ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9820 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

Sec. 18.07.031. Certificate of need required.

(a) A person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

(b) Notwithstanding the expenditure threshold in (a) of this section, a person may not convert a building or part of a building to a nursing home that requires licensure under AS 18.20.020 unless authorized under the terms of a certificate of need issued by the department.

Sec. 18.07.111. Definitions.

In this chapter,

(1) "category of health services" means a major type, program, unit, division, or department of care provided through a health care facility, whether inpatient or outpatient, including an outpatient department, psychiatric wing, kidney dialysis program, radiotherapy, burn unit, or newborn intensive care unit, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(2) "certificate" means a certificate of need issued by the department under AS 18.07.041 , 18.07.043, or 18.07.071;

(3) "commencement of activities" means the visible commencement of actual operations on the ground for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers, which operations are readily recognizable as such, and which operations are done with intent to continue the work until such activities are completed;

(4) "commissioner" means the commissioner of health and social services;

(5) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need to which all parties participating in those activities have obligated themselves to perform;

(6) "construction" means the erection, building, alteration, reconstruction, improvement, extension, or modification of a health care facility under this chapter, including lease or purchase of equipment, excavation, or other necessary actions;

(7) "department" means the Department of Health and Social Services;

(8) "health care facility" means a private, municipal, state or federal hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical facility; the term excludes

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020 (09) and AS 47.55; and

(B) the offices of private physicians or dentists whether in individual or group practice;

(9) "nursing home bed" means a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity.

Sec. 08.70.180. Definitions. (definition to be added to 18.07.111)

(4) "nursing home" means a facility which is operated in connection with a hospital or in which nursing care, intermediate care, and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery within the state for the accommodation of convalescents or other persons who are not acutely ill but who do require skilled or intermediate nursing care and related medical services; the term "nursing home" is restricted to those facilities the purpose of which is to provide skilled or intermediate nursing care and related medical services for a period of not less than 24 hours a day to individuals admitted because of illness, disease or physical or mental infirmity;

January 31, 2000

Dear Representative:

I am an anesthesiologist in Fairbanks and in the Matanuska Valley in Alaska. This is a letter in support of dismantling the certificate of need process which currently blocks diversification of medical facilities available to patients in Alaska.

The certificate of need (CN) process is theoretically put in place to allow construction of medical "centers of excellence" in areas where competition would be detrimental to a community's resources. Proponents of enforcing the CN process will argue that it supports the survivability of exclusive health care resources to patient populations in areas that cannot support two such competing entities. This argument is viable in unsophisticated areas with minute populations and poor insurance remuneration for the medical services that are rendered in them. There may have been a time when Alaska's communities fit this description, but it has long since passed.

The certificate of need process (CN) now serves the interests of big business only. Unlike the lower 48 states, Alaska enjoys almost zero-percent managed healthcare market penetration. This translates into big remuneration for healthcare facilities in Alaska; indeed, the State has the best health insurance remuneration rates in the country. These excellent reimbursement rates allow Providence Hospital and Alaska Regional Medical Center to operate as the most profitable hospitals in their respective nationwide networks.

These cash-rich not-for-profit facilities further enhance their businesses by actively working to restrict potential competitors. The primary way that powerful Alaska hospitals achieve this end is by political lobbying for continued enforcement of CN in the areas that they do business. Healthcare facilities such as Providence Medical Center and Fairbanks Memorial Hospital are viscous in their anti-competition behaviors and will stop at nothing to maintain their exclusive market positions. These behaviors are self-serving and do not serve Alaska's citizenry.

I ask you to support the elimination of the certificate of need process in Alaska. A vote for elimination of this process is a vote for expansion and diversification of the State's healthcare resources, and hence for growth in the health care market. A vote against elimination of the CN process is a vote for big business and will result in a continued health care monopoly in Alaska.

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

Sincerely,

John D. Rosoff, MD

John D. Rosoff
PMB 221
3875 Geist Road, Ste. E
Fairbanks, AK 99709
Cell: 907/360-8213
Voice/fax: 907/456-4439
picobella@aol.com

Subject: FAIRBANKS SURGERY CENTER
Date: Tue, 30 Nov 1999 09:12:06 -0900
From: "Dr. Jon Lieberman" <jlieberman@mail.tvcclinic.com>
To: brian porter <Representative_Brian_Porter@legis.state.ak.us>

Dear Representative Porter:

I am a general surgeon in Fairbanks, Alaska at Tanana Valley Clinic.

I am sending this message in support of a Fairbanks surgery center that should be seperate from Fairbanks Memorial Hospital. I have many patients that need to have surgery but wish to not go to the hospital for ambulatory surgery. Furthermore, the patients feel that the hospital charges too much for there ambulatory surgery service. Healthy competition would improve quality of health care and lower costs.

There was a recent competition for a Fairbanks Surgery Center Centificate of Need. Tanana Valley Clinic, Fairbanks Surgery Center, and Fairbanks Memorial Hospital all competed for this certificate. The State came back with the decision that there was no need for a surgery center. The Fairbanks community knows that this is a politically motivated decision facilitated by aggressive lobbying on the part of the Fairbanks Memorial Hospital Foundation

I think that the "Certificate of Need" process was an exercise that lent the appearance of fair play. In fact, I think that decisions were made covertly and are not in the best interest of the Fairbanks community.

Sincerely
Jon F. Lieberman, M.D.
General Surgeon
Tanana Valley Clinic

Tanana Valley Clinic

Family Medical Care

Since 1959

FEB 07 2000

February 1, 2000

Representative Fred Dyson
State Capitol, Room 104
Juneau, AK 99801-1182

SUBJECT: Certificate of Need for Out-Patient Surgical Facilities.

Dear Representative Fred Dyson:

I am sure you are aware of the recent Certificate of Need hearings in Fairbanks regarding a proposal by three different entities to construct an out-patient surgical facility. The Tanana Valley Clinic was one of the applicants in this process. The certificate was denied to all of the applicants based on data which suggested that there was no need for such a facility. The physicians of the Tanana Valley Clinic feel that the data was somewhat flawed as it came primarily from records of the Fairbanks Memorial Hospital and may not have reflected patients who chose to have surgery elsewhere due to the high cost locally. We feel that a small out-patient surgical center would be able to offer more cost-effective services in Fairbanks. I would like to raise an important point for your consideration and that is that the certificate of need was originally established in 1976 to prevent the unnecessary duplication of high cost items or facilities. Based on the original limit of 1 million dollars in 1976, the increased cost of living would relate to a current limit of 5 million dollars. If one considered the increase in medical cost since 1976, the 1 million would relate to 7 million dollars at the current time. A legislative remedy to this dollar limitation would obviate the entire complicated certificate of need process in regard to this proposed facility. I would urge you to support legislation which we expect to be introduced which would address this problem.

Thank you very much for your consideration.

Sincerely,

Ralph A. Wells MD

Ralph A. Wells, M.D.
Obstetrics/Gynecology

RAW/dr

1001 Noble Street • Fairbanks, Alaska 99701
(907) 459-3500 • FAX (907) 456-8770

Subject: Opposition to HB 297
Date: Mon, 7 Feb 2000 20:37:43 -0900
From: "Jerry L. Woods" <bellwoodbnb@juno.com>
To: Representative_Fred_Dyson@legis.state.ak.us
CC: Representative_Joe_Green@legis.state.ak.us, Representative_Carl_Morgan@legis.state.ak.us, Representative_Jim_Whitaker@legis.state.ak.us, Representative_Tom_Brice@legis.state.ak.us, Representative_AllenKemplen@legis.state.ak.us, Representative_John_Coghill@legis.state.ak.us, Representative_Jeanette_James@legis.state.ak.us

Certificate of Need

Dear Representative:
I am a Board of Trustees member and Board Treasurer for the Wesley Rehabilitation and Care Center (WRCC) in Seward, Alaska. Serving for the last three years In this voluntary position has made me keenly aware of the difficulties facing those agencies whose goals and mission direct them to serve the public and, in the case of WRCC, in a private, non-profit status. Our board takes very seriously the need to be licensed and regulated in the protection of the public.

I urge you to vote against HB297. This bill was introduced on behalf of an individual whose CON application was denied. The hospital and nursing home association did not ask for this bill and is not supporting it.

There are several reasons for you to oppose the bill including:
1) There are significant fiscal implications to the State's Medicaid budget if this bill is approved. Yet, this bill received only one committee referral, that of HESS. It should be referred to the Finance Committee where the complex questions relating to Medicaid can be appropriately dealt with.
2) The growth in the consumer price index and the inflation factors used in the Medicaid rate setting process do not support increasing the dollar threshold for CON review from $1 million to $7 million. Using the CPI could potentially increase the threshold to $2 million.
3) The timing of the bill is not appropriate. Alaska hospitals are going through significant debate and negotiations regarding changes to the Medicaid rate setting process. CON approval assures that the capital costs are considered in the rate setting. The balance of regulatory review and Medicaid rate setting is an issue for all Alaska hospitals.
4) All Alaska hospitals and nursing homes are opposed to this bill. Who does this bill benefit? Not the industry. And not the public. This bill aids only one small special interest group.
5) Hospitals have the full expense of emergency services, bad debts, and charity care and other services that are unprofitable but needed in the community. When patients leave the hospital for the allegedly less expensive ASC, the fixed costs of the existing facility will be spread among fewer patients, inevitable increasing the cost to other patients. CON review allows for any price advantage individual consumers may obtain to be weighed against the increased cost to the entire community.
6) Healthcare marketplace competition works only in states where capitated and other prospective payment systems are controlling health care costs. Eleven of the states that eliminated CON did so in the mid-1980's primarily in response to the managed care environment. Alaska does not have capitated health care plans, we have no HMOs, and very low managed care.
7) The bill does not help to assure access to quality health care for all Alaskans.

Please vote against HB 297.

Sincerely,

Jerry L. Woods

Seward

Tanana Valley Clinic

Family Medical Care

Since 1959

FEB 22 2000

February 16, 2000

Representative Fred Dyson
State Capital, Room 104
Juneau, AK 99801-1182

Dear Representative Fred Dyson:

I would like you to consider the possibility of increasing the limits imposed by the Certificate of Need. I feel that with the inflation and cost of living standard increases that that limit should be raised. Please consider this in your decision-making process.

Sincerely,

Jean M. W. Tsigonis, M.D.
Family Practice

JWT/dr

1001 Noble Street • Fairbanks, Alaska 99701
(907) 459-3500 • FAX (907) 456-8770

February 16, 2000

Alaska State Legislature
State Capitol MS 3100
Juneau, AK 99801

RE: House Bill (HB) 297.

To the following Health Education, Social Services Committee:

The Honorable Rep. Fred Dyson, Co-Chairman
The Honorable Rep. John Coghill, Jr., Co-Chairman
The Honorable Rep. Tom Brice
The Honorable Rep. Joe Green
The Honorable Rep. Allen Kemplen
The Honorable Rep. Carl Morgan, Jr.
The Honorable Rep. Jim Whitaker

The Honorable Rep. Jeannette James

I am writing this letter to inform you of my position of favor regarding (HB) 297. As a member of the Anchorage community for many years, I have personally seen the benefits of one-day, ambulatory surgery for the patient as well as the patient's family. The main benefit of ambulatory surgery centers is the drastic decrease in the need for long stay, high cost in-hospital admission. I urge you to consider the importance of going forth with a favorable "yes" to a nationally accepted, community oriented, state of the art healthcare facility that serves all persons and offers the care they should expect from the community in which they live.

Thank you for your time.

Sincerely,

Teresa M. Manning R.N.

VALLEY

FEB 10 2000

FEB 10

February 7, 2000

Representative Fred Dyson
Capitol Building
Room 104
Juneau, AK 99801-1182

Dear Representative Dyson:

Please accept this resolution unanimously passed by the Valley Hospital Association Operating Board of Directors urging the State of Alaska Legislature to leave the existing Certificate of Need Laws of the State of Alaska unchanged.

Representing a fully accredited, freestanding community hospital, I urge you to consider this matter carefully. Healthy competition and business growth are critical to the health care market. Today's health care institutions must be efficient, lean, and practical to remain fiscally viable. At the same time, our citizens expect their community hospitals to represent the best interests of the community and to be responsible stewards of the community's resources. With this CON process in place, Alaska guarantees our citizens that health care providers will be both profitable *and* accountable.

In light of national healthcare trends, board members and administrators of Valley Hospital Association are specifically concerned that for-profit ventures will choose to serve only those with the means to pay and will leave all charity, Medicare, and Medicaid patients to our existing delivery system. If this happens, many of the mission-oriented programs designed to meet the needs of our specific community will be eliminated.

I would welcome an opportunity to discuss this with you personally. Please call me at (907) 373-3575. Thank you for your consideration of this important matter to our citizens and to our community hospital.

Sincerely,

Kristan Cole

Kristan Cole
President
Operating Board of Directors

515 E. DAHLIA ST., P.O. BOX 1687, PALMER, AK 99645 (907) 746-8600

RESOLUTION

Whereas, the State of Alaska established the Certificate of Need in 1973 to control unneeded health expenditures and to minimize undue duplication and fragmentation;

Whereas, based on January 1999 data from the American Health Planning Association, 75% of all states require some form of Certificate of Need review to ensure accountability and responsible stewardship of community resources;

Whereas, the Certificate of Need review has the ability to facilitate the development of a responsible marketplace in which the desired benefits of competition and real value in health care are realized;

Whereas, the Certificate of Need considers cost, quality, capacity, convenience and access issues at the community level in order to balance competing needs and the community's priorities;

Whereas, the Certificate of Need process holds health care institutions more accountable for their responsible stewardship of the public's resources;

Whereas, the Board of Directors of Valley Hospital Association, Inc. recognizes its joint responsibilities of clinical and financial stewardship to the Mat-Su Valley;

Whereas, the Valley Hospital Association, Inc. Board of Directors recognizes that expensive health planning decisions in a relatively small community must always be made for the greatest good;

Whereas, altering, amending, or doing away with the present Certificate of Need procedure would likely undermine the financial viability of Valley Hospital, which strives to represent the best interests of our community by relying on profitable services to support other mission-driven health programs;

Therefore be it resolved that the majority of the Valley Hospital Association, Inc. Operating Board of Directors calls upon the Alaska Legislature to leave the existing Certificate of Need Laws of the State of Alaska unchanged. In particular, the Valley Hospital Association, Inc. Operating Board of Directors advises the Alaska Legislature to maintain the $1,000,000 Certificate of Need threshold currently recommended by the State of Alaska.

Be it resolved that the majority of the Valley Hospital Association, Inc. Operating Board of Directors calls upon all health care providers to join in supporting these efforts to encourage continued healthy discussions of health policy planning in the Mat-Su Valley, keeping in mind that all policy decisions should be made for the community's greatest good.

Valley Hospital Association, Inc.

Operating Board President

ATTEST:

AMENDMENT

IN: House (STA)

To: CS HB 297 (STA)
Lauterbach "N" 3/15/00

Page 1, line 14: After "facility" delete [OTHER THAN A NURSING HOME]

Page 1 line 14: After "facility" Insert <u>that is an ambulatory surgical facility</u>

Page, 2, lines 7-8: Delete all material and renumber remaining sections accordingly.

1-LS1303\N
Lauterbach
3/15/00

CS FOR HOUSE BILL NO. 297(STA)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE STATE AFFAIRS COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES JAMES, Rokeberg, Kott, Bunde

A BILL

FOR AN ACT ENTITLED

"An Act relating to the certificate of need program; and providing for an effective date."

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

* **Section 1.** AS 18.07.031(a) is amended to read:

(a) Except as provided in (c) of this section, a [A] person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

* **Sec. 2.** AS 18.07.031 is amended by adding a new subsection to read:

(c) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility other than a nursing home at a site may make an expenditure of

any amount in order to relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided at the new site is greater. However, notwithstanding the expenditure threshold in (a) of this section, a person may not use the site from which the health care facility relocated for another health care facility unless authorized under a certificate of need issued by the department.

* **Sec. 3.** AS 18.07.111 is amended by adding a new paragraph to read:

(10) "nursing home" has the meaning given in AS 08.70.180.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 18.07.031(c), added by sec. 2 of this Act, applies to a relocation that begins on or after the effective date of this Act.

* **Sec. 5.** This Act takes effect immediately under AS 01.10.070(c).

HB 298

1-LS1218\D
Ford
2/17/00

CS FOR HOUSE BILL NO. 298( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES MURKOWSKI, Brice, Phillips

A BILL

FOR AN ACT ENTITLED

"An Act requiring that health care insurers provide coverage for treatment of diabetes."

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

* **Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.390. Coverage for treatment of diabetes. (a) A health care insurer that offers in this state a health care insurance plan shall initially and at each renewal provide coverage for the cost of treating diabetes, including medication, equipment, supplies, outpatient self-management training or education, and nutrition therapy, if diabetes treatment is recommended by a health care provider. The coverage required by this section is subject to standard policy provisions applicable to other benefits, including deductible or copayment provisions. Coverage for the cost of diabetes outpatient self-management training or education and for the cost of nutrition therapy is only required if provided by a health care provider with training in the treatment of diabetes.

(b) In this section,

(1) "diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes;

(2) "health care provider" means a person licensed to provide health care services as required by the state.

1-LS1218\D
Ford
2/17/00

CS FOR HOUSE BILL NO. 298( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES MURKOWSKI, Brice, Phillips

A BILL

FOR AN ACT ENTITLED

"An Act requiring that health care insurers provide coverage for treatment of diabetes."

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(b) In this section,

(1) "diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes;

(2) "health care provider" means a person licensed to provide health care services as required by the state.

ALASKA STATE LEGISLATURE

Chair:
MILITARY AND VETERANS AFFAIRS

Member:
JUDICIARY
COMMUNITY AND REGIONAL AFFAIRS
LABOR AND COMMERCE

REPRESENTATIVE LISA MURKOWSKI
Government Hill • Elmendorf • East Anchorage

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Sponsor Statement
HB 298

"An Act requiring that health care insurers provide coverage for treatment of diabetes."

House Bill 298 would require that health insurers in Alaska provide coverage for diabetes equipment, supplies, training and education as deemed necessary by state licensed health care providers. To date, 37 states have enacted legislation providing similar diabetes insurance coverage.

Over 30,000 Alaskans are affected by diabetes. Without education or proper treatment, diabetes can lead to kidney failure, amputation, nerve damage, blindness, extended hospitalizations, heart disease, and strokes. These medical complications, associated suffering, and resulting costs are often avoidable through patient education on proper nutrition, exercise, blood sugar monitoring, and medication.

Education is the foundation of quality diabetes care. It is the process of providing the person with diabetes the knowledge and skills needed to perform self-care, prevent crisis and make important life style changes required to effectively avoid complications. Through proper education, the diabetic may assume his/her appropriate role as an active participant in the treatment plan.

A number of published studies by the American Diabetes Association show decreases in health care utilization for people with diabetes receiving appropriate education and access to supplies. A Wisconsin study estimates annual savings of $917 per person with diabetes that translates into savings for the insurance industry as well. HB 298 promotes better health, and ultimately, lower health costs for the people of Alaska.

I urge your support of HB 298.

The American Diabetes Association serving Alaska supports HB 298
"An Act requiring that health care insurers provide coverage for treatment of diabetes."

Alaska's population includes 30,000 people affected by diabetes.
Diabetes is a disease that is largely self-managed. To stay healthy a person with diabetes needs access to the proper supplies such as test strips, meters, insulin and other medications and devices. People with diabetes must also be educated on how to properly use these supplies in conjunction with diet and exercise to best manage diabetes.

HB 298 will insure that state regulated health plans cover diabetes supplies, equipment and the education needed to learn to self-manage the disease.

Properly managed, diabetes both improves a person's health and results in cost savings. The Diabetes Complications and Control Trials demonstrated that good blood glucose control reduces costly complications like:

- Blindness by 60%
- Kidney disease by 56%
- Microvascular nerve disease by 61%

Additional studies show reductions in hospitalization, length of hospital stays, and emergency room visits following participation in diabetes self-management education programs:

- The Maine Diabetes Control Project program resulted in 32% fewer hospitalizations and shorter hospital stays
- A Maryland program resulted in a 40-50% decreased risk of hospitalization and 50% lower frequency of emergency room visits
- Rhode Island found a 63% reduction in emergency room visits after participation in an education program.
- A study done for the American Diabetes Association estimates savings of $917/patient/year as the most likely scenario
- A Wisconsin study showed no rise in premiums after that state's law was passed. New Mexico and Maine reported no expected premium increases as a result of the legislation.

Recent advances in the treatment of diabetes and a strong understanding of the importance of education for self-management of diabetes provide the opportunity for people to live healthier and more productive lives with diabetes and the chance to reduce both short-term and long-term costs.

A potential benefit to employers from better diabetes care is less time missed due to diabetes related illness and hospitalization, along with the improved productivity that comes when employees are healthy. More dramatic is the improvement in the quality of life for people with diabetes.

HB 298 is not radical or new legislation. To date 37 states have passed similar legislation. They include large and small, rural and urban states. As recently as last year 6 states as diverse as California and South Dakota enacted similar laws. Of the 37 states, half the legislation was signed by Republican and half by Democratic Governors. Similarly, legislatures of various political leanings have passed the legislation.

We urge you to support HB 298.

American Diabetes Association®

Thank You!

Mission
to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

February 10, 2000

Representative Lisa Murkowski
State Capital, Juneau, Alaska

Dear Representative Murkowski:

In the time you read this letter 2200 Americans will be told they have diabetes, a disease with no cure.

The passage of HB 298 "An Act requiring that health care insurers provide coverage for treatment of diabetes" is vital to the survival of the 30,000 Alaskans affected by diabetes.

Insurance coverage is a priority issue brought to the American Diabetes Association serving Alaska. Self-management of diabetes, guided by a medical team, has proven that good blood sugar control is the key to avoiding the tragic and expensive complications of diabetes.

Diabetes is the leading cause of:

- Blindness (diabetes is the leading cause of adult blindness in the United States),
- Stroke
- Heart Disease
- Kidney Failure
- Amputation
- Neuropathy (loss of feeling in limbs).

Diabetes is serious, causing 193,000 deaths per year.

Home glucose monitoring and new pharmaceutical treatments for diabetes allow those who live each day with diabetes the self-management tools to assess their medical condition at any given moment and respond. Thus avoiding time consuming and costly emergency treatment or hospitalization.

Control of **diabetes** translates to the reduction of complications. Dollars spent to reimburse home glucose monitoring will reduce the complications of diabetes. **Home care costs** average **$2500 per year, avoid one day** of hospitalization with IV therapy and the cost of care has paid for itself.

You will receive volumes of clinical, statistical and financial data regarding diabetes. I hope I can share the human side of diabetes.

- Senior Citizens – Medicare now covers testing supplies and insulin pumps, seniors do not have to choose between diabetes care and heat in winter.
- Families – How do you choose between care for a child with diabetes and making ends meet for a family of 4?
- Working Individuals – Who rely on the security of health insurance benefits to control their diabetes, too often find that many supplies, the tools they need to stay healthy and alive, are excluded from coverage.

HB 298 will help thousands of Alaskans. Thank you for your support and caring,

Michelle A. Cassano
Area Executive Director
American Diabetes Association, serving Alaska
907-272-1424 mcassano@diabetes.org

Feb 11, 2000

Representative Lisa Murkowski
State Capitol
Suite 406
Juneau, AK
99801
Dear Representative Murkowski,

I am writing to offer support for the introduced legislation providing coverage for treatment of diabetes (HB298). I am the Alaska Area Diabetes Control Officer with Indian Health Service. I would like to point out several compelling arguments for enacting this mandate.

Indian Health Service has over 10 years' worth of quality improvement data on a number of elements of diabetes care. Enclosed is a summary chart of the Fiscal Year 1998 audit broken into Indian Health Service Areas. This information is based on manual chart audits done by standardized criteria. There is a distinct correlation seen in patient education, self-monitoring of blood sugars (a measure of patient self-management) and blood sugar control. Alaska for example has the highest percentage of patients with good blood sugar control (defined as a hemoglobin A1c < 7.5). I believe this is directly linked to the fact that Alaska also has the highest percentage of Native American patients who have received diet education, exercise education, and who perform self-monitoring.

It is important to realize that Native patients currently receive these educational services and blood sugar monitoring supplies for free through the Indian Health Service. But as our health care system moves to tribal health corporations, we will need third party reimbursement to continue these key areas of diabetes management. The evidence for the effectiveness of patient education and home monitoring is there in our audit data. HB298 would have an immediate impact on Native and non-Native diabetic patients by increasing their options for learning improved self-management of this chronic condition affecting daily life.

There is good evidence for the cost-effectiveness of this legislation as well. I enclose two articles: one on the direct medical costs of complications resulting from Type 2 diabetes (Diabetes Care July 1998), and the other is a cost effectiveness analysis on the related chronic disease condition of hypertension (British Medical Journal September1998).

Diabetes is the number one cause of non-traumatic amputation, number one cause of acquired blindness, number one cause of kidney failure resulting in dialysis, and a major contributor to heart disease in this country. The United Kingdom Prospective Diabetes Study (multiple articles in the British Medical Journal and the Lancet beginning 9/98) has shown that better blood sugar control significantly decreases the chance of developing each of these complications. The high cost of these events compared to the low cost of screening tests to prevent complications is compared in the Diabetes Care article.

Anything that contributes to better glucose control (patient education, monitoring supplies) may cost a little more in the short run, but will save the huge medical costs of complications ($27,630 for a heart attack, $53,659 for end-stage kidney disease) as quoted in the Diabetes Care article.

The British Medical Journal article on hypertension concludes that the economic analysis of tight BP control (including increased patient visits and increased medication use) "has a cost effectiveness ratio that compare favorably with many accepted healthcare programs." We have every reason to believe that this is true for blood sugar control as well.

I hope that you will take these important data analyses into consideration when acting upon the proposed legislation. If you have any questions, please contact me at (907) 729-1126 or by e mail jkelly@anthc.org.

Sincerely,

Jane Kelly, MD
ANC-Diabetes
4315 Diplomacy Drive
Anchorage AK 99508

Dear Representative,

I am writing to ask for your support of diabetes insurance reform legislation in Alaska. This legislation, House Bill 298, will ensure that Alaskans will have access to diabetes medicines, equipment and education. This is so critical to the 30,000 Alaskans who have diabetes because self-management on a daily basis is their only lifeline to health. I have an 11-year-old daughter who has Type I, insulin-dependent diabetes, and uses an insulin pump. Our family is insured with minimal coverage for her supplies which cost about $300-$500 a month. The insurance company denied switching from 5 shots a day to a continuous infusion pump until we twice appealed through our physician pleading medical necessity to prevent long-term complications. I know many others who battle with their insurance companies to cover equipment and supplies for daily glucose monitoring and the life-saving medications.

We're encouraged that research shows that having the tools to manage her disease now will prevent the known complications of this disease including pregnancy complications, blindness, kidney failure, nerve damage and amputations. It is a bargain to pay for prevention of these expensive medical complications! My daughter, Lauren Bell, and I will be traveling to Juneau on Tuesday, Feb. 22 to attend the hearing in the HESS committee on this HB 298, and would be happy to speak with you about our personal and community support of this Diabetes Insurance Reform.

Thank you for considering my request for your support of this important legislation.

Sincerely,
Mary Lou Kelsey
Homer AK

Mary Lou Kelsey
e-mail<wmbell@alaska,net>
Box 894, Homer, Ak.,99603
907-235-7739 or 299-1985

12/5/97

To whom it may concern.

I don't have diabetes, and I no longer have a family member suffering from this awful disease either. You see, my husband died of "diabetes related complications" on Sept 28, 1997, just 2½ weeks after he turned 34. The medical examiner wasn't able to find anything more specific to list on the death certificate. It seems that nobody does blood-insulin level tests anymore for autopsy purposes.

My husband suffered from diabetes for 17 years. In the last year he was diagnosed with diabetic nephritis and went blind from diabetic retinopathy. He was repeatedly turned down for government assistance and

was unable to receive proper medical care for years. He was turned down for Social Security Disability in July, 1997, two months before he died. After his death, they expedited his appeal and determined that he has been disabled since July of 1996. He has contacted your office several times since we moved here in 1991. You have always done everything possible to help him. He has received advice, literature, a list of pharmaceutical companies that provide free medication, and blood sugar test strips, and always compassion from your office. He was told many times that you wish you could do more, but there just wasn't enough funding.

I cried today when I opened your request for donations. At first, I almost just threw it away. But instead I want to thank you for reminding me that there are still others suffering. I don't have much, but I want to help. I also have a One Touch II, lancets, test strips, and other supplies that I would like to donate. As soon as I get a chance I will bring these items to your office.

I also want you to know that I contacted the Anch. Daily News & they ran a story about the problems we had obtaining medical care. It ran in the Sunday edition, 11/9/97. I sent copies of it with a 3page letter to every member of the AK legislature, Congress, and President Clinton. I have received a few responses, and I am still bugging

them on a regular basis. The State of Alaska does not consider diabetes serious enough to provide help to those who suffer from it, and the federal government doesn't consider advanced diabetes complications to be a disability. I believe that there needs to be some changes. I don't intend to leave them alone until it happens.

Once again, thank you for reminding me that there is still a need to fight this terrible disease. I wish I could do more to help. My prayers are with all of you as you continue to help others.

Sincerely,

Joy Spencer

Joy Spencer
3067 Arctic Blvd., #3
Anch., Ak 99503

Studies on Diabetes Insurance Coverage HB 298

By providing diabetes patients reimbursement for diabetes education and supplies, studies show we can lower the cost of providing care to those afflicted with the disease by reducing hospitalizations, visits to the emergency room and, in the lor- er-term, the serious complications of diabetes.

- The State of Maine and the CDC sponsored a diabetes self-management training program in 30 hospitals and health centers, following 1,488 patients over 3 years. Result: A 32% reduction in hospital admissions with **a savings of $293 per participant, or $3 saved for every $1 spent on diabetes self-management training.**
- Maryland recently established a **Diabetes Care Program** for its Medicaid population to deliver a system of comprehensive and preventive care for people with diabetes. The program promotes preventive services such as outpatient diabetes education, nutrition counseling, therapeutic footwear, blood glucose monitors and supplies. The State of Maryland Diabetes Care Program (DCP) concluded, "...enrollment in the DCP resulted **in 40-50% decreased risk of hospitalization and 50% lower frequency of emergency room visits** compared to a control group."
- Merk-Medco Managed Care, which offers a **specialized diabetes program**, testified before Congress in 1996 that, a recent outcomes study conducted with almost 2,000 patients enrolled in our Diabetes Patient Support Program showed that hospitalizations were reduced by 21 percent; **diabetes specific hospitalizations were reduced by 25 percent; diabetes-specific outpatient visits were reduced by 53 percent.**
- Honeywell Corporation, with $6.7 billion in 1995 revenues and 53,000 employees has made a commitment to its workers with a program called Lifesavers. The program consists of four modules, including one for diabetes, that has produced a net return to the company of $434,000 over the past three years and enabled the company to reduce the allocation to its self-insurance fund by $1.8 million in 1995. As part of its diabetes module the company reimburses for all test strips and supplies needed for blood glucose monitoring and for two health education courses per year. (BAH, Successful Disease Management: Diabetes page 7-8).
- Diabetes education has long been acknowledged as a critical component of care. According to Healthy People 2000, the national health promotion and disease prevention report prepared under the direction of the Bush Administration: **"Patient education is generally considered an integral aspect of patient management and a mainstay of patient self-care. It is**

so widely accepted as standard diabetes management that a rigorous study design that denies education to a control group would be unethical." Unfortunately, access to such education is still very inconsistent. Only some 35% of people with diabetes have attended patient education classes (Diabetes Care, August 1994). According to a study published jointly by the American Association of Diabetes Educators, American Diabetes Association, The American Dietetic Association, Centers for Disease Control and Prevention and the National Diabetes Advisory Board, **"Lack of reimbursement is probably the most significant impediment to the development of diabetes outpatient education programs.** It is simpler to receive reimbursement for inpatient care and bury the costs of education, but it is far more expensive and far less effective."

- The Congressional Budget Office (CBO) analyzed the potential costs of a package of Medicare preventive services and determined that if Medicare pays for diabetes education and blood test strips, the Federal government will begin to save money after three years. Congressional Budget Office, "Preliminary Cost Estimate for The Medicare Preventive Benefits Improvement Act," CBO December 1995 Baseline, January 3, 1996 training.

- A Wisconsin study done after passage of **their insurance reform legislation** found that directing the private insurance market to offer a comprehensive diabetes benefit covering education, equipment and supplies **did not have an appreciable impact on premiums.** It estimated that the mandate resulted in cost of 0.1% of premium.

- Recent studies in both Pennsylvania and California analyzed proposed diabetes insurance reform legislation. The Pennsylvania report **"...finds evidence to suggest that providing diabetics with supplies, medication, self-management education, and medical nutrition therapy can be both medically and cost effective."** The California study concludes that, "research conducted on the cost effectiveness of these programs indicates that in the short run program costs may approximately equal cost savings, and that over longer time periods the programs are cost-effective."

Common Issues Regarding Insurance Coverage For Diabetes

Responses from Steve Bieringer, Regional Advocacy Director, American Diabetes Association & David Holtzman, Director, Government Affairs, American Association of Diabetes Educators.

ISSUE: Mandating coverage of benefits will increase the cost of health insurance which may have the unintended consequence of increasing the number of uninsured as employers decrease their contributions or drop insurance.

RESPONSE: The insurance industry often raises these issues in general as an argument against mandates. I have not seen, and they have never produced, a study that shows Diabetes Insurance Reform will increase costs resulting in lost coverage for people. In fact numerous studies show that covering diabetes equipment, supplies and the education to learn to self-manage the disease will reduce costs. Short-term costs are reduced because of fewer hospitalizations, length of hospital stays and fewer emergency room visits. Lessening complications of diabetes such as blindness, end-stage renal disease, and microvascular disease reduces long-term costs. The industry opposes the diabetes mandate simply because they are afraid it will open the door to other mandates that may have a cost.

ISSUE: Small employers moving to self-funding to avoid state insurance laws; the majority of Alaskans are not impacted because their plans are not subject to state law.

RESPONSE: It is true that a federal law, ERISA, not state law, regulates the self-insured plans usually associated with large employers. It does not lessen the need for state insurance reform to help the 30% or so who are in state regulated plans. Of those covered by health plans not subject to state insurance laws, many already have the benefit of such coverage. The Medicare program provides coverage of monitors, strips and diabetes education. The Federal Employee Health Plan requires, with a few exceptions for some collective bargaining units, coverage for pumps, monitors, strips and education. Some, but not all, self-funded self-insuring plans provide coverage for strips and monitors although education is covered in limited cases. Finally, Alaska's Medicaid program covers monitors, strips and medical nutrition therapy for people with Type 1 or Type 2 diabetes

ISSUE: Mandated offers vs. mandated coverage

RESPONSE: While some insurers may offer this benefit and some employers may purchase it, serious gaps are left with mandatory offerings. Those gaps prevent and make it difficult for people with diabetes to receive the needed supplies, equipment, and education. Of the 37 states that require coverage and the three that have mandatory offering, only one does not include access or reimbursement to diabetes education. The experience of the mandatory offering states is not good. When coverage is provided only by way of a mandatory offering of a rider, the cost of coverage for the rider is borne exclusively by the people with diabetes participating in the coverage. In addition, the cost of the insurer's overhead is added to the costs of the rider pool. Experience shows that for many people with diabetes the cost of the rider is greater than the out of pocket expense they incurred prior to the rider.

FEB 07 2000

Feb 3, 2000

Dear. Representative Dyson

I would like to see the House HES committee push HB 298 through the legislative session this year.

I have had insulin dependant diabetes mellitus since 1978. Diabetic supplies are needed to control my blood sugars. I have tested my blood 4 times a day since 1981. If my blood sugar is "Normal", I will have fewer complications and have less overall costs.

Insurance has not been wonderful for reimbursement. I personally have spent a lot of money to take care of myself. Insurance companies must reimburse for the cost of diabetes medications, Supplies + patient education.

Help the + housands of Alaskans + me too in passing HB 298.

Sincerely

Donald Novotney
1120 Timberline Ct.
Juneau, AK 99801
907 780 4300

Subject: Re:HB 298, Diabetes Insurance Reform
Date: Fri, 18 Feb 2000 11:16:37 -0900
From: "William Bell" <wmbell@alaska.net>
To: bbogren@diabetes.org
CC: Representative_Lisa_Murkowski@ligis.state.ak.us, Representative_Gail_Phillips@legis.state.ak.us

February 17, 2000
Dear Representative,

I am writing to ask for your support of diabetes insurance reform legislation in Alaska. This legislation, House Bill 298, will ensure that Alaskans will have access to diabetes medicines, equipment and education. This is so critical to the 30,000 Alaskans who have diabetes because self-management on a daily basis is their only lifeline to health. I have an 11 year old daughter who has Type I, insulin-dependent diabetes, and uses an insulin pump. Our family is insured with minimal coverage for her supplies which cost about $300-$500 a month. The insurance company denied switching from 5 shots a day to a continuous infusion pump until we twice appealed through our physician pleading medical necessity to prevent long term complications. I know many others who battle with their insurance companies to cover equipment and supplies for daily glucose monitoring and the life-saving medications. We're encouraged that research shows that having the tools to manage her disease now will prevent the known complications of this disease including pregnany complications, blindness, kidney failure, nerve damage and amputations. It is a bargain to pay for prevention of these expensive medical complications! My daughter, Lauren Bell, and I will be traveling to Juneau on Tuesday, Feb. 22 to attend the hearing in the HESS committee on this HB 298, and would be happy to speak with you about our personal and community support of this Diabetes Insurance Reform. Thank you for considering my request for your support of this important legislation. I look forward to your response.
Sincerely,

Mary Lou Kelsey
e-mail<wmbell@alaska,net>
Box 894, Homer, Ak.,99603
907-235-7739 or 299-1985

American Diabetes Association®

Representative Fred Dyson
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182
Correspondence via electronic mail

February 18, 2000

Dear Representative Dyson:

I am writing to ask for your support of diabetes insurance reform legislation in Alaska. This legislation will ensure that Alaskans have access to diabetes medicines, equipment and education. House Bill 298, sponsored by Rep. Murkowski, is scheduled next Tuesday for a hearing in the House Health Education and Social Services committee. The Senate Health Education and Social Services Committee sponsored companion legislation, Senate Bill 276.

Diabetes is a serious disease affecting more than 30,000 Alaskans. It is the leading cause of kidney failure, blindness, nerve damage and amputations. Diabetes is a major risk factor for heart disease and stroke. In addition to these serious health complications, diabetes care results in significant medical costs.

Diabetes complications can be minimized and health care costs can be significantly reduced with access to the proper supplies, equipment, and education. Some insurance plans in our state do cover diabetes supplies and education, but Alaska does not currently require insurers to provide this coverage. Many people with diabetes have trouble obtaining reimbursement from their insurers and are unable to manage their disease.

Diabetes is a disease that is largely self-managed. In order to stay healthy, the patient must have access to supplies, such as test strips, blood glucose meters and insulin. People with diabetes need training on how to use these supplies. Patient education is also essential to support the lifestyle changes required for successful self-management of the disease.

Please take a moment to review the material enclosed with this letter. This material demonstrates why diabetes insurance reform will promote improved health and will also lower health costs for people living with diabetes in Alaska.

Your support for this important legislation is greatly appreciated.

Sincerely,
Betsy Turner-Bogren
Fairbanks District Manager
American Diabetes Association
E-mail: bbogren@diabetes.org

Enclosures

American Diabetes Association®

The Case for Diabetes Insurance Reform in Alaska

Objective: Improved access to diabetes self-management education, equipment and supplies.
Results: Cost savings and better health for 30,000 Alaskans with diabetes.

WHAT WILL THIS LEGISLATION DO?

It will require that individual and group health insurance policies provide coverage for diabetes equipment and supplies and for diabetes education for self-management.

WHO WILL BENEFIT AND WHY IS IT NEEDED?

30,000 Alaskans have diabetes. Many have trouble obtaining the medically necessary equipment, supplies, and self-management education that providers prescribe.

Numerous studies show that access to the proper equipment, supplies and education results in improved health care at no additional cost, and often a cost savings.

HOW CAN THERE BE COST SAVINGS?

Short-term savings, as documented in states where this legislation is in place, are due to fewer hospitalizations, length of hospital stays, and emergency room visits, as the following studies show:

- 32% fewer hospitalizations and hospital days in Maine,
- 40-50% drop in hospitalizaiton and 50% lower frequency of emergency room visits in Maryland,
- 63% reduction in emergency room visits for insulin using diabetics in Rhode Island.

Long-term savings, as documented in states where this legislation is in place, result from a reduction in expensive long-term complications as documented in the Diabetes Control and Complications Trial:

- Blindness reduced by 60%,
- Kidney disease reduced by 56%,
- Microvascular nerve disease reduced by 61%.

HOW MUCH WILL THE COST SAVINGS BE?

It is hard to say exactly but experience and studies show:

- In Maine, $3 saved for every $1 spent on diabetes self-management training, saving $293 per participant,
- Estimated savings of $2,319 per patient each year in a county hospital setting as reported in the New England Journal of Medicine,
- Estimated savings of $437,500 per year for education involving 12,950 individuals with diabetes as reported in the Journal of the American Dietetic Association,
- Estimates savings of $917 per patient in the most likely scenario of a study for the American Diabetes Association,
- Per person costs for Medicaid patients after diabetes education dropped from $5,271 to 3,533.

IS THIS NEW, CUTTING EDGE LEGISLATION?

No. In fact, thirty-seven states have passed similar legislation. It has been signed by Republican and Democratic governors alike.

WILL INSURANCE PREMIUMS RISE?

Not according to a Wisconsin study undertaken after its law passed. New Mexico and Maine report no expected increases in administrative costs.

Transcribed summary of the

Diabetes Preventive Care Cost Impact Study
for the American Diabetes Association

April 11, 1997
Susan K Albee, F.S.A.
Tim D. Lee, F.S.A.
Milliman & Robertson, Inc.

I. Executive Summary

Milliman & Robertson, Inc. (M&R) was engaged by the American Diabetes Association to **study the expected impact on insured health care costs of requiring insurers** and HMOs **to cover certain supplies, equipment and education related to diabetes treatment. Currently, many private insurance plans do not cover such items.** The ADA contends that coverage of supplies and education will likely result in net savings to insurers due to resulting improved health for people with diabetes.

Our analysis supports this view based on a number of published studies which show decreases in health care utilization for people with diabetes receiving appropriate education and access to supplies. We first looked at expected cost savings in an un-discounted, unmanaged environment; in other words, without considering the effects of managed care. Using cost date from M&R's extensive health cost database, we have translated the findings from the published studies into annual potential dollar cost savings per person with diabetes. Our estimates of the net cost impact range from average annual net savings of $1,971 to a net cost of $237 per person with diabetes per year. **The most likely scenario shows $917 in annual savings. These figures are based on average annual cost savings over a five year period expressed in 1996 dollars.**

The study is applicable to commercial insurance coverage for the under age 65 population. The supplies and education covered include test strips, syringes, lancets, glucose monitors, outpatient education courses and nutritional counseling. The analysis compares expected health care costs for people with diabetes with full coverage a listed above to the costs of those with no coverage of these items.

The following report outlines the assumptions used in reaching these conclusions. In our analysis, we relied upon published data sources to support estimates of the impact of providing the proposed package of benefits in terms of utilization savings. **Numerous studies show that education and access to supplies for self-management of diabetes improve ling-term health for people with diabetes.** However, the potential effect on overall health care costs for a commercially insured population has not been quantified sufficiently. In this study, we have applied cost data from M&R database resources to the impact data to arrive at cost impact estimates.

II. Background

Approximately 8 million people in the United States have been diagnosed with diabetes and another estimated 8 million with diabetes have not been diagnosed *(National Diabetes Information clearinghouse, "Diabetes Statistics").* **Diabetes is a costly disease, with approximately 1 in 7 health care dollars in the United States attributable to the diabetic population** according to a 1992 study by Lewin-VHI. *(Altman, "Health Care Expenditures for People with Diabetes Mellitus", 1992).*

Studies have shown that people with diabetes often do not receive adequate care and education about the condition. An estimated 65% have never attended a class or program about diabetes. This includes 41% of individuals with Type I diabetes, 51% of insulin-treated individuals with non-insulin-dependent diabetes, and 76% of individuals with non-insulin-dependent diabetes not treated with insulin. *(Betschart, "Frequency and Determinants of Diabetes Patient Education Among Adults in the U.S.*

Population"). **Lack of adequate preventive care may also be a problem.** In one HMO studied it was determined that 94% of members with diabetes had not had documented annual foot exams and 78% were not referred to an ophthalmologist. Lab screenings were also not up to ADA standards of care. *(Davidson, "The Quality of Outpatient Care Provided to Diabetic Patients in a Health Maintenance Organization").*

III. Covered Services

In some cases, **lack of reimbursement from health insurance plans for education and supplies may be a deterrent for adequate care.** While education received during an inpatient stay or an office visit is usually covered, often **outpatient education programs are not. Supplies** such as glucose monitors, test strips, and syringes are **often paid out of pocket by the patient.**

We have evaluated a set of services that might be covered under a health insurance plan. The set of services includes medically necessary supplies, including test strips, syringes, lancets, and monitors. In addition, outpatient education courses that cover basic information on the disease, meal planning, testing, use of medications, and necessary preventive care are included. Services also include nutritional counseling by a licensed nutritionist. While some of these items may be covered under current insurance plans, **coverage is not universal.**

This report analyzes the cost impact of moving from an insurance plan in which none of these items are covered to one in which all specified services are covered.

IV. Methodology

. . .

V. Healthcare Costs for People with Diabetes

The first step in our evaluation of potential cost savings was to build a model showing expected healthcare costs for a diabetic population. In doing so., we relied on relative costs for diabetics to non-diabetics published in a study developed by Lewin-VHI. We adjusted cost ratios from that study to arrive at ratios of costs per diabetic under age 65 to costs per capita for the total under age 65 population (rather than to non-diabetics).

Based on our analysis, the costs per person with diabetes are 3.4 times the average costs per insured individual. We used such cost ratios by type of healthcare service times utilization for a standard insured population to estimate utilization rates for a diabetic population. Because the cost data from the Lewin study was from 1987 and was not limited to an insured population, we used M&R's Health Cost Guidelines (our database of healthcare costs) charge per service assumptions in order to calculate per capita claim costs for a diabetic population.

. . .

VI. Preventive Approaches and Associated Cost Savings

Numerous published studies support the view that cost savings will be achieved by utilizing various preventive measures to control diabetes. We have used the results of these studies to support estimates of utilization savings that can be achieved. These assumptions are significant in the development of our results.

Maine Diabetes Control Project

The **Maine Diabetes Control Project concluded that participation** in the Ambulatory Diabetic Education and Follow-Up (ADEF) program **resulted in 32% fewer hospitalizations and hospital days** in the year following completion of the education program.

State of Maryland Diabetes Care Program

There are additional studies that support the conclusion that inpatient days can be reduced through self-management support. The **State of Maryland Diabetes Care Program** (DCP) report **concludes that enrollment in the DCP resulted in 40% - 50% decreased risk of hospitalization and 50% lower frequency of emergency room compared to a control group.** The study showed little difference in number of physician office visits between cases and control. While this study includes only the Medicaid population, it suggests that hospital days and emergency room visits can be significantly reduced with appropriate diabetes management.

The Diabetes Control and Complications Trial

The Diabetes Control and Complications Trial (DCCT) was a **ten year study** that examined whether keeping blood glucose levels at as close to "normal" level as possible would reduce long-term complications of diabetes. The study, published in the *New England Journal of Medicine,* **showed that tight control of blood glucose levels reduced the incidence of kidney disease by 56%, blindness by 60%, and microvascular nerve disease by 61%.** While the study only included individuals with insulin-dependent diabetes, we believe the results may translate to those with non-insulin-dependent diabetes.

Other Studies

Numerous **additional studies have shown reduced hospitalizations associated with diabetes education and care programs, ranging from a 20% to a 73% reduction. A 63% reduction in emergency room visits was seen as a result of Rhode Island's Diabetes Outpatient Education Program for insulin-using diabetics.**

Based on these studies, we have projected a potential range of utilization savings:

Utilization Savings Assumptions

Service Category	Optimistic	Base	Pessimistic
Inpatient - Hospital and Physician	50%	32%	20%
Outpatient - Hospital and Physician	20%	10%	0%
Emergency Room - Hospital and Physician	50%	32%	20%

VII. Additional Benefit Costs

There are initial costs for covering preventive items to the extent they are not currently covered. Exhibit 2 shows the expected costs of education, supplies, and additional medical services under Low, Medium, and High Cost Scenarios. Education costs are based on outpatient programs which are distinct from education received during physician or hospital visits.

Expected initial annual costs per person with diabetes, expressed in 1996 dollars are:

Low:	$457
Medium:	$603
High:	$1,111

These **estimates are based on average costs over a five year period.** Many of the underlying assumptions used in the development of supply and education costs are based on a prior study performed by M&R for the Washington State Department of Health.

Additional Medical Services

In addition, as noted in the introduction to this report, **current medical care is often inadequate**. Thus, we would assume that **with better management of the disease, more preventive services** in the form of office visits and lab testing **will take place**. We have assumed the following annual additional services per year in the three scenarios:

Additional Medical Services Assumptions

Service	Low	Medium	High
Physician Visits	1 per year	2 per year	4 per year
Lab Procedures	2 per year	4 per year	8 per year

Physician visits may include vision exams, primary care physician visits, podiatry exams, and other visits to specialists. **The above figures are estimates of required additional visits in order to arrive at level recommended by the ADA *Standards of Care*.**

VIII. Cost Impact Models

Exhibit 3 shows the resulting cost modes. The *Uncovered Cost Model* is reproduces in this exhibit, showing total **annual costs per diabetic of $7,872.** Next, the savings assumptions, frequency, charge per service, and annual cost per diabetic are shown for each of the ten service categories under the optimistic, base, and pessimistic assumptions.

. . .

The per capita per year costs are summed to arrive at total costs before the addition of costs for supplies, education, and additional medical care. Gross savings equal costs in the *Uncovered Cost Model* less costs in the covered model before additional benefit costs.

The gross cost savings equal $2,428 per person with diabetes per year in the Optimistic Scenario, $1,520 in the Base Scenario, and $874 in the Pessimistic Scenario.

The resulting 5 year average net cost savings are then calculated by subtracting the Low, Medium, and High Additional Benefit costs from the gross cost savings. Net Cost Savings are shown below:

5 Year Average Net Cost Savings / (Additions)

	Optimistic Covered Cost	Base Covered Cost	Pessimistic Covered Cost
Low Additional Benefit Cost	$1,971	$1,063	$417
Medium Additional Benefit Cost	$1,825	$917	$271
High Additional Benefit Cost	$1,317	$409	($237)

. . .

While we have used a five year time horizon in most of our calculations, we expect the utilization savings for complications of diabetes to continue long beyond this time period.

. . .

X. Conclusion

Diabetes is a costly disease affecting millions of Americans. There are, however, measures that can be taken to control the complications of diabetes. **Proper education and preventive care can have a significant effect on the long-term health of people with diabetes.**

Based on the assumptions described in this report, **this study shows that covering the proposed package of benefits for people with diabetes will likely result in net savings to insurers and managed care organizations.** The net **savings estimates per person with diabetes per year range from $1,971 to ($355) over a five year time period.** These ranges are based on what we believe are reasonable assumptions, although the actual impact could be outside this range.

CS FOR HOUSE BILL NO. 298(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES MURKOWSKI, Brice, Phillips

A BILL

FOR AN ACT ENTITLED

"An Act requiring that health care insurers provide coverage for treatment of diabetes."

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

* **Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.390. Coverage for treatment of diabetes. (a) A health care insurer that offers in this state a health care insurance plan shall initially and at each renewal provide coverage for the cost of treating diabetes, including medication, equipment, supplies, outpatient self-management training or education, and nutrition therapy, if diabetes treatment is recommended by a health care provider. The coverage required by this section is subject to standard policy provisions applicable to other benefits, including deductible or copayment provisions. Coverage for the cost of diabetes outpatient self-management training or education and for the cost of nutrition therapy is only required if provided by a health care provider with training in the treatment of diabetes.

(b) In this section,

(1) "diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes;

(2) "health care provider" means a person licensed to provide health care services as required by the state.

February 17, 2000

FEB 22 2000

Representative Fred Dyson
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Representative Dyson,

I am writing to ask for your support of diabetes insurance reform legislation in Alaska. This legislation, House Bill 298 and Senate Bill X, will ensure that Alaskans have access to diabetes medicines, equipment and education. Diabetes insurance reform will promote improved health and will lower health costs for people in Alaska. This legislation needs your support.

- ✓ **Diabetes is a serious disease affecting 30,000 Alaskans.** It is the leading cause of kidney failure, blindness, nerve damage and amputations. Diabetes is also a major risk factor for heart disease and stroke. These serious health complications can result in significant medical costs.
- ✓ **Diabetes is a disease that is largely self-managed.** In order to stay healthy, a person with diabetes must have access to supplies, such as test strips, meters and insulin. People with diabetes need training on how to use these supplies. Patient education is also essential to support the nutritional, exercise and lifestyle changes required for successful self-management of the disease.
- ✓ **Studies show that diabetes complications can be minimized and health care cots can be significantly reduced** when people with diabetes have access to supplies and patient education. Some insurance plans in our state do cover diabetes supplies and education, but Alaska does not currently require insurers to provide this coverage. Many people with diabetes have trouble obtaining reimbursement from their insurers and are unable to successfully self-manage their disease.
- ✓ **Diabetes affects my life on a daily basis:** Although I don't have this disease, my partner does. I know how much time he spends just tracking the reimbursements he should be getting, spending time on the phone trying to explain to the insurer what was missed and his medication bills are over a thousand dollars a month.
- ✓ **The reimbursements** will be short all the supplies (test strips, syringes) one time and will be paid another time. Insurer will pay the full amount of a medication one month and 3 months later will only pay a portion. It is almost a full time job just to track all the money owed, money received, not to mention the time to try to get the insurance company to straighten it all out and pay their portion.

Thank you for considering my request for your support of this important legislation.
I look forward to your response.

Respectfully,

Jill Jaeckel
P.O. Box 91012
Anchorage, AK 99509-1012

cc: ADA / file

Representative Fred Dyson
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Dyson:
I come from a family with a strong history diabetes. My grandfather died in kidney failure as a result of diabetes. My mother has had diabetes for twenty years and controls her diabetes through a lot of expense and perseverence, multiple insulin injections every day, 4 blood sugar tests a day and through the educational support of her diabetes nurse educator. Thus far she has avoided the serious complications of diabetes.

I am writing to ask for your support of diabetes insurance reform in Alaska. This legislation has abeen introduced by Representative Murkowski as HB 298. As of the end of year 1999, 37 states had already passed diabetes insurance reform legislation. It is time for Alaska to join the ranks and affirm to it's citizens that their health matters.

Diabetes affects 30.000 people in the state of Alaska alone. The complications of diabetes are serious and perhaps more importantly, costly. It is the leading cause of kidney failure, blindness, limb amputations, and heart attacks and stroke.

I have been a diabetes educator for 14 years. I have seen patients who have received education turn their lives around. I have seen patients drop their blood glucose to normal, and no longer require their medications. This usually requires routine appointments and follow-ups on a yearly basis. I have also had patients who came for one appointment, did not return for follow-ups because their insurance would not pay, and then see the same patients a few years later, only this time they have developed some of the complications of diabetes. Perhaps they have had to have eye surgery, or they have developed kidney disease.

Currently I am seeing a patient who has type 1 diabetes. She had only catastrophic insurance when she developed diabetes. Now it is a preexisting condition, and no one else will cover her. Unfortunately, if she develops a toe infection and needs to have her great toe removed, her catastrophic insurance will cover this, at much greater expense, both in terms of money and quality of life.

I urge you to support this bill.

Sincerely,

Kathy L. Jacques RN, CDE
Certified Diabetes Educator Anchorage

Representative Dyson
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

February 22, 2000

Dear Representative Dyson:

I am writing to ask for your support of the diabetes insurance reform legislation in Alaska. This legislation House Bill 298, will ensure that all Alaskans with diabetes will have access to diabetes medicines, equipment and education. Diabetes insurance reform will promote improved health for people with diabetes and lower health costs for all people in Alaska.

Diabetes is a serious disease affecting 30,000 Alaskans. It is the leading cause of kidney failure, blindness, nerve damage and lower extremity amputation. Diabetes is also a major risk factor for heart disease and stroke. These serious health complications can result in significant medical costs and decreased quality of life for those affected by them.

Diabetes is a chronic disease that is largely self-managed. Staying healthy with diabetes means having access to both education and supplies such as test strips, meters and medications. Patient education is essential to support the life style changes and educate the person about the management of the disease.

Studies have shown that diabetes complications can be minimized and health care costs can be significantly reduced when people with diabetes have access to education and diabetes supplies. Some insurance plans in our state do cover education and diabetes supplies, but Alaska does not currently require insurers to provide this coverage. Many people with diabetes have trouble obtaining reimbursement from their insurers and are unable to manage their diabetes successfully.

As a registered nurse, certified diabetes educator and a person who has lived with type 1 diabetes for 16 years I have a strong belief that all people with diabetes need and deserve to receive the tools they need to manage their disease. We can prevent complications and promote quality of life for all people with diabetes. I urge you to please support this important legislation.

Thank you for considering my request. I look forward to your response.

Sincerely,

Mindy Tomazevic RN, CDE
9826 Dinaaka Dr
Eagle River, AK 99577

Subject: HB 289
Date: Tue, 22 Feb 2000 12:32:40 -0800 (PST)
From: teddy bare <teddybear69_68@yahoo.com>
To: Representative_Fred_Dyson@legis.state.ak.us

Dear Representative Dyson,

I am a constitute from Chugiak and wish to request your support for House Bill 298. This bill will require that insurance companies provide coverage for treatment of diabetes that is not currently covered by all insurance companies. This legislation is vital to the well being of many Alaskans, men, women, and children that have the disease. This is not an issue of government mandating to private business as much as it is insuring that all Alaskans have access to essential treatment for diabetes through equal access to insurance coverage.

Please support this legislation and pass it out of your committee with a recommendation for passage. I would appreciate very much your support for this bill. I am available to discuss any concerns you may have with the bill.

In-addition to being your constitute, I am the volunteer Chairman for the Alaska Diabetes Organization. Although no one in my family has diabetes I because knowledgeable of its great cost in terms of illness and death to Alaskans and have given my time to ease their suffering and find a cure.

Sincerely,

Phillip C. Petrie
24532 Teal Loop
Chugiak, Alaska 99567
Telephone 907-688-1114 (home) 269-8187 (work)

Subject: HB 298
Date: Wed, 23 Feb 2000 11:47:35 -0900
From: "Treat, Carol" <ctreat@anmc.org>
To: "'representative_fred_dyson@legis.state.ak.us'" <Representative_Fred_Dyson@legis.state.ak.us>
CC: "'bbogren@diabetes.org'" <bbogren@diabetes.org>

Dear Representative Dyson,

I am writing to ask for your support of diabetes insurance reform legislation in Alaska. This legislation, House Bill 298 and the companion bill (to be introduced later this week), will ensure that Alaskans have access to diabetes medicines, equipment, and education. Diabetes insurance reform will promote improved health and will lower health costs for people in Alaska. This legislation needs your support because:

-Diabetes affects 30, 000 Alaskans and is growing

-Diabetes is a disease that is largely self managed

-Diabetes complications can be minimized and health care costs can be significantly reduced

-My parents have diabetes and so I may get it in my older years. This is the case for many Americans. Better health care coverage will provide better outcomes to people like me.

Pleas support HB 298 for all Alaskans and Americans.

Sincerely,

Carol Treat MS RD
10316 Lee Street
Eagle River AK. 99577
email: alaskanopportunities@msn.com

Senator Mike Miller
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Miller:

I am writing to ask for your support of diabetes insurance reform in Alaska. This legislation has abeen introduced by Representative Murkowski as HB 298.

Diabetes affects 30.000 people in the state of Alaska alone. The complications of diabetes are serious and perhaps more importantly, costly. It is the leading cause of kidney failure, blindness, limb amputations, and heart attacks and stroke. These complications can be prevented or greatly delayed by empowering the patient to take care of his diabetes.

Good diabetes care involves access to education by experienced diabetes educators. A person with diabetes needs access to supplies such as glucose meters, test strips, medications and insulin. On a day to day basis these items seem expensive to the patient, $5 or more per day. However, a single year of these expenses is far far less than a month of dialyses, or a cardiac bypass. Some insurance plans in our state do cover diabetes supplies and education, but Alaska does not currently require insurers to provide this coverage. Many people with diabetes have trouble obtaining reimbursement form their insurers.

I have been a diabetes educator at Providence Alaska Medical Center for the past eleven years. During this time I have seen patients who have received education turn their lives around. I have seen patients drop their blood glucoses to normal, and no longer require their medications. This usually requires routine appointments and follow-ups on a yearly basis. I have also had patients who came for one appointment, did not return for follow-ups because their insurance would not pay, and then see the same patients a few years later, only this time they have developed some of the complications of diabetes. Perhaps they have had to have eye surgery, or they have developed charcot's foot because their blood glucoses have remained high.

Currently I am seeing a patient who has type 1 diabetes. She had only catastrophic insurance when she developed diabetes. Now it is a preexisting condition, and noone else will cover her. Unfortunately, if she develops a toe infection and needs to have her great toe removed, her catastrophic insurance will cover this, at much greater expense, both in terms of money and quality of life.

I urge you to support this bill.

Sincerely,

Bette Seaman
Registered Dietitian
Certified Diabetes Educator

February 21, 2000

Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear: Senator Mike Miller
Senator Pete Kelly
Senator Drue Pearce
Senator Gary Wilken
Senator Kim Elton
Representative Jim Whitaker
Representative Allen Kemplen
Representative Gail Phillips
Representative Janette James
Representative Fred Dyson
Representative Joe Green
Representative Carl Morgan
Representative Tom Brice
Representative John Coghill, Jr.
Representative Lisa Murkowski

I am writing to ask for your support of diabetes insurance reform legislation in Alaska, HB 298 and SB 276. This legislation will insure that Alaskans with diabetes have access to medicines, equipment, and education necessary for the management of this chronic disease. Diabetes reform will help promote health and lower health costs for people in Alaska.

Diabetes is a serious disease affecting 30,000 Alaskans. It is the leading cause of kidney failure, blindness, nerve damage, and amputations. Diabetes is also a major risk factor for heart disease and stroke. All these health complications can result in significant medical costs.

These medical costs could be reduced through preventive maintenance of the disease; mainly, through self-management including testing of blood sugar levels with meters, lancets, and test strips; injecting insulin using alcohol swabs and needles; or through oral medication. However, people diagnosed with this disease require education and continual medical support from the beginning in order to know how to manage their disease. When people are diagnosed with diabetes, they are confronted with a myriad of information and health care professionals, not to mention being faced with a disease that could eventually cause early mortality.

Being faced with such a disease is traumatic enough without the added complication of finding out that your health insurance provider will either not cover any of the expenditures related to the maintenance of the disease, will only pay a small portion of the costs, or treats the disease as a preexisting condition and therefore requires a waiting period, six months to a year, before benefits will take over. Are these fair to people, who in most cases, do not have any family or medical history indicating that they may be prone to the disease?

I'm an active member of the national and local chapter of the American Diabetes Association, mostly due to the fact that my sister was diagnosed with the disease 21 years

ago. I have watched her face the knowledge of dealing with the disease and observed the many roadblocks placed in her path for the maintenance of this dreaded disease. When my sister was originally diagnosed at age 8, she was provided with the care needed to maintain this disease only because she was the dependent of active duty military personnel. In our family's case, the road was paved with the necessary medical care professionals, education, and medicines necessary to help her maintain her disease.

However, that care changed. Once she reached the age of 23, her health care was threatened because she lost her dependent status. Suddenly, she is a college student with no health insurance and a very expensive disease to manage. My sister spent over six months being denied by three insurance companies before being eligible for the State's chronic care insurance. However, the State's chronic care insurance does not cover daily needs in the maintenance of diabetes. Luckily, within a year, she had finished her degree at the University of Alaska Fairbanks and was able to obtain a position with the university and with that, obtained health insurance coverage. However, she still had to wait six months before her benefits would cover any medical or equipment costs related to her disease due to the preexisting clause.

This is just one example of many that are played out everyday in the life of a person with diabetes. What about the other 30,000 Alaskans dealing with this disease that don't have access to the medicines, health care professionals, and education necessary for a productive life? When people with diabetes don't have the tools necessary to maintain the disease, they are forced to cut back their health care. In other words, these people are not checking their blood sugar levels as often as they should, not taking the necessary insulin to utilize the food that they eat, and not visiting with a physician on a regular basis to analyze their health. This leads to disaster: namely, emergency hospital visits. But unless health insurers are required in the State of Alaska to provide Alaskans with diabetes the tools necessary to treat and maintain this chronic disease, health costs will continue to increase for all Alaskans.

Therefore, I strongly urge you to take into consideration the points I have addressed here and support the passage of this legislation, HB 298 and SB 276, to make life better for Alaskans with diabetes. Thank you for considering my request for your support of this important legislation. I look forward to your response.

Sincerely,

Susan M. Earp
(907) 488-0867

cc: Betsy Turner-Bogren, American Diabetes Association

HB 300

1-GH2061\D
Lauterbach
4/11/00

CS FOR HOUSE BILL NO. 300(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical support orders for children; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

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

*** Section 1.** AS 11.51.122(a) is amended to read:

(a) A person commits the crime of aiding the nonpayment of child support if the person

(1) knows that an obligor has a duty under an administrative or judicial order for **periodic** payment of child support **or for the provision of health care coverage for a child under a medical support order**; and

(2) intentionally

(A) withholds information about the residence or employment of the obligor when that information is requested by a child support enforcement agency; [OR]

(B) **being an employer of the obligor, withholds information**

New Text Underlined [DELETED TEXT BRACKETED]

about the eligibility of the obligor's children for coverage under the employer's health insurance plan or about the cost of the coverage of the children under the plan when that information is requested by a child support enforcement agency; or

(C) participates in a commercial, business, or employment arrangement with the obligor, knowing at the time that the arrangement is made that it will allow the obligor to avoid paying all or some of the support when it is due or to avoid having a lien placed on assets for the payment of delinquent support; receipt of a substantial asset for less than fair market value from an obligor after the obligor's support order has been established constitutes a rebuttable presumption that the person receiving the asset knew that the transfer would allow the obligor to avoid paying all or some of the support or to avoid having a lien placed on the asset.

*** Sec. 2.** AS 11.51.122(b) is amended to read:

(b) In a prosecution under **(a)(2)(B) and (C)** [(a)(2)(B)] of this section, it is a defense that the

(1) defendant did not intend to assist the obligor in the nonpayment of child support **or in the avoidance of a duty to provide health care coverage of a child**; or

(2) obligor did not intend to avoid paying child support **or to avoid providing health care coverage of a child**.

*** Sec. 3.** AS 25.20.050(k) is amended to read:

(k) Upon the motion of the child support enforcement agency or another party in the action to establish paternity, the tribunal shall issue a temporary order for support of the child whose paternity is being determined. **The order may require periodic payments of support, health care coverage, or both.** The order shall be effective until the tribunal issues a final order on paternity and a permanent order for support is issued or the tribunal dismisses the action. The temporary order may only be issued if the tribunal finds clear and convincing evidence of the paternity of the putative father on the basis of the results of the genetic tests and other evidence admitted in the proceeding.

* **Sec. 4.** AS 25.20.050(l) is amended to read:

(l) The tribunal shall consider a completed and signed form for acknowledging paternity that meets the requirements of AS 18.50.165(a) as a legal finding of paternity for a child born out of wedlock. For an acknowledgment signed on or after July 1, 1997, the acknowledgment may only be withdrawn by the earlier of the following dates: (1) 60 days after the date that the person signed it, or (2) the date on which judicial or administrative procedures are initiated to establish child support **in the form of periodic payments or health care coverage** for, or to determine paternity of, the child who is the subject of the acknowledgement. After this time period has passed, the acknowledgment may only be contested in superior court on the basis of fraud, duress, or material mistake. The parent wishing to contest the acknowledgment carries the burden of proof by a preponderance of the evidence. Unless good cause is shown, the court may not stay child support or other legal responsibilities while the action to contest the acknowledgment is pending.

* **Sec. 5.** \S 25.24.210(e) is amended to read:

(e) If the petition is filed by both spouses under AS 25.24.200(a), the petition must state in detail the terms of the agreement between the spouses concerning the custody of children, child support **in terms of periodic payments and in terms of health care expenses**, visitation, spousal maintenance and tax consequences, if any, and fair and just division of property, including retirement benefits. Agreements on spousal maintenance and property division must fairly allocate the economic effect of dissolution and take into consideration the factors listed in AS 25.24.160(a)(2) and (4). In addition, the petition must state

(1) the respective occupations of the petitioners;

(2) the income, assets, and liabilities of the respective petitioners at the time of filing the petition;

(3) the date and place of the marriage;

(4) the name, date of birth, and current marital, educational, and custodial status of each child born of the marriage or adopted by the petitioners who is under the age of 19;

(5) whether the wife is pregnant;

(6) whether either petitioner requires medical care or treatment;

(7) whether any of the following has been issued or filed during the marriage by or regarding either spouse as defendant, participant, or respondent:

(A) a criminal charge of a crime involving domestic violence;

(B) a protective order under AS 18.66.100 - 18.66.180;

(C) injunctive relief under former AS 25.35.010 or 25.35.020; or

(D) a protective order issued in another jurisdiction and filed with the court in this state under AS 18.66.140;

(8) whether either petitioner has received the advice of legal counsel regarding a divorce or dissolution;

(9) other facts and circumstances that the petitioners believe should be considered;

(10) that the petition constitutes the entire agreement between the petitioners; and

(11) any other relief sought by the petitioners.

* **Sec. 6.** AS 25.27.020(a) is amended to read:

(a) The agency shall

(1) seek enforcement of child support orders of the state in other jurisdictions and shall obtain, enforce, and administer the orders in this state;

(2) adopt regulations to carry out the purposes of this chapter and AS 25.25, including regulations that establish

(A) procedures for hearings conducted under AS 25.27.170 and for administrative enforcement of support orders;

(B) subject to AS 25.27.025 and to federal law, a uniform rate of interest on arrearages of support that shall be charged the obligor upon notice if child support payments are 10 or more days overdue or if payment is made by a check backed by insufficient funds; however, an obligor may not be charged interest on late payment of a child support obligation, other than a payment on arrearages, if the obligor is

(i) employed and income is being withheld from the

obligor's wages under an income withholding order;

(ii) receiving unemployment compensation and child support obligations are being withheld from the obligor's unemployment payments under AS 23.20.401; or

(iii) receiving compensation for disabilities under AS 23.30 and child support obligations are being withheld from the obligor's compensation payments;

(C) procedures for establishing and disestablishing paternity under AS 25.27.165 and 25.27.166, including procedures for hearings; and

(D) procedures under which the agency shall enter into contracts or agreements with financial institutions, including brokerage houses, insurance companies, and other companies providing individual investment, transaction, or deposit accounts, doing business in the state to develop and operate an automated data match system as required by 42 U.S.C. 666(a)(17); the agency may pay a reasonable fee to a financial institution for conducting a data match under a contract or agreement under this subparagraph; the fee may not exceed the actual costs incurred by the financial institution for conducting the data match;

(3) administer and enforce AS 25.25 (Uniform Interstate Family Support Act);

(4) establish, enforce, and administer child support obligations administratively under this chapter;

(5) administer the state plan required under 42 U.S.C. 651 - 669 (Title IV-D, Social Security Act) as amended;

(6) disburse support payments collected by the agency to the obligee, together with interest charged under (2) (B) of this subsection;

(7) establish and enforce administratively under this chapter, or through the superior courts of the state, child support orders from other jurisdictions pertaining to obligors within the state;

(8) enforce and administer spousal support orders if a spousal support obligation has been established with respect to the spouse and if the support obligation

established with respect to the child of that spouse is also being administered; and

(9) obtain a medical support order **that meets** [AS PART OF A CHILD SUPPORT ORDER IF HEALTH CARE COVERAGE IS AVAILABLE TO THE OBLIGOR AT A REASONABLE COST; THE AGENCY SHALL CONSIDER WHETHER ADEQUATE HEALTH CARE IS AVAILABLE TO THE CHILD THROUGH THE INDIAN HEALTH SERVICE OR OTHER INSURANCE COVERAGE BEFORE IT ORDERS AN OBLIGOR TO PROVIDE HEALTH CARE COVERAGE THROUGH INSURANCE OR OTHER MEANS; THE MEDICAL SUPPORT ORDER MUST MEET] the requirements of AS **25.27.060(c) and** 25.27.063;

(10) act on behalf of the Department of Health and Social Services in the enforcement of AS 47.07.025(b);

(11) establish or disestablish, administratively under AS 25.27.165 - 25.27.166 or through court action, the paternity of a child;

(12) promptly provide to the Bureau of Vital Statistics, in a format approved by the bureau, any final agency decision administratively establishing or disestablishing the paternity of a child born in this state; and

(13) act as the central registry for all child support orders and exchange information as required by federal law.

* **Sec. 7.** AS 25.27.060(c) is amended to read:

(c) In a court **or administrative** proceeding where the support of a minor child is at issue, the court **or agency, as applicable,** may order either or both parents to pay the amount necessary for support, maintenance, nurture, and education of the child. **Regardless of whether a support order for periodic payments is issued, the** [THE] court **or agency** shall issue a medical support order**. The medical support order shall require health care insurance coverage for the child** [AS PART OF A CHILD SUPPORT ORDER] if health care **insurance** coverage is available to **either parent for the child** [THE OBLIGOR] at a reasonable cost. The court **or agency** shall consider whether the child is eligible for services through the Indian Health Service or other insurance coverage before ordering **either parent** [THE OBLIGOR] to provide health care coverage through insurance or other means. **The court or agency**

shall allocate equally the cost of health care insurance for the child between the parents unless there is good cause to allocate the costs unequally. If the obligor has the duty to make periodic payments for non-medical child support, the obligor's periodic payments shall be decreased by the amount of the other parent's portion of payments for health insurance ordered by the court or agency and actually paid by the obligor. If the obligor has a duty to make periodic payments for non-medical child support, the periodic payments shall be increased by the obligor's portion of payments for health insurance if the other parent is ordered to and actually does obtain and pay for insurance. Except as otherwise provided in this subsection for uncovered expenses exceeding $5,000, the court or agency shall allocate equally between the parents the cost of reasonable health care expenses not covered by private insurance or government assistance unless there is good cause to allocate the costs unequally. One parent shall reimburse the other parent for the first parent's share of the uncovered expenses paid by the parent within 30 days after receipt by the first parent of the bill for the health care, payment verification, and, if applicable, a health insurance statement indicating what portion of the cost is uncovered. Reasonable, uncovered expenses exceeding $5,000 in a calendar year shall be allocated based on the parents' relative financial circumstances when the expenses occur, as determined by the court or agency. The medical support order must meet the requirements of AS 25.27.063. Upon a showing of good cause, the court may order the parents required to pay support to give reasonable security for payments.

* **Sec. 8.** AS 25.27.062(a) is amended to read:

(a) Unless the court or agency is establishing only a medical support order, a [A] judgment, court order, or order of the agency under this chapter providing for support must contain an income withholding order. Except as provided in (m) of this section, the income withholding order must provide for immediate income withholding if the support order is

(1) being enforced by the agency and was issued or modified on or after July 8, 1994; or

(2) not being enforced by the agency and was issued on or after July 8,

1994.

* **Sec. 9.** AS 25.27.063(b) is amended to read:

(b) If **a parent** [AN OBLIGOR] who is required to provide health care coverage under a medical support order is eligible for family health coverage through an employer, the court or agency issuing the medical support order shall send a copy of the medical support order to the employer. If the agency has notice that the **parent** [OBLIGOR] has changed or will be changing employment and is or will be eligible for family health coverage through the new employer, the agency shall send a copy of the medical support order to the new employer.

* **Sec. 10.** AS 25.27.140(a) is amended to read:

(a) If **a** [NO] support order has **not** been entered, the agency may establish paternity and a duty of support**, which may include periodic payments of support, a medical support order, or both,** utilizing the procedures prescribed in AS 25.27.160 - 25.27.220 and may enforce a duty of support utilizing the procedure prescribed in AS 25.27.230 - 25.27.270. Action under this subsection may be undertaken upon application of an obligee, or at the agency's own discretion if the obligor is liable to the state under AS 25.27.120(a) or (b).

* **Sec. 11.** AS 25.27.140(c) is amended to read:

(c) **Unless the agency is establishing only a medical support order, a** [A] decision of the agency determining a duty of support shall include an income withholding order as provided under AS 25.27.062.

* **Sec. 12.** AS 25.27.160(b) is amended to read:

(b) **Except as provided in (c) of this section, the** [THE] notice and finding of financial responsibility served under (a) of this section must state

(1) the sum or periodic payments for which the alleged obligor is found to be responsible under this chapter;

(2) the name of the alleged obligee and the obligee's custodian;

(3) that the alleged obligor may appear and show cause in a hearing held by the agency why the finding is incorrect, should not be finally ordered, and should be modified or rescinded, because

(A) no duty of support is owed; or

(B) the amount of support found to be owed is incorrect;

(4) that, if the person served with the notice and finding of financial responsibility does not request a hearing within 30 days, the property and income of the person will be subject to execution under AS 25.27.062 and 25.27.230 - 25.27.270 in the amounts stated in the finding without further notice or hearing.

* **Sec. 13.** AS 25.27.160 is amended by adding a new subsection to read:

(c) If the agency is establishing only a medical support order, the notice and finding of financial responsibility must state

(1) that health care insurance shall be provided for the child to whom the duty of support is owed if health care insurance is available to the alleged obligor at a reasonable cost and that the alleged obligor and the other parent shall share equally the cost of the health care insurance and the costs of reasonable health care expenses not covered by insurance;

(2) the name of the alleged obligee and the obligee's custodian;

(3) that the alleged obligor may appear and show cause in a hearing held by the agency why the finding is incorrect, should not be finally ordered, and should be modified or rescinded, because

(A) no duty of support is owed;

(B) health care insurance for the child is not available to the alleged obligor at a reasonable cost;

(C) adequate health care is available to the child through the Indian Health Service or other insurance coverage; or

(D) there is good cause to allocate the costs of health insurance or uninsured health care expenses unequally between the parents;

(4) that, if the person served with the notice under this subsection does not request a hearing within 30 days, a copy of the medical support order will be sent to the person's employer under AS 25.27.063(b) without further notice or hearing for inclusion of the child in family health coverage if it is available through the person's employer.

* **Sec. 14.** AS 25.27.170(d) is amended to read:

(d) **Except as provided in (g) of this section, the** [THE] hearing officer shall

determine the amount of periodic payments necessary to satisfy the past, present, and future liability of the alleged obligor under AS 25.27.120, if any, and under any duty of support imposable under the law. The amount of periodic payments determined under this subsection is not limited by the amount of any public assistance payment made to or for the benefit of the child.

*** Sec. 15.** AS 25.27.170(f) is amended to read:

(f) **Except as provided in (g) of this section, if** [IF] the alleged obligor requesting the hearing fails to appear at the hearing, the hearing officer shall enter a decision declaring the property and income of the alleged obligor subject to execution under AS 25.27.062 and 25.27.230 - 25.27.270 in the amounts stated in the notice and finding of financial responsibility.

*** Sec. 16.** AS 25.27.170 is amended by adding a new subsection to read:

(g) If the agency is establishing only a medical support order, the hearing officer shall enter a decision about the parents' respective responsibilities for the child's health care expenses that complies with the requirements of AS 25.27.060(c).

*** Sec. 17.** AS 25.27.180(a) is amended to read:

(a) Within 20 days after the date of the hearing, the hearing officer shall adopt findings and a decision determining whether paternity is established and whether a duty of support exists, and, if a duty of support is found, **the decision must specify**

(1) unless a medical support order only is being established, the amount of periodic payments or sum for which the alleged obligor is found to be responsible**; and**

(2) the parents' respective responsibilities for the costs of the child's health care; this medical support order must be in compliance with AS 25.27.060(c).

*** Sec. 18.** AS 25.27.244(s)(6) is amended to read:

(6) substantial compliance" regarding a support order or payment schedule means that, with respect to **periodic payments required under** a support order or a negotiated payment schedule under (g) of this section, whichever is applicable, the obligor has

(A) no arrearage;

(B) an arrearage in an amount that is not more than four times the monthly obligation under the support order or payment schedule; or

(C) been determined by a court to be making the best efforts possible under the obligor's circumstances to have no arrearages under any support order **that requires periodic payments** or **under a** negotiated payment schedule relating to child support.

*** Sec. 19.** AS 25.27.246(n)(5) is amended to read:

(5) "substantial compliance" regarding a support order or payment schedule means that, with respect to **periodic payments required under** a support order or a negotiated payment schedule under (f) of this section, whichever is applicable, the obligor has

(A) no arrearage;

(B) an arrearage in an amount that is not more than four times the monthly obligation under the support order or payment schedule; or

(C) been determined by a court to be making the best efforts possible under the obligor's circumstances to have no arrearages under any support order **that requires periodic payments** or **under a** negotiated payment schedule relating to child support.

*** Sec. 20.** AS 25.27.900(5) is amended to read:

(5) "duty of support" includes a duty of support imposed or imposable by law, by a court order, decree, or judgment, or by a finding or decision rendered under this chapter whether interlocutory or final, whether incidental to a proceeding for divorce, legal separation, separate maintenance, or otherwise, and includes the duty to pay arrearages of support past due and unpaid together with penalties and interest on arrearages imposed under AS 25.27.020(a)(2)(B) **and the duty to provide health care coverage in compliance with AS 25.27.060(c) and 25.27.063;**

*** Sec. 21.** AS 25.27.900(11) is amended to read:

(11) "support order" means any judgment, decree, or order that is issued by a tribunal for the support and maintenance of a child or of a parent with whom the child is living; "support order" includes a judgment, decree, or order

(A) on behalf of a child who has reached the age of majority

if the judgment, decree, or order was lawfully issued; and

(B) for **any or all of the following:**

(i) monetary support, including arrearages;

(ii) payment of health care costs or maintenance of health insurance;

(iii) reimbursement of related costs;

(iv) payment of attorney fees and legal costs and other fees; **or** [AND]

(v) penalty, interest, and other relief as required by a tribunal;

*** Sec. 22.** AS 47.07.025(b) is amended to read:

(b) Through the child support enforcement agency or on its own behalf, the department may garnish the wages, salary, or other employment income of a person who

(1) is required by a medical support order under **AS 25.27.060(c)** [AS 25.27.063] to provide coverage of the costs of medical care to a child who is eligible for medical assistance under this chapter;

(2) has received payment from a third party for the costs of the services; and

(3) has not used the payments to reimburse, as appropriate, the other parent or custodian of the child, the provider of the services, or the department.

*** Sec. 23.** AS 25.27.063(a) is repealed.

*** Sec. 24.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT AMENDMENT OF COURT RULE. This Act amends Rule 90.3, Alaska Rules of Civil Procedure, by specifying that a medical support order may be issued even when a support order for periodic monetary payments is not issued and by setting the requirements for medical support orders.

*** Sec. 25.** This Act takes effect immediately under AS 01.10.070(c).

HES - PLEASE DISTRIBUTE to the Committee Members

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF REVENUE
CHILD SUPPORT ENFORCEMENT DIVISION

Please Reply To:

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Anchorage, AK 99501-6699
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800-478-3300 Toll Free in Alaska
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Toll Free Alaska TTY: (800) 370-6894

February 29, 2000

HB 300

The Honorable Fred Dyson
Alaska State Legislature
State Capitol, Room 106
Juneau, AK 99801-1182

Dear Representative Dyson:

At the meeting of the House HESS committee on February 24, the committee asked four questions about House Bill 300.

1. *If this bill passes, what can be done about existing cases where a financial support amount was put on the order and the custodial parent did not want financial support?*

   If the bill passes and CSED is able to establish separate medical orders, we will establish regulations allowing us to vacate the financial portion of the support order in these cases.

2. *Where in state and federal statute does it say that CSED may only enforce medical support by using insurance to offset Medicaid expenditures?*

   State and federal laws do not limit the type of medical support that can be collected. However, we believe that focusing on health insurance is the most cost-effective way of addressing this issue. We have recently met with a contractor for the Division of Medical Assistance who will help us find non-custodial parents and identify their insurance carriers. We believe that working together we will be able to increase reimbursement for the State.

   Federal law only requires that CSED assure that parents provide health insurance at a reasonable cost. 45CFR303.31 describes the requirements for coverage. State law goes one step further, allowing that uncovered medical expenses be allocated between the parents.

3. *What is the definition of reasonable that is used in Sections 1, 2, 3, 8, 11, and 12 of HB300?*

   Reasonable is defined in federal regulations, 45CFR303.31(a)(1). "Health insurance is considered reasonable in cost if it is employment related, or other group health insurance, regardless of the service delivery mechanism." Our policy is to follow the federal definition. However, if the cost of the insurance appears excessive when compared to the amount of the order, we will review the case.

4. *What is the definition of adequate that is in Sections 1 and 11 of HB300?*

   The word adequate was added into the existing statute in 1994. There have been instances where courts have found that Indian Health service was not adequate given the special health needs of the child.

Please let me know if you have any other questions.

Sincerely,

Barbara

Barbara Miklos
Director

cc: Larry Persily, Deputy Commissioner, Department of Revenue

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HB 300

TONY KNOWLES
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 19, 2000

The Honorable Brian Porter
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Speaker Porter:

Thanks to the inception of Denali Kid Care in March 1999, 12,000 more Alaska children and pregnant women have basic medical care. The success of this program will have far-reaching and long-term effects on the health and well-being of Alaskans.

The vast success of Denali Kid Care has brought more into focus, however, an ongoing problem with Medicaid benefits and its effect on Alaska's child support system. This bill corrects the problem by clarifying that a child support order need not be automatically established when a custodial parent receives medical benefits through Medicaid.

The Child Support Enforcement Division (CSED) must, under federal law, issue a medical support order whenever a custodial parent receives medical benefits through Medicaid. The support order requires either parent to provide health care coverage for the child if it is available at a reasonable cost. Currently, the CSED cannot establish a medical support order only; it must be in conjunction with a child support order that seeks monthly support payments. The custodial parent, however, may not want to pursue child support for various reasons. The current requirement to do so, then, becomes a disincentive to seek valuable medical benefits through Denali Kid Care. To allow more flexibility in such cases, this bill gives parents the option of requesting a medical support order only, without an accompanying child support order.

This bill also amends the medical support statutes to provide that either parent, not simply the obligor parent, may be required to provide health care coverage if coverage is available to the parent at a reasonable cost. By making this change, the bill assures that

the statutory requirements for medical support orders are consistent with the requirements of Alaska Civil Rules and related federal law. This bill also makes it clear that a medical support order can be issued regardless of whether health care coverage is currently available to either parent. This makes medical support a continuing obligation on the part of either parent to provide health care coverage for the child whenever it is available at a reasonable cost.

In the interest of the health of Alaska's children. I urge your prompt and favorable action on this bill.

Sincerely.

Tony Knowles
Governor

WES — PLEASE SCHEDULE HB 300

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF REVENUE
CHILD SUPPORT ENFORCEMENT DIVISION

Please Reply To:

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January 28, 2000

The Honorable Fred Dyson
Alaska State Legislature
10928 Eagle River Road
Suite 140
Eagle River, AK 99577

Dear Representative Dyson:

I am requesting that the House Health, Education and Social Services Committee hear HB300. This bill will help parents and assure that the State of Alaska is in compliance with federal requirements.

The Child Support Enforcement Division (CSED) is required to establish medical support orders whenever someone receives medical benefits through Denali Kid Care and other Medicaid programs. Alaska law requires that we establish a medical order in conjunction with a monthly financial order. This bill allows us to establish medical support orders only, without an accompanying financial support order.

There are times when the custodial parent does not want us to establish a monthly financial order. Right now, we are required to establish a monthly support amount and then suspend enforcement of the financial order. However, the debt does not go away. This can lead to problems. Also, there have been cases when the custodial parent will choose not to receive Medicaid benefits for the children because he/she does not want to have a child support case set up.

This bill also amends the statutes to provide that either parent, not simply the obligor parent, may be required to provide health care coverage if coverage is available to the parent at reasonable cost. The bill also clarifies language so that CSED can issue a medical support order before health care coverage is available. The order, however, must require that a parent provide health care coverage only if coverage is available to the parent at a reasonable cost.

We believe that this bill is a win-win bill for all parties and hope we can have a hearing soon. Please call me if you have any questions.

Sincerely,

Barbara

Barbara Miklos
Director

cc: Larry Persily, Deputy Commissioner, Department of Revenue

Sectional Analysis House Bill 300
"An Act relating to the establishment and enforcement of medical support orders for children and providing for an effective date."

This bill makes three changes to child support statutes. First, under existing statutes, an order for medical support can only be established in conjunction with a financial support order. This bill changes the law so that a medical support order may be established on its own. Second, this bill amends the medical support statutes to provide that either parent, not simply the obligor parent, may be required to provide health care coverage. Third, this bill amends the law to require that a medical support order be issued regardless of whether health care coverage is currently available to either parent.

Since so many statutes address child support, changes must be made to many different sections.

Section 1 removes the requirement in AS 25.27.020(a) (9) that a medical support order be issued only as part of a child support order. It also amends the statutes to provide that either parent, not simply the obligor parent, may be required to provide health care coverage.

Section 2 accomplishes the same as Section 1. However, this section amends AS 25.27.060(c), which addresses court orders.

Section 3 amends AS 25.27.063(a) so that either parent may be ordered to provide medical support, not just the obligor. It also adds language clarifying that the parent must provide health insurance only if the health insurance is available at a reasonable cost. This makes this section consistent with other statutes.

Section 4 amends AS 25.27.063(b) so that either parent may be ordered to provide medical support, not just the obligor.

Section 5 amends AS 25.27.140(a) to allow CSED to establish a medical support order as part of a duty of support.

Section 6 amends AS 25.27.140(c) so that it is clear that CSED will not send out an income withholding order with a medical support order only.

Section 7 amends AS 25.27.160 to include the establishment of medical support orders in the same procedures used to establish child support orders. The section

clarifies that CSED must serve the obligor with a notice and finding of financial responsibility to establish a medical support order only. However, it exempts medical support orders from certain requirements, including the requirement that the notice set a periodic payment amount and that the notice inform the obligor of the possibility that the obligor's property and assets will be subject to execution.

Section 8 adds a new section to AS 25.27.160 that delineates the requirements for a notice and finding of financial responsibility for a medical support order.

Sections 9 and 10 amend AS 25.27.170(d) and 25.27.170(f) so that hearing officers of the Department of Revenue have clear direction when holding hearings for medical support orders only. In Section 9, when the hearing relates to medical support only, the hearing officer is not required to determine the amount of periodic payments. In Section 10, when the hearing relates to medical support only, the obligor's property and income is not subject to immediate execution if the obligor fails to appear at the hearing.

Section 11 describes what must happen in a hearing for a medical support order only. The hearing officer shall determine whether either parent is required to provide health care coverage, taking into consideration whether coverage is available to either parent at a reasonable cost and whether adequate health care is available through Indian Health Service or other insurance coverage.

Section 12 adds the requirement that a decision issued by a hearing officer include a medical support order. It removes the requirement that the hearing officer determine the amount of periodic payments if a medical support order only is being established.

Section 13 adds the duty to provide health care coverage to the definition of duty to support.

Section 14 specifies that the legislation takes effect immediately.

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. HB 300

Revision Date/Time (Note if correction) _____ Dept. Affected Revenue

Title Medical Support Orders for Children BRU Child Support Enforcement

Component Child Support Enforcement

Sponsor Governor

Requester House Health, Education and Social Services Component No. 111

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
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						
CHANGE IN REVENUES ( )						

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 (FY2000) cost: _____

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The main feature of this legislation would allow the Child Support Enforcement Division to issue a medical support order without it having to be in conjunction with an order for financial support. Under existing statutes, an order for medical support can only be established in conjunction with a financial support order. This bill changes the law so that a medical support order may be established on its own.

Prepared by: Barbara Miklos, Director Phone _____

Division Child Support Enforcement Division Date/Time 2/3/00 1:34 PM

Approved by: Wilson Condon, Commissioner Date _____

Agency Department of Revenue

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MEMORANDUM April 11, 2000

SUBJECT: Medical Support Orders (CSHB 300(HES), draft version "D")

TO: Representative Fred Dyson
Attn: Wes Keller

FROM: Terri Lauterbach
Legislative Counsel

Enclosed is a draft CS for HB 300. There is quite a bit of new material in the draft. This has been the first chance for the Legal Services Division to clarify this Governor's bill and to ensure that all affected laws have been considered. There seem to me to be many laws not in HB 300 that need amending in order to accommodate the concept of medical support orders being authorized separately from orders for periodic monetary payments. In this regard, I have added secs. 1-5, 8, 18-19, 21-22, and 24.

You directed that HB 300 be re-worked to accomplish the following:

(1) allow separate medical support orders;

(2) not allow CSED to "second-guess" the courts; and

(3) keep responsibility for a child's health care coverage with the parents, when financially feasible for the parents.

To meet the first directive, the enclosed draft removes all statutory language that requires medical support orders to be "part of a child support order." Such language is deleted from current law in secs. 6 and 7, and additional clarifications about medical support being separate from orders for periodic payments are added in secs. 1-5, 10, 11, 13, and 16-21.

To meet the second directive, the enclosed draft enacts in the statutes the requirements currently applicable to court decisions. This new language appears in sec. 7 of the draft. The courts apply these requirements in court cases. Under this draft, the CSED will apply these requirements in agency cases. The requirements for medical support orders are consolidated in sec. 7 (AS 25.27.060(c)) in order to avoid the need for duplicative provisions elsewhere in the statutes. Therefore, duplicative details about medical support orders in sec. 6 of this draft are shown as deleted in this CS, and duplicative details about medical support orders that had been proposed in secs. 8, 11, and 12 of the original HB 300 have been omitted from this CS. Instead, references to AS 25.27.060(c) are used, where applicable, such as in secs.

6, 16-17, 20 , and 22 of the enclosed draft, and AS 25.27.063(a) is repealed because it merely repeated the provisions of AS 25.27.060(c). Consolidating the provisions relating to medical support should help readability of the statutes as well as ensure consistency between court and CSED treatment of medical support orders.

To at least partially meet the third directive, the requirements for medical support orders in sec. 7 of the draft include a requirement that parents share the costs of health care expenses not covered by the Indian Health Services, insurance, or government assistance. Since government assistance is based on the household income of the household where the child lives and examining the noncustodial parent's finances is normally part of determining the parent's ability to make periodic child support payments, I am not sure how you would propose to take into consideration the financial ability of a non-custodial parent to reimburse the state for health care provided through Medicaid when only a medical support order is being established, not an order for periodic payments.

Consequently, this draft is still unclear in one very important respect. AS 25.27.120(a) says that an obligor is liable to the state in the amount of assistance granted under AS 47.07 (which is the law establishing Medicaid, including Denali Kid Care) up to the amount of support provided for in a medical order of support. I am not aware of any law that requires an "amount" in a medical order of support. According to AS 47.07.025(b), this apparently means only that, when the obligor provides insurance for a child covered by Medicaid, the obligor must send payments received from the insurance company to the state. Does the HESS Committee want to set the maximum liability differently for an obligor's responsibility to reimburse the state for Medicaid costs for their children (including Denali Kid Care costs)? If so, how would you like to amend AS 47.07.025(b)? (This law appears in sec. 22 of the enclosed draft.

PA
No insurance provided
State pays no medical NO liability

I have enclosed a sectional summary and a copy of Civil Rule 90.3(d) and AS 25.27.120(a). Please let me know if I can be of further assistance.

TML:jdr:pl
00-155.jdr

Enclosures

Govt is there for picking up pieces of broken families perhaps by default ~~I presume that~~ we don't want to make more pieces. - Easy when looking @ desire for quality care for our kids & looking @ good deal re Denali kid care) to unintentionally send message that 65+ ~~old~~ is ultimately responsibility

graphs (a) and (b) were applied. An order under this paragraph may be issued only with respect to a child whose parents are both minors, and the order terminates when either parent becomes 18 years of age. The court must specify in writing the reasons why it considers it to be appropriate to order a grandparent to pay child support under this paragraph and the factors considered in setting the amount of the child support award. In this paragraph, "grandparent" means the natural or adoptive parent of the minor parent.

COURT RULES ON MEDICAL COVERAGE

Rule 90.3, Alaska Rules of Civil Procedure

(d) **Health Care Coverage.**

(1) *Health Insurance.* The court shall address coverage of the children's health care needs and require health insurance for the children if insurance is available to either parent at a reasonable cost. The court shall consider whether the children are eligible for services through the Indian Health Service (or any other entity) or other insurance coverage before ordering the obligor to provide health care coverage through insurance or other means. The court shall allocate equally the cost of this insurance between the parties unless the court orders otherwise for good cause. An obligor's child support obligation will be decreased by the amount of the obligee's portion of health insurance payments ordered by the court and actually paid by the obligor. A child support award will be increased by the obligor's portion of health insurance if the obligee is ordered to, and actually does obtain and pay for insurance.

(2) *Uncovered Health Care Expenses.* The court shall allocate equally between the parties the cost of reasonable health care expenses not covered by insurance unless the court orders otherwise for good cause. A party shall reimburse the other party for his or her share of the uncovered expenses within 30 days of receipt of the bill for the health care, payment verification, and, if applicable, a health insurance statement indicating what portion of the cost is uncovered. Reasonable, uncovered expenses exceeding $5,000 in a calendar year will be allocated based on the parties' relative financial circumstances when the expenses occur.

(e) **Child Support Affidavit and Documentation.** Each parent in a court proceeding at which child support is involved must file a statement pleading under oath which states the parent's adjusted annual income and the components of this income as provided in subparagraph (a)(1). This statement must be filed with a party's initial pleading (such as the dissolution petition, divorce complaint or answer, etc.), motion to modify, and any response to a

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date and amount of each payment, the name of the obligee, and the total amount of arrearages of support past due and amount of unpaid penalties and interest imposed under AS 25.27.020(a)(2)(B). The agency is required to provide only one audit each year for each obligee and obligor under this section. (§ 8 ch 118 SLA 1982; am § 10 ch 68 SLA 1988; am § 88 ch 87 SLA 1997)

Delayed amendment. — Under § 148(c), ch. 87, SLA 1997, as amended by § 53, ch. 132, SLA 1998, effective July 1, 2001, this section is amended to read: "Within 30 working days after receipt of a written request from an obligor, the obligor's legal representative, the obligee, or the obligee's legal representative, the agency shall provide an audit of all child support payments made by the obligor and received by the agency. The audit shall include the date and amount of each payment, the name of the obligee, and the total amount of arrearages of support past due and amount of unpaid penalties and interest imposed under AS 25.27.020(a)(2)(C). The agency is required to provide only one audit each year for each obligee and obligor under this section."

Revisor's notes. — Formerly AS 47.23.105. Renumbered in 1990.

Cross references. — For nonseverability of § 53, ch. 132, SLA 1998 from other provisions of that act, see § 55, ch. 132, SLA 1998 in the 1998 Temporary and Special Acts.

Effect of amendments. — The 1997 amendment, effective July 1, 1997, made a subparagraph reference substitution in the next-to-last sentence.

Sec. 25.27.107. Certification of arrears. [Effective July 1, 1999.] Within 30 days after receipt of a written request from an obligee or an obligee's personal representative, the agency shall provide the obligee with a document that certifies whether or not the obligor was, at the end of the most recent calendar year,

(1) in arrears under the support order in an amount more than four times the monthly obligation under the order in cases where a payment schedule has not been established for payment of continuing support and accumulated arrears under the support order; or

(2) in arrears under a payment schedule in an amount more than four times the monthly obligation under the payment schedule if a payment schedule has been established for payment of continuing support and accumulated arrears under the support order. (§ 27 ch 132 SLA 1998)

Effective dates. — Section 58, ch. 132, SLA 1998 makes this section effective July 1, 1999.

ALASKA STATUTES

Sec. 25.27.120. **Obligor liable for public assistance furnished obligee.** (a) An obligor is liable to the state in the amount of assistance granted under AS 47.07 and AS 47.27 to a child to whom the obligor owes a duty of support except that, if a support order has been entered, the liability of the obligor for assistance granted under AS 47.27 may not exceed the amount of support provided for in the support order, and, if a medical order of support has been entered, the liability of the obligor for assistance granted under AS 47.07 may not exceed the amount of support provided for in the medical order of support.

(b) An obligor is liable to the state in the amount of the cost incurred if the state is maintaining a child to whom the obligor owes a duty of support in a foster home or institution, except that if a support order has been entered, or an agreement for payment of that cost executed between the obligor and the state, the liability of the obligor may not exceed the amount provided in the support order or agreement.

(c) Within 30 days after the agency knows the identity and address of an obligor who resides in the state and who is liable to the state under this section, the agency shall send written notification by certified mail to the obligor and the obligee of the obligor's accruing liability and that the obligor shall make child support payments to the agency. The notice required under this subsection must be in clear, concise, and easily readable language. The notice may accompany other communications by the agency.

(d) If the agency fails to comply with (c) of this section, interest does not accrue on the liability to the state unless a support order or medical support order, as applicable, has been entered.

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MEMORANDUM April 11, 2000

SUBJECT: Sectional Summary of CSHB 300(HES). (Draft Version "D")

TO: Representative Fred Dyson
Attn: Wes Keller

FROM: Terri Lauterbach
Legislative Counsel

Following is a sectional summary of CSHB 300(HES), draft version "D".

Sections 1 and 2. These two bill sections address the ambiguity of the phrase "child support" in AS 11.51.122(a). The ambiguity arises under HB 300 because "child support" could mean either periodic payments or payments for medical support. Sections 1 and 2 resolve the ambiguity by providing that failure to give information about health insurance coverage is also criminal. However, if you wish, these sections could be clarified the other direction - so that they clearly relate only to child support that is in the form of periodic monetary payments.

Section 3. This section allows temporary child support to be restricted to medical support.

Section 4. This section clarifies the term "child support." The change clarifies that an acknowledgment of paternity may not be withdrawn after the date on which judicial or administrative procedures are initiated to establish either monetary or medical child support.

Section 5. This section is about dissolutions. It clarifies the term "child support" to ensure that agreements between the parties to the dissolution provide for health care expenses of the child.

Section 6. This section corresponds to sec. 1 of HB 300, but is in the proper drafting form, which requires setting out the whole subsection, not just paragraph (9). In paragraph (9), rather than specifying the details that must be covered by a medical support order, the language merely refers to the requirements of AS 25.27.060(c) and 25.27.063.

Section 7. This section is amended to refer both to court and agency medical support orders. The new language comes from the court rules already applicable to health care coverage except that I have added a reference to "government assistance" on page 7, line 11, based on my understanding that the committee wishes to retain some responsibility for the parents to cover health care expenses that may not be covered by either private insurance or Medicaid,

such as co-payments or uncovered categories of care. Placing the court rule language in the statutes ensures that both CSED and the courts are issuing comparable medical support orders.

Section 8. Provides that an income withholding order is not required if only a medical support order is issued. I realize that the option of requiring an income withholding order even if only medical support has been ordered has been discussed by the committee; however, I need further instructions in order to draft that concept. An income withholding order must state an amount to be withheld from the obligor's paycheck during each pay period. How would the level of income withholding be set if only medical support was ordered? How would the CSED or court know ahead of time what the government's cost for the child were going to be?

Section 9. Since either parent may have insurance available for the child, "obligor" is changed to "parent" in this section.

Section 10. Clarifies that medical support may be separate from periodic payments of support.

Section 11. Same concept as sec. 8.

Section 12. Refers to an exception explained in the next section of the CS so that the notice and finding of responsibility can be different if only a medical support order is being established.

Section 13. This section sets out the contents of a notice and finding of responsibility when only a medical support order is being established.

Sections 14 - 17. These sections provide details for a hearing officer to follow when only a medical support order is being established. Section 14 and 15 refer to the language in sec. 16. A reference is used in secs. 16 and 17 (to AS 25.27.060(c)) so that duplicative language doesn't have to be used and all of the requirements of AS 25.27.060(c) will clearly govern the hearing officer's decision.

Sections 18 - 19. These sections relate to the laws that allow an occupational license or driver's license to be suspended when a child support obligor is in arrears. The definitions of "substantial compliance" are clarified so that they refer only to arrears in periodic payments, not failure to pay under an order that is only for medical support. If the committee wishes to make these definitions include arrears under medical support orders, let me know how you would want to define "substantial compliance" with respect to medical support.

Section 20. This section clarifies that, under a "duty of support" imposed by a court or CSED, there may only be a duty to provide health care coverage, not periodic payments of money.

Section 21. This section clarifies that a support order does not necessarily include all of the items listed in subparagraph (B). The word "and" is changed to "or" in (B)(iv) and the introductory language following "(B)" is further clarified.

Section 22. This section governs reimbursement to DHSS for the costs of Medicaid for a child when there is a medical support order in effect for the child. Current law requires only that the obligor must send to DHSS any third-party reimbursements that are received by the obligor for the child's health care. The reference is changed here to AS 25.27.060(c) because AS 25.27.060(c) is the section under which medical support orders are issued to the parent, not AS 25.27.063. AS 25.27.063 requires that a copy of the support order be sent to the parent's employer.

Section 23. AS 25.27.063(a) is repealed because it unnecessarily overlaps with AS 25.27.060(c).

Section 24. Refers to the court rule amendment.

Section 25. Immediate effective date. The committee may wish to consider whether there needs to be implementation time for new CSED regulations, amendments to court rules, or other matters.

TML:glc
00-171.glc

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: January 21, 2000 FURTHER REFERRALS: Judiciary
Finance

Date of Committee Action: 4/11/00

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 300

HOUSE BILL NO. 300 MEDICAL SUPPORT ORDERS FOR CHILDREN

"An Act relating to the establishment and enforcement of medical support orders for children; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB 300 (HES) [ ] the same title [4] 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) _____ [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [4] zero fiscal note(s) DOR

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

CHAIR'S SIGNATURE _____ 4/11/00