ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
6888 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

SB

203

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF REVENUE

ALCOHOLIC BEVERAGE CONTROL BOARD

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

March 28, 1991

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

RE: SB 203

Dear Senator Sturgulewski:

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

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

Thank you for the opportunity to comment.

Sincerely,

Patrick L. Sharrock
Director, ABC Board
277-8638

PS/cl

91-49

Revenue - ABC Bd. Position

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

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

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

April 9, 1991

Honorable Arliss Sturgulewski
Senator
State of Alaska
Room 127, Capitol

Dear Senator Sturgulewski;

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

Sincerely,

Alfred G. Zangri
Chief

06-142LH

DHSS (Vital Stats) Stmt

MATERNAL CONSEQUENCES

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

- nicotine, hydrogen cyanide, carbon monoxide and other poisonous cross the placenta
- oxygen deprivation
- deficits in behavior and cognitive development may occur

1988 study by National Committee [illegible] Infant Mortality found that;

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

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

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

Alaska Data -- 1989 births

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

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

Alaska mothers have the following low birth weight rates:

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

THE FOLLOWING PAGES
WERE TREATED AS A UNIT
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555 West Northern Lights Blvd., Suite 103, Anchorage, Alaska 99503-2301
(907) 276-5864 Fax (907) 258-9314
Walter L. Hays, Executive Director
Shannon Jones, President

AMERICAN LUNG ASSOCIATION of ALASKA

April 25, 1991

VIA FAX

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

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

RE: SB 203

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

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

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

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

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

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

I urge your strong support for SB 203.

misc. back-up

Warning:

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

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

GBD:bjw
4/25/89

ORDINANCE 114582

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

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

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

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

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

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

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

10.11.696. WARNING SIGNS OR NOTICES

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

Before the Board of Health of King County, Washington:

RULE AND REGULATION NO. 42

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

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

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

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

SECTION 5.60.060. WARNING SIGNS.

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

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

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

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

Passed this 15th day of December, 19 88.

KING COUNTY BOARD OF HEALTH
KING COUNTY, WASHINGTON

Chair

Member

Member

ATTEST:

Secretary

Municipality of Anchorage

Department of Health and Human Services

825 "L" Street
P.O. Box 196650 Anchorage, Alaska 99519-6650

Tom Fink, Mayor

April 29, 1991

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

Dear Senator Sturgulewski:

SUBJECT: SB 203

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

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

Thank you for your support of this bill.

Sincerely,

Helen D. Beirne

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

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

ANCHORAGE, ALASKA
AO NO. 91- 23

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

THE ANCHORAGE MUNICIPAL ASSEMBLY ORDAINS:

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

16.60.039 Warning Signs or Notices.

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

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

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

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

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

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

SMOKING AND PREGNANCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERENCE LIST - SMOKING AND PREGNANCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Members of the Senate HESS Committee:

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

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

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

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

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

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

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

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

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

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

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

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

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

Benefits for the Fetus

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

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

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

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

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

The Health Benefits of SMOKING CESSATION

a report of the Surgeon General

1990

Executive Summary

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

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

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 203

Revision Date: _____ Department Affected: _____

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

BRU: Alcoholic Beverage Control Board

Component: _____

Sponsor: Sen. Sturgulewski & Sen. Menard

Requestor: Sen. HES Committee

COMPONENT SERIAL NO. 0 1 0 0

Expenditures/Revenues: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

GENERAL FUND	2.2	.9	.9	.9	.9	.9
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	2.2	.9	.9	.9	.9	.9

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

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

ANALYSIS: (Attach a separate page if necessary.)

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

Prepared By: Patrick L. Sharrock Phone: 277-8638

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

Approved by Commissioner: _____

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

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

Rev 10/90

Revenue 2.2 FN

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

Initial Issue

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

Annual Issue

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

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

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI

111 C STREET, SUITE 550
ANCHORAGE, ALASKA 99501
(907) 561-7615

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

Senate

Sponsor Statement on:

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

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

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

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

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

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

Enclosures

- sponsor statement -

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 6, 1991 FURTHER REFERRALS: Finance

Date of Committee Action: 5-15-91

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

SENATE BILL NO. 203 ADD SMOKING WARNING TO ALCOHOL SIGNS

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

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

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

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact _____

[ ] zero fiscal note _____

APPROVES PREVIOUS: (Dept/Date)

[✓] fiscal note(s) DOR 4/10/91

[ ] zero fiscal note(s) _____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*DNP*	*NR*	*AM*
Cheri Jacobus	✓				
Darrell Ellis	✓				
[illegible]	✓				
John C. Douglas	✓				
Betty Davis	✓				

CO-CHAIRMAN'S SIGNATURE (LINCOLN)

SB

211

Alaska State Legislature

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

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

Senator Virginia Collins

February 10, 1992

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

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

Dear Representative Lincoln, Georgianna,

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

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

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

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

Sincerely,

Senator Virginia Collins
District F-B

Sponsor Stmt

PRINTED ON RECYCLED PAPER

Alaska State Legislature

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

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

Senator Virginia Collins

CSSB 211 (Finance)

Coverage of All Advanced Nurse Practitioners
Under Medicaid

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

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

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

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

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

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

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

additional Sponsor Statement

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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

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

MEMORANDUM February 19, 1991

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

TO: Senator Virginia Collins

FROM: Terri Lauterbach
Legislative Counsel

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

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

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

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

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

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

Legal Services Division

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TML:lmb/mai
91-054.lmb

Enclosure

SENATE BILL 211

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

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

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

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

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

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

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

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

DHSS Position

DP_92_1

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

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

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

Kimberly B. Busch, Director
Division of Medical Assistance

DATE: _____

Theodore A. Mala, MD, MPH
Commissioner

DATE: 15 January 1992

PP-92-1

POSITION STATEMENT ON THIRD PARTY REIMBURSEMENT FOR NURSE PRACTITIONERS

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

August, 1987

P.E.E.R.'s Position

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

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

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

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

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

The Significant Contribution of Nurse Practitioners in Alaska

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

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

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

Nurse Practitioners Position

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

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

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

The National Trends

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

Conclusion and Our Recommendations

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

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

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

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

Table 1

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

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

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

Alaska State Legislature

House HESS

Please enter into the record my testimony to the _____
committee name

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

including this. 2 pgs

SB 211 MEDICAID

February 9, 1992

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

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

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

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

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

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

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

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

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

I urge your passage of SB211.

Sincerely,

Dixie L Light

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

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 211

Revision Date: _____
Department Affected: Health & Social Services
Title: An Act Providing for Coverage of Advanced Nurse Practitioners
BRU: Medicaid
Component: Non-Facility
Sponsor: Senator Collins
Requestor: _____
COMPONENT SERIAL NO. 0 2 3 0

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

GENERAL FUNDS	27.7	54.0	66.5	81.9	100.6	123.9
FEDERAL FUNDS	30.1	59.8	73.2	89.8	110.2	135.2
OTHER FUND SOURCE:	0	0	0	0	0	0
TOTAL	57.8	113.8	139.7	171.7	210.8	259.1

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

See attached analysis

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

Approved by Commissioner: _____
Agency: Health and Social Services
Date: 1/15/92

FN 57.8 DHSS

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

Revised 1/15/92

Fiscal Note Analysis

SB 211

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

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

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

$$\begin{aligned} 6 \times \$41,472 &= \$248,832 \\ 6 \times \ 12,442 &= \ \ 74,652 \\ &\ \ \$323,484 \end{aligned}$$

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

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

FY 93

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

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

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

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

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

FY 94 and following

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

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

SB

232

Alaska State Legislature

REPRESENTATIVE
MARK BOYER

VICE-CHAIRMAN
HOUSE FINANCE COMMITTEE

FAIRBANKS

1098 LAKEVIEW TERRACE
FAIRBANKS, ALASKA 99701
(907) 456-6473

JUNEAU

P.O. BOX V
STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3466

House of Representatives

MEMORANDUM

DATE: May 10, 1991

TO: Representative Georgianna Lincoln, Co-chair
Representative Pat Carney, Co-chair
House HESS Committee

FROM: Representative Mark Boyer MB

RE: Scheduling of CSSB 232 (HES) - Revenue Bonds

I would respectfully request that you schedule CSSB 232 (HES), relating to revenue bonds issued by the University of Alaska, for a hearing by the House HESS Committee at your earliest convenience. I introduced an identical bill, HB 260, which was heard in your committee on April 26 and passed out. I intentionally held my bill in the House Rules Committee because I expected that I would be able to more easily move the Senate version through the committee process when it reached the House than move my bill in the Senate. CSSB 232 (HES) passed the Senate this week by a vote of 18-0. HB 260/SB 232 is one of my top priorities this session and I'd like to have it on the House floor by the end of next week.

The bill is a necessary addition to legislation that passed last session which allowed the Board of Regents of the University to issue debt. The bill provided that the Board could enter into agreements securing bonds and that those agreements might provide for fixing and collecting fees, rentals, or charges to secure payment of the bonds. CSSB 232 (HES) would grant the Board of Regents additional ability to pledge revenues in the amount of $6 million to cover the cost of building and furnishing the UAF recreation center.

This specific authority is a necessary component to issue revenue bonds. Revenue bonds are bonds secured only by the revenues of particular facilities. The existing permission to issue debt did not grant the University the ability to pledge revenues to secure this specific debt. CSSB 232 (HES) would rectify this deficiency. The bill would also authorize indebtedness for the student recreation center in Fairbanks.

The new recreation center will be a $5 million addition to the current Patty Center and connected by a covered walkway. The new facility is scheduled to be completed in 1993. The

facility at UAF will house an indoor jogging track, three basketball courts, aerobic and weight rooms and a field for touch football and soccer.

Student activity fees will be increased $75, but the cost won't go into effect until the center is being used. The fees will be used to reimburse the cost of building and furnishing the structure. During the past fall the students at UAF voted to support these fee increases for this purpose. User fees from community groups will also contribute to the building fund.

If you have questions or comments please don't hesitate to contact my office at 465-3467.

HOUSE HESS COMMITTEE MINUTES OF 4/26/91 ON
HB 260

NUMBER 465

REP. MARK BOYER, PRIME SPONSOR OF HB 260, AGAIN ADDRESSED THE COMMITTEE. REP. BOYER ASKED THAT BRIAN ROGERS JOIN HIM AT THE TABLE.

REP. BOYER ANNOUNCED THAT SINCE HB 260 WAS INTRODUCED IT HAD GAINED URGENCY BECAUSE IT COULD OFFER ADDITIONAL OPPORTUNITIES FOR THE UNIVERSITY. REP. BOYER EXPLAINED THAT HB 260 PROVIDED THE BOARD OF REGENTS OF THE UNIVERSITY THE ABILITY TO ISSUE SPECIFIC REVENUE BONDS, WITH SPECIFIC STRINGS ATTACHED. HE SAID THAT STUDENTS AT THE UNIVERSITY OF ALASKA, FAIRBANKS VOTED TO TAX THEMSELVES FOR CONSTRUCTION OF A RECREATIONAL FACILITY ON THE CAMPUS, BUT THAT THE SYSTEM CANNOT BOND FOR A SPECIFIC PROJECT, WITH SPECIFIC REVENUES. REP. BOYER REPEATED THAT HB 260 PROVIDED VERY SPECIFIC AUTHORITY.

REP. BOYER REFERRED TO THE JOHN BUTROVICH BUILDING WHICH WAS INCOMPLETE. A FEDERAL DEPARTMENT OF DEFENSE APPROPRIATION FOR A SUPER COMPUTER CENTER MIGHT OFFER A MEANS OF COMPLETING THAT BUILDING THROUGH BONDING. REP. BOYER REITERATED THAT THIS OPPORTUNITY WAS NOT KNOWN TO HIM WHEN HB 260 WAS INTRODUCED.

NUMBER 490

REP. C. DAVIS CONFIRMED THAT HB 260 WOULD AUTHORIZE THE BOARD OF REGENTS TO ENTER INTO AGREEMENTS ON REVENUE BONDS IN GENERAL AND SPECIFICALLY FOR THE RECREATION CENTER.

REP. BOYER RESPONDED THAT DURING HEARINGS IN THE SENATE IT WAS OBVIOUS THAT SUBSECTION 2 WAS REDUNDANT AND THE PROPOSED CS DELETED THAT SECTION.

NUMBER 510

BRIAN ROGERS, VICE PRESIDENT FOR FINANCE FOR THE UNIVERSITY SYSTEM, SUPPORTED THE RECREATION CENTER PROJECT BECAUSE THE STUDENTS HAD INDICATED IT WAS OF GREAT IMPORTANCE AND THEY WERE WILLING TO PAY INCREASED FEES FOR IT. HE EXPLAINED THAT IT WAS NOT A SPECTATOR FACILITY BECAUSE THE COMMUNITY HAD ADEQUATE FACILITIES; THAT THIS STRUCTURE WOULD BE FOR INDIVIDUAL AND GROUP TRACK AND OTHER RECREATION. MR. ROGERS INDICATED THAT STAFF AND FACULTY CHARGES WOULD ALSO BE INCREASED.

MR. ROGERS STRESSED THAT THE UNIVERSITY HAD BEEN CONSERVATIVE IN ITS DEBT ISSUANCE TO DATE, AND DESCRIBED IN DETAIL THE ISSUANCE OF BONDS IN THE PAST. MR. ROGERS BELIEVED A PORTION OF THE BUTROVICH BUILDING COULD BE FUNDED THROUGH REVENUE BONDS ISSUED AGAINST THE DEPARTMENT OF DEFENSE OR PRIVATE USE OF THE SUPER COMPUTER.

MR. ROGERS REFERRED TO COMMUNICATION WITH THE UNITED STATES FOREST SERVICE IN AN EFFORT TO HAVE A JOINT LABORATORY AT THE JUNEAU CAMPUS. HE ADDED THAT REVENUE BONDS WOULD BE HELPFUL IN THAT EVENT.

MR. ROGERS EXPLAINED CURRENT LAW AND NOTED THAT THE UNIVERSITY IS ALLOWED TO ISSUE DEBT FINANCING FOR BUILDINGS UP TO A CERTAIN SIZE. HE STRESSED THAT THE CS ALLOWS THE PLEDGE OF SPECIFIC STUDENT REVENUES TO A PROJECT. THIS WOULD ALLOW THE UNIVERSITY TO PLEDGE THE REVENUES, AND THE LEGISLATURE COULD NOT STOP THEM FROM SPENDING THEM IN THE FUTURE FOR THAT PROJECT.

NUMBER 540

REP. C. DAVIS ASKED IF STUDENT HOUSING COULD BE ACCOMPLISHED SIMILARLY.

MR. ROGERS REPLIED THAT IT COULD, AND DESCRIBED AN ANCHORAGE HOUSING PROJECT.

NUMBER 550

REP. HANLEY ASKED HOW MUCH OF THE PROJECT THE STUDENT FEES WOULD COVER.

MR. ROGERS REPORTED THAT IT WOULD BE 100 PERCENT AND EXPLAINED EFFORTS TO GET A LOWER BOND RATE.

NUMBER 560

REP. C. DAVIS ASKED FOR CLARIFICATION THAT THE DEBT LIMIT REFERRED TO A SPECIFIC PROJECT, AND THAT THERE COULD BE MULTIPLE PROJECTS.

MR. ROGERS RESPONDED IN THE AFFIRMATIVE.

NUMBER 570

REP. HANLEY VERIFIED THAT THE UNIVERSITY COULD DO "10 DIFFERENT BUILDINGS FOR $6 MILLION EACH IF YOU WANTED TO AND WOULDN'T COME TO THE LEGISLATURE." REP. HANLEY'S CONCERN WAS THAT THEY COULD PLEDGE OTHER REVENUES -- ENROLLMENT FEES ON A SMALL CAPITAL SPENDING PROGRAM."

MR. ROGERS RESPONDED THAT WAS CORRECT, UP TO A POINT. HE ANNOUNCED THAT AT A RECENT MEETING THE BOARD HAD ADOPTED A DEBT POLICY FOR THE UNIVERSITY THAT WOULD LIMIT DEBT TO FIVE PERCENT OF ANTICIPATED UNRESTRICTED REVENUES. HE EXPLAINED DIVERSION OF EXISTING REVENUE OPTIONS.

NUMBER 588

REP. LINCOLN ASKED IF THE BOARD OF REGENTS WAS REQUIRED TO APPROVE THIS TYPE OF DEBT.

MR. ROGERS REPLIED THEY WERE, AND THAT IN FEBRUARY THE BOARD AUTHORIZED THE UNIVERSITY ADMINISTRATION TO PURSUE DEBT FINANCING FOR THE RECREATION CENTER. MR. ROGERS DECLARED THAT ONLY THE BOARD CAN AUTHORIZE ISSUANCE OF DEBT, AND EVEN WITH THE LEGISLATION NO DEBT CAN BE ISSUED WITHOUT BOARD APPROVAL. HE VOICED THE SUPPORT OF THE BOARD FOR THE LEGISLATION.

REP. BOYER INDICATED THAT HE HAD MINUTES FROM THE BOARD'S FEBRUARY MEETING WHICH CONTAINED A PARAGRAPH TO APPROVE THE FUNDING CONCEPT FOR THE FACILITY.

TAPE 43, SIDE B

NUMBER 000

REP. LINCOLN ASKED THAT THOSE MINUTES BE PROVIDED TO THE COMMITTEE.

REP. LINCOLN MOVED TO ADOPT CSHB 260 (HES). THERE WAS NO OBJECTION, AND IT WAS SO ORDERED.

REP. LINCOLN MOVED TO PASS CSHB 260 (HES) WITH THE ZERO FISCAL NOTE, WITH INDIVIDUAL RECOMMENDATIONS. THERE WAS NO OBJECTION, AND IT WAS SO ORDERED.

(7)

HOUSE COMMITTEE REPORT

Date Referred: May 9, 1991 FURTHER REFERRALS: Finance

Date of Committee Action: 5/13/91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: CSSB 232(HES)

CS FOR SENATE BILL NO. 232 (HES) UNIV. OF ALASKA REVENUE BONDS

"An Act relating to revenue bonds issued by the University of Alaska; and providing for an effective date."

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

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

ADOPTS: ______ letter of Intent

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

APPROVES PREVIOUS: (Dept/Date)
[ ] fiscal note(s) ______
[X] zero fiscal note(s) University of AK 4/11/91

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
[signature]	✓	Mark Hanley		X	
[signature]	✓				
J. C. Gonzales	✓				
Bettye Davis	✓				
Cheri Davis	✓				

[signature]
CHAIRMAN'S SIGNATURE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

No. 1
Bill Version: SB 232
(S) Publish Date: 4/12/91

Revision Date:
Department Affected:
Title: University of Alaska Revenue Bonds
BRU: University of Alaska Fairbanks
Component: UAF/Fairbanks Campus
Sponsor: Senator Steven Frank
Requestor:
COMPONENT SERIAL NO. 0 7 4 1

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

Changes in CS SB232 (HES) have no fiscal impact. This fiscal note is appropriate.

12/2000 date — Comte Aide (initial)

Prepared By: Jim Lynch, Controler — Phone: 907-474-7711
Division: University of Alaska — Date: 04/11/91

Approved by Commissioner: Jim Lynch for Brian Rogers
Agency: University of Alaska — Date: 04/11/91

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

Rev 10/90

Page ___ of ___

SB

269

KODIAK ISLAND MEDICAL ASSOCIATES

3 EAST REZANOF DRIVE • KODIAK, ALASKA 99615 • (907) 486-6065 or 486-3177

MARK WITHROW, M.D. • GENERAL PRACTICE
CAROL JUERGENS, M.D. • INTERNAL MEDICINE
BRAD BRINGGOLD, M.D. • FAMILY PRACTICE

K. LOGAN PORTER, M.D. • FAMILY PRACTICE
JON HLAVINKA, M.D. • FAMILY PRACTICE

March 15, 1991

To: Fred Zharoff & Cliff Davidson

RE: Chlamydia testing at the Public Health Center in Kodiak

Dear Fred and Cliff,

Kodiak Island Medical Associates provides the physician coverage for the Public Health Center in Kodiak on a bi-monthly basis. Specifically, we do pap smears and testing for gonorrhea and provide counselling concerning methods of birth control. We see approximately 20 patients a month. The purpose of this letter is to inform you of one service that is not provided there that is critical in encounters with these patients. The Public Health Center at this point does not provide chlamydia testing for these clients/patients. Chlamydia is the most common sexually transmitted disease in this country. It far out numbers gonorrhea, syphilis, etcetera. Chlamydia infections in woman can lead to serious sequellae including pelvic inflammatory disease with resultant infertility and much increased risk in ectopic pregnancy. Other complications include pregnancy difficulties with preterm labor and neonatal disease. Chlamydial infections are usually asymptomatic and when symptoms are present they are frequently mild and nonspecific. This means that you cannot tell that a patient has chlamydia on clinical grounds alone. Because of the paucity of symptoms and serious side effects of undetected infections there have been developed numerous tests for diagnosis. I feel it is a disservice to our patients at the Public Health Center to not test routinely for chlamydia. This is letter is to encourage funding for the relatively small numbers of patients that would need this service at the Public Health Center Sexually Transmitted Disease Clinic. I have discussed this in some detail with Gary Bledsoe, the Sexually Transmitted Disease Coordinator in Anchorage and my understanding is that funds are just not available. However, I have learned that other cities in the state do have funding for this vital service. I would suggest coordination with Dr. John Middaugh, State Epidemiologist, Dr. Ted Mala, the Commissioner and Wendy Thon, the Nurse Coordinator for Family Health.

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD

P.O. BOX V
ROOM 427
STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3762

Senate Committee on Health, Education and Social Services

MEMORANDUM 16 Jan 1992

TO: Representative Pat Carney
Representative Georgiana Lincoln

FROM: Senator Arliss Sturgulewski

RE: Senate Bill 269

I respectfully request that you schedule Senate Bill 269 for a hearing before the House HESS Committee as soon as is possible.

This legislation, which the Senate HESS Committee introduced at the request of Senator Zharoff, provides that the Department of Health and Social Services use the most current method available for testing of gonorrhea and chlamydia and that it shall make available to other testing agencies the best testing methods available as well.

The department currently uses an outdated testing method and it is our intent that it be replaced with a DNA hybridization test. The language in the legislation will give the department the flexibility to use the most current method as technology changes.

I appreciate your consideration of this legislation.

cc: Senator Zharoff

Sponsor Statement

Sectional Analysis
CS for Senate Bill 269
Testing for Chlamydia and Gonorrhea

Section 1: Findings. This section establishes the reasons for providing a testing program for the detection of chlamydia and for the replacement of the out dated Thayer-Martin bacterial culture with the DNA hybridization test for the detecting of gonorrhea.

Section 2: Requires that the Health and Social Services Department begin testing for chlamydia by providing the DNA hybridization test through their regular system and specifying that they should, now and in the future, use the best and most current testing procedure available for the diagnosis of gonorrhea and chlamydia.

Sectional

NAME: CSSB 269(HES)
TITLE: "AN ACT RELATING TO TESTING FOR CHLAMYDIA AND GONORRHEA."

SPONSOR(S): HEALTH, EDUCATION & SOCIAL SERVICES

CURRENT STATUS: (H) HES STATUS DATE: 05/19/91
THEN FIN, RLS

HEARING:(H) HES FEB 06 08:30 AM

04/26/91	1008	(S)	READ THE FIRST TIME - REFERRAL(S)
04/26/91	1008	(S)	HES, THEN FINANCE
05/08/91	1153	(S)	HES RPT CS 3DP SAME TITL
05/08/91	1153	(S)	FISCAL NOTE TO SB & CS PUBLISHED (DHSS)
05/17/91	1388	(S)	FIN RPT 5DP (HES)CS
05/17/91	1388	(S)	FN TO HES CS PUBLISHED (S.FIN/DHSS)
05/18/91	1423	(S)	RULES TO CALENDAR 5/18/91
05/18/91	1436	(S)	READ THE SECOND TIME
05/18/91	1436	(S)	HES CS ADOPTED UNAN CONSENT
05/18/91	1436	(S)	ADVANCED TO THIRD READING UNAN CONSENT
05/18/91	1436	(S)	READ THE THIRD TIME CSSB 269(HES)
05/18/91	1436	(S)	PASSED Y19 N- A1
05/18/91	1461	(S)	TRANSMITTED TO (H)
05/19/91	1641	(H)	READ THE FIRST TIME - REFERRAL(S)
05/19/91	1641	(H)	HES, FINANCE

Senate Bill History

There being no further testimony on the measure, SENATOR COTTEN moved and asked unanimous consent to pass CSHB 88 (HES)(title am) out of the Senate HESS Committee with individual recommendations. Hearing no objection, it was so ordered.
#
Number 214
#SB269
SB 269, relating to testing for chlamydia and gonorrhea, was the next piece of legislation the committee addressed. VICE-CHAIRMAN FISCHER noted the bill was introduced by the committee. KATHERINE A. KELLY, Dr. PH, Chief, Section of Laboratories, Division of Public Health, Department of Health and Social Services, read a position statement into the record: "S.B. 269 recognizes that chlamydia is a disease of significance in Alaska due to its long term effects and potential damage to newborns. It also observes that the present method of testing for gonorrhea is unreliable for use in rural Alaska, and that more effective technologies are available. The bill also states that although new methods, such as DNA hybridization, may be more expensive, they are more cost effective in the long run by identifying disease and reducing complications.

"The Department of Health and Social Services supports a statewide chlamydia program and the institution of advanced technologies such as DNA hybridization. We feel strongly that it is our charge to produce and use the best medical information possible to identify and control public health problems such as chlamydia and gonorrhea. Additionally, we recognize that "best medical practice" differs between urban and rural Alaska, especially when it comes to laboratory testing. Tests which may be reliable for a specimen, which is immediately hand carried to one of our public health laboratories in Anchorage, Juneau, or Fairbanks, will not give valid results for a specimen mailed from Barrow, Kodiak, Wrangell or even more remote sites. New methods for specimen preservation and analysis now allows us to provide rapid and extremely accurate testing throughout the entire state, and we are eager to make them available to our health care providers and their patients.

"The division currently provides only gonorrhea testing and no chlamydia testing. In order to improve the accuracy of gonorrhea tests from rural sites and to establish statewide chlamydia testing, additional funding will be necessary. From previous statistics, we estimate that the division will perform approximately 48,000 gonorrhea and 24,000 chlamydia tests in a year. The reason for the change is that males can be diagnosed by symptoms more often than females. The cost for these tests is $288,800.

"The division supports SB 269's recognition of chlamydia as an important health problem, and the need for state of the art technology to identify and control this disease. Alaska's public health professionals should have access to the best available tests and treatment in order to conduct an efficient chlamydia/gonorrhea

screening program.

Number 266

VICE-CHAIRMAN FISCHER asked if the federal government provides any funding for the testing of chlamydia. DR. KELLEY explained that the federal government, in the past, has been nonsupportive of chlamydia testing. The problem was the recognition of chlamydia as a significant sexually transmitted disease eclipsed about the same time of AIDS and most of the federal money was drawn to the AIDS Program rather than supporting chlamydia. She noted that there are federal dollars that support the state's Gonorrhea Testing Program and that does help with what the state is presently spending which are about $55 thousand. Vice-Chairman Fischer asked who does the cultures. Dr. Kelley indicated that doctors take samples in OBGYN practices, public health nurses, nurse practitioners, and community health aids, all collect samples for gonorrhea and would do so for chlamydia testing. Vice-Chairman Fischer asked if school nurses would take samples. Dr. Kelley indicated that school nurses wouldn't take samples.

Number 294

SENATOR MENARD asked why a school nurse wouldn't take samples. DR. KELLEY said if there are students in the schools who are concerned about infection or have symptoms, they would be referred to a community health clinic. Senator Menard asked if there are community health centers in all the villages in rural areas. Dr. Kelley indicated that there are centers in most of the areas.

VICE-CHAIRMAN FISCHER questioned what the department's proposed committee substitute does. DR. KELLEY said the present piece of legislation specifically ties the department to a technology, DNA hybridization technology, and bio technology, and is a moving target as every year new and better ways to test are put on the market. She said the department was concerned that if they were tied to a specific testing method, in two years that may not be the best method or best medical practice. The department would prefer language that says they should be using the best available methods. She suggested deleting on lines 12 and 13, page 2.

Number 347

SENATOR COTTEN moved for the adoption of the proposed committee substitute. Hearing no objection, it was so ordered.

VICE-CHAIRMAN FISCHER noted the best available method could become very expensive and suggested wording such as, "The department shall consider the best current method." He asked if the tests are expensive. DR. KELLEY explained that there are other tests at a wide range of cost. If the department, for example, were to go to $100 dollar tests, they would definitely have to come before the legislature for an increment. She said there is some control

through the budget process. Dr. Kelley said the department is held to the best and standard practices and are to use only those tests that have been well documented to work.

SENATOR COTTEN moved and asked unanimous consent to make an amendment on page 2, line 11, delete DNA hybridization testing and insert "the best current testing method available," and delete lines 12 and 13. It would then read, "The department shall make available on a statewide basis the best current testing method available to detect gonorrhea and chlamydia." SENATOR MENARD suggested making it a conceptual amendment.

Number 419

VICE-CHAIRMAN FISCHER asked if the tests are done in state laboratories. DR. KELLEY indicated they are. Vice-Chairman Fischer asked if there will be a need for additional laboratory staffing. Dr. Kelley explained there would be an additional need for staffing but the process is very automated. One person can run over 200 tests, per day, with the proper equipment and kits. She noted the department has identified increased mailing costs for the shipping of the kits. The kits are approximately $4.00 per kit. Vice-Chairman Fischer asked if there are any laboratories in the state that do testing. Dr. Kelley said it is her understanding that Humana Hospital has already undertaken the tests. Most of the other chlamydia testing that is being done in the state is sent to Seattle.

Number 436

CHRISTY GARRETT, legislative staff to Senator Fred Zharoff, said the funding is presently in the Senate budget. However, in the past, when the budget has been submitted, the funding has been deleted during the process. She said she doesn't really believe the funding will stay in the budget. Funding for the program is obviously more than it would be for the current Gonorrhea Program. Information has been received, especially from rural areas, that chlamydia testing is very much needed. Ms. Garret said when she spoke with the Department of Health and Social Services Section of Epidemiology, they indicated that the current test for gonorrhea is not as effective as it could be and that by using the DNA hybridization test, they could get a better test for gonorrhea and chlamydia at the same time. She urged that the funding be maintained in the budget.

SENATOR MENARD asked how the program would be implemented if half of the money was appropriated. DR. KELLEY said if the funding was reduced, the department would reduce the scope of the program so it would only be available through the department's own public health clinics.

VICE-CHAIRMAN FISCHER asked how much was spent last year. DR. KELLEY said nothing was spent for chlamydia, and for gonorrhea

approximately $55 thousand was spent in state dollars and another $50 thousand to $80 thousand in federal funds. She noted that the cultures are live organisms transported through the U.S. mail. Sometimes the cultures from rural areas die, due to bad weather, etc., before they get to the laboratory. Many times the testing needs to be done again. The new technology doesn't require live organisms and the samples are good for over a week regardless of temperature, etc.

Number 507

There being no further public testimony, VICE-CHAIRMAN closed the public hearing. SENATOR MENARD moved and asked unanimous consent to move CSSB 269 (HES), out of committee with individual recommendations. There being no objection, the motion carried.
#
Number 512
#SB139
The last order of business to come before the committee members was SB 139, relating to early childhood and parenting education. SENATOR JONES, sponsor of the measure, said that the Joint Committee on School Performance was established through legislation to examine and recommend areas that warranted legislative attention. The committee's overall goal is to find ways to improve school performance in Alaska. One of the critical areas identified was early parenting education. He said there was testimony regarding the importance of early childhood and parenting education which relates to the child's future learning potential. Senator Jones referred to the national achievement tests and indicated that Alaska does fairly well, but there are some areas that do bring up concern. The committee found that a coordinated approach for increasing school performance is a critical need. We must go beyond conventional questions to identify social help and bodily related problems that exist in Alaska. He said more attention should be given to better pre-schooling, child care, and parenting education program.

Senator Jones said SB 139 attempts to set into place standards by which all early childhood programs are involved. He said in conjunction with Department of Education, there is a proposed committee substitute for review which recommends that the committee would be better positioned within the jurisdiction of the Department of Education and not under Community and Regional Affairs.

SENATOR JONES discussed information in the committee members packets regarding the statewide plan and written questions in relation to the plan. He urged that the legislation be passed.

Number 564

WILLIE ANDERSON, NEA-Alaska, testified in support of the legislation. He indicated that they support the bill for a number

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

State of Alaska Epidemiology

Bulletin

Department of Health and Social Services
Theodore A. Mala, MD, MPH, Commissioner

Division of Public Health
Peter M. Nakamura, MD, MPH, Director

Section of Epidemiology
John Middaugh, MD, Editor

3601 C Street, Suite 576, P.O. Box 24-0249, Anchorage, Alaska 99524-0249 (907) 561-4406

Bulletin No. 8 April 29, 1991

1990 Annual Infectious Disease Report
Number of Cases by Region

	Southeast		Southcentral		Northern		Total	
	1990	1989	1990	1989	1990	1989	1990	1989
AIDS	2	0	14	15	0	3	16	18
Amoeba	1	0	2	3	1	0	4	3
Anthrax	0	0	0	0	0	0	0	0
Botulism	0	0	6	4	2	1	8	5
Botulism - infant	0	0	0	0	0	0	0	0
Brucellosis	0	0	0	0	0	0	0	0
Campylobacter	20	22	58	36	5	4	83	62
Cholera	0	0	0	0	0	0	0	0
Diphtheria	0	0	0	0	0	0	0	0
Diphyllobothrium latum	0	0	3	1	0	0	3	1
Encephalitis	0	0	5	8	2	4	7	12
Enchinococcus	0	0	0	1	0	0	0	1
Enterotoxigenic E. coli	0	0	0	0	0	0	0	0
Giardia	48	33	110	108	14	15	172	156
Gonorrhea	27	20	1019	988	135	147	1181	1155
Hepatitis A	6	27	171	568	13	48	190	643
Hepatitis B	7	12	40	40	11	8	58	60
Hepatitis non-A non-B	2	3	4	5	3	1	9	9
Hepatitis unspecified	1	1	1	3	5	1	7	5

misc. back-up

Legionnaires' disease	0	0	0	1	0	0	0	1
Leprosy	0	0	0	0	0	0	0	0
Leptospirosis	0	0	0	0	0	0	0	0
Malaria	1	3	0	0	1	0	2	3
Meningitis - aseptic	14	6	81	23	13	8	108	37
Meningitis - hemophilus	3	7	12	9	4	8	19	24
Meningitis - meningococcal	1	4	9	5	2	2	12	11
Meningitis - unspecified bacterial	4	0	9	20	7	6	20	26
Mumps	1	1	4	1	1	0	6	2
Paralytic shellfish poisoning	3	0	13	0	0	0	16	0
Pertussis	6	1	12	0	0	0	18	1
Plague	0	0	0	0	0	0	0	0
Polio	0	0	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	0	0	0
Rabies (Animal)	0	0	11	46	15	25	26	71
Reye syndrome	0	0	1	0	0	0	1	0
Rheumatic fever	0	0	0	1	0	1	0	2
Rubella	0	0	0	0	0	0	0	0
Rubeola	45	1	20	0	15	0	80	1
Salmonella	6	8	89	46	12	16	107	70
Shigella	3	3	7	21	1	1	11	25
Smallpox	0	0	0	0	0	0	0	0
Syphilis	6	2	14	19	7	2	27	23
Tetanus	0	0	0	0	0	0	0	0
Trichinosis	0	0	0	3	1	5	1	8
Tuberculosis	11	2	43	40	12	18	66	60
Tularemia	0	0	1	0	1	0	2	0
Typhoid	0	0	0	0	0	0	0	0
Yellow Fever	0	0	0	0	0	0	0	0
Yersinia enterocolitica	2	3	13	5	0	1	15	9

Since only a portion of all reportable illnesses are reported, these figures represent trends rather than actual incidence. More complete reporting of cases to the Division of Public Health will result in more accurate statistics. The above figures represent both military and civilian reporting.

Total Population 1990:

Southeast	68,989
Southcentral	368,563
Northern	112,491
Total	550,043

January 1991

A PROPOSED IMPROVEMENT OF THE ALASKA CHLAMYDIA/GONORRHEA TESTING PROGRAM

Chlamydia and gonorrhea are known to cause significant acute morbidity and severe complications including pelvic inflammatory disease, ectopic pregnancy, pelvic abscess, peritonitis, disseminated gonococcal infection (arthritis, meningitis, endocarditis), newborn eye infections and pneumonia. Gonorrhea rates have ranged from 1310.5 per 100,000 in 1978 to 216.1 per 100,000 in 1989 (5,394 and 1,155 cases, respectively). Our knowledge of chlamydia prevalence is based on several studies of varying duration; positivity rates of 7-23% were found in the populations studied. A study involving family planning clinics in Anchorage and Bethel found that Alaska had the highest rate of chlamydia among participating Northwest clinics (Alaska, Idaho, Oregon, Washington).

Currently, the State of Alaska uses Thayer-Martin bacterial cultures to diagnose gonorrhea. This is an outdated and inappropriate method. In ideal conditions, recovery rates of 90-95% are possible with cultures. However, adverse environmental conditions, complex collection procedures, long transportation lines, and other problems reduce the effectiveness of cultures to unacceptable levels. Until recently, effective laboratory tests to diagnose chlamydia have not been available. Limited testing has been done in special studies using research protocols in Bethel, Fairbanks, Juneau, and Ketchikan, Kotzebue, and Barrow.

New advances in medical technology (DNA hybridization) now provide a solution to the relative ineffectiveness of gonorrhea culturing and the first affordable tests to diagnose chlamydia statewide. Because this test is <u>not</u> adversely affected by environmental conditions and does <u>not</u> require viable isolates, several major problems noted above are eliminated. This technology is highly specific and sensitive. Cases of gonorrhea undiagnosed due to culture failure would be largely eliminated and the subsequent disease complications avoided. This test is also superior to other previously available but more expensive chlamydia tests. The test also enables chlamydia and gonorrhea to be identified from a single clinical specimen.

Recommendations

1. Implement DNA hybridization tests to detect gonorrhea and chlamydia and eliminate use of cultures to diagnose gonorrhea.

2. Begin routine chlamydia screening in state-sponsored STD and family planning clinics statewide.

Cost Estimate

12x4000/mo gonorrhea test x ($2.21-3.32) = $106,080 - 159,360
12x2000/mo chlamydia test x ($3.75-4.32) = $90,000 - 103,680

Total supply costs (chlamydia and gonorrhea) = $196,080 - 263,040

These calculations assume a 20% reduction in current levels of gonorrhea screening, and approximately one-half of the tests required for gonorrhea screening (female only) needed for chlamydia screening.

Summary

1. Current tests used do not meet community standards and will result in failure to diagnose preventable disease.

2. Shifting to a new test system will cost more.

3. Adoption of the new test will improve gonorrhea control and will enable for the first time a statewide program to control chlamydia infection.

April 26, 1991 SENATE JOURNAL p. 1008

SB 269

SENATE BILL NO. 269 by the Senate Health, Education and Social Services Committee, entitled:

"An Act relating to testing for chlamydia and gonorrhea."

was read the first time and referred to the Health, Education and Social Services Committee and the Finance Committee.

May 8, 1991 SENATE JOURNAL p. 1153

SB 269

The Health, Education and Social Services Committee considered SENATE BILL NO. 269 (An Act relating to testing for chlamydia and gonorrhea) and recommended it be replaced with

CS FOR SENATE BILL NO. 269 (HES)

and do pass The report was signed by Senator Fischer, Vice-Chair, and concurred in by Senators Cotten and Menard.

Fiscal note for SENATE BILL NO. 269 and the Committee Substitute published today from Department of Health and Social Services.

SENATE BILL NO. 269 was referred to the Finance Committee.

May 17, 1991 SENATE JOURNAL p. 1388

SB 269

The Finance Committee considered SENATE BILL NO. 269 (An Act relating to testing for chlamydia and gonorrhea) and a majority of the committee recommended the Health, Education and Social Services Committee Substitute offered on page 1153 be adopted and do pass. The report was signed by Senators Pourchot and Kerttula, Co-Chairs, and concurred in by Senators Adams, Shultz and Uehling.

Fiscal note for the Committee Substitute published today from Senate Finance Committee.

SENATE BILL NO. 269 was referred to the Rules Committee.

FISCAL NOTE No. 2

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: CSSB 269(HES)
(S) Publish Date: 5/17/91

Revision Date: _____ Department Affected: Dept. of Health & Social Services
Title: Testing for chlamydia and gonorrhea BRU: State Health Services
Component: Laboratory Services
Sponsor: Zharoff
Requestor: Senate Finance COMPONENT SERIAL NO. [ ][ ][ ][ ]

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	15.0	15.0	15.0	15.0	15.0	15.0
SUPPLIES	146.8	146.8	146.8	146.8	146.8	146.8
EQUIPMENT	5.0	5.0	5.0	5.0	5.0	5.0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	166.8	166.8	166.8	166.8	166.8	166.8
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	166.8	166.8	166.8	166.8	166.8	166.8
FEDERAL FUNDS						
OTHER						
TOTAL	166.8	166.8	166.8	166.8	166.8	166.8

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

Prepared By: Pat Pourchot Phone: 465-4935
Division: Senator Pat Pourchot Date: 5-17-91
Co-chairman, Senate Finance Committee
Approved by Commissioner: _____
Agency: _____ Date: _____

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

Rev 10/90 FN DHSS · FY 92 Page ___ of ___

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 19, 1991 FURTHER REFERRALS: Finance

Date of Committee Action: 2/6/92

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: CSSB 269(HES)

CS FOR SENATE BILL NO. 269 (HES) TESTING FOR CHLAMYDIA AND GONORRHEA

"An Act relating to testing for chlamydia and gonorrhea."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title
[ ] have attached amendments(s)
[✓] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[✓] fiscal impact DHSS [ ] fiscal note(s) _____

[ ] zero fiscal note _____ [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Kathi Cay	✓				
Marks Miller	✓				
Bettye Davis	✓				
Jo Douglas	✓				
Cheri Davis	—				
Mark Hanley	X	check fiscal note			

Kathi J. Cay
CHAIRMAN'S SIGNATURE

SB

313

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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

240 Main Street, Suite 500
Juneau, Alaska 99801-2101

M E M O R A N D U M December 10, 1991

SUBJECT: Sectional analysis (SB 313)

TO: Senator Arliss Sturgulewski

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of SB 313:

Section 1 - Requires insurers and hospital or medical service corporations that offer individual or group disability insurance, to provide coverage for treatment of phenylketonuria. Provides that certain insurance policies are excluded from this required coverage. Allows the insurer or service corporation to impose reasonable contract limitations on the required coverage, not including a preexisting condition exclusion or higher deductible or copayment than for other conditions.

Section 2 - Technical amendment that imposes the required coverage in section 1 upon hospital or medical service corporations.

Section 3 - Applicability section that requires that coverage mandated under section 1 only applies to insurance policies and contracts entered into or renewed on or after the effective date of the Act.

MFF:LMB
91-304.lmb

Sectional Analysis

February 3, 1992

Sheree Elliott
HC03-8100-B
Palmer, Alaska 99645

RE: Senate Bill #313 - An Act Relating to Phenylketonuria (PKU)

Senator Sturgulewski,

I am writing you in support of the bill you are introducing to the State legislature regarding insurance coverage for Phenylketonuria (PKU).

My husband, Tom and I have a five year old daughter with PKU. When Morgan was born in Anchorage in 1986 I was employed at National Bank of Alaska. My medical insurance is with Blue Cross. When it came time to purchase formula for Morgan I had to fight with Blue Cross to cover the cost of 80%. I finally won. However, if the time comes when I choose to quite work, I will not have medical insurance. If I can not be sure that I can get an insurance company to cover the special formula Morgan must have to insure she is a normal and healthy child I will be forced to keep employment with NBA just so my husband and I have insurance coverage on our daughter.

The number of children affected by PKU in Alaska is so small that we wouldn't be talking more then pocket change for the insurance companies. Also, it should be noted that most other states have already mandated insurance companies to cover phenylketonuria if they want to do business in their state.

Your support to this bill is imperative. Please give it so that all health care policies, group and individual, will provide insurance coverage for phenylketonuria in the state of Alaska.

Sincerely,

Sheree Elliott

Sheree Elliott,
Thomas Elliott

257-3457

Department of Commerce & Economic Development / POSITION PAPER

SB 313: "An Act relating to insurance coverage for treatment of phenylketonuria."

SB 313 mandates insurance coverage for phenylketonuria. The department is neutral on this bill.

Phenylketonuria (PKU) is an affliction impacting newborn children which requires treatment with a special and expensive formula for survival. Alaska has about one case per year.

The treatment of PKU is expensive and beyond the ability of most persons to bear. Fortunately, its occurrence is sufficiently infrequent as to pose a negligible overall public cost.

Glenn A. Olds, Commissioner

Date: 2-3-92

GAO/DK/dgl1378D-2
020392a

Commerce Position

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI
3/11/92

Senate

3111 C STREET, SUITE 550
ANCHORAGE, ALASKA 99503
(907) 561-7615

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

Sponsor Statement on:

SB 313 "An Act relating to insurance coverage for the treatment of phenylketonuria."

Senate Bill 313 would amend state law by adding a new section to AS 21.42 requiring insurers and hospital or medical service corporations that offer individual or group disability insurance to provide coverage for treatment of phenylketonuria(PKU).

PKU is a rare inherited metabolic disorder. Babies born with PKU are unable to process proteins, such as milk, and so in order to remain healthy, they must maintain a strict diet and are placed on a mineral and vitamin enriched formula. If this is not done, then the build up of proteins causes severe brain damage and mental retardation. This bill would require insurance companies to cover the cost of PKU formula.

Enclosed is a position paper from Commissioner Mala in support of this bill. Commissioner Mala points out that the cost of the formula is far less than the cost of treatment for the permanent and long term damage caused by the lack of treatment. The Department of Health and Social Services, Division of Public Health has submitted a zero Fiscal Note.

Michael Ford, Legislative Counsel, Division of Legal Service prepared a sectional analysis of SB 313 which I have enclosed.

Also enclosed are zero Fiscal Notes from the Department of Administration, Division of Retirement and Benefits; the Department of Commerce and Economic Development, Division of Insurance; and the University of Alaska, Statewide Budget Office.

Sponsor Statement