ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4553 HHES HB 332 - HB 342

125

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LAW

POUCH K – STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

OFFICE OF THE ATTORNEY GENERAL

December 14, 1984

M E M O R A N D U M

TO: Honorable Bill Sheffield
Governor

FROM: Arthur H. Peterson for Norman C. Gorsuch
Attorney General

RE: Attached bill relating to report of certain injuries
Our file: 377-019-85

Attached is a bill, requested by the division of Alaska State Troopers, Department of Public Safety, which requires physicians and other health care providers to report to the police their treatment of persons who have received gunshot or stab wounds, or have been intentionally seriously injured. Failure to make a required report is a class B misdemeanor offense, carrying a maximum penalty of a $1,000 fine and 90 days in jail. Persons who report in good faith are protected from civil or criminal liability.

Alaska is one of the very few states that do not require a doctor to report these potentially life-threatening injuries. The absence of such a provision hampers the timely investigation of some serious assaults, especially in bush areas.

A virtually identical bill, HB 583, was introduced at your request last session (Department of Law file no. 377-021-84), but remained in the House HESS Committee at adjournment.

A draft transmittal letter to the legislature explaining the bill and the need for this legislation is also attached.

NCG:GAH:lb

cc w/enc.: Hon. Robert J. Sundberg, Commissioner
Department of Public Safety

Colonel Michael Kolivosky, Director
Division of Alaska State Troopers
Department of Public Safety

D R A F T

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill that will require physicians, nurses, paramedics, hospital staff, and other health care providers to report their treatment of persons suffering from gunshot wounds, nonaccidental stab wounds, and nonaccidental serious injuries.

An oral transmission of the report must be made immediately (no later than 24 hours) to a state trooper, local police department, or local village police officer, and this must be followed by a written report. Both reports must include the name and present whereabouts of the injured person, and a description of the character and extent of his injuries. Failure to make a report as required is a class B misdemeanor, carrying maximum penalties of a $1,000 fine and up to 90 days in jail. A person who makes a report in good faith is immune from civil or criminal liability for making the report.

The purpose of this reporting requirement is twofold. It will allow police officers to take steps to protect the victim of a crime who may be too badly injured or too frightened to report the assault. It will also allow officers to immediately investigate the apparent commission of a serious crime, and may aid in the apprehension of the offender and the protection of the public from future

harm.

Alaska is one of very few states in the nation which do not require a treating physician to report gunshot or stab wounds. The absence of such a requirement under current law means that some serious assaults are never reported to law enforcement authorities, especially in the remote villages and rural areas of the state. Even if a shooting or stabbing is eventually reported to the authorities, investigation may be hampered by the passage of time and the loss of valuable evidence.

The bill requires the report of all gunshot wounds. Other than those, only injuries that appear to have been deliberately inflicted must be reported. Clearly accidental injuries are excluded from the law's requirements. In light of the justified public concern about the level of violent crime in our society, and the important public safety interests which this reporting requirement would serve, I urge your prompt action on this bill.

Sincerely,

Bill Sheffield
Governor

Official Business

COMMITTEE: HOUSE HESS

DATE: 2-11-88

SIGN-IN

Subject of meeting:
HB 277 Immunization of Minors
HCR 4 Children's Law Task Force
HB 332 Burn Injuries
HB 409 WAMI

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY? if yes, which one
Chris Cuper		2828	Rep. Collins	HCR 4 ✓
Elizabeth Ward	Box H-06 Juneau	5-3093	HSS	277 yes
Jan Wagoner	Box FP	23[illegible]	ACPE	no
Shannon Hohler	Box 1746 Soldotna, AK	262-3825		Yes 211 ✓
David B Alexander	9601 Boatfort Anchorage, 99516	346-2477	ASMA	HB @ 1:30 ~~1770~~ ~~Yes~~
Gayle Horetski	Box N Juneau 99811	465-4322	DPS	HB 332 Yes
CHARLES STEINER Steiner	1001 Noble FBX AK	452-1611	Self, AAMA	HB 277 Here @ 1:30 YES
Nina Keeler Kinney	Dept of Public Safety PO Box N Juneau 99811	465-4356	Dept. of Public Safety	HCR 4 Available for questions ✓
DAVID JOHNSON	3612 TONGASS AVE KETCHIKAN	225-5146	ALASKA STATE MEDICAL ASSOCIATION	YES ~~ADD~~ HB 332
Commissioner Munson Yvonne Close	Box H-05 Juneau	465-3030	DHSS	YES

5-1358B
Hein
2/10/88

Original sponsors: Koponen and Collins

IN THE HOUSE PROPOSED BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 332 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the reporting of certain injuries."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.337. ~~PHYSICIANS~~ Health Care Professionals TO REPORT CERTAIN INJURIES. (a) A ~~physician~~ health care professional who treats or attends to a person with an injury described in (b) of this section shall make certain that an oral report of the injury is made promptly to the Department of Public Safety, a local law enforcement agency, or village public safety officer. The ~~physician~~ health care professional shall make certain that a written report of ~~the~~ and injury under (b)(1) or (2) of this section is submitted to the Department of Public Safety ~~in Juneau~~ within three working days after the person is treated. The report shall be on a form provided by the department.

(b) The following injuries shall be reported under (a) of this section:

(1) second or third degree burns to five percent or more of a patient's body;

(2) a burn to a patient's upper respiratory tract or laryngeal edema due to the inhalation of super-heated air;

(3) a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;

(4) an injury apparently caused by a knife, axe, or other sharp or pointed instrument, unless the injury was clearly accidental; and

patient, unless the injury was clearly accidental.

(c) A person who violates this section is guilty of a violation. The court shall send a certified copy of a judgment of conviction under this section to the state medical board.

(d) In this section, "~~physician~~ health care professional" does not include a practitioner of religious healing.

"health care professional" includes an emergency medical technician, a health aide, a physician, a nurse, a paramedic, and a physician's assistant, but

(e) A person who, in good faith, makes a report under this section, or who participates in judicial proceedings related to a report under this section, is immune from any civil or criminal liability which might otherwise be incurred as a result of making such a report or participating in such judicial proceedings.

5-1358L
Hein
2/10/88

Original sponsors: Koponen and Collins

IN THE HOUSE BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 332 (HESS)

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(3) a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;

(4) an injury apparently caused by a knife, axe, or other sharp or pointed instrument, unless the injury was clearly accidental; and

(5) an injury that is likely to cause the death of the

patient, unless the injury was clearly accidental.

(c) A person who violates this section is guilty of a violation. The court shall send a certified copy of a judgment of conviction under this section to the state medical board.

(d) In this section, "physician" does not include a practitioner of religious healing.

The Commonwealth of Massachusetts

Department of Public Safety

Michael S. Dukakis
Governor

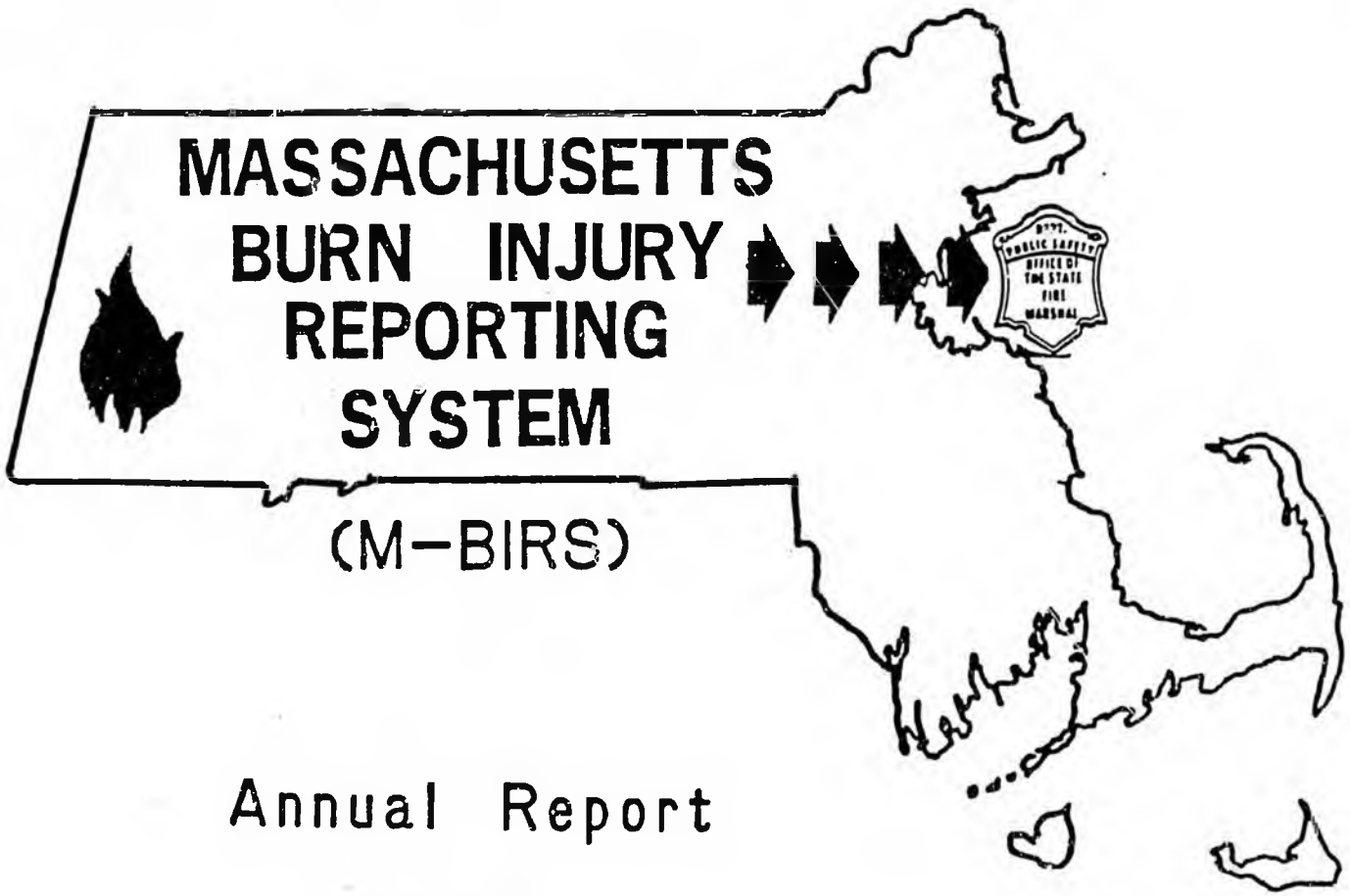
Charles V. Barry
Secretary

Frank J. Trabucco
Commissioner

Joseph A. O'Keefe
State Fire Marshal

MASSACHUSETTS BURN INJURY REPORTING SYSTEM

(M-BIRS)



Annual Report

1985

The Commonwealth of Massachusetts

Department of Public Safety

JOSEPH A. O'KEEFE, PE
State Fire Marshal

OFFICE OF THE STATE FIRE MARSHAL
1010 Commonwealth Avenue
Boston, Massachusetts 02215
(617) 566-4500

MAY 5 1986

THE MASSACHUSETTS BURN INJURY REPORTING SYSTEM (M-BIRS)

The Massachusetts Burn Injury Reporting System was implemented on June 1, 1984 in accordance with Chapter 112, Section 12A of the Massachusetts General Laws.

Under the provisions of the law, the treatment of all burns of 5% or more of a person's body surface area must be reported immediately to the Commissioner of Public Safety by the attending physician and/or the treatment facility.

M-BIRS was established primarily as an additional tool in the war against arson by establishing an early warning system for the detection of arsonists who may burn themselves accidentally in the course of their crime, as is not uncommon.

The M-BIRS system is the first such mandatory burn reporting mechanism in the nation. Many other states are now considering instituting a similar system and the State of New York has established their burn reporting system patterned closely after the M-BIRS.

1985, the first full year of operation for M-BIRS, saw the reporting of more than 600 serious burns, some of them under highly suspicious circumstances and presently under investigation.

The M-BIRS has had the anticipated ancillary benefits of establishing an automated burn data base for use in developing effective burn prevention programs in the Commonwealth.

With the continued cooperation of local fire, police and health organizations, M-BIRS will reach its optimum effectiveness in the fight against arson and the protection of our citizens from fire and burns.

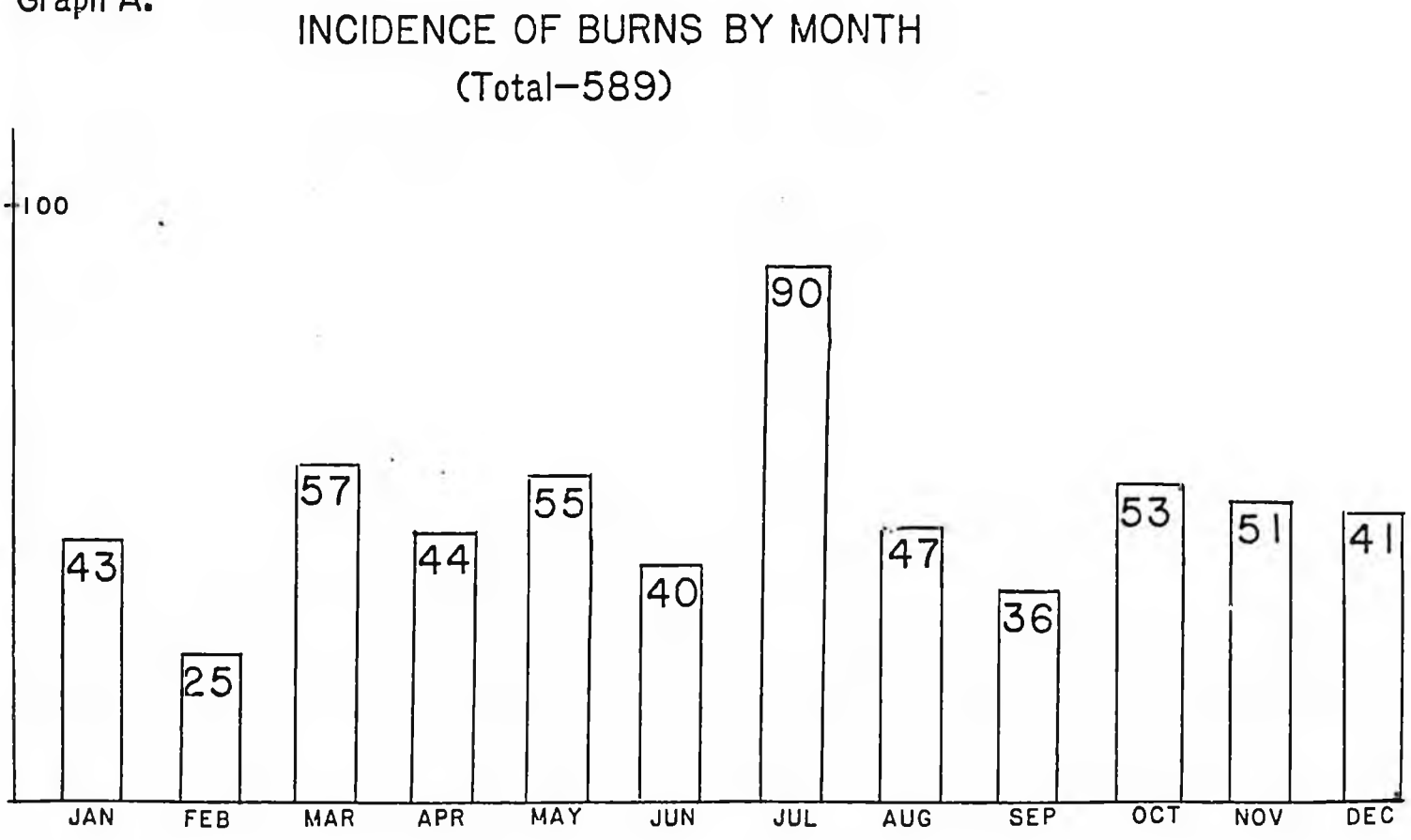
Joseph A. O'Keefe
State Fire Marshal

MASSACHUSETTS BURN INJURY REPORTING SYSTEM

In 1985, the first full year of the Massachusetts Burn Injury Reporting System (M-BIRS), 589 burn reports were received from 94 Massachusetts hospitals and health clinics (see Table 1.). Burn injuries of 5% or more of the body surface area must be reported to the Commissioner of Public Safety immediately through a 24-hour toll free hotline by the initial attending physician or medical facility. Then, the burn must be reported on a card and mailed to the State Fire Marshal's Office.

An average of 49 burns were reported monthly, ranging from 25 in February (the low) to 90 in July (the high). Based on the average, twice as many serious burns occur in July than can be expected in other months. This is consistent with analysis of burn reports submitted in 1984. (The Burn Registry was implemented on June 1, 1984.) July was also the "worst" months for burns in 1985. Graph A. below shows the reported burns by month.

Graph A.



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

Table 2.

LEADING CAUSES OF BURNS REPORTED IN EACH MONTH

JANUARY-41

Cause	# Burns
Scald	10
House Fires	7
Cooking	6
Gasoline	3
Smoking Materials	2
Electrical	2
Hot Car Parts	2
All others	19

FEBRUARY-25

Cause	# Burns
Scald	10
House Fires	4
Smoking Materials	2
Grease	2
All Others	7

MARCH-57

Cause	# Burns
Scald	19
House Fires	17
Cooking	4
Smoking Materials	2
Gasoline	2
All others	13

APRIL-44

Cause	# Burns
Scald	13
Cooking	5
House Fires	4
Explosion	3
Motor Vehicle Accident	3
Chemical	3
Electrical	2
All Others	11

MAY-55

Cause	# Burns
Scald	13
Hot Car Part	6
Gasoline	5
Cooking/BBQ	5
Electrical	4
House Fire	3
Chemical	2
All others	17

JUNE-40

Cause	# Burns
Scald	8
Cooking/BBQ	4
Fireworks	4
Hot Car Part	3
Sunburn	3
Chemical	3
All Others	15

JULY-90

Cause	# Burns
Hot Car Parts	15
Fireworks	14
Hot Liquid Scalds	11
Smoking Materials	5
Cooking/BBQ	3
Sunburn	3
Boat Fires	2
All others	37

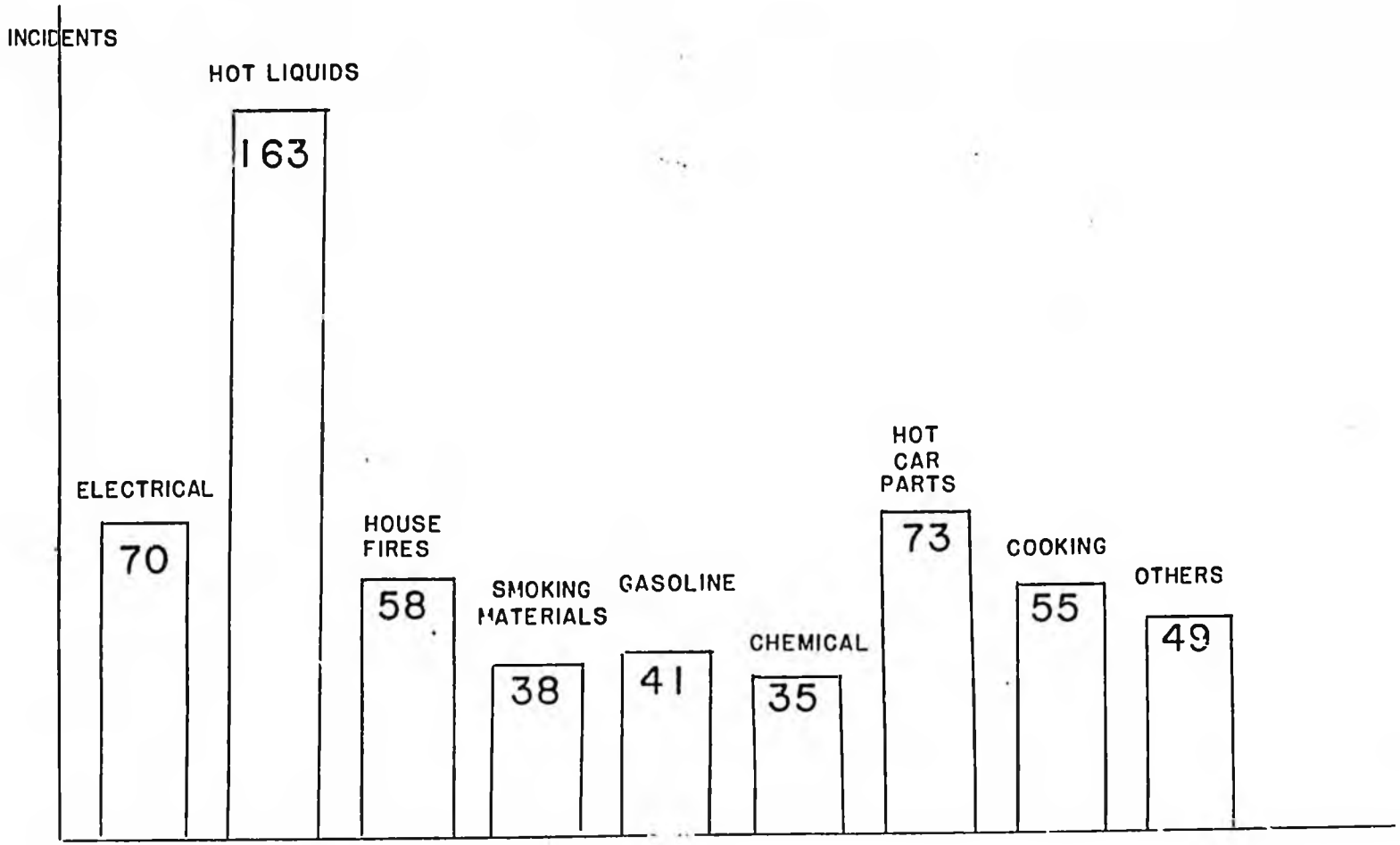
AUGUST

Cause	# Burns
Hot Liquid Scalds	13
Gasoline	6
Hot Car Parts	5
Appliances	3
Electrical	3
All others	17

Graph C.

LEADING CAUSES OF BURNS

Total Population



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

MASSACHUSETTS BURN INJURY REPORTING SYSTEM

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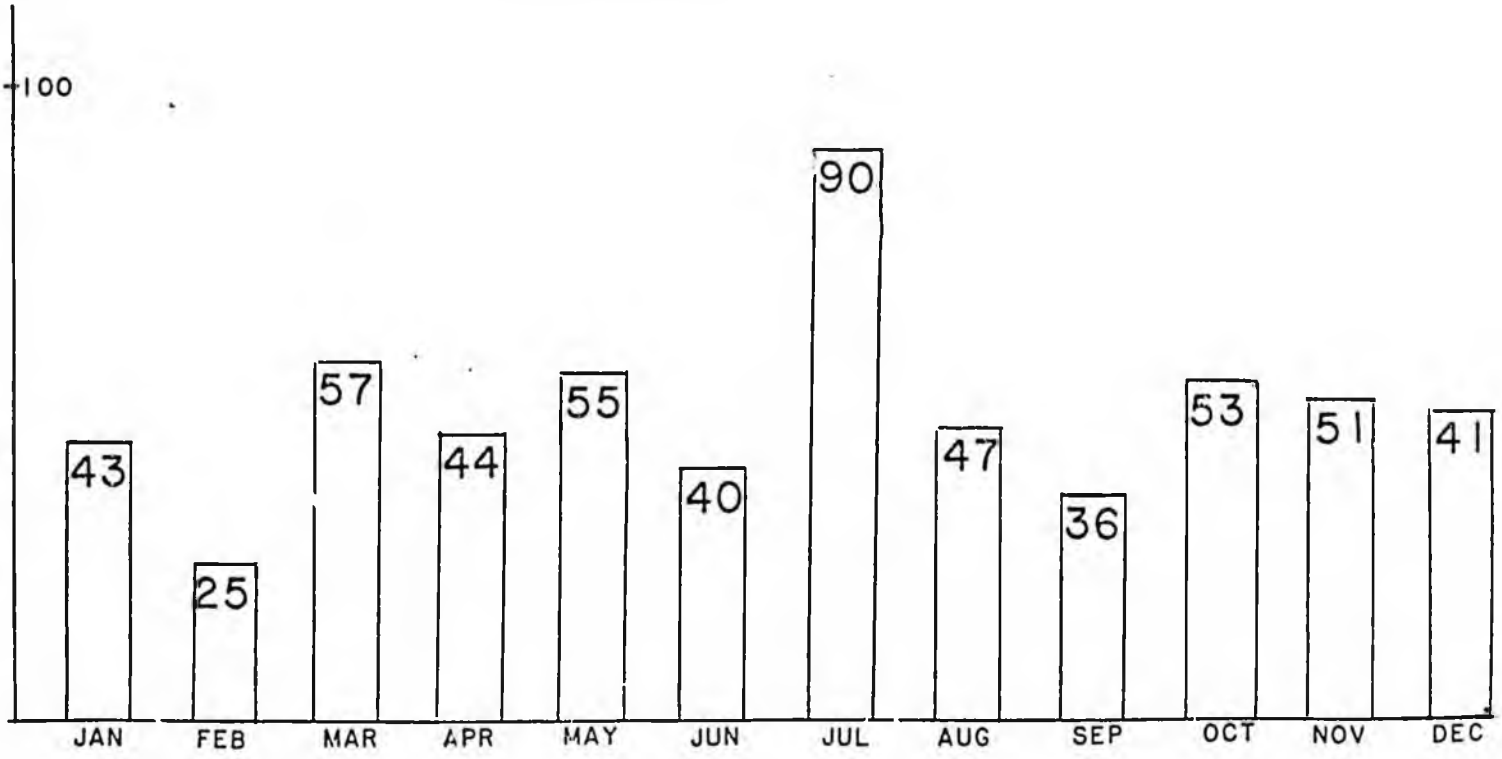
Graph A.

INCIDENCE OF BURNS BY MONTH
(Total–589)



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

CAUSES BY MONTH

For every month except July, the number 1 ranked cause of burns is hot liquid scalds. These scalds are due to knocked over cups of coffee, too hot tub water, and cooking accidents.

For the winter months, November, December, January, February and March, house fires are the number 2 ranked cause of burns.

In May through October, radiator explosions and hot car parts are a leading cause of burns, becoming number 1 in July.

For all months of the year, cooking accidents are a leading and consistent cause of burns. They rank number 2, 3, or 4 depending on the season.

From May through October, gasoline is a leading cause of burns.

It is interesting to note that the top five ranked causes of burns: scalds, house fires, cooking accidents, gasoline and hot car parts/ radiator explosions, are consistent. They change places in the ranking and reorder themselves based on seasonal fluctuations. (See Table 2.).

AFFECTED AGE GROUPS

Adults (aged 21-64) comprise over half, 52% of the total burns reported; children 10 and under account for 22% of burn victims and teenagers represent 18%. (See Graph B.).

CAUSES

The leading cuases of burn injuries in Massachusetts during 1985 were: hot liquid scalds; electrical burns; house fires; cooking accidents;

Table 2.

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JANUARY-41

Cause	# Burns
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Cooking	6
Gasoline	3
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Electrical	2
Hot Car Parts	2
All others	19

FEBRUARY-25

Cause	# Burns
Scald	10
House Fires	4
Smoking Materials	2
Grease	2
All Others	7

MARCH-57

Cause	# Burns
Scald	19
House Fires	17
Cooking	4
Smoking Materials	2
Gasoline	2
All others	13

APRIL-44

Cause	# Burns
Scald	13
Cooking	5
House Fires	4
Explosion	3
Motor Vehicle Accident	3
Chemical	3
Electrical	2
All Others	11

MAY-55

Cause	# Burns
Scald	13
Hot Car Part	6
Gasoline	5
Cooking/BBQ	5
Electrical	4
House Fire	3
Chemical	2
All others	17

JUNE-40

Cause	# Burns
Scald	8
Cooking/BBQ	4
Fireworks	4
Hot Car Part	3
Sunburn	3
Chemical	3
All Others	15

JULY-90

Cause	# Burns
Hot Car Parts	15
Fireworks	14
Hot Liquid Scalds	11
Smoking Materials	5
Cooking/BBQ	3
Sunburn	3
Boat Fires	2
All others	37

AUGUST

Cause	# Burns
Hot Liquid Scalds	13
Gasoline	6
Hot Car Parts	5
Appliances	3
Electrical	3
All others	17

Table 2. (cont'd)

SEPTEMBER-36

Cause	# Burns
Hot Liquid Scalds	12
Gasoline	7
House Fires	2
Chemical	2
Smoking Materials	2
All others	11

NOVEMBER-51

Cause	# Burns
Scalds	20
Chemical	4
House Fires	4
All others	21

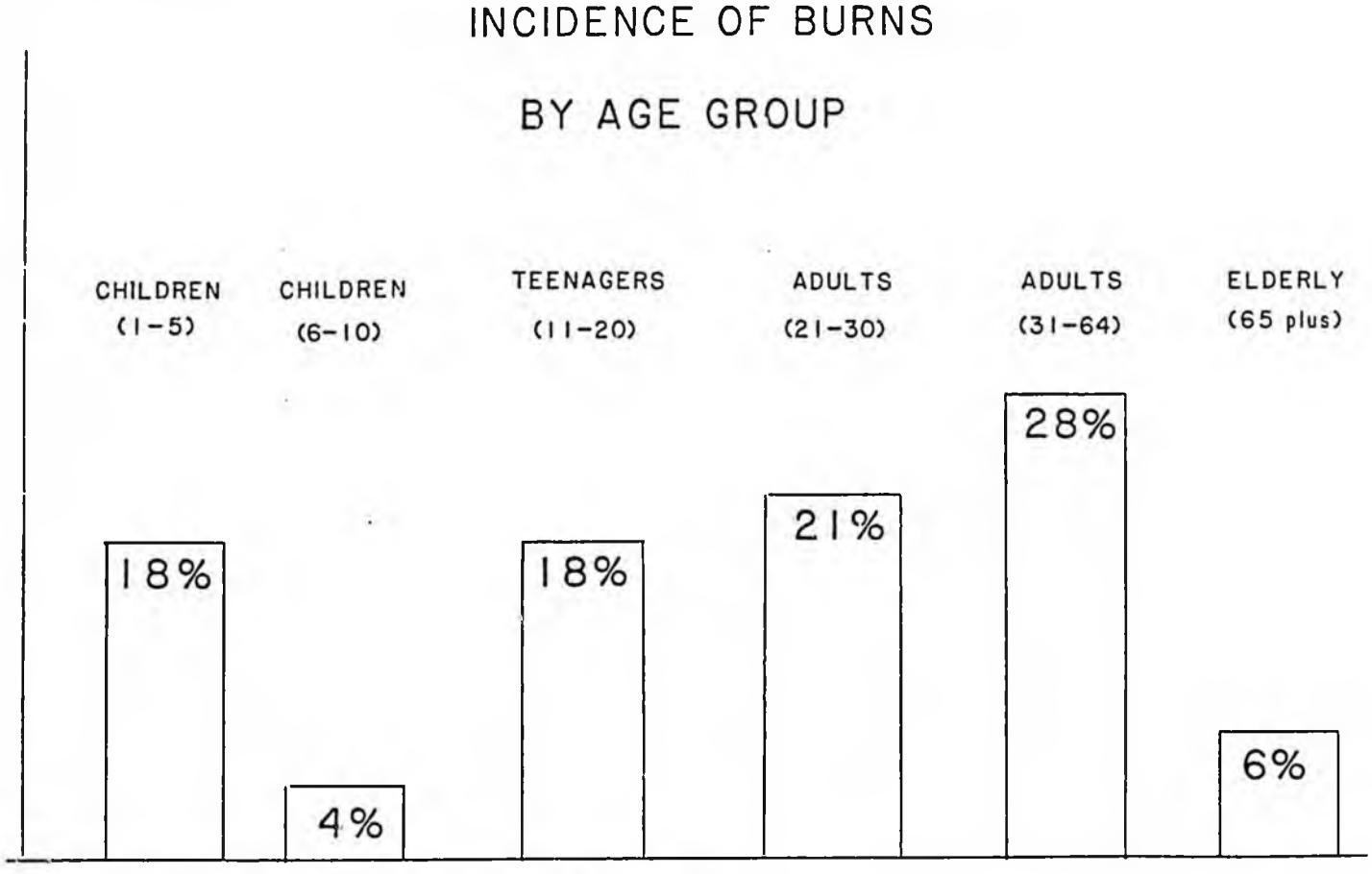
OCTOBER-53

Cause	# Burns
Scalds	18
Gasoline	9
Smoking Materials	4
Hot Car Parts	4
House Fires	2
All others	16

DECEMBER-41

Cause	# Burns
Scalds	14
House Fires	4
Cooking	3
Electrical	2
Woodstoves	2
All others	16

Graph B.

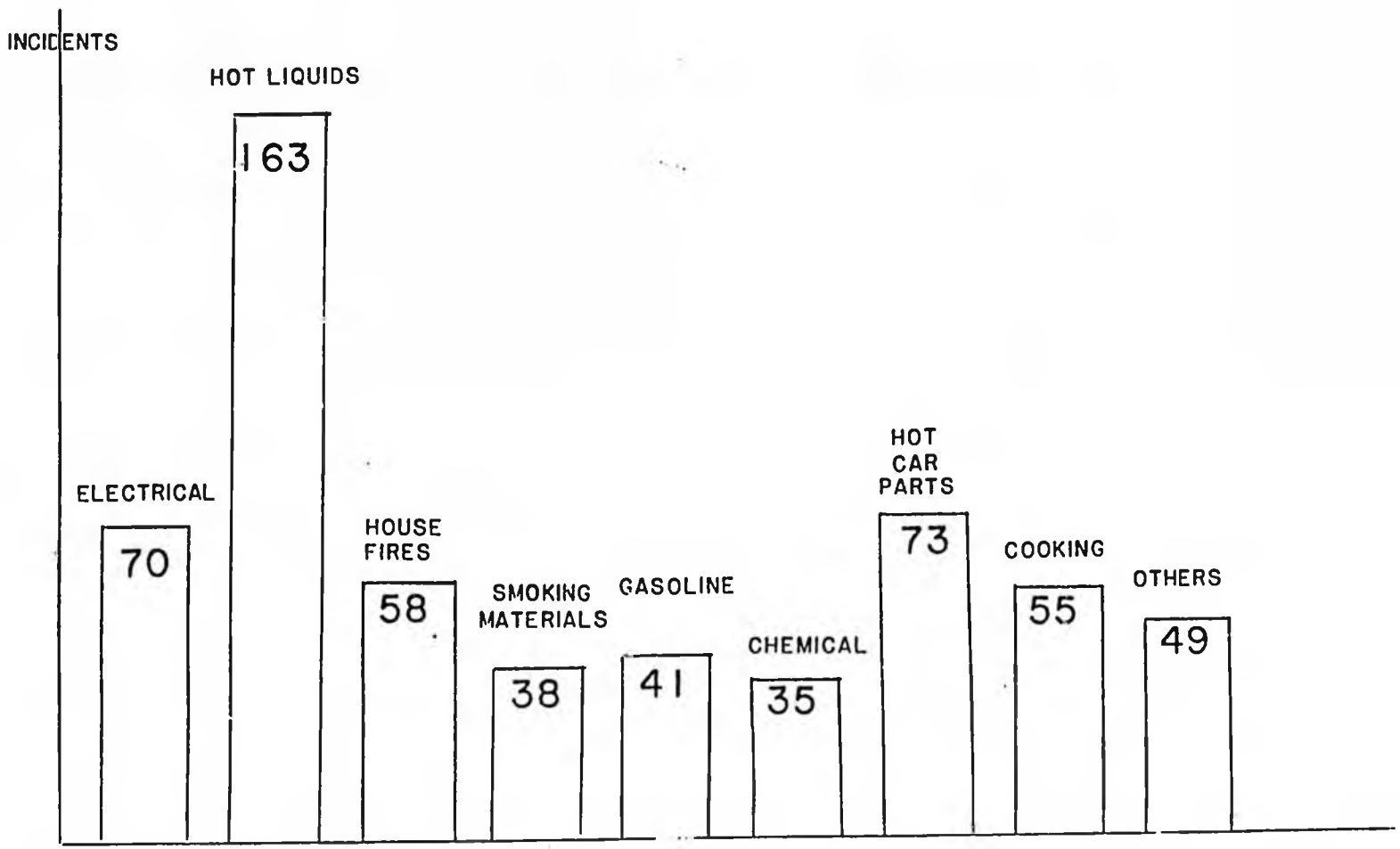


SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

Graph C.

LEADING CAUSES OF BURNS

Total Population



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

hot car parts and radiator explosions; fireworks; and steam scalds. This is based on total burns.

CAUSES BY AGE GROUP

Children 5 and under accounted for 18% of all reported burns. 82 of the 106 burns for this age group, or 77% were caused by hot liquid scalds from coffee, tea, boiling water, and excessively hot bath water. 6% were received in house fires.

The 6-10 year old age group counted 29 victims; 50% of these burns were caused by hot liquid scalds and 16% occurred in house fires.

111 victims were teenagers 11-20 years old. 14% were caused by radiator explosions and hot car parts. 14% of these burns occurred while using gasoline. An additional 14% were due to fireworks. 12% of burns in this age group were cooking accidents.

21-30 year olds are the largest group of burn victims representing 21% of the total. The leading causes of burns for this age group were: car radiator explosions/hot car parts (16%); chemcial burns (15%); hot liquid scalds (13%); cooking accidents (12%); and misuse of smoking materials (7%).

72 victims were 31-40 years old. 18% of these burns were caused by hot car parts and radiator explosions; 13% occurred in house fires; 9% happened while working with gasoline.

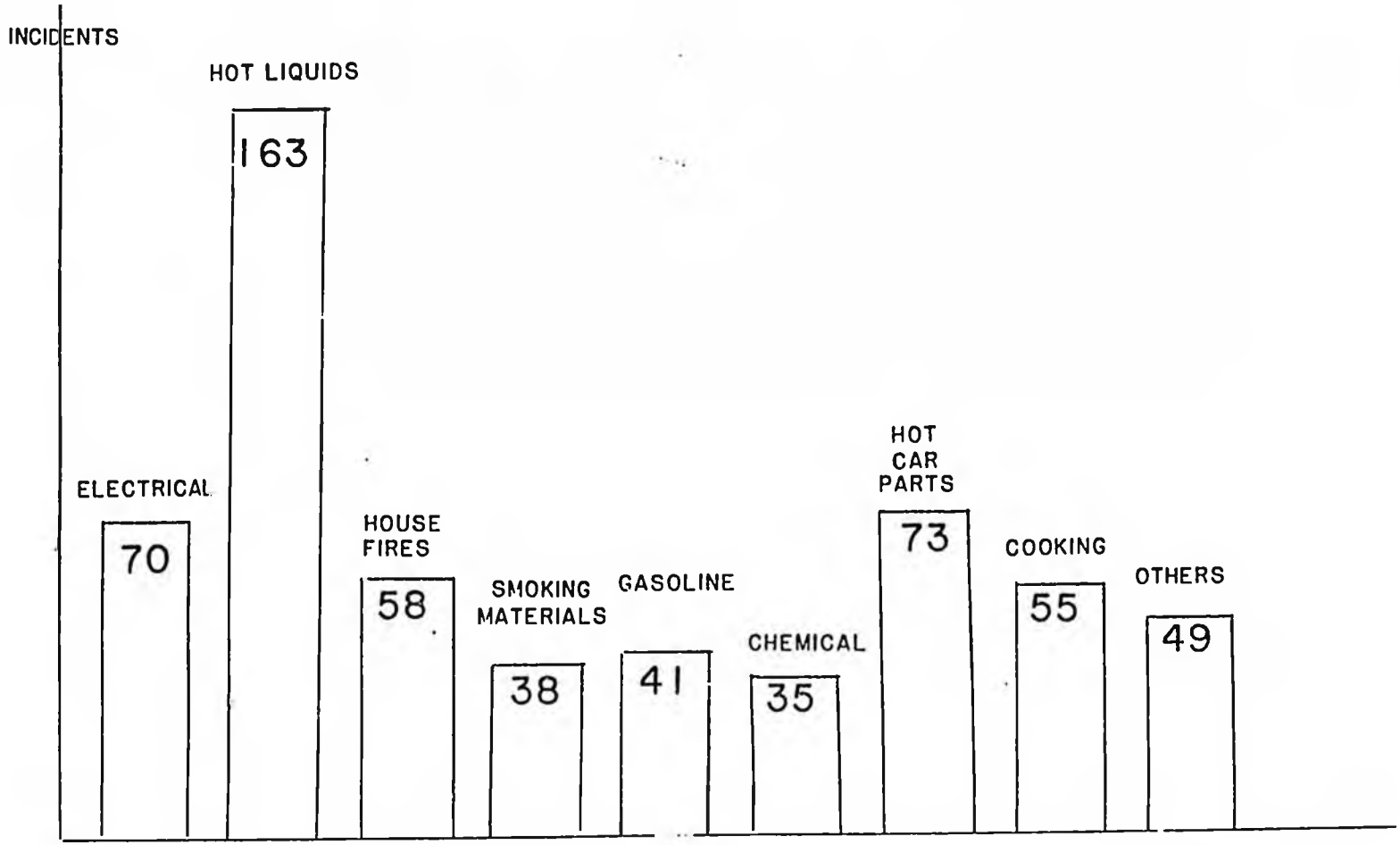
9% of the reported burn victims were aged 41-50. Nearly one-quarter of these burns were from hot car parts and radiator explosions. Hot liquid scalds caused 18%. 12% of these burns occurred in house fires. 9% of the burns were the result of the misuse of smoking materials.

6% of 1985's burn injuries involved 51-64 year olds. Hot liquid spills and house fires each caused 15% of these burns. 11% were due to the misuse of smoking materials.

Graph C.

LEADING CAUSES OF BURNS

Total Population



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

Table 3.

TABLE OF CAUSES OF BURNS BY AGE GROUP

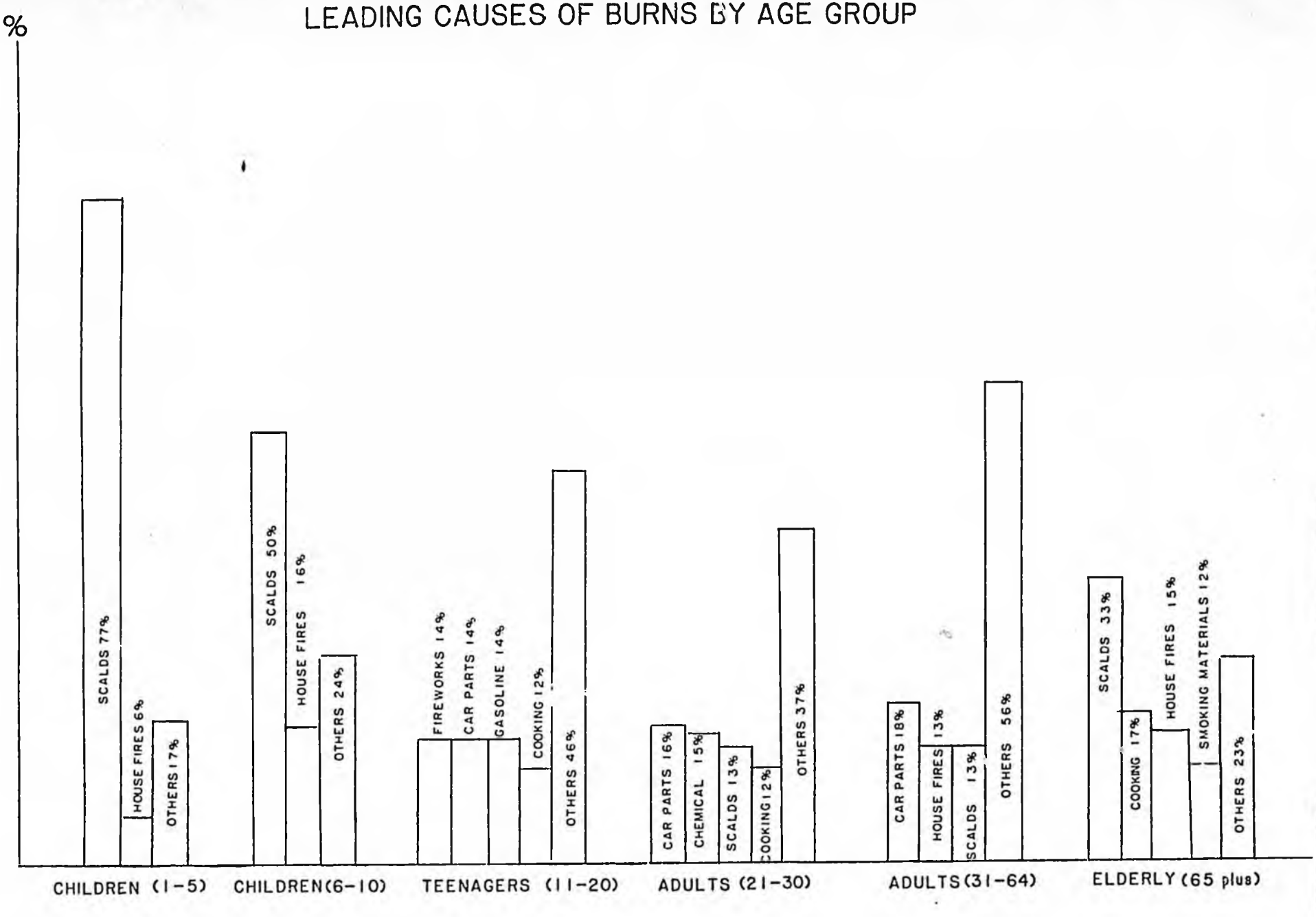
CAUSES	AGE 0-5	6-10	11-20	21-30	31-40	41-50	51-64	65+	UNK	ROW TOTAL
Hot Liquid Scalds	84	13	12	18	7	10	7	13	2	166
House Fires	7	4	3	13	10	7	7	6		57
Radiator Explosion/ Hot Car Parts	1	0	16	20	11	9	5	1	1	63
Car Fires	0	0	3	4	3	2	0	0		12
Gasoline	0	3	15	8	7	6	2	1		42
Cooking Accidents	5	0	13	16	3	7	4	7		55
Fireworks	1	2	15	1	4	[illegible]	0	1		24
Smoking Materials	2	3	3	9	4	5	5	5		36
Chemicals	3	0	7	14	3	1	2	0		30
Steam	2	3	2	3	2	2	0	1		15
Electricity	0	0	4	10	5	2	3	1		25
Clothing On Fire	0	0	2	0	0	0	2	2		6
Brush/Bon Fire	2	0	4	4	1	2	0	1		14
Gunpowder	0	0	5	2	0	1	0	0		8
Sunburn	0	0	2	2	2	0	0	0		6
Boat Fires	0	0	0	0	2	0	2	0		4
Appliances	4	1	1	0	1	0	0	1		8
Portable Heaters	0	0	3	1	0	0	0	0		4
Furnaces	0	0	1	0	1	3	1	0		6
Bombs	0	0	0	1	0	0	0	0		1
Self-Immolation	0	0	0	3	1	0	0	0		4
Plane Crashes	0	0	0	0	0	1	0	0		1
Undetermined									1	1
Column Total	111	29	111	129	67	58	40	40	4	589
Column % of Total*	19%	4%	18%	21%	11%	9%	6%	6%		100%

*Percentages are rounded off and may not appear to total 100%.

SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

Graph D.

LEADING CAUSES OF BURNS BY AGE GROUP



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

Table 4.

LEADING CAUSES OF BURNS BY AGE GROUP

AGE 0-5 Total = 111

Hot Liquid Scalds-84
House Fires-7

AGE 6-10 Total = 29

Hot Liquid Scalds-13
House Fires-4

AGE 11-20 Total = 111

Hot Car Parts/
Radiator Explosion-16
Gasoline-15
Fireworks-15
Cooking-13

AGE 21-30 Total = 129

Hot Car Parts/
Radiator EXplosions-20
Chemicals-14
Hot Liquid Scalds-18
Cooking-16
Smoking Materials-9

AGE 31-40 Total = 67

Hot Car Parts/
Radiator Explosions-11
House Fires-10
Hot Liquid Scalds-7
Gasoline-7

AGE 41-50 Total = 58

Hot Car Parts/
Radiator Explosions-19
Hot Liquid Scalds-10
House Fires-7
Cooking-7
Smoking Materials-5

AGE 51-64 Total = 40

Hot Liquid Scalds-7
House Fires-7
Smoking Materials-5
Hot Car Parts/
Radiator Explosions-5

AGE 65 and over Total = 40

Hot Liquid Scalds-13
Cooking-7
House Fires-6
Smoking Materials-5

The elderly, people aged 65 and over, accounted for 6% of total burn victims. Hot liquid scalds caused one-third (33%) of these burns. Cooking accidents caused 17% of the elderly's burns. 15% occurred as the result of house fires; and 125 were due to the misuse of smoking materials.

Graph D. shows the leading causes of burns for each age group. Table 3. shows the total number of burns by cause and age group. Table 4. shows only the leading causes of burns by age group.

GEOGRAPHICAL DEMOGRAPHICS

Burn victims during 1985 came from 180 different Massachusetts cities and towns and from every county. People came from all the large population centers and from many rural communities. (See Table 5.) Massachusettts hospitals also treated and reported the burn injuries of 30 people who live outside of Massachusetts. Graph E. depicts the number of burn victims by their county of residence.

CONCLUSIONS

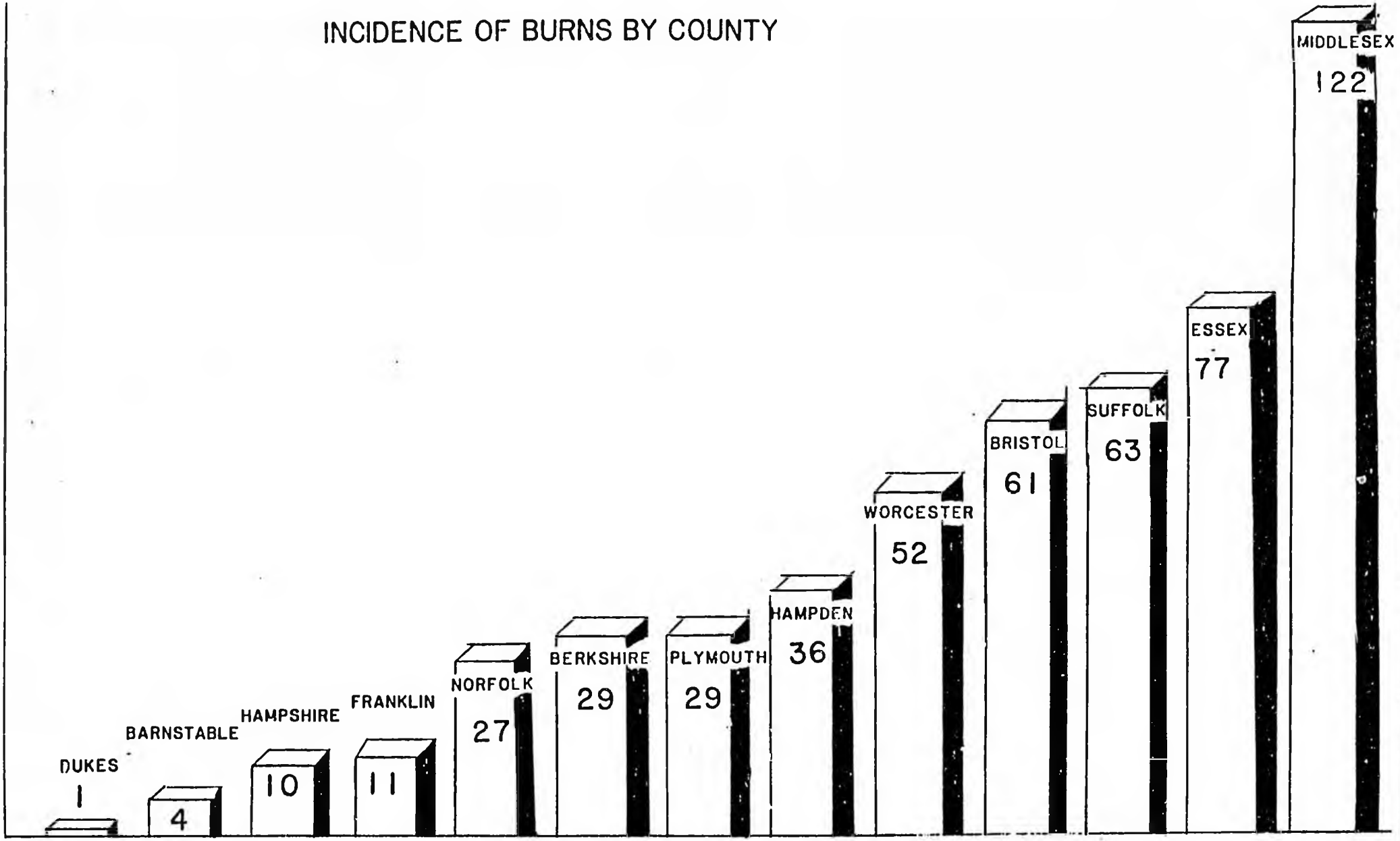
The preceding analysis of Massachusetts burns in 1985 shows the extent to which fire prevention and burn prevention overlap. It is our hope that fire prevention agencies, public health officals, the medical community, educators, and community groups can together use this information to form a "road map" for burn prevention strategies.

It is abundantly clear that the public needs greater education on preventing scalds to young children in the home; on how to react to cooking accidents which get out of control; the dangers inherent in car radiators and hot car parts; the dangers in using fireworks and gasoline; and the message about the careless use and disposal of smoking materials cannot be reiterated enough.

Some of these messages should be communicated all year long, and some should be targeted to the season when they most frequently occur.

The audience for burn prevention messages is also quite clear. Parents should be the target for messages about keeping pot handles from hanging over the edge of the stove; for testing bath water and for not letting children bathe unattended; for keeping cups of coffee and tea far from the reach of curious hands. Teenagers need education on not touching car radiators while hot and under pressure; about proper auto mechanics and the proper use of gasoline; the dangers of fireworks; and how to react to cooking accidents. All age groups need to learn the incredible importance of installing and maintaining smoke detectors and of practicing home exit drills, since house fires are a leading cause of burns and deaths across all age groups.

Graph E.



SOURCE: 1985 reports to the Massachusetts Burn Injury Reporting System (M-BIRS).

Table 5.

1985 BURN REPORTS BY VICTIMS ADDRESS

ABINGTON - 1
ACTON - 1
ACUSHNET - 3
ADAMS - 2
AMESBURY - 1
ARLINGTON - 4
ATHOL - 3
ATTLEBOROUGH - 6
AYER - 1

BARNSTABLE - 2
BELCHERTOWN - 1
BELMONT - 2
BERNARDSTON - 1
BEVERLY - 5
BILLERICA - 8
BLACKSTONE - 1
BOSTON - 54
BOURNE - 1
BRAINTREE - 6
BROCKTON - 19
BROOKFIELD - 1
BROOKLINE - 1
BURLINGTON - 1

CAMBRIDGE - 11
CARLISLE - 1
CHELMSFORD - 3
CHELSEA - 4
CHICOPEE - 2
CLINTON - 1
CONWAY - 1

DANVERS - 1
DARTMOUTH - 7
DEDHAM - 1
DIGHTON - 3
DOUGLAS - 1
DRACUT - 3
DUDLEY - 1

EAST BRIDGEWATER - 2
EAST LONGMEADOW - 1
EASTHAMPTON - 5
EVERETT - 1

FAIRHAVEN - 1
FALL RIVER - 8
FITCHBURG - 2
FLORIDA - 1
FRAMINGHAM - 6
FREETOWN - 4

GARDNER - 1
GLOUCESTER - 6
GRAFTON - 2
GRANBY - 3
GREAT BARRINGTON - 2
GREENFIELD - 4
GROTON - 1

HANSON - 2
HAVERHILL - 6
HINGHAM - 1
HINSDALE - 2
HOLDEN - 4
HOLLISTON - 3
HOLYOKE - 4
HUDSON - 1

IPSWICH - 2

LANESBORO - 2
LAWRENCE - 9
LENOX - 1
LEOMINSTER - 5
LEXINGTON - 1
LOWELL - 16
LUNENBURG - 2
LYNN - 21

MALDEN - 7
MANSFIELD - 2
MARLBOROUGH - 2
MARSHFIELD - 1
MASHPEE - 1
MEDFIELD - 1
MEFORD - 9
MELROSE - 1
METHUEN - 5
MILFORD - 1
MONTAGUE - 1
(Turners Falls-1)

NATICK - 1
NEEDHAM - 2
NEW BEDFORD - 9
NEWTON - 5
NORTH ADAMS - 2
NORTH ANDOVER - 3
NORTH ATTLEBORO - 3
NORTHBOROUGH - 2
NORTHBRIDGE - 3
NORTON -1
NORWOOD - 2

ORANGE - 1
OTIS - 1

PALMER - 1
PEABODY - 9
PEPPERELL - 1
PITTSFIELD - 10
PLYMOUTH - 1

QUINCY - 10

RANDOLPH - 1
REHOBOTH - 1
REVERE - 5
ROCHESTER -1
ROCKLAND - 1
ROWLEY - 1

SALEM - 4
SALISBURY - 3
SAUGUS - 1
SCITUATE - 2
SHELBURNE FALLS - 1
SHERBORN - 1
SHREWSBURY - 1
SOMERSET - 3
SOMERVILLE - 8
SOUTHBRIDGE - 1
SPENCER - 2
SPRINGFIELD - 8
STOCKBRIDGE - 2
STOUGHTON - 2
SWANSEA - 1

Table 5. (cont'd)

1985 BURN REPORTS BY VICTIMS ADDRESS (CONT'D)

TAUNTON - 7
TEMPLETON - 1
TEWKSBURY - 3
TOWNSEND - 2
TYNGSBORO - 3

UXBRIDGE - 1

WAKEFIELD - 2
WARE - 1
WAYLAND - 4
WEBSTER - 5
WEST SPRINGFIELD - 1
WEST STOCKBRIDGE - 1
WEST TISBURY - 1
WESTFIELD - 6
WESTFORD - 1
WESTON - 1
WESTPORT - 2
WEYMOUTH - 2
WILBRAHAM - 1
WILLIAMSTOWN - 3
WILMINGTON - 1
WINCHESTER - 4
WOBURN - 5
WORCESTER -11

UNKNOWN - 30

OUT OF STATE - 30

BURN REPORTS BY COUNTY OF VICTIMS' ADDRESS

BARNSTABLE - 4
BERKSHIRE - 29
BRISTOL - 61
DUKES - 1
ESSEX - 77
FRANKLIN - 11
HAMPDEN - 36
HAMPSHIRE - 10
MIDDLESEX - 122
NANTUCKET - 0
NORFOLK - 27
PLYMOUTH - 29
SUFFOLK - 63
WORCESTER - 52

Table I.

Hospitals

Addison Gilbert-6
Amesbury-0
Anna Jacques-3
Athol Memorial-5
Atlanticare-1
Brigham and Women's-26
Baystate Medical-9
Boston City Hospital-5
Berkshire Medical Center-21
Beverly-7
Beth Isreal-1
Bon Secours-14
Boston V.A.-1
Brockton-5
Burbank-3
Cardinal Cushing-12
Carney-1
Central-1
Charlton Memorial-13
Chelsea Memorial-1
Children's-8
Choate Memorial-2
Cooley Dickinson-3
Fairhaven-1
Fairlawn-1
Fairview-3
Falmouth-1
Farren Memorial-3
Faulkner-0
Framingham Union-10
Franklin Medical Center-5
Goddard Memorial-5
Henry Heywood-3
Haverhill Municipal-9
Harrington Memorial-5
Hillcrest-1
Holden District-4
Holyoke-10
HS-Medford-1
Hubbard Regional-8
Hunt Memorial-1
Ipswhich-I
J.B. Thomas-2
Jordan-0
Lahey-4
Lawrence General-2
Lawrence Memorial-5
Leominster-6
Lowell General-11
Ludlow Hospital Society-0
Lynn-25
Malden-6
Marlborough-5
Mary Lane-4
M.A. Eye and Ear-1
Melrose/Wakefield-2
Mercy-10
M.A. General-92
Milton-Whitinsville-3
Milton-3
Morill Place-1
Morton-12
Mt. Auburn-5
North Adams Regional-6

Table I (cont'd)

Nantucket-1
Nashoba Community-6
New England Medical Center-3
New England Memorial-4
Noble-8
Norwood-3
Parkwood-10
Providence-2
Quincy City-13
Salem-6
Sancta Maria-2
Shriner's Institute-5
South Shore-13
Springfield-1
St. Anne-3
St. Elizabeth-1
St. John's-12
St. Joseph-2
St. Luke-Middleborough-1
St. Luke-NewBedford-11
Sturdy Memorial-9
Tobey-1
UMass-Worcester-13
Union-Lynn-1
UNK-2
Vineyard-1
Whidden Memorial-1
Whittinsville-4
Winchester-6
Wing Memorial-6
Worcester City-8
VHS-1

(Please Post)

REPORT ALL BURNS IMMEDIATELY!

It's the law!*

DPS/DPH BURN INJURY REGISTRY 1-800-682-9229

Victim's Name & Address: _____

_____

Age of Victim: _____ Date of Injury: _____ Degree of Burn: _____

Local Police Chief Notified: _____ Area(s) Burned: _____

Cause of Burn: _____

Address Where Burn Occurred: _____ _____ _____
Street & Number City/Town Zip Code

Name & Address of Hospital: _____

Attending Physician: _____ Forward this information to: Commissioner of Public Safety, State Fire Marshal's Office, 1010 Commonwealth Avenue, Boston, Massachusetts 02215

(PRINT or TYPE)

24-hour toll-free hotline:

1-800-682-9229

Frank J. Trabucco
Commissioner

Chapter 112, Section 12A
Massachusetts General Laws *

Joseph A. O'Keefe
State Fire Marshal

STATE OF NEW YORK
DEPARTMENT OF STATE
ALBANY, N.Y. 12231

GAIL S. SHAFFER
SECRETARY OF STATE

September 5, 1985

TO: Physicians, Hospital Administrators, Emergency Room Heads, Medical Facility Directors

FROM: Gail S. Shaffer, Secretary Of State
Francis A. McGarry, State Fire Administrator

SUBJECT: Compliance by physicians and medical facilities with §265.26 of the New York State Penal Law regarding the reporting of burn injuries.

Chapter 201 of the Laws of 1985 establishes a requirement for the reporting of certain burn injuries to the New York State Office of Fire Prevention and Control.

This legislation, effective November 1, 1985, adds a new section 265.26 of the Penal Law as follows:

§265.26 Burn injury and wounds to be reported.

Every case of a burn injury or wound, where the victim sustained second or third degree burns to five percent or more of the body and/or any burns to the upper respiratory tract or laryngeal edema due to the inhalation of super-heated air, and every case of a burn injury or wound which is likely to or may result in death, shall be reported at once to the Office of Fire Prevention and Control. The State Fire Administrator shall accept the report and notify the proper investigatory agency. A written report shall also be provided to the Office of Fire Prevention and Control within 72 hours. The report shall be made by (a) the physician attending or treating the case, or (b) the manager, superintendent or other person in charge whenever such case is treated in a hospital sanitarium or other medical facility.

The intentional failure to make such report is a class A misdemeanor.

This statute was enacted in an effort to combat arson through the rapid identification and apprehension of suspected arsonists who may suffer burn injuries during the commission of their crimes. The statute will also provide a burn injury data base from which effective burn prevention and fire safety education programs may be developed.

The statute is explicit in requiring immediate reports of burn injuries and written reports within 72 hours. To facilitate the reporting of burn injuries, the Office of Fire Prevention and Control has a toll-free telephone, 1-800-345-5811, answered 24 hours a day and is providing postage-paid burn injury report forms. Enclosed are report form(s) and informational materials on burn injury reporting.

The procedures for reporting burn injuries are as follows:

1. *Immediately call the New York State Office of Fire Prevention and Control's 24-hour hotline at:*

   1-800-345-5811

2. *Tell the operator you are reporting o burn injury and give the operator the following information.*

   A. Victim's name, address and date of birth
   B. Address where burn injury occurred
   C. Date and time of burn injury
   D. Degree of burns and percent of body burned
   E. Area(s) of body injured
   F. Injury severity
   G. Apparent cause of burn injury
   H. Name and address of reporting facility
   I. Attending physician

3. *Complete the Burn Injury Report Form within 72 hours and submit it to:*

   Burn Injury Reporting System
   New York State Department of State
   Office of Fire Prevention and Control
   162 Washington Avenue
   Albany, NY 12231

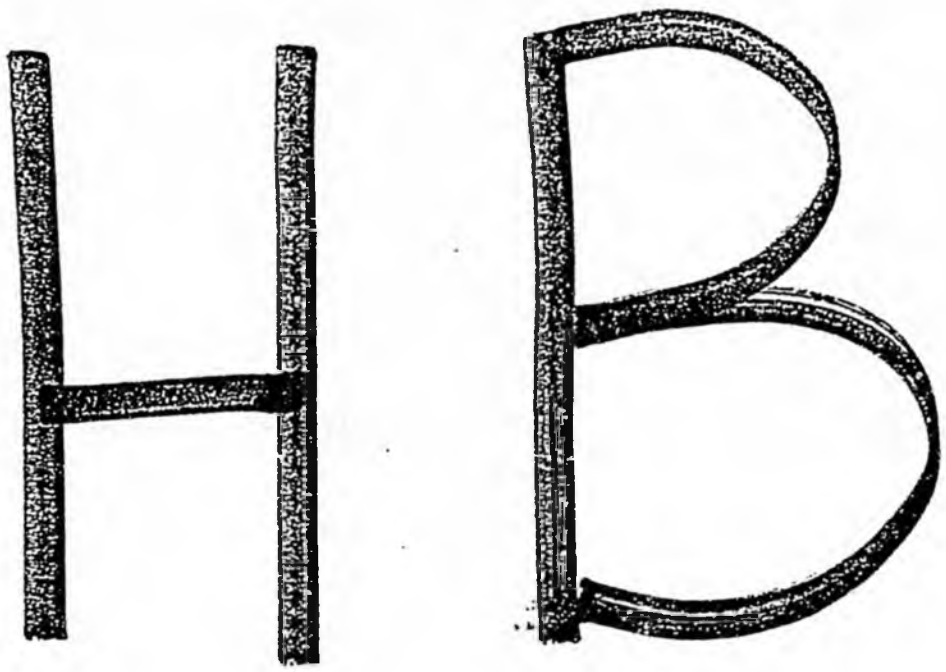
Participation in the burn injury reporting system by yourself and/or your staff will ensure compliance with the law and aid in documenting burn injuries and the reduction of arson incidence in the State of New York.

Thank you for your cooperation in this matter. For additional report forms, information or questions, please contact:

New York State Department of State
Office of Fire Prevention and Control
162 Washington Avenue
Albany, NY 12231
(518) 474-6746

FAM:ed

Enclosures



342

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

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

Mary Van Nimwegen

H HESS 1-28-88 8:30a.m.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

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

Mary Van Nimwegen

H HESS 1-28-88 8:30a.m.

BACKGROUND **RECOMMENDATION**

Teenage Prenatal Care: 73

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

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

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

Senator Rick Halford

Senate District 1
Chugiak, Eagle River, East Anchorage, Fort Richardson

Senate Finance Committee
Co-Chairman

TO: All Legislators

FROM: Senator Rick Halford

DATE: March 26, 1988

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

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

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

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

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

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

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

January 28, 1988

LETTER OF INTENT
TO
CSHB 342 (HESS)
BY THE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

In order to make prenatal care more accessible and affordable to low-income high-risk pregnant women, it is the intent of the Legislature that the Department of Health and Social Services adequately advertise the benefits offered by CSHB 342 (HESS). The Department shall report back to the legislature no later than January 31, 1989 how the program is being advertised and the number of participants.

It is further the intent of the Legislature that the Department keep a record as to the number of babies born to Medicaid mothers who are low birthweight and/or die within the first year of life. The Department shall report back to the legislature no later than January 31, 1990 and annually thereafter.

Rep. ~~Niilo Koponen~~, Co-Chair
House HESS Committee

Rep. Johnny Ellis, Co-Chair
House HESS Committee

SB 348

(7)

HOUSE COMMITTEE REPORT

Date referred: 1/11/88 FURTHER REFERRALS: Finance

DATE: 1-28-88

The Health, Education and Social Services Committee has considered HB 342

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

RECOMMENDS:

[X] replace with CSHB 342 (HESS) [ ] the same title

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

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ________ Committee

ADOPTS: [X] ________ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[X] fiscal impact

[ ] zero fiscal note

[ ] zero with analysis

[ ] same as previous fiscal note published ________

[ ] same as previous zero fiscal note published ________

SIGNING DO PASS:

Joyce Munson

Hy Ellis

Niilo Koponen

Bill Hudson

Max F. Gruenberg

Dave Donley

SIGNING OTHER RECOMMENDATIONS:

Randall E. Phillips No Rec.

Niilo Koponen

Co-Chairman's signature

Hy Ellis

HB 342

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

I. Purpose of HB 342

The purpose of HB 342 is to add two new groups of eligibles to the Medicaid Program: Pregnant women and children up to the age of five whose household incomes do not exceed 100% of the federal poverty level. The children would be phased in by age, one year each year until all children age five and under are covered.

II. Sectional Analysis

Section 1 — Section 1 amends AS 47.07.020(b), which delineates the optional groups of people who are eligible for Medicaid, by adding pregnant women and children up to age five whose household incomes do not exceed 100% of the federal poverty level.

Section 2 — Section 2 amends AS 47.07.030(b) to specify that case management and nutrition services for pregnant women are covered Medicaid services in Alaska.

Section 3 — Section 3 amends AS 47.07.035 by adding pregnant women and children up to the age of five whose household incomes do not exceed 100% of the federal poverty level to the existing list. The purpose of this section is to provide guidance to the department on the order in which optional Medicaid services and optional coverage groups are to be eliminated in the case of inadequate funding for the Medicaid Program.

III. Recommendations

Congress created this new Medicaid option recognizing that one in four children in America live in poverty; that the number of children living in poverty has grown each year since 1975; and that the United States is tied for last place among the 22 industrialized nations in infant mortality. In Alaska, although our welfare standards are generous compared with many other states, we have the highest mortality rate of all 50 states for infants between one month and one year of age.

This Medicaid option allows the state great flexibility in providing Medicaid coverage to pregnant women and children, while removing many of the current barriers to eligibility. It is estimated that close to 1,000 women will qualify for Medicaid each year, and nearly 5,000 children will be eligible each year when all children under age 5 are covered.

The program design would include a one time eligibility determination for pregnant women, so that once found eligible the woman would be covered by Medicaid through the 60 day postpartum period for all covered services. Additionally, this group of pregnant women and children will not be subject to the $1,000 resource limit of the Aid to Families With Dependent Children Program.

POSITION PAPER/Department of Health & Social Services

All pregnant women will receive case management services to better coordinate delivery of health care services and identify high risk pregnancies, with a goal of improved pregnancy outcome. Nutrition services will be available to high risk women who are not served by the Women, Infants and Children (WIC) Program. Children will receive all Medicaid services, including Early, Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT has proven especially useful in early identification and treatment of potentially handicapping medical, social and psychological conditions; it's success is due to monitoring of all Medicaid children by Public Health Nurses to assure that appropriate services are received.

Addition of this Medicaid option will allow the state to claim matching federal dollars for all general fund dollars spent on health care for pregnant women and children under five. The Department recommends that Section 2 be amended by adding "and nutrition" after "case management" so that nutrition services will be available to high risk women who are not served by the Women, Infants and Children (WIC) Program.

The Department believes enactment of this legislation would be a sound investment in children which would pay for itself economically and socially. The Department spends millions of dollars each year on neo-natal intensive care and long term institutional care for children which may have been prevented by provision of adequate pre-natal care to their mothers. It has been estimated that $1.00 spent on pre-natal care could ultimately save up to $11.00 if all the costs of caring for permanently disabled children are considered.

However, the expense of this program requires policy makers to consider the many competing and worthy needs of the medically indigent and others. The Governor's Interim Commission on Children and Youth (GICCY) recommended the pregnant women Medicaid option authorized by this legislation in its report. A plan for the implementation of the GICCY recommendations is being developed by the Governor.

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

Date: 1/26/88

Recommended by: Elizabeth Ward
Elizabeth Ward, Director
Division of Public Health

Date: January 26, 1988

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

Date: January 27, 1988

A PROPOSAL FOR COMPREHENSIVE PRENATAL CARE AND HEALTH SERVICES FOR CHILDREN

ALASKA HEALTHY BABY PROJECT

WHAT IS IT?

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

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

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

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

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

WHO

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

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

WHY

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

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

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

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

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

HOW

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

The state would also have to provide funding for these services: The FY 89 cost of adopting the option is $3,063.1 million ($1,477 5 state funds); for FY 90 the cost is $6,880.8 million ($3,397.1 state funds). The increase from FY 89 to FY 90 is because the program cannot be implemented until January 1, 1988 resulting in only ½ year funding the first year.

WHAT WILL HAPPEN?

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

CONTACTS:

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

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

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

POUCH H-06
JUNEAU, ALASKA 99811-9976

PHONE:

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

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

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

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

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

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

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

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

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

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

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

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

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

POUCH H-06
JUNEAU, ALASKA 99811-9976

PHONE:

THE HEALTH OF ALASKA'S MOTHERS AND BABIES

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

EXAMPLES OF GAPS IN PRENATAL CARE

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

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

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

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

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

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

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

POSTNEONATAL MORTALITY IN ALASKA

Definitions:

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

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

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

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

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

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

   1984
   - Natives - 9.2
   - Whites - 4.5

   1979-85
   - Natives - 9.6
   - Whites - 4.3

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

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

	1985 Rate
• Southwest AK	10.0
• Northern AK	9.1

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

2/3 of neonatal deaths are LBW

1/4 of postneonatal deaths are LBW

This is true for both Whites and Natives.

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

7. Teens account for:

(1984 - 85 data)

9% of births

17% of Neonatal deaths

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

8. Single mothers account for:

16% of births

24% of Neonatal deaths

33% of all PN deaths

9. Natives account for:

20% of births

26% of Neonatal deaths

42% of all PN deaths

10. The bush accounts for:

14% of births

18% of Neonatal deaths

26% of all PN deaths

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

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

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

12. Causes of Death

- Neonatal: (of Whites and Natives respectively)

  Congenital Anomalies (29% and 22%)

  Respiratory Distress Syndrome (16% and 16%)

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

- Postneonatal: (of Whites and Natives respectively)

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

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

  For Whites, Congenital Anomalies (13%)

  For Natives, Pneumonia and Influenza (11%)

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

Further Detail:

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

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

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

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

- Anchorage/Matanuska - Susitna Region

  Anchorage Borough

  Matanuska-Susitna Borough

- Gulf Coast Region

  Kenai Peninsula Borough

  Kodiak Island Borough

  Valdez-Cordova Census Area

- Interior Region

  Fairbanks North Star Borough

  Southeast Fairbanks Census Area

  Yukon-Koyukuk Census Area

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

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

(4) The bush: Census Areas

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

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

PRENATAL CARE COSTS

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

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

-- one visit every 2 weeks for next 8 weeks

-- one visit every week thereafter until delivery

-- total number of prenatal visits = 14 to 15 v[illegible]

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

Alaska Women's Health Service - Prenatal Care

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

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

Delivery Fees

Vaginal delivery	$ 700
Cesarean Section	$ 1,400

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

Neighborhood Health Center

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

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

OPTIONS FOR INCREASING PRENATAL SERVICES

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

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

Eligibility

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

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

III. Enhancement of Services

-- case management

-- nutritional services

-- presumptive eligibility

-- no resource limit

-- one time eligibility

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

NUMBER OF WOMEN OF CHILD BEARING AGE IN ALASKA

BY AGE AND RACE

1984 Alaska Vital Statistics Annual Report

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

1984 LIVE BIRTHS BY AGE AND RACE OF MOTHER

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

PROBLEMS TO BE DISCUSSED

Access to Care

Teen Pregnancies

Nutrition for Pregnant Women

Sudden Infant Death Syndrome

Data Related to Infant Births and Deaths

INFANT MORTALITY

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

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

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

ALASKA HEALTHY BABY PROJECT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SB 348 AND HB 342

JANUARY 20, 1988

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

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

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

ARE TIED FOR LAST PLACE.

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

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

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

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

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

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

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

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

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

PREVENTION CAN BE COST EFFECTIVE

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

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

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

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

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

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

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

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

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

SPEECH BEFORE HOUSE FINANCE COMMITTEE -- 2/16/88

Mr. Chairman and members of the committee, thank you for this opportunity to speak about HB 342 or what has become to be known as "The Alaska Healthy Baby Project."

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

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

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

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

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

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

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

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

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

After the committee substitute was passed out of the HESS Committee, I was notified that the title perhaps does not adequately reflect what is contained in the bill. I understand that there is a proposed Finance Committee substitute that makes the necessary change.

March 3, 1987 -- House HESS Committee receives initial information on Alaska's infant and post neo-natal mortality rates. Committee also receives information on the need for prenatal care. This was Day One of the Week of the Child.

October 22, 1987 -- House HESS Committee holds work session on maternal and child health.

January 28, 1988 -- House HESS Committee holds public hearing on HB 342 and passes the bill out of committee.

Prenatal care for low-income women is recommendation #73 of the GICCY report.

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ALASKA STATE HOUSE

OFFICE OF MAJORITY WHIP

CO-CHAIR
HEALTH, EDUCATION & SOCIAL SERVICES

LABOR & COMMERCE
SUBCOMMITTEE ON FOREIGN TRADE

REPRESENTATIVE JOHNNY ELLIS

M E M O R A N D U M

TO: House HESS Members

FROM: Rep. Johnny Ellis JE

DATE: January 27, 1988

SUBJECT: HB 342, "The Alaska Healthy Baby Project"

From the testimony heard at our interim committee meeting on maternal and child health, the need for more accessible and affordable prenatal care for low-income high-risk pregnant women became apparent. Statistics show that 16% of all births in Alaska occur to women who receive inadequate or no prenatal care. One in 21 of those babies were born at health risk because they weighed under 5 1/2 lbs at birth.

Alaska has the highest infant mortality rate in the nation and 40% of all infant deaths can be attributed to low birth weight. In a twelve month period (1983-84), over 4.5 million state dollars were spent for the care of babies in Providence Hospital's Newborn Intensive Care Unit. The average cost per baby was $47,200, and the care of 14 babies cost more than $100,000 each. Numerous birth defects and health complications can be prevented with basic prenatal care.

House Bill 342 would take advantage of a new Medicaid option that allows the state to offer health care for pregnant women and their young children with incomes up to 100% (up from 78%) of the federal poverty guidelines. Fifty percent of the program costs and 75% of the position costs would be covered by new federal dollars.

I ask for your support of this legislation and helping to implement "The Alaska Healthy Baby Project."

Original sponsors: Ellis, Koponen,
Brown, et al.

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 342 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to medicaid eligibility for needy children and pregnant women."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children) or 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income);

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement,

but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level.

* Sec. 2. AS 47.07.030(b) is amended to read:

(b) In addition to the mandatory services specified in (a) of

this section, the department may offer only the following optional services: case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

* Sec. 3. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) chiropractic services;

(2) adult dental services;

(3) emergency hospital services;

(4) treatment of speech, hearing, and language disorders;

(5) optometrists' services and eyeglasses;

(6) occupational therapy;

(7) prosthetic devices;

(8) medical supplies and equipment;

(9) clinic services;

(10) physical therapy;

(11) personal care services in a recipient's home;

(12) long-term care noninstitutional services;

(13) inpatient psychiatric facility services;

(14) intermediate care facility services for the mentally retarded;

(15) intermediate care facility services;

(16) pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level;

(17) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;

(18) [(17)] skilled nursing facility services for persons under age 21;

(19) [(18)] aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;

(20) [(19)] individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;

(21) [(20)] individuals under age 21 under supervision of

the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

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

MEMORANDUM January 28, 1988

SUBJECT: Constitutionality of bill title of CSHB 342(HESS)

TO: Representative Johnny Ellis and
Representative Niilo Koponen
Co-Chairmen, House HESS Committee

FROM: Edward H. Hein EHH
Legislative Counsel

After further review of the bill title adopted by the House HESS Committee for CSHB 342 (HESS), a question has been raised about its constitutionality. Under art. II, sec. 13 of the Alaska Constitution, the subject of each bill must be expressed in the title. It is thought that the title does not adequately reflect changes made by sec. 3 of the bill. That section amends AS 47.07.035, which establishes the order in which Medicaid coverage is to be eliminated if there is not enough money allocated in the state budget to provide coverage for all services and groups on the list. The higher a service is on the list the sooner it is eliminated. Thus, by placing pregnant women and needy children on the list as number 16 out of 21 items, those services numbered 1 - 15 are affected. Since the bill title does not mention that this priority is affected, it is arguable that the title does not meet the constitutional requirement, and that the bill could be subject to a legal challenge on that basis. Therefore, it is recommended that the prudent course would be to amend the bill title accordingly.

I would recommend the following amendment for your consideration:

> At page 1, line 7, after "women" insert "; and reordering the priorities for eliminating coverage under medicaid"

It is my understanding that you will advise the next committee of referral, the House Finance Committee, of this memorandum.

EHH:bb
wkb2/013

HB 342 -- "An Act relating to medical assistance for needy persons."

File Contents

1) Memorandum from the bill's sponsor

2) Copy of HB 342

3) Fiscal note from the Dept. of Health and Social Services

4) Position paper from the Dept. of Health and Social Services

5) "Alaska Healthy Baby Project"

6) "Prevention Saves Alaska's Babies and State's Money"

7) "Examples of Gaps in Prenatal Care"

8) Testimony from Elizabeth Ward, DHSS, given before the Children's Caucus

9) Testimony from Nancy Bennett, DHSS, given before the Children's Caucus

Official Business

COMMITTEE: HOUSE HESS

DATE: 1-28-88

SIGN-IN

Subject of meeting:

HB342: Medicaid Eligibility

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY? if yes, which bill:
Nancy Bennett	PO Box H-07	3355	Div. Med Assist	Yes
Elizabeth Ward	Box H-06	3090	Div Public Hlth	yes
Harlan Knudsen	319 Seward	586-1790	Health Assn	No
JAY LIVEY	BOX H-06 (DHSS)	3030	DHSS	No
Gail Stadt	Box AA	3520	Lt. Gov. Office	NO
Sherrie Goll	419 Kennedy St. Juneau, Ak 99801	586-4788	Ak Women's Lobby	HB 342

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION : HB 342
PUBLISH DATE : _____

FISCAL NOTE

REQUEST: _____

Revision Date: _____
Title : An Act relating to Medical Assistance for needy persons
Sponsor : Ellis, Koponen, et al
Requestor : _____

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		245.9	461.1	461.1	461.1	461.1
TRAVEL		46.0	48.0	48.0	48.0	48.0
CONTRACTUAL		31.9	37.5	37.5	37.5	37.5
SUPPLIES		2.2	2.9	2.9	2.9	2.9
EQUIPMENT		12.0	17.0	17.0	17.0	17.0
LAND & STRUCTURES						
GRANTS, CLAIMS		2,610.8	6,388.6	7,555.5	8,722.4	9,889.3
MISCELLANEOUS						
TOTAL OPERATING		2,948.8	6,955.1	8,122.0	9,288.9	10,455.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		1,421.9	3,404.3	3,987.6	4,571.1	5,154.5
FEDERAL FUNDS		1,526.8	3,550.8	4,134.2	4,717.7	5,301.1
OTHER						
TOTAL						

POSITIONS:

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

ANALYSIS : (Attach a separate page if necessary)

SEE ATTACHED

Prepared by : Kim Busch, Director Kim Busch Phone : 465-3355
Division : Medical Assistance Date : _____

Approved by Commissioner : Myra M. Munson Myra M. Munson Date : Jan 20, 1988
Agency : Health and Social Services

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

ANALYSIS

ALASKA HEALTHY BABY PROJECT

PLAN FOR IMPLEMENTATION

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

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

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

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

    (Estimate 974 eligibles: $4,163 per pregnant woman x 974 = $4,054,762 + $1,298 per child x 974 = $1,166,852 = Total $5,221,614). These cost estimates are based on actual average 1986 expenditure data for pregnant women and children age 5 and under. NOTE: the January 1, 1989 implementation date will result in ½ the program expenditures under Medicaid services for pregnant women and children during the first year.

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

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

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

Year One

		Fed match	GF match
Cost	Medicaid services for pregnant women assuming ½ year costs	$1,013,690	$1,013,690
	Medicaid services for children one year of age assuming ½ year costs	$ 291,713	$ 291,713
	Case management services 5 nurses at 75/25 federal state match plus travel, supplies, equipment and risk insurance assuming 3/4 year cost and 10.0 for outreach	$ 192,743	$ 87,956
	Two new eligibility technicians for the Division of Public Assistance - $36,300 assuming ½ year cost of $18,150 each at 50/50 state/federal match plus equipment	$ 21,150	$ 21,150
	Public Assistance computer system data processing	$ 7,450	$ 7,450
	TOTAL	$1,526,746	$1,421,959

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

		Fed match	GF match
Cost	Medicaid services for pregnant women	$2,027,381	$2,027,381
	Medicaid services for children one and two years of age.	$1,166,852	$1,166,852
	Case management services, full year cost	$ 253,700	$ 107,200
	Three new eligibility technicians for the Division of Public Assistance - $36,300 each at 50/50 state federal match plus equipment	$ 59,000	$ 59,000
	Full year cost of two eligibility technicians added year one	$ 36,300	$ 36,300
	Public Assistance data processing	$ 7,450	$ 7,450
	TOTAL	$3,550,683	$3,404,183

Year Three

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

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

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

Year Four

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

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

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

Year Five

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

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

TOTAL	$ 590,876	$ 590,876

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

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

ALASKA HEALTHY BABY PROJECT
Summary

	YEAR					
	1989	1990	1991	1992	1993	TOTAL
Pregnant Women Coverage for medical services	2,027.4	4,054.8	4,054.8	4,054.8	4,054.8	18,246.6
Medical services for children:						
Age one year	583.5	1,166.9	1,166.9	1,166.9	1,166.9	5,251.1
Age two years		1,166.9	1,166.9	1,166.9	1,166.9	4,667.6
Age three years			1,166.9	1,166.9	1,166.9	3,500.7
Age four years				1,166.9	1,166.9	2,333.8
Age five years					1,166.9	1,166.9
Division of Public Assistance Eligibility Technicians plus equipment						
two - first year	42.3	72.6	72.6	72.6	72.6	332.7
three - second year		118.0	118.0	118.0	118.0	472.0
DPA computer upgrade	14.9	14.9	14.9	14.9	14.9	74.5
Case Management	280.7	360.9	360.9	360.9	360.9	1,724.3
Total Yearly Cost	2,948.8	6,955.1	8,122.0	9,288.9	10,455.8	37,770.6
Yearly General Fund Cost	1,421.9	3,404.2	3,987.6	4,571.1	5,154.5	18,539.3
Yearly federal cost	1,526.8	3,550.8	4,134.2	4,717.7	5,301.1	19,230.6

AFDC INCOME STANDARDS

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

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

ALASKA'S FEDERAL POVERTY LEVEL

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

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

RESOURCE LIMITS

AFDC

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

APA/SSI

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