

ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

8264 SENATE HEALTH EDUCATION & SOCIAL SERVICES

Appendix B

MOTIONS AND VOTING TALLY

LICENSING FEES

Recommend all licensing boards be required to establish professional fees sufficient to cover their costs plus a prorated share of the overhead costs of agency services to these boards and commissions.

YES 10 NO 0 ABSTAIN 0 ABSENT 1

PERFORMANCE OF LICENSING FUNCTION

Recommend the Commissioner of the Department of Commerce and Economic Development be allowed to contract on an annual basis with professional associations to perform licensing subject to a yearly, independent audit.

YES 10 NO 0 ABSTAIN 0 ABSENT 1

STANDARDIZED COMPENSATION

Recommend that compensation to board members be standardized.

YES 10 NO 0 ABSTAIN 0 ABSENT 1

ALASKA HISTORICAL COMMISSION

Recommend combination of the Alaska Historical Commission, the Historic Sites Advisory Committee, and the State Geographic Board into an Alaska Historical Commission.

YES 10 NO 0 ABSTAIN 0 ABSENT 1

HUMAN RESOURCE INVESTMENT BOARD

Recommend combination of the Governor's Council on Vocational and Career Education, the Employment Security Advisory Council, and the Job Training Council into the Human Resource Investment Board, excluding the Correctional Industries Commission.

YES 9 NO 0 ABSTAIN 0 ABSENT 2

HUMAN RELATIONS COMMISSION

Recommend that the Alaska Women's Commission, the Alaska Commission on Children and Youth, and the Juvenile Justice and Family Services Advisory Committee be combined under the Human Relations Commission, and that the Council on Domestic Violence and Sexual Assault not be included in this group.

YES 10 NO 0 ABSTAIN 0 ABSENT 1

OLDER ALASKANS COMMISSION

Recommend that the duties of the Older Alaskans Commission and the Alaska Pioneers' Homes Advisory Board be combined under the Older Alaskans Commission.

YES 8 NO 1 ABSTAIN 0 ABSENT 2

BOARD OF FISHERIES

Recommend that Alaska's representative on the Pacific Marine Fisheries Commission be appointed from the members of the Board of Fisheries.

YES 9 NO 0 ABSTAIN 0 ABSENT 2

BOARD OF PAROLE AND VICTIM COMPENSATION

Recommend that the Board of Parole and the Violent Crimes Compensation Board be combined into the Board of Parole and Victim Compensation, and that this 7 person board include one physician member.

YES 5 NO 4 ABSTAIN 0 ABSENT 2

MOTION DID NOT PASS, DUE TO LACK OF MAJORITY OF TOTAL MEMBERSHIP

ALASKA SCIENCE AND TECHNOLOGY FOUNDATION

Recommend that the duties of the Alaska Science and Technology Foundation and the Science and Engineering Advisory Commission be combined under the Alaska Science and Technology Foundation.

YES 9 NO 0 ABSTAIN 0 ABSENT 2

CORDOVA ROAD TASK FORCE

Recommend that the Cordova Road Task Force, which has completed its duties, be eliminated.

YES 9 NO 0 ABSTAIN 0 ABSENT 2

FUTURE OF AGRICULTURE TASK FORCE

Recommend that the Future of Agriculture Task Force, upon completion of duties this Spring, be eliminated.

YES 9 NO 0 ABSTAIN 0 ABSENT 2

STATE OFFICERS COMPENSATION COMMISSION

Recommend that the State Officers Compensation Commission be eliminated.

YES 5 NO 4 ABSTAIN 0 ABSENT 2

MOTION DID NOT PASS, DUE TO LACK OF MAJORITY OF MEMBERSHIP

BOARDS WITH NO CHANGE

Recommend that no change be made in the function or membership of the following boards, and that they each preserve their status as a separate board. Motion amended to add the Board of Real Estate Appraisers, Real Estate Commission, the Board of Clinical Social Work Examiners, Board of Psychologist and Psychological Associate Examiners, Board of Dispensing Opticians to this list:

Aerospace Development Corporation Board of Directors, Alaska
Alcoholic Beverage Control Board
Alcoholism and Drug Abuse, Advisory Board
Arts, Alaska State Council on the
Arctic Winter Games Corporation, Board of Directors (2 from Alaska)
Assessment Governing Board, National (Federal - Governor nominates)
Assessment Review Board, State
Bar, Board of Governors of the Alaska (receives no state funds)
Boards and Commissions, Governor's Task Force on (temporary)
Broadcasting Commission, Alaska Public
Christopher Columbus Quincentenary Jubilee (1 from Alaska)
Clemency Advisory Committee, Executive
Coastal Policy Council, AK
Coastal Resources Research and Development Institute, National (Private)
Commercial Fisheries Entry Commission, AK
Correctional Industries Commission
Cook Inlet Regional Citizens Advisory Council (Fed)
Disability, National Organization on (Private-1 from AK)
Emergency Medical Services, Advisory Council on
Emergency Response Commission, AK State
Employment of People with Disabilities, Governor's Committee on
Fishermen's Fund Advisory & Appeals Council
Game, Board of
Handicapped and Gifted, Governor's Council (Federal/State)
Historical Records Advisory Board, State
Human Rights, State Commission for
Humanities Forum, Alaska (Federal/State)
Iditarod National Historic Advisory Committee (Federal - Governor nominates)
Incentive Awards Board
International Business, Advisory Board of the AK Center for (Governor and Chancellor are consulted. UA Board of Regents approves nominations.)
Interstate Oil Compact Commission
Judicial Conduct, Commission on (Alaska Constitution)
Judicial Council (Alaska Constitution)
Labor Relations Agency, Alaska
Libraries, Advisory Council on
Licensing Boards:
 Accountancy, Alaska State Board of Public
 Architects, Engineers, and Land Surveyors, State Board of Registration for
 Barbers & Hairdressers, Board of
 Big Game Commercial Services Board
 Chiropractic Examiners, Board of
 Dental Examiners, Board of
 Marine Pilots, Board of
 Medical Board, State
 Nursing, Board of
 Nursing Home Administrators, Board of
 Pharmacy, Board of
 Physical Therapy and Occupational Therapy Board, State
 Teaching Practices Commission, Professional
 Veterinary Examiners, Board of
Local Autonomy, Task Force on (temporary)
Local Boundary Commission (Alaska Constitution)
Marine Highway Task Force (temporary)
Marine Research Board, Regional (Federal)
Mental Health Board, Alaska
Mental Health Trust Authority Board of Trustees, Alaska (not yet effective)
Minerals Commission, Alaska

Municipal Bond Bank Authority, Alaska (recommend line agency)
 Natives, Joint Federal-State Commission
 on Policies and Programs Affecting Alaska (Federal/State)
 North Pacific and Bering Sea Fisheries Advisory Body (Federal)
 North Pacific Fishery Management Council (Federal)
 Occupational Safety and Health Review Board
 Oil and Gas Conservation Commission, Alaska
 Oil Spill Recovery Institute (Private)
 Older Persons Action Group (Private, 1 appointed by Governor)
 Permanent Fund Corporation Board of Directors, Alaska
 Personnel Board
 Police Standards Council, Alaska
 Prince William Sound Citizens Advisory Council (Federal)
 Private Industry Council, Alaska
 Public Offices Commission, Alaska
 Railroad Corporation Board of Directors, Alaska
 Reapportionment Board (Alaska Constitution)
 Royalty Oil and Gas Development Advisory Board, Alaska
 RATNET
 Rural Cap (Fed 1 appointed by Gov)
 Safety Advisory Council, AK
 School Choice, Advisory Commission on (temporary)
 Seafood Marketing Institute, AK
 Selective Service System (Fed, 5 regional boards in Alaska, Governor nominates)
 Student Loan Corporation, Alaska
 Subsistence Resource Commissions, National Park and Park Monument (ANILCA)
 Subsistence Advisory Council (temporary)
 Tourism Coordinating Committee
 Trans-Alaska Pipeline Liability Fund, Board of Trustees (Fed)
 Trans-Alaska Pipeline System, Presidential Task Force on the (Fed)
 Uniform State Laws, National Conference of Commissioners on
 (National-1 from AK)
 United Nations Day (International, 1 appointed by Gov)
 University of Alaska Board of Regents
 Utilities Commission, AK Public
 Water/Wastewater Works Advisory Board
 Western Interstate Commission for Higher Education
 Workers' Compensation Board, AK
 Yukon River Delegation (US/Canada)

Vote on Motion as amended:

YES 4 NO 6 ABSTAIN 0 ABSENT 1

MOTION AS AMENDED WAS DEFEATED

Vote on Original Motion

YES 10 NO 0 ABSTAIN 0 ABSENT 1

B & C TASK FORCE and
CHRISTOPHER COLOMBUS QUINCENTENARY JUBILEE

Recommend that the Governor's Task Force on Boards and Commissions and the Christopher Columbus Quincentenary Jubilee be eliminated upon completion of duties.

YES 9 NO ABSTAIN 0 ABSENT 9

LICENSURE OF MARITAL AND FAMILY THERAPISTS

Recommend the establishment of a separate Board of Marital and Family Therapy, and that this board be required to pay all of its expenses, including the overhead costs of services provided by the Division of Occupational Licensing.

YES 6 NO 0 ABSTAIN 0 ABSENT 5

CLINICAL SOCIAL WORK EXAMINERS

PSYCHOLOGIST AND PSYCHOLOGICAL ASSOCIATE EXAMINERS

Recommend that the Board of Clinical Social Work Examiners and the Board of Psychologist and Psychological Associate Examiners each preserve their status as separate boards, and that these boards be required to pay all of their expenses, including a prorated share of the overhead costs of services provided by the Division of Occupational Licensing.

YES 6 NO 0 ABSTAIN 0 ABSENT 5

REAL ESTATE COMMISSION, BOARD OF CERTIFIED REAL ESTATE APPRAISERS, BOARD OF DISPENSING OPTICIANS, BOARD OF EXAMINERS IN OPTOMETRY

Recommend that the Board of Certified Real Estate Appraisers, the Real Estate Commission, the Board of Dispensing Opticians, and the Board of Examiners in Optometry each preserve their status as separate boards, and that these boards be required to pay all of their expenses, including a prorated share of the overhead costs of services provided by the Division of Occupational Licensing.

YES 6 NO 0 ABSTAIN 0 ABSENT 5

BOARD OF EDUCATION

Recommend that the Board of Education also serve as the Block Grants Advisory Committee, so as to preserve this committee's function within state government, and, in doing so, continue to qualify for federal Chapter 2 Block Grants funds.

YES 7 NO 0 ABSTAIN 0 ABSENT 4

COUNCIL ON PHYSICAL FITNESS AND SPORTS

Recommend that the Athletic Commission and the Alaska Amateur Sports Authority preserve their status as separate boards.

YES 2 NO 5 ABSTAIN 0 ABSENT 4
MOTION FAILED

COUNCIL ON PHYSICAL FITNESS AND SPORTS

Recommend that the Athletic Commission and the Alaska Amateur Sports Authority be combined into the Council on Physical Fitness and Sports

YES 5 NO 2 ABSTAIN 0 ABSENT 4
MOTION FAILED DUE TO LACK OF MAJORITY OF TOTAL TASK FORCE MEMBERSHIP

COUNCIL ON PHYSICAL FITNESS AND SPORTS

Make no recommendation on the proposal to combine the Athletic Commission and the Alaska Amateur Sports Authority, and the Council on Physical Fitness and Sports, (where three members of the new Council be designated as Athletic Commissioners to perform duties now performed under the Athletic Commission) and place this board under section of boards needing further review.

YES 7 NO 0 ABSTAIN 0 ABSENT 4

SOIL AND WATER CONSERVATION BOARD

Recommend that the Water Resources Board and the Soil and Water Conservation Board be combined into the Soil and Water Conservation Board.

YES 7 NO 0 ABSTAIN 0 ABSENT 4

BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES

Recommend licensing of midwives, and, consistent with this, recommend support for HB 382, relating to the licensing of midwives and the creation of a midwives licensing board.

YES 7 NO 0 ABSTAIN 0 ABSENT 4

COUNCIL ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

Recommend that the Council on Domestic Violence and Sexual Assault preserve its status as a separate board.

YES 7 NO 0 ABSTAIN 0 ABSENT 4

BOARDS NOT RECOMMENDED FOR EXTENSION

Recommend that the following boards not be extended past their sunset or termination date:

- Code Revision Commission, Alaska (Sunsets 1993)
- Governmental Roles, Task Force on (Terminated 6/92)
- Hazardous Substance Spill Technology Review Council (Sunsets 1994)
- Health Resources and Access Task Force (Terminates 1993)
- Mental Health Trust Commission, Interim (terminated with passage of SB 65, 1991, which goes into effect with dismissal of Weiss v. State)
- Sentencing Commission, Alaska (Sunsets 1993)
- Storage Tank Assistance, Board of (Sunsets 1996)
- Trans-Alaska Pipeline, Task Force on Construction of the (Terminated 2/92)
- Waste Reduction and Recycling Task Force (Terminated 4/92)

YES 7 NO 0 ABSTAIN 0 ABSENT 4

BOARDS RECOMMENDED FOR ELIMINATION

Recommend the following boards be eliminated:

- Agriculture Task Force, Future of (temporary)
- Boards and Commissions, Governor's Task Force on
- Christopher Columbus Quincentenary Jubilee
- Cordova Road Task Force (duties completed)
- Electrical Examiners, Board of
- Forestry, Board of
- Health Care Task Force, Universal (INACTIVE)
- Mechanical Examiners, Board of
- Medicaid Rate Advisory Commission
- Subsistence Use of Fish and Game, Commission on (INACTIVE)
- Telecommunications Information Council

YES 7 NO 0 ABSTAIN 0 ABSENT 4

BOARDS WITH NO RECOMMENDATION AT THIS TIME;
HELD FOR FURTHER REVIEW

MAKD NO RECOMMENDATION AT THIS TIME ON THE FOLLOWING
BOARDS, AND HOLD THEM FOR FURTHER REVIEW:

1. Conservation and Multiple Use Board
 - Wood-Tikchik State Park Management Council
 - Recreation Rivers Advisory Board
 - AK Chilkat Bald Eagle Preserve Advisory Council
2. AK Housing Board
 - AK Housing Finance Corp.
 - AK State Housing Authority
3. Commerce, Trade, and Industry Board
 - AK Industrial Development and Export Authority
 - Agricultural Revolving Loan Fund Board
 - Commercial Fishing and Agriculture Bank
 - AK Energy Authority Board of Directors (loan/grant function)
4. State Employees' Retirement Board
 - Public Employees Ret. Board
 - Teachers' Ret. Board
5. Tourism Marketing Council, Alaska (Sunsets 1993)
6. Federal Areas, Citizens' Advisory Commission on (Sunsets 1998)
YES 7 NO 0 ABSTAIN 0 ABSENT 4

Appendix C

BOARDS LISTED BY AUTHORITIES

BOARDS AND COMMISSIONS WITH STATUTORY AUTHORITY

Accountancy Board
Aerospace Development Corp.
Agricultural Loan Fund
Alcoholic Beverage Control
Alcoholism/Drug Abuse
Amateur Sports Authority
Architects, Engineers, Land Surveyors
Arts Council
Assessment Review Board
Athletic Commission
Bald Eagle Preserve
Bar Association
Barbers and Hairdressers
Big Game Commercial Services
Broadcasting Commission
Children and Youth
Chiropractic Examiners
Coastal Policy Council
Code Revision Commission
Commercial Fisheries Entry
Commercial Fishing/Agriculture Bank
Compensation Commission
Correctional Industries Commission
Dental Examiners
Disability Review Board
Dispensing Opticians
Domestic Violence/Sexual Assault
Education
Electrical Examiners
Emergency Medical Services
Employment of People With Disabilities
Employment Security Advisory
Energy Authority
Federal Areas
Fisheries
Fishermen's Fund Advisory
Forestry
Game
Geographic Board
Hazardous Substance Spill Tech. Review Council
Historic Sites Advisory
Historical Commission
Housing Authority
Housing Finance Corporation
Human Rights
Incentive Awards Board
Industrial Development/Export Authority
Labor Relations Agency
Land Use Council Advisors
Marine Pilots
Mechanical Examiners
Medicaid Rate Advisory Commission
Medical Board
Mental Health Trust Authority (not yet in effect)
Minerals Commission
Municipal Bond Bank
Nursing
Nursing Home Administrators
Occupational Safety
Oil and Gas Commission
Optometry
Out-of-Home Care Review Panel (Local)

Statutory Authority, conid.
 Pacific Marine Fisheries
 Parole Board
 Permanent Fund
 Permanency Planning (State Panel)
 Personnel Board
 Pharmacy Board
 Physical Therapy/Occupational Therapy
 Pioneers' Home Advisory
 Police Standards Council
 Postsecondary Education
 Professional Teaching
 Psychologist/Psychological Associate Examiners
 Public Offices Commission
 Railroad Corporation
 Real Estate Appraisers
 Real Estate Commission
 Recreation Rivers Advisory
 Royalty Oil/Gas Development
 Safety Advisory Council
 Science/Engineering Advisory
 Science and Technology Foundation
 Seafood Marketing Institute
 Sentencing Commission
 Social Work Examiners
 Soil/Water Conservation
 Storage Tank Assistance
 Student Loan Corporation
 Subsistence Use of Fish and Game
 Teachers' Retirement Board
 Telecommunications
 Tourism Coordinating Committee
 Tourism Marketing Council
 Trans-Alaska Natural Gas Pipeline
 Utilities Commission
 Veterinary Examiners
 Violent Crimes
 Waste Reduction and Recycling
 Water/Wastewater Works
 Water Resources
 Western Interstate Commission
 Women's Commission
 Wood-Tikchik Park
 Workers' Compensation

STATUTORY AND CONSTITUTIONAL AUTHORITY

Judicial Conduct (AK Constitution Art. IV, Sec. 10 and AS 22.30.010)
 Local Boundary Commission (AK Constitution Art. X, Sec. 12 and AS 44.47.565)
 University of Alaska Board of Regents (AK Constitution Art. VII, Sec. 3 and AS 14.40.120)

CONSTITUTIONAL AUTHORITY

Judicial Council (AK Constitution Art. IV, Sec. 8)
 Reapportionment Board (AK Constitution Art. VI)

NON-STATUTORY (created by resolution or by related statutes)

Executive Clemency Advisory Committee (AS 33.20.070, AS 33.20.080 relate)
 Governmental Roles, Task Force on (Leg Res No. 7, 17th Leg, 1991)
 Health Resources and Access Task Force (Leg Res No. 45, 17th Leg, 1991)
 RATNET (AS 44.21.320 relates; FCCS HB 50 "Letter of Intent" - 1981)

BOARDS AND COMMISSIONS WITH STATE/FEDERAL AUTHORITY

Emergency Response Commission
 Handicapped and Gifted
 Mental Health Board
 Older Alaskans Commission
 Vocation/Career Education
 Uniform State Laws

BOARDS AND COMMISSIONS WITH FEDERAL AUTHORITY

Historical Records Advisory
Humanities Forum
Iditarod Advisory Council (Governor nominates)
Interstate Oil Compact Commission
Job Training Council
Juvenile Justice/Family Services Advisory
Libraries Advisory
Natives, Joint Fed-State Commission
North Pacific/Bering Sea Fisheries (Governor nominates)
North Pacific Fishery (NPFMC) (Governor nominates)
Pacific Salmon Commission (Governor nominates)
Private Industry Council
Selective Service System (Governor nominates)
Subsistence Resource Commissions
Trans-Alaska Pipeline (TAPS) (Governor nominates)
Yukon River Delegation

CURRENT TASK FORCES (NON-STATUTORY)

Agriculture, Future of
Boards and Commissions
Marine Highway
Salmon Strategy
School Choice
Subsistence Advisory

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STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

WALTER J. HICKEL, GOVERNOR

P.O. BOX 110800
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500
FAX: (907) 463-3841

December 22, 1992

RECEIVED
DEC 23 1992

LEGISLATIVE AUDIT

Mr. Randy S. Welker
Legislative Auditor
Division of Legislative Audit
P.O. Box 112300
Juneau, AK 99811-3300

Dear Mr. Welker:

The Department of Commerce and Economic Development (DCED) appreciates the opportunity to comment on the preliminary Special Report on Selected Boards and Commissions Issues dated October 30, 1992.

Several recommendations pertaining to DCED were made in the report. Each recommendation is addressed below.

The cycle for reestablishment after the first sunset should be increased. (page 11)

The department fully supports this recommendation. Many boards and commissions have demonstrated outstanding performance of duties in accordance with the law, yet continue to be subject to sunset review every four years. Not only will increasing the number of years between reviews place less demand on audit resources, it will also allow boards and commissions to focus their efforts on their statutory missions rather than continuation every four years. While the review should be a routine process, it places a level of anxiety upon board members who must bear the burden of ensuring the continuation of their licensing board.

As you indicate in the audit report, even if the sunset review cycle is increased, any legislator would continue to have the authority to request a performance review or special audit of a board or commission under AS 24.20 at any time. This provision will encourage boards to continue working effectively between sunset review periods knowing that oversight of their activities may occur at any time.

The legislature may want to consider removing some of these boards from sunset. (page 12)

The department supports the removal of those boards mandated under Federal law or the Alaska Constitution from the sunset process. The Board

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

WALTER J. HICKEL, GOVERNOR

P.O. BOX 110800
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500
FAX: (907) 463-3841

December 22, 1992

RECEIVED
DEC 23 1992
LEGISLATIVE AUDIT

Mr. Randy S. Welker
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

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As you indicate in the audit report, even if the sunset review cycle is increased, any legislator would continue to have the authority to request a performance review or special audit of a board or commission under AS 24.20 at any time. This provision will encourage boards to continue working effectively between sunset review periods knowing that oversight of their activities may occur at any time.

The legislature may want to consider removing some of these boards from sunset. (page 12)

The department supports the removal of those boards mandated under Federal law or the Alaska Constitution from the sunset process. The Board

of Nursing Home Administrators, consisting of three members, must exist for the State to qualify for federal medicaid funding.

The Department of Commerce and Economic Development (DCED) should establish fee levels for occupational licensees that are more reflective of actual regulatory cost of the occupation. (page 27)

Each of the two recommendations that were made under this section is addressed separately. The section reads:

We recommend DCED establish licensing fees which are more reflective of actual efforts spent on regulation. DCED should consider:

- (1) an alternate method of allocating occupational licensing examiner costs, investigator costs, and hearing officer costs:
(page 29)

In the most recent proposed fee regulations, the Division of Occupational Licensing gave careful consideration to the following factors:

- (a) We wanted fees to remain relatively constant over time and not be subject to regular and wide fluctuations. If a time-keeping system were to be used, wide fluctuations could happen, especially if heavy investigative activity were to occur in an area with few licensees.
- (b) The proposed fees eliminate specific allocation of hearing examiners, investigators, and licensing examiners that are not dedicated to a specific board. These nonspecified personal services would now become part of general overhead. The general overhead ensures a consistent level of support to provide for day-to-day operations, as well as enforcement services when needed. Likewise, each licensing program will be responsible for dedicated expenses, such as travel or an Executive Secretary assigned exclusively to a board.
- (c) Enforcement services must exist whether or not the services are used with respect to a particular area of licensure. In addition, hearing examiners and investigators frequently answer questions from the public, licensees, and applicants regarding scope of practice, how to qualify, etc. These overhead costs are difficult to allocate to individual licensing programs, and therefore, we believe the costs of these activities should be spread equally over all occupations.

By statute, AS 08.01.065, the division is charged with the responsibility of establishing fees for all occupations under centralized licensing, including those areas regulated by licensing boards. The method chosen to spread costs across all occupations provides an equitable means to reasonably attain self-sufficiency in all occupational licensing programs. Each licensee regardless of occupation, will be contributing an equal share toward personnel resources of the division.

The department can appreciate your audit findings that allocation of occupational licensing examiner costs may be more reflective of costs if the costs were based on effort spent on regulation. However, use of a positive time keeping system is not realistic. Such a system when added to the level of activity that goes on day-to-day would only place another burden on staff that must already respond to a myriad of issues daily.

The department is mandated by statute to review fees annually and will give consideration to the methodology used to allocating costs in our next review of licensing fees.

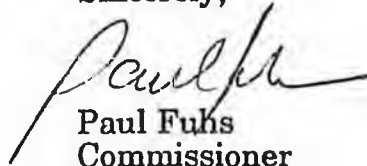
- (2) consider including commissioner or fiscal overhead in their allocation. (page 29)

I agree with this recommendation. Centralized departmental administrative services and the commissioner's time are support services rendered to the entire department. The department will consider these costs the next time that licensing fees are adjusted.

In summary, the department supports some of the audit findings as addressed above, but does not fully concur with how undesignated personnel costs should be allocated to the various occupations.

Thank you for the opportunity to comment on the preliminary audit report. If we can be of further assistance, please contact this office.

Sincerely,


Paul Fuhs
Commissioner

PF/GB/mme023.GB
122292a

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8 3



Official Business

Alaska State Legislature

SENATOR TIM KELLY

State Capitol
Juneau, AK 99801-1182

SPONSOR STATEMENT FOR SB 83:

AN ACT RELATING TO AN ALCOHOL SERVER EDUCATION COURSE

Alcohol abuse is a severe problem in Alaska, impacting individuals, families, and communities throughout our State. This legislation -- which addresses the problem by requiring alcohol server education -- passed the House last session and the Senate Labor & Commerce Committee before dying in the closing minutes of the session in the Senate Finance Committee.

Alaska ranks 4th in the nation for per capita alcohol consumption, and has one of the highest rates of fetal alcohol syndrome in the country, with more than 30 infants born each year with alcohol related impairments. In 1991, there were more than 1,700 alcohol related vehicular accidents, resulting in 38 deaths. In Anchorage alone, there were more than 1,800 DWI arrests in 1991.

SB 83 was originally crafted last session to help address this problem through alcohol education for servers with cooperation from Mothers Against Drunk Driving (MADD), the alcohol industry, the Department of Motor Vehicles (DMV), and the Alcohol Beverage Control Board (A.B.C. Board).

Under SB 83, the A.B.C. Board would establish criteria with which to evaluate education programs currently available, and then approve a package of alcohol server education courses. This package would include a variety of courses which would ensure accessibility to alcohol servers in both urban and rural Alaska. Various instruction mediums, ranging from classroom instruction to viewing a video cassette followed by written exercises, would likely be utilized depending on the program.

Courses would include such topics as alcohol's affect on the body and behavior, particularly driving ability, drunk driving and civil liability laws, identifying fraudulent IDs, methods of recognizing the problem drinker, use of community treatment programs, and methods to peacefully terminate service to the problem customer and get him or her home safely, to name a few.

Senator Tim Kelly
Sponsor Statement - SB 83
Page 2

Alcohol servers would have 30 days from the date the A.B.C. Board approves a package to complete a course, and, for new employees, 30 days from the date of hire. Proof of completion of an approved course must be kept on the licensed premises during working hours.

Alcohol server education is already required by ordinance in the Municipality of Anchorage.

If enacted, SB 83 should go a long way towards reducing incidents of drunk driving, and help increase alcohol servers' awareness on how to serve alcohol responsibly.

This bill maintains a zero fiscal note, and has the support of the A.B.C. Board, Mothers Against Drunk Driving, the Alaska Cabaret, Hotel, Restaurant & Retailers Association, the Anchorage Restaurant & Beverage Association, the Bristol Bay Area Health Corporation, and the Municipality of Anchorage Health & Human Services Commission.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SB 83

Revision Date: _____ Dept. Affected: Revenue
 Title: Alcohol Server Education Course BRU: Alcoholic Beverage Control Board
 Component: _____
 Sponsor: Senator Kelly
 Requestor: S HES COMPONENT SERIAL NO. 0100

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	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	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE FUND SOURCE:	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

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 (FY93) Impact: \$ None

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Patrick L. Sharrock, Director
 Division: Alcoholic Beverage Control Board
 Approved by Commissioner: Pat L. Sharrock
 Agency: Department of Revenue

Phone: 277-8633
 Date: 2/3/93
 Date: 2/8/93

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COMMISSIONER'S OFFICE

STATE OF ALASKA

DEPARTMENT OF REVENUE

ALCOHOLIC BEVERAGE CONTROL BOARD

WALTER J. HICKEL, GOVERNOR

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

February 4, 1993

The Honorable Tim Kelly
Alaska State Senate
State Capitol
Juneau, AK 99801-1182

RE: SB 83

Dear Senator Kelly:

This letter intends to express the Alcoholic Beverage Control Board's support for SB 83. As you may know, the board is currently informally requested under Municipality of Anchorage ordinance to approve training programs presented within the municipality.

The board believes that server training stimulates employees' and licensees' ability to responsibly serve the public. If this legislation is enacted into law, the board will begin drafting regulations to fulfill its charge.

If you have any questions, please do not hesitate to call.

Sincerely,



Patrick L. Sharrock
Director, ABC Board
(907) 277-8638

PS/cl

93- 022



*Alaska Cabaret, Hotel,
Restaurant & Retailers Association*

*P.O. Box 104890 • Anchorage, Alaska 99510
401 SK Street • (907) 272-8199 • Fax: (907) 277-8640*

February 16, 1993

Senator Tim Kelly
State Capitol
Juneau, AK 99801-1182

Dear Senator Kelly,

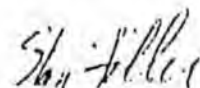
The membership of the Alaska Cabaret, Hotel, Restaurant and Retailers Association endorses and supports Senate Bill 83 which you introduced. We feel that statewide mandatory alcohol server training benefits those in the beverage alcohol industry as well as the general public.

As a statewide trade association, we began offering server training on a voluntary basis as a service to our members in 1984. In 1986, such training was made mandatory in Anchorage and since that time we have trained and certified over 10,000 servers. We have instructors throughout the State and our instructors do travel to more remote areas upon request. Our TAM seminars (Techniques of Alcohol Management) have been given in Nome, King Salmon, Yakutat and Haines.

Our members are convinced that education is the tool to be used in reducing alcohol-related accidents - education of the general public as well as server education. In a 1990 report to Congress, the Secretary of Health and Human Services stated, "Evaluations of servers' post-training behavior suggest that training has a positive effect...on the probability of patron intoxication." We believe that the TAM program has very positive effects and devote a good deal of association effort and support to maintaining and enhancing its effectiveness.

Training all employees in responsible beverage service techniques can only benefit our industry and the general public. CHARR strongly endorses Senate Bill 83 and you have our appreciation for your support of this legislation.

Yours truly,


Stan Filler
President



401 K Street Anchorage, Alaska P.O. Box 104839 Anchorage, Alaska 99510
(907) 272-8133 Fax: (907) 277-8640

February 5, 1993

Senator Tim Kelly
State Capitol
Juneau, AK 99801-1182

Dear Senator Kelly:

The Anchorage Restaurant and Beverage Association (ARBA) strongly endorses and supports Senate Bill 83 you introduced making alcohol server training mandatory in Alaska.

Long before such training was made obligatory in Anchorage by the Municipal Assembly, ARBA working with the statewide trade association Cabaret, Hotel, Restaurant, and Retailers Association (CHARR), introduced the Techniques of Alcohol Management (TAM) program on a voluntary basis for the benefit of our members. To date, over 10,000 persons have attended a TAM Seminar here in Alaska.

We firmly believe that education is the most useful tool in reducing alcohol-related accidents. Education, such as provided by the TAM program, can instill the knowledge, confidence and motivation to prevent illegal beverage alcohol problems. Alcohol server training gives servers and sellers a knowledge and understanding of their key role in reducing alcohol-related accidents and provides them with the tools required to reduce such accidents. Well trained employees are essential to any business, and we believe that society, as well as our industry, can only benefit from teaching responsible beverage service techniques to all servers.

Our Association strongly endorses Senate Bill 83 and has asked me to express our sincere appreciation to you.

Yours truly,

Carol Wilson
Executive Director

BRISTOL BAY AREA HEALTH CORPORATION

P.O. BOX 130 • DILLINGHAM, ALASKA 99576

(907) 842-5201 or (907) 842-5202

February 3, 1993

Senator Tim Kelly
Senate Labor & Commerce
State Capitol
Juneau, AK 99801-1182

Dear Senator Kelly,

We appreciate this opportunity to respond to your introduction of SB 83 and SB 84. The Bristol Bay Area Health Corporation has supported these bills in the past and will continue to advocate passage in the form of this letter of support.

We renumerate our concerns regarding alcohol abuse as our main social problem in our region and we encourage any efforts to resuscitate interest to curb underage drinking and educate alcohol servers. The alcohol servers course has the potential to change the alcohol establishments policies and procedures; increase marketing to generate increased profits, educate servers on the alcohol beverage laws, provide servers with tools and techniques that can be used with patrons, and additional education efforts can be focused on the consequences of prenatal drinking that can cause birth defects.

Once again, thank you for introducing these key pieces of legislation and the best of luck in their passage.

Sincerely, .

BRISTOL BAY AREA HEALTH CORPORATION



Robert G. Clark
Chief Executive Officer

RCJ/ve

cc: Senator George Jacko
Senator Georgianna Lincoln
Representative Lyman Hoffman
Representative Irene Nicholia
Representative Carl Moses
file

Pioneer Bar & Liquor Store, Inc.

CHRISTINE M. TENGS
President

141-143 Second Ave.
Post Office Box 190
Haines, Alaska 99827
(907) 766-9101 Business
(907) 766-2474 Office
(907) 766-3374 FAX

Senator Tim Kelly
State Capitol
Juneau, AK 99801-1182

Dear Senator Kelly:

I am writing to show my support for Senate Bill 83. As the owner of a bar, liquor store and restaurant in which beverage alcohol is served, I firmly believe that we in the industry play a key role in reducing alcohol related accidents and preventing underage persons from illegally trying to buy. Educational programs (such as the TAM program) give servers the knowledge and confidence they need to be professional in handling situations which otherwise might have disastrous consequences.

Although people in my business may argue against being mandated to provide training for their personnel, I believe, in the long run, they will see the benefits. It could show up in a simple change of attitude amongst their staff (and eventually their customers). Where it will really hit home, however, is in a reduction in the number of lawsuits and, perhaps one day, lower insurance rates.

As far as I can see, this is a win-win situation. Thank you for Senate Bill 83.

Sincerely,

Christy Tengs

02/19/93
13:40:45

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)
TCN:30237 SCHEDULED FOR:02/19/93 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVIC

LTN1150
BY:VAL
FOR:VAL

LOCATION:VALDEZ
SB 83

MS. DAWN R. JACOBS

TESTIFY

02/19/93
13:47:59

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)
TCN:30237 SCHEDULED FOR:02/19/93 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVIC

LTN1150
BY:ANC
FOR:ANC

LOCATION:ANCHORAGE

SB 83
SB 83

JERRY MCCUTCHEON
PAT SHARROCK ABC

TESTIFY
TESTIFY

02/19/93
13:55:00

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)
TCN:30237 SCHEDULED FOR:02/19/93 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVIC

LTN1150
BY:GLN
FOR:GLN

LOCATION:GLENNALLEN

SB 83
SB 83

MR. DOUG RHODES
MR. JOHN STRANG

RESTAURANT/BAR OBSERVE
GAKONA LODGE OBSERVE

S B

g 1

POSITION PAPER

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

Position Paper

The Department of Health and Social Services supports SSSB 91 which would provide payment under Alaska's Medicaid program for direct entry midwife services.

Passage of SSSB 91 would provide another alternative for expectant mothers who depend upon the medical assistance program for pregnancy care and childbirth assistance. At present, physician and hospital services are payable under medical assistance along with some pregnancy related nursing services.

Licensure of direct entry midwives was established following passage of HB 382 by the 17th Legislature. In the short time since, 10 direct midwives have been licensed; that number may be expected to reach up to 25 over the next year.

Draft regulations of the Division of Occupational Licensing indicate the direct entry midwife services must include appropriate prenatal care, the delivery, and post-partum care over the 6 weeks following the birth. The draft regulations are very specific about the type of care to be delivered and the times of delivery. Births delivered under a midwife's care typically take place within the home, at the midwife's office, or at a birthing center. AS 8.65.140 specifies a protocol for direct entry midwives to follow for determining when a "difficult" birth should be referred to a physician's care.

The literature on this topic and our consultation with other states indicates that where licensure of midwives has been instituted it was done to improve pregnancy outcomes through increasing the skill level of persons practicing midwifery, improving the awareness of expectant mothers of the impact of nutrition and similar activities, improving the accessibility to services, and by providing a professional alternative that is acceptable to those who choose to not pursue services from a more institutional source.

Data on the impact of licensed midwife services is very limited. Information from the Bureau of Vital Statistics indicates that of all births, 42% are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwife's Association indicate a much higher percentage of Medicaid eligibility of 70% to 80%. (The accompanying fiscal notes assumes 50%)

A comparison of vital statistics to payment information also indicates that a large number of the births involving Medicaid payment are of low birth weight. Under the draft licensure requirements for direct entry midwives some low birth weight

POSITION PAPER

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

pregnancies would be referred to a physician while others may be delivered by the mid-wife, having benefitted from the frequent lab test, nutrition counselling and referral for medical examination that are required.

Payment of direct entry midwife services may have some downward effect on medical assistance program costs to the extent that expectant mothers choose to use midwife services instead of the more costly physician and hospital services. The accompanying fiscal note estimates a net cost savings of \$73,800 during FY94 and greater in following years. While this is a estimate based on no experience, the department certainly does not anticipate a requirement for additional funding as a result of SSSB 91.

The placement of direct entry midwife services as (1) in AS 47.07.035 is the appropriate placement. Of the optional services available under Medicaid, direct entry midwives services should have the lowest priority for payment because other alternative services are available.

Recommended by:

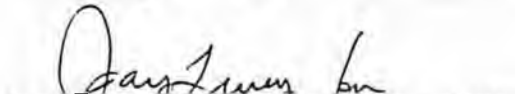


Kimberly B. Busch
Director
Div. of Medical Assistance

Date:

3-18-93

Approved by:



Theodore A. Mala, MD, MPH
Commissioner

Date:

3-19-93

H:\POLICY\HSSPLAN3\LEG93\SB91\SSSB91.PP

A M E N D M E N T

OFFERED IN THE SENATE
TO: SSSB 91

BY SENATOR LEMAN

Page 1, line 1, after "Act":

Insert "prohibiting unfair discrimination against direct-entry midwives who perform services within the scope of their certification;"

Page 1, after line 4:

Insert a new bill section to read:

**** Section 1.** AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, [OR] licensed clinical social worker, or certified direct-entry midwife."

Page 1, line 5:

Delete "Section 1"

Insert "Sec. 2"

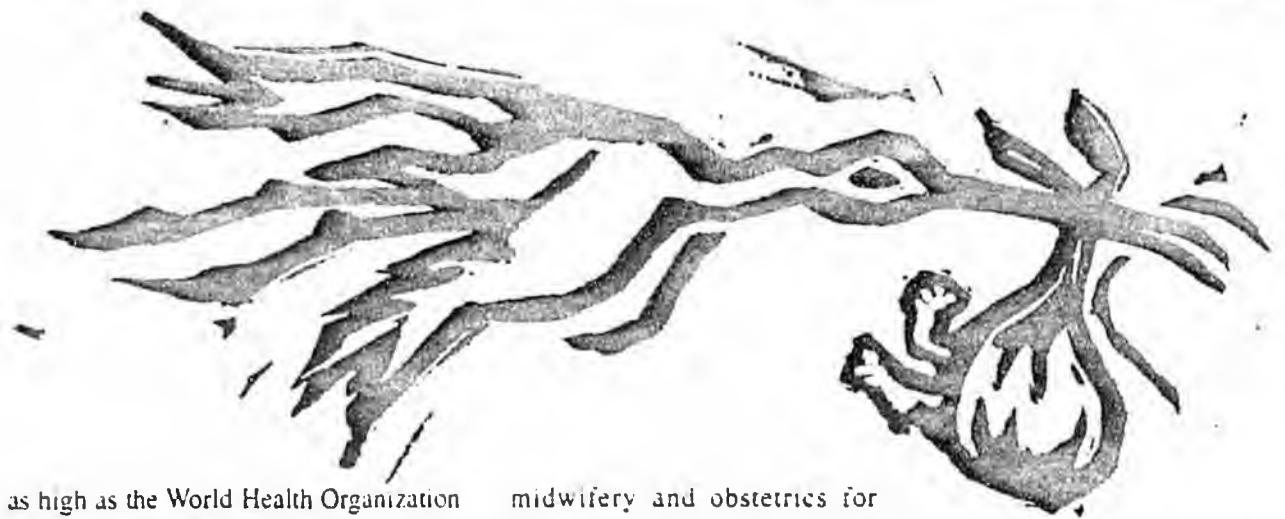
Renumber the following bill sections accordingly.

HOME DELIVERY

MIDWIFE WORKS. SO SHOULD MIDWIVES.

When Janet Podell became pregnant in 1989, she determined to have “the real thing”—the fully natural, satisfying birth experience that had eluded her when her first two children were born. Although midwives had assisted her in the two unmedicated births, the impersonality, tension, conflict, and pointless restrictions she experienced in the hospital had left her feeling frustrated and violated. Both times, for example, she was separated from the baby and from her husband after the birth. After moving to western Massachusetts, Podell found a pair of midwives to attend her birth at home. What resulted was a qualitatively different experience: She felt as if she had really given birth under her own power, in an atmosphere of loving support.

BY ARCHIE BRODSKY



States (a rate twice as high as the World Health Organization recommends). Indeed, any medical intervention in childbirth tends to necessitate further intervention by disrupting the normal physiology of labor and by immobilizing, enervating, disabling, and dispiriting the mother.

A midwife strives to avoid such intervention. Rather than "deliver" the baby, she brings out the birthing woman's own physical and emotional strength—resources left untapped or suppressed by standard obstetrical practices. This is more than touchy-feely rhetoric. It translates into concrete clinical expertise: an appreciation of the variations of normal labor, of the way some problems can correct themselves with time, of the influence of emotional support and a sense of well-being during labor, and of many nonchemical, noninvasive means of encouraging progress.

An obstetrician's highly specialized knowledge represents only a narrow segment of the whole range of knowledge relevant to childbirth. A midwife draws upon a traditional body of knowledge that guides her both in forming a supportive bond with a pregnant woman and in shaping a positive experience of—and attitude toward—birth. In addition to emphasizing prenatal education and preparation, she comes to know the woman, her environment, and the way she lives, and thus can better understand her reactions and assist her during labor.

Podell writes: "The midwives gave me all the room I needed, but they were never distant; they were always right there, offering energy, a sip of juice, a word of encouragement. Their presence comforted me and gave me confidence. One thing I didn't understand... Without internal exams, how could they tell how the labor was progressing?... They said my body would know what to do and when. And to my very great surprise, they were right."

Instead of pain medication, midwives use noninvasive methods, physical as well as psychological, to help women cope with pain. The midwifery model in its pure form does not allow the use of anesthetic or analgesic drugs in normal births, since these medications interfere with the natural process of labor. Home-birth attendants avoid the use of such drugs entirely, since the safety of a home birth depends on supporting the natural process and not creating added risks. In hospitals, on the other hand, nurse-midwives sometimes make pragmatic compromises, giving pain medication to women who want it in order to make other benefits of midwifery available to them.

It should always be a woman's right to choose between

midwifery and obstetrics for whatever reasons matter to her, including her preferences regarding pain medication. At the same time, as the midwifery model comes to be more widely known and better understood, more women may approach the pain of childbearing in a positive way, as Podell did: "The labor was short, intense, and sweet. It wasn't any less painful than the others, but I tried to put all my concentration on welcoming the pain, on assenting to open up. Away from the interference of the hospital, comfortable in my own familiar house, I felt a lovely sense of freedom. I wasn't anybody's patient. I was myself, doing a task I had really been preparing for since childhood."

The beneficial effects of the laboring woman's sense of well-being, comfort, and control are enhanced in the home or (to a lesser degree) in the home-like setting of a midwife-run birth center. In the words of the prominent Dutch obstetrician G.J. Kloosterman: "The advantages of home confinements are that in her own home the expectant mother is not considered a patient, but a woman, fulfilling a natural and highly personal task. She is the real center around which everything (and everybody) revolves. The midwife or doctor and the maternity aide nurse are all her guests, there to assist her. This setting reinforces her self-respect and self-confidence."

This endorsement of home birth runs counter to the prejudices of most Americans, who have been led to believe that the

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CORRECTION

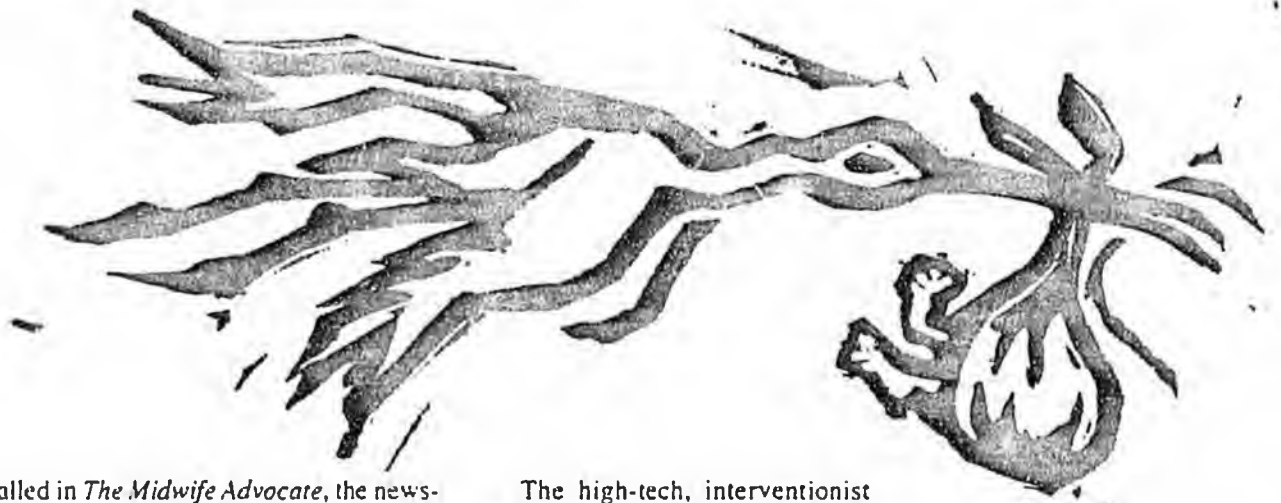
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HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

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As Podell later recalled in *The Midwife Advocate*, the newsletter of Massachusetts Friends of Midwives: "I came away from my hospital births with a sense of helplessness. I came away from my home birth feeling that I had learned deep and amazing lessons about my own strength and resilience, about trusting my body and my instincts....What would happen in this fearful society of ours if all the mothers who gave birth had such an experience?"

Podell is one of many American women who have chosen to give birth outside of a hospital during the last 10 to 15 years. Disillusioned with the routine intrusiveness of conventional hospital obstetrics, they have voted with their feet by giving birth at home with the help of family, friends, and supportive attendants. Some of these women, inspired by the rediscovery of birth as a natural and social event, have become midwives themselves, learning their trade by working with more experienced midwives or with sympathetic physicians.

This social movement, until recently marginalized by organized medicine as a softheaded countercultural rebellion, is now finding common ground with mainstream economic and public-health concerns: the rapid escalation of health-care costs; the loss of obstetricians resulting from the epidemic of malpractice suits; and the high rate of infant mortality among the inner-city poor. Midwifery works, people want it, and it provides an answer to some urgent policy questions. But although midwifery has made progress in recent years, a variety of laws and regulations still prevent midwives from offering their services to everyone who could benefit from them.

The advantages of midwifery depend on a more thoroughgoing change than just plugging in one type of practitioner in place of another. If the law confines midwives to the role of obstetrical handmaidens working exclusively in hospitals under the direction of physicians, it will prevent them from making their full contribution. For the word *midwifery* really stands for a fundamentally different model of maternity care: different people doing different things, often in a different place.

Midwives reject the view that giving birth is a medical procedure like having a gall bladder removed. Instead, they understand it as a natural process that ordinarily does not require drugs, surgery, or high-tech equipment. Obstetricians, whose skills and techniques are best reserved for complicated births, are in most cases not well prepared to attend normal births. They know how to intervene but not how to support without intervening.

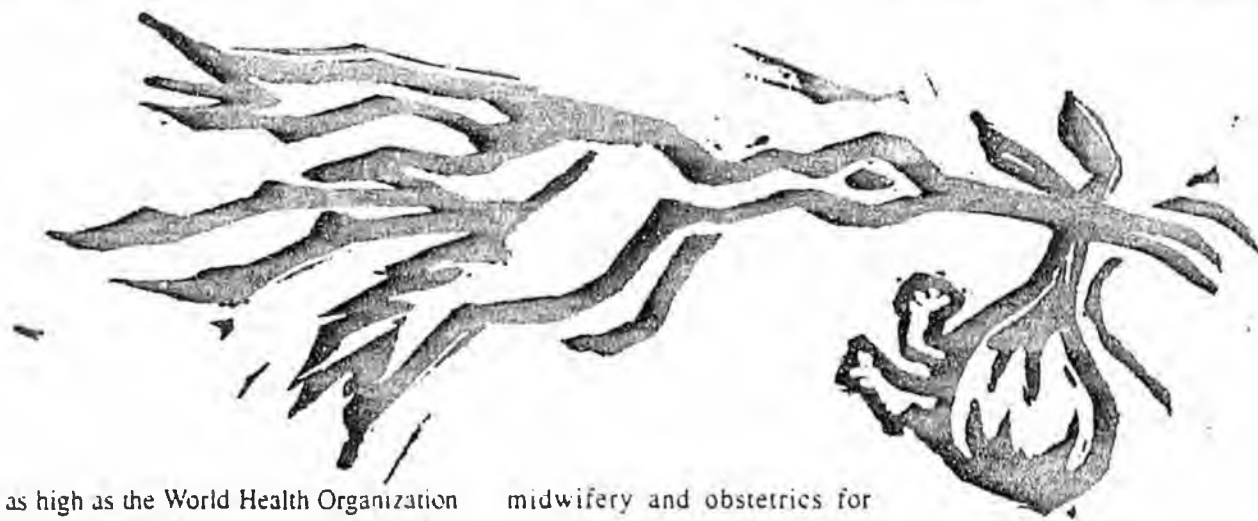
The high-tech, interventionist approach of obstetricians is illustrated by the widespread use of electronic fetal monitoring. EFM—which records fetal heart tones and the pressure of uterine contractions, either through electrodes passed through the birth canal and attached to the baby's scalp or through a transducer placed on the mother's abdomen—may have a legitimate rationale in high-risk births. But from the beginning it was marketed indiscriminately to physicians hungry for precise diagnostic information.

As a result, by the mid-1970s most U.S. hospitals had adopted EFM for routine use, without any controlled studies showing it to be more effective than traditional, noninvasive methods of listening to the baby's heart. Now studies published in the last two years in such prestigious publications as the British journal *The Lancet* and *The New England Journal of Medicine* have shown that, in the absence of specific indications for its use, EFM not only has no demonstrated benefit in reducing childhood disabilities but may even be dangerous.

EFM plays a major role in the futile cycle of defensive obstetrics brought on by malpractice hysteria. For legal protection the physician uses the monitor so he can show, if anything goes wrong, that he "did all he could." But with the monitor readings a matter of record, his actions will be further scrutinized to see if he once again "did all he could" in response to an abnormal reading.

Alarmist reactions to insignificant variations in monitor readings contribute to the current 24-percent cesarean-section rate in the United

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best outcomes occur when childbirth is managed by obstetricians in hospitals where medical technology is readily available and where there is little hesitation about using it. This view equates safety with active technological intervention carried out by highly specialized personnel in an institutional setting.

Proponents of this position offer three main arguments. First, they cite the decline in maternal and infant mortality that coincided with the shift to medicalized, institutionalized childbirth in this century. But such a sweeping historical comparison is meaningless because it disregards many other changes that occurred at the same time: better nutrition, sanitation, and personal hygiene; fewer large families and closely spaced children; the development of antibiotics; and improvements in diagnosis, risk assessment, and instrumentation. Contemporaneous comparisons, such as one conducted by the New York Academy of Medicine from 1930 to 1932, have almost invariably shown that midwife-attended or home births have outcomes as good as or better than physician-attended or hospital births.

British statistician Marjorie Tew, in her 1990 book *Safer Childbirth? A Critical History of Maternity Care*, uses data from the special British birth surveys of 1958 and 1970 to make detailed comparisons—regional, historical, and individual—of the outcomes of home vs. hospital birth and of high-intervention vs. low-intervention birth in populations closely matched for risk factors. Tew concludes that increased hospitalization and obstetrical intervention cannot be credited with improving the safety of childbirth. To her, in fact, the weight of the evidence suggests that these changes have done more harm than good.

Second, opponents of midwifery argue that mortality statistics show babies are at greater risk if they are born outside a hospital. This fallacious comparison, first made in a 1978 press release by the American College of Obstetricians and Gynecologists, rests on raw statewide figures showing that the risk to a baby's life was two to five times greater in an out-of-hospital birth. But the "out-of-hospital" category included not only intentional home births, but also late miscarriages, premature and precipitous births, and unplanned home births. Such undifferentiated data say nothing about the safety of planned, properly attended home births.

Finally, when forced to confront the lack of statistical evidence in their favor, proponents of orthodox obstetrics say, "OK, so the differences in safety are too small to show up in the data. But even one unnecessary infant death is too many—especially if it's yours." This argument, while highly effective in inducing fear and guilt in parents, fails to take into account the countervailing risks of medicalized birth, such as infections resulting from hospital sepsis or from unnecessary surgical procedures and the many complications that can result from interfering with the progress of labor.

Opponents of midwifery also ignore a large body of evidence that low-intervention maternity care by midwives results in outcomes as good as or better than those of hospital births. Since 1925, for example, the Frontier Nursing Service in Ken-

tucky has provided outstanding maternity care to a poor, geographically remote population. The service, whose midwives attended nearly all births at home (sometimes on horseback) until the late 1960s, has compiled an outcome record that compares favorably with that of mainstream America.

In a remarkable real-life experiment in Madera County, California, neonatal mortality dropped from 24 to 10 per 1,000 when nurse-midwives were introduced into a poor agricultural area in 1960. Pressure from the state medical association ended the program in 1963. Midwives were replaced by obstetricians, whereupon neonatal mortality rose to 32 per 1,000. The number of women receiving no prenatal care doubled.

Midwifery programs are having an important impact among the urban poor as well. With one-third of its largely black and Hispanic clients classified as high-risk, the North Central Bronx Hospital midwifery service has the lowest cesarean-section rate in New York City and lower-than-average rates of low birth weight and perinatal and neonatal mortality. In a well-controlled study involving low-income women in a Houston hospital, published in 1991 in *The Journal of the American Medical Association*, the continuous companionship of a *doula*—a woman trained to provide labor support—shortened the duration of labor, cut the cesarean-section rate in half, and reduced the need for other interventions along with the incidence of maternal fever and prolonged infant hospitalization. And the *doula* provides only part of a midwife's comprehensive skills and services.

Two years ago the National Birth Center Study reported on birth outcomes for nearly 12,000 women admitted to freestanding birth centers in the United States, three-fourths of them operated by midwives. In this largely low-risk population, the low overall perinatal-neonatal mortality rate of 1.3 per 1,000 was comparable to that of low-risk hospital births. Moreover, it was achieved with minimal intervention (most notably, a 4.4-percent cesarean-section rate), low morbidity, and high levels of satisfaction. Similar findings were obtained in a review of more than 3,000 out-of-hospital (mainly home) births attended by licensed direct-entry midwives in Arizona between 1978 and 1985.

Further evidence comes from Holland, where the national health-care system deliberately reversed a trend toward American-style hospital births a decade ago. In a study published recently in the British journal *Midwifery*, researchers who analyzed all Dutch births in 1986 found that, at all risk levels after 32 weeks' gestation, perinatal mortality was "much lower under the noninterventionist care of midwives than under the interventionist management of obstetricians." And this is in a country with an ethnically diverse population (including guest workers).

Studies also find that midwifery is much less expensive than conventional obstetrics. The cost-effectiveness of the midwifery model follows from its reliance on natural processes and settings rather than on expensive technology. In one of the first demonstrations of the cost-saving potential of midwifery, Blue Cross/Blue Shield estimated that its costs for a birth in the Maternity Center Association's Childbearing Center in Manhattan in 1976-77 averaged only 37.6 percent of the cost of an



uncomplicated birth in a nearby hospital (including both hospital and physician charges). As documented in a report prepared for the Federal Trade Commission, Blue Cross/Blue Shield's decision (against formidable opposition) to authorize reimbursement for the center was a major breakthrough in making the freestanding birth center a viable concept in the United States.

Since then, this initial indication of the savings to be achieved through broader application of the midwifery model has been borne out by other research, most notably a Health Insurance Association of America (HIAA) study published in 1989. These savings can be realized in a number of ways:

Lower fees. According to the HIAA study, the average physician's fee for a normal pregnancy and birth is \$1,492, while a midwife's fee averages \$994. A midwife's fee typically covers more time spent before, during, and after the birth and includes comprehensive services that otherwise would require a team of providers.

Lower site-related costs. According to the HIAA study, a normal birth involving a one-day stay in a birth center costs \$2,111, compared with \$3,233 for a one-day hospital stay. (These figures include practitioners' fees.) Since the average length of stay in a hospital is longer than in a birth center, the difference in practice is even greater. Thus, the average hospital cost for a normal vaginal delivery is \$2,842 in addition to the physician's fee of \$1,492, for a total of \$4,334.

In a home birth there are no site-related expenses. In Australia, for example, an estimate published in the *Journal Family Physician* indicated that insurers and families might save \$83 million a year if 30 percent of births took place at home. Of course, the cost of maintaining hospital backup for cases requiring transfer must be factored into the overall costs of out-of-hospital birth services. But such on-call auxiliary services require only a fraction of the institutional resources routinely used and paid for under the present system.

Reduced use of technology. Midwives rely much less on technical procedures that entail material costs, increased practitioners' fees, and (often) longer hospital stays. A birth by cesarean section costs an average of \$7,186, compared to \$4,334 for a vaginal birth in a hospital. Since midwife-attended births have a cesarean-section rate 50 percent to 70 percent lower than physician-attended births in comparable populations with equivalent outcomes, the savings to be realized from this aspect of the midwifery model are enormous. If all of New York state's hospitals operated in the manner of the North Central Bronx midwifery service, the reduction in

cesareans alone might save nearly \$150 million annually. Ending the indiscriminate use of other specialized procedures, such as electronic fetal monitoring, ultrasound, IVs, and episiotomy, would also save money.

Lower training costs. The Congressional Office of Technology Assessment calculated that the cost of training a certified nurse-midwife in 1985 averaged \$16,800, compared with \$86,100 to train a general physician, let alone an obstetrician. Since midwifery training is more appropriate for a large majority of births, there is great potential for savings here.

Lower liability costs. As of 1987, 71 percent of obstetrician-gynecologists had been named in one or more liability claims, compared with 10 percent of nurse-midwives. Direct-entry midwives (those not trained and regulated by the nursing profession) are even more rarely sued. Why these disparities? First, obstetricians deal with more complicated cases with a greater likelihood of a tragic outcome. Second, obstetricians have deeper pockets. (Like physicians, certified nurse-midwives—registered nurses with additional training in midwifery—have malpractice insurance; direct-entry midwives generally do not, except in states where they are licensed.)

Third, and perhaps most important, people who choose a midwife (especially a direct-entry midwife) commit themselves to sharing the risks and responsibility

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ties of birth. Rather than expect a guaranteed perfect outcome, they participate with an understanding of nature's uncertainties. The midwife actively encourages this informed participation. And because she establishes a relationship of trust, full and open communication, and emotional support, the midwife does not leave her clients feeling abandoned and resentful in the event of a tragic outcome.

Lower health-care costs after birth. The costs of childbirth pale beside those of taking care of premature and sick infants and children. According to the HIAA survey, it costs nearly \$1,000 a day to keep a baby in a neonatal intensive care unit; a 30-day stay can cost \$30,000. Hospitals that bear these often uncompensated costs should heed the documented success of midwifery programs, over a range of settings and income levels, in reducing the incidence of low birth weight, which is directly associated with prematurity. To the extent that midwives' emphasis on a healthy environment during pregnancy can reduce the short- and long-term effects of malnutrition, smoking, heavy drinking, and drug use on maternal and child health—in some cases preventing lifelong disability—the contribution of midwives to reducing health-care costs may be incalculable.

In the case of midwifery, the evidence is overwhelming that better care can cost less. Indeed, the American system of obstetrics is so inappropriate and inefficient that only as a protected monopoly could it have gained and held its dominant position. It could not have survived, and cannot now survive, in a free market. But the monopoly is well entrenched by law.

Direct-entry midwives are legal in some states, illegal in others. In a plurality of states their legal status is uncertain. But if a state's medical-practice act includes childbirth among the conditions exclusively reserved for medicine, then direct-entry midwifery is presumed to be illegal. And in the Catch-22 of midwifery regulation, some states (such as Rhode Island) won't let midwives practice without a license but won't license them either.

This patchwork of laws resulted in part from deliberate efforts by organized medicine to create a protected monopoly and in part from an unconscious societal assumption that midwifery had disappeared. During the past few decades, midwifery has been allowed back in a limited role in the form of certified nurse-midwives. CNMs practice legally in every state, but their scope of practice—indeed, their ability to practice at all—is often severely restricted when physicians withhold the requisite institutional or logistical support.

Direct-entry midwives are often prosecuted for practicing either medicine or midwifery without a license. Sometimes these prosecutions help clarify the legal status of midwives. In 1990, after charges were brought against a Pennsylvania midwife who attended Amish clients, a judge ruled that state law did not prohibit the unlicensed practice of "lay" midwifery. But in Illinois in 1991 a court decision calling for clarification of the state's medical-practice act led to legislation that included childbirth within the scope of the act. Midwives have also

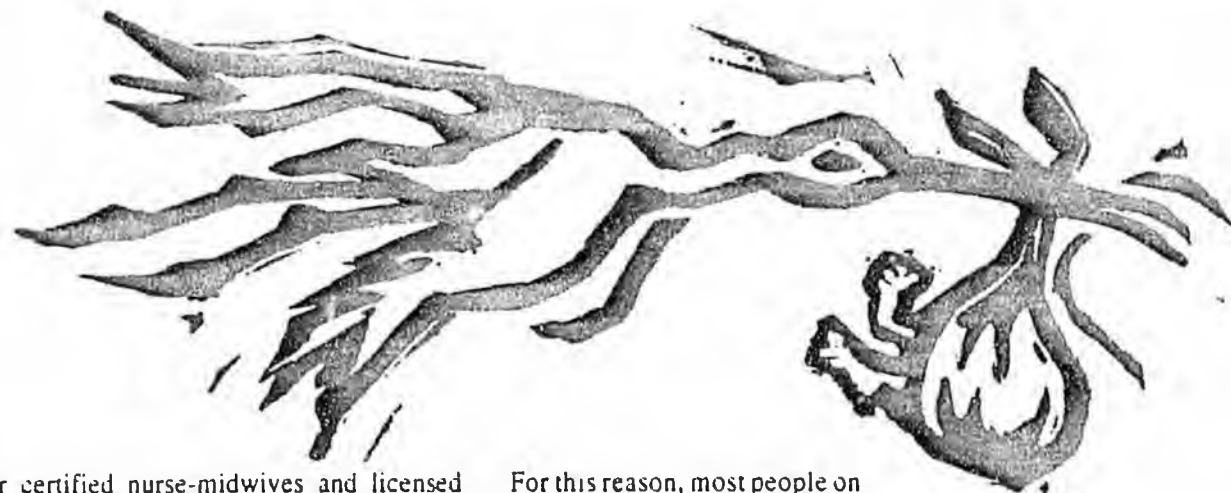
suffered setbacks in Southern states such as Alabama, where public-health departments have forcibly retired the experienced "granny" midwives who often were the only providers of maternity care for the rural or urban poor. In Arkansas, public outcry over such action persuaded the legislature to legalize direct-entry midwifery. In Georgia, however, recently issued regulations have made the practice of direct-entry midwifery a felony.

A decade ago in REASON, Sarah Foster documented the various tactics that the medical establishment uses to intimidate and exclude midwives ("Up Against the Birth Monopoly," September 1982). In one of the more prominent cases to have occurred since then, a local obstetrician pilloried nurse-midwife Debby Sweeney in front of her students at the Medical College of Georgia School of Nursing in 1986, falsely charging that she was practicing medicine illegally and endangering her patients. The obstetrician's group practice prevented Sweeney from continuing to teach in one of the hospitals affiliated with the college, complaining that they "could not allow their patients to be exposed to students who are being instructed by one who advocates the home delivery concept." Sweeney had run afoul of the medical establishment by advertising her home-birth practice.

Such anticompetitive tactics thus far have limited the availability of qualified attendants for out-of-hospital births and deprived women and families of information about birth options. Unless a woman happens to know someone who knows the local midwife, she may see and hear only horror stories about home birth.

Reform is coming, however. Many prestigious institutions are calling for more widespread adoption of midwifery or a low-intervention approach to childbirth. These include the World Health Organization, the European Economic Community, the Institute of Medicine, the Office of Technology Assessment, the General Accounting Office, the American Public Health Association, and the National Commission to Prevent Infant Mortality. The strongest advocacy has come from the women's health movement. A detailed position paper issued jointly in 1990 by the Women's Institute for Childbearing Policy, the National Women's Health Network, the National Black Women's Health Project, and the Boston Women's Health Book Collective argues for a midwifery-based maternity care system that favors out-of-hospital birth settings.

The great stone face of the birth monopoly is visibly cracking. Hospitals hit hard by the loss of obstetricians are advertising for midwives. HMOs, after considerable resistance, are incorporating midwifery services. Boston will be joining New York, San Diego, and other localities in setting up a public out-of-hospital birth center for low-income women. At the federal level, direct reimbursement for midwives has been mandated for the armed services, Civilian Health and Medical Programs of Uniformed Services (CHAMPUS), and Medicaid. One by one, state governments are authorizing limited prescrip-



tion privileges for certified nurse-midwives and licensed direct-entry midwives. They are also beginning to remove the statutory and regulatory barriers to direct third-party reimbursement for midwives.

In a major breakthrough, Ontario recently recognized midwifery as an independent, self-regulating profession authorized to practice in the home, birth center, or hospital. Ontario's action set a precedent for Canada, which had made no provision for midwifery in its national health-care system. In the United States, legislative efforts continue in New York, California, and other states to legalize midwifery as an independent profession.

Licensing clearly is preferable to illegality; however, in states where midwives currently are unregulated, midwives and their supporters are divided over whether it is better to be licensed or to continue on a laissez-faire basis. Midwives who oppose licensing consider midwifery a "spiritual art," in the words of Ohio midwife Kimberly French, that cannot be regulated by uniform standards as medicine is. "Would we be willing to give up certain aspects of our craft in exchange for certification, such as handling breech births, vaginal births after cesareans, and twins?" asks French in the periodical *Friends of Homebirth*. "What about the woman who is left with no other option but a cesarean if we, as midwives, were restricted...by law?"

Furthermore, opponents of licensing are reluctant to exclude midwives who might not meet the formal criteria established by the law. "I feel strongly," writes Maine midwife Jill Breen in *The Midwife Advocate*, "that there always will and should be a place for the apprentice-trained midwife, the community-called midwife, the non-medically-oriented midwife."

With few exceptions, midwives who support licensing do so not to protect their hard-won turf or to save the public from unqualified practitioners, but because they are weary of their denigrated status as "lay practitioners." They are interested not so much in excluding others as in including themselves in the professional health-care system. Longtime Oregon midwifery advocate Alan Solares, whose arguments against licensing were influential a decade ago, has now changed his position. He addresses the concerns of many midwives today who feel that "they cannot fairly compete in a health-care system based increasingly on third-party payment."

Implicit in Solares's argument is the assumption that, in today's highly professionalized society, the benefits of third-party reimbursement, public visibility and trust, and secure hospital backup cannot be obtained without some concession to "professional standards" and "consumer protection."

For this reason, most people on both sides of the debate would welcome a system of voluntary certification such as New Hampshire's, which sets standards for certification but does not bar uncertified midwives from practicing as long as they do not claim to be certified. But this is not a likely prospect in many states.


For now, midwives and others who seek to open up the health-care market will continue to face rear-guard obstacles such as unequal access to reimbursement, regulatory mechanisms that place competing practitioners under the control of physicians, an information monopoly that can frustrate informed choice even when more overt restraints are halted, and a long accumulation of prejudice against non-technological alternatives to conventional health care. The hardest obstacle, however, may well be a certain faintheartedness in the American public, an ingrained reliance on "consumer protection" even at the expense of consumer choice. ■


Archie Brodsky, a senior research associate at the Harvard Medical School's Program in Psychiatry and the Law, is a former president of Massachusetts Friends of Midwives and co-author of Medical Choices, Medical Chances and Home Birth: A Practitioner's Guide to Birth Outside the Hospital. The author is indebted to Carol Sakala of the Women's Institute for Childbearing Policy for some of the information in this article.


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Dollars and Sense: Midwifery Care is Cost-Effective Care

Midwifery Fact Sheet

 The average professional fees of midwives are lower than those of physicians. Therefore, midwifery care can offer a cost-effective, quality-assured alternative to otherwise prohibitive and escalating maternity fees across the state.

 Midwives use fewer expensive technologies to provide safe care. Consequently, client charges are significantly lower. Comparisons of midwifery care and physician care have shown that midwives have equally good outcomes, while using fewer interventions. ^{1,2,3}

 Midwifery care is preventive care. Midwives spend time to provide education, information and social support to their clients. All of these factors have been cited as significant contributors to reducing adverse outcomes, especially prematurity and low birthweight. ^{7,8}

 Midwives are able to offer a choice of birth settings. Out-of-hospital births, either at home or in a licensed birth center, offer the low-risk, healthy woman a safe option at considerable savings. The cost of an out-of-hospital birth is 50% to 70% less than a hospital birth. ³ Recognizing these substantial savings in health dollars, a majority of private health insurance plans now encourage midwife-attended out-of-hospital birth by reimbursing 80- 100% of these charges. ^{12,13}

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Birth Outside the Hospital

Midwifery Fact Sheet

Trends in birth setting.

In 1940, 50% of births in this country took place at home, with a doctor or midwife in attendance. By 1960, birth had been moved almost exclusively into the hospital. During the 1970's, a notable increase in out-of-hospital births signaled a new debate among consumers and health professionals on the appropriate place for labor and birth.

Today, approximately 1% of American families choose to give birth outside the hospital. These families choose home birth, or delivery in a free-standing birth center (not a hospital facility). The majority of out-of-hospital births, in Alaska, as well as throughout the United States, are attended by midwives.

Reasons for out-of-hospital birth:

Why do families choose out-of-hospital birth? A number of consistent themes emerge from the literature including:

- ① increase of control over the childbirth experience;
- ② avoidance of unnecessary medical routines and interventions;
- ③ continuous care by a known and supportive birth attendant;
- ④ labor and delivery among loved ones and in familiar surroundings;
- ⑤ avoidance of the high cost of hospitalization.

Safety: What the Studies Say

For most people concerned with childbirth, a central issue is safety. What do we know about the relative risks of childbirth in various settings? Studies reporting outcomes from well-organized out-of-hospital birth practices, both in the U.S. and abroad, show very low rates of adverse outcomes for mothers and infants. Holland, for example, where 35% of deliveries take place in the home, has one of the lowest perinatal mortality rates in the world. There is no evidence that birth in the hospital is safest for women at low medical risk. ^{1,4}

Some early reports on outcomes of out-of-hospital births were misleading because they compared hospital and non-hospital births without determining whether these births were planned and/or attended by a qualified person. In other words, late miscarriages, premature births, taxi cab deliveries, and other unexpected out-of-hospital births were included in the outcome data. ^{5,6}

Other studies which considered these factors found that the neonatal mortality rates of the planned out-of-hospital births with a qualified attendant averaged 4/1000, below the national rate, while for the unplanned groups the rates averaged 97/1000. ^{7,8,9}

In controlled studies, those births planned to occur outside the hospital with midwives in attendance were associated with lower rates of obstetrical interventions than births planned to occur in the hospital with physicians and other care providers. In some studies, planned out-of-hospital births also had lower rates of complications than the hospital births. ^{10,11,12}

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Several authors have estimated that the probability of an emergent complication arising during an out-of-hospital labor, in a well-screened, healthy population of women, in which the loss of time in transit to a hospital could increase the risk of an adverse outcome, would be less than 1 in 1,000.^{13,14}

Midwifery Practice Ensures Safety

Midwives attending out-of-hospital births ensure optimum safety for their clients by:

- ⊙ Accepting into care only women who have no pre-existing medical conditions, who want to have natural labor and birth (without medical interventions or pain medication) and who are experiencing a normal pregnancy;
- ⊙ Providing comprehensive prenatal care that includes on-going screening for complications, education, support and personal attention;
- ⊙ Ensuring continuous, one-to-one care during labor, carefully monitoring the progress of labor, and maternal/fetal condition;
- ⊙ Maintaining the skills and equipment needed for treating emergent and unexpected conditions, such as hemorrhage or neonatal resuscitation;
- ⊙ Establishing consultation and referral relationships with obstetricians and pediatricians who can provide hospital treatment if indicated.

In summary, an out-of-hospital birth that is planned, with a well-trained attendant, is a safe, satisfying, and economical choice.

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What do international experts say about midwifery?

"...I came to see that midwifery wasn't just a way of substituting cheaper obstetrical care for the poor and deprived...I discovered that the countries with the lowest infant mortality rates in the world also had medical care systems in which the whole of normal obstetrical practice was carried on by midwives."

George A. Silver, M.D.
Professor Emeritus of Public Health, Yale University

Source: *The Next Fifty Years of Nurse-Midwifery Education*, Maternity Center Association, New York, 1983, page 66.

"...there is evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process. Consequently, it is perhaps not surprising that in the U.S. one finds the highest obstetrical intervention rates as well as serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread, independent midwifery practice in the United States as a most important counterbalance to the present situation."

Mursden G. Wagner, M.D.
Maternal and Child Health Officer for the European Region, World Health Organization

Source: "Infant Mortality in Europe: Implications for the United States; Statement to the National Commission to Prevent Infant Mortality". *Journal of Public Health Policy*, Winter 1988: 473-484.

"Midwifery provides a balance between the family and medical perspectives on birth. To negotiate and balance the different meanings and perspectives of birth within the health care system, it is essential for midwives to have a legitimate and powerful role within the system. Midwifery should be powerful enough to influence both the nature and delivery of services. This, I believe, would greatly enhance maternity care, which ultimately is the crux of the matter...the safe, loving and skilled care of women, their babies and their families at one of the most important points of life...birth."

Leslie Page
Director of Midwifery, Oxfordshire, England

Source: "The midwife's role in modern health care" in *The Midwife Challenge*, Sheila Kitzinger, ed. Pandora: London, 1988, page 259-260.

"The midwife must be able to advise the expectant mother, give her moral support, to make her enthusiastic for a natural childbirth, and above all, to supervise her in such a way that all minor and major abnormalities are recognized or at least suspected as early as possible. I am convinced that she is able to do this as well as a doctor, and very often better...Without the presence and acceptance of the midwife obstetrics becomes aggressive, technologic, and inhuman."

G.J. Kloosterman, M.D.
Former President, International Federation of Obstetricians and Gynecologists

Source: "The Midwife: Her Task and Responsibility in a Technologic World" in *The Five Standards for Safe Childbearing*, David Stewart, ed. NAPSAC International: Marble Hill, Missouri, 1981, pages 157-158.

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FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB91

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act providing for coverage of midwife services under Medicaid BRU: Medical Assistance
 Sponsor: Leman Component: Medicaid Non-facility
 Requestor: _____ COMPONENT SERIAL NO. 00229

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	65.0	75.8	88.3	102.9	119.9	139.8
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	65.0	75.8	88.3	102.9	119.9	139.8

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
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REVENUE FUND SOURCE						
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FUNDING:

(Thousands of Dollars)

1002 Federal Receipts	32.5	37.9	44.2	51.4	59.9	69.9
1003 GF Match	32.5	37.9	44.1	51.5	60.0	69.9
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	65.0	75.8	88.3	102.9	119.9	139.8

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 (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is to be read in conjunction with notes for other components of the medical assistance programs. For this bill the components included are Medicaid Facility (00230), Medicaid Non-facility (00229) and Claims Processing (00243). Cost figures for hospitals, physicians, midwives, and claims processing are identified in the attachment.

Prepared by: Dave W. Williams, HPIII *DW Williams* Phone: 465-5826
 Division: Medical Assistance

Date: Mar. 18, 1993

Approved by Commissioner: Theodore A. Mala, MD, MPH *Jay Mala*
 Agency: Department of Health & Social Services

Date: 3-19-93

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Passage of SB 91 would provide another choice to expectant mothers who are dependent upon medical assistance for pregnancy care and childbirth assistance. At present, physician and hospital services are payable under medical assistance along with some pregnancy related nursing services. Payment of direct entry midwife services may have some downward effect on medical assistance program costs to the extent that expectant mothers choose to use midwife services instead of the more costly physician and hospital services.

There are now 10 licensed direct entry midwives in Alaska; a number which might grow to 25 over the next year. The estimated number of births that will be delivered by these professionals during FY94 is 250 of which an estimated 125 would be eligible for reimbursement under the medical assistance program. Of the 125 eligible for Medicaid an estimated 50%, or about 60 births, would be shifted from hospital and physician care to direct entry midwife care.

FY94 Costs:

Medicaid Facility

A survey completed last year of the uncomplicated Medicaid births shows that a course of prenatal care by current licensed providers, with a hospital birth, averages about \$5,000. Based on that survey and updated information the average cost for the hospital portion of services for a birth is calculated as \$3,000. The cost of Medicaid facility services would be reduced by \$180,000 for the 60 births shifted away from hospitals under this bill.

Medicaid Non-facility

Non-facility costs would increase under the bill by the cost of the 125 birthing services provided by direct entry midwives, the cost of any birthing facilities involved, and be reduced by the alternative cost of physician fees for prenatal, delivery, and post-partum care. Direct entry midwife services are costed at an average of \$1,480 per birth (80 percent of the \$1,850 average general public rate). Physician costs are estimated at \$2,000 per birth for pre-natal, delivery, and post-partum.

Midwife services	\$1,480 X 125 = \$185,000
Physician fees	<u>\$2,000 X 60 = (120,000)</u>
Net Medicaid Non-facility	\$ 65,000

Claims Processing

Based on current experience, the addition of a new provider category and services to the Medicaid Management Information System (MMIS, claims payment system) will require \$30,000. Another \$1,500 cost is required for development of a provider manual. These first year costs for changes to the system receive a 75% federal match and require 25% state general funds.

Additional contractual costs will be incurred for processing the claims submitted by nurse midwives. The cost is shown as \$6.23 per claim. This fiscal note assumes that the midwives will submit 2 to 3 claims per month more than would be done by physicians and the submissions would cover 5 months. For the 125 births the cost for claims processing would be approximately \$9,700.

NOTES:

The Alaska Midwife's Association reports a range of fees for service of \$1,400 to \$2,300 with a statewide, non-weighted average fee of \$1,350.

Current statistics from the Bureau of Vital Statistics indicate that approximately 42% of births are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwife's Association indicate a much higher percentage of Medicaid eligibility of 70% to 80%.

This fiscal note assumes 50% eligibility for those using the services.

FY 95 and subsequent year's claims are adjusted for growth at 11% and medical inflation at 5%.

Net fiscal impact of all Division of Medical Assistance fiscal notes for SSSB91 is as follows:

Totals	FY94	FY95	FY96	FY97	FY98	FY99
Medicaid Facility	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
Med. Non-facility	65.0	75.8	88.3	102.9	119.9	139.8
Claims	41.2	11.3	13.2	15.4	17.9	20.9
NET	(73.8)	(122.7)	(143.0)	(166.7)	(194.3)	(226.5)

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB91

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act providing for coverage of midwife services under Medicaid BRU: Medical Assistance
 Sponsor: Leman Component: Medicaid Facility
 Requestor: _____ COMPONENT SERIAL NO. 00230

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
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REVENUE FUND SOURCE						
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FUNDING:

(Thousands of Dollars)

1002 Federal Receipts	(90.0)	(104.9)	(122.2)	(142.5)	(166.0)	(193.5)
1003 GF Match	(90.0)	(104.9)	(122.3)	(142.5)	(166.1)	(193.6)
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)

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 (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is to be read in conjunction with notes for other components of the medical assistance programs. For this bill the components included are Medicaid Facility (00230), Medicaid Non-facility (00229) and Claims Processing (00243). Cost figures for hospitals, physicians, midwives, and claims processing are identified in the attachment.

Prepared by: Dave W. Williams, HPIII *DW* *K. W. B...*
 Division: Medical Assistance

Phone: 465-5826
 Date: Mar. 18, 1993

Approved by Commissioner: *Jay L...*
Theodore A. Mala, MD, MPH
 Agency: Department of Health & Social Services

Date: 3-19-93

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Passage of SB 91 would provide another choice to expectant mothers who are dependent upon medical assistance for pregnancy care and childbirth assistance. At present, physician and hospital services are payable under medical assistance along with some pregnancy related nursing services. Payment of direct entry midwife services may have some downward effect on medical assistance program costs to the extent that expectant mothers choose to use midwife services instead of the more costly physician and hospital services.

There are now 10 licensed direct entry midwives in Alaska; a number which might grow to 25 over the next year. The estimated number of births that will be delivered by these professionals during FY94 is 250 of which an estimated 125 would be eligible for reimbursement under the medical assistance program. Of the 125 eligible for Medicaid an estimated 50%, or about 60 births, would be shifted from hospital and physician care to direct entry midwife care.

FY94 Costs:

Medicaid Facility

A survey completed last year of the uncomplicated Medicaid births shows that a course of prenatal care by current licensed providers, with a hospital birth, averages about \$5,000. Based on that survey and updated information the average cost for the hospital portion of services for a birth is calculated as \$3,000. The cost of Medicaid facility services would be reduced by \$180,000 for the 60 births shifted away from hospitals under this bill.

Medicaid Non-facility

Non-facility costs would increase under the bill by the cost of the 125 birthing services provided by direct entry midwives, the cost of any birthing facilities involved, and be reduced by the alternative cost of physician fees for prenatal, delivery, and post-partum care. Direct entry midwife services are costed at an average of \$1,480 per birth (80 percent of the \$1,850 average general public rate). Physician costs are estimated at \$2,000 per birth for pre-natal, delivery, and post-partum.

Midwife services	$\$1,480 \times 125 =$	\$185,000
Physician fees	$\$2,000 \times 60 =$	<u>(120,000)</u>
Net Medicaid Non-facility		\$ 65,000

Claims Processing

Based on current experience, the addition of a new provider category and services to the Medicaid Management Information System (MMIS, claims payment system) will require \$30,000. Another \$1,500 cost is required for development of a provider manual. These first year costs for changes to the system receive a 75% federal match and require 25% state general funds.

Additional contractual costs will be incurred for processing the claims submitted by nurse midwives. The cost is shown as \$6.23 per claim. This fiscal note assumes that the midwives will submit 2 to 3 claims per month more than would be done by physicians and the submissions would cover 5 months. For the 125 births the cost for claims processing would be approximately \$9,700.

NOTES:

The Alaska Midwife's Association reports a range of fees for service of \$1,400 to \$2,300 with a statewide, non-weighted average fee of \$1,850.

Current statistics from the Bureau of Vital Statistics indicate that approximately 42% of births are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwife's Association indicate a much higher percentage of Medicaid eligibility of 70% to 80%.

This fiscal note assumes 50% eligibility for those using the services.

FY 95 and subsequent year's claims are adjusted for growth at 11% and medical inflation at 5%.

Net fiscal impact of all Division of Medical Assistance fiscal notes for SSSB91 is as follows:

Totals	FY94	FY95	FY96	FY97	FY98	FY99
Medicaid Facility	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
Med. Non-facility	65.0	75.8	88.3	102.9	119.9	139.8
Claims	41.2	11.3	13.2	15.4	17.9	20.9
NET	(73.8)	(122.7)	(143.0)	(166.7)	(194.3)	(226.5)

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB91

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act providing for coverage of midwife services under Medicaid BRU: Medical Assistance Administration
 Sponsor: Leman Component: Claims Processing
 Requestor: _____ COMPONENT SERIAL NO. 00243

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	41.2	11.3	13.2	15.4	17.9	20.9
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	41.2	11.3	13.2	15.4	17.9	20.9

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
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REVENUE FUND SOURCE						
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FUNDING:

(Thousands of Dollars)

1002 Federal Receipts	28.5	5.6	6.6	7.7	9.0	10.5
1003 GF Match	12.7	5.7	6.6	7.7	8.9	10.4
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	41.2	11.3	13.2	15.4	17.9	20.9

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 (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is to be read in conjunction with notes for other components of the medical assistance programs. For this bill the components included are Medicaid Facility (00230), Medicaid Non-facility (00229) and Claims Processing (00243). The FY94 cost includes one-time costs for \$30,000 changes to the Medicaid Information System and \$1,500 for development of a provider manual. Costs continuing over fiscal years are for an FY94 claims processing cost estimated to include 2 to 3 claims per month for 5 months for each birth. The cost of each claim is estimated at the current \$6.23. Growth in utilization is estimated at 11% and inflation at 5% per year. Federal participation is shown at 75% for claims processing. Additional information and cost figures for hospitals, physicians, midwives, and claims processing are identified in the attached notes.

Prepared by: Dave W. Williams, HPIII *DW Williams*
 Division: Medical Assistance

Phone: 465-5826
 Date: Mar. 18, 1993

Approved by Commissioner: Theodore A. Mala, MD, MPH *Jay Meyer*
 Agency: Department of Health & Social Services

Date: 3-19-93

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FY94 Costs:

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Midwife services	$\$1,480 \times 125 = \$185,000$
Physician fees	$\$2,000 \times 60 = (120,000)$
Net Medicaid Non-facility	\$ 65,000

Claims Processing

Based on current experience, the addition of a new provider category and services to the Medicaid Management Information System (MMIS, claims payment system) will require \$30,000. Another \$1,500 cost is required for development of a provider manual. These first year costs for changes to the system receive a 75% federal match and require 25% state general funds.

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NOTES:

The Alaska Midwife's Association reports a range of fees for service of \$1,400 to \$2,300 with a statewide, non-weighted average fee of \$1,850.

Current statistics from the Bureau of Vital Statistics indicate that approximately 42% of births are to persons meeting eligibility guidelines for Medicaid services. Reports from the Alaska Midwife's Association indicate a much higher percentage of medicaid eligibility of 70% to 80%.

This fiscal note assumes 50% eligibility for those using the services.

FY 95 and subsequent year's claims are adjusted for growth at 11% and medical inflation at 5%.

Net fiscal impact of all Division of Medical Assistance fiscal notes for SSSB91 is as follows:

Totals	FY94	FY95	FY96	FY97	FY98	FY99
Medicaid Facility	(180.0)	(209.8)	(244.5)	(285.0)	(332.1)	(387.1)
Med. Non-facility	65.0	75.8	88.3	102.9	119.9	139.8
Claims	41.2	11.3	13.2	15.4	17.9	20.9
NFT	(73.8)	(122.7)	(143.0)	(166.7)	(194.3)	(226.5)

S B

9 2



SENATOR FRED F. ZHAROFF

ALASKA STATE LEGISLATURE

P. O. BOX 405, KODIAK, ALASKA 99615 (907) 488-5259 (FAX 1LSO)

DURING SESSION:

STATE CAPITOL, JUNEAU, ALASKA 99801-1182 • (907) 485-3473 • FAX: (907) 483-3043

DISTRICT C

KODIAK ISLAND • RURAL SOUTHEAST • SOUTH KENAI PENINSULA

CSSB 92 Sponsor Statement - Sen. Zharoff

This bill adds a provision in AS 14.08.071 whereby the communities in REAA school areas are able to voice their positions on education and education related issues of concern to them via an advisory vote on the regular school ballot. REAA schools are spread over a wide area, it is often difficult for members of the community to attend board meetings and make their feelings known. This bill allows the school board to adopt a resolution requesting that an advisory question be on the next ballot. They then get a certified count from the communities regarding each communities stance on this question.

The bill was amended in the Community and Regional Affairs Committee to specify the deadline for when the resolutions must be filed with the Division of Elections to accommodate the Division's time frame for preparing the ballot.

The Department of Education and the Division of Elections support this bill. I believe it is a non-controversial bill, and I would appreciate the committee's affirmative action.

POSITION PAPER: DEPARTMENT OF EDUCATION

Division: Administrative Services

Bill Number: SB 92

Bill Title: An Act relating to an advisory vote during regional education attendance area school board elections; and providing for an effective date.

Sponsor: Senator Zharoff

Position Statement: Explain briefly what the bill does, its impact and Department's position, i.e. a) support, b) do not support, c) neutral or d) oppose

SB92 allows REAA school boards to place advisory questions, on the next election ballot. The Department of Education supports this bill because it provides an avenue for citizens to inform REAA school boards of their opinion on relevant educational issues. It therefore, keeps school board members more in touch with the priorities of their constituents.

Director: Garv Bader **Division:** Administrative Services

Signature: *Garv M. Bader* **Date:** Feb 23 1993

Commissioner/Depnty: Jerry Covev/Mike Maher

Signature: *Mike Maher* **Date:** 2/23/93

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SB 92

Revision Date: _____
Title: An Act relating to an advisory vote during regional educational attendance area school board elections; and providing for an effective date.

Dept. Affected: EDUCATION
BRU: Executive Administration
Component: Administrative Services

Sponsor: Senator Zharoff
Requestor: Senator Zharoff's Office

COMPONENT SERIAL NO. 157

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						

REVENUE FUND SOURCE: _____

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other:						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: \$ _____

ANALYSIS: (Attach a separate page if necessary)

There are no costs for the Department of Education associated with Senate Bill 92.

Prepared by: Gary M. Bader
Division: Administrative Services
Approved by Commissioner: _____
Agency: Department of Education

Phone: 465-2875
Date: February 19, 1993
Date: 2/23/93

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FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SB92

Revision Date: _____
Title: REAA Advisory Votes
Sponsor: Senator Zharoff
Requestor: _____

Department Affected: Office of the Governor
BRU: Division of Elections
Component: General and Primary Elections
COMPONENT SERIAL NO. 22

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0.7	0	0	0	0	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	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0.7	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE FUND SOURCE:	0	0	0	0	0	0
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FUNDING:

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0.7	0	0	0	0	0
1005 GF/Program	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0.7	0	0	0	0	0

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 (FY93) impact: 0

ANALYSIS: (Attach a separate page if necessary.) This figure covers cost printing an additional ballot card for 1 REAA.

Prepared by: Shelly Growden, Acting Director
Division: Division of Elections

Phone: 465-4611
Date: 3/22/93

Approved by Commissioner: Lt. Governor John B. Coghill
Agency: Office of the Lt. Governor

Date: 3/22/93

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KETCHIKAN, ALASKA 99901
(907) 225-9658 OR 225-9659

Robert Weinstein
SUPERINTENDENT

March 3, 1993

Senator Fred Zharoff
Alaska Senate
P.O. Box V
Juneau, Alaska 99811

Dear Senator Zharoff:

At its meeting last week, the Southeast Island School District Board of Education reviewed SB 92, your legislation which would allow advisory questions to be placed upon an REAA ballot at the request of the School Board. The Board is in support of this legislation, as the Board believes there needs to be a legal mechanism to permit such advisory votes.

Sincerely,

A handwritten signature in cursive script that reads "Rob Weinstein".

Robert Weinstein
Superintendent

RW:eb

cc: Board Members

SB

101

Department of Health and Social Services
Division of Public Assistance
February 16, 1993

DISCUSSION PAPER
SENATE BILL NO. 101/HOUSE BILL NO. 67

Senate Bill 101/House Bill 67 are identical measures that represent the Administration's response to the problems of welfare dependency and increasing costs in Alaska's cash public assistance programs. This set of changes has the dual goals of producing immediate savings in program costs and curbing the rate of increase in the welfare caseload.

SB 101/HB 67 achieves substantial cost savings in the Aid to Families with Dependent Children (AFDC) program by reducing benefit payments by 6.3 percent to January 1991 levels, suspending the calendar year 1994 automatic cost-of-living allowance (COLA) adjustment in payment levels, and reducing the payment standards for two-parent AFDC families (AFDC Unemployed Parent and Incapacitated Parent cases) to the same level as the standards for single-parent (AFDC Basic) families.

In addition to saving program dollars, this change establishes payment equity among single-parent and two-parent AFDC families of the same size. SB 101/HB 67 also makes a cost-neutral adjustment to the payment standards for AFDC families headed by a non-needy relative in order to bring Alaska's AFDC program into conformity with federal requirements that payment standards be incremented equally for each additional child.

SB 101/HB 67 amends the Adult Public Assistance (APA) statutes to achieve savings in payments to the aged, disabled, and blind. APA benefits are reduced to the level in effect in January 1990, resulting in a net reduction in assistance to individual recipients of 3.7 percent. The scheduled January 1994 COLA increase is suspended. The APA statutes are also amended to allow the State to be reimbursed for Interim Assistance paid to individuals applying for federal Supplemental Security Income (SSI) benefits by collecting the Interim Assistance from their retroactive entitlement to SSI benefits.

SECTIONAL ANALYSIS of SB 101/HB 67

Section 1 of the bill amends AS 47.25.320(a) to reduce Aid to Families with Dependent Children (AFDC) maximum payment levels by 6.3 percent, effectively rolling them back to the levels in effect on January 1, 1991. The maximum grant amounts specified in the current statute were established in 1982.

Under the COLA provision at AS 47.25.320(d), those amounts have been increased annually to reflect cost-of-living increases. The maximum monthly grant amount for one adult and one child is specified in AS 47.25.320(a)(2)(A) as \$500; COLA adjustments have increased this standard to \$845 as of January 1993. Section 1 reduces the standard to \$792.

This section makes a similar adjustment to the payment increment for additional children specified at AS 47.25.320(a)(2)(C). The increment has increased because of COLA adjustments from \$65 in 1982 to \$105 in 1993; SB 101/HB 67 reduces the increment to \$98 for each additional child.

Section 1 amends AS 47.25.320(a)(3) to reduce by 6.3 percent the maximum grant amount for a pregnant woman in her last trimester or an adult whose only dependent child receives SSI benefits. The maximum grant amount specified for such "Adult-only" AFDC cases is set by regulation at \$530 per month as of January 1993. Section 1 reduces the standard to \$497.

Section 1 also amends and renumbers AS 47.25.320(a)(2)(C) to restructure the payment standards for AFDC Unemployed Parent and Incapacitated Parent families by setting the increment for the second parent at \$98, the same as the increment for a second or additional child. The increment for the second parent is currently set by regulations at 7 AAC 45.520 (a)(2) and statute at AS 45.25.320(e). The January 1993 payment standard for a family of two parents and one child is \$1040. This change reduces the standard to \$890 and adds \$98 for each additional child, the same as the proposed standards for single-parent households of the same size.

Finally, Section 1 restructures the payment standards for AFDC households headed by a non-needy specified relative ("Adult-not-included" cases). This cost-neutral change is necessary to conform the program to federal law. The federal Department of Health and Human Services has cited Alaska's AFDC payment standards for households of this type as out of compliance with the requirement that the payment increment for each child above the base level for one child be the same.

Current law sets the payment standard for one child at \$200, two children at \$400, and the increment for a third or additional child at \$65. COLA adjustments since 1982 have increased these standards to \$335 for one child, \$672 for two, and \$105 for each additional child as of January 1993. Section One sets the standard at \$452 for one child and \$98 for each additional child.

The changes in benefit levels imposed by Section 1 would take effect on July 1, 1993.

Section 2 of the bill amends AS 47.25.320(d) to suspend for calendar 1994 the automatic COLA adjustment to the AFDC payment standards. This adjustment, which is based on the federal SSI COLA, occurs each January and is expected to be approximately 3 percent in January 1994. Section 2 also includes language that directs that the 1994 COLA, as well as the previous AFDC COLAs that are, in effect, rescinded by Section 1, will not be restored after 1994. Under Section 2, the annual AFDC COLA adjustments would resume in calendar 1995.

Section 3 allows the Department of Health and Social Services to use its regulatory authority to set standards of need that exceed the payment standards set in Section 1. Federal law allows the states to pay a reduced percentage (a "ratable reduction") of the amount that is established as necessary for the basic household expenses that the AFDC payment is intended to cover. Alaska has historically paid 100 percent of need.

Ratable reductions may be structured to create a payment "gap" that works as an incentive for recipients to earn income. The administration intends to use the authority provided in Section 3 to establish AFDC need standards that are 6.3 percent above the payment standards set in Section 1, effectively maintaining the January 1993 basic need standards and creating a small payment gap that assures that current AFDC recipients who receive small grants will continue to be eligible for Medicaid and Job Opportunities and Basic Skills Training (JOBS) program services, and providing a small incentive for recipients to work.

The authority provided by Section 3 could also be used, given sufficient appropriations to cover additional AFDC and Medicaid program costs, to create a larger payment gap that allows recipients to retain more of their earnings and earn larger amounts without losing eligibility for AFDC and AFDC-related benefits.

Section 4 amends 47.25.430(b) to suspend the January 1994 COLA increase in Adult Public Assistance benefits. This adjustment, which is based on the federal SSI COLA, is expected to be approximately 3 percent. Section 4 also includes language that directs that the 1994 COLA, as well as the previous APA COLAs that are, in effect, rescinded by Section 5, will not be restored after 1994. Under Section 4, the annual APA COLA adjustments would resume in calendar 1995.

Section 5 amends AS 47.25.430(a) to reduce Adult Public Assistance payments to the levels in effect on January 1, 1990. The January 1993 APA payment to a typical individual who also receives SSI benefits is \$374; Section 5 would reduce that payment to \$331. The payment to a typical couple would be reduced from \$544 to \$484.

Because of increases in the amount of SSI benefits since 1990, the total assistance income of a typical single APA recipient would decrease from \$808 (combined SSI and APA) to \$778 - a reduction of 3.7 percent. A typical couple's combined assistance would be reduced from \$1196 to \$1156 - a 3.3 percent reduction. The APA benefits of recipients who do not receive SSI would be similarly reduced.

The APA need standards are set by regulation at 7 AAC 40.310. Section 5 gives the Department of Health and Social Services the direction and authority to reduce the standards.

The changes in benefit levels imposed by Section 5 would take effect on July 1, 1993.

Section 6 amends AS 47.25.455 to allow the state to be reimbursed for Interim Assistance benefits paid to APA applicants while they are waiting for the Social Security Administration to determine their disability. Social Security typically takes 4 months or longer to make a disability determination. APA applicants must be disabled under SSI standards before they qualify for regular APA and Medicaid benefits; Interim Assistance provides these individuals with a \$280 monthly payment for basic living expenses until they are determined eligible to receive SSI and regular APA benefits.

Once APA applicants are determined to be disabled, they are retroactively eligible for SSI from the date they applied. Such individuals typically receive 4 or more months of retroactive SSI benefits (at up to \$434 per month) for the months they received Interim Assistance. Federal law allows the states to be reimbursed for the Interim Assistance from the applicant's retroactive SSI benefits. Section 6 establishes the authority for Interim Assistance reimbursement in Alaska by requiring applicants to repay the Interim Assistance they receive if they are found eligible for SSI. The Social Security Administration would make the individual's retroactive SSI payment to the Division of Public Assistance. DPA would retain the first \$280 of each month's retroactive SSI benefit and forward the balance to the recipient.

Section 6 also eliminates retroactive eligibility for regular APA benefits to individuals who have received Interim Assistance. Under current law, an Interim Assistance recipient who is found eligible for SSI is retroactively entitled to APA benefits; this entitlement is reduced by the amount of Interim Assistance the individual already received each month. Interim Assistance reimbursement will achieve savings only if the retroactive entitlement is eliminated. Section 6 adds a new subsection (d) to AS 47.25.455 that repeals the retroactive entitlement to APA benefits of Interim Assistance who are found eligible for SSI.

The changes in Section 6 take effect on July 1, 1993.

Section 7 repeals AS 47.25.320(e), which established the payment standards for AFDC Unemployed Parent cases when the AFDC-UP program was enacted in 1990. This change is necessary to conform to the change to AS 47.25.320(a)(2) made in Section 1, establishing the payment standards for two-parent AFDC families at the same level as the standards for single-parent families.

Section 8 provides transitional authority to allow DHSS to adopt implementing regulations for SB 101/HB 67 before the effective date of the law. The regulations would take effect on the effective date of the legislation. This provision is intended to facilitate timely implementation on the statutory changes included in the bill.

Section 9 provides for an effective date for the bill of July 1, 1993.

FISCAL NOTE

No. 5

Bill Version: SB 101

STATE OF ALASKA
1993 LEGISLATIVE SESSION

I (S) Publish Date: 2-5-93

Revision Date: _____	Dept. Affected: <u>Health and Social Services</u>
Title: <u>An Act Relating to Eligibility</u>	BRU: <u>Assistance Payments BRU</u>
<u>for and Payments of Public Assistance. Section 2'</u>	Component: <u>Aid to Families with Dependent Children (AFDC)</u>
Sponsor: _____	COMPONENT SERIAL NO. <u>0220</u>
Requestor: <u>Governor</u>	

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(2,107.3)	(4,424.4)	(4,645.7)	(4,878.0)	(5,121.9)	(5,378.0)
MISCELLANEOUS						
TOTAL OPERATING	(2,107.3)	(4,424.4)	(4,645.7)	(4,878.0)	(5,121.9)	(5,378.0)

CAPITAL						
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REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts	(960.9)	(2,017.5)	(2,118.5)	(2,224.4)	(2,335.5)	(2,452.5)
1003 GF Match	(960.9)	(2,017.5)	(2,118.5)	(2,224.4)	(2,335.5)	(2,452.5)
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other	(185.5)	(389.4)	(408.7)	(429.2)	(450.9)	(473.0)
TOTAL	(2,107.3)	(4,424.4)	(4,645.7)	(4,878.0)	(5,121.9)	(5,378.0)

POSITIONS:

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

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

SUSPEND AFDC COLA

Formula AFDC program savings from suspension of the COLA in FY94.

The FY94 reduction is included in the FY94 Gov Budget. DO NOT Duplicate Reduction.

Prepared by: Jan L. Hansen, Director *for Randy...*
 Division: Division of Public Assistance
 Approved by Commissioner: Theodore A. Mala, MD, MPH
 Agency: Department of Health and Social Services

Phone: 465-3347
 Date: 12/30/92
 Date: 12/31/92

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Suspend AFDC COLA

The Division of Public Assistance administers two assistance programs which have statutory provisions for annual cost-of-living payment increases: Aid to Families with Dependent Children (AFDC) and Adult Public Assistance (APA). Under existing statutes, benefit levels for both of these entitlement programs are increased by the same percentage as any cost-of-living adjustment (COLA) in the federal Supplemental Security Income program. These benefit adjustments are made in January of each year; we currently estimate that the January 1994 adjustments will be 3.0 percent.

This proposes legislation that provides for a suspension of the cost-of-living adjustment in the AFDC program during fiscal year 1994. The general fund savings by this action would be approximately \$960.9 million.

Suspending the COLAs does not reduce individual benefit amounts; it simply does not award an increase in January 1994, leaves statutory authority in place to award COLAs in future years, and reduces the base on which future COLAs will be awarded.

The COLA percentage could be awarded in the AFDC standard of need, and not in AFDC payment calculations, creating a payment gap that serves as an incentive to work. Increased Food Stamp benefits will partially offset the loss of the COLA in household budgets.

Since July 1, 1980 AFDC and APA need standards and maximum payment levels have been automatically increased annually by the same percentage of Social Security and SSI benefits increase. In addition to the automatic COLA the legislature approved AFDC and APA benefit level increases in 1981 and 1983. These increases have maintained formula program maximum payment levels measured as a percentage of the Federal Poverty Guideline for Alaska at approximately 77% for an AFDC family of three and 111% for a single APA client (125% APA couple).

Assumptions used in fiscal note calculation:

1. The January 1, 1994 Federal SSI COLA will be 3.0%.
2. AFDC program caseloads increase at an average annual rate of 5%.
3. Proposed legislation provides for suspension of the January 1, 1994 COLA.

Currently maximum benefit levels are set by AS 47.25.320(a) and 7 AAC 45.520. These benefit levels vary according to size and composition of the assisted family. In accordance with AS 47.25.320(d), AFDC benefits (funded 50% General Fund, 50 percent federal match) are adjusted upward in January of each year by the same percentage as the federal Supplemental Security Income (SSI) program cost-of-living adjustment.

The FY94-FY99 formula impact of the COLA assumes the suspension of the January 1994 increase is not restored retroactively, therefore the maximum AFDC payment base is lower in subsequent fiscal years. FY95 is the first full year of impact of suspension of the January 1994 COLA. The impact in FY94 occurs only during the second six months of the fiscal year.

AFDC	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>FY98</u>	<u>FY99</u>
AFDC Caseload Average Caseload	13858	14550	15278	16042	16844	17686
* Average Payment reduction for the 1/1/94 COLA suspension that is not restored retroactively	\$25.34	\$25.34	\$25.34	\$25.34	\$25.34	\$25.34
TOTAL FY REDUCTION	2107.3	4424.4	4645.7	4878.0	5121.9	5378.0
Funding Source						
Federal	960.9	2017.5	2118.5	2224.4	2335.5	2452.5
GF	960.9	2017.5	2118.5	2224.4	2335.5	2452.5
I/A	185.5	389.4	408.7	429.2	450.9	473.0

* The \$25.34 per year represents the minimum savings as the actual savings would be compounded annually by any subsequent COLAS.

The FY94 reduction is included in the FY94 agency budget request. Do not duplicate reduction.

FISCAL NOTE

Bill Version: SB 101

STATE OF ALASKA
1993 LEGISLATIVE SESSION

B) (S) Publish Date: 2-5-93

Revision Date: _____ Dent. Affected: Health and Social Services
 Title: An Act Relating to Eligibility BRU: Assistance Payments BRU
for and Payments of Public Assistance. Sections 1, 2, 3 Component: Aid to Families with Dependent Children (AFDC)
 Sponsor: _____ COMPONENT SERIAL NO. 0220
 Requestor: Governor

Expenditures/F revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(8,600.1)	(9,035.3)	(9,482.1)	(9,956.3)	(10,454.0)	(10,976.6)
MISCELLANEOUS						
TOTAL OPERATING	(8,600.1)	(9,035.3)	(9,482.1)	(9,956.3)	(10,454.0)	(10,976.6)
CAPITAL						

REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts	(3,921.6)	(4,120.0)	(4,324.0)	(4,540.0)	(4,767.0)	(5,005.5)
1003 GF Match	(3,921.6)	(4,120.0)	(4,324.0)	(4,540.0)	(4,767.0)	(5,005.5)
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other	(756.9)	(795.3)	(834.1)	(876.3)	(920.0)	(965.6)
TOTAL	(8,600.1)	(9,035.3)	(9,482.1)	(9,956.3)	(10,454.0)	(10,976.6)

POSITIONS:

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

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

IMPLEMENT RATABLE REDUCTION

Formula AFDC program savings from a ratable reduction in AFDC payment level.

The FY94 reduction is included in the FY94 Gov Budget. DO NOT Duplicate Reduction.

Prepared by: Jan L. Hansen, Director for Ranklyman, acting
 Division: Division of Public Assistance
 Approved by Commissioner: Theodore A. Mala by Jaggdwar
 Agency: Department of Health and Social Services

Phone: 465-3347
 Date: 12/30/92
 Date: 12/31/92

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Ratable Reduction in AFDC Payment Level

Aid to Families with Dependent Children (AFDC)

This proposes legislation that provides for a ratable reduction of AFDC benefits. A provision of the Medicare Catastrophic Illness Act of 1988 requires, as a condition of future approval of Medicaid State Plans, maintenance of AFDC payment levels at or above those in effect for April 1988.

A ratable reduction of monthly maximum payments to their 1991 benefit level would result in an average payment reduction per family of \$52 for each month of FY94.

Ratable reductions are the single most effective method of immediately reducing program costs. They equitably distribute benefit reductions across the caseload, rather than impact specific groups. Food Stamp benefit increases will partially offset the decreases in cash benefits.

The AFDC reduction can be structured to create a "gap" between the need standard and the payment standard which creates an incentive for earned income by allowing for increased income from earnings without termination of AFDC. "GAP" exists when payments are made at a percentage of the need standard. Reductions in AFDC benefits will also make AFDC a slightly less attractive alternative to work.

Of the 39,911 people who will receive AFDC each month, 24,759 are children under the age of 19. Roughly two-thirds of all AFDC households consist of a parent and one or two children, with no other source of cash income but the PFD. The typical AFDC household in Alaska consists of a mother and one child. In FY94, without the reductions, this household would have expected to receive \$871 per month in AFDC cash assistance, assuming no other source of income. In all months that this family receives assistance, the grant amount will be reduced by \$79 due to imposition of a ratable reduction to the 1991 payment level. The AFDC formula reduction from this reduction is \$8.6 million (\$3.9 million GF).

Assumptions used in fiscal note calculation:

1. AFDC program caseloads increase at an average annual rate of 5%.
2. The ratable reduction to AFDC maximum payment levels is to 1991 levels. This effectively rolls back COLA increases of 3.0% (January 1, 1993) and 3.7% (January 1, 1992).
3. The adjustment in payments is effective July 1, 1993.

Maximum benefit levels are set by AS 47.25.320(a) and 7 AAC 45.520. These benefit levels vary according to the size and composition of the assisted family. In accordance with AS 47.25.320(d), AFDC benefits (funded 50 percent General Fund, 50 percent federal match) are adjusted upward in January of each year by the same percentage as the federal Supplemental Security Income (SSI) program cost-of-living adjustment.

A provision of the Medicare Catastrophic Coverage Act of 1988 requires, as a condition of future approval of Medicaid State Plans, maintenance of AFDC payment levels at or above those in effect for April 1988. The proposed reduction does not conflict with this requirement, so long as payments remain at or above the April 1988 level.

The FY94-FY99 formula impact of the ratable reduction assumes the reduction is not restored retroactively, therefore the maximum AFDC payment base is lower in subsequent fiscal years.

AFDC	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>FY98</u>	<u>FY99</u>
AFDC Caseload Average Caseload	13858	14558	15278	16042	16844	17686
* Average Payment reduction for the ratable reduction that is not restored retroactively	\$51.71	\$51.72	\$51.72	\$51.72	\$51.72	\$51.72
TOTAL FY REDUCTION	8600.1	9035.3	9482.1	9956.3	10454.0	10976.5
Funding Source						
Federal	3921.6	4120.0	4324.0	4540.0	4767.0	5005.5
GF	3921.6	4120.0	4324.0	4540.0	4767.0	5005.5
I/A	756.9	795.3	834.1	876.3	920.0	965.6

* The \$51.72 per year represents the minimum savings as the actual savings would be compounded annually by any subsequent COLAS.

The FY94 reduction is included in the FY94 agency budget request. Do not duplicate reduction.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Bill Version: SB 101

BI (S) Publish Date: 2-5-93

Revision Date: _____ Dept. Affected: Health and Social Services
Title: An Act Relating to Eligibility BRU: Assistance Payments BRU
for and Payments of Public Assistance, Sections 4, 5 Component: Adult Public Assistance (APA)
Sponsor: _____
Requestor: Governor COMPONENT SERIAL NO. 0222

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(4,051.9)	(4,247.7)	(4,460.2)	(4,683.3)	(4,917.4)	(5,163.4)
MISCELLANEOUS						
TOTAL OPERATING	(4,051.9)	(4,247.7)	(4,460.2)	(4,683.3)	(4,917.4)	(5,163.4)

CAPITAL						
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REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(3,815.6)	(4,001.0)	(4,202.0)	(4,412.0)	(4,632.0)	(4,864.0)
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other	(236.3)	(246.7)	(258.2)	(271.3)	(285.4)	(299.4)
TOTAL	(4,051.9)	(4,247.7)	(4,460.2)	(4,683.3)	(4,917.4)	(5,163.4)

POSITIONS:

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

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

IMPLEMENT RATABLE REDUCTION

Formula APA program savings from a ratable reduction in APA payment level.

The FY94 reduction is included in the FY94 Gov Budget. DO NOT Duplicate Reduction.

Prepared by: Jan L. Hansen, Director
Division: Division of Public Assistance
Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services

Phone: 465-3347
Date: 12/30/92
Date: 12/31/92

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Ratable Reduction in APA Payment Level

Adult Public Assistance (APA)

Federal rules require, as a condition of federal Medicaid funding, APA payment levels at least as high as those in effect for March 1983 or maintenance of total program expenditures for the immediately preceding year. A reduction to the 1990 APA maximum payment level would result in an average payment reduction per client of approximately \$37 for each month of FY94. Ratable reductions are the single most effective method of immediately reducing program costs. They equitably distribute benefit reductions across the caseload, rather than impact specific groups.

Food Stamp benefit increases will partially offset decreases in cash benefits.

In FY94, the maximum state supplemental payment for an APA individual living independently is \$384. A ratable reduction to the 1990 payment level would reduce the state payment to an individual APA client by \$53 each month. The APA payment is currently 111% of poverty and would be reduced to 104% of poverty. The APA formula reduction from the ratable is 3.8 million GF.

Assumptions used in fiscal note calculation:

1. APA program caseloads increase at an average annual rate of 5%.
2. The ratable reduction to APA maximum payment levels is to 1990 levels. This rolls back COLA increases of 3.0% (January 1, 1993) 3.7% (January 1, 1992) and 5.4% (January 1, 1991).
3. The adjustment in payments is effective July 1, 1993.

Adult Public Assistance payment levels are set in regulation at 7 AAC 40.310, as authorized by AS 47.25.430(b). These benefit levels vary according to the composition of the household and the type of living arrangement. Current statute at AS 47.25.430(b), provides for COLA adjustments at the same percentage as the SSI program. APA payments are funded with 100 percent General Fund monies.

The APA program is essentially supplemental to federal Social Security and SSI benefits; APA applicants are required to apply for payments from the Social Security Administration, and nearly all APA recipients receive federal payments which are subtracted from the APA maximum payment standard to determine the amount of their APA payments. Under current state law, both federal benefit levels and APA benefit levels are adjusted concurrently each January.

Federal rules require, as a condition of federal Medicaid matching funds, maintenance of APA payment levels at least as high as those in effect for March 1983, or maintenance of total APA program expenditures for a calendar year at a level at least as great as the expenditures for the immediately preceding year (Interim Assistance expenditures are not considered in the calculation.) Alaska's compliance is not threatened by this proposed ratable reduction in APA payments.

The FY94-FY99 formula impact of the ratable reduction assumes the reduction is not restored retroactively, therefore the maximum APA payment base is lower in subsequent fiscal years.

APA	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>FY98</u>	<u>FY99</u>
APA Caseload Average Caseload(less Interim Assistance)	9207	9653	10136	10643	11175	11734
*Average Payment reduction for the ratable reduction that is not restored retroactively	\$36.67	\$36.67	\$36.67	\$36.67	\$36.67	\$36.67
TOTAL FY REDUCTION	4051.9	4247.7	4460.2	4683.3	4917.4	5163.4
GF	3815.6	4001.0	4202.0	4412.0	4632.0	4864.0
I/A	235.3	246.7	258.2	271.3	285.4	299.4

*The \$36.67 per year represents the minimum savings as the actual savings would be compounded annually by any subsequent COLAS.

The FY94 reduction is included in the FY94 agency budget request. Do not duplicate reduction.

FISCAL NOTE

No. 2

Bill Version: SB 101

(S) Publish Date: 2-5-93

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act Relating to Eligibility BRU: Assistance Payments BRU
for and Payments of Public Assistance, Section 6 Component: Adult Public Assistance (APA)
 Sponsor: _____
 Requestor: Governor COMPONENT SERIAL NO. 0222

Expenditures/Revenues:	(Thousands of Dollars)					
	FY94	FY95	FY96	FY97	FY98	FY99
OPERATING						
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING:	(Thousands of Dollars)					
1002 Federal Receipts	434.0	1,016.3	1,076.1	1,135.9	1,195.7	1,255.5
1003 GF Match						
1004 GF	(434.0)	(1,016.3)	(1,076.1)	(1,135.9)	(1,195.7)	(1,255.5)
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

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

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

IMPLEMENT INTERIM ASSISTANCE REIMBURSEMENT

Enact Interim Assistance Reimbursement that recovers state Interim Assistance benefits from the retroactive SSI benefits of applicants found eligible for SSI.

The FY94 GF savings is included in the FY94 Gov Budget. DO NOT Duplicate Reduction.

Prepared by: Jan L. Hansen, Director *for Randy Moran, acting* Phone: 465-3347
 Division: Division of Public Assistance Date: 12/30/92
 Approved by Commissioner: Theodore A. Mala, MD, MPH *Theodore A. Mala by Jay Stuey* Date: 12/31/92
 Agency: Department of Health and Social Services

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Enact Interim Assistance Reimbursement and Eliminate Retroactive APA Payments to Interim Assistance Recipients After SSI Application Approved.

State statute AS 47.25.455 requires the State to pay \$280 per month to persons eligible under this statute while the Social Security Administration is processing their disability applications. SSI regulations allow states to be reimbursed for their Interim Assistance costs out of the retroactive SSI entitlements of applicants who are ultimately found eligible for federal SSI benefits.

Because of concerns that disability assistance can be easily abused, the process of proving or disproving disability for Social Security purposes has gradually become lengthy and complex. Concerns that people may need help badly while that process is allowed to unfold led to Alaska's enactment of Interim Assistance for APA Aid to the Disabled applicants who are awaiting a disability determination by the Social Security Administration. Although a high proportion (about 60%) of all Disability applicants are ultimately determined to be not legally disabled, an Alaska Supreme Court decision (Moore v. Beirne) determined that AS 47.25.455 requires that the state continue interim assistance until all Social Security administrative processes are complete and all administrative appeal rights have been exhausted.

Under existing state law, Alaska applicants for Adult Public Assistance receive Interim Assistance for an average of 8.8 months before a decision is made on their eligibility for SSI benefits. The Interim Assistance case is converted retroactively to Adult Public Assistance, effective with the date of APA application, after the SSI decision is made. Interim Assistance recipients receive \$280 in Interim Assistance. The proposed change does not eliminate any monthly assistance payments to recipients; it simply recovers Interim Assistance by reducing retroactive windfall payments.

The proposed changes to AS 47.25.455 would enable DHSS to effectively recover Interim Assistance benefits from the retroactive SSI benefits of APA applicants who are found eligible for SSI. APA applicants would be required to agree to have their retroactive SSI benefits paid to DHSS to reimburse the state for the Interim Assistance they would receive. There would be no retroactive entitlement to regular APA benefits.

\$280 of the monthly retroactive SSI benefit would be collected by DHSS, and the remaining \$154 in retroactive SSI would be paid to the client.

	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>FY98</u>	<u>FY99</u>
Cases per month	32	34	36	38	40	42
Average Reimbursement Amount	\$1130.20	\$2491	\$2491	\$2491	\$2491	\$2491
TOTAL	434.0	1016.3	1076.1	1135.9	1195.7	1255.5

The FY94 reduction is included in the FY94 agency budget request. Do not duplicate reduction.

282

FISCAL NOTE

Bill Version: SB101

(S) Publish Date: 2-5-93

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act Relating to Eligibility BRU: Assistance Payments BRU
for and Payments of Public Assistance, Section 4 Component: Adult Public Assistance (APA)
 Sponsor: _____
 Requestor: Governor COMPONENT SERIAL NO. 0222

Expenditures/Revenues: (Thousands of Dollars)

	FY94	FY95	FY96	FY97	FY98	FY99
OPERATING						
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(607.7)	(1,274.2)	(1,338.0)	(1,404.8)	(1,475.1)	(1,548.8)
MISCELLANEOUS						
TOTAL OPERATING	(607.7)	(1,274.2)	(1,338.0)	(1,404.8)	(1,475.1)	(1,548.8)

CAPITAL						
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REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

	FY94	FY95	FY96	FY97	FY98	FY99
1002 Federal Receipts						
1003 GF Match						
1004 GF	(572.2)	(1,200.2)	(1,260.4)	(1,323.3)	(1,389.5)	(1,459.0)
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other	(35.5)	(74.0)	(77.6)	(81.5)	(85.6)	(89.8)
TOTAL	(607.7)	(1,274.2)	(1,338.0)	(1,404.8)	(1,475.1)	(1,548.8)

POSITIONS:

	FY94	FY95	FY96	FY97	FY98	FY99
FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

SUSPEND APA COLA

Formula APA program savings from suspension of the COLA in FY94.

The FY94 reduction is included in the FY94 Gov Budget. DO NOT Duplicate Reduction.

Prepared by: Jan L. Hansen, Director for Ranlym, acting
 Division: Division of Public Assistance
 Approved by Commissioner: Theodore A. Mala, MD, MPH
 Agency: Department of Health and Social Services

Phone: 465-3347
 Date: 12/30/92
 Date: 12/31/92

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Suspend APA COLA

The Division of Public Assistance administers two assistance programs which have statutory provisions for annual cost-of-living payment increases: Aid to Families with Dependent Children (AFDC) and Adult Public Assistance (APA). Under existing statutes, benefit levels for both of these entitlement programs are increased by the same percentage as any cost-of-living adjustment (COLA) in the federal Supplemental Security Income program. These benefit adjustments are made in January of each year; we currently estimate that the January 1994 adjustments will be 3.0 percent.

This proposes legislation that provides for a suspension of the cost-of-living adjustment in the APA program during fiscal year 1994. The general funds savings by this action would be approximately \$572.2 million.

Suspending the COLAs does not reduce individual benefit amounts; it simply does not award an increase in January, leaves statutory authority in place to award COLAs in future years, and reduces the base on which future COLAs will be awarded. Increased Food Stamp benefits will partially offset loss of COLAs in household budgets.

Since July 1, 1980 AFDC and APA need standards and maximum payment levels have been automatically increased annually by the same percentage of Social Security and SSI benefits increase. In addition to the automatic COLA the legislature approved AFDC and APA benefit level increases in 1981 and 1983.

These increases have maintained formula program maximum payment levels measured as a percentage of the Federal Poverty Guideline for Alaska at approximately 77% for an AFDC family of three and 111% for a single APA client. (125% APA couple)

Assumptions used in fiscal note calculation:

1. The Federal SSI COLA will be 3.0%.
2. APA program caseload increases at an average annual rate of 5%.
3. Proposed legislation provides for suspension of the January 1, 1994 COLA.

Adult Public Assistance payment levels are set in regulation at 7 AAC 40.310, as authorized by AS 47.25.430(b). These benefit levels vary according to the composition of the household and the type of living arrangement. Current statute at AS 47.25.430(b) provides for COLA adjustments at the same percentage as the SSI program. APA payments are funded with 100 percent General Fund monies.

The APA program is essentially supplemental to federal Social Security and SSI benefits; APA applicants are required to apply for payments from the Social Security Administration, and nearly all APA recipients receive federal payments which are subtracted from the APA maximum payment standard to determine the amount of their APA payments. Under current state law, both federal benefit levels and APA benefit levels are adjusted concurrently each January.

Federal rules require, as a condition of federal Medicaid matching funds, maintenance of APA payment levels at least as high as those in effect for March 1983, or maintenance of total APA program expenditures for a calendar year at a level at least as great as the expenditures for the immediately preceding year (Interim Assistance expenditures are not considered in the calculation.) Alaska's compliance is not threatened by a one-year suspension of the APA COLA.

Under this proposed change in the law, the State will pass along the 1/1/94 COLA increase allowed in the federal SSI program, but will not increase the state supplemental contribution to recipients.

The FY94-FY99 formula impact of the COLA assumes the prior suspension of the January 1994 increase is not restored retroactively, therefore the maximum APA payment base is lower in subsequent fiscal years. FY95 is the first full year of impact of suspension of the January 1994 COLA. The impact in FY94 occurs only during the second six months of the fiscal year.

APA	<u>FY94</u>	<u>FY95</u>	<u>FY96</u>	<u>FY97</u>	<u>FY98</u>	<u>FY99</u>
APA Caseload Average Caseload (less Interim Assistance)	9207	9653	10136	10643	11175	11734
* Average Payment reduction for the 1/1/94 COLA suspension that is not restored retroactively	\$11	\$11	\$11	\$11	\$11	\$11
TOTAL FY REDUCTION	607.7	1274.2	1338.0	1404.8	1475.1	1548.8
GF	572.2	1200.2	1260.4	1323.3	1389.5	1459.0
I/A	35.5	74.0	77.6	81.5	85.6	89.8

*The \$11 per year represents the minimum savings as the actual savings would be compounded annually by any subsequent COLAS.

The FY94 reduction is included in the FY94 agency budget request. Do not duplicate reduction.