ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

8456 SENATE STATE AFFAIRS

The costs incurred by the City and Borough of Sitka (CBS) were attributed to a situation where the costs of replacement employees were higher than anticipated. It was reported to us that the Borough Assembly made the decision to participate in RIP based on projections of salary and benefits for replacement employees that subsequently proved to be inaccurate. When replacement employees were actually paid near or even above the outgoing RIP participant's salary then all projected savings were eliminated, turning the savings program into a cost for CBS.

1989 RIP legislative intent had two aspects

RIP's implementing legislation stated that the program was

> *intended to* ***realize sufficient economies to offset the cost of administration*** *and benefits to state agencies and other employers resulting from the award of retirement credits and to result in* ***a net reduction in personal services costs*** *to the state or other employers during a period of declining revenues.*

This intent has two specific parts. The program was to pay for itself (*realize sufficient economies to offset the cost ...*) and was to provide for savings in personal services costs to the state (*a net reduction in ...*).

Overall, 1989 RIP did pay for itself

As discussed previously, most of the savings realized under the 1989 RIP were of an incremental nature. The assumptions, methodologies, and approach that we used to estimate savings could not practically consider all the variables that could have an affect on the actual savings realized. And as mentioned, seven of the employers appear not to have realized savings to offset the costs of their participation.

Despite these considerations, we are confident that the program achieved the first aspect of its established intent. In our view, on balance, the program ***realized sufficient economies to offset the cost of administration and benefits*** provided as an early retirement incentive. The incremental savings accumulated by the state agencies and other participating employers from RIP did, when considered for the organizations as a whole, exceed the cost to the employer for providing the additional three years of service.

RIP did generate a net reduction in personal service costs but budget impact is uncertain

We are also confident that state agencies realized a *net reduction in personal services costs*, or savings, through RIP. For the RIP participant positions (also known as PCNs for position control number in budgetary terms), where replacements were hired in at lower pay, there was a net reduction. State agencies spent, and will prospectively spend less for those specific PCNs in the first, second, and third years than they would have, had the RIP retiree remained as the incumbent.

Doubts are often expressed about the savings generated by RIP because they rarely, if at all, are reflected in state agency budget requests. Further, the incremental nature of most of the 1989 RIP savings contribute further to this lack of visibility in agency budgets. When savings are generated through the elimination of positions left vacant by RIP participants, then the budgetary impact is more clearly reflected in the fewer number of positions in the agencies' budget requests.

However, when savings are primarily due to the incremental difference between RIP participants' personal service costs and those of their replacements, identifying savings for legislative consideration is more difficult and subtle. Such savings get lost in a blend of budgetary incremental adjustments such as those generated by new union contracts, new positions for new programs, new positions for old programs, adjustments for vacancy and turnover, etc.

Accordingly, we believe the savings shown for the various state agencies in Schedule 2 on page 10 were realistic, and for the most part, have been or will be realized. However, we cannot reasonably estimate how much of these savings were reflected in agency budget requests or remained in year-end balances that lapsed back to the general fund, although we believe that, to some degree, both of these happen.

Savings and program recommendations discussed further in Auditor Comments

In the following Auditor Comments section we offer examples of how state agencies may be using RIP-generated savings, and discuss how the university is using savings for what they term "budget reallocation" and "budget reduction" purposes. We also suggest that the legislature provide for improved monitoring of RIP-generated savings, when considering any future RIPs.

AUDITOR COMMENTS

As concluded in the previous section, we are confident that RIP generated a *net reduction in personal services costs* (as intended by its authorizing legislation). However, existence of these savings is met with some skepticism, because they do not appear to be reflected in state agency operating budgets. Often, agencies take advantage of the flexibility afforded from the reduction of personal services costs to reallocate and use the savings without legislative budgetary oversight. To the skeptics, and from a conservative budgetary viewpoint, to the extent this occurs, such reallocations do not represent savings, nor do they result in a *net reduction in personal services costs*.

Four examples illustrate how RIP "savings" may have been used besides budget reduction

For example, consider the *net reduction in personal service costs* that may or may not be involved in the following situations:

1. RIP savings are used to hire temporary staff. With the RIP savings that an agency generates in its personal services budget, management decides to hire temporary workers to carry out a special project. The work was important, necessary to the agency's functioning, but until the flexibility provided by the RIP, the agency never had the available funding to accomplish the task.

   Although RIP generated the savings used to hire the staff and pay the overtime, agency management has decided how those savings were used. In this instance, RIP generated a savings, but from a budgetary aspect, none would be reflected in a *net reduction in personal services costs*.

2. RIP savings are transferred to contractual budget category. With the savings generated by RIP an agency transfers authorizations from the personal services to the contractual services budget category. With this increased funding, the agency contracts for some or all of the services that had previously been performed by the RIP retiree.

   Again, in this example RIP has provided savings. Through the use of a budgetary mechanism, even a *net reduction in personal services costs* has been achieved. However, as in the first example, it is agency management that is deciding how to reallocate RIP savings, and from a budget reduction viewpoint, no savings are realized despite the personal services cost reduction.

3. RIP savings allotted to other programs. One difficulty that both we and officials at the University of Alaska had with estimating RIP savings was the treatment of "budget reallocation" savings. University officials reported that RIP provided administrators

increased flexibility and was used in part, to reconfigure the instructional staff at various campuses in response to student demand (see inset at right).

For example, if an accounting professor retired under RIP, that position itself may be left vacant but the savings generated may be used for a myriad of other activities.

Again, RIP has generated savings, and to some extent, a *net reduction in personal services costs* was probably generated, but all was done outside the influence of legislative budget review. From the budgetary aspect, no savings were realized, because none were reflected in the university's budget request.

UNIVERSITY REALLOCATION INDICATES HOW RIP SAVINGS ARE USED

One university campus wrote us describing what they did with more than $170,000 in savings (projected over a three-year period) generated by one retiring professor.

> ***The position vacated by the [RIP participant] was an associate professor of Business Administration at the Sitka campus. The position was not filled in order to save money that could be reallocated for use in meeting the changing needs of the campus' constituency. Reallocation of funds saved by not filling this position made it possible to increase business program offerings in the consortium arrangement with Sheldon Jackson College, partially fund a faculty position in Computer Information Systems, add courses outside of the faculty member's expertise and eliminate courses no longer pertinent. The work of the position was accomplished through the hire of temporary faculty for teaching, and non-teaching duties were reassigned to another employee.***

All assumptions and projections of savings made by the university were reasonable and supportable, but in light of the narrative above, it is debatable about whether the projections could be considered "savings." Since we wanted to be conservative in developing our estimates of savings, we classified this particular situation as a "budget reallocation." In erring on the side of conservatism, we defined budget reallocations as not being savings.

Because we knew more about the circumstances surrounding University retirees, we actually were more conservative in refining their cost estimates than we could be with state government retirees. We have limited insight into how State of Alaska savings may have been similarly reallocated.

4. <u>RIP participant's position is cut</u>. When RIP generates savings through elimination of a position, without a budgetary monitoring system, even these more discrete savings can be temporary. For example, an agency eliminates a position from the budget left vacant by a RIP retiree. The agency has decided to either to absorb the RIP participant's workload with existing staff, discontinue the services provided by the retiree, or perhaps, as mentioned above, "contract-out" the tasks. Now, from a budgetary perspective, RIP savings are more readily realized, since agency budget requests are reduced to reflect the eliminated position.

However, two years later, perhaps under a different administration, management requests and obtains funding for a "new" position. The new position is needed to perform all or most of the tasks that were previously done by the RIP retiree. If funded, the legislature is reallocating, probably unknowingly, a portion of RIP's *net reduction in personal services costs.*

Legislature was concerned about RIP accountability

The legislature was concerned about the accountability of RIP savings. The program's implementing legislation required the Office of Management and Budget (OMB) to submit annual reports on RIP and its impact each January 15 from 1991 through 1994. The report required to provide the

> *information necessary for the legislature to evaluate the effectiveness of the program in achieving its objectives. The report should include information on the designated organizational units under the retirement incentive plans including the cost of the retirement incentive program per participant, the cost to the state, the cost to the employee, the annual budgeted amount by agency for the retirement incentive, and the projected or actual savings over the three-year period.*

The 1991 report, did contain the information specified in the legislation, and we used the report as a basis for developing the costs and savings included in this report. However, the costs and data specified and submitted does not provide necessary information regarding how the projected savings were utilized or how they affected the subsequent FY 92 budget.

Either OMB or Legislative Finance should monitor future RIPs

In addition to the report information required by the 1989 RIP legislation, the legislature should consider directing either OMB or the Division of Legislative Finance to specifically monitor RIP-generated savings. The legislature should direct one of these agencies to account for savings generated by vacant positions and the incremental differences in salary and benefits for various state agency budget request units.

By breaking down and analyzing the budgetary impact of RIP retirees, these budget review agencies could develop an adjustment factor to be used in budget construction and review. Such a factor, similar to the adjustments currently made for personnel vacancy and turnover, could be used to reduce agency personal services budget requests. Such a factor would reflect the amortization of projected RIP savings over the same time period as that provided by additional credited service.

Further, any new positions that may be included in each agency's annual budget request should be scrutinized in the context of the duties and services formerly provided by RIP participants. In addition, OMB or the Division of Legislative Finance should review the use of temporary employees and agency overtime to determine if any significant increases could be attributable to RIP.

Improved monitoring would provide enhanced legislative oversight of savings

By implementing such an upfront, monitoring and control procedure, the legislature could provide greater assurance that RIP-generated savings are being used to reduce personal service costs. Further, such a procedure more clearly identifies the amount and impact of program savings. Legislative oversight of how the savings generated from RIP are used would be improved, and such ongoing monitoring would allow the legislature a decision-making role in how savings are to be reallocated.

UNIVERSITY ALSO USE RIP SAVINGS TO RESPOND TO BUDGET REDUCTIONS

University officials also reported that they used the large savings generated by RIP participants to meet across-the-board budget reductions.

In FY 90, because of cutbacks in general fund appropriations, the university directed all departments to cut their budget by 2.5%.

For the School of Fisheries and Ocean Science (SFOS), this represented a cut of more than $100,000. An SFOS support engineer retired under RIP and was not replaced. Three year savings generated by the retirement were estimated to be more than $190,000.

SFOS used a third of the three-year savings generated by their RIP participant (approximately $64,000) to partially offset the impact of the across-the-board reduction. Such use of RIP-generated savings clearly meets both the mandate for RIP to generate a net reduction in personal services costs and satisfies the conservative budgetary perspective that all savings must necessarily involve a budget reduction.

1990 measure reduced emphasis on savings

In 1990 the legislature amended the 1989 RIP to allow employees to "make up the difference" if the State could not project a savings for their position. This amendment had the effect of eliminating any possibility for the State to realize a *net reduction in personal services costs* for those employees.

Otherwise eligible employees, for whom no savings could be projected over a five-year period, could now participate in RIP by paying off the State's projected costs. Accordingly, under the legislation the State just "broke even" on 78 additional participants, realizing no *net reduction in personal services costs* for those individuals.

From legislative committee minutes of the testimony and discussion of the amending legislation, the primary concern appeared to be one of equity. From testimony and discussion it seems the intent of the legislature was to allow all state employees that met the basic eligibility criteria an opportunity to participate in the program, regardless of the savings that might be generated from their particular situation.

RIP reduces personal services costs, central issue is who decides how savings are used

In summary, concerns about savings generated by RIP are often misdirected. RIP, if structured appropriately, does generate personal service cost savings. Skepticism of the program is not so much attributable to an absence of any real savings, but rather exists because the current budget review process does not adequately track and reflect economies generated. Only if there are major lay-offs and budget cutbacks, do savings generated by RIP become readily apparent in state agencies' budget requests.

This lack of a developed budget control process, limits the legislature in performing its oversight role. Decision making is transferred to agency administrators. They get to decide how to reallocate or use RIP savings, with no specific legislative inquiry or direction.

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EMPLOYER COMMENTS AND DISCUSSION

The opening section of the 1989 legislation that implemented RIP stated that

> *since it may be necessary for state agencies and other employers who participate in the state retirement systems to reduce their personal services costs because of declining state revenue, reimplementation of the [1986] retirement incentive program encouraging employees to retire voluntarily, will reduce the hardship of layoffs.*

However, as it turned out, concerns about layoffs and declining revenues proved, for most employers, not to be a critical factor.

Stable fiscal conditions and prior RIP may have reduced need for staff cut savings

As summarized in the Report Conclusions section, most savings generated by the 1989 RIP were due to the incremental difference in the personnel costs of retiring workers and their replacements. A comparatively small part of the savings on a statewide basis were due to the reduction in public employment. We surmise that savings generated by the elimination of positions were minimal because of two factors:

1. The fiscal situation was better. The fiscal situation faced by the State of Alaska, most local governments, and school districts proved not to be as adverse as had been anticipated when the merits of the 1989 RIP were being debated. As a result, there was not as much pressure or need to eliminate positions in order to meet demanding budget cutbacks.

2. The impact of the earlier RIP. If local governments and school districts had an excessive number of positions, their management likely took full advantage of the earlier 1986 RIP to reduce the number of employees. That RIP was implemented at a time when both the fiscal situation and prospects at all levels of government were more problematic. With the advent of the 1989 RIP, local governments and school districts were in a situation where all or most retirees necessarily had to be replaced.

Three employers criticize RIP as causing "brain drain" and being a costly alternative

Three of the participating employers surveyed in the course of our review expressed two common complaints regarding RIP. One is the concern over the loss of experience, sometimes referred to as "brain drain." Another employer-expressed concern was that RIP is sometimes used "as an easy way out," and that other, less costly alternatives to reducing personnel costs were not being considered.

One respondent wrote that his local assembly was

> *not thrilled with RIP. This notable lack of enthusiasm was due to the potential loss of long term employees -- the real loss to the organization of those years of experience*

Another local personnel officer observed that snow removal in his community had been adversely affected by the loss of experienced snowplow operators. Increased property damage to mailboxes, taking more time to clear streets and improper maintenance of equipment were all "hidden" costs of losing experienced employees to RIP.

Another local government participant responded that

> *Any net savings identified in this study is an imaginary figure. There exist other alternatives to personnel cost reduction not being* [considered]. *My belief is that the most favorable outcome of a RIP is that it may be used as a tool to encourage selected employees to terminate employment when the government is unable or unwilling to achieve this result through intelligent and sound personnel management. It's an easy way out.*

Auditor discussion - The loss of experience and "brain drain" are concerns that have been expressed during legislative deliberations and consideration of RIP. In some situations, as discussed next in this section, the participating employer often welcomes the increased flexibility and new ideas brought in by new employees. But for some areas of service, such as operating heavy equipment, the loss of experience can be more telling.

The second criticism, we think neglects one of the other stated aspects and purposes of RIP. RIP was designed in part to mitigate the social hardship of layoffs. The legislature felt it was good public policy to have people in the community receiving retirement payments rather than having a like number receiving unemployment checks. Given these additional program aims, RIP cannot be judged strictly on a cost-benefit basis.

In our view, the legislature recognized that under RIP, it would cost money to reduce staff compared to achieving the same goal through lay-offs at little or no additional cost, but with greater negative social impact. The 1989 RIP, as it turned out, was implemented at a time when across-the-board layoffs and cutbacks proved not to be a widespread necessity. In these circumstances, the costliness of the program become more evident, and its social benefits were obscured.

RIP provides increased administrative flexibility

Early retirement incentive programs have other benefits beyond costs savings. These programs can be used to achieve important non-financial goals such as increased managerial flexibility in restructuring operating procedures, in making promotions, and an increased ability to maintain a balance in the age and composition of the workforce (something that might not occur with seniority-based lay-offs).

The 1989 RIP did produce other benefits beyond the estimated cost savings. One school district in responding to our survey commented that

> *RIP allows us more flexibility. We give our teachers tenure, RIP allowed us flexibility in our staffing. Also now a district can establish new directions for programs that was nearly impossible to pursue with long-entrenched faculty.*

Both the Anchorage School District (ASD) and the university reported that RIP provided administrators with increased staffing flexibility. Both the university and ASD grant tenure to their professors and teachers, respectively. One benefit of RIP was that it allowed the two organizations to replace tenured faculty with entry level instructors and teachers without tenure. As a result, it was easier to reassign and transfer instructors without having to consider the limitations and restrictions that are involved with the prerogatives of tenured staff.

Fairbanks school board feels that repeated RIPs disrupts recruitment

In a September 1990 resolution (see inset on next page), the Fairbanks North Star Borough School Board expressed its concern over the need for, and the impact of, repeated RIPs. In adopting a resolution opposed to the creation of another RIP program the board felt that while the program assisted schools in responding to fiscal emergencies, that its repeated use when there was no crisis is disruptive to normal teacher turnover and harmful to recruitment.

As reflected by the resolution the board felt that teachers develop expectations that another RIP will eventually be offered. This expectation encourages employees who might normally retire to postpone doing so until the next RIP. The number of retirees then accumulate and when a RIP is offered, all leave the district collectively, causing havoc in teacher recruiting and a major loss of experienced personnel all at once.

<u>Auditor discussion</u> - The 1989 RIP program was designed to maximize "local control." The decision whether to participate is made at the local level, as is establishing the criteria for which employees may retire. To some extent, this local option flexibility has led to what some may consider are abuses of RIP. Rather than using the program to lessen the impact of layoffs and realize savings, some employers used RIP as a means to provide additional

FNSBSD BOARD OPPOSES IMPLEMENTATION OF RIP WHEN NO FISCAL EMERGENCY EXISTS, CONCERNED ABOUT EFFECT OF TEACHER EXPECTATIONS

I September 1990 the Fairbanks school board adopted the following resolution opposing any new retirement incentive program.

WHEREAS, the State of Alaska passed an Early Retirement Incentive Plan in 1986 to help school districts and other public agencies realize significant personnel cost reductions in response to a statewide fiscal emergency; and

WHEREAS, the State of Alaska passed another Early Retirement Incentive Plan in 1989, although there was not a fiscal emergency; and,

WHEREAS, this is creating the expectation that there will be another Retirement Incentive Plan program offered again in several years; and,

WHEREAS, this expectation works counter to the program's intent of encouraging people to retire, because of instead of the normal attrition rate, employees who might normally retire will postpone doing so until such time as another Retirement Incentive Program is offered; and,

WHEREAS, our district also has serious concerns about a teacher work shortage and fears it will become more and more difficult to replace our valuable and experienced work force; and,

WHEREAS, our district does not wish to lose our experienced employees, but has decided it would not be fair to deny them access to a Retirement Incentive Plan once it is passed into law;

NOW, THEREFORE, BE IT RESOLVED that the Fairbanks North Star Borough Board of Education requests the Legislature and the Governor not enact any future legislation authorizing early retirement.

compensation and consideration. Under our reading of the 1989 legislation, such use of the program is permissible. RIP is a "take-it-or-leave-it" program in which employers can structure their participation in the program in any manner they wish within the broad confines of the program eligibility requirements.

<u>"Speed-up" scenario is a drawback to RIP's goal to save employers money</u>

The "speed-up" scenario has been generally recognized as a drawback to RIP. Providing incentives may speed up the retirement of individuals who would have retired in the near future with or without an added incentive. Under RIP, the employer must pay the added cost of providing the incentive even though the employee would have eventually retired anyway at no extra cost.

Two participants cite impact of the "speed-up" scenario in criticizing estimated savings

Some employers contacted during the course of the review pointed out that the savings estimated using our assumptions and approach tended to inflate totals. In their comments they cited the "speed-up" scenario as contributing to an overstatement of savings. One employer commented that under the formula we suggested be used to calculate savings or costs that

> *Savings for our school district are based on a "bogus" assumption. What is not considered is when would have these individuals have normally retired if there had been no RIP. It is possible that the individuals would have retired anyway,*[without the school district having to pay any additional RIP employer contribution costs.]

Another district commented that *normal retirement would generate far greater savings for each district. The cost for RIP has to be budgeted for, while the "savings" are used for other purposes.*

Auditor discussion - Under the methodology used in this report, participants who would have normally retired would generate a certain amount of savings over the costs involved to provide the three additional years of service. Had they retired without RIP then there would have been no additional employer costs involved, and the district would have realized even more savings, either by eliminating the position or replacing the retiree with a lower paid replacement.

It is likely that some of the almost 1,800 RIP participants would probably have taken normal retirement, involving no additional contribution from their employer. We acknowledge that this normal retirement factor does overstate our savings estimate, but there was no practicable way for us to calculate its effect and adjust our estimates accordingly.

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NOTES TO SCHEDULE 1

Note 1 - General Assumptions, Methodology, and Approach to Develop Estimates

Unless otherwise discussed in a specific note, the estimated savings or costs presented in Schedule 1 on page 8 were calculated using the following assumptions, methodology, and approach:

1. Savings and costs totals represent projections over a three year period.

2. For most participants, the calculations of estimated savings or costs reflect the projected costs of salaries and benefits for both the RIP retiree and their replacement. However, some employers used salaries only as a basis for their projections and estimates. In any event, for any one participant's calculation the same basis was used for both the retiree and the replacement employee.

3. In addition to the administrative costs involved with each RIP participant, the estimated savings/costs also reflect any administrative fees paid by the employer for individuals who were eligible for the program but did not participate.

Note 2 - State of Alaska

Savings presented for the State of Alaska represent a combination of projected savings. The total includes both:

1. Three year projected savings for individuals who qualified and participated in the initial RIP program.

2. Net savings projected over a five year period for individuals who participated under the amended RIP program. According to OMB records, 78 of the State of Alaska's 739 participants did not generate any savings, and accordingly do not contribute to the total savings of $6,033,100. The table below summarizes savings estimates and the number of participants for both the 3-year and 5-year periods

	Participants	**Savings**
3 YEAR PERIOD	547	$ 5,131,400
5 YEAR PERIOD	192	901,700
TOTALS	739	$ 6,033,100

Note 3 - University of Alaska

We reduced the savings for the University of Alaska by more than $ 4,900,000 from estimates developed by the University. The adjustments were made in an effort to make the totals more comparable with those developed by the State of Alaska for their RIP participants. The university originally calculated RIP savings of $9,240,700.

A large portion of these savings total was attributable to extended vacancies in the RIP participant positions that were eventually filled. Further, the university noted that some of the "savings" were actually reallocated to other staff and programs rather than being used to offset budget reductions (see inset on page 14 for discussion of the university's budget reallocation process). We based our adjustments on salary, vacancy, and budgetary information provided to us by the university.

Note 4 - Anchorage School District (ASD)

In calculating savings estimates for TRS participants, ASD used the average, district-wide teacher and administrator salaries as a basis for the replacement employees' salary and benefit costs. Since a large segment of the replacement teachers were actually first year, newly hired teachers starting at or near the entry level pay scale, use of the district-wide average is conservative in that it would tend to understate the estimated savings.

ASD's estimated savings as listed in the schedule are based on three year projections. The district also projected savings for a five year period. ASD's five-year projected RIP savings breakdown as follows:

Retirement System	Estimated Savings
TRS Participants	$ 6,578,000
PERS Participants	528,000
Total 5-year savings projections	$ 7,106,000

Both the 3-year savings listed in the schedule on page 8 and the 5-year savings summarized above, have been reduced to reflect almost $673,000 that the district paid out as retirement incentives. Depending on when participants retired, they were eligible for payments of 2.5% to 5% of their salary and from $50 to $100 for each year of service as an incentive to participate in RIP.

Note 5 - Kenai Peninsula Borough Schools (KPBS)

Although KPBS had thirteen fewer participants than the Fairbanks North Star Borough Schools, the district had $400,000 more in estimated savings. This difference was largely a result of KPBS not replacing some of their RIP participants, whereas Fairbanks filled all the teaching vacancies left by the participating employees.

Note 6 - Fairbanks North Star Borough School District (FNSBSD)

In estimating savings, FNSBSD used the average salary and benefit costs for all newly hired teachers for the first school year following the RIP period. For PERS participants, FNSBSD used the actual salary of the replacement employee as a basis for projecting the savings generated by the RIP participant.

Note 7 - City of Fairbanks

More than $580,000 of the projected savings were generated from the city not replacing four individuals who participated in RIP. Thirteen of the twenty-two participants were from either the city's police or fire departments. At the time these 13 individuals retired, the city consolidated its police and fire protection functions into a single department of public safety. Many of these 13 retirees were high ranking officers, whose command and management functions were combined and restructured as part of the consolidation process.

This consolidation of command responsibilities made it difficult to determine which retiree was replaced by which promoted officer. Thus, it was not practicable to match these promoted individuals with the outgoing RIP retirees. However, the city is certain that available funding was used to recruit and hire entry level officers into the new public safety agency. Accordingly, they based their estimates of projected savings on the difference in salaries and benefits between the retiring officers and these entry level recruits.

Note 8 - North Slope Borough School District (NSBSD)

In calculating savings estimates for TRS participants, NSBSD used the average, district-wide teacher salary as a basis for the calculating the replacement employees' salary and benefit costs. Since a large segment of the replacement teachers were actually first year, newly hired teachers starting at or near the entry level pay scale, use of the district-wide average is conservative in that would tend to understate the estimated savings.

Note 9 - Matanuska-Susitna Borough Schools (MSBS)

In calculating savings estimates for TRS participants, MSBS used the average, district-wide teacher salary as a basis for calculating the replacement employees' salary and benefit costs.

Since a large segment of the replacement teachers were actually first year, newly hired teachers starting at or near the entry level pay scale, use of the district-wide average is conservative in that it would tend to understate the estimated savings.

Note 10 - North Slope Borough (NSB)

For all but one of NSB's 12 RIP participants, estimated savings are based on three-year projections. The other individual's savings are estimated over a five-year period.

Note 11 - Calculated Estimates for Nine School Districts not responding to our survey

We developed the estimate of savings for nine school districts which did not respond to our survey. For these districts we calculated savings for their RIP participants using the average participant savings for all districts who did respond to our survey. Savings from districts calculated using this approach totalled to $860,800 (3% of the total estimated savings statewide) for 75 RIP participants (4%). Districts for which savings were calculated using this approach were:

District	No. of TRS Retirees	Estimated Savings of TRS Retirees @ $15,359/ea	No. of PERS Retirees	Estimated Savings of PERS Retirees @ $6,798/ea	Total Calculated Savings for Schools (Rounded)
Lower Kuskokwim Schools	18	$ 276,462	7	$ 47,586	$ 324,000
Bering Strait Schools	4	61,436	13	88,374	149,800
Southwest Region Schools	6	92,154	3	20,394	112,500
Delta/Greely Schools	7	107,513	0	-0-	107,500
Kuspuk Schools	2	30,718	5	33,990	64,700
Unalaska City School District	2	30,718	1	6,798	37,500
Iditarod Area Schools	0	-0-	5	33,990	34,000
Nenana City Schools	1	15,359	0	-0-	15,400
Skagway City School	1	15,359	0	-0-	15,400

Note 12 - Matanuska-Susitna Borough

For all but two of the borough's nine RIP participants, estimated savings are based on three-year projections. The other two individuals' savings are estimated over a five-year period.

Note 13 - Kenai Peninsula Borough

Almost $200,000 of the borough's $224,900 in estimated savings is attributable the elimination of one management position.

Note 14 - City of Hoonah

More than $90,000 of the city's $118,000 in estimated savings is attributable to the elimination of one position.

Note 15 - City of Kodiak

Estimated savings are based on a combination of three-year and five-year projections. Two of the RIP participants' savings are based on five-year projections.

Note 16 - Fairbanks North Star Borough

One of the individuals' estimated savings are based on a three-year projection while the other is based on a five-year projection.

Note 17 - Bristol Bay School District (BBSD)

The estimated projected savings for BBSD of $14,600 reflect an additional cost of $10,144 retirement bonus paid to the RIP participant. The bonus represented 21% of the participant's annual salary.

Note 18 - City of Ketchikan

As related on page 7 of the report, if the City of Ketchikan can collect from its one RIP participant, it will realize a projected estimated savings of $20,200. However, as of the date of this report, the city has not collected the employer costs that it conditionally paid on behalf of the city's participant.

THE SEAL OF THE STATE OF ALASKA

Senate Committee On
State Affairs

① In SB 1, does cost saving have to be demonstrated in ≥ 3 year period or 5 year period?

1/

3/12/93
SB1

Mike McGuary - FAI +
equipment Operator

Wendy Redwood UA +
UA [illegible] significant savings
optional program to employees
[illegible] [illegible] savings [illegible] [illegible] [illegible] [illegible]
other [illegible] – [illegible] portions
[illegible] [illegible] [illegible] [illegible]

Peter [illegible] + [illegible]

Larry [illegible] +
= 2 – [illegible]
#2
#4 narrow [illegible] for [illegible]

Kelly [illegible] +
teacher

Dennis Gel[illegible] ASEA
11% of [illegible] retirees [illegible] in
[illegible] < $40k/yr

Faye [illegible]
Amends [illegible] [illegible] [illegible] state employees
[illegible] employees treated as [illegible] [illegible]

Shane [illegible]
[illegible] Support [illegible] plan in late 50s
oppose to Amend #1

Gary Sampson - Correction rep

Steve Balgiano - Corrections

3/1/93

SBI

9:45a Shelby Stanley / Kris Lethin re: SBI

Jack Kriepheder OMB

Design is more exp to ERP

Sus to take savings - care proj that people will retire anyway

unfunded liability - does ERP increase?

ERPs should be an unusual event

hire contractor   Mercer?

actuarial part

rest to State

Ck w/ Bill Scott re actuaries

2/3/93

Bd I

[illegible]

mgt [illegible] not mandated

Barry [illegible]

Fed [illegible] $750K in 1989

Lin Preston — JRTS teacher

$1.5 million savings [illegible] [illegible] (on $35 million budget)

Bob Dietrick — [illegible] teacher

$1.2 million [illegible]

Mike [illegible] — JRTS [illegible]

70 PPB = savings $1.5 mil

Bill Kelleher — custodians staff

[illegible] [illegible] [illegible]

SBI

[illegible]

[illegible]

[illegible]

[illegible]
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[illegible] To [illegible]

[illegible]

[illegible]

[illegible]

SB

5

JOHNNY ELLIS
SENATOR

STATE CAPITOL, ROOM 9
JUNEAU, ALASKA 99801-1182
(907) 465-3704
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ALASKA STATE LEGISLATURE
SENATE

MEMORANDUM

TO: Sen. Loren Leman, Chair
Senate State Affairs Committee

FROM: Sen. Johnny Ellis

RE: Scheduling CS SS SB5 — The Brianna Hurley Bill

DATE: March 26, 1993

Please consider scheduling CSSS SB5 (HES) -- The Brianna Hurley Bill. This bill is a repeat of my bill from last year, HB 438, which failed to reach the Senate floor for a vote in the last few hours of the session. It is named after Brianna Hurley, now nearly three years old, who was born with cerebral palsy.

Current eligibility requirements for Medicaid allow parents to give up their child to the care of an institution — which is often much more expensive to the State — but will not allow parents to keep their child at home and still qualify for health coverage.

The sponsor substitute reflects changes which will delay the effective date of this legislation in order to allow the Department of Health & Social Services (DHSS) to implement federally-approved Medicaid waivers for home and community-based health care. Waivers are better than options in that they provide habilitation, environmental modifications and respite care — services greatly needed by children and families. The CS changes give DHSS the flexibility to fill waiver slots as they are needed.

So why have the option? Because there may not be enough waiver slots for all the children needing services. Studies have shown that the cost of institutionalization can be up to three times as expensive as the cost of home and community based care.
Since Alaskans are paying for those children in institutions and foster care anyway, why not allow them to come home and be with their families?

JOHNNY ELLIS
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ALASKA STATE LEGISLATURE
SENATE

MEMORANDUM

TO: Sen. Loren Leman, Chair
Senate State Affairs Committee

FROM: Sen. Johnny Ellis

RE: Scheduling CS SS SB5 — The Brianna Hurley Bill

DATE: April 6, 1993

Thank you for scheduling CSSS SB5 (HES) — The Brianna Hurley Bill. This bill is a repeat of my bill from last year, HB 438, which failed to reach the Senate floor for a vote in the last few hours of the session. It is named after Brianna Hurley, now nearly three years old, who was born with cerebral palsy.

This [illegible] new group of people — children with severe disabilities who want to live at home — to the optional list of Medicaid-eligibles in Alaska. Alaska's current eligibility requirements for Medicaid allow parents to give up their child to the care of an institution — which is often much more expensive to the State — but will not allow parents to keep their child at home and still qualify.

The sponsor substitute reflects changes which will delay the effective date of this legislation in order to allow the Department of Health & Social Services (DHSS) to implement federally-approved Medicaid waivers for home and community-based health care. The CS changes give DHSS more flexibility to fill waiver slots *and* use the option, so that children who *only* need medical care (which is what CS SS SB 5 provides) — don't fill up valuable and limited waiver slots.

Why do we need the option? There may not be enough waiver slots for all the children needing services. Studies have shown that the cost of institutionalization can be up to three times as expensive as the cost of home and community-based care. Since Alaskans are paying for those children in institutions and foster care anyway, why not allow them to come [illegible]

SPONSOR STATEMENT

JOHNNY ELLIS
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ALASKA STATE LEGISLATURE
SENATE

SS SB 5 the "Brianna Hurley Bill"

SECTIONAL ANALYSIS

SECTION 1

AS 47.07.020 is amended by adding a new section, (10), which describes a new group of people to be eligible for Medicaid assistance.

10(A) Is under the age of 19 and qualifies as a disabled person under Social Security
10(B) Requires or is at risk of needing an "institutional" level of care
The care is appropriately provided outside the institution
The cost of providing the care is no more than the cost of institutional care
10(C) If in an institution, the person would be eligible for Medicaid under other provisions in this chapter
10(D) Home and community-based services are not available to them under a waiver (yet to be approved by the federal government)

SECTION 2

AS 47.07.030 is amended to add a new subsection (c) which allows DHSS to offer a service with waivers because they were directed to apply for waivers by a *concurrent or joint resolution of the legislature.*

(usually new services are authorized through *legislation* passed by the legislature. The waivers for home and community based services, which DHSS applied for last year, were an exception)

SECTION 3

AS 47.07.035 is amended by adding a new section, (23), which places the group of individuals described in section 1 in the priority order of groups served by Alaska's Medicaid program. It is placed in this particular position because this is where the services end and the groups of people to receive services begin.

SECTION 4

Sections 1 and 3 take effect 180 days after the effective date of Medicaid plan amendments (*Medicaid waivers for home and community-based services)* approved by the federal government. We want to get the waivers up and running before implementing the Medicaid option.

SECTION 5

Section 2 takes effect immediately.

JOHNNY ELLIS
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ALASKA STATE LEGISLATURE
SENATE

WHAT SERVICES DOES SS SB 5 — THE BRIANNA HURLEY BILL — OFFER?

The Brianna Hurley Bill (SS SB5) adds a new Medicaid optional eligibility group consisting of those persons under age 19 who reside at home and who would be Medicaid-eligible if they were residing in medical institutions. It places this group of people in the priority order of groups served by Alaska's Medicaid program. Children who qualify would be eligible for basic hospital doctor care, health services, hospice for kids, case management — everything in normal EPSTD coverage.

DOES THIS BILL HAVE ANY MEANS OF COST CONTAINMENT?

Yes. It only applies to kids under the age of 19 who meet the requirement for an institutional level of care *and* their care is more cost-effective if provided at home.

WHO IS ELIGIBLE FOR THE SERVICES PROVIDED BY THE BRIANNA HURLEY BILL?

- Is under the age of 19 and would be eligible for Medicaid in an institution
- Requires or is at risk of needing an "institutional" level of care
- The cost of providing care is no more than the cost of institutional care
- Home and community based services are not available to this person under a waiver

WHAT GROUPS OF CHILDREN DOES THE BRIANNA HURLEY BILL COVER?

The DH&SS estimates about 100 children (listed below) would be eligible for the option as of June 1990 — Families & advocates estimate there are more children.

- 20 children in Hope Cottages, one of Alaska's two ICF-MR's
- 5 children in hospitals
- 11 children in foster care
- 9 children in nursing homes
- Estimated 55 children at home (paid through private insurance from parents or Medicaid)

CONCLUSION

Please support both the Brianna Hurley Bill (SS SB 5) and the Department of Health and Social Services budget amounts needed to implement Medicaid waivers (will be included in a supplemental budget). The effective date of this legislation is 180 days after the federally-approved effective date of the waivers.

Alaska C.O.P.E. Coalition of Parents Educating for the Disabled & Medically Complex

P.O. Box 220584 Anchorage, AK 99522-0584 • Elaine Hurley, Chair

Dear Legislator's;

YOU MUST PASS SENATE BILL # 5 THIS YEAR !!!

Somewhere before you lays Senate Bill 5, the Brianna Hurley Bill. This bill is calling for a Medicaid Option for disabled children who are eligible for an institutional level of care. If passed this option would allow children to remain at home with their parents instead of forcing them into expensive institutions or medical foster homes as an only "option" to accessing Medicaid coverage. Removing children from their families and communities is not only more expensive for this State, but it is also inhumane.

Senate bill 5 is a repeat of last year's House bill 438 which passed through the House and both the Finance and HESS committees before simply running out of time before it could get a vote. This was not only a disappointment, but to the families that need this option and are waiting, it was a disgrace! Are we going to run out of time again this year? Are our children going to have to wait until next year or the year after? How long must we wait? Some of these children are very sick and may not have another year, like Brianna Hurley whom the bill is named after and is suffering from a terminal brain disease. How much longer must she and other children wait?

Alaska is now the only State that does not offer a Medicaid waiver or option to children who experience disabilities, WHY? Why has every other State except Alaska been able to recognize this need and allow for it?

There's a lot of controversy over what this Legislature is doing or not doing. Send a message to all Alaskans that you care about your Alaskan families and children who experience disabilities. Don't let another year go by. THIS BILL MUST GO THROUGH THIS YEAR!!!

If you had to walk into an institution or foster home and tell a child "I'm sorry little one maybe next year you can go home, maybe next year you can live with those that love you instead of this home" could you do it? Well if you don't pass Senate bill 5 this year, essentially that's what your saying.

PLEASE PASS SENATE BILL 5 AND BRING OUR CHILDREN HOME!!!

Sincerely,
Your Alaskan Families

TESTIMONY

FRAN DURNER / Anchorage Daily News

Elaine and Douglas Hurley with 18-month-old daughter Brianna.

January 1992 Article / Anch. Daily News

NEWS ARTICLE

Caught in a Health Care Trap

Medicaid rules push middle-class family toward poverty

By JAY BLUCHER
Daily News reporter

Douglas and Elaine Hurley had it all — a new marriage, good jobs, a promising future. The only thing that would have made their lives perfect, they thought, was a child.

But when their daughter, Brianna, was born with severe medical problems, the Hurleys were forced to surrender much of what they had so Medicaid would pay for her care.

Eighteen months ago, before Brianna's birth, the Hurleys were a two-income family earning more than $40,000 a year. Douglas, 24, was working full time as a baker and commercial fisherman, and Elaine, 26, was holding down three part-time jobs as a secretary and bookkeeper. They had been married for just two years.

"We scrimped, saved and planned for this baby and thought we had what people think of as the American dream — money for a down payment on a house, college funds, savings accounts — if not attainable, then at least in sight," says Douglas.

Brianna was born with cerebral palsy and epilepsy. She also has severe brain damage caused by viral encephalitis contracted in the womb. The disease, often fatal, causes paralysis.

At 7 months old, Brianna also suffered a stroke.

Some doctors tell the Hurleys that Brianna might learn to walk by age 6 or 7. Others, such as Dr. Jerome Mednick, a pediatric neurologist in San Francisco, say she will never walk or talk.

Now, when other children her age are toddling, Brianna has only recently been able to muster the muscle coordination to wave her right hand. She cannot support herself upright or crawl, and the entire left side of her body is impaired. She is like a limp rag doll, with the motor skills of a 2-month-old.

While the Hurleys accept Brianna's special needs, the cost of caring for her at home was unexpected.

"We thought to ourselves, 'OK, we'll deal with it; there's help available for families like us,' " says Elaine.

But little did they realize that their decision to care for Brianna at home would force them to cash in their lives for a welfare check.

Since birth, Brianna has required extensive medical attention ranging from emergency hospitalizations — as when her seizures caused a semi-comatose state for 30 days — to regular visits with pediatricians, neurologists, nutritionists and other specialists. As a disabled infant, she also receives regular occupational, physical and speech therapy services through the state's Infant Learning Program.

She's had every manner of diagnostic test, and these continue.

At a big price.

The specialized infant formula she needs to gain weight costs $7 a case, and lasts only a week because Brianna still cannot eat solid foods. The medications needed to control her seizures cost $700 per month. Her medical bills average $4,000 a month. And in Brianna's future looms extensive orthopedic surgery and probably an expensive liver transplant. (Th drugs that help control her seizur have damaged her liver.)

The Hurleys estimate Brianna' medical bills will cost $60,000 annually for the next five years. More than $20,000 remains unpaid now.

At first, the couple had reasonably good medical insuranc through Douglas' employer. It pai 80 percent of the family's medical costs. But after just three months in which Brianna's total medical costs topped $60,000, Blue Cross o Washington and Alaska reduced i coverage to 50 percent.

Douglas' employer at the time, William Pargeter, who owns Harry's restaurant and owned the now-defunct Kayak Club, could have continued the higher coverage, but at greater cost.

Pargeter says he was acutely aware of the Hurleys' high medic expenses because the Kayak Club was in the midst of a bankruptcy reorganization at the time and he

Please see Page D-2, TRA

• Continued from Page D-1

was looking for a new health insurance plan for his employees.

"But this family's high medical costs made the insurance companies leery of accepting the whole group," he says. "In fact, one carrier flatly refused to carry us as long as Douglas was employed with us."

Rather than offering his employees a health plan that excluded the Hurleys, Pargeter instead opted for a less comprehensive Blue Cross plan for all

Blue Cross officials would say only that the company opted for a less expensive health plan.

Other insurance companies wouldn't accept the family because Brianna's medical needs were "pre-existing."

The Hurleys soon owed thousands of dollars with no hope of ever repaying it on their existing incomes. Threatening phone calls from bill collectors now punctuate their days. Their credit ratings are ruined.

We were taking food out of our own mouths in order to send $10 here, $20 there, for medical bills left unpaid by our insurance, but we were falling hopelessly behind," says Elaine.

The couple realized their only option was Medicaid, the federal health-care program administered by individual states to help the poor. But Medicaid has a strict income limit, and the Hurleys exceeded it.

This family of three, to qualify for Medicaid, would have to begin living on $1,334 a month, before taxes. Or, as they were told by Medicaid officials, they would have to "spend down to 133 percent of the federal poverty level."

This meant Douglas had to quit his job in September and go on unemployment, which pays him $760 a month. Elaine could bring in only $574 a month to stay under Medicaid's limit, so she could accept only part-time work as a bookkeeper.

"I despise living this way, feeling like I'm on the dole looking for a handout, but it's the only way my daughter's medical bills can be paid," says Douglas.

"It's frustrating to be a capable and willing-to-work father who wants to be the provider for my family, and yet be forced by bureaucratic rules to *not* work," says Douglas.

Income wasn't the only thing they had to cut. The Hurleys were required by Medicaid rules to deplete their savings accounts, college funds for Brianna, certificates of deposit, individual retirement accounts, and to trim their possessions to one car of no more than $1,500 value, household goods of $500 value, and $250 worth of baby furniture.

Every three months, state public assistance officials grill the family about new sources of income — inheritances, church donations or money from other family members.

"It makes me feel so demeaned, like I have no worth, no self-esteem," says Douglas.

> *‘I despise living this way, feeling like I'm on the dole looking for a handout . . . It's frustrating to be a capable and willing-to-work father who wants to be the provider for my family, and yet be forced by bureaucratic rules to not work.’*
>
> — **Douglas Hurley**

Since he's been unemployed, he's gotten several good job offers at considerably more salary.

"I've been reduced to turning down good jobs in order to care for my daughter," he says. "Now isn't that a perverse situation?"

Elaine is just as frustrated.

She worries that the couple may never be able to afford a home, have other children or excel in a career that could provide the security every family seeks.

They could do all that, however, if they did just one thing: Put Brianna in an institution or make her a ward of the state. Then Medicaid would pay for her care and release her parents from income limits.

Unacceptable, say the Hurleys.

"We want to be able to look at ourselves in the mirror and say that we did everything we possibly could to help her, no matter the sacrifice," says Elaine.

Equally distasteful is a third option — for the couple to legally separate. Elaine could accept public assistance as a single parent and Douglas would be free to return to work and pay child support.

"So the state would actually reward the breakup of a loving family," says Douglas sarcastically.

Chris Ashenbrenner, program officer for the state's medical assistance office, says the Hurleys are not alone.

"Because there's no nationwide health plan in this country, people such as the Hurleys are among the gap group, people caught in the middle-class health crisis," she says.

But she also says it's unfair to blame Medicaid.

"It's the whole health care mess in this country and insurance companies that are allowed to drop coverage when claims get too high or certain limits are reached."

David Maltman, executive director of the Governor's Council fo Handicapped and Gifted, says it happen to anyone.

He agrees that Alaska's current cy needlessly impoverishes wo families trying to care for a dis child at home.

Responding to the problem council has examined the Med system and recommended imp ments to make home care more a able to persons with disabilities.

In 1990, the legislature requir similar study by an independent mission known as Project Ch whose final report will be present January. Both the council and Pr Choice recommend that the state a for a waiver from federal Med rules.

This would let Medicaid waive income limits for families like Hurleys.

Alaska is one of only a handf states that have not adopted a w program or something known as "Katie Beckett option."

In 1981 Katie Beckett, a 3-yea girl from Iowa who, like Bria suffered from viral encephalitis, granted a federal waiver by Pres Ronald Reagan. He cited the cas overregulation.

Since then, a majority of U.S. st have adopted either waiver progr or Katie Beckett options.

Medicaid's Ashenbrenner says A ka has never applied for this partic waiver or option because the s already has an adequate welfare gram, with the most generous eligi ty standards in the country.

This rationale, however, does consider people like the Hurleys family caught in precisely the regul ry paradox that such waiver progr were intended to address.

The Hurleys see a waiver or Bec option as their only relief fro poverty sentence.

"Sometimes, you get the impres these Medicaid people think of i their own money," says Elaine.

She glances lovingly at Bria who responds with a curious l When all the frustrations become much, the Hurleys focus on wh most dear.

They shower Brianna with at tion. The tiniest of achievements, s as a simple wave of her hand, br them renewed hope for her future

"Her wonderful disposition thro all of this really makes it easy on hearts, knowing that as difficult a gets for us sometimes, her love rem unconditional," says Douglas.

He marvels at his daughter's r ience as she sleeps in his arms.

"She's so beautiful, so innocent She has no idea any of this is happ ing, no idea that she's . . . diffe . . . or how difficult all of this been for her parents," he says.

Brianna stirs.

"Ssshhh, little one. It's OK. Dad here."

Daily News - 12/31/92

BRIANNA HURLEY: CATCH-22

In January, we wrote about Elaine and Douglas Hurley's struggles to care for their 18-month-old daughter, Brianna, born with cerebral palsy and mysterious seizures. Her severe medical problems and the accompanying medical bills forced her parents to exist at the federal poverty level to qualify for Medicaid.

Nearly one year later, they are still caught in a medical Catch-22.

Legislation that might have helped the Hurleys — a waiver from federal Medicaid parental income rules — failed to pass in the state's last legislative session.

The strain of caring for Brianna and fighting both state and federal bureaucracies proved too great for the Hurleys' marriage; the couple divorced earlier this year.

As a single parent, Elaine Hurley can earn $963 per month, before taxes, to keep her daughter qualified for Medicaid. Because her daughter's severe medical problems are considered to be a "pre-existing condition" by private health insurance companies, Elaine can't buy health insurance of any kind for Brianna; Medicaid is her only option.

Earlier this month, the state's Division of Mental Health and Developmental Disabilities paid for Brianna to go to the Mayo Clinic in Rochester, Minn., for more specialized diagnosis and care. The Mayo Clinic doctors say her condition is terminal.

Elaine Hurley is considering a move to Seattle or elsewhere in the Lower 48, hoping to locate near a pediatric center that may offer opportunities to prolong Brianna's life.

— *Jay Blucher*

Therapist Gale Andrus trains Zachary to eat normally

YOUNGSTER MAY FINALLY SPEND CHRISTMAS OUTSIDE HOSPITAL

By DEBRA McKINNEY
Daily News reporter

Life would have been far easier for Larry McKenzie had he just walked away. He and his wife had split up when she was two months pregnant, and hadn't seen each other since. He didn't even know the baby had been born until the hospital called him with insurance questions.

Zachary McKenzie arrived two months early on Dec. 29, 1987. Within hours of his birth, the 3-pound boy was moved to a Seattle hospital with problems so severe he wasn't expected to last the day.

The upper end of his esophagus led to a dead end, not his stomach, and the lower end detoured into his lungs. He couldn't swallow without choking. And acids and other stomach fluids threatened to flow into his lungs and drown him. On top of that was a heart problem for which he needed

Please see Page F-2, **HOMECOMING**

Larry has become his son's primary caregiver during the evenings.

755 2511

ADN 1/7/92

Medicaid reform

Start with a waiver, but do more

In photographs, Brianna Hurley looks like any healthy, happy 18-month old. The picture that ran in Monday's Daily News showed her sitting on her mother's lap. Her pink sweat shirt had white ponies on it, and her straight brown hair was swept back with a matching pink barrette. She shared the couch with her father and a doll.

But the photograph doesn't tell you the whole story. Yes, Brianna is as sweet looking as they come. And it's obvious her parents, Elaine and Douglas Hurley, love her. But their daughter can't hug her doll, or even sit upright on the couch by herself. Born with cerebral palsy and epilepsy, brain damaged from viral encephalitis, felled by a stroke, Brianna can't walk or talk, and may not ever.

Elaine and Douglas Hurley's life is like that photograph: It turned out different than it looked. It's not just that their daughter was born with the problems she has; they have found the personal strength to deal with that. But their financial resources — their jobs, insurance and savings — proved wholly inadequate in the face of $60,000-a-year medical bills.

> *There's something wrong with a system that pays for institutional care but won't help a family that wants to care for its loved one at home. There's something wrong with a system that takes two people with good work histories and tells them they can't work.*

Had they put their daughter in an institution, Medicaid would have paid for her care without restricting the Hurleys' income. But the couple wants to take care of their daughter, at home, themselves. So they've had to quit their jobs, deplete their savings and sell off household goods to meet Medicaid's income limitations.

There's something wrong with a system that pays for institutional care but won't help a family that wants to care for its loved one at home. There's something wrong with a system that takes two people with good work histories and tells them they can't work.

The state of Alaska can help the Hurleys and families like them by applying for an option — used by other states — that would let Medicaid waive the income limits for families who want to care for disabled members outside of an institution.

But while that's a quick fix — and a necessary one — there is more wrong here than simply Medicaid.

There's something wrong with an insurance company that can reduce coverage just when it's needed most, as happened to the Hurleys. There's something wrong with an insurance industry that can refuse to cover prior conditions or high-risk people. There's something wrong with a system that doesn't address catastrophic illnesses. And there's something very wrong with a system that leaves some 90,000 Alaskans with no insurance coverage at all.

The Alaska legislature can ask for a Medicaid waiver. But that's only a stopgap measure toward ensuring everyone the right to medical care. It's only a reminder of how desperately this country needs to reform its health care system.

Remember, the family in the photograph could be yours. If this could happen to the Hurleys, it could happen to you.

Helping Kids, Helping Families

While the new Clinton administration hammers out its version of health care reform, states continue to struggle with universal coverage for their own citizens. Among the most vulnerable populations are children with special health care needs.

Mimi Bodel and Martha King

Two-year-old Justin Smith's body doesn't produce the human growth hormone, a condition that costs $3,000 a month to treat. Although father Brad's employer-based insurance covers a large portion of the treatment, the premiums are escalating rapidly and the family is afraid it will lose its coverage. Justin's parents struggle to pay their share of the costs as it is. "Our whole life is devoted to paying medical bills. We can't afford to do more," says mother Cindy. When she sought state assistance, Cindy found no program for which her family was eligible because they made too much money. State health officials told her she apparently had three choices:

- Buy private insurance for Justin (at $1,000 a month, due to his "pre-existing" condition);
- get divorced and go on welfare; or
- move to Canada.

"This sounds more like an American nightmare than the American dream," exclaims Cindy, who says she cannot pay for a private insurance policy, and she refuses to leave her husband or country. And so the Smiths wonder whether Justin will be able to continue receiving hormone treatments or have to quit and be lucky to reach three feet in height on his own.

John, a healthy full-term baby at birth, got sick when he was 5 months old. It seemed like the flu—but within 12 hours, parents Carol and Curt Terwilliger knew they had serious trouble. The baby had spinal meningitis. He slipped into a coma and sustained damage to every part of his brain. His life, and that of his parents, was irrevocably altered.

This sounds more like an American nightmare than the American dream.

Now, at seven, John has multiple problems: spastic quadriplegia, cortical blindness, mental retardation and a convulsive disorder. John also has two parents who love him, two healthy younger siblings and colored beads on the spokes of his wheelchair. But it takes 45 minutes to feed John a small bottle of liquid, and 45 minutes to spoon feed him a single meal. Carol, an MBA, gave up her career as a fiscal operations officer in a Medicare program to become full-time mom and caretaker for a child with special needs.

"Luckily I can stay home," says Carol, "because we can cover our expenses with Curt's salary and his employer's excellent insurance program." Nonetheless, the family is well aware that any change of job or company insurance carrier could put them in jeopardy of discontinuing John's coverage.

Donald Penzenik did have bad luck with employer-based insurance and was forced to "spend down" his family's resources to qualify his "uninsurable" son for Medicaid. Michael, who has cerebral palsy, mental retardation, scoliosis and a seizure disorder, was dropped by the insurance company that had covered him. In the meantime, Donald's new employer would not include Michael in the health coverage for his other family members. Desperate to provide for their son, the Penzeniks turned to Medicaid, but at great cost to the family's security.

"I impoverished my family," says Penzenik. "This was our reward for raising our child with severe disabilities at home. To qualify for Medicaid, *all* family assets, including our savings, individual retirement accounts and life insurance policies were 'spent down,' leaving my family unprotected and vulnerable to financial disaster." Now Donald and his wife, a nurse, are restricted in the amount they may earn, and they may not save for their other children's college or for retirement in order to keep Michael covered under Medicaid.

Today, serious illness and chronic conditions affect children from all sectors of the American population. Estimates of the numbers of children vary, but several surveys of different conditions (developmental disabilities, diabetes, cystic fibrosis, childhood cancers and other chronic medical needs) suggest that between 10 percent and 15 percent of American children have a chronic health condition; about 5 percent have serious health care needs; and 1 percent to 2 percent, or about 1 million children,

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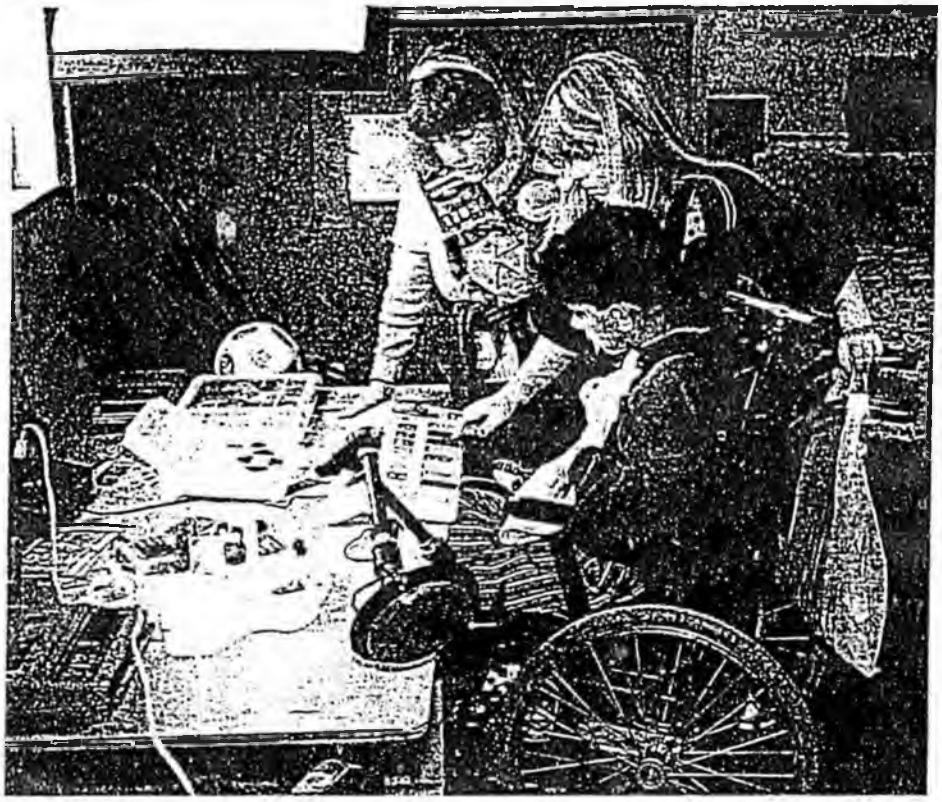
Mimi Bodel recently completed a graduate internship at NCSL. Martha King manages the NCSL Maternal and Child Health Project, which is funded under a grant from the federal Maternal and Child Health Bureau



Conrad delaParra, 11, can't walk or talk, but he manages to communicate with his school friends. His middle class family is determined that he live at home, even though they would get more financial assistance if he was institutionalized.

have severe chronic impairments.

These children and families have a large stake in the national health care reform debate. The Clinton administration backs "managed competition," and may endorse a "minimum package" of benefits for all Americans. The insurance industry now supports an "essential package" of health benefits for everyone. Whether a "minimum package" or "essential benefits" would meet the extensive needs of children with chronic ailments and serious disabilities is a million-dollar question. Advocates remain hopeful in light of the federal ruling against Oregon's health reform and cost containment initiative. The Bush administration rejected Oregon's proposal, saying it discriminates against people with disabilities and conflicts with the Americans with Disabilities Act. But now there's a new ballgame in town.

In the meantime, families look to states for assistance in the immediate future. Thousands of families who are not poor enough to qualify for Medicaid, but are neither well-insured nor independently wealthy, struggle daily to provide care for their children and to make ends meet. Look at the problems such families face: obtaining and keeping private insurance for children who are considered high-risk by insurance companies; paying for expensive care not covered by insurance policies, such as various therapies, in-home nursing help, high-tech medical equipment and van lifts; staying within the lifetime expenditure caps of insurance policies (virtually impossible for families who have children with severe and chronic health problems); getting the support needed to keep their families intact, such as respite care, parent education, home modifications, cash assistance and special equipment; fighting public policies that will assist them only if they institutionalize their children; and dealing with barriers and public attitudes that make it difficult to get a baby-sitter, or take a child to a restaurant, a movie theater or to school.

In addition to high costs and insurance problems, families face extreme emotional stress. For example, Carol Bennet, whose twins were 10 weeks premature, says her marriage suffered and eventually broke up from the strains created by the boys' need for constant care and attention. She struggled as a waitress to care for Trevor and Travis, both of whom have special health care needs. Travis has cerebral palsy, cannot walk and takes seizure medication. Trevor, who also cannot walk and just began talking at age 6, is mentally retarded. After wearing herself out trying to be a breadwinner and caretaker, Carol reluctantly placed Trevor in a group home for children with multiple disabilities.

"I couldn't afford to keep both of them at home without help, but I'm not poor enough to qualify for Medicaid to help me at home. But Medicaid would pay for institutional care," Carol explains. "Both boys had savings accounts, and I had to give the money back to our families so I could meet the eligibility requirements."

Rhonda delaParra faced pressure to institutionalize her son Conrad after he suffered severe brain damage at age 2. As a happy, seemingly healthy infant, Conrad walked, talked and laughed. Then something happened and he went into a coma. The family is still not sure what caused it, maybe an asthma attack.

"'If you take him home, you're on your own' they told me," reports Rhonda. Ironically, the state would have paid for the expensive institutional care. Now, at age 11, Conrad is mentally retarded, his vision is poor, he can't walk or talk. Conrad's new step-dad, Joe, would like to adopt him, but adoption might jeopardize Conrad's eligibility for Supplemental Security Income, a federal cash assistance program. Joe works seven days a week as it is to support them, and the family doesn't think it could make it without the assistance.

"There's a gap between the needs and the distribution of services," says Rhonda. "They don't offer services that people really need, like counseling, and they don't offer anything for the middle class. With a little assistance, families could cope with keeping their child at home—nobody wants their child to live with strangers, and we don't want to be indigent before we can get some help."

The bias toward institutional care in most states stems from Medicaid reimbursement policies. Many of the extensive services needed by children with severe health problems or disabilities are reimbursable under Medicaid only if the child is in a facility such as a state insti-

Dollars and Sense: Federal Assistance

Children with disabilities qualify for help under the following major federal programs: Medicaid, the Maternal and Child Health (MCH) Block Grant, and the Individuals with Disabilities Education Act.

Medicaid

Medicaid is a major source of funding for low-income families of children with special health care needs. Medicaid programs cover children age 5 and under who come from families with incomes up to 133 percent of the federal poverty level (states have the option of covering infants up to 185 percent of the poverty level). By 2002, those up to age 19 with family incomes up to the poverty level must be covered.

States must also provide "medically necessary" treatment for children up to age 21 to correct or ameliorate physical or mental problems. This requirement applies to all services reimbursable under federal guidelines, including optional services not covered under a state's regular Medicaid plan.

Waivers allow states to cover certain nonmedical services for Medicaid-eligible people who otherwise would be served in an institutional setting at an equal or higher cost. As of 1991, through this option, 46 states offered home- and community-based services to about 50,000 people with developmental disabilities and other special health care needs. Although most are adults, Medicaid-eligible children with disabilities also benefit from this option.

A state may also cover optional services that are not in its Medicaid plan for a small targeted group of people, such as children who depend on a ventilator. The waiver allows Medicaid reimbursement for home care services for a limited number of people who otherwise would need institutional care.

Under the Tax Equity and Fiscal Responsibility Act (TEFRA), states may offer Medicaid services without regard to family income, to certain children with severe disabilities who are living at home.

Maternal and Child Health Block Grant

Thirty percent of the federal money coming to states through this program must be earmarked for children with special health care needs. States provide $3 for every $4 in federal funds. States determine eligibility requirements for receiving services and may charge fees, except to low-income women and children.

State health agencies usually provide MCH block grant services, which may include case management and counseling, home nursing, respite care, hospitalization, surgical care, therapy and training for families.

Grants for special projects of regional and national significance are available to states through the MCH block grant to help implement the family-centered, community-based approach to services and care for children with special health care needs.

Individuals with Disabilities Education Act (IDEA)

Under IDEA, all eligible children with disabilities, beginning at age 3, must receive a free and appropriate public education. The law provides funds to local schools to help pay the excess costs of educating students with disabilities, including funds for special therapies and adaptive equipment. States must meet this requirement to receive federal funds for children in preschool under federal formulas for special education grants.

The act also provides funds to help states develop early intervention services for infants and toddlers with developmental disabilities and other problems. IDEA requires an interagency coordinating council, composed of representatives from many federal agencies, to work on behalf of such children.

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tution or a licensed group home. Exceptions are possible, most notably under the federal "Home- and Community-Based Services" waiver. This waiver allows Medicaid payment for certain nonmedical services, such as respite care or habilitation services, for eligible children who otherwise would be served in an institutional setting at an equal or higher cost. But children who are not certified as needing institutional care, in most cases, do not qualify for such community services.

In addition, many children at home do not qualify for Medicaid because their family's income is too high. But if they move to an out-of-home setting, their income as children may be considered separately, thereby qualifying them for assistance. Again, exceptions exist, such as a state's option to serve a small number of children dependent on a ventilator. But the relative numbers are small. These public policies exclude thousands of families who would benefit from community services.

State legislators, asked to help fill the gaps for these families, face their own problems. State coffers are empty, revenues continue to shrink and new federal mandates require more services for more people. Advocates pressure lawmakers to fund community services to assist families in need, arguing that community care is cheaper than institutional care. In many cases it is. But budget watchdogs fear the "woodwork" effect: Those people not currently eligible for state assistance would "come out of the woodwork" if states expand eligibility criteria for community services.

For example, when Arizona recently expanded its services for people with developmental disabilities, the number of consumers more than doubled, from 5,000 to 11,500. Caseloads suddenly jumped from 47 to as high as 80 families per case manager, although federal guidelines advise a caseload of no more than 30.

Deborah Meintel, a case supervisor in the Arizona Division of Developmental Disabilities, says that the size of such caseloads detracts from the time and attention given to each family. "I'm not trying to get away from being account-

Help for Families That Can't Get Medicaid

A few state insurance plans help cover citizens who either can't afford or don't qualify for private insurance. While most of the plans don't cover many of the services needed by children with special health care needs, they help. Such programs include:

Massachusetts: CommonHealth
✓ Sells health care benefits on a sliding scale to qualifying families.
✓ Provides broad benefits—therapy, equipment and mental health services.
✓ Funded by state appropriation ($15 million in 1992).

Minnesota: Children's Health Plan
✓ Sells inexpensive basic health services to low-income families.
✓ Funded by annual $10 million state appropriation.

Florida: Healthy Kids Corporation
✓ Sells liberal health coverage on a sliding scale through public schools.
✓ Funded by grants and limited state funds.

Florida: Developmental Evaluation and Intervention
✓ Catches problems early through evaluations in neonatal intensive care units.
✓ Provides family support.

New Jersey: Catastrophic Illness in Children Relief Fund
✓ Assists families with catastrophic medical expenses.
✓ Funded through annual surcharge on certain employers.

Texas: Early Intervention
✓ Provides support, therapy, equipment and transportation through 75 local programs.

Wisconsin: Family Support
✓ Supplies up to $3,000 in extensive services a year to families and children.

About half the states: High-risk Pools
✓ Expensive, but available to those uninsurable through private insurance.
✓ Most have a waiting period before covering pre-existing conditions.

able, but I feel we're meeting the needs of the system, and we need to get back to meeting the needs of the family."

Patti, an Arizona school teacher whose 1-year-old son Ben has Down syndrome, recalls that it took six weeks to be assigned a caseworker, becoming number 60 in her caseload. Patti received the paperwork to apply for services, but was told of an indefinite state freeze on funds and services due to budget constraints. Ben was put on a waiting list, and was ineligible for federal services until he had state services first. "It's a Catch-22," Patti declares.

Budget watchdogs fear the "woodwork" effect: Those people not currently eligible for state assistance would "come out of the woodwork."

Advocates insist that home care is better for the child than out-of-home placement, and is preferred by most families. The key, they say, is to provide adequate financial support and a comprehensive array of services to meet the individual family's needs.

Most states provide at least some support for families caring for children with disabilities at home. Services most commonly offered include case management, respite care, parent education, home adaptations, special equipment and transportation. Other services may include information and referral, parent and family counseling, peer support groups, homemaker services, attendant care, in-home nursing, future planning and cash assistance.

In addition to family support, many states provide other forms of assistance, but often a gap exists between the intention and the reality.

"There's a theoretical system," says Carol Terwilliger, of California, "but it is so badly funded and understaffed that the only way it will work is if the parent is able to pour time into it. You're a coordinator, researcher, therapist. It's up to the families to keep on top of things, to get services and see that the service providers work together."

Although children with special health care needs are relatively few, their expenses can be enormous. These children consume an estimated 25 percent to 50 percent of all child health care expenses.

Carol Terwilliger explains, "Anything that's 'special needs' is extremely expensive because the market is so small. And the price for anything that goes through the medical market immediately gets kicked up. A standing frame costs $700; plastic foot braces are $1,400 a pair; a therapeutic foam wedge for sleeping runs $100. And these are all for a growing child, so they have to be replaced every two years or so. Just the growth adjustment to John's wheelchair cost $900 this year."

When the cost of their care is high, insurance companies drop families or raise premiums to prohibitive levels. Massachusetts addresses this problem through its CommonHealth plan. "The plan allows parents to make sure that their children's needs are met without going bankrupt, and it keeps families together," explains Representative John McDonough. "It's a humane, cost-effective, sensible way to address the needs of a vulnerable population. I wish we could do it for everyone."

Cheryl Gresek, the mother of a Massachusetts boy with a rare and costly heart condition, is a firm advocate of the CommonHealth program. It was a life-saver for the Greseks after they were priced out of their employer-based health plan. The Greseks had paid premiums for four years without making a claim, but when they suddenly faced serious and expensive health care needs for their son Daniel, their premiums skyrocketed, first to $766 a month. They sold their condo, and paid. The next year, their premium jumped to $1,371 a month. They couldn't pay and had to drop out. After much expense, anguish and searching, the Greseks were referred to the new CommonHealth program, which insured Daniel for $58 a month, a premium determined by the family's income.

Even families whose employers offer excellent insurance benefits fear loss of coverage if they change jobs, get laid off, or if their employer changes health insurance coverage. They also face the possibility of exceeding their plan's total dollar limit, and most plans also limit the types of services covered. Insurance policies usually have pre-existing conditions clauses, which deny or restrict coverage for new enrollees of conditions that will be expensive to treat. A recent proposal by the Health Insurance Association of America (HIAA) recognizes problems in the current insurance system. HIAA's new position supports agreement among private insurers to provide unspecified essential benefits for everyone, regardless of medical history.

Although children with special health care needs are relatively few; their expenses can be enormous.

In the meantime, both the Massachusetts CommonHealth program and the Minnesota Children's Health Plan (CHP), to some extent, address these insurance issues for children.

"The idea is to get health care to kids who need it," says Minnesota Representative Lee Greenfield of the Children's Health Plan, which covers primary and outpatient health care. "We don't screen kids, we don't have any prior conditions clause—everyone's welcome." Nonetheless, Minnesota's program doesn't cover many of the services needed by children with special health care needs. CHP proponents had hoped to expand the program to cover acute care needs and inpatient hospital services, but policymakers found the costs prohibitive. The state's new MinnesotaCare plan, which builds on the success of the Children's Health Plan to cover uninsured adults, will eventually replace CHP and cover inpatient and acute care. Funding will come from a new tax on hospitals and other health care providers and a 5-cent increase in the state's cigarette tax.

In response to the growing outcry for help, the federal government assists states and families of children with special health care needs through changes and additions to Medicaid, the Maternal and Child Health Block Grant and the Individuals with Disabilities Education Act. But much of the financial burden under new federal mandates falls on states. Caught between added demands and limited resources, the states are in an increasingly awkward, and unsupportable, position.

A class action lawsuit under way in Pennsylvania (*Scott, et al. vs. Snider, et al.*) is a case in point. The lawsuit charges Pennsylvania with negligence for slow response to the federal mandate to actively seek out eligible children and enroll them in Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Under EPSDT, states must provide extensive treatment services to Medicaid-eligible children who need them. The lawsuit also requests Pennsylvania to set Medicaid payments for providers high enough to ensure children on Medicaid access to providers. A victory for the plaintiff on this provider payment issue would open the door to additional cost increases for states. As of mid-December, the plaintiffs and the state continued to work toward a settlement.

Pennsylvania Representative Ronald Cowell views the lawsuit as a potentially unifying force. "All in all, I think the outcome of this lawsuit will be very positive. It has prodded the state to re-examine the way it handles Medicaid, and by doing some reorganizing, we can probably improve the situation. We may even be able to draw down some additional federal money as well."

Senate colleague James Greenwood sees the additional federal support as critical. "Children who need health care should have health care, and we recognize that Medicaid's EPSDT program is a cost-effective way to provide services to children. However, it's unfortunate that we have been given a federal mandate without the time or the resources to implement it effectively. This is a well-intentioned policy, but it creates an impossible burden on the states."

A recent U.S. Supreme Court ruling, in *Sullivan vs. Zebley*, also has a major impact on Medicaid spending in most states for children with special health care needs. The court found that Supplemental Security Income (SSI) requirements for children were more restrictive than for adults and ordered the states to rectify the situation. As a result, many more children with disabilities will be eligible for SSI, and therefore Medicaid, in most states. This is good news for families of children with special health care needs, but expensive for states.

But for many parents, it's a question of paying now, or paying more later. "The sooner you get treatment and services to families of [these] children, the better," says Carol Bennet. "Doctors and pediatricians should have a lot more material on hand. My children were late being diagnosed, and there really is a need to start with these children early. There needs to be a set of guidelines, steps to follow, some package of information. You get little snips of things from here and there."

Numerous studies show that early intervention substantially enhances development in children with delays and disabilities, supports family-based care and uses public money efficiently. According to some estimates, for every $1 spent on early intervention states can save between $3 and $7 in future expenditures for institutionalization and special education.

Carol Terwilliger says the prevailing practices don't make sense. "If you don't invest in these children now, they will be institutionalized at great cost to the state. But they might be able to live differently if the money is spent in the early years, on support for the family and training and health care for the child."

Rhonda delaParra echoes her plea. "We care for Conrad at home because we love him. Conrad is a human being and he has a right to be here. And if legislators say, 'Why should we pay for services for a child who will wind up in an institution sooner or later,' I say, why not later rather than sooner?"

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CS SS SB 5 (HES)

Revision Date: 03/29/93
Title: An Act relating to Medicaid eligibility of persons eligible to be institutionalized ...
Sponsor: Ellis, Salo, Lincoln, Duncan
Requestor: Senate State Affairs Committee

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility
COMPONENT SERIAL NO. 229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,165.7	692.2	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	1,165.7	692.2	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

	FY94	FY95	FY96	FY97	FY98	FY99
1002 Federal Receipts	582.8	346.1	0.0	0.0	0.0	0.0
1003 GF Match	582.9	346.1	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	1,165.7	692.2	0.0	0.0	0.0	0.0

POSITIONS:

	FY94	FY95	FY96	FY97	FY98	FY99
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)

The fiscal impact of this bill results from adding new Medicaid recipients. Cost calculations are shown on attached page. Cost per recipient and number of new recipients are taken from home and community-based services waiver applications and supporting documents.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. The cost of serving new eligibles who would also be covered under a waiver is not included in this fiscal note. Some of the cost impact of SB 5 would be increased if that amendment is not fully funded.

The Department has limited experience identifying children living in the community who need an institutional level of care. Any variance with the predicted number of those eligible will impact costs.

Prepared by: Kimberly B. Busch
Division: Division of Medical Assistance
Phone: 465-3355
Date: 04/02/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 4/6/93

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ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

FY 94 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$102.2
Number of new recipients, not on waivers, in FY 94 needing hospital or NF level of care:	21
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing hospital or nursing facility level of care: $102.2 x 21 x 50% =	$1,073.1

FY 94 Medicaid service costs per recipient needing ICF/MR level of care:	$32.9
Number of new recipients, not on waivers, in FY 94 needing ICF/MR level of care:	36
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing ICF/MR level of care: $32.9 x 36 x 50% =	$592.2

Total FY 94 cost of Medicaid services for all new recipients: $1,073.1 + $592.2 =	$1,665.3

Component Breakout:

Medicaid Non–Facility (70 percent of total costs)	$1,165.7
Medicaid Facility (30 percent of total costs)	$499.6

FY 95

FY 95 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$111.1
Number of new recipients, not on waivers, in FY 95 needing hospital or NF level of care:	6
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing hospital or nursing facility level of care: $111.1 x 6 x 100% =	$666.6

FY 95 Medicaid service costs per recipient needing ICF/MR level of care:	$35.8
Number of new recipients, not on waivers, in FY 95 needing ICF/MR level of care:	9
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing ICF/MR level of care: $35.8 x 9 x 100% =	$322.2

Total FY 95 cost of Medicaid services for all new recipients: $666.6 + $322.2 =	$988.8

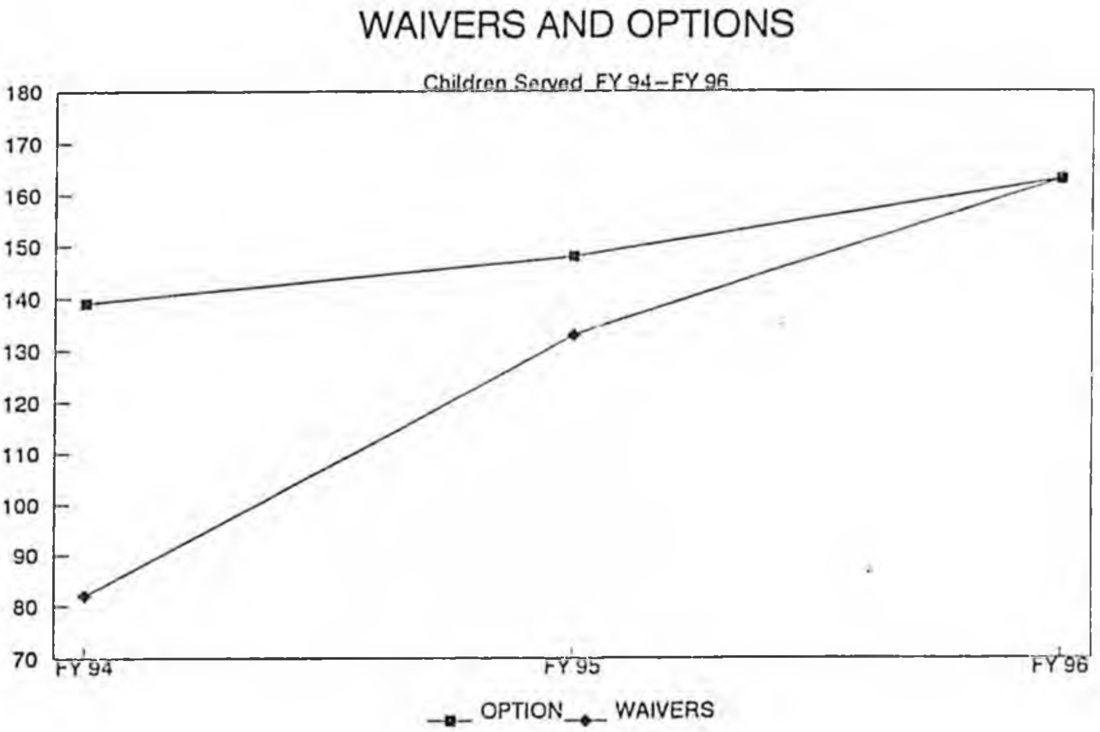
Component Breakout:

Medicaid Non–Facility (70 percent of total costs)	$692.2
Medicaid Facility (30 percent of total costs)	$296.6

FY 96 – FY 99:

It is assumed that all new eligibles covered under this bill in FY 96 or after would receive coverage under waivers if this bill did not pass.

ANALYSIS (cont.):



FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CS SS SB 5 (HES)

Revision Date: 03/29/93
Title: An Act relating to Medicaid eligibility of persons eligible to be institutionalized ...
Sponsor: Ellis, Salo, Lincoln, Duncan
Requestor: Senate State Affairs Committee

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Facilities
COMPONENT SERIAL NO. 230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	499.6	296.6	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	499.6	296.6	0.0	0.0	0.0	0.0

CAPITAL						

REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	249.8	148.3	0.0	0.0	0.0	0.0
1003 GF Match	249.8	148.3	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	499.6	296.6	0.0	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: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from adding new Medicaid recipients. Cost calculations are shown on attached page. Cost per recipient and number of new recipients are taken from home and community-based services waiver applications and supporting documents.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. The cost of serving new eligibles who would also be covered under a waiver is not ncluded in this fiscal note. Some of the cost impact of SB 5 would be increased if that amendment is not fully funded.

The Department has limited experience identifying children living in the community who need an institutional level of care. Any variance with the predicted number of those eligible will impact costs.

Prepared by: Kimberly B. Busch
Division: Division of Medical Assistance
Phone: 465-3355
Date: 04/02/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 4/6/93

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ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

FY 94 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$102.2
Number of new recipients, not on waivers, in FY 94 needing hospital or NF level of care:	21
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$102.2 x 21 x 50% =	$1,073.1

FY 94 Medicaid service costs per recipient needing ICF/MR level of care:	$32.9
Number of new recipients, not on waivers, in FY 94 needing ICF/MR level of care:	36
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$32.9 x 36 x 50% =	$592.2

Total FY 94 cost of Medicaid services for all new recipients:	
$1,073.1 + $592.2 =	$1,665.3

Component Breakout:	
Medicaid Non–Facility (70 percent of total costs)	$1,165.7
Medicaid Facility (30 percent of total costs)	$499.6

FY 95

FY 95 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$111.1
Number of new recipients, not on waivers, in FY 95 needing hospital or NF level of care:	6
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$111.1 x 6 x 100% =	$666.6

FY 95 Medicaid service costs per recipient needing ICF/MR level of care:	$35.8
Number of new recipients, not on waivers, in FY 95 needing ICF/MR level of care:	9
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$35.8 x 9 x 100% =	$322.2

Total FY 95 cost of Medicaid services for all new recipients:	
$666.6 + $322.2 =	$988.8

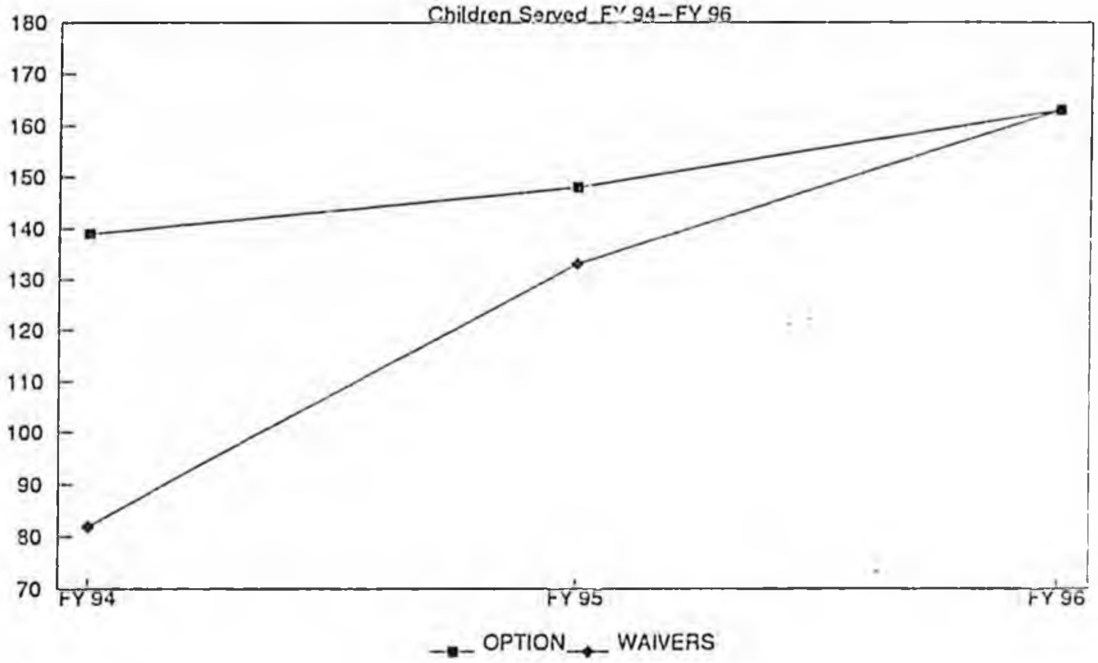
Component Breakout:	
Medicaid Non–Facility (70 percent of total costs)	$692.2
Medicaid Facility (30 percent of total costs)	$296.6

FY 96 – FY 99:

It is assumed that all new eligibles covered under this bill in FY 96 or after would receive coverage under waivers if this bill did not pass.

ANALYSIS (cont.):

WAIVERS AND OPTIONS



FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CS SS SB 5 (HES)

Revision Date: 03/29/93
Title: An Act relating to Medicaid eligibility of persons eligible to be institutionalized ...
Sponsor: Ellis, Salo, Lincoln, Duncan
Requestor: Senate State Affairs

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Claims Processing
COMPONENT SERIAL NO. 243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	25.1	9.0	0.0	0.0	0.0	0.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	25.1	9.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	12.5	4.5	0.0	0.0	0.0	0.0
1003 GF Match	12.6	4.5	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	25.1	9.0	0.0	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: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from an increase in claims processing charges due to increasing new recipients. Cost calculations are shown on the attached page. In addition, FY 94 impact include one-time changes to the Medicaid Management Information System to add a new category of eligibility.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. Failure to fully fund this amendment would increase the cost of SB 5.

Prepared by: Kimberly B. Busch
Division: Division of Medical Assistance
Phone: 465-3355
Date: 04/02/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 4/6/93

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ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

Number of new recipients in FY 94:	57
x claims processing charges per recipient	$0.6
Percent of time in FY 94 recipients are covered	50%
FY 94 claims processing charges (57x$0.6x50%)	$17.1
One–time MMIS modification costs	$8.0
Total FY 94 Claims Processing	$25.1

FY 95:

Number of new recipients in FY 95:	15
x claims processing charges per recipient	$0.6
Total FY 95 Claims Processing (15 x $0.6)	$9.0

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CSSSSB5(HES)

Revision Date:	03/29/93	Dept. Affected:	Health and Social Services
Title:	An Act relating to Medicaid eligibility	BRU:	Public Assistance Administration
		Component:	Eligibility Determination
Sponsor:	Ellis		
Requestor:	Senate State Affairs	COMPONENT SERIAL NO.	270

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	46.8	48.2	49.7	51.1	52.7	54.3
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	5.0	5.0	5.0	5.0	5.0	5.0
SUPPLIES	0.5	0.5	0.5	0.5	0.5	0.5
EQUIPMENT	3.5	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	55.8	53.7	55.2	56.6	58.2	59.8
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	27.9	26.8	27.6	28.3	29.1	29.9
1003 GF Match	27.9	26.9	27.6	28.3	29.1	29.9
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	55.8	53.7	55.2	56.6	58.2	59.8

POSITIONS:

FULL-TIME	1	1	1	1	1	1
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)

CSSSSB5 (HES) expands Medicaid eligibility to cover severely disabled children in home and community-based care. The Division of Medical Assistance estimates that 139 disabled children who do not currently receive Medicaid would become eligible in FY94 under CSSSSB5 (HES) and the Governor's amended budget. This caseload would grow to 148 in FY95 and 163 in FY96.

Additional public assistance field eligibility staff would be required to process applications and maintain Medicaid cases for these additional clients. One additional Eligibility Technician I/II would be necessary to cover the increased caseload.

Prepared by: Jan L. Hansen, Director
Division: Division of Public Assistance
Phone: 465-2680
Date: 4/2/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 4/6/93

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(Rev 11/92)93/fono sle/DGI1

Position Title Eligibility Technician II			
Time Status PFT	Staff Months 12.0		
No. of Positions 1	Range/Step 14B	Bargaining Unit GGU	
Location Anchorage		Election District House 15	

TYPE of EXPENDITURE		AMOUNT
Salary		32.8
Benefits		14.0
Premium Pay		
Other		
Total Personal Services		46.8
Travel		
Contractual		5.0
Commodities		0.5
Equipment		3.5
Other		
Total Cost		55.8

FUNDING SOURCE for TOTAL COST		
1002	Federal Receipts	27.9
1003	GF Match	27.9
1004	General Fund	
1005	GF/Program Receipts	
1006	GF/Mental Health Trust	
1007	I/A Receipts	
1061	CIP Receipts	
Other		

Justification

CSSSSB5 (HES) expands Medicaid eligibility to cover severly disabled children in home and community-based care. The Division of Medical Assistance estimates that 139 disabled children who do not currently receive Medicaid would become eligible in FY94 under CSSSSB 5 (HES) and the Governor's amended budget. This caseload would grow to 148 in FY95 and 163 in FY96.

Additional public assistance field eligibility staff would be required to process applications and maintain Medicaid cases for these additional clients. One additional Eligibility Technician I/II would be necessary to cover the increased caseload.

REQUEST for NEW POSITION

AGENCY: Health and Social Services
BRU: Public Assistance Administration
COMPONENT: Eligibility Determination (270)

Page 1 of 1
Revised Date:

FY94

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SS SB 5

Revision Date:	3/19/93	Dept. Affected:	Health and Social Services
Title:	An Act relating to Medicaid eligibility of persons eligible to be institutionalized ...	BRU:	Medical Assistance
		Component:	Medicaid Non-Facility
Sponsor:	Ellis, Salo, Lincoln, Duncan		
Requestor:	Senate HESS Committee	COMPONENT SERIAL NO.	229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,165.7	692.2	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	1,165.7	692.2	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	582.8	346.1	0.0	0.0	0.0	0.0
1003 GF Match	582.9	346.1	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	1,165.7	692.2	0.0	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: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from adding new Medicaid recipients. Cost calculations are shown on attached page. Cost per recipient and number of new recipients are taken from home and community-based services waiver applications and supporting documents.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. Some of the cost impact of SB 5 would be increased if that amendment is not fully funded.

The Department has limited experience identifying children living in the community who need an institutional level of care. Any variance with the predicted number of those eligible will impact costs.

Prepared by:	Kimberly B. Busch	Phone:	465-3355
Division:	Division of Medical Assistance	Date:	03/22/93
Approved by Commissioner:	Theodore A. Mala, MD, MPH	Date:	3/23/93
Agency:	Department of Health & Social Services		

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ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

FY 94 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$102.2
Number of new recipients, not on waivers, in FY 94 needing hospital or NF level of care:	21
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$102.2 x 21 x 50% =	$1,073.1

FY 94 Medicaid service costs per recipient needing ICF/MR level of care:	$32.9
Number of new recipients, not on waivers, in FY 94 needing ICF/MR level of care:	36
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$32.9 x 36 x 50% =	$592.2

Total FY 94 cost of Medicaid services for all new recipients:	
$1,073.1 + $592.2 =	$1,665.3

Component Breakout:	
Medicaid Non–Facility (70 percent of total costs)	$1,165.7
Medicaid Facility (30 percent of total costs)	$499.6

FY 95

FY 95 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$111.1
Number of new recipients, not on waivers, in FY 95 needing hospital or NF level of care:	6
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$111.1 x 6 x 100% =	$666.6

FY 95 Medicaid service costs per recipient needing ICF/MR level of care:	$35.8
Number of new recipients, not on waivers, in FY 95 needing ICF/MR level of care:	9
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$35.8 x 9 x 100% =	$322.2

Total FY 95 cost of Medicaid services for all new recipients:	
$666.6 + $322.2 =	$988.8

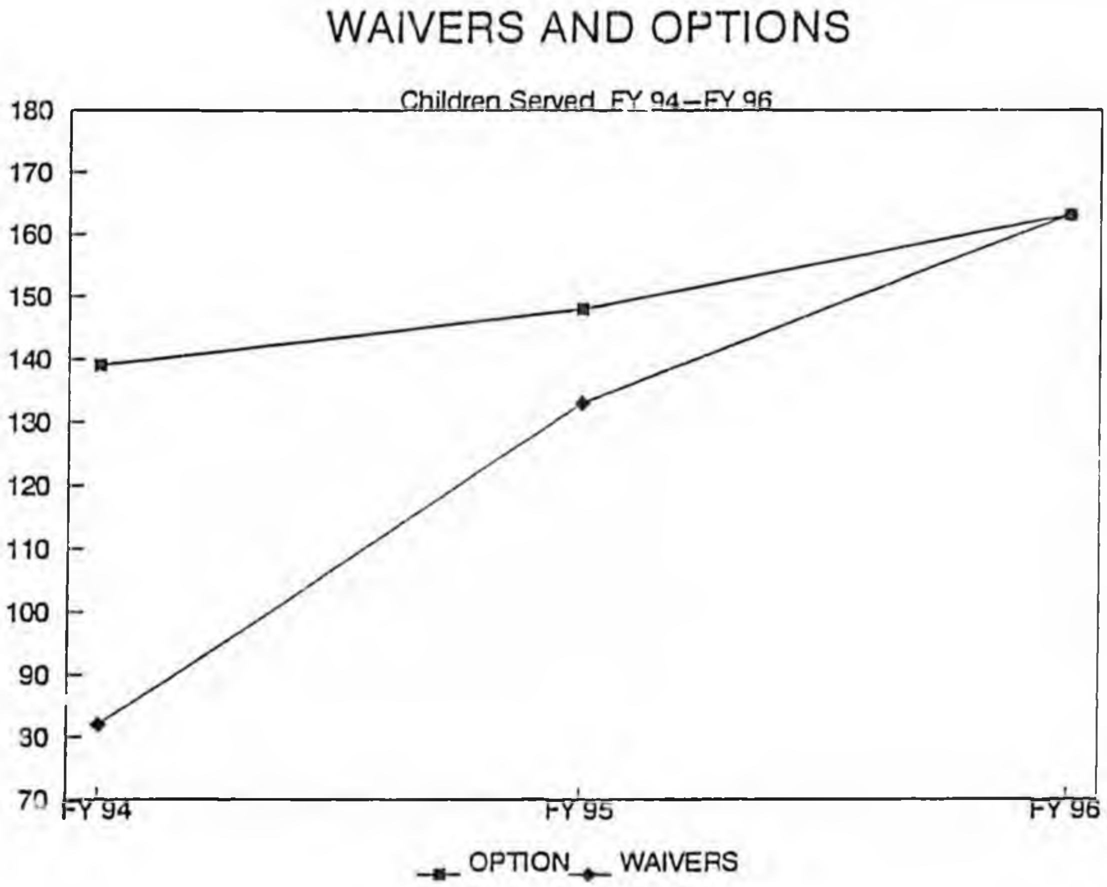
Component Breakout:	
Medicaid Non–Facility (70 percent of total costs)	$692.2
Medicaid Facility (30 percent of total costs)	$296.6

FY 96 – FY 99:

It is assumed that all new eligibles covered under this bill in FY 96 or after would receive coverage under waivers if this bill did not pass.

Revision Date: 3/19/93 BILL NO. SS SB 5

ANALYSIS (cont.):



FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SS SB 5

Revision Date: 3/19/93
Title: An Act relating to Medicaid eligibility of persons eligible to be institutionalized ...
Sponsor: Ellis, Salo, Lincoln, Duncan
Requestor: Senate HESS Committee

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Facilities
COMPONENT SERIAL NO. 230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	499.6	296.6	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	499.6	296.6	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	249.8	148.3	0.0	0.0	0.0	0.0
1003 GF Match	249.8	148.3	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	499.6	296.6	0.0	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: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from adding new Medicaid recipients. Cost calculations are shown on attached page. Cost per recipient and number of new recipients are taken from home and community-based services waiver applications and supporting documents.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. Some of the cost impact of SB 5 would be increased if that amendment is not fully funded.

The Department has limited experience identifying children living in the community who need an institutional level of care. Any variance with the predicted number of those eligible will impact costs.

Prepared by: Kimberly B. Busch KB
Division: Division of Medical Assistance
Phone: 465-3355
Date: 03/22/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 3/23/93

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FISCAL NOTE

ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

FY 94 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$102.2
Number of new recipients, not on waivers, in FY 94 needing hospital or NF level of care:	21
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$102.2 x 21 x 50% =	$1,073.1

FY 94 Medicaid service costs per recipient needing ICF/MR level of care:	$32.9
Number of new recipients, not on waivers, in FY 94 needing ICF/MR level of care:	36
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$32.9 x 36 x 50% =	$592.2

Total FY 94 cost of Medicaid services for all new recipients:	
$1,073.1 ÷ $592.2 =	$1,665.3

Component Breakout:	
Medicaid Non-Facility (70 percent of total costs)	$1,165.7
Medicaid Facility (30 percent of total costs)	$499.6

FY 95

FY 95 Medicaid service costs per recipient needing hospital or nursing facility level of care:	$111.1
Number of new recipients, not on waivers, in FY 95 needing hospital or NF level of care:	6
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$111.1 x 6 x 100% =	$666.6

FY 95 Medicaid service costs per recipient needing ICF/MR level of care:	$35.8
Number of new recipients, not on waivers, in FY 95 needing ICF/MR level of care:	9
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$35.8 x 9 x 100% =	$322.2

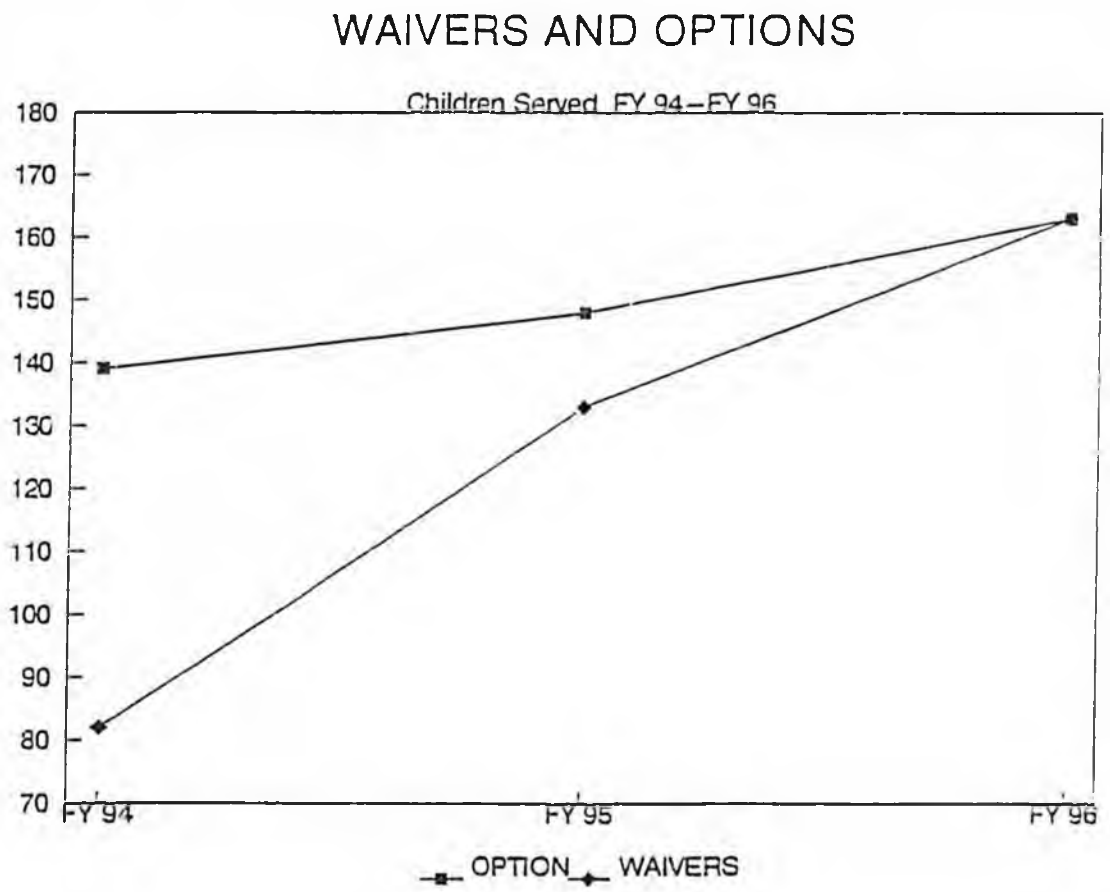
Total FY 95 cost of Medicaid services for all new recipients:	
$666.6 + $322.2 =	$988.8

Component Breakout:	
Medicaid Non-Facility (70 percent of total costs)	$692.2
Medicaid Facility (30 percent of total costs)	$296.6

FY 96 – FY 99:

It is assumed that all new eligibles covered under this bill in FY 96 or after would receive coverage under waivers if this bill did not pass.

ANALYSIS (cont.):



WAIVERS AND OPTIONS

Children Served FY 94–FY 96

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SS SB 5

Revision Date: 03/19/93
Title: An Act relating to Medicaid eligibility of persons eligible to be institutionalized ...
Sponsor: Ellis, Salo, Lincoln, Duncan
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Claims Processing
COMPONENT SERIAL NO. 243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	25.1	9.0	0.0	0.0	0.0	0.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	25.1	9.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	12.5	4.5	0.0	0.0	0.0	0.0
1003 GF Match	12.6	4.5	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	25.1	9.0	0.0	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: 0.0

ANALYSIS: (Attach a separate page if necessary)
The fiscal impact of this bill results from an increase in claims processing charges due to increasing new recipients. Cost calculations are shown on the attached page. In addition, FY 94 impact include one-time changes to the Medicaid Management Information System to add a new category of eligibility.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. Failure to fully fund this amendment would increase the cost of SB 5.

Prepared by: Kimberly B. Busch
Division: Division of Medical Assistance
Phone: 465-3355
Date: 03/22/93

Approved by Commissioner: Theodore A. Mala, MD. MPH
Agency: Department of Health & Social Services
Date: 3/25/93

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Revision Date: 03/19/93 BILL NO. SS SB 5

ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:	
Number of new recipients in FY 94:	57
x claims processing charges per recipient	$0.6
Percent of time in FY 94 recipients are covered	50%
FY 94 claims processing charges (57x$0.6x50%)	$17.1
One–time MMIS modification costs	$8.0
Total FY 94 Claims Processing	$25.1
FY 95:	
Number of new recipients in FY 95:	15
x claims processing charges per recipient	$0.6
Total FY 95 Claims Processing (15 x $0.6)	$9.0

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SSSB5

Revision Date:
Title: An Act relating to Medicaid eligibility
Sponsor: Ellis
Requestor:

Dept. Affected: Health and Social Services
BRU: Public Assistance Administration
Component: Eligibility Determination
COMPONENT SERIAL NO. 270

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	46.8	48.2	49.7	51.1	52.7	54.3
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	5.0	5.0	5.0	5.0	5.0	5.0
SUPPLIES	0.5	0.5	0.5	0.5	0.5	0.5
EQUIPMENT	3.5	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	55.8	53.7	55.2	56.6	58.2	59.8
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	27.9	26.8	27.6	28.3	29.1	29.9
1003 GF Match	27.9	26.9	27.6	28.3	29.1	29.9
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	55.8	53.7	55.2	56.6	58.2	59.8

POSITIONS:

FULL-TIME	1	1	1	1	1	1
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)

SSSB5 expands Medicaid eligibility to cover severely disabled children in home and community-based care. The Division of Medical Assistance estimates that 139 disabled children who do not currently receive Medicaid would become eligible in FY94 under SSSB5 and the Governor's amended budget. This caseload would grow to 148 in FY95 and 163 in FY96.

Additional public assistance field eligibility staff would be required to process applications and maintain Medicaid cases for these additional clients. One additional Eligibility Technician I/II would be necessary to cover the increased caseload.

Prepared by: Jan L. Hansen, Director
Division: Division of Public Assistance
Phone: 465-2680
Date: 3/23/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 3/23/93

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Position Title Eligibility Technician II		No. of Positions 1	Range/Step 14B	Bargaining Unit GGU
Time Status PFT	Staff Months 12.0	Location Anchorage		Election District House 15

TYPE of EXPENDITURE	AMOUNT
Salary	32.8
Benefits	14.0
Premium Pay	
Other	
Total Personal Services	46.8
Travel	
Contractual	5.0
Commodities	0.5
Equipment	3.5
Other	
Total Cost	55.8

FUNDING SOURCE for TOTAL COST		
1002	Federal Receipts	27.9
1003	GF Match	27.9
1004	General Fund	
1005	GF/Program Receipts	
1006	GF/Mental Health Trust	
1007	I/A Receipts	
1061	CIP Receipts	
Other		

Justification

Sponsor Substitute for Senate Bill No. 5 expands Medicaid eligibility to cover severely disabled children in home and community-based care. The Division of Medical Assistance estimates that 139 disabled children who do not currently receive Medicaid would become eligible in FY94 under SSSB 5 and the Governor's amended budget. This caseload would grow to 148 in FY95 and 163 in FY96.

Additional public assistance field eligibility staff would be required to process applications and maintain Medicaid cases for these additional clients. One additional Eligibility Technician I/II would be necessary to cover the increased caseload.

REQUEST for NEW POSITION

AGENCY: Health and Social Services
BRU: Public Assistance Administration
COMPONENT: Eligibility Determination (270)

Page 1 of 1
Revised Date:

FY94

SB

21

SENATOR DAVE DONLEY
ALASKA STATE LEGISLATURE

SB 21
GRANDPARENTS VISITATION RIGHTS

SB 21, referred to as the Grandparents Visitation Rights bill, has never had a public hearing in the Legislature. Currently the bill is still in its first committee of referral, the Senate State Affairs Committee.

I would like the support of senior groups and grandparents for this straight-forward and necessary bill. SB 21 would allow grandparents to petition Superior Court for an order establishing reasonable visitation rights with their grandchildren. Of course, visitation rights would only be granted if the Court deemed it was in the best interest of the child.

While we are in the throes of budget discussions and health care reform, I still think this bill deserves attention this session. It is a simple bill with no partisan undertones and I see no reason why it should not pass the Legislature this year. Please join me in asking your elected representatives to move the bill this session.

If you need additional information on SB 21 contact my office in Juneau at 465-3892. You may also send a free public opinion message through the Anchorage Legislative Information Office (LIO) by phoning 258-8111 and dictating a message of support on SB 21. The message must be less than 50 words and can go to any or all legislators.

January-May: STATE CAPITOL • JUNEAU, AK • 99801-1182 • (907) 465-3892 • FAX: (907) 465-6595
June-December: 716 W. 4TH AVE. • STE. 430 • ANCHORAGE, AK • 99501 • (907) 258-8181 • FAX: (907) 258-5571

CO-CHAIR: Anchorage Caucus • *MEMBER:* Senate Judiciary Committee • Senate Resources Committee

Produced in House

PREFACE

A growing number of grandparents throughout the country have been denied access to their grandchildren by the children's parents or other custodians and have sought legal assistance in obtaining visitation. At least one hundred appellate court decisions involving grandparent visitation rights have been published to date. Yet grandparent visitation law remains a relatively new area of domestic relations law, and there is little literature on the handling of grandparent visitation cases for judges, domestic relations attorneys, mediators and other professionals working in the family law arena.

In the Fall of 1987, the Administration on Aging of the U.S. Department of Health and Human Services provided funds to the American Bar Association for a one-year project focusing on grandparent visitation rights. The project was jointly sponsored by three American Bar Association entities: the Commission on Legal Problems of the Elderly, the Family Law Section, and the National Legal Resource Center for Child Advocacy and Protection. One of the primary goals of the project was to publish this legal resource manual to provide up-to-date information on statutory and case law, existing legal literature, case representation, judicial practice, the role of experts and the use of mediation.

We have many acknowledgements to make. First, we thank the Administration on Aging for providing the grant which made this project possible. We appreciate the tremendous efforts of the authors who contributed to this book. The following authors took time off from their various fields of practice to draft and redraft chapters for the manual: Judge Ernest Rotenberg, Leonard L. Loeb, Marcia B. Gevers, Patricia Fernandez, Dr. Pamela Langelier, and Dr. John Haynes. We also appreciate the help of our Advisory Committee members, who volunteered their time and shared their knowledge: Edith Engel, Dr. Arthur Kornhaber, Dr. Doris Jonas Freed, Leonard Loeb, Bruce Kaufman, T.H. Guerin, Paula Monopoli, Professor Judith Areen, and Daniel Skoler. We thank Inga Van Eysden and Kimberly Shanks, law students who did extensive research and drafted portions of the manual. On the American Bar Association staff we have numerous individuals to thank. We appreciate the guidance and supervision of Nancy Coleman, Staff Director of the Commission on Legal Problems of the Elderly, and Howard Davidson and Bob Horowitz, Director and Associate Director of the National Legal Resource Center for Child Advocacy and Protection. We also would like to thank Beverly Y. Lyons for word processing and performing numerous other helpful tasks, and Norma Gregerman for publication production.

Ellen C. Segal
Naomi Karp

February, 1989

From Grandparent-Visitation Disputes: A Legal Resource Manual

. . . About the American Bar Association Commission on Legal Problems of the Elderly

In 1978, the American Bar Association established the Commission on Legal Problems of the Elderly to examine law-related concerns of older persons. The Commission has encouraged legal services for the elderly, particularly through involvement of the private bar; and has explored legal issues surrounding long term care, home care, guardianship, home equity conversion, surrogate decision-making, and Social Security due process.

. . . About the American Bar Association National Legal Resource Center for Child Advocacy and Protection

Since 1978 the Resource Center has worked to improve laws and professional practices in the child welfare arena. It routinely offers educational opportunities to lawyers and other professionals involved in child abuse, foster care, child support, and other substantive areas of law. One of its principal goals is to improve the way courts and public agencies handle their child welfare caseloads, particularly with an eye towards protecting the rights of children and families. Towards this end, the Center works with legislators, judges and agency administrators in the development and implementation of new laws and policies.

. . . About the American Bar Association Family Law Section

The Family Law Section was established in 1958 to promote the objectives of the ABA by improving the administration of justice in the field of family law, by study, conferences, and publication of reports and articles with respect to providing assistance and guidance to the practice of family law, and to provide assistance with the teaching, promulgation of, and improvement of the welfare and strength of the family unit and its members in all related matters.

Chapter I

INTRODUCTION

American grandparents are becoming increasingly vocal about being denied access to their grandchildren. It appears that more and more grandparents are being deprived of the opportunity to see their grandchildren. These visitation problems seem to reflect broad changes in American society: the divorce rate is growing, family members no longer live in close proximity to one another, and the traditional family unit is becoming diffused. The visibility of the grandparent visitation issue also seems to reflect demographic and political changes: as our population ages, older persons are becoming more verbal about issues affecting them, and legislators, policy makers and service providers are giving those issues more attention.

In the last two decades, grandparents have gained ground in their efforts to obtain court-ordered visitation. Under the common law parental rights doctrine, courts generally refused to order visitation rights for grandparents over the objections of the child's parents. Since 1965, every state (excluding the District of Columbia) has enacted a statute enabling grandparents to petition for visitation rights with grandchildren.

These state statutes vary a great deal. They differ on who is authorized to petition for visitation, when a grandparent may petition, and what standard a court should apply in deciding whether to grant visitation privileges.
The volume of litigation in the grandparent visitation area is growing rapidly. As many as one hundred or more cases may have reached the state appellate court level since 1980; many more have been filed at the trial court level.

Although domestic relations is traditionally governed by state law, there has been considerable activity on the federal level concerning grandparent visitation. In 1982 and 1983, the House of Representatives' Select Committee on Aging Subcommittee on Human Services held hearings on the issue. House Concurrent Resolution 67 was adopted on April 24, 1985 expressing the sense of the Congress that a uniform State act should be developed and adopted which provides grandparents adequate rights to petition State courts for privileges to visit their grandchildren.

APPENDIX A

GRANDPARENT VISITATION STATUTES*

	State	Citation to Statute	On Death[1] of Parent	On Divorce[2] of Parents	After Living with[3] Grandparent	General[4] Provision
1.	Alabama	Ala. Code §30-3-3 (1983)	X	X		
2.	Alaska	Alaska Stat. §25.24.150 (1983)	X	X		
3.	Arizona	Ariz. Rev. Ann. §25-337.01 (Supp. 1987)	X	X		
4.	Arkansas	Ar. Stat. Ann. §9-13-103 (Supp. 1987)	X	X		
5.	California	Cal. Civ. Code §§197.5, 4601 (West 1984 & Supp. 1987)	X			X
6.	Colorado	Colo. Rev. Stat. §19-1-116 (1986)	X	X		
7.	Connecticut	Conn. Gen. Stat. Ann. §§46b-59, -59a (West 1986 & Supp. 1988)				X
8.	Delaware	Del. Code Ann. tit. 10, §950(7) (Supp. 1986)		X		
9.	Florida	Fla. Stat. §61.13(2)(b)2c (Supp. 1987)		X		
10.	Georgia	Ga. Code Ann. §19-7-3 (Supp. 1988)	X			
11.	Hawaii	Haw. Rev. Stat. §571.46(7) (1985)		X		
12.	Idaho	Idaho Code §32-1008 (1983)				X
13.	Illinois	Ill. Ann. Stat. ch.40, para. 607(b)(c) (Smith-Hurd Supp. 1988)	X	X		
14.	Indiana	Ind. Code Ann. §§31-1-11.7-1 to .7-8 (Burns 1987 & Supp. 1988)	X	X		

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*Reprinted, with minor editorial and substantive changes, from J. Atkinson 2 Modern Child Custody Practice §8.19 (1986 & Supp. 1987)

FOOTNOTES

[1] Under this type of provision, visitation could be granted to a grandparent whose son or daughter (the parent of the child) died.

[2] Several statutes also specifically provided for grandparent visitation while the parents are separated, where the marriage was annulled, or where there are or have been child custody proceedings.

[3] The length of the time in which the child lived with the grandparent triggered the right of the grandparent to seek visitation: twelve months (Minnesota and Pennsylvania) and six months (Texas and New Mexico).

[4] "General provision" refers to visitation statutes which did not specify or restrict the circumstances under which a grandparent could obtain visitation.

	State	Citation to Statute	of Parent	of Parents	Grandparent	Provision
15.	Iowa	Iowa Code Ann. §§598.35-.36 (West 1987 & Supp. 1988)	X	X		
16.	Kansas	Kan. Stat. Ann. §60-1616(b) (Supp. 1987)				X
17.	Kentucky	Ky. Rev. Stat. Ann. §405.021 (Baldwin 1984)				X
18.	Louisiana	La. Rev. Stat. Ann. §9:572 (West Supp. 1988)	X	X		
19.	Maine	Me. Rev. Stat. Ann. tit. 19, §752 (Supp. 1988)				X
20.	Maryland	Md. Fam. Law Code Ann. §9-102 (1984)		X		
21.	Massachusetts	Mass. Gen. Laws Ann. ch.119, §39D (West Supp. 1988)	X	X		
22.	Michigan	Mich. Comp. Laws Ann. §§722.72(b), 722.72b (West Supp. 1988)	X	X		
23.	Minnesota	Minn. Stat. Ann. §257.022 (West 1982 & Supp. 1988)	X	X	X	
24.	Mississippi	Miss. Code Ann. §§93-16-1. -3, -5, -7 (Supp. 1988)	X	X		
25.	Missouri	Mo. Ann. Stat. §§452.400, .402 (Vernon 1986)	X	X		
26.	Montana	Mont. Code Ann. §§40-9-101 to -102 (1987)				X
27.	Nebraska	Neb. Rev. Stat. §§43-1801 to -1803 (Supp. 1986)	X	X		
28.	Nevada	Nev. Rev. Stat. §§125A.330, .340 (1987)	X	X		
29.	New Hampshire	N.H. Rev. Stat. Ann. §458:17 VI (1983)		X		
30.	New Jersey	N.J. Stat. Ann. §9:2-7.1 (West Supp. 1988)	X	X		
31.	New Mexico	N.M. Stat. Ann. §§40-9-1 to -4 (1986 & Supp. 1988)	X	X	X	
32.	New York	N.Y. Dom. Re. Law §§72, 240(1) (McKinney 1986 & 1988)	X	X		X
33.	North Carolina	N.C. Gen. Stat. §§50-13.2(b1), .2A, .5(j) (1987)		X		
34.	North Dakota	N.D. Cent. Code §14-09-05.1 (Supp. 1987)				X
35.	Ohio	Ohio Rev. Code Ann. §3109.05(B) (Anderson Supp. 1987)		X		
36.	Oklahoma	Okla. Stat. Ann. tit. 10, § [illegible] (West 1987)	X	X	X	
37.	Oregon	Or. Rev. Stat. §§109.121, .123 (1987)	X	X		

	State	Citation to Statute	On Death[1] of Parent	On Divorce[2] of Parents	After Living with[3] Grandparent	General[4] Provision
38.	Pennsylvania	23 Pa. Cons. Stat. Ann. §§5311-5314 (Purdon Supp. 1988)	X		X	
39.	Rhode Island	R.I. Gen. Laws §§15-5-24.1 to .2 (1981 & Supp. 1987)	X	X		
40.	South Carolina	S.C. Code Ann. §20-7-420(33) (Law. Co-op. 1976)				X
41.	South Dakota	S.D. Codified Laws Ann. §§25-4-52 to -54 (1984)	X	X		
42.	Tennessee	Tenn. Code Ann. §36-6-301 (Supp. 1988)				X
43.	Texas	Tex. Fam. Code Ann. §14.03(e)-(g) (Vernon Supp. 1988)	X	X	X	
44.	Utah	Utah Code Ann. §30-3-5(4),(7) (Supp. 1988)				X
45.	Vermont	Vt. Stat. Ann. tit. 15, 1011-1016 (Supp. 1988)	X	X		
46.	Virginia	Va. Code Ann. §20-107.2 (Supp. 1988)		X		
47.	Washington	Wash. Rev. Code Ann. §26.09.240 (Supp. 1988)				X
48.	West Virginia	W. Va. Code §§48-2-15(b)(1), 48-2B-1 (1986)	X	X		
49.	Wisconsin	Wis. Stat. Ann. §767.245 (West Supp. 1988)				X
50.	Wyoming	Wyo. Stat. §20-2-113(c) (Supp. 1988)	X	X		

CSHB 93(HES)am

(d) If the petition is filed by both spouses under AS 25.24.200(a), the court shall examine the petitioners or petitioner present and consider whether

(1) the spouses fully understand the nature and consequences of their action;

(2) the written agreements between the spouses concerning child custody, child support, and visitation are just as between the spouses and in the best interests of the children of the marriage; in determining whether the parents' agreement on visitation is in the best interests of the children under this paragraph, the court may also consider whether the agreement should include visitation by grandparents and other persons;

(3) the written agreements between the spouses relating to the division of property, including retirement benefits, spousal maintenance, and the allocation of obligations are just; the spousal maintenance and division of property must fairly allocate the economic effect of dissolution and take into consideration the factors listed in AS 25.24.160(a)(2) and (4);

(4) the written agreements constitute the entire agreement between the parties; and

(5) the conditions in AS 25.24.200(a) have been met.

* Sec. 5. AS 25.24.230 is amended by adding a new subsection to read:

(i) Notwithstanding AS 25.24.220(g), the court may, in addition to granting the relief sought by the petitioning spouses, provide in a decree of dissolution for visitation rights of a grandparent or another person who is not a petitioning spouse."

Representative C.Davis moved and asked unanimous consent that Amendment No. 2 be adopted.

Representative Barnes objected.

The question being: "Shall Amendment No. 2 be adopted?" The roll was taken with the following result:

CSHB 93(HES)am

CSHB 93(HES)am
Second Reading
Amendment No. 2

Yeas:	23	Boyer, Brown, Bruckman, Carney, Davidson, B.Davis, C.Davis, Donley, Ellis, Finkelstein, Foster, Gruenberg, Grussendorf, Hudson, Jacko, Koponen, Kubina, Larson, Mackie, MacLean, Moyer, Navarre, Parnell
Nays:	13	Baker, Barnes, Gonzales, Hanley, Leman, Martin, M.A.Miller, M.W.Miller, G.Phillips, R.Phillips, Sharp, Taylor, Zawacki
Excused:	2	Ivan, Lincoln
Absent:	2	Choquette, Ulmer

And so, Amendment No. 2 was adopted and the new title appears below:

> "An Act eliminating a requirement that a court consider the findings and recommendations of a neutral mediator when awarding shared child custody; relating to court orders concerning control of a minor's property rights in child custody proceedings; relating to visitation rights of grandparents and other persons in child custody disputes; allowing a grandparent or other person to petition a court for visitation rights with a child; and allowing a court to consider nonspousal visitation rights when reviewing a dissolution agreement."

Representative Gruenberg moved and asked unanimous consent that CSHB 93(FIN)am be held in second reading for the February 7, 1992, calendar. There being no objection, it was so ordered.

HB 189

The following was read the second time:

> CS FOR HOUSE BILL NO. 189 (FINANCE)
> "An Act establishing the Alaska heritage endowment fund and amending the responsibilities of the Alaska State Museum and of the Museum Collections Advisory Committee; and providing for an effective date."

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07/01/93

BRIEFS

Grandparents' Visitation Rights

Under the common law, grandparents were given no legal rights to visit or communicate with their grandchildren over the objections of a parent.[1] A parent's obligation to allow grandparent visitation was historically seen as a moral one, not a legal one.[2] Yet today all fifty states have created a legal right by legislation granting grandparents such a right in some circumstances.[3] While some states seem to be following a trend to expand grandparent visitation rights, "[t]he majority of state statutes only permit grandparent visitation in one of two situations: (1) where the grandchild's parents have been either separated or divorced; or (2) where one of the grandchild's parents have died."[4]

Within these two situations, determination of granting visitation rights focuses on the best interests of the child. "The State's authority to order grandparent visitation over the objections of the child's parents derives from the State's *parens patriae* power to protect the welfare of children and [thus]. . . must be grounded upon the best interests of the child."[5]

Where the child's parents are no longer married or are living apart, courts have awarded grandparents visitation rights on such bases as a child's past cohabitation with the grandparent and the existence of close emotional ties between the grandparent and child.[6] In the same types of situations, visitation rights have been denied grandparents in the best interests of the child where, for instance, animosity existed between the custodial parent and grandparent.[7] Other courts have asserted that, absent special circumstances, the custodial parent, who has likely been deemed fit and proper by the court, should be the sole authority on whether grandparent visitation rights are in the best interests of his/her child.[8] Where one or both of a child's parents have died, courts have used similar reasoning in the decision of whether or not the grant of grandparent visitation rights is in the best interests of a child.[9]

One specific context in which courts and legislatures have considered grandparents' rights is following the adoption of a grandchild. Although there is no uniformity among the states with regard to this issue, "most legislatures and courts have not permitted grandparents to petition for visitation with the grandchild following an adoption of the child by strangers."[10] However, appellate courts in New York and California have interpreted their state statutes to permit such visitation upon a determination that it is in the child's best interest.[11]

On the other hand, when a stepparent or blood relative adopts a child, the majority of courts and legislatures permit the continuation of grandparents' rights to visit their grandchildren.[12] In this situation, the Illinois Supreme Court has asserted that "such factors as the length and quality of the relationship between grandparents and child, the child's need for continuity in his relationship with people who may have played a significant nurturing role in his life and the effect of the termination of the child's relationship with the parent who had relinquished his rights" must be considered.[13]

The situations discussed thus far have dealt with children in families who, because of divorce, death or adoption, were removed from the normal situation of an intact family. The majority of state statutes confine the rights of third parties petitioning for visitation to children living within such impaired families. However, some state legislatures, "in response to changing sociological pressures, and in recognition of the importance of certain extended family relationships have expanded the rights of third parties to petition for visitation with minor children."[14]

Such broad visitation rights, as have been granted in several states including Connecticut, Kentucky, and Kansas, can effect a subordination of the decisions of parents within an intact family to the decisions of judges. When this occurs, constitutional rights of parental rearing are implicated. The Supreme Court has recognized a fundamental right to rear one's children as one sees fit which is derived from the liberty component of the Fourteenth Amendment.[15] Because such legislation invades the area of constitutionally protected parental autonomy, it has been subject to much criticism. One state, Illinois, rescinded legislation, which expressly granted grandparental visitation rights for children in intact families, only one year after it was enacted.[16]

The constitutional rights of grandparents to visit their grandchildren have been claimed under the due process clause and the equal protection clause. However, such arguments do not seem to have met with much success. The argument that grandparents possess a liberty interest in visitation is weakened by the absence of such a right at common law. The argument that the right to visit children of intact families should be equally protected with the right to visit children whose parents are divorced or not living has also been rejected by at least one court which found that there were valid reasons for treating the two situations differently.[17]

Conclusion

In conclusion, the majority of states provide grandparents with a statutory right to petition for visitation in situations where their grandchildren are not in a traditional family whose married parents object to visitation. On the other hand, only a few state visitation statutes are so open ended that they allow grandparents to obtain visitation with children living in intact families. In all visitation decisions, the courts look to the best interests of the child thus the essence of the conflict is in who should decide what are a child's best interests: parent or state.

ENDNOTES

1. *See* 59 Am. Jur.2d *Parent and Child* 102 (1987).
2. Annotation, *Grandparents' Visitation Rights*, 90 A.L.R.3d 222, 228 (1979).
3. Edward M. Burns, *Grandparent Visitation Rights: Is It Time for the Pendulum to Fall?*, 25 Fam. L.Q. 59, 60 (1991).
4. Rebecca Brown, *Grandparent Visitation and the Intact Family*, 16 S. Ill. U. L.J. 133 (1991).
5. Burns, *supra* note 3, at 70.
6. *See, e.g., Looper v. McManus*, 581 P.2d 487 (Okla. Ct. App. 1978), *Brenner v. Brenner*, 248 P.2d 425 (Cal. Ct. App. 1952).
7. *See, e.g., Re marriage of Lindsey*, 511 N.E.2d 196 (Ill. App. Ct. 1987).
8. *See, e.g., Chodzko v. Chodzko*, 360 N.E.2d 60 (Ill. 1976).
9. *See, e.g., Veazey v. Stewart*, 472 S.W.2d 102 (Ark. 1971).
10. Burns, *supra* note 3, at 67 (emphasis added).
11. *See Johnson v. Fallon*, 129 Cal. App. 3d (1982), *Sibley v. Sheppard*, 429 N.E.2d 1049 (1981).
12. Burns, *supra* note 3, at 68.
13. *Lingwall v. Hoener*, 483 N.E.2d 512 (Ill. 1985).
14. Samuel V. Schoonmaker et al., *Constitutional Issues Raised by Third-Party Access to Children*, 25 Fam. L.Q. 95 (1991).
15. *See Meyer v. Nebraska*, 262 U.S. 390 (1923).
16. *See* Ill. Ann. Stat. ch.40, para. 607 (Smith-Hurd Supp. 1991).
17. *Ward v. Ward*, 537 A.2d 1063 (Del. Fam. Ct. 1987).

5TH STORY of Level 1 printed in FULL format.

Los Angeles Times

August 17, 1993, Tuesday, Home Edition

SECTION: Part A; Page 1; Column 1; Metro Desk

LENGTH: 2194 words

HEADLINE: COLUMN ONE;
PARENTS GET AN OUNCE OF PREVENTION;
HOME VISITORS ACT AS EXTENDED FAMILIES FOR STRESSED-OUT MOTHERS AND FATHERS IN
BID TO CURB CHILD ABUSE. HAWAII'S PROGRAM IS THE PROTOTYPE, AS OTHER STATES TRY
TO REPLICATE THE RESULTS.

BYLINE: By SHARI ROAN, TIMES HEALTH WRITER

DATELINE: OAHU, Hawaii

BODY:

At the Kapiolani Medical Center, where half of all Hawaii's births take place, new parents leave the hospital with a baby and a promise. If things at home become too stressful, parents are told, they can call for help.

That can make a world of difference.

The offer to assist families with the challenges of being a parent is at the heart of a novel child abuse prevention strategy that has brought this isolated state to the attention of health and social service workers nationwide.

While abuse and neglect cases are soaring in most states, Hawaii has greatly curbed child abuse by attempting to mimic the days long ago when relatives and neighbors flocked to a young family's home to lend assistance and support.

"Many other societies have extended families; seldom are people alone in raising a family as they are in this country," said Gail Breakey, director of the Hawaii Family Stress Center and a pioneer of the state's program. "We started to look at domestic violence as a result of this isolation."

Although the era of the extended family is long gone, the concept of helping new parents -- for free -- has been updated and reinvigorated in Hawaii.

The program works this way:

* When children are born, as many families as possible are screened -- with their agreement -- in the hospital for well-known risk factors that can lead to child abuse or neglect. The families considered at risk are offered assistance.

* The assistance comes from a home visitor: a trained worker who helps the family deal with the situations and stresses that can lead to the harming of a child. Home visits usually take place weekly and are offered over a period of years.

Hawaii's success is so talked about that desperate health and child welfare representatives from almost every state have sought a blueprint of the program and have lured Hawaii's experts to the mainland for training workshops and conferences.

Last year, almost 3 million U.S. children were reported to child protective services as alleged victims of maltreatment, a 7.8% increase over the previous year and a 50% jump from 1985.

"There isn't a lot known about how to prevent child abuse. But we know that if we can intervene early, before there is abuse, we can make a big difference," said Leslie Mitchel, of the Chicago-based National Committee for Prevention of Child Abuse. The agency is organizing one of the largest home visitation programs in the nation, called Healthy Families America.

Following the Hawaii model, Healthy Families America has 22 programs under way in 16 states. Programs are in the planning stage in almost every state, including California.

The Hawaii program began in a low-income part of the island in 1975. Like officials from every state, social services workers there were appalled at the relentless increase in child abuse cases. As with other states, Hawaii had numerous programs to deal with families after abuse was reported, but officials began to feel that the programs were like patches on a badly fraying fabric.

They began to think about the causes of child abuse, said Gail Breakey, director of the Hawaii Family Stress Center and a pioneer of the state's program. What they came up with was the extended-family approach.

"By the end of the 1970s, we knew what we were doing was working," Breakey said. "Families were so satisfied and there was no abuse or neglect."

By the late 1980s, a state-funded study of the program showed a 1% abuse rate compared to a 20% rate usually seen in high-risk families nationwide.

Convinced of its value, the Hawaii Legislature institutionalized the program -- setting up the goal of screening every family of every newborn by as early as 1995, and offering assistance to those who need it. Now, about half of all families statewide are screened and 10% of those enter the program.

During screening, trained social workers in Hawaii look for such risk factors as unmarried parents, substance abuse, unemployment, lack of prenatal care and inadequate family income. For those without the multitude of stresses linked to low income, risk factors can include poor parenting skills, not wanting the baby, and a history of mental illness, said Betsy Pratt, a home visitation expert with the Hawaii Family Stress Center.

"We can't look at a family and say this family is at risk for abusing a child. But we can divide families into two groups. One we are reasonably sure will do OK. The other group will need extra support to do well," she said.

Nationwide, there are about 4,000 home visitation programs, although not all have attempted to duplicate Hawaii's program because they lack the funds for such extensive, long-term service. At least 200 programs are operating in California, according to Healthy Families California, a nonprofit, privately funded program that helps interested communities plan home visitation programs.

By offering parent training classes, friendly advice and emotional support to parents of young children, proponents believe they can prevent most child abuse, which usually victimizes children under age 1.

"People don't want to abuse their children," said Sherry Glueck, a Contra Costa County mother who started a home visitation program modeled on Hawaii's. "But many are overwhelmed, hungry, tired and alone. This is what causes child abuse. But if you send in someone to provide warmth and support, one-on-one, it is inspiring."

Others are wary of the movement. They see home visitation as Big Brother telling people how to parent. Even some proponents of home visitation wonder if Hawaii's success can be replicated elsewhere. Hawaii officials credit at least part of their success to the strong emphasis on family -- or ohana -- that exists in island culture. Hawaii is also unique in that it offers universal health coverage to all its residents, and that makes it easier to extend preventive services, such as the child abuse prevention program.

The ways families raise their children in Southern California, however, are as diverse as the many cultures that populate the region. And a method like Hawaii's may not translate to some cultures.

"We like the Hawaii model, but we have concerns about how it might work in South-Central L.A.," said Linda Smith, director of Health Families California.

Hawaii's home visitors help in many ways. A visit might include teaching a parent how to discipline a toddler without spanking or simply how to feed a sleepy newborn. Or, the visitor might tell a single mother how to apply to receive food stamps or how to get her toddler into Head Start.

"There is so much you can do for these families," said Mary Sokup, a home visitor who on this day is visiting the home of Yvette Medeiros and Garrett Wells, and their two children, ages 3 years and 4 months. "We take the families on outings, teach them songs to sing with their children, bring them diapers or a toothbrush, help them fill out paperwork. At some houses, you say, 'Give me a broom and a bucket.' We try to provide whatever they need to make their lives less stressful. Sometimes, we are just there to listen."

Sokup is pleased with the progress of this family, which lives in a two-room, government-subsidized apartment in the run-down Aiea section of Honolulu. Medeiros and Wells are unmarried and unemployed, and the stresses of raising a fussy baby and active toddler in the tiny apartment can frazzle nerves.

With Sokup's help, the family located a secondhand washing machine. Sokup -- whom the family calls "Auntie," a term of endearment in Hawaii -- tipped off Garrett about a possible job. She has coaxed the couple to hold the baby more often instead of putting him in the crib with a propped-up baby bottle. Yvette has followed Sokup's advice to enroll Joshua, the precocious toddler, in preschool.

Sokup does not do the legwork for the couple, however. A goal of all home visitors is nurturing a family's sense of independence, pride and confidence.

"We are there to share with the family, not to tell them what to do," said Cristina Nealon, a home visitor in Oahu.

Home visitors recognize that being a parent does not come instinctively to everyone.

"Some need support in parenting because their parenting skills are pretty poor," Pratt said. "With others, we can teach them how to cope with stress so they don't feel so oppressed by it. Basically, the grandmother who lived two blocks away used to provide what a home visitor provides."

But home visitation is not without criticism. Even though families voluntarily accept the services of a home visitor, there will be a stigma attached to asking for help with parenting, some warn. Others fear that the programs will dictate what parents must do and what values to instill in children.

"People are going to say: 'The government is going to teach you how to be a parent?' " said Andrea Camp, an aide to Rep. Patricia Schroeder (D-Colo.). "We're in favor of home visitation. But I fear that, in a political arena, where things are simplified, this idea can be misinterpreted and seen as politically explosive. I think it might be shot down."

The heavy burden on the home visitors is another criticism of the concept. Some family service organizations wonder if visitors will be safe in certain neighborhoods.

"It's scary to some people," said Lorraine Lima of the Bienvenidos Children's Center Family Services Division in East Los Angeles, where home visitation is offered. "They wonder how their workers will be treated in the home."

Governments might also hesitate to divert precious social services funds into prevention programs, where the benefits may not become apparent for a decade or longer.

Although the method employs a decidedly soft touch, it is the hard numbers that have impressed child advocates nationwide.

A New York program for teen-age mothers modeled after the Hawaii concept recorded a 4% rate of abuse or neglect among mothers who received visitation, while a Sacramento visitation program recorded a 1% abuse rate among its high-risk mothers -- both similar to Hawaii's statistics and far below the 20% national rate for high-risk families.

Officials for Healthy Families America, which was launched last year with funding from Ronald McDonald's Children's Charities, say 46 states have expressed interest in the program and 22 of those have set up demonstration sites. Legislatures in Iowa, Minnesota and Utah have passed bills to provide a steady source of funds for the projects. Similar proposals are pending in Texas, Maine, Massachusetts and Illinois.

"We are realizing now that we will never stem the tide of child abuse until we intervene at the earliest point in a child's life," said Deanne Tilton, a member of the U.S. Advisory Board on Child Abuse and Neglect, which called for widespread implementation of home visitation in a 1991 report. "If we wait for the official child protective system to get involved, it's too late."

One-third of confirmed cases of child abuse fail to receive any type of rehabilitative service, such as court-ordered counseling, visits from a social worker or placement of the child in foster care, studies find. Children who have been abused are at much greater risk for school problems, medical problems, juvenile delinquency and criminal behavior in adulthood.

The cost merely to investigate and provide short-term treatment for a single case of abuse is $2,000, according to the National Center on Child Abuse and Neglect. A significant number of abused or neglected children end up in foster care at a yearly cost of $4 billion to the nation.

"The roots of many of our social problems are in very, very bad childhood situations," said Hawaii's Breakey. "We have to start thinking about early childhood."

Although prevention of child abuse clearly saves money, home visitation also costs money -- lots of it. Programs vary, but a fairly intense visitation program costs about $2,000 per family per year -- considered costly for a prevention program. And, statistically, four out of five of those high-risk families would not abuse or neglect their children anyway.

In order to justify the costs, advocates are shifting away from the notion of home visitation as solely a child-abuse prevention tactic. In Hawaii, programs receiving state funding must also immunize children, discuss family planning options and enroll a significant percentage of their families in prenatal home visitation programs to reduce the incidence of low-birth-weight and drug-exposed infants.

The expansion of services has also worked well, perhaps in part because Hawaii has a universal health care plan. Hawaii's home visitation programs achieved a 98% immunization rate among 2-year-olds last year, far above the national average of 50%.

"This is not just 'how many bruises have we prevented?' " said Smith, of Healthy Families California. "We have to look at what else we can do with home visitation. We have to look at enhancing the child's health, optimizing child development and strengthening families. What we are finding, more and more, is that if we want to protect the child, we have to strengthen the family."

LANGUAGE: ENGLISH