

ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9809 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

03/27/99
10:00:08

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (TESTIFIERS ONLY)
TCN:90425 SCHEDULED FOR:03/27/99 10:00 TO 13:00
PUBLIC HEARING HOUSE HEALTH, EDUCATION & SOCIAL SERVICE

LTN1150
BY:JNU
FOR:ALL

LOCATION: ANCHORAGE

HB 129	TODD	HESS	TESTIFY
HB 129	KEITH	TATON	TESTIFY
HB 129	SOPHIA	MASEWICZ	TESTIFY
HB 129	MICHAEL	GRAHAM	TESTIFY
HB 129	LEWIS	SEARS	TESTIFY
HB 129	FRED	GIDDINGS	TESTIFY

LOCATION: MATSU

HB 129	MR	DON	CHICARELL	TESTIFY
HB 129	MR	ERIC	HENDERSON	TESTIFY



Alaska State Legislature

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

committee on HB 129, dated 03/27/99
bill/subject

I am speaking out against HB 129.

It is clear to me that school principals need whatever employment protection collective bargaining can bring them. One only needs to remember the attempted railroading of Bill Harlow, principal of Colony High School, in the fall of 1997. Also, pick up a copy of the Frontiersman dated March 23, 1999 and read the article entitled "Vindicated". Without collective bargaining and the resulting negotiated agreement justice would have never seen the light of day in the case of Dr. Chicarell.

Lastly, Rep. Ogan's premise for drafting this bill is in error; principals do not create policy, they are charged with carrying out policy.

Again, I am asking you not to support HB 129.

Signed: Steven L. Levine *[Signature]*
Testifier

Representing (Optional)

P.O. Box 875011, Wasilla, AK 99687
Address

373-3220
Phone No.

ASSOCIATION OF ALASKA SCHOOL BOARDS

Advocates for Alaska's Youth

IN SUPPORT OF HB 129

COLLECTIVE BARGAINING FOR PRINCIPALS

The Association of Alaska School Boards supports House Bill 129, which exempts principals from collective bargaining under the Public Employee Relations Act as Class (a)(3) employees with the unlimited right to strike.

This bill helps clarify that as educational leaders, principals are part of the management team. School boards do not believe it is appropriate to be negotiating with their front line people who articulate the district vision and mission within our communities and help implement strategies for effective public education.

We need to empower our principals to act as leaders, and let them take the risks necessary to organize their schools using available resources in a way that best promotes student achievement. Ties to unions can sometimes hinder that progress.

AASB believes that treating principals as management, while maintaining student contact, classroom instruction, and evaluating teachers, allows them to help shape the formulation of policy in a more meaningful way. Good policy is designed from diverse viewpoints. Let's give principals one more reason to think outside the box, to do whatever it takes to help improve student performance in the least restrictive environment.

Matanuska-Susitna Borough School District

Dr. Robert A. Lehman, Superintendent

125 W. Evergreen, Palmer, AK 99645

Phone: (907) 746-9255 Fax: 745-0194



"Developing Productive Citizens
in an Ever-Changing World"

TO: Representative Scott Ogan
FROM: Dr. Robert A. Lehman, Superintendent
DATE: March 24, 1999
SUBJECT: Testimony Regarding House Bill 129

A handwritten signature in black ink, appearing to be 'R. Lehman', is written over the 'FROM' line of the header.

Thank you for this opportunity to testify on House Bill 129. I am sorry that due to a prior commitment, I am unable to deliver my comments in person. I appreciate Representative Ogan reading this into the record on my behalf. I would like to recognize Scott Ogan for the foresight and awareness that led to his introduction of this bill, which would eliminate the unionization of school principals.

To be candid, when I first reviewed this legislation I had mixed feelings about it. This bill proposes a change in the way that we do business as educators. As both an experienced superintendent and trainer of school administrators, I felt an obligation to consider how this legislation would affect the children of Alaska. Several hours of contemplating this and discussing it with colleagues failed to generate one single reason that the unionization of principals in any way enhances student achievement.

In order to validate my findings, I surveyed professional research on principal unionization. I found that the elimination of principal unions and tenure is a national issue. Within the past few years several states, including Georgia, Massachusetts, North Carolina, Wisconsin and Oregon have eliminated the unionization of school leaders. New York, New Jersey and Pennsylvania are moving in this direction. Is it coincidental that these are some of the same states that have made the most progress in moving toward standards based instruction and accountability? According to the National Association of Secondary School Principals, only in 16 states, Alaska included, do principals receive tenure or equivalent rights to a continuing contract.

Why is the concept of collective bargaining for principals on the endangered species list? There are several reasons to eliminate unionization at this level.

The first has to do with the core of the principal's job. Let's make no bones about the fact that schools fail primarily because of poor teaching. Textbooks may be outdated or in short supply, teachers may be underpaid, classes may be too large and parents may even be neglectful, but new books, affluent teachers, smaller classes and attentive parents alone do not insure student learning. We seem to have lost sight of the main reason for principals. They exist not to maintain the status quo, but rather to lead the development of an effective learning relationship between teachers and students. Principals must be empowered to produce results in this realm and then be held accountable for those results.

Another reason that principals should be released from the constraints of unions has to do with the amount of authority delegated to them. They should have a great deal of authority. They need the freedom to organize their schools in a way that makes the best use of available resources for students. It is up to us as superintendents to foster the growth of principals and to determine how much power to delegate to each at any given time. Principals will end up with real authority and respect from the staff and community if they earn it through their actions. They cannot command it based on a union agreement, which by its nature has a ceiling defined by the limitations of the least qualified members. Rather than bargain collectively, they should actively be set free to compete to the ultimate benefit of excellence in schooling.

Additionally, most districts employ a management team operation. This provides a structure for administrators to participate in management planning under the leadership of the superintendent. The elimination of unions will allow principals to be included in the team and to help shape the formulation of policy.

Educational policy has to do with the specific things that make quality education happen. School boards set policy in terms of goals and purposes. They approve specific policies drawn by the administrative team. In this process, the first hand experience and perspective of principals is essential to the making of sound policies. Good policy is designed from diverse viewpoints, independent thinking, and objectivity. It also considers the minority viewpoint. Unions foster single points of view.

The most compelling reason that principals should stay out of unions is the fact that principals are management. Success should be measured based on how well the job is done in comparison to others in similar roles.

We want principals to continue to have a great influence on school systems in Alaska. We need to empower principals who unashamedly do the job better than anybody else and who want a reward system based on performance. These things are the bane and peril of unions. They also have little attraction for principals who are interested only in keeping the lid on and avoiding change.

The passage of this bill will be a landmark in your efforts to stop the decline of our system and enable us to improve the quality of instruction. As Sitting Bull said, "It is time to put our minds together and see what we can do for our children." The children of Alaska deserve no less.

cc: Carl Rose, Executive Director, Association of Alaska School Boards
Darroll Hargraves, Executive Director, Alaska Council of School Administrators

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 129

Revision Date: _____
 Title: "An Act excluding school principals from collectively bargaining under the Public Employment Relations Act."
 Sponsor: Representative Ogan
 Requestor: (H) HES

Department Affected: Administration
 BRU: _____
 Component: Personnel
 COMPONENT SERIAL NO. 56

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

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

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 99) cost: \$ 0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill does not have a fiscal impact on the Department of Administration.

Prepared by: Mike McMullen
 Division: Personnel

Phone: 465-4431
 Date: _____

Approved by Commissioner: Robert Poe, Jr.
 Agency: Department of Administration

Date: 3/23/99

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HB

142

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: March 19, 1999

FURTHER REFERRALS:

Finance

Date of Committee Action: 4/10/99

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 142

HOUSE BILL NO. 142

EDUCATION CREDIT FOR FISHERY TAXES

"An Act relating to the education credit for the fisheries business tax and the fisheries resource landing tax; and providing for an effective date."

recommends it be replaced the same title
 with the following committee substitute _____ a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

fiscal note(s) indeterminate
DOR

fiscal note(s) _____

zero fiscal note(s) DOR

zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
	✓			
	✓			
			✓	
			✓	
	✓			

CHAIR'S SIGNATURE

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 142

BY REPRESENTATIVE DAVIS

- 1 Page 1, line 10, following "association":
- 2 Insert "that is recognized by the Council for Higher Education Accreditation"

- 3 Page 2, line 12, following "association":
- 4 Insert "that is recognized by the Council for Higher Education Accreditation"

Sectional Summary of HB 142

"An act relating to the education credit for the fisheries business tax and the fisheries resource landing tax."

Section 1 of the bill amends AS 43.75.018(a) by providing that certain contributions to certain public Alaska postsecondary educational or vocational institutions are allowed as credits against the fisheries business tax.

Sections 2 of the bill amends AS 43.75.018(c) to provide that each public postsecondary educational and vocational institution receiving contributions subject to AS 43.075.018 must include information on the contributions received and how the contributions were used in its annual operating budget request.

Section 3 of the bill amends AS 43.77.045(a) by providing that certain contributions to certain public Alaska postsecondary educational or vocational institutions are allowed as credits against the fisheries resource landing tax.

Section 4 of the bill amends AS 43.77.045(b) to provide that each public postsecondary educational and vocational institution receiving contributions subject to AS 43.77.045 must include information on the contributions received and how the contributions were used in its annual operating budget request.

Section 5 of the bill provides that this bill will take effect immediately under AS 01.10.070(c).

Sec. 43.75.018. Fisheries business education credit.

(a) For cash contributions accepted for direct instruction, research, and educational support purposes, including library and museum acquisitions and contributions to endowment, by an Alaska university foundation or by a nonprofit, public or private, Alaska two-year or four-year college accredited by a regional accreditation association, a person engaged in a fisheries business is allowed as a credit against the tax due under this chapter

(1) 50 percent of contributions of not more than \$100,000; and

(2) 100 percent of the next \$100,000 of contributions.

(b) [Repealed, Sec. 12 ch 71 SLA 1991].

(c) Each public college and university shall include in its annual operating budget request contributions received and how the contributions were used.

(d) A contribution claimed as a credit under this section may not

(1) be claimed as a credit under another provision of this title; and

(2) when combined with credits taken during the taxpayer's tax year under AS 21.89.070, AS 43.20.014, AS 43.55.019, AS 43.56.018, AS 43.65.018, or AS 43.77.045, exceed \$150,000.

History -

(Sec. 7 ch 58 SLA 1987; am Sec. 53 ch 21 SLA 1991; am Sec. 10 - 12 ch 71 SLA 1991; am Sec. 8 ch 21 SLA 1994; am Sec. 21 ch 126 SLA 1994; am Sec. 20 ch 81 SLA 1996)

Revisors Notes -

In 1991, to harmonize the amendments made by chs. 21 and 71, SLA 1991, the words "by an Alaska" were inserted before "university foundation" in (a) of this section.

Cross References -

For statement of legislative purpose in connection with the enactment of this section, see Sec. 1, ch. 58, SLA 1987 in the Temporary and Special Acts.

For legislative findings, intent, and purpose relating to the amendment of subsection (d) by ch. 81, SLA 1996, see Sec. 1, ch. 81, SLA 1996 in the Temporary and Special Acts.

Amendment Notes -

The first 1991 amendment, effective June 11, 1991, in subsection (a), added "or university foundation" to the end of the first sentence.

The second 1991 amendment, effective January 1, 1992, rewrote subsection (a), repealed subsection (b), and added subsection (d).

The first 1994 amendment, effective May 6, 1994, inserted a section reference in paragraph (d)(2).

The second 1994 amendment, effective July 1, 1994, deleted the former first sentence in subsection (c), relating to the annual departmental report on the credits taken under this section.

The 1996 amendment, effective June 21, 1996, in paragraph (d)(2), inserted a section reference and made related stylistic changes.

Editors Notes -

Section 9, ch. 21, SLA 1994 makes the 1994 amendment to (d) of this section retroactive to January 1, 1994.

Section 29, ch. 81, SLA 1996 makes the 1996 amendment of subsection (d) retroactive to January 1, 1994.

Sec. 43.77.045. Fisheries resource landing tax education credit.

(a) In addition to the credit allowed under AS 43.77.040, for cash contributions accepted for direct instruction, research, and educational support purposes, including library and museum acquisitions and contributions to endowment, by an Alaska university foundation or by a nonprofit, public or private, Alaska two-year or four-year college accredited by a regional accreditation association, a person engaged in a floating fisheries business is allowed as a credit against the tax due under this chapter

(1) 50 percent of contributions of not more than \$100,000; and

(2) 100 percent of the next \$100,000 of contributions.

(b) Each public college and university shall include in its annual operating budget required contributions received and how the contributions were used.

(c) A contribution claimed as a credit under this section may not

(1) be claimed as a credit under another provision of this title; and

(2) when combined with credits taken during the taxpayer's tax year under AS 21.89.070, AS 43.20.014, AS 43.55.019, AS 43.56.018, AS 43.65.018, or AS 43.75.018, exceed \$150,000.

History -

(Sec. 23 ch 81 SLA 1996)

Cross References -

For legislative findings, intent, and purpose relating to the enactment of this section by ch. 81, SLA 1996, see Sec. 1, ch. 81, SLA 1996 in the Temporary and Special Acts.

Effective Date Notes -

Section 30, ch. 81, SLA 1996 makes this section effective June 21, 1996, in accordance with AS 01.10.070(c).

Editors Notes -

Section 29, ch. 81, SLA 1996 makes the 1996 enactment of this section retroactive to January 1, 1994.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 142

Revision Date/Time (Note if correction) April 6, 1999 Dept. Affected Revenue
 Title Education Credit for Fishery Taxes BRU Revenue Operations
 Component Income and Excise Audit
 Sponsor Representative Davis
 Requester HESS Component Serial No. 113

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

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

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

** see attached analysis

Prepared by Brett Fried, Economist Phone 465-3682
 Division Income and Excise Audit Date/Time April 6, 1999
 Approved by Wilson L. Condon Date April 6, 1999
 Commissioner
 Agency Department of Revenue

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ALASKA DEPARTMENT OF REVENUE
Income and Excise Audit Division

Education Credit for Fishery Taxes
HB 124
April 6, 1999
Page 2 of 3

BILL ANALYSIS

Section 1 broadens qualifications for credits against the fisheries business tax (AS 43.75.018) to include contributions made to public nationally accredited Alaska postsecondary educational or vocational institutions. Currently, only contributions made to regionally accredited universities or colleges qualify.

Section 2 directs postsecondary educational or vocational institutions to include the amount of contributions received under section 1, and how they were used, in their annual operating budget request.

Section 3 broadens qualifications for credits against the fisheries resource landing tax (AS 43.77.045) to include contributions made to public nationally accredited Alaska postsecondary educational or vocational institutions. Currently, only contributions made to regionally accredited universities or colleges qualify.

Section 4 directs postsecondary educational or vocational institutions to include the amount of contributions received under section 2, and how they were used, in their annual operating budget request.

Section 5 provides for an immediate effective date.

OPERATING EXPENDITURES

The Department of Revenue does not anticipate additional costs for administering the provisions of this bill.

REVENUE

The attached analysis discusses possible revenue reductions from credits taken under this bill.

ISSUES OF CONCERN

The number of institutions that would qualify depends on how "public" and "nationally accredited" are defined.

Alaska Department of Revenue
Income and Excise Audit Division

Education Credit for Fishery Taxes

HB 142

April 6, 1999

Page 3 of 3

Analysis of SB 241

	FY 96-98 <i>ALL TAX TYPES</i>	FY 96-98 <i>FISHERIES TAXES</i>	<i>PERC. Total</i>
Credits Claimed*	\$7,218,379	\$397,104	5.5%
Contributions*	\$10,162,356	\$574,206	5.7%
Number of Taxpayers	55	8	14.5%

* Maximum qualifying contribution per taxpayer is \$200,000, maximum credit is \$150,000 (first \$100,000 contribution is 50% credit; next \$100,000 is 100% credit)

Current Credit Program

Regionally accredited institutions in Alaska

University of Alaska

Alaska Pacific University

Sheldon Jackson College

Amended Credit Program would add the following institution:

Nationally accredited public institutions in Alaska

Alaska Vocational Technical Center

This analysis assumes that "public" does not include religiously affiliated or for-profit schools and "nationally accredited" refers to "accredited by a national accreditation association recognized by the Secretary of Education of the U.S. Dept. of Education."

Revenue Loss

Although it is impossible to know how adding AVTEC to the list of qualifying institutions will affect the amount of education credits, AVTEC's emphasis on "market driven education in response to the needs of Alaska business and industry"* could translate into a doubling of current qualifying fish tax contributions. Currently, contributions that qualify for credits under the fisheries business and fishery resource landing tax are approximately \$200,000 year.

* Quote from message on AVTEC's web site from Director Fred W. Esposito.



STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF EDUCATION

ALASKA VOCATIONAL TECHNICAL CENTER

P.O. Box 889 • 809 Second Ave. • Seward, Alaska 99664
Phone: (907) 224-3322 Fax: (907) 224-3380



February 16, 1999

Representative Gary Davis
State Capital
Room 513
Juneau, Alaska 99801

Dear Representative Davis:

In the last two years AVTEC has returned \$140,000.00 donated for training purposes by Yukon Delta Fisheries Development Association and their partner, Golden Age Fisheries. The funds were donated as a result of the Fisheries Resource Landing Tax Credit statute.

The Alaska Department of Revenue has disqualified the donations based on the wording of AS 43.77.045 which states that the institution receiving the donation must be "a non-profit, public or private, Alaska two-year or four-year college accredited by a regional accreditation association".

AVTEC has national rather than regional accreditation and is not a two-year or four-year college. The problem could be solved by amending sec. 43.77.045 to read "a non-profit, public or private, Alaska two-year or four-year college (or a public postsecondary institution accredited by a regional or national accreditation association) accredited by a regional accreditation association." The section in parentheses being added and the underlined part deleted.

Your assistance in correcting this oversight would be greatly appreciated. Should you need further explanation please don't hesitate to call. Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Fred W. Esposito".

Fred Esposito
Director, AVTEC

cc: Beth Lape
Special Assistant, DOE

AVTEC Statewide Advisory
Board Members

Additional Information



ALASKA STATE LEGISLATURE

REPRESENTATIVE GARY DAVIS

HOUSE BILL 142 SPONSOR STATEMENT

"An act relating to the education credit for the fisheries business tax and the fisheries resource landing tax; and providing for an effective date."

Under Alaska statutes, some fisheries businesses may receive a tax credit by making cash contributions to educational institutions. Floating fisheries businesses receive the credit against the fisheries resource landing tax and processors receive the tax credit against the fisheries business tax. These cash contributions benefit both the recipients and donors. The recipients benefit from additional monies for education—especially important in these times of declining revenue dollars. Donors benefit because they can target organizations that are vital to their operations and receive a tax credit. The contributions are applied as a credit against the tax due.

Currently only regionally accredited, two-year or four-year, public or private, institutions can receive these cash contributions. HB 142 proposes amendments to AS 43.77.045 the fisheries resource landing tax education credit and AS 43.75.018 the fisheries business education credit. The bill extends the ability to receive donations to nationally or regionally accredited vocational institutions such as AVTEC. The Alaska Department of Revenue disqualified \$140,000 in donations to AVTEC in the past two years because of the wording in the current statute. This bill would remedy this problem and allow for additional revenue sources for postsecondary institutions.

HB

147

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 147

Revision Date: _____
 Title: "An Act relating to vulnerable adults..."
 Sponsor: Health, Education & Social Services
 Requestor: (H) HES

Department Affected: Administration
 BRU: Senior Services
 Component: Protection, Community Services, Administration
 COMPONENT SERIAL NO. 2083

Expenditures/Revenues: (Thousands of Dollars)
 Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2000	FY 2001	FY2002	FY 2003	FY 2004	FY 2005
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

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

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

Estimate of any current year (FY 99) cost: \$ _____

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill will have no fiscal impact on the Department of Administration.

HB 147 increases the department's legal authority to protect vulnerable adults from harm perpetrated by guardians, attorneys-in-fact, or surrogate decision makers by making changes and additions to AS 47.24.015 (c), .019 (a), .019 (c), and .050 (b). The amended language in these sections includes the additions of the terms "guardians, attorneys-in-fact, or surrogate decision makers" as possible perpetrators of harm. Additional amended language gives the department clear authority to petition for a "change of guardian." The amended language also gives the department authority to not disclose a report of harm to "guardians, attorneys-in-fact, or surrogate decision makers" who are alleged perpetrators who are being investigated as such.

Prepared by: Dwight Becker
 Division: Senior Services

Phone: (907) 269-3674
 Date: _____

Approved by Commissioner: Robert Poe Jr.
 Agency: Department of Administration

Date: 3/26/99

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District 32 Representative John Coghill

SPONSOR STATEMENT

HB-147

The Joint Senate/House Long-Term Care Task Force presented this legislation to the House HESS Committee. The Committee then assigned it to a sub-committee for review and revisions. House Bill 147, "An Act relating to vulnerable adults," is before us today.

Current law states that the Department of Administration must terminate an investigation if the suspected abused vulnerable adult requests them to do so. Additionally, an alleged perpetrator who is the guardian or surrogate may also terminate the investigation.

We have a responsibility to protect those seniors who are no longer able to protect themselves. House Bill 147 does that by allowing the Department to continue with their investigation if they have reason to believe the vulnerable adult is in need of protection.

Please join me and the members of the sub-committee by offering your support for this much needed and very important legislation. Thank you.

HB

149

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 149

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Economic Development
 Title An Act relating to Insurance coverage for treatment BRU Insurance
of mental illness and substance abuse Component Insurance'
 Sponsor Davis
 Requester _____ Component Serial No. 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

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

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill has no fiscal impact on this component.

Prepared by Marianne K. Burke, Director Phone 465-2215
 Division Insurance Date/Time 4/6/99 2:30 PM
 Approved by Commissioner Deborah B. Sedwick Date 4.6.99
 Agency Commerce & Economic Development

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April 6, 1999

Representative Gary Davis
Alaska House of Representatives
Juneau, Alaska 99811

Re: HB 149 - Insurance for Mental Illness

Dear Representative Davis:

I have empathy for the purpose of this bill, because I have a sister who suffers with mental illness. However, this bill mandating health care benefits defeats the purpose of Health Care Reform, to lower health care costs and insure more people.

Mandated health care benefits drive up the cost of insurance and increasing the cost of insurance results in fewer individuals being insured. I know many self-employed people who can not afford major medical insurance at the present time, so with additional mandated benefits, there will be more people who can't afford it.

Sincerely,

Dave Moe

cc: Rep. Fred Dyson

FRA FRA

Paul Robinson, President
 Dona Keppers, Vice-President
 Joanne Trefathan, Treasurer
 Barbara Blackshear, Secretary
 Emily F. Ennis, Executive Director

FAIRBANKS RESOURCE AGENCY

805 AIRPORT ROAD, SUITE 1 • FAIRBANKS, ALASKA 99701 • (907) 456-8901 • FAX 452-5171

April 6, 1999

Dear HESS Finance Subcommittee Member:

Please restore the "DD Institutional Prevention" increment to its full funding of \$965,800, as included in the Governor's budget recommendations. This critical funding is needed to assure that DD Community Services can provide the care previously available at Harborview Developmental Center, our state's now-closed institution for adults with mental retardation and other developmental disabilities. The full funding will also assist in assuring adequate services for disabled children and adults living in our communities.

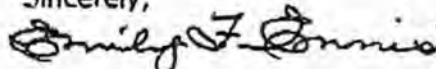
Without full funding, DD organizations cannot begin to solve the current workforce crisis facing them. Due to inadequate pay, benefits and training, qualified employees are not being recruited and retained by DD organizations to provide direct care services. In addition, the turnover rate for employees is exceedingly high, again due to factors related to compensation. These workforce problems increasingly impact the quality of services.

Although DD programs have been expanded over recent years, all new funds have been allocated toward the waitlist. The quality of services that organizations are able to offer has diminished as a result of rising costs without increased funding. The closure of Harborview saw very little savings that were redirected back to DD community services. Yet, these community services are the institutional "back-up" for the state of Alaska!

Please also remember that the state of Alaska made a promise to families when Harborview closed: that their sons and daughters would be just as safe and well cared for in their home communities. This assurance was made to the families who saw their children leave Harborview and to others who have similar needs. The DD community organizations are trying hard to keep that promise.

With full funding, we can prevent the further erosion of DD Community Services, especially in our critical workforce, and strive to keep the promise of well-being in our communities. Thank you for your consideration of the full funding of \$965,800 for DD Institutional Prevention.

Sincerely,



Emily F. Ennis
 Executive Director

Employment Services • Residential Services • Family Services • Respite Care Services • Senior Services
 A United Way Agency

TOTAL P.02

Connecting Ties, Inc.

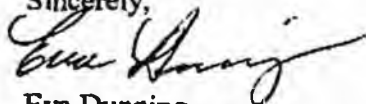
PO Box 2017
Valdez, AK 99686
(907) 835-3274

April 6, 1999

Dear Rep. Fred Dyson

I am a provider to people who experience mental and physical challenges. I have worked in this field for over 30 years. I strongly feel that by cutting funds to any program that helps people who experience mental and physical challenges will have a wide variety of repercussions. All I ask is for you to look very closely at what you do today how it will effect people tomorrow. Alaska worked hard at making Alaska institutional free, I would hope that you would not jeopardize their well being for a dollar.

Sincerely,



Eva Dunning
Executive Director



ALASKA STATE LEGISLATURE

REPRESENTATIVE GARY DAVIS

HOUSE BILL 149 SPONSOR STATEMENT

"An Act relating to insurance coverage for treatment of mental illness and substance abuse; repealing provisions of ch. 8, SLA 1997, that terminates required mental health benefit coverage; and providing for an effective date"

Last year the legislature established a task force to look into the issue of equality between insurance coverage of mental health compared to that of physical health. House Bill 149 contains the recommendations approved by the majority of the task force membership.

This legislation requires businesses with 20 or more employees that provide health insurance benefits for their staff to provide mental health and substance abuse insurance benefits that are equal to those for physical health. Specifically, an insurance plan providing health care cannot:

- require different deductibles, coinsurance or copayments;
- use different claim payment methodologies;
- require different pre-notification of treatment or second opinions;
- limit coverage by provisions for such things as preexisting illnesses that are not applicable to other covered illnesses, or limit treatment services to either inpatient or outpatient services;
- deny reimbursement solely because treatment was interrupted or not completed; and
- impose different annual or lifetime benefit limits, maximum out-of-pocket expenses, day limits or number-of-visit limits.

Coverage for substance abuse is included with mental health coverage because it is common for these ailments to co-exist. People suffering from mental illness may unconsciously attempt to "self-medicate" with drugs or alcohol. For this reason, it is inappropriate to treat one disorder and not address the other. Including substance abuse coverage allows the entire disorder to be treated rather than just one portion.

Recognizing that costs can be contained through managed care, the legislation does not prohibit the involvement of a managed care organization in providing mental health and substance abuse treatment. However, the involvement may not diminish or negate the legislation's requirements, nor may the organization use administrative or clinical protocols that reduce access to treatment.

Mental health disorders cost the economy hundreds of thousands of dollars each year. Whether for treatment, social services, disability payments or lost productivity, the costs are staggering. Many mental disorders are treatable. With early and appropriate treatment, many individuals are able to remain at work and continue to be productive, contributing members of society. To date, however, this treatment has not been readily accessible or financially viable. Even those with coverage normally have such low coverage that they soon run out of benefits and are forced to either discontinue treatment or leave their place of employment to qualify for public assistance.

House Bill 149 requires coverage for mental health disorders equal to coverage for medical health disorders. It recognizes that individuals with any type of medical disorder should be allowed access to coverage.

Session: State Capitol, Juneau, AK 99801 • Phone 907/465-2693 or 800/463-2693 • Fax 907/465-3835
Interim: 145 Main St. Lp., Ste. 223, Kenai, AK 99611 • Phone 907/283-7095 or 907/224-2051 • Fax 907/283-3075
Email: Representative_Gary_Davis@legis.state.ak.us

SPONSOR STATEMENT



ALASKA STATE LEGISLATURE

REPRESENTATIVE GARY DAVIS

HOUSE BILL 149

SECTIONAL ANALYSIS

"An Act relating to insurance coverage for treatment of mental illness and substance abuse; repealing provisions of ch. 8, SLA 1997, that terminates required mental health benefit coverage; and providing for an effective date."

Section 1: Housekeeping measure amending AS 21.36.090 (d) to remove the reference to AS 21.42.365 which is repealed by section 4 of this bill.

Section 2: Repeals and reenacts AS 21.54.150, Coverage for treatment of mental illness and substance abuse, to require health care insurance plans providing coverage for five or more employees in a group market to provide coverage for the treatment of mental illness and substance abuse.

Prohibits the insurer from

- requiring a different deductible, coinsurance or copayment for the determination of mental illness and substance abuse coverage;
- using a different claim payment methodology in determining mental illness and substance abuse coverage;
- requiring prenotification of treatment or second opinions unless the requirement is applicable to other covered major illnesses;
- limiting coverage by provisions of the contract that are not applicable to other covered major illnesses such as preexisting illnesses or provisions requiring the exact date of onset to be known;
- limiting treating services to either an inpatient or outpatient service;
- denying reimbursement for services solely because treatment was interrupted or not completed; or
- imposing annual or lifetime benefit limits, maximum out-of-pocket expenses, day limits, or number of visit limits that are different for the determination of mental illness or substance abuse benefits than for determination of benefits relating to other covered illnesses.

Exempts employers with few than 20 permanent, full-time employees from having to provide this coverage.

States that a health insurance plan that provides coverage for treatment of mental illness through a managed care organization

- may not diminish or negate the provisions of this statute;
- must provide timely and appropriate access to care;
- must provide quantity location and specialty distribution of health care providers; and
- may not use administrative or clinical protocols that reduce access to medically necessary treatment.

Provides definitions for mental illness, substance abuse, treatment of mental illness and treatment of substance abuse.

Section 3 Housekeeping measure amending AS 21.87.340 to remove the reference to 21.42.365 which is repealed in Section 4 of this legislation

Section 4: Repeals AS 21.42.365, Coverage for treatment of alcoholism or drug abuse

Section 5: Repeals sections 116 and 122 of chapter 81 of the 1997 session laws which applied a sunset provision to the previous wording of the statute on mental illness benefits

Section 6: Provides an effective date of July 1, 1999.

Repealed by HB 149.

Sec. 21.54.150. Mental health benefits.

(a) Except as provided in (d) of this section, a health care insurance plan sold in the large employer group market that provides both medical and surgical benefits and mental health benefits shall meet the following requirements:

(1) if the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not provide for an aggregate lifetime limit on mental health benefits;

(2) if the plan includes an aggregate lifetime limit on substantially all medical and surgical benefits, the plan must

(A) include the mental health benefits within the aggregate lifetime limit and may not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(B) provide an aggregate lifetime limit for mental health benefits that is not less than the aggregate lifetime limit for medical and surgical benefits;

(3) if the plan includes different aggregate lifetime limits or none on different categories of medical and surgical benefits, the plan must provide for aggregate lifetime limits on mental health benefits consistent with federal law;

(4) if the plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not provide for an annual limit on mental health benefits;

(5) if the plan includes an annual limit on substantially all medical and surgical benefits, the plan must

(A) include the mental health benefits with the annual limit and may not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(B) provide an annual limit for mental health benefits that is not less than the annual limit for medical and surgical benefits; and

(6) if the plan includes different annual limits or none on different categories of medical and surgical benefits, the plan must provide for annual limits on mental health benefits consistent with federal law.

(b) Except as provided otherwise in this title, a health care insurance plan is not required to provide mental health benefits.

(c) Except as otherwise provided in this title, this section does not affect the terms and conditions relating to the amount, duration, or scope of mental health benefits under a health care insurance plan that provides mental health benefits, including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity.

(d) This section does not apply if application of this section would result in an increase in the cost under the health care insurance plan of at least one percent.

Repealed by HB 149

Sec. 21.42.365. Coverage for treatment of alcoholism or drug abuse.

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, except for catastrophic illness insurance, providing coverage for five or more employees of an employer in the group market shall provide a covered employee or the employee's dependent the following coverage for treatment of alcoholism or drug abuse:

- (1) benefits of at least \$9,600 over two consecutive benefit years; and
- (2) lifetime benefits of at least \$19,200.

(b) The benefits described in (a) of this section shall be adjusted January 1, 1999, by the director and every three years thereafter to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor. The base year for the first adjustment shall be calendar year 1996.

(c) A health care insurer that offers a health care insurance plan providing coverage under this section may not

(1) require that a covered employee or the employee's dependent be responsible for a deductible or copayment that is different for the determination of benefits relating to treating alcoholism or drug abuse than for the determination of benefits for treating another covered illness;

(2) use a different claim payment methodology in determining the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for treating another covered illness;

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other covered major illnesses;

(4) limit coverage by provisions of the insurance contract that are not applicable to other covered major illnesses, including provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

(d) Notwithstanding (a) of this section, if an employer employs fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, a health care insurer is not required to provide the coverage specified in (a) of this section to the employer but shall offer that coverage to the employer as optional coverage.

(e) In this section,

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self-control in using alcoholic beverages or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either

approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "catastrophic illness insurance" means a health care insurance plan that provides benefits for hospital and medical care with a lifetime maximum benefit per insured of at least \$250,000 and that has a deductible of at least \$5,000;

(4) "cost" means the least of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse;

(B) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or

(C) the charge agreed to by contract between the treatment provider and the health care insurer;

(5) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility.

Chapter 81, SLA 1997
Chapter: CH081
Source: HCS CSSB 104 (FIN)
Action Date: June 13, 1997
Effective Date: See Chapter
97

AN ACT

Relating to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; relating to the portability and availability of health care insurance; making amendments to the insurance statutes to conform to federal requirements regarding health insurance; relating to the repeal of certain small employer health care insurance provisions; requiring that uninsured and underinsured motor vehicle insurance apply to claims of an insured even if other policy limits are not exhausted; repealing delayed provisions relating to dental, vision, and hearing insurance in secs. 3 and 4, ch. 101, SLA 1992; repealing delayed provisions relating to small employer health care insurance in secs. 4, 7, 9, and 12, ch. 39, SLA 1993; repealing the delayed effective date in sec. 5, ch. 101, SLA 1992, and in sec. 13, ch. 39, SLA 1993; and providing for an effective date.

Section 1. PURPOSE. The purpose of secs. 3, 11, 12, 31 - 34, 43 - 57, 59 - 90, 99 - 102, 108, 111, 112, 115 - 119, and 122 of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

Sec. 116. AS 21.54.150, enacted by sec. 59 of this Act, is repealed.

Sec. 122. Section 116 of this Act takes effect September 20, 2001.

**POSITION STATEMENT OF
HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)
ON HOUSE BILL 149 (MENTAL HEALTH PARITY)**

April 8, 1999

The Health Insurance Association of America ("HIAA") is a national trade association of commercial health insurance companies which provide health insurance for approximately 55 million Americans.

Over the past two years, an increasing number of states have considered legislation requiring expansive coverage for mental health benefits, far beyond what is required under federal law.

In 1998 alone, 32 states considered 88 bills requiring what advocates have termed "mental health parity." Wary of the cost associated with mental health parity mandates, most states have rejected such proposals. To date, only 14 states have enacted a mental health parity mandate exceeding what is required under federal law. The only state to do so this year is Pennsylvania. However, with only one exception (Vermont), the states that have chosen to adopt mental health parity mandates have placed significant limitations on parity requirements. Examples include: exempting individual and small employer group health plans; limiting the mandate to serious or biologically-based mental illnesses; and permitting employers who experience more than a minimal cost increase as a result of the mandate to opt out.

Position Statement

**Health Insurance Association
of America (HIAA)**

HIAA Position Statement
HB 149 - Mental Health Parity
Page 2

Significantly, most employers and many individuals already purchase insurance coverage for mental illness, often with reasonable limits on inpatient and outpatient treatment. According to the Employee Benefits Research Institute, 98% of employees in medium and large firms have coverage for inpatient mental health care and 97% have coverage for outpatient care. Although many purchasers of insurance opt for less than full "parity" between benefits for physical and mental illness, existing levels of coverage represent a significant commitment providing benefits for mental illness.

Health benefit mandates, including mental health parity mandates, constrain the ability of insurance purchasers and consumers to choose for themselves what is the appropriate level of coverage for their needs based on the best available information about medical technologies and treatments at the time. Mandates unwisely lock into law what should be a flexible and evidence-based decision about appropriate levels of coverage made in the context of rapidly advancing medical knowledge and evolving medical technologies. Choices about the distribution of health insurance dollars among different types of benefits should remain in the hands of purchasers and consumers, who are in the best position to determine what is the most efficient and appropriate allocation of their resources.

HIAA Position Statement
HB 149 - Mental Health Parity
Page 3

Among other problems with mental health mandates are:

* Forcing the purchase of benefits that consumers may not want or can't afford only ensures that many more individuals will be unable to afford any insurance at all. Some national studies show that for every 1% increase in the cost of insurance, between 200,000 and 600,000 individuals lose coverage [1]. Similar research on small businesses has found that with each 1% increase in premiums, 2.6% of small employers offering health insurance drop the coverage [2]. If mental health parity increases the cost of insurance by 4 to 10%, as many studies estimate [3], states pursuing such mandates can expect that between 10.4% and 26% of their small employers no longer will be able to afford coverage.

* Small employers are singled out to bear the cost. Large employers who can afford to self-insure are unaffected by state mental health mandates. Under ERISA, they are exempt from such mandates and retain the ability to purchase coverage with reasonable limits on mental health benefits. Small employers don't have this option. They typically can't afford to establish a self-insured health plan governed by ERISA.

* Some of the studies referred to also assume that benefits for physical illnesses will be reduced to compensate for

additional mandated mental health benefits. For example, several studies conducted by Coopers & Lybrand place too much emphasis on cost offsets that may not materialize, and ignore the true cost increases that will be borne by employees and consumers. It is also important to note that the final cost estimates developed by Coopers & Lybrand only reflect the financial impact on employers. The analysis assumes that employers will find various ways to offset the cost increases -- such as passing the cost on to employees. This does not mean that those costs do not exist or are unimportant; it simply means that *someone else is paying the bill*, namely the employee or individual health insurance purchaser. To understand the full impact of any proposal, the full cost should be considered rather than just the employer's contribution portion.

* The term "mental health parity" is misleading. Open-ended mandates for "mental health parity" sound appealing but have the effect of eliminating accountability for determining what constitutes a medically recognized mental illness and may result in fewer available dollars for the treatment of serious mental diseases. Critics charge that the Diagnostic and Statistical Manual of Mental Disorders (DSM), a widely-used

classification of mental ailments, increasingly "medicalizes many behaviors once considered traceable to character flaws."

According to one commentator:

"There is a clear motive for defining new mental disorders and marketing psychotropic medications for adults. . . . [A]s recently as 18 years ago, the DSM had only 106 mental disorders [compared to the 300 now listed. As a result,] less money is available to treat those with serious, debilitating mental illnesses whose sufferers have little clout." [4]

* Open-ended mental health mandates will effect a massive shifting of costs from existing social programs to private, largely small employer-based, insurance. In many states, mental health activists have proposed mandates that would classify problems such as learning disabilities as a mental illness subject to mandatory coverage. If enacted, such proposals would effect a massive shift of costs from existing social programs to employer-sponsored health plans. Because ERISA exempts self-funded health plans maintained by large employers from state mandates, the weight of this cost shift will fall largely on small employers.

I would note one other small problem (no pun intended): There could be some coverage confusion regarding small employers. Alaska's Small Employer Health Care Insurance statute (AS 21.56) defines small employers as those with two to 50 employees.

This bill states an insurer shall provide coverage for mental illness and treatment of substance abuse in employer group plans covering five or more employees, but then says the insurer must only offer such coverage as an option if an employer has "fewer than 20 permanent, full-time employees," i.e., employers who have up to 19 employees. When is a small employer a small employer. You go try to figure it out.

- [1] Independent studies on file with HIAA.
- [2] See Morrisey, et al, "Small Employers and the Health Insurance Market." p.155, n. 16, *Health Affairs* (Winter 1994)
- [3] See HIAA fact sheet, *State Mental Health Mandates: Cost and Effect on Coverage* (summarizing studies on cost of mental health parity).
- [4] Herb Kutchins, Professor of Social Work, California State University, Sacramento (quoted in the *New York Times*, September 28, 1997).



Health Insurance Association of America

Sender's direct tel.: 202-824-1737

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FAX MESSAGE

TO: Wes Keller 907-465-4587
CC: Gordon Evans 907-586-3762
FROM: Joe Holahan
DATE: April 6, 1999
PAGES: 11 (including this page)

Wes,

I have attached an excerpt from the U.S. Health and Human Services (HHS) study with their cost estimates for mental health parity under the 1996 federal parity law. See page 6 for their estimate of the cost of substance abuse parity only. Note that the cost impact varies, depending on the type of health plan involved. The estimated effect is greatest for fee-for-service plans.

HHS estimates that full parity (mental health and substance abuse) would increase the cost of fee-for-service coverage by 5% (see chart on page 5). We believe this is a conservative estimate.

Managed Care● **Mental Health Parity**● **Publications**● **Database**● **Links**● **Calendar**● **Homepage**

Search

Parity**The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits**

Merrile Sing
 Steven Hill
 Suzanne Smolkin
 Nancy Heiser

U.S. Department of Health and Human Services
 Public Health Service
 Substance Abuse and Mental Health Services Administration
 5600 Fishers Lane
 Rockville, MD 20857

Additional Copies

For additional copies of this document or associated background reports, please write or call the Knowledge Exchange Network, 11426-28 Rockville Pike, Suite 405, Rockville, MD 20852, 1-800-789-2647.

Originating Office

Office of Managed Care
 Center for Mental Health Services, SAMHSA
 5600 Fishers Lane, 15C-17
 Rockville, MD 20857
 March 1998
 DHHS Publication No. (SMA) 98-3205 Printed 1998

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Options for Providing Parity in MH/SA Insurance Benefits

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Estimated Premium Increases for Child Health Plans

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Parity Report
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Parity

Chapter 4 - Cost Estimates

One main goal of this study was to project the costs of providing parity for mental health and substance abuse (MH/SA) insurance benefits. We did this by using an actuarial model to predict the premium increases for three benefit options. One option gives full parity, and the other two give partial parity, for MS/SA benefits. Information about the relative costs of parity options can be used by employers and benefit managers who want to assess the tradeoffs between offering full or partial parity for MH/SA benefits.

In this chapter, we present the three parity benefit options we developed and discuss the updated actuarial model we used to determine our cost estimates of premium increases for families. We also determine increases in premiums for child health plans with parity that states may develop as a result of the Balanced Budget Act of 1997. Finally, we offer some caveats for interpreting the results.

Options for Providing Parity in MH/SA Insurance Benefits

The three benefit options we analyzed in this study were developed in consultation with this project's policy advisory panel. The panel included representatives from the business community and from mental health, substance abuse, and managed care organizations in the public and private sectors (see Appendix C).

We estimated premium increases for one full and two partial MH/SA parity benefit options. In this study, "full parity" means that insurance benefits for any group of MH/SA diagnoses must be the same as insurance benefits for medical/surgical diagnoses with respect to three areas--cost sharing (such as copayment or coinsurance amounts), service limits (such as the number of outpatient visits or inpatient hospital days), and annual or lifetime spending limits (such as annual or lifetime benefit maximums).

Partial parity means that benefits for MH/SA diagnoses must be the same as benefits for medical/surgical diagnoses in two of the three areas listed above. One of the partial parity options requires parity with respect to cost sharing and spending limits. The other requires parity with respect to service limits and spending limits. Both partial parity options comply with the Mental Health Parity Act of 1996, since they require parity with respect to spending limits.

The costs of each full and partial parity option are predicted for the following diagnosis groups and plans:

- three diagnosis groups for families (all MH/SA diagnoses, MH diagnoses only, SA diagnoses only); and all MH/SA diagnoses for children only; and
- four plan types (FFS, PPO, POS, and HMO).

The baseline (initial), partial parity, and full parity MH/SA benefit options for a FFS plan are listed in Table 4.1. Full parity plans are listed in Table 4.2. For each plan type, the full parity benefit options have unlimited MH/SA

inpatient days and outpatient visits. The cost-sharing requirements are the same as the cost-sharing requirements for medical/surgical benefits for the typical plan. For FFS plans, the cost-sharing requirement for covered services under the full parity option includes a 20 percent coinsurance payment for inpatient and outpatient services.

The typical plan was determined based on a review of the literature (O'Grady, 1996; KPMG Peat Marwick, 1997). In addition, our expert of actuaries and economists reviewed our assumptions about the benefit packages.

TABLE 4.1
PARTIAL AND FULL PARITY BENEFIT OPTIONS FOR A FEE-FOR-SERVICE PLAN

MH/SA Service	Baseline Benefits (Typical FFS Benefits)	Partial Parity		Full Parity
		Parity in Service Limits	Parity in Cost Sharing	
Inpatient Hospital	30 days 20% coinsurance	Unlimited days Days 1-30: 20% coinsurance More than 30 days: 50% coinsurance	30 days 20% coinsurance	Unlimited days 20% coinsurance
Outpatient	20 visits 50% coinsurance	Unlimited visits 50% coinsurance	20 visits 20% coinsurance	Unlimited visits 20% coinsurance

TABLE 4.2
FULL PARITY BENEFIT OPTIONS

MH/SA Service	Fee-For-Service	PPO		POS		HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Inpatient Hospital	Unlimited days 20% coinsurance	Unlimited days 10% coinsurance	Unlimited days 30% coinsurance	Unlimited days fully covered	Unlimited days 20% coinsurance	Unlimited days covered in full
Outpatient Services	Unlimited visits 20% coinsurance	Unlimited visits 10% coinsurance	Unlimited visits 30% coinsurance	Unlimited visits \$10 copayment	Unlimited visits 20% coinsurance	Unlimited visits \$10 copayment

Method for Estimating Costs

We used actuarial cost models developed by the HayGroup to estimate the costs of the full and partial parity benefit options. The model in our study improves on models in previous actuarial studies in several ways. First, it was recently revised by the HayGroup. This revised version includes expense data from managed behavioral health care companies, separate expense data for substance abuse services, and separate data on MH/SA expenses for children. Earlier versions of the HayGroup model did not include these features.

Second, the assumptions we used to estimate the premium increases, as defined in chapter 3, were reviewed by this project's expert panel of actuaries and economists. Many of our initial assumptions were revised according to their comments. Third, our assumptions incorporate new data and case study findings that were not available in 1996. Finally, we produced separate estimates for a wider range of benefit options, diagnosis groups, and health plan types than previous studies. The updated actuarial model and assumptions are described more fully in Sing and Hill (1998a).

The Estimation Process

The estimation process is as follows. The models predict premiums for health plans by using data on the benefit packages of the full and partial parity benefit options. These data include information on covered services, service

limits, and cost-sharing arrangements. The model then builds in assumptions about administrative costs, the level of utilization management, and patients' responses to changes in their out-of-pocket costs.

The cost of each parity benefit option is the difference between the predicted premium for that option and the estimated premium for a "baseline plan." In this study, a baseline plan is a typical health plan covering medical/surgical and MH/SA services. For each plan type, it is the benefit package that has the most enrollees (the statistical mode). For example, a typical FFS plan covers 30 days of inpatient care and 20 outpatient visits for MH/SA services (O'Grady, 1996). In comparison, a full parity FFS plan would cover unlimited inpatient days and outpatient visits for MH/SA services.

Appendix B illustrates how to compute the premium increase due to a benefit option with increased MH/SA insurance benefits. The new premium is the sum of the baseline MH/SA and medical/surgical expenditures plus the increase in MH/SA expenditures. The percentage premium increase is the difference between the new premium and the baseline premium, divided by the baseline premium. A large percentage change in MH/SA expenditures causes a small change in premiums, because MH/SA expenditures account for only a small part of premiums (4 percent to 6 percent of the expense data in the HayGroup model, depending on the type of health care plan).

The HayGroup Actuarial Model

The HayGroup actuarial model has been used extensively to study the effects of proposed policies for the federal government. Earlier versions of this model were developed under contract with the Congressional Research Service (CRS). These versions were used to predict the costs of the Mental Health Parity Act of 1996 and the Domenici-Wellstone amendment to the Health Insurance Reform Act of 1996. The model was recently updated in consultation with the National Institute of Mental Health. The updated model includes data from managed behavioral health plans, separate expense data for children, and substance abuse data (Hay/Huggins Company, Inc., 1997b).

Sturm (1997) recently criticized an older version of the HayGroup model. He believes that the model overstates the costs of parity because it does not adequately account for managed care in the delivery of MH/SA services. This criticism is no longer relevant since the revised model includes data and assumptions for managed behavioral health plans.

Assumptions about PPO and POS plan network use and provider discounts. The HayGroup actuarial model is adjusted to incorporate three features of PPO and POS plans. These features are (1) network provider discounts, (2) coverage for in-network and out-of-network services, and (3) the effects of utilization management by POS gatekeepers.

Enrollees in PPO and POS plans pay lower out-of-pocket costs when they use network providers. These lower costs encourage enrollees to use these providers. Enrollees in PPOs can self-refer to any provider they wish to see. However, many enrollees in POS plans are assigned to a primary care network provider called a "gatekeeper." The gatekeeper must authorize all in-network service use (Jensen, et al., 1997). Providers in PPO and POS networks agree to charge a discounted price for the services they provide to PPO and POS plan enrollees.

For PPO and POS plans, the HayGroup model assumes that 70 percent of care is given by network providers. The

model also assumes that the plan receives a 15 percent discount from network providers. For POS plans only, the model assumes that the use of in-network services is further reduced by 12 percent due to services denied by gatekeepers. The model assumes that POS out-of-network service use increases by 15 percent. This is based on the assumption that some POS plan enrollees will seek treatment out of network (and pay a higher coinsurance rate) when the gatekeeper denies in-network care.

Types of MH/SA treatment. The model does not separately compute expenditures for psychotherapeutic drugs, intensive nonresidential care, and SMI. This is because usable expense data for these services are not available. However, expenses for intensive nonresidential care services and partial hospitalization are included in the model's inpatient and outpatient expense data.

Estimated Premium Increases for Families

The model predicts that *full parity for all MH/SA diagnoses will raise family premiums for a composite of plans by 3.6 percent* (Table 4.3). By "composite" we mean a weighted average of fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO) plans. Mental health care accounts for most of this increase (3.4 percent).

Although MH/SA expenditures would increase by 75 percent, the premium increase is 3.6 percent because MH/SA expenditures are only 4 percent to 6 percent of health expenditures at baseline, depending on the type of plan. Premium increases are the largest for FFS plans and PPOs (5.0 and 5.1 percent).⁵ Premium increases are lower for tightly managed HMOs (0.6 percent) (Table 4.4).

⁵ Total premiums rise slightly more in PPO plans than in FFS plans because MH/SA expenditures are a larger proportion of the PPO premium (4.3 percent) than of the FFS premium (3.9 percent).

Our tables do not report separate estimates for the parity options for serious mental illnesses (SMI), since the model cannot compute premium increases for changes in these benefits. However, a very "rough" estimate for SMI parity options can be obtained by pro-rating the predicted cost increases for the mental health parity options.

One way to do this is to use findings from two studies conducted by Milliman and Robertson, Inc. One study (Melek and Pyenson, 1996b) estimated that parity for SMI, as defined in S.298 (which did not pass), would increase premiums by 2.5 percent. The other study (Melek and Pyenson, 1996a) estimated that parity in benefits for all mental health diagnoses would increase premiums by 2.8 percent.

These studies suggest that expenses for SMI represent 89 percent of the increase in expenditures for all mental health diagnoses due to parity, since 2.5 percent is 89 percent of 2.8 percent. Therefore, to get a rough estimate of the increase in premiums due to parity for SMI, we can assume that the premium increase for SMI parity is 89 percent of the premium increase for mental health parity.

TABLE 4.3
AVERAGE PREMIUM INCREASES AGGREGATED ACROSS PLAN TYPES

MH/SA Diagnoses	Average Premium Increase		
	Parity in Cost Sharing	Parity in Service Limits	Full Parity
MH/SA	0.4	1.2	3.6

4

MH only	0.3	1.1	3.4
SA only	0.1	0.03	0.2

NOTES:

1. The premium increases for FFS, PPO, POS, and HMO plans were aggregated by assuming the following distribution of enrollees among plan types:

FFS 20%
PPO 30%
POS 20%
HMO 30%

2. The table indicates increases in family premiums. Family premiums are computed from the individual adult and child premiums using the following formula:

$$\text{Family premium} = (1 + .84 * 1.08) * \text{adult premium} + 1.22 * \text{child premium}$$

This formula assumes that 84 percent of employees are married, the cost of coverage for the spouse is 1.08 times more than the cost for the employee, and that there are 1.22 children per family on average. The demographic assumptions are based on data from the Current Population Survey. The cost of coverage for a spouse relative to the employee is based on data for a typical plan (Hay/Huggins Company, Inc., 1997a).

3. Premium increases do not necessarily add up within columns due to rounding.

TABLE 4.4
PERCENTAGE INCREASES IN TOTAL PREMIUMS BY DIAGNOSIS AND PLAN TYPE

Diagnosis	Percentage Increase in MH/SA Expenses			Percentage Increase in Total Family Premium		
	Parity in Cost Sharing	Parity in Service Limits	Full Parity	Parity in Cost Sharing	Parity in Service Limits	Full Parity
FFS						
MH/SA	15.4	41.7	126.8	0.5	1.4	5.0
MH only	13.5	40.5	119.8	0.4	1.3	4.8
SA only	1.9	1.2	7.0	0.1	0.05	0.3
PPO						
MH/SA	17.0	40.0	117.7	0.6	1.5	5.1
MH only	14.8	38.7	111.4	0.5	1.4	4.8
SA only	2.2	1.3	6.3	0.1	0.1	0.3
POS						
MH/SA	0.2	33.9	64.6	0.00	1.7	3.5
MH only	0.2	33.4	63.1	0.00	1.7	3.4
SA only	0.00	0.4	1.6	0.00	0.02	0.1

	HMO					
MH/SA	6.1	3.7	11.6	0.3	0.2	0.6
MH only	5.5	3.7	10.9	0.3	0.2	0.6
SA only	0.6	0.00	0.7	0.03	0.00	0.04

NOTE: Premium increases do not necessarily add up within columns due to rounding.

→ **Parity for substance abuse benefits.** Full parity for substance abuse would increase expenditures on substance abuse care by about 26 percent (not shown), but the total premium for the composite plan would increase by 0.2 percent. This premium increase is low relative to the premium increase for all mental health diagnoses for two reasons.

First, and most importantly, few people would use expanded benefits. Consumers of long-term substance abuse treatment are rare in the privately insured population, because few are employed. For employed people who do receive substance abuse treatment, few require long-term care. Wesson (1995) reports that most detoxification patients do not need inpatient or residential treatment. Furthermore, inpatient treatments are short-term, so that 30 days per year of inpatient substance abuse benefits are reasonable.

Second, our projections use a baseline plan with more generous substance abuse benefits than the typical plan. We assume that the lifetime benefit maximum for both mental health and substance abuse treatment is \$50,000 for the typical plan before parity. This implies that the lifetime benefit maximum for substance abuse services only for the typical plan is less than \$50,000 (by the amount of the mental health benefits used).

Under the Mental Health Parity Act of 1996, the lifetime benefit maximum for mental health treatment is \$1 million, but no benefit maximum is specified for substance abuse services.

For purposes of this study, we assume that there is a \$50,000 lifetime benefit maximum for substance abuse services. Therefore, the benefit maximum for substance abuse treatment under the act is greater than the benefit maximum for substance abuse treatment before the act.

Partial parity options. The premium increases predicted by the model for the partial parity options as defined in this study are much lower. For all MH/SA diagnoses, the composite premium increases are 0.4 percent or less if there is parity in cost sharing. If there is parity in service limits, the composite premium increases are 1.2 percent or less.

The partial parity premium increases are higher when there is parity for service limits compared with parity for cost sharing because there is a greater increase in benefits when there is parity for service limits. Specifically, for most plan types, parity for service limits increases the number of covered inpatient hospital days from 30 days to 365 days and increases the number of covered outpatient visits from 20 visits to an unlimited number of visits.

In contrast, when there is parity for cost sharing, there is generally no change (or a relatively small change) in the out-of-pocket expenses for inpatient care because the typical health plan already offers parity with respect to inpatient cost sharing. For outpatient visits, there is a decrease in the FFS coinsurance rate of 50 percent to 20 percent, and a decrease in the HMO copayment amount from \$20 to \$10.

Estimated Premium Increases for Child Health Plans

Under the Balanced Budget Act of 1997, states will receive block grants to fund health insurance for uninsured, low-income children (Mann and Guyer, 1997). States may either expand Medicaid eligibility and provide full Medicaid benefits for uninsured children, or they may establish or expand a separate state program for children.

Estimating the costs of parity in this program is difficult for two reasons. First, we do not know what the baseline benefit packages are. States that do not expand Medicaid may use any of three standard benefits packages or a package that is actuarially equivalent to one of these. Second, we do not know the prevalence of MH/SA disorders among the covered children. States have great latitude in choosing which children are covered. Within the scope of this project, we could not fully address the costs of parity for these programs for uninsured children, but we make predictions that are likely to be conservative estimates of the true costs of parity for separate state programs for children. Our estimates are not relevant for Medicaid expansions.

We produced actuarial estimates of the costs of full and partial parity for all MH/SA diagnoses for currently insured children of employees of medium and large employers (Table 4.3). The premiums are estimates of the average costs of coverage for one child. Unlike employer-sponsored insurance, the premiums do not include any costs for covering adults.

We estimate that full parity for child health plans would increase MH/SA expenditures for currently insured children with FFS coverage by 158.9 percent and the total premiums by 7.0 percent. In contrast, full parity for children's MH/SA benefits in a tightly managed HMO would increase premiums by 0.8 percent. We do not present a composite premium, because we do not know what types of delivery systems states might use for their block grant programs.

The estimated increases in MH/SA expenses and premiums for children are greater than the estimates for families shown in Table 4.1 because MH/SA expenses account for a greater portion of children's premiums. Data on children's MH/SA expenses indicate that children use such services at a much lower rate than adults, but children who use MH/SA services have, on average, higher expenditures than adults (Sturm, 1997; Grazier and G'Sell Associates, 1997).

The estimates in Table 4.5, which are based on data for children who are currently privately insured, are likely to be lower than the actual costs of parity for uninsured children. If states provide insurance coverage to currently uninsured children, these children are likely to use more MH/SA services than those who are currently insured. For example, Frank, et al. (1994) estimate that, if the uninsured population (adults and children) were given insurance coverage, the number using MH/SA treatment services would be 0 percent to 5 percent higher than the currently insured population.

However, the costs of covering uninsured *children* are uncertain, especially because states may choose to cover only some uninsured children. In addition, the state may establish a program with more or less generous medical/surgical benefits than those typical of medium and large employers, depending on how the state applies the benefit standards law.

TABLE 4.5
INCREASES IN CHILDREN'S MH/SA EXPENDITURES AND PREMIUMS FOR FULL PARITY BY PLAN
TYPE

Plan Type	Percentage Increase in MH/SA Expenses			Percentage Increase in Total Child's Premium		
	Parity in Cost Sharing	Parity in Service Limits	Full Parity	Parity in Cost Sharing	Parity in Service Limits	Full Parity
FFS	14.4	56.3	158.9	0.5	2.2	7.0
PPO	15.6	53.2	143.7	0.7	2.3	7.0
POS	0.3	38.0	81.3	0.00	2.2	4.9
HMO	6.0	3.5	11.2	0.4	0.2	0.8

NOTE: Estimates based on privately insured children, using typical benefit packages of medium and large employers. The premiums are estimates of the average costs of coverage for one child. Estimates do not adjust for likely greater service use among uninsured children or differences between private insurance benefits and those of health block grant programs for children.

Interpreting the Estimates

Readers should keep several features of the model and our assumptions in mind when interpreting the predicted premium increases. First, this model (and other actuarial models) does not account for employer responses to parity mandates. Employers could respond to an anticipated premium increase due to a parity mandate by increasing employee contributions, dropping health insurance coverage, dropping or reducing coverage for MH/SA services, reducing other benefits, or increasing management of MH/SA services. These responses would lead to a lower premium increase than that estimated by this model. Therefore, our estimates indicate only the *initial* premium increase due to parity.

Second, these estimates are made with a baseline benefit package that is more generous than those used in previous actuarial estimates. Our baseline benefit package for each plan has a \$1 million lifetime spending limit for mental health services, which reflects the Mental Health Parity Act of 1996. However, the baseline packages for previous actuarial estimates have a much lower lifetime spending limit for MH/SA services (such as \$50,000). If our baseline packages had this lower limit, our projected premium increase for a composite of plans would be 4.2 percent instead of 3.6 percent.

Third, these estimates are based on the characteristics of a typical health plan for each plan type. But among each plan type there is great diversity in benefit and management levels.

Fourth, in this study we estimated premium increases for family coverage. Many previous studies estimated premium increases for single adults. This model predicts lower premium increases for single adults than for families. According to the model, full parity in MH/SA benefits for single adults would raise premiums for the composite plan by 3.1 percent (as opposed to 3.6 percent for families). For FFS plans, the model estimates a 4.3 percent premium increase for single adults, compared to 5.0 percent for families.

The adult-only premium increase for expanded MH/SA benefits is lower than the estimate for family coverage because the relative cost of MH/SA coverage for children in this model is higher than the relative cost of non-MH/SA benefit coverage. For non-MH/SA benefits, the revised HayGroup model assumes that the relative cost of children to adults is 58 percent (i.e., for every \$100 in adult costs, children cost \$58). For MH/SA benefits, the relative costs of children to adults is about 68 percent.

April 8, 1999

FAX TO:

Rep. Fred Dyson	465-4587	Rep. John Coghill	465-3258
Rep. Joe Green	465-4316	Rep. Carl Morgan	465-2197
Rep. Jim Whittaker	465-2070	Rep. Tom Brice	465-2937
Rep. Allen Kemplin	465-6615		

SUBJECT: Mental Health Parity (HB-149)

We strongly support HB-149. I feel it will really enhance the ability of mentally effected residents of the State of Alaska to lead productive and independent lives instead of becoming public burdens.

We have two examples in our immediate family which the passage of this bill would effect positively.

1. We have a son who has mental chemical imbalance problems. With psychiatric consultation and prescribed medication, he can function normally and operate his own commercial fishing business. He carries his own independent medical insurance but unfortunately, it does NOT cover psychiatric care or medications for the same. Because his income is currently below the poverty level, he cannot afford to pay for this treatment himself. The burden to pay for this expensive treatment therefore falls on us his parents. We are of retirement age which also makes the financial burden greater. As our income diminishes our ability to sustain this assistance may be overwhelming. His alternative would be to go on Medicaid and public assistance, but he would have to divest himself of his business, thus reducing his ability to support himself and his minor child. The passage of HB-149 would go a long way to solving this catch 22 situation.

2. We have a nephew who, after several years of in house treatment in a state mental institution has been able to cope with his mental disabilities and with proper on going consultation and medical treatment, been able to be discharged to live an independent life. In order to fund this treatment, he has been forced to go on permanent disability thru Social Security and Medicaid programs and assistance from his mother. Under this program, he can have no earned income. If insurance was available to cover his mental health costs, he possibly could work to support himself and alleviate the needs for Social Security and Medicaid assistance. A productive individual is a much more happy, secure and useful citizen.

We sincerely hope we can count on you and the other committee members to show your support for HB-149 and help move it on into law. Let's make it happen for Alaskan Citizens of all abilities. Better health make stronger constituents.

Respectfully
Dean & Melinda Dewey



2355 Ke-See-An Drive, Juneau AK 99801 FAX 789-7076


 Coastal Helicopters,
Inc.

Fax

To: Representative Fred Dyson **From:** Dot Wilson *Dot Wilson*

Fax: 465-4587 **Pages:** 1

Phone: 789-5800 **Date:** April 8, 1999

Fax: HB149 **CC:**

Urgent
 For Review
 Please Comment
 Please Reply
 Please Recycle

• Comments: Please do not pass HB 149. Mandated benefits as outlined in this bill will cause a burdensome increase in health care costs for small businesses and will likely result in those business cancelling health insurance they now provide. Others may decide not to provide health insurance in the first place.

In looking at the task force which drew up this legislation, it is interesting to note that the business community was not included. The only people assigned to the task force were the ones who would directly benefit from the passage of this bill; i.e.; Commissioner of H&SS, Insurance industry representatives and mental health care advocates. What about someone to represent the **EMPLOYER WHO WILL BE PAYING THE BILLS!**

This is essentially a tax being imposed on employers who are trying to provide support to their employees. Why are all state and local governments exempted? Are their employees exempt from mental illness and substance abuse also?

At the moment we do not have 20 employees eligible for health insurance coverage. If this bill passes, and if we ever do have 20 employees, we will no longer provide health insurance coverage. We will simply insist the employees pay all their own premiums.

ALLEN MARINE TOURS, INC.
P.O. BOX 1049
SITKA, ALASKA 99835

FACSIMILE TRANSMITTAL SHEET

TO:	REP. FRED DYSON	FROM:	LAUREN ALLEN
COMPANY:	ALLEN MARINE	DATE:	April 9, 1999
FAX NUMBER:	465-4587	TOTAL NO. OF PAGES INCLUDING COVER:	1
ALLEN MARINE PHONE NUMBER:	907 747 8100		
RE:			

Comments on HB 149, Mental Health Insurance:

Please vote no. Small businesses are already inundated with costs... this added insurance would cost thousands of dollars. This is coverage that employees may not want or need.

ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907)-456-5081
Fax# (907)-456-8245



Session Contact:
(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 416

REPRESENTATIVE JOHN COGHILL

Mandated Mental Health Coverage

Federal law mandates that if employers provide health insurance and have 50 employees or more, they must also provide mental health and substance abuse insurance as well. HB 149 expands this provision to include employers who have 20 or more employees. The assumption is that this legislation will increase the mental health coverage available for the estimated 44,000 Alaskans who require mental health treatment. I am not convinced this HB 149 will accomplish that. In fact, I believe it is possible that by mandating mental health parity we are at risk to reduce the availability of insurance coverage.

I have two major concerns with the mandated approach:

1. Are we really expanding to more mental health patients, mental health services?
2. Are we unfairly placing an added burden on Alaska's small businesses without a real compelling interest on the part of the State of Alaska?

While it is estimated that there are about 44,000 Alaskans that need mental health services, we do not know how many of these people are currently getting those services through Denali Kid Care, medicaid, medicare, and private sources. According to information provided to this committee by the Alaska Mental Health Board, 14,700 of those are children that most likely qualified under the expanded eligibility guidelines set by Denali Kid Care. We certainly do not know how many more, if any, Alaskans will receive those services if we umbrella small businesses under federal mandates and increase the pool of eligible employees.

Nationally, statistics show that state mandated general health insurance benefits have increased insurance premiums by 15 to 30 percent and the number of insured Americans has been on the rise with 40 million Americans in January of 1997 were uninsured.¹ Part of the reason behind the increase in uninsured might be that mandating certain levels of coverage eliminates the availability of no-frills, large deductible insurance plans that are available to middle-classed citizens. According to Dr. William Custer with Georgia State University, the probability for being uninsured increases by almost six percent when state mandates require mental health service coverage.²

¹ <http://www.Capitol.com>: "Should Uncle Sam Control Your Health Insurance?" by John C. Goodman; Jan. 2, 1997.

² *Health Insurance Coverage and the Uninsured*, William S. Custer, Ph.D., Center for Risk Management and Insurance Research, Georgia State University

Estimates put the cost of mandating mental health care anywhere from 1 percent to 12 percent. Added insurance mandates could cost the small business with 20 employees between \$2,500 and \$15,000 a year. Maybe the increase is only a 1% increase in costs or the employer could pass the increase on to the employees, but are we increasing availability of mental health services if that 1 percent increase is enough to cause the small business owner to not offer insurance.

In a 1998 analysis by The Urban Institute, it was determined that benefit mandates for drug and alcohol treatment decrease overall insurance coverage. *"While most firms may not drop coverage because such a mandate is enacted, the mandate may contribute to higher premiums over time, and these higher premiums lead some people to drop their employer-sponsored or individual coverage."*³

Dr. Michael Morrissey, Director of the Hill Center, and his colleague, Dr. Gail Jensen, have concluded that state insurance mandates "probably don't" make most workers better-off:

*"The laws often add substantially to the cost of coverage, and the higher costs of insurance are paid by workers in the form of lower wages. Some firms and their workers choose to go without insurance entirely as a result of the insurance mandates. While some workers will benefit, many are made worse-off."*⁴

Morrissey and Jensen concluded in a report to the Health Insurance Association of America that state mandates cost one in four Americans their health insurance.⁵ Further statistics in the report are as follows:

- One-fifth to one-quarter of the uninsured have no health insurance because of the high cost of mandated benefit requirements. That equals more than 10 million Americans.
- State mandates raise premiums by up to 13 percent for businesses that offer health insurance to their employees.
- 18 percent of small businesses without health coverage would buy it in the absence of state mandates.

Dr. Mark Schiller, board member of the Association of American Physicians and Surgeons, said in a guest opinion of the New York Times that mental health parity will cause more Americans to become uninsured and distracts us from searching for solutions to the real problems in our health care system.⁶

³ *Variations in the Uninsured: State and County Level Analysis*, The Urban Institute, June 1, 1998, <http://www.urban.org/health/variater.html>

⁴ "Do State Insurance Mandates Make Most Workers Better-Off?" *HealthPolicy*, Volume 10, Number 2; December 17, 1999;

⁵ *Mandated Benefit Laws & Employer-Sponsored Health Insurance*, Gail A. Jensen, Ph.D and Michael A. Morrissey, Ph.D, Jan. 1999 for the Health Insurance Association of America

⁶ *The New York Times*, "Mental Health Misstep", Mark Schiller, June 15, 1999

If more people become uninsured, the pressure will be on us to once again redefine poverty so more people will be eligible for medicaid services. The end result is that we take medical choice away from more middle-class Alaskans and make their medical needs the decision of government.

Does the State of Alaska have a compelling interest to impose more state mandates on that sector of our private economy that is made up of small businesses, when we do not even know what the benefits or negative impact will be? Considering the outcome is more predictably a negative one, I feel we have a compelling interest to go down this road very cautiously.

I would like to see us adopt a health care policy that will put the patient in control of the type of insurance and services he or she wants and needs. We need a program that provides more commercial medical choice for our working citizens.

I remain committed to working on better private health care delivery for all Alaskans through private insurance access.

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: March 19, 1999

FURTHER REFERRALS: Labor and Commerce
Finance

Date of Committee Action: 4/11/00

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 149

HOUSE BILL NO. 149

INSURANCE: MENTAL HEALTH & SUBSTANCE ABUSE

"An Act relating to insurance coverage for treatment of mental illness and substance abuse; repealing provisions of ch. 8, SLA 1997, that terminates required mental health benefit coverage; and providing for an effective date."

recommends it be replaced with the following committee substitute _____ the same title
 a new title

additional referral to _____ Committee

attached amendment(s)

A.DOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____

APPROVES PREVIOUS: (Dept/Date) _____

fiscal note(s) _____

fiscal note(s) _____

zero fiscal note(s) _____

zero fiscal note(s) CEID

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>		<input checked="" type="checkbox"/>		
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>	<input checked="" type="checkbox"/>			
<i>[Signature]</i>	<input checked="" type="checkbox"/>			

CHAIR'S SIGNATURE

[Signature]

4/11/00

HB

175

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 175

Revision Date/Time (Note if correction): _____
 Title: Requiring community notice of application for
foster group homes.
 Sponsor: Rep. Green
 Requestor: House (HES)

Dept. Affected: Health and Social Services
 BRU: Family & Youth Services Management
 Component: Family & Youth Services Management
 COMPONENT SERIAL NO. 2306
 See also (SN#): _____

Expenditures/Revenues: (Thousands of Dollars)

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

OPERATING	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ()						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY1999) cost: \$0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill will have no fiscal impact on the Department if enacted.

S 4/7/99

Prepared by: Theresa Tanoury
 Division: Family & Youth Services
 Approved by Commissioner: Karen Perdue, Commissioner
 Agency: Department of Health & Social Services

Phone: 465-3191
 Date/Time: 4/6/99 10:02 AM
 Date: 4/7/99

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4/8/99

HB 175

Good afternoon Mr. Chairman and members of the committee.

I'd like to thank you for providing me with the opportunity to testify in favor of HB 175 which will allow communities all throughout the state to be notified of the establishment of FGHs in their neighborhoods.

My name is Sonia Vasconi. I come before you as a parent, a neighbor and a concerned citizen.

Let me start this testimony by giving you some basic background regarding FGHs as I see it.

The idea behind the establishment of FGHs was well intended. Keeping large group of siblings together was logical & thoughtful.

However, what FGHs have become resembles little of what they ^{were intended to be} ~~were~~ ~~intended~~.

Today, a single FGH parent can care for up to 8 or more unrelated children in a home. These children ^{can potentially} ~~usually~~ present severe mental dysfunctions such as sexual predatory behavior, arsonist tendencies and ^{aggressive behaviors} ~~aggressive behaviors~~. Some or perhaps all of them have "wrap around services"

which provides these children with psychological and social services at home or at other facilities.

These facts and the increased traffic from social workers, relatives, friends and the police have a tremendous impact in neighborhoods surrounding FGHs.

* This situation creates frustration among those of us who try to do the right thing. We abide by the laws, faithfully pay our taxes & try to raise our children the best we can by, among other things, living in the safest neighborhood we can possibly afford, sometimes w/ sacrifices.

Suddenly, we find ourselves dealing with safety issues we didn't previously have and nobody took the time to inform us about. And ^{when} we tried to inform ourselves we found that the system is arrogant and answers are vague and misleading.

We are expected to embrace these programs in our neighborhoods when we don't even know what they are all about.

Additionally, foster parents find themselves ~~in~~ a kind as well. Sometimes, they, themselves, don't know enough

about the children they are supposed to care for. And when safety issues arise they are limited by what they can say or do. This adds more confusion to the whole situation.

Ignorance creates suspicion. Let's put the issues on the table at our community councils. That's what they were created for.

House Bill 175 is the least a community should be entitled to have: the right to be notified.

This bill encourages communication and creates a balance between the needs of FGHs and the communities that they are dependent on for the success of these programs

Thanks again Mr. Chairman and members of this committee for introducing legislation that assists both foster parents and the communities in addressing the needs of foster children.

I ~~will~~ respectfully encourage you to support and help this bill be enacted into law.

I'll be glad to answer any questions you may have.

Foster Group Homes Questions and Answers for Applicants and Division Staff

Why did the division add foster group homes to licensing regulations? **MAC. 50.415**

- Regulations will ensure consistency in addressing space and supervision in foster homes formerly operating under waivers that allowed them to care for more than three foster children.
- Regulations will continue to address children's placement needs identified in former regulations
 - keeping siblings together and
 - ensuring continuity of care for a child, including placement with a relative, when feasible.
- This will be accomplished by converting foster homes with large numbers of children to group foster homes and licensing new applicants for large numbers of children as group foster homes rather than using a variance.
- Regulations will allow the development of foster homes where more than three foster children may be in care to meet specific placement needs identified by the division:
 - group homes for adolescents preparing for independent living;
 - group maternity homes for pregnant and parenting teens; and
 - other group homes only on regional administrator initiative or approval.

What is the difference in definition?

- "foster home" has the meaning given in AS 47.35.900, ["foster home" means a place where the adult head of household provides 24-hour care on a continuing basis to one or more children who are apart from their parents;] usually for no more than six children;
- "foster group home" means a foster home in which one or more foster parents operate not more than one group home for no more than eight children;

What extra regulations must a foster group home meet?

- One year of foster care experience with no more than two foster children in care.
- No more than eight children may reside in a foster group home. Of the eight,
 - no more than two children under 30 months of age are permitted; and
 - up to eight children who are unrelated to the foster parent are permitted.
- If more than six children are in care, one foster parent must generally be available in the home.
- A foster group home shall provide at least
 - 35 sq. feet of usable indoor space per child, exclusive of hallways, bathrooms, storage areas, office space, furnace and laundry rooms, crib space, and any area children are prevented from using; and 75 square feet of outdoor recreation space per child for the maximum number of children outside at any one time...
- A foster group home shall provide at least
 - 70 square feet per child in a single resident bedroom;
 - 50 square feet per child in a multi-resident bedroom;
 - a bedroom ceiling height of at least 6.5 feet if bunk beds are used;
 - one bedroom for every four children in care; and
 - one full bathroom for every six children in care.
- If a group foster home has more than five foster children in care, a fire safety inspection is needed. We expect a "Group R. Division 4 Occupancy from the UBC will apply. That is a residential group care facility for ambulatory, nonrestrained persons who may have a mental or physical impairment (each accommodating more than five and not more than 15 clients or residents, excluding staff)."

Will the division give a variance for a regular foster home to be able to accept a fourth foster child for care or will the home need to convert to a foster group home?

- The division needs to be consistent in applying the rules statewide to meet the intent of creating the group home category.
- A foster home would be converted to a foster group home for the period that the home provides care for more than three foster children or for more than six children total, including children of the foster parent. A new (one page) application would be needed.

Will the division give a variance for any of the group home requirements?

- A variance is always possible if there is an alternative method of meeting the safeguarding intent of a requirement or if the home is a relative foster home.

What if an applicant wishes to apply to care for eight children ages three to ten years old?

- The needs of children in state custody rather than the skills or interests of applicants will determine resource development and use.
- The applicant is to be informed of the division's resource need as stated in the beginning of this flier.
- The division would not place more than three children in a home licensed in that age range.

Is the division concerned about allowing more than six children in care (three in foster care) when the division reduced the number of children allowed in care in 1990 to address poor care in foster homes?

- Yes, however the division determined that a group home category would meet the specific needs stated in the beginning of this flier.
- Administrators, placement workers and licensing representatives should articulate that need to applicants and should honor the intent. Policy statements are being drafted for the manuals.

Must a group foster home applicant agree to care for the maximum of eight children?

- No. An applicant may request the full number or any lower number based on their wishes and the type of placement need the division has requested the home to meet.
- Applicants also consider family circumstances, training, experience, skill, space etc.

What are examples of group foster homes that exist or might be recruited?

- An applicant may have three children of their own and be applying to care for a sibling group of four more children who are friends of the family. The total is seven.
- An applicant may have six children of their own and be applying as a relative foster group home for one more child. The total is seven.
- An applicant with no children of their own might request licensure for five children, rather than eight. There are currently at least two highly skilled foster homes where both foster parents are generally available in the home. These homes specialize in meeting specific treatment needs such as sex offender treatment. These homes were recruited or approved by a regional administrator.
- An applicant with one adolescent might request to care for four or five additional adolescents in a program that emphasizes independent living skills.
- Experienced foster parents in a large city have been recruited to be a "stand-by" foster homes licensed for four children placed in emergency shelter care for only two or three days per child placed. The creation of these specialized homes were regional administrator initiated.
- An applicant may be applying to provide prematernal/maternity care for three pregnant or parenting teens. Infants of the teens will be counted resulting in up to six children in the home.

September 1, 1998

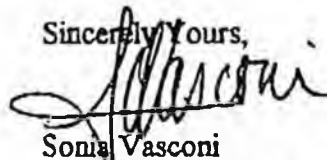
Representative Joseph Green
Room 118
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Green:

We appreciate all your help regarding the Foster Group Home in Oceanview. Attached is a report which summarizes events and issues surrounding the 311 Bree Ave. facility. I thought this report would be of help to you as you take up these issues with other policy makers in the upcoming Legislative session. I also want to thank you for meeting with Bree Ave. neighbors in early August; I regret that I could not attend that meeting as I was Outside on vacation. I gather it was a very good meeting for all who attended.

I look forward to working more with you on these issues in the upcoming months. Should you have any questions, please contact me at (907) 345-8830.

Sincerely Yours,



Sonia Vasconi

Bree Ave. Neighborhood Group

Issues Regarding Foster Group Homes in Neighborhoods

During this past April, residents of Bree Ave. in Anchorage learned that a Foster Group Home was established at 311 Bree Ave. This Group Home, and events related to it, raised a number of general concerns that have generated neighborhood interest. These concerns are:

- Neighborhood safety
- Municipal zoning regulations
- DFYS' lack of assistance

Since April, Bree Ave. residents have brought these general issues to public officials at both the State and Municipal levels and have yet to reach any resolution. Therefore, we feel it is important to summarize events around these concerns and present them as a package to various public officials and interested parties who need to be involved in these issues. While we are specifically presenting these issues relative to the situation encountered with the Bree Ave. Foster Group Home, these three general issues are potentially present in many Foster Group Homes throughout Anchorage and Alaska. Consequently, it is important to address these issues broadly and consider some of the policies surrounding them. Hopefully, you will be able to use the resources you have to help balance the needs of foster children with neighborhood concerns.

Neighborhood Safety

DFYS' licensing of the Foster Group Home at 311 Bree Ave. immediately raised a number of safety concerns among neighbors since there are approximately 15 children (most under the age of 12 years old) on Bree Ave., plus a number of other children residing on an adjacent street, Pacific View. The Group Foster Home is also next to Johns Park which is enjoyed by many families with children who may not live in the immediate vicinity. Given the number of small children in the area, the neighborhood was immediately concerned that potentially dangerous foster children (e.g. Emotionally disturbed children) may be placed in the foster home. As Stephen McComb, a DFYS representative, indicated at a neighborhood meeting in May that placement of foster children with sexual aggression, or anger management problems in the Bree Ave. facility, with its proximity to neighborhood children and a park is "setting them (Foster Children with these particular problems) up for failure."

Despite DFYS' acknowledgment that the location carried risks to both foster children and other youngsters, a foster child was placed there who, early on the morning of July 6 was apprehended by Anchorage police after he chased his Foster Parent out of the house and threatened him with grave harm. Details around this incident are sketchy due to confidentiality requirements, however, the neighborhood learned that the foster child had snuck away from the Foster Home for at least three hours without the knowledge of his foster parent. It is not clear where the child may have wandered during

his absence from the house. The more basic concern is that on the night of the incident the child was away from the Foster Home for a substantial period of time without the Foster Parent's knowledge.¹

There have been reports of other incidents at the Bree Ave. Foster Group Home that have required the assistance of the Anchorage Police Department: *A Disturbance* on June 4, 1998 and another *Assault* on August 22-23, 1998. The nature of the incidents and the frequency of police visits to the Foster Group Home translates to a level of risk that is unacceptable for neighborhood safety.

Municipal Zoning Regulations

In any discussion regarding placement of Foster Group Homes, Zoning requirements become a critical factor. In fact, 7 AAC 50.500 states the following:

"A license is issued or denied on the basis of the applicant's compliance with the requirements of AS 47.35 and this chapter. *The enforcement of local ordinances, such as zoning regulations and local building codes, is the responsibility of local officials.*" (Emphasis added)

It is clear that 7 AAC 50.500 references local ordinances and leaves enforcement responsibilities with local officials. When Bree Ave. residents looked to local zoning requirements we found some interesting facts. We started our review of zoning regulations with Anchorage Municipal Code, Title 21.40.030 which addresses R-1 and R-1A single-family districts. This initial review centered on whether or not Foster Group Homes required a conditional use permit. This review focused on a category of use known as "Quasi-institutional houses" ("QIH"). Further review indicated that Foster Group Homes do not fall under the *present* definition of QIH and, in fact, fall under the definition for "Family Residential Care" which does not require a permit. This legal "placement" has not always been the case and was changed to its present arrangement during the 1986-87 time frame as part of the work completed by the Child Care Task Force. Prior to the Child Care Task Force Ordinance of 1987, child care facilities housing more than 5 children were considered commercial uses and only found in commercial districts. Under the requirements then in place, Foster Group Homes were QIHs and required a conditional use permit. Therefore, prior to the Child Care Ordinance, a Foster Group Home was viewed as a commercial enterprise which required a permit (and likely public hearing process).

With the proliferation of neighborhood Foster Group Homes funded by public money, the time has come for the municipality to take up this issue again and either

¹ Apparently, the Foster Parent was not aware of the child's absence until the child attempted to get back into the house when a motion detector was activated. For further background around this incident. See Attachment 1, Anchorage Daily News article published on July 10, 1998.

revert to the previous handling of Foster Group Homes (under the umbrella of a QIH) or designate a new separate classification that explicitly requires the approval of neighborhoods that are affected by its placement.

While it may not be acceptable in some circles to view Foster Group Homes as commercial enterprises, substantial public money is spent to support not only the children, but also the mortgages taken on the houses in which they are placed as well as the primary caregivers. In fact, a case can be made that payments to caregivers amount to subsidies that provide caregivers with the incentive to accept either the maximum number of children allowed by State regulations or those children who have problems that carry the greatest funding. Some of the children found in the 311 Bree Ave. house are designated as Emotional Disturbed and carry greater funding than those who do not carry that designation. The end result of this system is a patchwork of revolving-door facilities (that some neighbors have characterized as "mini-orphanages") in which placement is driven by the financial need of the foster parent more than by the needs of the children. This is the perverse result of well-intended subsidies that have the potential to be "gamed" by foster parents who may see the opportunity for financial gain. While this may not be true in the majority of Foster Group Homes, it is naive to ignore the possibility that a Foster Parent's financial requirements may translate into a willingness to accept more children with more difficult needs than they can actually care for in a responsible manner. The financial incentives in place can lead to an escalation of risk that is actually born by Foster Parents, Foster Children and neighborhoods. Eventually, the welfare of all three groups may be compromised because of the need to get the highest stipend available to support the infrastructure needed to provide care to six seriously disturbed children.

One way to insure that this "escalation of need" does not occur is to place more stringent limits on the number of foster children allowed in a Foster Group Home. Presently, the limit for a facility like the one at 311 Bree Ave. is 6 children. A more appropriate ratio for a Foster Group Home may be one emotionally disturbed child per single foster parent or two emotionally disturbed children per married couple and emotionally disturbed children cannot be co-mingled with foster children who have not been classified as such.² We also believe that the city needs to greatly restrict the use of neighborhood Foster Group Homes that are used as emergency placement facilities for emotionally disturbed children. If the municipality is unable or unwilling to incorporate changes such as these into the zoning ordinances, then the municipality should revert to pre-Child Care Ordinance requirements which classified a Foster Group Home as a commercial enterprise requiring a conditional use permit.

DFYS' Lack of Assistance

One of the most frustrating aspects of this situation has been the difficulty we have had in getting information from DFYS. No matter what type of information we requested,

² It is important to note that neighbors are only addressing Foster Group Homes that are used to house youths who are emotionally disturbed, have anger management problems or are sexual predators.

DFYS has been slow to respond. Whether it be a request for general information on Foster Group Homes or for information on the qualifications of the Foster Parent at the Bree Ave. facility, DFYS has consistently been unresponsive. In fact, DFYS was reluctant to listen to our concerns until a teleconference in late April, 1998 which was attended by Bree Ave. residents, Representative Joe Green and Mr. Russ Webb, Deputy Commissioner of DHSS. As a result, another meeting was arranged through Rep. Joe Green's office and DFYS sent two representatives to a neighborhood meeting that was held on May 8.³

At the May 8th meeting, neighborhood concerns were aired with Stephen McComb and Gwen McAlpine of DFYS. Mr. McComb and Ms. McAlpine gave their personal promise to not place children in the Bree Ave. Foster Group Home who were either sex offenders or had anger management problems. While this promise indicated good will, the apparent limit of DFYS' oversight regarding child placement restricts the actual effectiveness of this promise. The limit of DFYS' placement authority is implied by an August 4, 1998 letter from Mr. Webb to Rep. Green. In that letter to Rep. Green Mr. Webb indicates that "... it is important for you to know that the child involved in the incident (*the July 6 assault*) was neither in the custody of nor placed in the foster home by a state agency." (See, Attachment 3) This statement is particularly disturbing since we were under the impression that DFYS would be the only entity that approved the placement of foster children in the Bree Ave. Foster Group Home. If it is indeed true that other entities may use the Bree Ave. facility, DFYS acting alone cannot insure that emotionally disturbed foster children will not be placed there. From Mr. Webb's statement one can infer that DFYS does not have the ability to know the particular profiles of all children who are housed in a facility that DFYS licenses. The possibility of "mixing" profiles without DFYS' knowledge implies an unfortunate lack of control which leads to situations where children of varying needs and temperaments are assigned to facilities licensed by DFYS without DFYS' coordination. Rather than expecting the neighborhood to rely on DFYS promises, the preferred alternative is to implement more stringent licensing and placement requirements (e.g. lower child-to-foster parent ratios and low risk type of children) in neighborhood Foster Group Homes, at least for the moment.

We were also frustrated with DFYS' statements made to the regarding the assault incident of July 6. In comments made to the Anchorage Daily News, Linden Staciokas, acting DFYS regional manager, indicated that she considered this incident "closed" (See, Attachment 1). While she may believe that the incident is "closed" it remains "open" for those of us who live in the neighborhood. Especially when one considers the nature of the incident and the fact that in the five months since the Foster Group Home has been operating, police have intervened on at least three occasions, two of which were assaults.

³See Attachment 2; May 4, 1998 letter from Russ Webb, Deputy Commissioner, DFYS to Honorable Joe Green. One should also note that in this letter, Mr. Webb indicated that DFYS committed to review three particular areas of neighborhood concerns: 1) Staffing ratios and supervision requirements; 2) Training requirements for Foster parents; 3) information on foster homes that can be shared with the community in which they are placed. As of the date of this writing, DFYS reviews on these topics have not been completed.

The statement by Ms. Staciokas does little to engender public confidence in DFYS' willingness or ability to address public concerns.

Conclusion

The situation at 311 Bree Ave. has caused neighbors to have concerns in three areas: Neighborhood safety; Municipal zoning; and DFYS' lack of assistance. We are specifically concerned about the following issues:

- 1) Allowing Foster Group Homes to be placed in a neighborhood without public notice and a conditional use permit;
- 2) The ratio of emotionally disturbed Foster children to foster parent;
- 3) The use of Foster Group Homes as a temporary facility which increases the number of emotionally disturbed Foster children in a household;
- 4) The nature of incentives which promote the placement of greater numbers of foster children with more demanding emotional needs into neighborhood Foster Group Homes;
- 5) The possibility that DFYS is not the only entity that can place children in Foster Group Homes;
- 6) The levels of training (vs. an orientation) required for Foster parents who are running Foster Group Homes.

Resources need to be made available to provide a complete assessment of policy options which are available to Municipal and State authorities. However, as recent events have proven, the existing situation at 311 Bree Ave. is far from satisfactory for the neighborhood and quite possibly, the Foster children. Reliance on neighborhood-based Foster Group Homes may have been an attractive idea when they were first embraced as a way to place "sibling groups" in one household, but recent events have prompted questions that need attention and new solutions. While some may feel it is too early to embrace any specific "fix", prompt action is required to insure that situations such as that found on Bree Ave. do not result in physical harm to neighborhood residents or other foster children. Lowering child-to-parent ratios for emotionally disturbed children may be a first step to insure more adequate care and safety, however, policy makers should also objectively examine the possible use of orphanages as a way of housing foster children with severe emotional needs. While there has been a movement away from orphanages, they may offer the ability to pool limited financial resources, focus rehabilitative efforts, and monitor program effectiveness in a more comprehensive manner.

Hopefully, we can work together to achieve a balance between the welfare of Foster Children and the neighborhoods who are being asked to bear risks that had not been previously assumed. The problems encountered in adequately caring for the needs of

emotionally disturbed children require a rational discussion between all who play a direct role in promoting the well-being of all children.

Respectfully Yours,

Bree Ave. Neighborhood Group

Alaska State Legislature

WHILE IN SESSION
CAPITOL BUILDING
JUNEAU, ALASKA 99801-1182
(907) 465-4931
1-800-870-4931
(907) 465-4316 FAX

INTERIM ADDRESS
716 WEST 4TH AVENUE
ANCHORAGE, ALASKA 99501
(907) 258-8198
(907) 258-8171 FAX



VICE-CHAIRMAN, JUDICIARY COMMITTEE
MEMBER, HEALTH, EDUCATION &
SOCIAL SERVICES COMMITTEE

BUDGET SUBCOMMITTEES
ALASKA COURT SYSTEM
DEPT. OF ENVIRONMENTAL CONSERVATION
DEPT. OF REVENUE

Representative Joe Green

District 10
House Majority Leader

Sponsor Statement

HB 175 – Notification of Foster Group Home

HB 175 requires the Department of Health and Social Services to notify a community council if they receive an application to establish a foster group home in the community council area.

The bill establishes a “foster group home” as a foster home in which one or more foster parents operate, on a 24-hour basis, a facility for four or more children who are living apart from their parents.

FOSTER GROUP HOMES STANDARD BY STANDARD EVALUATION

This is a supplemental standard by standard to be used as well as the foster home standard by standard when evaluating applicants for a foster group home license.

The foster group home applicants must be in compliance with all foster home standards -documented in 06-9371.

Foster Parent(s):

Licensing Representative Signature:	Date															
<p>50.415 Supervision of Children in Foster Homes</p> <p>(a) During the first year of license, no more than two unrelated children</p> <p>(c) No more than 8 children may reside in a foster group home. Of the 8,</p> <p style="margin-left: 20px;">(1) no more than 2 children under 30 months;</p> <p style="margin-left: 20px;">(2) except as provided in (a) of this section, up to 8 children who are unrelated to the foster parent are permitted</p> <p>(d) If more than 6 children are in care, one foster parent must generally be available in the home</p> <p>(e) The Division will establish the number of children for whom a foster group home is licensed on a case by case basis</p>	<p>How many years of licensed care has this foster home provided?</p> <p>License</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20%;">Capacity</td> <td style="border: 1px solid black; width: 20%;"></td> <td style="border: 1px solid black; width: 20%;">Ages</td> <td style="border: 1px solid black; width: 20%;"></td> <td style="border: 1px solid black; width: 20%;">to</td> </tr> <tr> <td></td> <td style="text-align: center;"># of own children</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;"># of own under 30 months</td> <td></td> <td></td> <td></td> </tr> </table> <p>Name of foster parent generally available:</p> <p>What days & hours is parent in the home?</p>	Capacity		Ages		to		# of own children					# of own under 30 months			
Capacity		Ages		to												
	# of own children															
	# of own under 30 months															
<p>50.510 Life and Fire Safety</p> <p>(a) Standards for life and fire safety administered by the Dept. of Public Safety apply to:</p> <p style="margin-left: 20px;">(2) foster group homes providing 24 hr. care for more than 5 children</p> <p>(c) A foster group home with 5 or fewer meets the applicable life and fire safety standards in the foster home SXS.</p>	<p>If more than 5 unrelated children, a fire inspection is requested to assure the home meets the applicable requirements for fire safety under Group R</p> <p>Fire Inspection report on file?</p>															
<p>50.530 Space</p> <p>(a) A foster home must have indoor and outdoor space to meet the needs of children in care</p> <p>(b) A foster group home shall provide</p> <p style="margin-left: 20px;">(1) 35 sq ft. per child of usable indoor space</p> <p style="margin-left: 20px;">(2) 75 sq ft. per child of outdoor recreation space</p> <p>(c) Parks or other outdoor locations may be used if easily accessible and a plan for use is approved by licensing worker</p>	<p>Diagram of home showing sq. ft. and designated areas is on file. Yes <input type="checkbox"/> No <input type="checkbox"/></p>															

(d) A foster group home shall provide		
(1) 70 sq. ft. per child in a single resident bedroom		
(2) 50 sq ft. per child in a multi resident bedroom		
(3) bedroom ceiling height of 6.5 ft. if a bunk bed is used		
(4) one bedroom for every 4 children		
(5) one full bathroom for every 6 children		

Narrative summary and recommendations. Include the adequacy of furniture and supplies for the number of children to be licensed. Include a description of the outdoor space and/or a description of any nearby parks.

- New Application
- Conversion -Provisional to Biennial
- Biennial Renewal
- Change/Other _____

**FOSTER HOME
 STANDARD BY STANDARD EVALUATION
 7 AAC 50.005 - 7 AAC 50.990**

Foster Parent(s):	
Licensing Representative Signature:	Date:
Agency:	Field Office:
Type: <input type="checkbox"/> Foster Home <input type="checkbox"/> Employees (Add 06-9050) <input type="checkbox"/> Group Home (Add 06-9049)	
Division Approved Specializations: (Check any and all that apply.)	
<input type="checkbox"/> Emergency Shelter Care	<input type="checkbox"/> Pregnant and Parenting Adolescents
<input type="checkbox"/> Supervised Transitional Living	<input type="checkbox"/> Boarding Care
Dates of facility visits: (Note if scheduled or unscheduled)	Persons interviewed:

Relative Care Variance	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Supervisor Approval of Relative Variance
Documented in SxS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Signature:

<u>Reports, Forms Documents on File</u>	
<u>Provisional</u>	<u>Biennial Renewal</u>
<input type="checkbox"/> Application for License 06-9162	<input type="checkbox"/> Application for License 06-9162
<input type="checkbox"/> Clearance for License (all adults) 06-9437	<input type="checkbox"/> Clearance for License
<input type="checkbox"/> Fingerprint Cards (adults in home)	<input type="checkbox"/> Review Information 06-9390
<input type="checkbox"/> Background Information 06-9389	<input type="checkbox"/> Plan for Foster Care 06-9045
<input type="checkbox"/> Plan for Foster Care 06-9045	<input type="checkbox"/> Fingerprint Cards (new adults in household)
<input type="checkbox"/> Plan Reduction 2nd Hand Smoke 06-9444	<input type="checkbox"/> Self-Monitor Report is on file
<input type="checkbox"/> Emergency Evacuation Plan	<input type="checkbox"/> Variance Request(s)
<input type="checkbox"/> Three (3) Positive References	<input type="checkbox"/> Plan of Correction (if applicable) DO84-LIC-12
<input type="checkbox"/> Medical Release, if requested	<input type="checkbox"/> Training Hours Reported
<input type="checkbox"/> Well Water Results, if needed	
<input type="checkbox"/> Variance Request - Relative Placement	
<input type="checkbox"/> Variance Request - Non-related Placements	
<input type="checkbox"/> Inspection Reports, if requested (DEC/Fire)	

<u>Worksheets, If Completed</u>	<u>Employees</u>	<u>Group Home</u>
<input type="checkbox"/> Adults in the Home DO84-LIC-09	<input type="checkbox"/> Personnel Policies	<input type="checkbox"/> Fire Inspection Report
<input type="checkbox"/> Variance Worksheet DO84-LIC-11	<input type="checkbox"/> Staffing Plan	<input type="checkbox"/> Space Diagram
<input type="checkbox"/> Menu Evaluation DO84-LIC-01	<input type="checkbox"/> Employees in F.H. 06-9046	

Instructions for Standard by Standard Evaluation

Purpose:

The purpose of this form is to summarize findings of an on-site evaluation. The statements which appear on the left-hand side of the form summarize the regulations and are not identical to the Alaska Administrative Code. The form is used:

1. before issuing a provisional or biennial license;
2. when a complaint/allegation is investigated (optional);
3. when conditions in a facility indicate that revocation or denial of a license may become necessary;
4. when considered necessary by a supervisor.

Procedure:

The licensing worker completes the form at the time of or following the on-site visit. A copy is provided to the applicant or findings are summarized in a letter to the applicant. The original is filed in the facility record after approval or denial. If the evaluation covers more than one date, the licensing worker lists all dates of evaluation.

Form Retention:

The form is retained according to the Division retention schedule.

Detailed Instructions:

Each item being evaluated must be coded in the center column.

Coding Responses:

- X Standard Compliance
 - N/A Not Applicable
 - NC Non-Compliance
 - D Discussed - Applicant is informed and agrees to cooperate; also denotes items which may not be measured before actual operation
- Leave item blank if not evaluated

The items requiring discussion have been pre-entered. The licensing worker shows the discussion has to take place by entering a check mark. The code "D" is used only when a requirement cannot be measured before children are in care. When a requirement can be measured by observation, interview, or review of a tangible item such as a written policy or plan, the code should be standard compliance or non-compliance. "D" is considered as compliance.

In general, the documentation (left) column may be completed to specifically document compliance or non-compliance. The column is used by the reviewer to note observation, interview statements, file review findings, and other evidence that the facility meets or does not meet the requirements. The documentation column may also reference attachments of personnel record reviews, children's file reviews, or other supporting documents.

When non-compliance is indicated, the documentation column may be used to give the applicant's plan to come into compliance. When N/A is indicated, an explanation is required. The evaluation must be signed, dated, and submitted for review along with the license issuance approval form 06-9124.

Article 1 - Licensing Process

47.35.017 and 50.030 Application for License		
(e) Application is complete with required attachments		Date:
50.035 Where two (2) adults are head of household, both apply for license		
47.35.029 Content of License: Posting		
(l) Foster home license is available on request		
50.050 License Issued Under Emergency Conditions		
(a) Emergency license was issued		Date: to
47.35.027 Variances		
Variances for non-relative care requested and approved		
50.055 Variance for Foster Care by Relatives		
(a-b) Variance(s) documented and approved by supervisor		
(c) No risk to child's safety or well-being		
50.060 Self-Monitoring Report		
<i>NOTE: N/A for 1st year prov license or 1st biennial license</i>		
47.35.105 Complaints		Any complaints received? .
(e) Licensee did not retaliate against person filing a complaint		
47.35.110 Investigations		
(a) Cooperates during investigation		
Permits inspection of facility, record review, interviews of children in care, & provides documentation requested		

Article 2 - Administration

50.120 Foster Home Operation and Management		
(e) A foster home's practices must conform to statutes, this chapter and its practices		If any changes, was new plan submitted?
Acceptable plan for supervision submitted		
.400(a) ensures appropriate supervision		
.400(f) Designate an adult who is available to assist in an emergency		Designated adult: .
50.130 Records		
(a) (2) Establish and retain records for 3 years		
(3) Permit review of records		Records reviewed:
(b) Records are on forms prescribed / approved by Division		
(c) (1) Record for each child is dated and identifies who is making the entry		
(c) (2) Returned to the agency upon discharge, including all medical/dental records		Records given to:
.455 (f) A foster home shall:		
(1) Maintain medical, dental, immunization and treatment records		
(2) Document medical or dental care or treatment if the doctor or dentist does not provide documentation		Type of documentation done by foster parent:
.130 (d) Maintain confidentiality of information about a child and the child's family		Discussed confidentiality with children, extended family, & care providers?