insurance Plans

Cost sharing tends to reduce use of nonurgent services far more than urgent services; however, nonurgent well-visits are considered among the most important services for children. Managed care's focus on improving access well-child care might be one reason why its effects appear more positive in children than in adults. Creating incentives for insurance plans to limit cost sharing for well-child visits might improve children's access to basic services.

Could offering parents wider choice of plans reduce underinsurance and cost sharing? Ability to choose among plans to find the best mix of services and costs is a central tenet of market-driven health care. Benefits, however, have been mostly theoretical, in part because employers have little ability or incentive to provide choices.²¹ Most employers offer only one health plan, and most who offer multiple plans merely offer different payment structures (for example, HMO versus preferred provider organization, or PPO) for the same providers. Moreover, provider networks are often so large and overlapping that true competition rarely occurs.

Voltage Drop 4: Access To A Consistent Source Of Primary Care

Background. Once services can be accessed, actual health care delivery becomes possible. Well-child care (delivered mostly through pediatricians and family practitioners) is the cornerstone of child health services. Its goals are to prevent illness and promote health through immunizations, routine surveillance (such as developmental screening), and anticipatory guidance (such as car-seat counseling). National guidelines recommend at least twenty-six well-child visits by age twenty-one.²² Although benefits of well-child care remain underexplored, children who meet well-child-visit recommendations are half as likely as other children to visit an ED or be hospitalized and 30 percent more likely to be immunized.²³ Continuity of care (visits with the same provider) may improve these benefits. In a large HMO, children with high continuity of care received less ED and hospital care than other children.²⁴

- ▲ Top
- ▲ Voltage Drop 1: Access...
- ▲ Voltage Drop 2: Enrollme...
- ▲ Voltage Drop 3: Access...
- Voltage Drop 4: Access...
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Both frequency and continuity of well-child visits, however, vary widely. Black and Hispanic children have far fewer visits than white children.²⁵ English speakers are three times as likely as non-English speakers to have a regular source of care.²⁶ Children whose parents are not college graduates or who have incomes below 200 percent of poverty have fewer well-child visits than others.²⁷ Because these factors tend to cluster, many families who are nonwhite, non-English speaking, less educated, and poor have drastically limited access to well-child care.

Finally, some insurance plans may facilitate continuity more than others. Children in private or managed care plans are more likely than other children to have high continuity.²⁸ Moreover, 89 percent of parents who reported a usual provider for their child were allowed to choose the provider.²⁹

Children without access to well-child care often seek care in EDs. In 2002, 16 percent of children's ED visits were nonurgent.³⁰ Despite the much higher cost of ED visits, poor children are three times as likely as other children to use EDs for nonurgent care.³¹ EDs, however, are neither intended nor prepared to deliver the preventive care that these children lack. Thus, while EDs provide an important safety net for vulnerable populations, they do so inefficiently.

Policy implications. Access to consistent primary care is threatened by both insurance discontinuities (often related to parental employment transitions) and complex social factors associated with race/ethnicity, language, education, and income. How to overcome these barriers is a question not unique to children. Because primary preventive care, however, is particularly sensitive to barriers, children's health needs may be especially vulnerable.

Access to consistent primary care may be affected by issues such as the number of providers in underserved communities, choice of providers, availability of school-based health centers, patient outreach by community

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PEDIATRICS Vol. 96 No. 1 July 1995, pp. 1-4

Injury Prevention Counseling by Pediatricians: A Benefit-Cost Comparison

Ted R. Miller PhD¹ and Maury Galbraith MA¹

¹ National Public Services Research Institute, Children's Safety Network Economics and Insurance Resource Center, Landover, MD

Objectives. The American Academy of Pediatrics believes that health education, through office-based counseling, can contribute to childhood injury prevention. This report extends previously published work on the effectiveness of primary care-based counseling and compares the costs and estimated monetary value of the benefits of safety counseling targeting children ages 0 to 4 years.


Methods. We estimate the savings achievable with comprehensive childhood injury prevention counseling organized around the three Framingham Safety Surveys used in The Injury Prevention Program (TIPP) developed by the American Academy of Pediatrics. We verify the estimated savings by comparing them with the effects of pediatrician counseling from separate analyses of the most fully evaluated interventions—in child motor vehicle occupant injuries, burns, and falls.

Results. TIPP pediatrician injury counseling sessions between the ages of 0 and 4 years can achieve

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estimated savings of \$880 per child or \$80 per visit. If all 19.2 million children ages 0 to 4 years completed TIPP, we estimate that \$230 million would be saved annually in medical spending, and injury costs would decline \$3.4 billion. Each dollar spent on TIPP childhood injury prevention targeting children ages 0 to 4 years returns nearly \$13.

Conclusion. TIPP pediatrician injury counseling is a cost-effective method of preventing childhood injuries and should be more widely adopted.

Submitted on June 17, 1994

Accepted on October 31, 1994

This article has been cited by other articles:

11/1/07

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H. G. Gardner and the Committee on Injury, Violence, and Poison
Office-Based Counseling for Unintentional Injury Prevention
Pediatrics, January 1, 2007; 119(1): 202 - 206.

[Abstract] [Full Text] [PDF]

11/1/05

PEDIATRICS

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I. A. Claudius and A. L. Nager
**The Utility of Safety Counseling in a Pediatric Emergency
Department**

Pediatrics, April 1, 2005; 115(4): e423 - e427.

[Abstract] [Full Text] [PDF]

11/1/04

PEDIATRICS

▶ HOME

B. Zuckerman, G. D. Stevens, M. Inkelas, and N. Halfon
**Prevalence and Correlates of High-Quality Basic Pediatric
Preventive Care**

Pediatrics, December 1, 2004; 114(6): 1522 - 1529.

[Abstract] [Full Text] [PDF]

11/1/01

ARCHIVES OF PEDIATRICS & ADOLESCENT MEDICINE

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A. C. Gielen, M. E. H. Wilson, E. M. McDonald, J. R. Serwint, J. S.
Andrews, W.-T. Hwang, and M.-C. Wang

**Randomized Trial of Enhanced Anticipatory Guidance for Injury
Prevention**

Arch Pediatr Adolesc Med, January 1, 2001; 155(1): 42 - 49.

[Abstract] [Full Text] [PDF]

HEALTH EDUCATION RESEARCH

▶ HOME

N. Harre and A. Coveney

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
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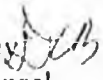
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

May 11, 2007

SUBJECT: Effect of mandatory insurance coverage on state health benefit plan (SB 170, Work Order No. 25-LS0868/C)

TO: Senator Lesil McGuire
Attn: Marit Carlson-Vandort

FROM: Dennis C. Bailey 
Legislative Counsel

This memorandum is a follow up to our conversations and my discussions with the Linda Hall and Katie Campbell at the division of insurance regarding applicability of the statutorily mandated insurance benefit for well baby exams to the state's health benefit plan.

The mandated coverage for well baby exams in the draft bill applies to "health care insurers." The other mandated coverages set out elsewhere in AS 21.42 also refer to "health care insurers."¹ A "health care insurer" for purposes of AS 21.42 is defined by AS 21.54.500(17), which provides:

(17) "health care insurer" means a person transacting the business of health care insurance, including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, a multiple employer welfare arrangement, a church plan, and a governmental plan, except for a nonfederal governmental plan that elects to be excluded under 42 U.S.C. 300gg-21(b)(2) (Health Care Portability and Accountability Act of 1996);

Applying the definition of a health insurer in AS 21.54.500(17) to the subject of mandated coverage, I understand that the division of insurance has concluded that the mandated coverages under AS 21.42 do not apply to the state's health care plan (in part) for the following reasons.

- The state is not an "insurer." Under AS 21.90.900(27), an "insurer" includes a person engaged as indemnitor, surety, or contractor in the business of entering

¹ See, e.g., AS 21.42.315 - 21.42.400. Some exclude fraternal benefit societies. Also, some refer to a "health care insurance plan" as defined in AS 21.42.500 by reference to AS 21.54.500 to mean "a health care insurance policy or contract by a health care insurer. . . ."

Senator Lesil McGuire
May 11, 2007
Page 2

into contracts of insurance or of annuity. The state, while providing health care insurance to its employees, is not acting as an indemnitor. The state operates a self-funded plan where indemnity is not involved.

- The state is not in the business of entering into contracts of insurance. Under AS 21.90.900(25), "insurance" means a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies.
- Under the definition of health care insurer the state is not a "person." Under AS 01.10.060(8), "person" includes a corporation, company, partnership, firm, association, organization, business trust, or society, as well as a natural person. The state does not fall within these categories.
- The state does not "transact the business of health care" by offering a governmental plan for health insurance.
- ERISA² does not apply to governmental employee benefit plans. *See* 29 U.S.C. 1003(b).

The bases for the division's conclusions may be a subject for debate,¹ but appear to provide a rational basis for the department's conclusion.

In summary, the state is not considered a health care insurer under the statutory definition of a health care insurer. Therefore the mandated benefit for well baby exams contemplated in the bill would not apply to the state's health care plan.⁴ Mandated benefits do apply to private health care insurance policies.

The area of health care insurance is particularly complex, especially when combined with the federal preemption considerations raised by ERISA. I routinely suggest consultation with the division of insurance for review of insurance bill drafts in order to take advantage of the division's expertise.

If I may be of further assistance, please advise.

DCB:ljw
07-269.ljw

² Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

¹ The definition in AS 21.54.500(17) has at least one difficulty because it refers to "a person" and includes categories of insurance that are not "persons," e.g. governmental plans. Further, the term that allows a governmental plan to opt out under 29 U.S.C. 300gg-21(b)(2) creates additional confusion. An analysis of these issues is beyond the scope of this memorandum.

⁴ I understand that most state employees do not receive health coverage through the state's health care plan. Instead, they receive coverage through union trust plans.



Voices for Alaska's Children and Youth

February 12, 2008

Dear Members of the Alaska State Senate,

Voices for Alaska's Children and Youth (VACY) is a statewide coalition compiled of numerous organizations representing early care and education, health care, youth development, hunger and poverty, advocacy, child abuse and neglect, businesses, faith based and non-profit agencies. VACY creates awareness and advocates for effective public policy on behalf of Alaska's children, youth and their families.

VACY is writing this letter in support of **SB170- Well Baby Exams** to ensure the long term physical and mental health of young children. Why are Well Baby Exams important:

- The brain development between birth and age three is the most active time every in a humans life.
- Trillion of synaptic connections are being made everyday, building the foundations for all later life.
- The American Academy of Pediatrics recommends 10 exams prior to a child's second birthday to prevent later more costly health care, educational cost but primarily to ensure all children grow up strong and healthy.

Success of Well Baby Exams:

- Well Baby exams not only monitor a child's physical health, but they are also screen for cognitive and social emotional development.
- In Alaska, The Early Childhood Comprehensive Systems Grant is facilitating a project called ABCD. Local pediatrician offices are providing regular developmental and social emotional screening during Well Baby Exams.
- This is an enhancement of the federally mandated Child Find requirements, and is successfully identifying children with cognitive and/ or social emotional concerns and referring them to early intervention services.

If well baby exams are not covered by insurance, more people will not participate in preventative health care and potentials cognitive, emotional and physical delays will go undetected.

Early identification and education are critical factors in reducing long term health cost and most importantly enhancing the physical and mental health of our children. Well-Baby exams are an effective solution to many rising health care cost because they prevent illness in the long run.

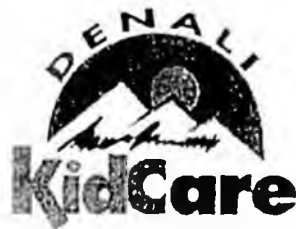
Please support **SB170- Well Baby exams** for the future of Alaska's children.

Thank you for your time
VACY Chair
Meghan Johnson M.S.
mjohnson@gmail.com
(907)360-7384

RECEIVED

FEB 29 2008

Income Guidelines (effective March 2008)



Household Size	Children with other Health Insurance	Children with no Health Insurance and Pregnant Women with or without Health Insurance
	Monthly Income (150% FPG)*	Monthly Income (175% FPG)*
1	1,625	1,896
2	2,188	2,553
3	2,750	3,209
4	3,313	3,865
5	3,875	4,521
6	4,438	5,178
7	5,000	5,834
8	5,563	6,490
each additional	563	657

Note: An unborn child of a pregnant woman is counted in the household size for pregnant woman coverage.

Key Points

- » Income figures are gross income (before taxes are taken out).
- » Income eligibility is determined based on biological or adoptive parent income.
- » Permanent Fund dividends are not counted as income.
- » A standard deduction per month for expenses related to employment may apply.
- » A standard deduction per month for dependent care expense may apply.
- » Child support payments may be allowed as a deduction.
- » Income records and proof of deductions must be submitted with application.
- » Anyone may apply for her/himself or on behalf of a child or teen.
- » Children with other health insurance may still be eligible.
- » Children, teens and pregnant women covered by Indian Health Service benefits may be eligible.
- » ***Not sure if you're eligible?
The only way to know for sure is to apply!***



Alaska

February 28, 2007

The Honorable Lesil McGuire
Alaska State Capitol Building
Juneau, Alaska 99801

RE: Senate Bill 170 – Health Insurance Coverage for Well Baby Visits

Dear Senator McGuire,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our appreciation for the amendments you will propose to Senate Bill 170. The National Federation of Independent Business is the largest small-business advocacy group in the state.

We understand the concern with health insurance coverage for well baby visits and believe a mandate that insurance companies must offer coverage is a prudent step towards your goal. This approach will assure that each employer will consider the need and advantages of this benefit for their employees. A mandatory offering, while underscoring the state's belief of the importance of this benefit, leaves the final decision between employees and employers, without the interference of the state.

We hope that the Senate Finance Committee will promptly schedule a final hearing on SB 170. With the changes you have proposed, the NFIB withdraws our previous opposition to the measure.

Sincerely,

Dennis L. DeWitt
Alaska State Director
National Federation of Independent Business

cc: Senate Finance Committee

SB

178

SFIN

FILE

SENATE FINANCE
COMMITTEE
Amendment # #1
To Bill Number: SB 178
Sponsor: Elton
Date: 2/3/07 Logged by: Mindy

AMENDMENT

Offered in the Senate Finance Committee
To: SB 178

Page 4, line 4:

Following the semicolon, add "or"

Page 4, line 5 through 6:

Delete "for all other districts"

Two-Year Education Funding Proposal SB 178

Key Features:

Forward funding - \$1.0 Billion set aside in Public Education Fund

Early funding - establishes FY09 funding level in advance

Elements	FY 2008 Increases	FY2009 Increases
1. Required Local Effort set at 3 mills <ul style="list-style-type: none"> • Provide uniform application of the RLE provision • Eliminates disparities between municipalities • Example, Lake & Peninsula Borough currently pays 4 mills while Mat-Su Borough pays 2.8 mills 	\$9.9 million	Projected the Full Value Determination based on 3 year avg. change. Increased property values at 3 mills.
2. Intensive student funding based on 2% of ADM <ul style="list-style-type: none"> • Districts over 1,000 ADM will receive intensive funding based on 2% of the ADM • Provides predictable level of funding for intensive services • Eliminates EED audits unless district claims more than 2% or those districts with fewer than 1,000 ADM 	\$18.7 million	
3. District Cost Factors <ul style="list-style-type: none"> • Permanently adopts 50% of the ISER cost factor study in FY08. • Updates original cost factors included in SB36. Meets statutory requirement to review and recommend changes 	\$48.6 million	
4. Hold Harmless for declining state funding due to <ul style="list-style-type: none"> • Declining enrollment • Consolidating schools for efficiencies • Formula adjustments • Examples - when a community falls below 100 students they are funded for 1 school instead of two schools; or - when a school falls below 10 students 	\$0.4	
5. Increase Base Student Allocation in FY2009 <ul style="list-style-type: none"> • \$200 increase per student from \$5,380 to \$5,580 		\$23.7 million
Total Formula Increases	\$77.6 million	\$23.7 million
Less Funding already in Governor's budget	- \$34.6 million	
General Fund Increase	\$43.0 million	\$23.7 million
Retirement System Funding outside Formula TRS employer rate set at 12.56% <ul style="list-style-type: none"> • FY07 rate currently 26% • Proposal will set employer rate at 12.56% in law • FY08 appropriation of \$270 million directly to TRS • Allows more funding to go to the classroom • Requires annual appropriation directly into the TRS 	\$77.5 million	
Total Two-Year Education Funding	\$120.5 million	\$23.7 million

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB 178
() Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Education
Title An Act relating to school funding, the base RDU K-12 Support
student allocation, district cost factors... Component Foundation Program
Sponsor Senate Finance Committee
Requester Senate Finance Committee Component No. 141

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	152,600.0	23,663.4	0.0	0.0	0.0	0.0
Miscellaneous						
TOTAL OPERATING	152,600.0	23,663.4	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	152,600.0	23,663.4				
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	152,600.0	23,663.4	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The \$152,600.0 for FY08 is a result of \$77.6 million in funding formula changes and \$75.0 million that was reduced in the FY08 operating budget to buy the TRS down from 26% to 12.56%.

Formula changes include required local effort set at 3 mills, intensive funding for districts with more than 1,000 students set at 2% of total student population, 50% of ISER recommended increase in districts cost factors and hold harmless for declining enrollments.

This bill also increases the Base Student Allocation in FY09 from \$5,380 to \$5,580

Monies from this fiscal note will be deposited into the public education fund.

Prepared by: Eddy Jeans, Director Phone 465-8679
Division: School Finance Date/Time 5/13/07 12:00 AM
Approved by: Eddy Jeans, Director Date 5/13/2007
Agency: Education & Early Development

School Districts	funding available in school districts budgets from TRS rate decrease from 26% to 12.56%	3 Mill rate, 50% ISER, 2% Intensive Blk Grant, Hold Harmless, BSA \$5380 less Gov. Proposed	YEAR 1 FY08 funding available over Gov. Budget	Year 2 FY09 funding available over FY08
ALASKA GATEWAY	282,465	271,798	554,263	229,314
ALEUTIAN REGION	83,188	37,322	120,510	46,356
ALEUTIANS EAST BOROUGH	287,445	510,654	798,099	180,422
ANCHORAGE	26,643,771	5,988,663	32,632,434	4,271,816
ANNETTE ISLAND	258,765	245,851	504,616	134,034
BERING STRAIT	1,899,375	2,464,271	4,363,646	1,194,546
BRISTOL BAY BOROUGH	145,640	236,353	381,993	84,118
CHATHAM	128,154	238,317	366,471	115,698
CHUGACH	169,752	22,509	192,261	43,280
COPPER RIVER	389,642	142,348	531,990	265,878
CORDOVA CITY	264,238	250,237	514,475	177,183
CRAIG CITY	320,713	191,964	512,677	203,078
DELTA/GREELY	573,925	136,836	710,761	397,596
DENALI BOROUGH	311,439	14,071	325,510	125,337
DILLINGHAM CITY	399,048	165,041	564,089	160,769
FAIRBANKS NORTH STAR BOROUGH	8,147,609	2,313,970	10,461,579	2,127,073
GALENA CITY	591,947	(263,045)	328,902	655,060
HAINES BOROUGH	195,703	241,686	437,389	63,088
HOONAH CITY	146,381	124,535	270,916	71,921
HYDABURG CITY	90,867	106,387	197,254	38,623
IDITAROD AREA	263,278	322,296	585,574	213,164
JUNEAU BOROUGH	2,979,446	1,539,998	4,519,444	(128,438)
KAKE CITY	93,727	244,459	338,186	54,403
KASHUNAMIUT	250,183	157,769	407,952	180,942
KENAI PENINSULA BOROUGH	5,258,894	6,204,274	11,463,168	2,172,566
KETCHIKAN GATEWAY BOROUGH	1,379,302	2,014,151	3,393,453	607,360
KLAWOCK CITY	150,223	118,197	268,420	60,946
KODIAK ISLAND BOROUGH	1,865,120	2,176,068	4,041,188	803,605
KUSPUK	351,933	319,639	671,572	276,376
LAKE AND PENINSULA BOROUGH	446,827	566,185	1,013,012	337,040
LOWER KUSKOKWIM	3,855,234	1,839,271	5,694,505	2,293,546
LOWER YUKON	1,231,247	2,757,699	3,988,946	1,265,840
MATANUSKA-SUSITNA BOROUGH	8,522,562	3,119,198	11,641,760	(411,652)
NENANA CITY	245,019	708	245,727	162,369
NOME CITY	460,170	284,283	744,453	278,478
NORTH SLOPE BOROUGH	1,971,061	1,527,268	3,498,329	922,960
NORTHWEST ARCTIC BOROUGH	1,797,386	2,064,256	3,861,642	1,197,154
PELICAN CITY	17,045	21,928	38,973	10,021
PETERSBURG CITY	389,597	465,920	855,517	186,883
PRIBILOF	95,551	98,927	194,478	83,266
SAINT MARY'S	165,992	135,777	341,766	102,890
SITKA BOROUGH	1,001,863	751,558	1,753,421	238,425
SKAGWAY CITY	93,937	(1,099)	97,838	41,942
SOUTHEAST ISLAND	219,025	202,052	421,077	130,204
SOUTHWEST REGION	636,802	417,907	1,054,709	425,136
TANANA	33,311	116,806	150,117	34,702
UNALASKA CITY	313,302	462,668	775,970	73,644
VALDEZ CITY	551,497	54,643	606,140	271,484
WRANGELL PUBLIC	220,855	243,989	464,844	133,719
YAKUTAT	91,638	246,859	338,497	56,454
YUKON FLATS	277,387	367,415	644,802	137,648
YUKON/KOYUKUK	642,224	236,638	878,862	448,764
YUPIIT	389,953	266,622	656,575	287,288
Mt. Edgecumbe	0	124,414	124,414	129,068
TOTAL	77,536,657	43,008,511	120,545,168	23,663,387

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB 178
() Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Education & Early Development
Title An Act relating to school funding, the base RDU K-12 Support
student allocation, district cost factors... Component AK Challenge Youth Academy
Sponsor Senate Finance Committee
Requester Senate Finance Committee Component No. 2837

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	384.2	0.0	0.0	0.0	0.0	0.0
Miscellaneous						
TOTAL OPERATING	384.2	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	384.2	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	384.2	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill would increase the Base Student Allocation (BSA) in FY09 from \$5,380 to \$5,580. This is a \$200 increase to the BSA.

Prepared by Eddy Jeans, Director
Division School Finance
Approved by Eddy Jeans, Director
Agency Education & Early Development

Phone 465-8679
Date/Time 5/13/07 4:29 PM
Date 5/13/2007

ALASKA MILITARY YOUTH ACADEMY

FY09 PROJECTION for FY09

257 x \$5580 x 7 =	10,038,420
203 x \$5580 x 60% =	679,644
less \$2,625,000	(2,625,000)
	8,093,064
<i>FY08 Projected State Aid at \$5,380</i>	7,708,904
FY09 INCREASE TO AMYA:	\$ 384,160

SB

185

HFIN

FILE

25-LS1616A
Luckhaupt
3/28/08

HOUSE CONCURRENT RESOLUTION NO.
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Introduced:
Referred:

A RESOLUTION

1 Suspending Rules 24(c), 35, 41(b), and 42(e), Uniform Rules of the Alaska State
2 Legislature, concerning Senate Bill No. 185, relating to the central registry of sex
3 offenders and child kidnappers and to the registration requirements for sex offenders
4 and child kidnappers.

5 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

6 That under Rule 54, Uniform Rules of the Alaska State Legislature, the provisions of
7 Rules 24(c), 35, 41(b), and 42(e), Uniform Rules of the Alaska State Legislature, regarding
8 changes to the title of a bill, are suspended in consideration of Senate Bill No. 185, relating to
9 the central registry of sex offenders and child kidnappers and to the registration requirements
10 for sex offenders and child kidnappers.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 6
Bill Version: CSSB 185(STA)
(S) Publish Date: 3/26/08

Identifier (file name): SB185-DOA-OPA-2-04-08 Dept. Affected: Administration
Title: "An Act relating to sex offenders and child kidnappers..." RDU: Legal and Advocacy Services
Component: Office of Public Advocacy
Sponsor: Senator Wielechowski
Requester: _____ Component Number: 43

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES ()							
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FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Interagency Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill expands the requirements for sex offender registration by adding the requirement of providing any electronic messaging address or internet identifier or any change in this information, and it amends the crime of failure to register as a sex offender or child kidnapper accordingly. While it is possible that this bill could have a fiscal impact on the agency by expanding the conduct that could trigger prosecution for failure to register as a sex offender, it cannot be predicted at this time. Therefore, OPA submits a zero fiscal note.

Prepared by: Joshua P. Fink, Director
Division: Office of Public Advocacy
Approved by: Rachael Petro, Deputy Commissioner
Department of Administration

Phone: 907-269-3501
Date/Time: 2/4/08, 12:00 p.m.
Date: 2/4/2008

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: CSSB 185(STA)
(S) Publish Date: 3/3/08

Identifier (file name): SB185CS(STA)-DPS-R&I-02-28-08 Dept. Affected: Public Safety
Title: "An Act relating to sex offenders and child kidnappers." RDU: Statewide Support
Sponsor: Senator Wielechowski Component: Records & Identification
Requester: Senate Judiciary Committee Component Number: 1190

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual	42.0		42.0	42.0	42.0	42.0	42.0	42.0
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	42.0	0.0	42.0	42.0	42.0	42.0	42.0	42.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF	42.0							
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	42.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This legislation requires sex offenders and child kidnappers to provide more extensive registration information than is currently required under AS 12.63.010 and consequently collected and maintained by the department.

Sex offender and child kidnapper registration information is entered into and maintained electronically in the state's central criminal history repository, the Alaska Public Safety Information Network (APSIN). Information is obtained from forms completed by offenders at initial registration, annual or quarterly verification, and upon a qualifying change in the offender's information. (Continued)

Prepared by: David Schade, Director
Division: Statewide Services
Approved by: Walt Monegan, Commissioner
Department of Public Safety

Phone: (907) 269-0202
Date/Time: 2/28/08 8:50 AM
Date: _____

FISCAL NOTE # 4

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. CSSB 185(STA)

ANALYSIS CONTINUATION

This legislation will require the department to revise its forms to include fields for offenders to report all Internet identifiers and addresses (e.g. email and instant messaging addresses) used by the offender. There is no fiscal impact anticipated as a result of making the forms revisions.

Significant new business logic would be needed to capture, manage, and interpret timeframes associated with various Internet identifiers. In addition to email and instant messaging addresses, Internet identifiers include any designations or monikers used for self-identification in Internet communications or postings on social networking sites (Facebook, MySpace, LinkedIn) and gaming (WoW, Second Life), potentially thousands per user, each with a variety of properties. Because the Internet is very dynamic with new services being created monthly (many of which quickly have millions of registrants) there will be an ongoing requirement to add new Internet identifiers and types to any database system that needs to track this information.

For the first year, considerable analysis, programming, and data entry changes in APSIN and the Sex Offender Registration (SOR) office's application will be necessary to add data fields for the entry of all Internet identifiers and addresses reported as being used by an offender. The programming changes and associated costs assume that the data is for the mainframe APSIN system and the SOR office application only. Changes to the public website display are not included nor are the cost of any reports. Costs are based on \$85 per hour.

Computation:

- Analysis during project: 80 hours
- Modify mainframe and screens (new screen for amount of data) and database to capture and store updates: 120 hours
- Mainframe database coordination and program moves: 40 hours
- Modify the migration process of mainframe data to the data warehouse: 40 hours
- Modify SOR office application to store and display the additional fields: up to 80 hours
- Final testing: 40 hours
- Initial operating costs: 95 hours

Ongoing operating costs (200 hours per year), additional storage, backup, and data management is estimated to cost \$42,000 annually.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSSB 185(STA)
(S) Publish Date: 2/19/08

Identifier (file name): SB185-DOA-PDA-1-28-08 Dept. Affected: Administration
Title: "An Act relating to sex offenders and child kidnappers..." RDU: Legal and Advocacy Services
Sponsor: Senator Wielechowski Component: Public Defender Agency
Requester: _____ Component Number: 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
OPERATING EXPENDITURES								
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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	(Thousands of Dollars)						
	FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
FUND SOURCE							
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Interagency Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill amends the requirements for sex offense registration by adding the requirement of providing any electronic messaging address or internet identifier or any change in this information, and amends the crime of failure to register as a sex offender or child kidnapper accordingly. This bill is not expected to have a fiscal impact on the Agency.

Prepared by: Quinlan Steiner, Director
Division: Public Defender Agency
Approved by: Rachael Petro, Deputy Commissioner
Department of Administration

Phone: 907-334-4414
Date/Time: 1/28/08 11:00 AM
Date: 1/28/2008

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB185HCSCS(FIN)-DOC-PM-4-9-08
() Publish Date: _____

Identifier (file name): SB185-DOC-OC-02-08-08 Dept. Affected: Corrections
Title: "An Act relating to sex offenders and child kidnappers" RDU: Population Management
Sponsor: Senators Wielechowski, Ellis, Elton, McGuire, Dyson Component: Statewide Probation & Parole
Requester: House Finance Component Number: 2826

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	Appropriation Required		Information				
	FY 2009	F / 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Personal Services	0.0	0.0	*	*	*	*	*
Travel	0.0	0.0	*	*	*	*	*
Contractual	0.0	0.0	*	*	*	*	*
Supplies	0.0	0.0	*	*	*	*	*
Equipment	0.0	0.0	*	*	*	*	*
Land & Structures	0.0	0.0	*	*	*	*	*
Grants & Claims	0.0	0.0	*	*	*	*	*
Miscellaneous	0.0	0.0	*	*	*	*	*
TOTAL OPERATING	0.0	0.0	*	*	*	*	*

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES ()						*	*
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	*	*	*	*	*
1003 GF Match	0.0	0.0	*	*	*	*	*
1004 GF	0.0	0.0	*	*	*	*	*
1005 GF/Program Receipts	0.0	0.0	*	*	*	*	*
1037 GF/Mental Health	0.0	0.0	*	*	*	*	*
Other Interagency Receipts	0.0	0.0	*	*	*	*	*
TOTAL	0.0	0.0	*	*	*	*	*

Estimate of any current year (FY2008) cost: 00

POSITIONS

Full-time	0	0	*	*	*	*	*
Part-time	0	0	*	*	*	*	*
Temporary	0	0	*	*	*	*	*

ANALYSIS: (Attach a separate page if necessary)

Passage of this legislation will have a fiscal impact on the Department of Corrections. A defendant convicted of a violation of AS 11.41.434 where the victim of the offense was under 14 years of age will be subject to electronic monitoring for the term of probation. Under AS 12.55.090(c) these offenders would be sentenced to probation up to 25 years.

Department of Corrections data shows there are 32 offenders currently convicted under AS 11.41.434 where the victim of the offense was under 14 years of age (calendar year 2002-2007). It is difficult for the department to determine if the statute would apply these offenders (Continued on Page 2)

Prepared by: Sharleen Griffin, Director
Division: Administrative Services
Approved by: Dwayne Peoples, Deputy Commissioner
Department of Corrections

Phone: (907) 465-3339
Date/Time: 4/9/08 8:15 AM
Date: 4/9/2008

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB185HCSCS(FIN)-DOC-PM-4-9-08

ANALYSIS CONTINUATION

Offenders are classified under the department's system as Sexual Assault of a Minor in the 1st Degree and a flag has to be marked in the system if it is a minor under the age of 14.

These offenders would then be placed on Passive Global Positioning System (GPS) - Intensive Supervision Surveillance Program (ISSP) monitoring and would require the department to have one Adult Probation Officer per every twenty offenders. This supervision program is monitored by a computer and alarm system 24 hours a day, 7 days a week. The system contacts a probation officer if the offender goes into a prohibited area.

The department anticipates the earliest any of the offenders would be placed on probation is starting in FY 2010 and one probation officer would be required for every twenty offenders.

It is anticipated that electronic monitoring will be at the discretion of the Courts.

During the period of 2002 to 2007, 32 offenders were sentenced under AS 11.41.434 for an average length of sentence of 9.2 years. Assuming that the Courts would utilize the electronic option for 1/4 to 1/2 of the offenders, the Department of Corrections would request an Adult Probation Officer no earlier than 2012 or 2013.

The Department will evaluate the sentence of offenders under AS 11.41.434 and request appropriate funding to operate the program on an annual basis.

Below is a representative cost for operating this program for 20 offenders:

	<u>PASSIVE GPS (ISSP)</u>
<u>Ratio</u>	
Number of Probation Officers	1
Number of Offenders	20
 <u>Annual Costs- 1 Probation Officer</u>	
Personal Services	\$98,335.00
Travel	\$2,000.00
Services (exclude GPS)	\$11,700.00
Commodities*	\$13,100.00
TOTAL	\$125,135.00
 <i>*Includes One Time Start Up Costs of \$10,700</i>	
 <u>Cost Per Offender / Per Day</u>	
GPS Monitoring Cost	\$6.25
Weekly Cost for 1 Offender	\$43.75
Annual Cost for 1 Offender	\$2,275.00
 <u>Annual Contractual Cost for GPS</u>	
Number of Offenders	20
Daily GPS Cost	\$6.25
Number of Days	365
TOTAL	\$45,625.00
 TOTAL ESTIMATED COST	\$170,760.00

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: SB185HSCS(FIN)-LAW-CRIM-04-08-08
 Bill Version: HSCSSB185(FIN)
 () Publish Date: _____

Identifier (file name): _____ Dept. Affected: LAW
 Title An Act relating to sex offenders and child kidnappers. RDU Criminal
 Component Criminal Justice Litigation
 Sponsor SENATOR(S) WIELECHOWSKI
 Requester HOUSE FINANCE Component Number _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
		FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
OPERATING EXPENDITURES							
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES ()							
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

SB 185 amends the crime of failure to register as a sex offender by providing that failure to submit an electronic address or a change of electronic address would be prohibited. The bill would allow a court to require a person convicted of a serious sexual assault to wear an ankle bracelet during the person's probationary period. The department does not expect a significant fiscal impact as a result of this bill.

Prepared by: Robert Meiners, Administrative Services Manager
 Division: Administrative Services Division
 Approved by: Takis Colborg, Attorney General
Department of Law

Phone: 907-465-5427
 Date/Time: 4/8/08 11:20 AM
 Date: 4/8/2008

Adopted
5/7/08

AMENDMENT 1

OFFERED IN THE HOUSE

TO: CS SB 185 (STA) (title am)

BY REPRESENTATIVE HAWKER

- 1 Page 3, line 26
- 2 Delete "belongs to"
- 3 Insert "has been registered by"

*Adopted
4/7/09*

AMENDMENT

2

OFFERED IN THE HOUSE

TO: CS SB 185 (STA) (title am)

BY REPRESENTATIVE HAWKER

- 1 Page 3, line 27 through page 4, line 1
- 2 Delete all material

*Amend to Amend
have apply to violators
Am #3 AS 11.41.410
Adopted 4/7/08*

*Mand 10 years
after that discretion
judge WITHDRAWN*

*Adopted
as amended
4/7/08*
3

25-LS0985\KA.1
Luckhaupt
3/29/08

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE CHENAULT

TO: CSSB 185(STA)(title am)

- 1 Page 1, line 1, following "kidnappers":
- 2 Insert ", to penalties for certain sex offenders,"
- 3
- 4 Page 2, following line 4:
- 5 Insert a new bill section to read:
- 6 "* Sec. 2. AS 12.55.015 is amended by adding a new subsection to read:
- 7 (j) In addition to penalties authorized by this section, the court shall order a
- 8 defendant convicted of a violation of AS 11.41.410 - 11.41.440 where the victim of
- 9 the offense was under 13 years of age to be subject to electronic monitoring for the
- 10 remainder of the person's life on the person's release from a correctional facility."
- 11
- 12 Renumber the following bill sections accordingly.
- 13
- 14 Page 4, line 4:
- 15 Delete "This Act applies"
- 16 Insert "Sections 1 and 3 - 5 of this Act apply"
- 17
- 18 Page 4, following line 7:
- 19 Insert a new subsection to read:
- 20 "(b) Section 2 of this Act applies to persons convicted of offenses committed on or
- 21 after the effective date of this Act."
- 22
- 23 Reletter the following subsection accordingly.

25-LS0985VKA.1

1

2 Page 4, line 9:

3 Delete "sec. 3"

4 Insert "sec. 4"

WITHDRAWN
4/7/08

Amendment #3 to Amendment #3 by Rep. Hawker

Monitoring period shall be a mandatory ten years following release from a correctional facility, and up to the remainder of person's life at discretion of the courts.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

April 8, 2008

SUBJECT: Amendment 3 incorporated in draft HCS CSSB 185(FIN)
(Work Order No. 25-LS0985L)

TO: Representative Kevin Meyer
Co-Chair of the House Finance Committee
Attn: Suzanne Cunningham

FROM: Gerald P. Luckhaupt *ERL*
Legislative Counsel

Enclosed is the draft HCS(FIN) you requested. I have two comments concerning Amendment 3 as adopted by the committee.

First, sec. 2 of the HCS(FIN) only applies to persons convicted of a violation of AS 11.41.410.¹ Applying this provision only to sexual assaults committed against children may not actually reach all the offenders that the committee may intend to reach, as most sexual offenses committed against children are prosecuted as sexual abuse of a minor and not as sexual assault.² It would appear to me that if the committee intended to apply this provision to offenders who commit sexual offenses against children that are unclassified felonies then AS 11.41.434, sexual abuse of a minor in the first degree, should also be included.

Second, the amendment changed the application of sec. 2 to children under the age of 14. Amendment 3 originally applied this new section to children under 13 years of age. The choice of 13 years of age was not arbitrarily selected but was based upon the age differentiation the legislature has previously made in the sexual abuse of a minor statutes. Typically, the legislature has separated out offenses based upon whether the victim was less than 13, less than 16 but at least 13 years of age, or at least 16 but less than 18 years of age. -to 13

¹ The committee removed the string citation that applied this new section to all sexual offenses. AS 11.41.410 is sexual assault in the first degree.

² Sexual abuse of a minor merely requires the state to prove that a offender was a certain age and the victim was a certain age and that a sexual act occurred. It is easier to prosecute than sexual assault which requires proof that a sexual act occurred and that the sexual act was without the consent of the victim.

Representative Kevin Meyer

April 8, 2008

Page 2

Finally, as a bit of reference to the committee, the maximum period of probation for a felony sex offense is 25 years³ with a mandatory period of probation of 15 years⁴ for an unclassified felony sex offense,⁵ following the offender's prison term imposed under AS 12.55.125(i). See AS 12.55.125(o).

GPL:ljw
08-214.ljw

Enclosure

³ See AS 12.55.090(e).

⁴ With an additional five year sentence of imprisonment suspended.

⁵ Sexual assault in the first degree, AS 11.41.41, and sexual abuse of a minor in the first degree, AS 11.41.434, are unclassified felony sex offenses.

Adopted
4/7/08

25-LS0985\KA.1
Luckhaupt
3/29/08

AMENDMENT

3 as Amended

OFFERED IN THE HOUSE

BY REPRESENTATIVE CHENAULT

TO: CSSB 185(STA)(title am)

1 Page 1, line 1, following "kidnappers":

2 Insert ", to penalties for certain sex offenders,"

3

4 Page 2, following line 4:

5 Insert a new bill section to read:

6 "* Sec. 2. AS 12.55.015 is amended by adding a new subsection to read:

7 (j) In addition to penalties authorized by this section, the court shall order a

8 defendant convicted of a violation of AS 11.41.410 ^[Delete] 1.41.440 where the victim of

9 the offense was under ¹⁴ 13 years of age to be subject to electronic monitoring for ^[up to] the

10 ~~remainder of the person's life~~ ^{The maximum length of probation} on the person's release from a correctional facility."

11

12 Renumber the following bill sections accordingly.

13

14 Page 4, line 4:

15 Delete "This Act applies"

16 Insert "Sections 1 and 3 - 5 of this Act apply"

17

18 Page 4, following line 7:

19 Insert a new subsection to read:

20 "(b) Section 2 of this Act applies to persons convicted of offenses committed on or

21 after the effective date of this Act."

22

23 Reletter the following subsection accordingly.

25-LS0985\KA.1

1

2 Page 4, line 9:

3 Delete "sec. 3"

4 Insert "sec. 4"

WITHDRAWN
4/7/08

AMENDMENT

4

OFFERED IN THE HOUSE

BY REPRESENTATIVE CHENAULT

TO: CSSB 185(STA)(title am)

1 Page 1, line 2, following "kidnappers;":

2 Insert "authorizing capital punishment for certain crimes committed against
3 children and authorizing the death penalty for those crimes; establishing sentencing
4 procedures for capital felonies; amending Rules 32, 32.1, and 32.3, Alaska Rules of Criminal
5 Procedure, and Rules 204, 209, 210, and 212, Alaska Rules of Appellate Procedure;"

7 Page 1, following line 4:

8 Insert new bill sections to read:

9 ** Section 1. AS 05.15.140(b) is amended to read:

10 (b) In an application for a permit, a municipality or qualified organization
11 shall disclose the name and address of each person responsible for the operation of the
12 activity and whether any person named

13 (1) has been convicted of a violation of a law of this state that is, or a
14 law or ordinance of another state that would be if committed in this state, a capital or
15 [AN] unclassified felony described in AS 11, a Class A felony, extortion, or a
16 violation of a law or ordinance of this state or another jurisdiction that is a crime
17 involving theft or dishonesty or a violation of gambling laws; or

18 (2) has a prohibited financial interest, as defined in regulations adopted
19 by the department, in the operation of the activity.

20 * Sec. 2. AS 11.31.100(d) is amended to read:

21 (d) An attempt is

22 (1) an unclassified felony if the crime attempted is a capital felony
23 [MURDER IN THE FIRST DEGREE];

24 (2) a class A felony if the crime attempted is an unclassified felony

1 [OTHER THAN MURDER IN THE FIRST DEGREE];

2 (3) a class B felony if the crime attempted is a class A felony;

3 (4) a class C felony if the crime attempted is a class B felony;

4 (5) a class A misdemeanor if the crime attempted is a class C felony;

5 (6) a class B misdemeanor if the crime attempted is a class A or class
6 B misdemeanor.

7 * Sec. 3. AS 11.31.110(c) is amended to read:

8 (c) Solicitation is

9 (1) an unclassified felony if the crime solicited is a capital felony
10 [MURDER IN THE FIRST DEGREE];

11 (2) a class A felony if the crime solicited is an unclassified felony
12 [OTHER THAN MURDER IN THE FIRST DEGREE];

13 (3) a class B felony if the crime solicited is a class A felony;

14 (4) a class C felony if the crime solicited is a class B felony;

15 (5) a class A misdemeanor if the crime solicited is a class C felony;

16 (6) a class B misdemeanor if the crime solicited is a class A or class B
17 misdemeanor.

18 * Sec. 4. AS 11.31.120(h)(2) is amended to read:

19 (2) "serious felony offense" means an offense

20 (A) against the person under AS 11.41, punishable as a capital,
21 an unclassified, or a class A felony;

22 (B) involving controlled substances under AS 11.71,
23 punishable as an unclassified, a class A, or a class B felony;

24 (C) that is criminal mischief in the first degree under
25 AS 11.46.475; or

26 (D) that is terroristic threatening in the first degree under
27 AS 11.56.807.

28 * Sec. 5. AS 11.31.120(i) is amended to read:

29 (i) Conspiracy is

30 (1) an unclassified felony if the object of the conspiracy is a capital
31 felony [MURDER IN THE FIRST DEGREE];

1 (2) a class A felony if the object of the conspiracy is a crime
2 punishable as an unclassified felony [OTHER THAN MURDER IN THE FIRST
3 DEGREE];

4 (3) a class B felony if the object of the conspiracy is a crime
5 punishable as a class A felony;

6 (4) a class C felony if the object of the conspiracy is a crime
7 punishable as a class B felony.

8 * Sec. 6. AS 11.41.100(b) is amended to read:

9 (b) Murder in the first degree is a capital [AN UNCLASSIFIED] felony and
10 is punishable as provided in AS 12.55.125(a) [AS 12.55].

11 * Sec. 7. AS 11.41.410(b) is amended to read:

12 (b) Except as provided in (c) of this section, sexual [SEXUAL] assault in
13 the first degree is an unclassified felony and is punishable as provided in AS 12.55.

14 * Sec. 8. AS 11.41.410 is amended by adding a new subsection to read:

15 (c) Sexual assault in the first degree is a capital felony if the victim of the
16 offense is less than 12 years of age."

17

18 Page 1, line 5:

19 Delete "Section 1"

20 Insert "Sec. 9"

21

22 Renumber the following bill sections accordingly.

23

24 Page 2, following line 4:

25 Insert new bill sections to read:

26 ** Sec. 10. AS 12.30.020(a) is amended to read:

27 (a) A person charged with an offense shall, at that person's first appearance
28 before a judicial officer, be ordered released pending trial on the person's personal
29 recognizance or upon the execution of an unsecured appearance bond in an amount
30 specified by the judicial officer unless the offense is a capital felony, an unclassified
31 felony, or a class A felony or unless the officer determines that the release of the

1 person will not reasonably assure the appearance of the person as required or will pose
2 a danger to the alleged victim, other persons, or the community. If the offense with
3 which a person is charged is a felony, on motion of the prosecuting attorney, the
4 judicial officer may allow the prosecuting attorney up to 48 hours to demonstrate that
5 release of the person on the person's personal recognizance or upon the execution of
6 an unsecured appearance bond will not reasonably assure the appearance of the person
7 or will pose a danger to the alleged victim, other persons, c the community.

8 * Sec. 11. AS 12.30.040(b) is amended to read:

9 (b) Notwithstanding the provisions of (a) of this section, a person may not be
10 released on bail either before sentencing or pending appeal if the person has been
11 convicted of an offense that is

12 (1) a capital felony, an unclassified felony, or a class A felony; or

13 (2) a class B or class C felony if the person has been previously
14 convicted of an offense in this state that is a capital felony, an unclassified feony, a
15 class A felony, or a violation of AS 11.41.260, 11.41.420 - 11.41.425, or 11.41.436 -
16 11.41.438 or of an offense in another jurisdiction with elements substantially similar
17 to an offense of this state described in this paragraph.

18 * Sec. 12. AS 12.47.110(b) is amended to read:

19 (b) On or before the expiration of the initial 90-day period of commitment, the
20 court shall conduct a hearing to determine whether or not the defendant remains
21 incompetent. If the court finds by a preponderance of the evidence that the defendant
22 remains incompetent, the court may recommit the defendant for a second period of 90
23 days. The court shall determine at the expiration of the second 90-day period whether
24 the defendant has become competent. If at the expiration of the second 90-day period
25 the court determines that the defendant continues to be incompetent to stand trial, the
26 charges against the defendant shall be dismissed without prejudice and continued
27 commitment of the defendant shall be governed by the provisions relating to civil
28 commitments under AS 47.30.700 - 47.30.915 unless the defendant is charged with a
29 crime involving force against a person and the court finds that the defendant presents a
30 substantial danger of physical injury to other persons and that there is a substantial
31 probability that the defendant will regain competency within a reasonable period of

1 time, in which case the court may extend the period of commitment for an additional
 2 six months. If the defendant remains incompetent at the expiration of the additional
 3 six-month period, the charges shall be dismissed without prejudice and either civil
 4 commitment proceedings shall be instituted or the court shall order the release of the
 5 defendant. If the defendant remains incompetent for five years after the charges have
 6 been dismissed under this subsection, the defendant may not be charged again for an
 7 offense arising out of the facts alleged in the original charges, except if the original
 8 charge is a class A felony, an [OR] unclassified felony, or a capital felony.

9 * Sec. 13. AS 12.55.025(i) is amended to read:

10 (i) Except as provided by AS 12.55.125(a)(3), 12.55.145(d), 12.55.155(t), and
 11 12.55.165, or in determining if a sentence of death should be imposed under
 12 AS 12.58, the preponderance of the evidence standard of proof applies to sentencing
 13 proceedings.

14 * Sec. 14. AS 12.55.125(a) is amended to read:

15 (a) A defendant convicted of murder in the first degree or murder of an unborn
 16 child under AS 11.41.150(a)(1) shall be sentenced to a definite term of imprisonment
 17 of at least 20 years but not more than 99 years, or shall be sentenced to death. A
 18 defendant convicted of murder in the first degree, but not sentenced to death, shall
 19 be sentenced to a mandatory term of imprisonment of 99 years when

20 (1) the defendant is convicted of the murder of a uniformed or
 21 otherwise clearly identified peace officer, fire fighter, or correctional employee who
 22 was engaged in the performance of official duties at the time of the murder;

23 (2) the defendant has been previously convicted of

24 (A) murder in the first degree under AS 11.41.100 or former
 25 AS 11.15.010 or 11.15.020;

26 (B) murder in the second degree under AS 11.41.110 or former
 27 AS 11.15.030; or

28 (C) homicide under the laws of another jurisdiction when the
 29 offense of which the defendant was convicted contains elements similar to first
 30 degree murder under AS 11.41.100 or second degree murder under
 31 AS 11.41.110;

1 (3) the court finds by clear and convincing evidence that the defendant
2 subjected the murder victim to substantial physical torture;

3 (4) the defendant is convicted of the murder of and personally caused
4 the death of a person, other than a participant, during a robbery; or

5 (5) the court finds by clear and convincing evidence that the defendant
6 is a peace officer who used the officer's authority as a peace officer to facilitate the
7 murder.

8 * Sec. 15. AS 12.55.125(f) is amended to read:

9 (f) If a defendant is sentenced under (a) or (b) of this section,

10 (1) imprisonment for the prescribed minimum or mandatory term may
11 not be suspended under AS 12.55.080;

12 (2) imposition of sentence may not be suspended under AS 12.55.085;

13 (3) imprisonment for the prescribed minimum or mandatory term may
14 not be reduced, except as provided in (j) of this section;

15 (4) a sentence of death may not be suspended under AS 12.55.080.

16 * Sec. 16. AS 12.55.125(i) is amended to read:

17 (i) A defendant convicted of

18 (1) sexual assault in the first degree, sexual abuse of a minor in the
19 first degree, or promoting prostitution in the first degree under AS 11.66.110(a)(2)
20 may be sentenced to a definite term of imprisonment of not more than 99 years and
21 shall be sentenced to a definite term within the following presumptive ranges, subject
22 to adjustment as provided in AS 12.55.155 - 12.55.175 or to death:

23 (A) if the offense is a first felony conviction, the offense does
24 not involve circumstances described in (B) of this paragraph, and the victim
25 was

26 (i) less than 13 years of age, 25 to 35 years;

27 (ii) 13 years of age or older, 20 to 30 years;

28 (B) if the offense is a first felony conviction and the defendant
29 possessed a firearm, used a dangerous instrument, or caused serious physical
30 injury during the commission of the offense, 25 to 35 years;

31 (C) if the offense is a second felony conviction and does not

1 involve circumstances described in (D) of this paragraph, 30 to 40 years;

2 (D) if the offense is a second felony conviction and the
3 defendant has a prior conviction for a sexual felony, 35 to 45 years unless the
4 defendant is sentenced to death;

5 (E) if the offense is a third felony conviction and the defendant
6 is not subject to sentencing under (F) of this paragraph or (I) of this section, 40
7 to 60 years;

8 (F) if the offense is a third felony conviction, the defendant is
9 not subject to sentencing under (I) of this section, and the defendant has two
10 prior convictions for sexual felonies, 99 years unless the defendant is
11 sentenced to death;

12 (2) attempt, conspiracy, or solicitation to commit sexual assault in the
13 first degree, sexual abuse of a minor in the first degree, or promoting prostitution in
14 the first degree under AS 11.66.110(a)(2) may be sentenced to a definite term of
15 imprisonment of not more than 99 years and shall be sentenced to a definite term
16 within the following presumptive ranges, subject to adjustment as provided in
17 AS 12.55.155 - 12.55.175:

18 (A) if the offense is a first felony conviction, the offense does
19 not involve circumstances described in (B) of this paragraph, and the victim
20 was

21 (i) under 13 years of age, 20 to 30 years;

22 (ii) 13 years of age or older, 15 to 30 years;

23 (B) if the offense is a first felony conviction and the defendant
24 possessed a firearm, used a dangerous instrument, or caused serious physical
25 injury during the commission of the offense, 25 to 35 years;

26 (C) if the offense is a second felony conviction and does not
27 involve circumstances described in (D) of this paragraph, 25 to 35 years;

28 (D) if the offense is a second felony conviction and the
29 defendant has a prior conviction for a sexual felony, 30 to 40 years;

30 (E) if the offense is a third felony conviction, the offense does
31 not involve circumstances described in (F) of this paragraph, and the defendant

1 is not subject to sentencing under (D) of this section. 35 to 50 years;

2 (F) if the offense is a third felony conviction, the defendant is
3 not subject to sentencing under (I) of this section, and the defendant has two
4 prior convictions for sexual felonies, 99 years;

5 (3) sexual assault in the second degree, sexual abuse of a minor in the
6 second degree, unlawful exploitation of a minor, or distribution of child pornography
7 may be sentenced to a definite term of imprisonment of not more than 99 years and
8 shall be sentenced to a definite term within the following presumptive ranges, subject
9 to adjustment as provided in AS 12.55.155 - 12.55.175:

10 (A) if the offense is a first felony conviction, five to 15 years;

11 (B) if the offense is a second felony conviction and does not
12 involve circumstances described in (C) of this paragraph, 10 to 25 years;

13 (C) if the offense is a second felony conviction and the
14 defendant has a prior conviction for a sexual felony, 15 to 30 years;

15 (D) if the offense is a third felony conviction and does not
16 involve circumstances described in (E) of this paragraph, 20 to 35 years;

17 (E) if the offense is a third felony conviction and the defendant
18 has two prior convictions for sexual felonies, 99 years;

19 (4) sexual assault in the third degree, incest, indecent exposure in the
20 first degree, possession of child pornography, or attempt, conspiracy, or solicitation to
21 commit sexual assault in the second degree, sexual abuse of a minor in the second
22 degree, unlawful exploitation of a minor, or distribution of child pornography, may be
23 sentenced to a definite term of imprisonment of not more than 99 years and shall be
24 sentenced to a definite term within the following presumptive ranges, subject to
25 adjustment as provided in AS 12.55.155 - 12.55.175:

26 (A) if the offense is a first felony conviction, two to 12 years;

27 (B) if the offense is a second felony conviction and does not
28 involve circumstances described in (C) of this paragraph, eight to 15 years;

29 (C) if the offense is a second felony conviction and the
30 defendant has a prior conviction for a sexual felony, 12 to 20 years;

31 (D) if the offense is a third felony conviction and does not

1 involve circumstances described in (E) of this paragraph, 15 to 25 years;

2 (E) if the offense is a third felony conviction and the defendant
3 has two prior convictions for sexual felonies, 99 years.

4 * Sec. 17. AS 12.55.125(f) is amended to read:

5 (f) Notwithstanding any other provision of law, a defendant convicted of a
6 capital, an unclassified, or a class A felony offense, and not sentenced to death or
7 subject to a mandatory 99-year sentence under (a) of this section, shall be sentenced to
8 a definite term of imprisonment of 99 years when the defendant has been previously
9 convicted of two or more most serious felonies. If a defendant is sentenced to a
10 definite term under this subsection,

11 (1) imprisonment for the prescribed definite term may not be
12 suspended under AS 12.55.080;

13 (2) imposition of sentence may not be suspended under AS 12.55.085;

14 (3) imprisonment for the prescribed definite term may not be reduced,
15 except as provided in (j) of this section.

16 * Sec. 18. AS 12.55.145(a) is amended to read:

17 (a) For purposes of considering prior convictions in imposing sentence under

18 (1) AS 12.55.125(c), (d), or (e),

19 (A) a prior conviction may not be considered if a period of 10
20 or more years has elapsed between the date of the defendant's unconditional
21 discharge on the immediately preceding offense and commission of the present
22 offense unless the prior conviction was for a capital, an unclassified, or a class
23 A felony;

24 (B) a conviction in this or another jurisdiction of an offense
25 having elements similar to those of a felony defined as such under Alaska law
26 at the time the offense was committed is considered a prior felony conviction;

27 (C) two or more convictions arising out of a single, continuous
28 criminal episode during which there was no substantial change in the nature of
29 the criminal objective are considered a single conviction unless the defendant
30 was sentenced to consecutive sentences for the crimes; offenses committed
31 while attempting to escape or avoid detection or apprehension after the