ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672
9944 HOUSE LABOR & COMMERCE

Alaska Current Law	Revised Uniform Partnership Act	Analysis
a successor registered agent before the resignation becomes effective. **SEC. 32.05.560. SERVICE OF PROCESS.** (a) The registered agent of a registered limited liability partnership is an agent upon whom process, notice, or demand required or permitted by law to be served upon the partnership may be served. (b) If a limited liability partnership fails to appoint or maintain a registered agent in this state or if its registered agent cannot with reasonable diligence be found at the registered office, the commissioner is an agent of the partnership upon whom the process, notice, or demand may be served. A person may serve the commissioner under this subsection by (1) serving on the commissioner or the designee of the commissioner a copy of the process, notice, or demand, with any papers required by law to be delivered in connection with the service, and a fee established by the department by regulation; (2) sending to the partnership being served by certified mail a notice that service has been made on the commissioner under this subsection and a copy of the process, notice, or demand and accompanying papers; notice to the partnership shall be sent to the address (A) of the last registered office of the partnership as shown by the records on file in the department; and (B) the use of which the person initiating the proceedings knows or, on the basis of reasonable inquiry, has reason to believe is most likely to result in actual notice; and (3) filing with the appropriate court or other body, as part of the return of service, the return		

Alaska Current Law	Revised Uniform Partnership Act	Analysis
receipt of mailing and an affidavit of the person initiating the proceedings that this subsection has been complied with. (c) The commissioner shall keep a record of processes, notices, and demands served upon the commissioner under this section. (d) This section does not affect the right to serve process, notice, or demand required or permitted by law to be served upon a limited liability partnership in another permitted manner. **SEC. 32.05.565. FINANCIAL RESPONSIBILITY.** (a) A registered limited liability partnership shall at all times have and maintain liability insurance or qualifying assets in an amount of value not less than $1,000,000 to satisfy liabilities described in AS 32.05.100(b). To the extent the partnership maintains liability insurance that is subject to a deductible, it shall maintain qualifying assets in the deductible amount, but the sum of the liability insurance and the qualifying assets is not required to exceed $1,000,000. (b) A foreign limited liability partnership may conduct business in this state under this chapter if it has and maintains liability insurance or qualifying assets in an amount of value not less than $1,000,000 to satisfy liabilities that arise from acts or omissions in this state of the type described in AS 32.05.100 (b). (c) To the extent that a registered limited liability partnership or a foreign limited liability partnership maintains liability insurance or qualifying assets under the laws of another jurisdiction, the liability insurance or qualifying assets maintained under		

Alaska Current Law	Revised Uniform Partnership Act	Analysis
those laws satisfy (a) - (b) of this section if the amount of the insurance or assets is equal to or greater than the amount required by (a) - (b) of this section. (d) In a court action against a registered limited liability partnership or foreign limited liability partnership in the courts of this state, upon request of a party to the court action and subject to an order of the court, the partnership shall provide a certification stating that the partnership is in compliance with this section, describing the method by which the partnership has complied with (a) - (c) of this section, and identifying the depository institution holding the qualifying assets or insurance carrier issuing the liability insurance specified in (a) - (c) of this section. (e) If a registered limited liability partnership or foreign limited liability partnership fails to maintain the insurance or qualifying assets required by (a) - (c) of this section, the partners are jointly and severally liable for the debts, obligations, and liabilities of the partnership, except that the aggregate amount for which the partners are jointly and severally liable is limited to the amount of insurance or qualifying assets that would have been required to satisfy the requirements of (a) - (c) of this section. (f) In this section, "qualifying assets" means (1) cash, federally insured deposits of a bank or other financial institution, and obligations of the United States or one of its instrumentalities having a maturity of not more than one year, if the partnership segregates the cash, deposits, or obligations from other partnership property and specifically designates the cash, deposits, or obligations for the exclusive purpose of		

Alaska Current Law	Revised Uniform Partnership Act	Analysis
satisfying liabilities described in AS 32.05.100 (b); or (2) a letter of credit issued by a federally insured depository institution for the benefit of persons in whose favor a judgment has been entered against the partnership arising from liabilities described in AS 32.05.100 (b).		

III. Reporting Requirements

Current Alaska Statute	Revised Uniform Partnership Act	Analysis
SECTION 32.05.570. Biennial report required. A registered limited liability partnership and a foreign limited liability partnership shall file a biennial report within the time established by AS 32.05. **SEC. 32.05.580. CONTENTS OF BIENNIAL REPORT.** A biennial report required under AS 32.05.570 must state (1) the name of the limited liability partnership and the state or country where it was formed; (2) the address of the registered office of the partnership in this state, the name of its registered agent in this state at that address, and, in the case of a foreign limited liability partnership, the address of its principal office in the state or country where it was formed; and (3) the names and addresses of the partners. **SEC. 32.05.590. FILING OF BIENNIAL REPORT.** (a) A biennial report required by AS 32.05.570 shall be filed with the department and is due before January 2 of the filing year. A domestic limited liability partnership and a foreign limited liability partnership registering during an even-numbered year shall file the biennial report each even-numbered year. A domestic limited liability partnership and a foreign limited liability partnership registering during an odd-numbered year shall file the biennial report each odd-numbered year. The biennial report is delinquent if not filed before February 1 of each odd- or even-numbered year as provided in this subsection.	**SECTION 1003. ANNUAL REPORT.** (a) A limited liability partnership, and a foreign limited liability partnership authorized to transact business in this State, shall file an annual report in the office of the [Secretary of State] which contains: (1) the name of the limited liability partnership and the State or other jurisdiction under whose laws the foreign limited liability partnership is formed; (2) the street address of the partnership's chief executive office and, if different, the street address of an office of the partnership in this State, if any; and (3) if the partnership does not have an office in this State, the name and street address of the partnership's current agent for service of process. (b) An annual report must be filed between [January 1 and April 1] of each year following the calendar year in which a partnership files a statement of qualification or a foreign partnership becomes authorized to transact business in this State. (c) The [Secretary of State] may revoke the statement of qualification of a partnership that fails to file an annual report when due or pay the required filing fee. To do so, the [Secretary of State] shall provide the partnership at least 60 days' written notice of intent to revoke the statement. The notice must be mailed to the partnership at its chief executive office set forth in the last filed statement of qualification or annual report. The notice must specify the annual report that has not been filed, the fee that has not been paid, and the effective date of the revocation. The revocation is	Both RUPA and current Alaska law require filing of a report however in Alaska the filing is only required Biennially. Both statutes contain provisions for cancellation of a registration statement or statement of qualification if the filing requirements are not complied with.

Current Alaska Statute	Revised Uniform Partnership Act	Analysis
(b) Proof to the satisfaction of the department that on or before February 1 the report was deposited in the United States mail in a sealed envelope, properly addressed with postage prepaid, satisfies the deadline of (a) of this section. (c) The department shall file the report if it conforms to the requirements of this chapter. If the department finds that the report does not conform to the requirements of this chapter, the report shall promptly be returned to the partnership for necessary corrections. **SECTION 32.05.600. VOLUNTARY WITHDRAWAL OF REGISTRATION.** A registered limited liability partnership may withdraw its registration by filing with the department a written withdrawal notice that is signed by a partner authorized to execute the withdrawal notice. **SECTION 32.05.610. CANCELLATION OF REGISTRATION UPON DISSOLUTION.** The registration of a registered limited liability partnership shall be cancelled upon the dissolution and the commencement of winding up of the partnership. A notice of cancellation shall be filed with the department and must state (1) the name of the registered limited liability partnership; (2) the date of filing of its initial registration; (3) the reason for cancellation; (4) the effective date, which must be a date certain, of cancellation if the cancellation is not to be effective upon the filing of the application; and (5) other information the general partners determine to be appropriate.	not effective if the annual report is filed and the fee is paid before the effective date of the revocation. (d) A revocation under subsection (c) only affects a partnership's status as a limited liability partnership and is not an event of dissolution of the partnership. (e) A partnership whose statement of qualification has been revoked may apply to the [Secretary of State] for reinstatement within two years after the effective date of the revocation. The application must state: (1) the name of the partnership and the effective date of the revocation; and (2) that the ground for revocation either did not exist or has been corrected. (f) A reinstatement under subsection (e) relates back to and takes effect as of the effective date of the revocation, and the partnership's status as a limited liability partnership continues as if the revocation had never occurred	

Current Alaska Statute	Revised Uniform Partnership Act	Analysis
SECTION 32.05.620. INVOLUNTARY CANCELLATION. (a) A registered limited liability partnership's registration may be cancelled involuntarily by the commissioner if (1) the partnership is delinquent six months in filing its biennial report or in paying a fee or penalty; (2) the partnership has failed for 30 days to appoint and maintain a registered agent in the state; (3) the partnership has failed for 30 days after change of its registered office or registered agent to file in the office of the commissioner a statement of the change; or (4) a misrepresentation of material facts has been made in an application, report, affidavit, or other document submitted under this chapter. (b) Before a registration may be cancelled under this section, the commissioner shall give the partnership written notice of its delinquency, failure, or misrepresentation by certified mail addressed to its registered agent, registered office, or partners at the last known address as shown by the records of the commissioner. If the partnership fails, within 60 days after the notice is sent by certified mail, to contest the alleged delinquency, failure, or misrepresentation, the partnership may be dissolved under (d) of this section. (c) If a registered limited liability partnership contests the proposed cancellation, the partnership may request a hearing. If, following a hearing, the commissioner decides there are grounds, under (a) of this section, for involuntary cancellation under this section, the partnership may appeal the decision to the superior court. (d) If the registration of a registered limited liability partnership is subject to cancellation under		

Current Alaska Statute	Revised Uniform Partnership Act	Analysis
(a) - (c) of this section, the partnership fails to correct the delinquency, failure, or misrepresentation as provided in this section, and there is no controlling order of the superior court, the commissioner shall cancel the partnership by issuing a certificate of involuntary cancellation. The certificate must contain a statement that the partnership's registration has been cancelled, and the date and the reason for the cancellation. The original certificate shall be placed in the department's files and a copy of it mailed to the partnership at its registered office or in care of its registered agent, at the last known address shown on the records of the department. Upon the issuance of the certificate of involuntary cancellation, the existence of the partnership ceases, except as otherwise provided in this chapter, and its name shall be available for use and may be adopted by another limited liability partnership on a date that is six months or more after the cancellation. (e) If the registration of a registered limited liability partnership is cancelled under this section, the registration may be reinstated within two years from the date of the certificate of cancellation if it is established to the satisfaction of the commissioner that in fact (1) there was no cause for the cancellation, or the delinquency, failure, or misrepresentation resulting in cancellation has been corrected; and (2) the partnership pays two times the amount of any delinquent fee and the amount the partnership would have paid had it not been cancelled during the two-year period. Unless the partnership being reinstated amends its registration to change its name to comply with AS 32.05.470 - 32.05.520, reinstatement may not be authorized if the name of the partnership is not distinguishable on the records of the department under AS 32.05.480 .		

ADDENDUM
SUMMARY OF 1996 LIMITED LIABILITY PARTNERSHIP ACT AMENDMENTS TO UNIFORM PARTNERSHIP ACT (1994)

These amendments authorize the creation of a new form of general partnership known as a limited liability partnership (LLP). An LLP formed under these amendments provides limited liability protection to the partners that is the same as they would have if they were shareholders in a corporation. The following chart summarizes the LLP Amendments.

RUPA SECTION	TITLE	SUMMARY OF THE PROVISIONS
§101	Definitions	Adds two new definitions - "foreign limited liability partnership and limited liability partnership" and modifies the definition of "statement" to include a Statement of Qualification filed by a domestic or a foreign LLP.
§103	Effect of Partnership Agreement; Nonwaivable Provisions	Adds a new subsection (b)(9) prohibiting the partnership agreement from varying the state law applicable to an LLP. See §106.
§106	Governing Law	Provides that the law of the state where the Statement of Qualification is filed governs the rights, liabilities, and obligations of the partners in an LLP.
§201	Partnership Entity	Adds a new subsection (b) stating that an LLP is the same entity as existed before the filing of a Statement of Qualification.
§306	Partner's Liability	New subsection (c), which creates the limited liability shield for partners, is the most important section in the Amendments. Unlike most existing LLC Acts, subsection (c) makes it clear that no creditor can break through the liability shield by latching onto a partner's right of contribution from the other partners. Filing the Statement of Qualification automatically amends the partnership agreement to eliminate any

		language in the partnership inconsistent with the LLP liability shield. See also §§ 307, 703, and 807(b).
§307	Actions by and Against Partnerships and Partners	Language is added to subsection (d) stating that a partnership creditor cannot seek to satisfy a partnership claim against a partner in an LLP unless the partner is personally liable for the obligation (e.g., because the partner created the creditor claim through his or her own negligence).
§703	Dissociated Partner's Liability to Other Persons	Language is added to subsection (b) stating that a dissociated partner in an LLP is not liable to partnership creditors for two years following the dissociation, unless the partner is personally liable for the obligation in question.
§807	Settlement of Accounts and Contributions Among Partners	New language is added to subsections (b), (c), and (d) to reinforce the limited liability shield given partners in an LLC in Section 306(c).
§903	Conversion of Limited Partnership to [General] Partnership	Language is added to subsection (e) making it clear that if the resulting entity is an LLP, the partners will have the liability protection given by the Amendments to LLP partners.
§906	Effect of Merger	Language is added to subsection (c)(3) reinforcing the limited liability shield protection if the resulting entity is an LLP.
§1001	Statement of Qualification	Sets forth the requirements for a Statement of Qualification: (1) vote necessary to amend the partnership agreement (or the contribution provisions of the partnership agreement if the agreement contains specific contribution provisions); (2) the name and address of the chief executive office and address of the office, if any, in this state and if not the name and address of the agent for service of process in this state; (3) a

		statement that the partnership elects to be a limited liability partnership; and (4) a deferred effective date, if any, (LLP status is effective upon the filing of the statement in the absence of a deferred effective date). The partnership's status as an LLP and hence the liability shield is effective until the Statement of Qualification is canceled or revoked (see Section 1003(c) - (f). Finally, subsection (g) states that an amendment or cancellation of a Statement of Qualification is effective upon filing or on a specified deferred effective date.
§1002	Name	Requires that the name of an LLP must end with "Registered Limited Liability Partnership," "Limited Liability Partnership," "R.L.L.P.," "L.L.P.," "RLLP," or "LLP."
§1003	Annual Report	All domestic and foreign LLP's authorized to transact business in the enacting state are required to file an annual report with the Secretary of State which contains the LLP's name and jurisdiction of formation, the LLP's chief executive office and, if different, current street address in this state, if any, and agent for service of process in this state if there is no current office in this state. Failure to file the report can result in administrative revocation of the Statement of Qualification. If the LLC corrects the default within two years following the effective date of the revocation, the revocation is retroactively negated and the status of the LLP continues "as if the revocation had never occurred."
§1101	Law Governing Foreign Limited Liability Partnership	This section states that the laws of the state of an LLP's formation govern the relations and liabilities of the partners. It also states that a foreign LLP cannot engage in any business in this state that is not permissible

		for a domestic LLC.
§1102	Statement of Foreign Qualification	The requirements for this statement are essentially the same as for the Statement of Qualification for a domestic LLP. See §1001. In addition, subsection (a)(1) requires that the foreign LLP's name end with one of the designations authorized for domestic LLCs. See §1002.
§1103	Effect of Failure to Qualify	Basically, this section states that the failure to qualify has no adverse legal effect (and subsection (c) specifically states that the failure does not waive the partners' liability shield). The only legal effects of failure to file a Statement of Foreign Qualification are: (1) the automatic appointment of the Secretary of State as the agent for service of process on the foreign LLP; and (2) the possibility of an injunctive action by the Secretary of State (see §1105).
§1104	Activities Not Constituting Doing Business	This section contains a nonexclusive laundry list of activities which a foreign LLP can conduct in the enacting state without having to file a Statement of Foreign Qualification. The activities on the list are similar to those found in equivalent provisions in most state corporation codes applicable to foreign corporations.
§1105	Action by [Attorney General]	This section gives the Attorney General of the state the authority to maintain an action against a foreign LLP to restrain it from doing business in the enacting state.
§1208-1211	Effective Date, Repealer, and Transition Rules for States That Have Adopted RUPA and Subsequently Enact the LLP Amendments	These provisions provide for a phased-in applicability of the LLP Amendments depending on whether the LLP is formed before or after the effective date of the LLP Amendments. If the state adopts RUPA and the LLP Amendments at the same time, the normal RUPA transition rules apply.

¶ 3.12 TABLES

TABLE 3.1 Comparison of Business Entities

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
PRECONDITIONS						
Nontax						
Enabling statutes	All states	All states	46 and D.C.	17 and D.C.	All states	All states
Limitations on number of owners	None	None (but see tax preconditions)	Generally 2	Same as General Partnership	At least 2 (RULPA § 101(7))	At least 2 (UPA § 6(1))
Permissible businesses	Any business purpose unless otherwise provided by statute (RMBCA § 3.01)	Same as C Corporation	Same as C Corporation	Same as General Partnership	Any business that a general partnership may conduct (RULPA § 106)	Any business for profit unless otherwise provided by statute (UPA § 6(1))
Tax						
Limited to domestic entities	No	Yes (IRC § 1361(b)(1))	No	No	No	No
Limitations on number of owners	None	No more than 35, with spouses treated as one (IRC §§ 1361(a)(2), 1361(c)(1))	Same as General Partnership	Same as General Partnership	Same as General Partnership	At least 2 but not publicly traded (IRC § 7704(b))
Limitations on who can own	None	Essentially only natural persons who are U.S. citizens or resident aliens (IRC §§ 1361(b)(1)(B), 1361(b)(1)(C))	None	None	None	None

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Limitations on what entity can own	None	Cannot own 80% or more of the stock of another active corporation (IRC §§ 1361(b)(2)(A) 1361(c)(6))	None	None	None	None
Limitations on permissible businesses	None	Cannot be a bank, insurance company, or DISC (IRC §§ 1361(b)(2)(B)-1361(b)(2)(E))	Very few, some states exclude certain activities, e.g., insurance	None	None	None
Limitations on capital structure	None	Single class of stock (SCOS) permitted with risk of non-pro rata distributions and debt recharacterizations as a SCOS; differences in voting rights ignored (IRC §§ 1361(b)(1)(D), 1361(c)(4)-1361(c)(6))	None	None	None	None
Limitations on character of income	None[b]	Status terminates if passive income exceeds 25% of gross receipts for 3 consecutive years and entity has "earnings and profits"[c]	None	None	None	None
CREATION						
Nontax						
Formal acts necessary	Yes (RMBCA § 1.20)	Same as C Corporation	Yes	Yes	Yes	No
Public filing necessary	Yes (RMBCA § 1.20)	Same as C Corporation	Yes	Yes	Yes	No

	C Corporation	*S Corporation*[8]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Amount of public disclosure[9]	Minimal (except for changes to important default rules) (RMBCA § 2.02 (a))	Same as C Corporation	Minimal or some, depending on enabling statute	Same as Limited Liability Company	Less than minimal (general partners must be identified, but inter se arrangements are private) (RULPA § 201(a))	None
Constitutive documents	Articles of incorporation, bylaws, and shareholder voting, control, and transfer restriction agreements (RMBCA §§ 2.02(a), 2.06(b))	Same as C Corporation	Articles of organization and operating agreement	Same as General Partnership plus a registration statement	Certificate of limited partnership and partnership agreement (RULPA) § 201(a))	Partnership agreement (UPA § 18)
Tax						
Election and owner consent	None	All persons who are shareholders on the day the election is made must consent to the election (IRC §§ 1362(a)(1)-1362(a)(2))	None	None	None	None
Effective date of election	None	Generally current year if made in first 2 1/2 months of current year; if first year, election must occur within 2 1/2 months of the earlier of when entity has shareholders, acquires assets, or "begins business"[10]	None	None	None	None

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Status terminated by documents	Liquidation; merger into non C entity (IRC § 331, 332, 336, 337)	Liquidation; merger into non-S entity; violation of eligibility requirements (e.g., shareholder agreement might inadvertently create second class of stock) (IRC § 1362(d)(2))	Liquidation; merger into nonpartnership entity; violation of two-member requirement (IRC § 708(b))	Same as Limited Liability Company	Same as Limited Liability Company	Same as Limited Liability Company
TRANSFERABILITY OF OWNERSHIP INTERESTS						
Nonfirm						
Default mode	Shares freely transferable	Same as C Corporation	Financial rights of all members are freely transferable, transfer of governance rights and complete membership interests requires unanimous consent[b]	Same as General Partnership	Financial rights of both limited and general partners are freely transferable; transfer of complete interests requires unanimous consent unless otherwise provided in partnership agreement (RULPA §§ 702, 704(a))	Financial rights of all partners are freely transferable, transfer of complete interests requires unanimous consent (UPA §§ 27, 18(g))

	C Corporation	S Corporation[a]	Limited Liability Company	Limited Liability Partnership	Limited Partnership	General Partnership
Permissibility of further restrictions						
Documentation	Articles of incorporation, by-laws, resolution of shareholders, or shareholder agreement; legend on certificate (otherwise ineffective against persons without knowledge) (RMBCA §§ 6.27(a), 6.27(b))	Same as C Corporation	Articles of organization, operating agreement	Same as General Partnership	Same as General Partnership	Partnership agreement
Judicial attitude	Strictly construed; absolute prohibitions and unanimous consent provisions disfavored	Same as C Corporation	Statutory restrictions and analogy to partnership support acceptance of self-imposed restrictions	Same as General Partnership	Same as General Partnership	Deference to freedom to contract
Assignee liable for assignor contributions and unlawfully received distributions	No liability (RMBCA §§ 6.22(a), 6.22(b))	Same as C Corporation	Assignee is liable	Same as General Partnership	Assignee is liable (RULPA § 704(b))	No provision

	C Corporation	S Corporation[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Tax						
Sales of interests by owners	Generally capital gain unless corporation is collapsible (IRC § 341)	Same as C Corporation	Generally capital gain unless entity has specified assets such as accounts receivable or substantially appreciated inventory (IRC §§ 741, 751)	Same as Limited Liability Company	Same as Limited Liability Company	Same as Limited Liability Company

[a]From a nontax perspective, there is no distinction between a C corporation and a S corporation.

[b]C corporations that are also personal holding companies pay additional taxes. See IRC § 541

[c]For interim years, there is a "sting tax" to the corporation as well. See IRC §§ 1375, 1363(d)(3). An S corporation may have Subchapter C "earnings and profits" as a carryover from prior C status or as a result of a merger with a C corporation.

[d]Securities laws may impose public disclosure requirements.

[e]IRC § 1362(b); Prop. Reg. § 1362-1(c)(3).

[f]Alternative means may create continuity of life. See Chapters 2 and 9.

[g]Serious tax consequences arise upon the termination of a C corporation, but there generally is no current tax impact to the termination of a partnership. The termination of an S corporation merely defers the Subchapter C termination consequences.

[h]Most enabling statutes do not *expressly* bifurcate interest, referring instead to the admission of an assignee with membership.

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
ORGANIC CHANGES IN ENTITY						
Nonfax						
Entity termination						
Susceptibility	Minimal (only through majority vote or judicial intervention) (RMBCA §§ 14.02(c), 14.20, 14.30)	Same as C Corporation	Dissociation of any member threatens dissolution unless some quorum of remaining members consent to avoid dissolution	Same as General Partnership as to dissolution; failure to renew registration ends LLP status	Moderate (RULPA §§ 801, 802)	Extreme (any dissociation of partner causes dissolution) (UPA §§ 31, 29)
Ability to avoid dissolution on account of member dissociation	N/A	N/A	Moderate, depending on enabling statute; under all statutes, unanimous consent by remaining members will avoid dissolution; many statutes allow constitutive documents to provide alternative means to avoid dissolution[f]	Same as General Partnership	Good; dissociation of limited partner does not cause dissolution; following dissociation of general partner, dissolution is avoided either by consent of all remaining partners or per agreement (RULPA § 801(4))	None; any dissociation causes dissolution

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Effect of termination on business	Ordinarily liquidation unless merged into another entity or subject to asset sale (RMBCA §§ 14.05(a), 17.06)	Same as C Corporation	Ordinarily liquidation unless business continues under "business continuation agreement"	Same as General Partnership	Ordinarily liquidation (RULPA §§ 801, 803, 804)	Ordinarily liquidation unless business continues under agreement (UPA §§ 38(2)(b), 40)
Result to owners						
Upon liquidation	Cash-out according to classes) (RMBCA § 14.05(a))	Cash-out according to number of shares of stock	Unless otherwise provided, cash-out according to return of contributions and then in proportion to distribution share	Same as General Partnership	Unless otherwise provided, cash-out according to return of contributions and then in proportion to distribution share (RULPA § 804)	Unless otherwise provided, cash-out according to return of capital and then in proportion to profit share (UPA § 40(b))
Of wrongful dissolution	N/A	N/A	Liable for damages; under some statutes, fair value does not include goodwill; under some statutes, default rule freezes in interest if dissolution is avoided	Same as General Partnership	Wrongfully dissociating general partner is liable for damages (any wrongful dissociation of limited partner is ineffective and therefore causes no damages) (RULPA §§ 602, 603)	Damages; if business continued, wrongful dissociater's investment not immediately paid and value of eventual payout excludes goodwill (UPA § 38(2)(c))

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Owner personal debt after entity termination and liquidation	Up to amount of liquidating distribution for 5 years after articles of dissolution filed if creditor shows good cause for not previously filing claim against entity (RMBCA §14.07(d)(2))	Same as C Corporation	Varies according to enabling statutes; distribution recapture provision continues to apply despite termination	Same as C Corporation, except where statute provides for recapture of unlawful distributions	General partner remains liable subject to general contract and tort statutes of limitations; limited partners' liability for distributions continues despite entity termination (RULPA § 403)	Yes, subject to UPA discharge provisions concerning dissociated partner and to general contract and tort statutes of limitations (UPA §§ 40(d), 36(2))
Impact on debts	Paid or transferred via merger (RMBCA § 11.06(a)(3))	Same as C Corporation	Paid or transferred via merger	Same as General Partnership, except partners not liable	Ordinarily paid from entity assets or by general partner (RULPA §§ 607, 804)	Ordinarily paid from entity assets or by partners unless business continues and debts are assigned to successor entity (UPA §§ 40(d), 41)
Mergers, exchanges, etc.						
Enabling statutes	Yes (RMBCA § 11.01(a))	Same as C Corporation	Most enabling statutes provide for mergers with limited liability companies and other organizations	None	None	None

	C Corporation	*S Corporation*[a]	*Limited Liability Company*	*Limited Liability Partnership*	*Limited Partnership*	*General Partnership*
Approval required	Yes, unless otherwise provided in articles of incorporation, by majority of board members present and majority of shareholder voting power (RMBCA § 11.03(b)(2))	Same as C Corporation	Those with management authority and the members; quantum of consent varies but is generally less than unanimous	Same as General Partnership	Unless otherwise agreed, general partner has discretion to make any fundamental change in the business, but is constrained by fiduciary duty to limited partners (RULPA § 403)	Unless otherwise agreed, any fundamental change in the business requires unanimous approval (UPA § 18(h))
Dissenters' exit rights	Yes (RMBCA § 13.02(a)(1))	Same as C Corporation	Only under some enabling statutes	Same as General Partnership	No (but general partner may be liable for damage and organic change may be enjoinable) (RULPA § 403)	Yes (unanimous approval rights give each partner the power to demand cash-out) (UPA § 38)
Tax (effect to owner)						
Reorganizations	Generally tax-free with basis carryover to extent owners continue their equity interest in successor organization; any cash received treated as either dividend or partial sale or exchange of stock (IRC §§ 354, 361)	Same as C Corporation, except merger of S corporation with C corporation where surviving entity is C corporation or where surviving entity cannot make Selection means that former S shareholders will no longer be S shareholders	Regardless of whether entity terminates under Section 708(b), generally no tax effect unless liability shares were altered in the surviving entity (IRC §§ 708(b), 752)	Same as General Partnership	Same as Limited Liability Company, except liability shifts are common when shifts are from limited partnerships to limited liability companies	Same as Limited Liability Company, except liability shifts are more common on general partnerships to limited partnerships or to limited liability companies

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. HB296

Revision Date/Time (Note if correction) _____
Dept. Affected Community & Econ. Dev.
Title Uniform Partnership Act
BRU Banking, Securities, and Corporations
Component Banking, Securities, and Corporations
Sponsor Judiciary
Requester House Labor and Commerce
Component Serial No. 1233

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 (FY00) cost: _____

POSITIONS

Full-time						
Part-time						
Temporary						

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

Prepared by Franklin T. Elder, Director Phone 465-2521
Division Banking, Securities and Corporations Date/Time 1/31/00 8:16 AM
Approved by Commissioner Deborah B. Sedwick Date 1/31/00
Agency Community and Economic Development

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ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE COMMITTEE

State Capitol
Juneau, AK 99801-1182
Telephone: (907) 465-4954
Fax: (907) 465-2040

February 3, 2000

A sectional analysis has been requested from Terry Bannister at Legal Services.

Janet

From: Art Peterson
Uniform Law Commissioner

SPONSOR STATEMENT
for
HB 296, UNIFORM PARTNERSHIP ACT

1/31/2000

Alaska currently has the 1914 version of the Uniform Partnership Act promulgated by the National Conference of Commissioners on Uniform State Laws. HB 296 updates that law.

The bill proposes enactment of the NCCUSL's 1994 comprehensive revision, and picks up its 1996 provisions on limited liability partnerships, along with a 1997 amendment by the NCCUSL. Making minor adjustments to accommodate Alaska drafting style requirements, HB 296 closely tracks the national version.

The changes reflect modern business practices and more than eight decades of court decisions and scholarship.

A fundamental aspect of the revision is the recognition of a partnership as a separate legal entity (the "entity" concept), and not merely as an aggregate of individuals (the "aggregate" concept). (Current law is a confusing blend of the two.) This principle is reflected in many provisions.

HB 296 recognizes the primacy of the partnership agreement over statutory rules, except for certain rules protecting specific partner interests in the partnership. It

addresses the fiduciary obligations of loyalty, due care, and good faith. It allows partners control and flexibility to meet their business needs, but defines "partnership" as a distinct entity. This bill also allows for the continuity of life of the partnership so that the partnership no longer dissolves every time a partner leaves. It also provides new rules for conversion and merger so that partnerships may convert to a limited partnership and vice versa, or may merge with another partnership or limited partnership.

The 1996 amendments on limited liability partnerships provide limited liability for general partners of a registered limited liability partnership. They provide greater protection to partners against personal liability than is the case under most of the existing state limited liability partnership statutes. Limited liability partnerships can be created simply by filing a registration statement. However, individual partners are personally liable for any injury they cause, and their personal assets are available to satisfy a judgment against them.

The bill integrates the nationally uniform version of the limited liability partnership law into the nationally uniform version of the regular partnership law, thus significantly improving upon Alaska's 1996 enactment on limited liability partnerships and facilitating the use of Alaska partnership law. It helps bring Alaska into the modern business world.

* * * * *

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February 1, 2000

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Krista S. Stearns, Co-chair
Alaska Bar's Business Law Section
Hicks, Boyd, Chandler & Falconer
825 W. 8th Avenue, Suite 200
Anchorage, Alaska 99501

Re: HB 296, Uniform Partnership Act
(last legislature's SB 198)

Dear Mr. Hume and Ms. Stearns:

HB 296 proposes enactment of the Revised Uniform Partnership Act in Alaska. It was promulgated by the National Conference of Commissioners on Uniform State Laws in 1994, and significantly amended by the NCCUSL (i.e., by adding the limited liability partnership provisions) in 1996. A 1997 amendment was also added by the NCCUSL. Alaska has the 1914 version of the Act!

In 1992, Alaska enacted the revision of the Uniform Limited Partnership Act (repealing the old AS 32.10 and enacting AS 32.11); in 1994, we enacted AS 10.50, on limited liability companies; and ch. 52, SLA 1996 enacted a set of amendments (primarily, AS 32.05.405 -- 32.05.760) on limited liability partnerships. In one way or another, those enactments are related to, but do not do the job of, HB 296.

The bill consists of two basic parts:

1. the 1994 comprehensive revision of the 1914 UPA, a key feature of which is statutorily establishing the "entity" concept of partnerships; and

2. the 1996 amendments of the 1994 version, presenting the limited liability partnership provisions, integrating them into the official revision of the UPA, itself.

I am enclosing for each of you an information packet prepared by the NCCUSL. It includes the official text of the Act and commentary, along with a fact sheet, summaries, and other helpful material. A copy of HB 296 is also in there.

January 3, 1997, I sent such a packet to John Tindall, your predecessor in the section, but I suspect that his copy is so dog-eared by this time that he probably has not passed it along to you.

We need to have an updated, nationally consistent UPA, with the properly integrated limited liability partnership provisions in it. There should be general support for such an Act. I trust that you and your colleagues in the section will endorse it.

Hope to hear from you soon. Thanks.

Yours truly,

Art Peterson

Arthur H. Peterson
Uniform Law Commissioner
for Alaska

Enclosure

cc w/o enc.: Rest of Alaska's ULC Delegation:
Jay A. Rabinowitz
W. Grant Callow
Tamara Brandt Cook
L. S. Kurtz, Jr.
Deborah E. Behr

UNIFORM PARTNERSHIP ACT – QUICK CHRONOLOGY

1914 – Original Uniform Partnership Act

1992 – Promulgation of Uniform Partnership Act (1992) by Uniform Law Commissioners

1993 – Amendments to Uniform Partnership Act (1992)
Becomes Uniform Partnership Act (1993)

1994 – Amendments to Uniform Partnership Act (1993)
Becomes Uniform Partnership Act (1994)

1996 – Amendments to Uniform Partnership Act (1994)
Adds Limited Liability Partnership. Becomes Uniform Partnership Act (1996)

1997 – Amendment to Uniform Partnership Act (1996), Section 801
Becomes Uniform Partnership Act (1997)

Copies of this Act may be obtained from:

NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS
211 E. Ontario Street, Suite 1300
Chicago, Illinois 60611
312/915-0195

A Few Facts About
THE UNIFORM PARTNERSHIP ACT (1994)(1996)(1997)

PURPOSE: This act revises the Uniform Partnership Act of 1914. The 1994 act establishes a partnership as a separate legal entity, and not merely as an aggregate of partners. It recognizes the primacy of the partnership agreement over statutory rules, except for specific rules protecting specific partner interests in the partnership. The 1994 act explicitly addresses the fiduciary responsibilities of partners to each other, providing for express obligations of loyalty, due care, and good faith. The act was amended in 1996 and 1997 to provide limited liability for partners in a limited liability partnership.

ORIGIN: Completed by the Uniform Law Commissioners in 1994, and amended in 1996 and 1997.

APPROVED BY: American Bar Association

ADOPTIONS OF UPA (1992)(1994):

Connecticut
Florida
West Virginia
Wyoming

ADOPTIONS OF UPA WITH 1996 and 1997 AMENDMENTS:

Alabama
Arizona **
Arkansas *
California **
Colorado
Delaware
District of Columbia
Hawaii
Idaho
Iowa
Kansas
Maryland
Minnesota
Montana
Nebraska
New Mexico
North Dakota
Oklahoma
Oregon
Puerto Rico **
US Virgin Islands
Vermont
Virginia **
Washington

2000 INTRODUCTIONS:

For any further information regarding the Uniform Partnership Act (1994)(1996)(1997), please contact John McCabe or Katie Robinson at 312-915-0195.

** *Limited Liability Partnership Equivalent*

(1/1/00)

(Please note: This information can also be found on our Web Site at www.nccusl.org)

Uniform Partnership Act (1997)

- A Summary of Summaries -

Because of the complex chronology of the Uniform Partnership Act since its initial revision in 1992, this short summary does two things, 1) it provides a short history of the revision process, and 2) it provides a short summary of the 1997 Amendment. An initial revision of the 1914 Uniform Partnership Act was promulgated in 1992. It was officially amended in both 1993 and 1994. In 1996, the Limited Liability Partnership Amendments to the Uniform Partnership Act were promulgated. In 1997, a short amendment was added to Section 801. **This progression through revision and amendment is now all together in one final act called the Uniform Partnership Act (1997).**

A summary of both the Uniform Partnership Act (1994) and the Limited Liability Partnership Amendments to the Uniform Partnership Act were prepared as separate documents. Both of these summaries are part of the materials explaining the Uniform Partnership Act (1997), and should accompany this document. If you do not find the two summaries accompanying this document, call the ULC national office at 312 915 0195 or FAX it at 312 915 0187 or send an e-mail to nccusl@nccusl.org. Any of these modes of communication will get you the full array of summaries.

The 1997 amendment to Section 801 of the Uniform Partnership Act reflects the changes in tax policy unveiled by the Internal Revenue Service in late 1996. Section 801 is the basic section in the Uniform Partnership Act governing dissolution of the partnership. The Uniform Partnership Act (1994) provided a safe harbor for a term or particular purpose partnership from dissolution when a partner dissociated. A majority in interest of the remaining partners could agree to continue the partnership within 90 days after the dissociation. This agreement saved the partnership from dissolution and winding up. In 1994, this was considered the most that could be done for the continuation of the partnership under the tax rules at that time.

Under the 1997 amendment, a partner's dissociation in a term or particular purpose partnership no longer triggers a dissolution and winding up, unless a majority in interest of partners agree to continue. The partnership continues under the 1997 amendment unless at least half the remaining partners move by express will to dissolve the partnership within 90 days after the initial dissociation. Only then is there a dissolution and winding up. The new rule favors the continuity of the partnership more than the old rule does. The new tax rules have simply eliminated the old concern for continuity of life as a corporate characteristic, making the new rule favoring continuity of a partnership feasible.

For Immediate Release:

Revised Uniform Partnership Act Reflects Modern Business Practices
28 Jurisdictions Have Now Updated Venerable 80-year-old Partnership Law

January 2000 -- Partnership law in the United States has been derived from only one source--the Uniform Partnership Act (UPA), originally promulgated in 1914 by the National Conference of Commissioners on Uniform State Laws, and subsequently enacted in 49 states. The more recent Revised Uniform Partnership Act (RUPA), was approved by the Conference in 1994, bringing the law of partnerships in line with modern business practices and trends while retaining many of the valuable provisions in the original act. It was amended in 1997 to provide limited liability for partners in a limited liability partnership.

Adopted with the newest amendments in 21 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands, and without the limited liability partnership amendments in four additional states, RUPA is the only revision since the original was promulgated. It governs the relations among general partners and between the partners and the partnerships.

RUPA makes basic revisions to several subjects in the Uniform Partnership Act. For example, it clearly expresses the primacy of the partnership agreement. That agreement is any agreement between the partners, whether written, oral or implied, concerning the partnership. An important concept of RUPA is that it operates, for the most part, as a default statute for matters that are not covered by the partnership agreement.

An important feature of the Revised Uniform Partnership Act is that it moves away from the aggregate approach to partnership law, and instead adopts an entity approach. RUPA states that a partnership is an entity distinct from its partners--thus achieving greater partnership stability under this more modern approach. A partnership may sue and be sued in the partnership name; property may be acquired in the partnership name as well.

The partner's interest is viewed as a separate group of rights and liabilities associated with participation in the partnership. No partner has an interest in specific property of the partnership. Creditors of a partner may attach the interest of a partner, but may not attach specific partnership property.

RUPA also changes the rule on the dissolution of a partnership. Partnership breakups under RUPA do not require a dissolution every time a partner leaves. In most cases, a partnership may buy out the interests of a partner who leaves. A term partnership will not dissolve so long as one-half of the partners choose to remain. RUPA also establishes and defines the scope of the partners' duties of care and loyalty, and the obligation of good faith and fair dealing.

The 1997 amendments to the Uniform Partnership Act provide greater protection to general partners of a registered limited liability partnership than is the case under most of the existing state limited liability partnership statutes.

The National Conference of Commissioners on Uniform State Laws is now in its 109th year. The organization comprises more than 300 lawyers, judges, and law professors, appointed by the states as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, to draft proposals for uniform and model laws and work toward their enactment in their legislatures. Since its inception in 1892, the group has promulgated more than 200 acts, among them such bulwarks of state statutory law as the Uniform Commercial Code, the Uniform Probate Code, and the Uniform Partnership Act.

For further information, please contact John McCabe or Katie Robinson at 312-915-0195, or Gabrielle Bamberger at 212-333-5222.

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

PLEASE REPLY TO:

- *1031 WEST 4TH AVENUE, SUITE 200*
  ANCHORAGE, ALASKA 99501-1994
  PHONE: (907) 269-5100
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- *KEY BANK BUILDING*
  100 CUSHMAN ST., SUITE 400
  FAIRBANKS, ALASKA 99701-4679
  PHONE: (907) 451-2811
  FAX: (907) 451-2846
- *P.O. BOX 110300-DIMOND COURT HOU*
  JUNEAU, ALASKA 99811-0300
  PHONE: (907) 465-3600
  FAX: (907) 465-6735

January 25, 2000

The Honorable Norman Rokeburg
Chair
House Labor & Commerce Committee
State Capitol
Juneau, AK 99801 - 1182

Re: HB 296 (relating to partnerships)

Dear Representative Rokeburg:

HB 296 has just been introduced and referred to the House Labor and Commerce Committee.

Alaska Uniform Law Commissioners request an early hearing on HB 296, relating to partnership. The bill updates our statutes to conform to amendments recommended by the National Conference of Commissioners on Uniform State Laws. Uniform laws are especially important to keep Alaska as an attractive market for interstate commerce.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Deborah E. Behr
Deborah E. Behr
Assistant Attorney General

DEB:jf

cc: Hon. Pete Kott, Chair, House Judiciary Committee
All Uniform Law Commissioners
Chrystal Smith, Legislative Contact, Dept. of Law
Pat Pourchot, Legislative Director, Office of the Governor

JAN 25 2000

03-C5LH

HB 298

C

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: February 28, 2000 FURTHER REFERRALS:

3-23-C
Finance

Date of Committee Action: 22 MAR 2000

The LABOR AND COMMERCE Committee considered: HB 298

HOUSE BILL NO. 298 REQUIRE HEALTH INS COVERAGE FOR DIABETES

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

recommends it be replaced with the following committee substitute CSHB 298 (L+C)

[ ] the same title
[ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) (2)

Adm

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) DCED, ~~DOT~~

2.28.00

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Murkowski	✓			
Harris	✓			
Brice	✓			
CISSNG	✓			
Halcro	✓			✓
Rokeberg			✓	
	(5)		(1)	

CHAIR'S SIGNATURE _____ 3-22-2000

ALASKA STATE LEGISLATURE

House of Representatives

Committee Assignments:

Labor & Commerce Committee, Chairman
Judiciary Committee, Member
Legislative Council, Member
Special Committees:
Utility Restructuring, Member
Economic Development, Member

Interim:
716 West 4th Avenue, Suite 640
Anchorage, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
State Capitol
PHONE: (907) 465-4968
FAX: (907) 465-2040

REPRESENTATIVE NORMAN ROKEBERG

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

FAX COVER SHEET

DATE: March 22, 2000 5:30 p.m.

TO: Legislative Drafter, HB 298, LS 1218/G, (maybe Mike Ford)

FAX: 2029 **VOICE:**

RE: House Labor & Commerce Committee Substitute for HB 298

MESSAGE: Please prepare in final a L&C CS for CSHB 298 (HES) with following amendments:

Amendment #1 as typed, ignore the comments about "tightened up" stuff that was a note to myself.

Amendment #3 as follows.

For your information, Amendment #2 was withdrawn.

Thank you. Janet

TOTAL NUMBER OF PAGES SENT, INCLUDING COVER SHEET: 3

3/17/00

AMENDMENT # 1

OFFERED IN THE HOUSE REPRESENTATIVE MURKOWSKI

moved
Halcro objects for discussion
unanimous adoption

TO: HB 298 (HES)

Page 1, line 1, following "that":
Insert "certain"

Page 1, line 6, following "plan":
Insert "that includes coverage for pharmacy services"

Page 1, line 8, following "supplies"
Delete ","
Insert "."

Page 1, line 8, before "outpatient"
Insert "For all health insurance plans, such coverage shall include"

Page 1, line 8, following "and":
Insert "medical"

Page 1, line9:
Delete "recommended"
Insert "prescribed"

Page 1, Line 12, following "of":
Insert "medical"

Tightened up ed. component

3/17/00
Rokeberg moved
objections
3/22/00
HNR withdrawn
no objection

Amendment #2

Proposed amendment to CSHB 298 (HES):

Page 2, Line 1, insert new subsection (b) to read:

(b) The amount of coverage for the cost of diabetes outpatient self-management training or education is limited to $1,000.00 per person per year.

Re-letter following subsection

Page 2, Line 6, add new Sec. 2 to read:

* Sec. 2. AS 21.42.390 (b) is repealed January 1, 2004.

Am to amendment
Halcro pg 2, line 1 delete > withdrawn 3/22/00

aside

3/22/00
Halcro moved
unanimous

Amendment # 3

OFFERED IN THE HOUSE Representative Murkowski

TO: CS HB 298(HES)

Page 2, Line 1, insert new subsection (b) to read:

(b) The amount of coverage for the cost of diabetes outpatient self management training or education is limited to $1,500.00 per person per year.

Re-letter following subsection

Page 2, Line 6, add new Sec. 2 to read:

* Sec. 2. AS 21.42.390 (b) is repealed January 1, 2003.

CShb 298 (Hes)

Interim
716 W. 4th Avenue
Anchorage, AK 99501
Phone: 907-269-0174
Fax: 907-269-0177

Session
State Capitol Bldg., Suite 406
Juneau, AK 99801
Phone: 907-465-3783
Fax: 907-465-293

REPRESENTATIVE LISA MURKOWSKI

GOVERNMENT HILL · ELMENDORF · EAST ANCHORAGE

Sponsor Statement
CS 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.

Testimony

CS HB 298 L&C Friday 17th of March 3:15

Michelle Cassano-In Juneau
Executive Director American Diabetes Association
801 West Fireweed Lane #103
Anchorage, AK 99503
Phone: 907-272-1424

Rick Mystrom-Teleconference 800-368-8772
Mayor of Anchorage
2727 Iliamna Avenue
Anchorage, AK 99517
Phone: 907-343-4431

Donna Young-In Juneau
Registered Nurse, Certified Diabetes Educator
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Phone: 907-550-2350

Young Shin-Anchorage LIO
Representative Alaska Chapter of American Association of Diabetes Educators
906 Clay court
Anchorage, AK 99503
Phone: 907-297-1179

American Diabetes Association.

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

Representative Norman Rokeberg
State Capitol
Juneau, Alaska 99801-1182

February 24, 2000

Dear Senator Rokeberg:

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

Talking Points:

- **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 costs 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.

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

Sincerely,
Michelle
Michelle A. Cassano
Executive Director

RECEIVED
FEB 24 2000

Enclosures

Alaska Office
801 W. Fireweed Lane, Suite 103, Anchorage, Alaska 99503 Tel: (907) 272-1424 Fax: (907) 272-1428
For Diabetes Information Call 1-800-DIABETES • http://www.diabetes.org

HOUSE BILL NO. CS 298

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY FIRST LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE MURKOWSKI

Introduced:
Referred:

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 oreducation 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 dependant 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.

AMENDMENT OFFERED IN THE HOUSE

Page 1, line 7:

Delete "offer"

Insert "provide"

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.

Benefits of Diabetes Education –Cost/benefit Analysis
Review of Literature

Diabetes education is essential to the management of diabetes. Numerous studies show that access to the proper equipment, supplies and education results in improved health care and quality of life for persons with diabetes. Following is a summary of a literature review on the cost benefit of diabetes education.

Sinnock, P. (1986). Reduced hospital utilization and cost savings associated with diabetes patient education. Journal of Insurance Medicine, 18, pp. 24-30.

This paper described the impact of patient education programs on heath care services used by patients with diabetes. The study reviewed several programs that provided patient education and concluded diabetes patient education can dramatically reduce the physical and economic costs of diabetes. Results of the data analysis showed:

- Los Angeles County Hospital, a 2-year study of 6,000 persons with diabetes demonstrated a 73% decrease in hospitalizations; cost savings $1.8 million over 2 years.
- Grady Memorial Hospital, Atlanta showed a 65% decrease in admissions for diabetic ketoacidosis; estimated savings of $3.5 million over 8 years.
- In Maine, a Centers for Disease Control state-based program demonstrated a 32% reduction in hospitalizations among 1,000 participants: net saving estimated at $293 per participant per year.
- Rhode Island diabetes education program demonstrated a 51 percent reduction in hospitalizations from diabetic acidosis and infection and a 63% reduction in emergency room visits; estimated cost estimate was $355 per participant per year.

Roccella E. J., (1976). Potential for reducing health care costs by public and patient education: a summary of selected studies. Public Health Reports, 91, pp. 223 -225.

This paper presented a study by Miller and Goldstein (1972) who assessed the effects of a telephone hot line developed by a California clinic for patients with diabetes. Individuals could call the hot line for diabetes information, medical advice, and prescriptions. Findings over a 2-year period included:

- A decrease in the incidence of diabetic coma from 300 to 100 cases,
- A 50% decrease in the number of emergency room the number visits
- An estimated decrease of 2,300 clinic visits for medications.

Rubin R., Williams, A., & Mendolson D. (1998). Clinical and economic impact of implementing a comprehensive diabetes management program in managed care. Journal of Clinical Endocrinology and Metabolism, 82, pp.: 2635 -2642.

A detailed analysis of diabetes management programs over five years demonstrated gross heath care savings of approximately 12% in the first year. Cost savings projections

increased each-year, rising to 31% at the end of five years. Diabetes management programs have been shown to reduce hospitalizations by up to 23%, with hospital lengths of stay reduced by as much as 78%.
Levitan V.H., (1995). Impact of Endocrine and diabetes team consultation on hospital length of stay for patients with diabetes. American Journal of Medicine

This study compared the length of hospitalization between patients who received care from a diabetes care team and those who received care solely by a general internist. The results of the study showed a reduction in hospital stays by as much as 56% or 5 days by those patients with diabetes that utilized the heath care team approach.

Miller L.V., (1972). More efficient care of diabetes in county hospital setting. New England Journal of Medicine, 286, pp. 1388-1391.

An integrated system of diabetes self-management training can care resulted in a 73% reduction in hospitalization and 78% reduction in average length of stay for 6,000 people with diabetes. An estimated savings of $2,319 per patient per year.

Davidson J.K., (1979). Spin-off cost benefits of expanded nutritional care. Journal of the American Dietetic Association, 75, pp. 250-257.

An intensive diabetes self-management training and care program was implemented in a county hospital setting. The study included 12,950 individuals with diabetes of which 10,500 were treated, evaluated and followed-up. Results: Severe ketoacidosis was reduced by 65% and lower extremity amputations were reduced by 45%. Savings were estimated to be $447, 500.

University of Maryland (1995). Evaluation of the State of Maryland's Diabetes Care Program. in a report to the Baltimore County Center for Health Program Development and Management

Maryland's Medicaid Diabetes Program is achieving its goal of providing integrated, continuous and accessible heath care to recipients with diabetes Analysis showed that compared to the control group, DCP enrollees incurred fewer hospitalizations, fewer emergency room visits and decreased costs.

DCCT: Why Do It?

And why'd it take so long?

By Marie McCarren

It seemed clear 20 years ago. People who have diabetes have (a) higher-than-normal blood sugar levels, and (b) complications. So high sugar must be causing complications. Keep blood sugar levels close to normal, and you'll also slow or prevent complications. Right?

Well, maybe. Remember—at one time, it seemed clear that the world was flat.

There were other possible explanations. Maybe something related to diabetes but unrelated to high blood sugar levels was causing complications. After all, many people who had high blood sugar levels for years never got complications, while others with well-controlled blood sugar levels got all of them.

Maybe high blood sugar secretly does all its damage soon after the person develops diabetes, but the complication doesn't show its ugly face till 10 or 20 years later. If so, then tight control after that critical early period would be wasted effort.

Regardless, most experts agreed that even if high blood sugar plays a role in the development of complications, it's probably not the only thing that does.

Let's assume that if blood sugar levels are kept at the normal level every minute of the day, every day of the year, the person won't get complications. That's simply not doable right now. Will not-quite-normal-but-as-close-as-we-can-get-today levels do the trick?

Researchers at the National Institutes of Health figured that if they were going to tell people to get tight control over blood sugar levels, they'd better be darn sure that people could actually achieve tight control at home, and that it would do them some good. So, the Diabetes Control and Complications Trial (DCCT) was conceived. Get a lot of volunteers with type I diabetes. Put half on tight control, half on standard therapy. Do a lot of tests. After many years, see if there's a difference in the number of complications between the two groups.

The National Commission on Diabetes, which included health-care professionals and people with diabetes, first proposed the idea to Congress in 1975. (Because the DCCT would use tax dollars, it had to be approved by Congress.) But it was a study before its time. In 1975, people didn't have the means to get tight control easily and safely. Also, doctors didn't have a reliable way to measure how tight the control was.

Then came treatment advances that made tight control possible. Multiple daily injections of insulin and insulin pumps allowed people to deliver insulin more like a normal pancreas would. Blood glucose monitors let people keep track of their blood sugar levels. People could get tight control fairly safely at home. Even more important was a new test, the glycosylated hemoglobin test (HbA1C). With HbA1C, doctors could better monitor average blood sugar levels over several months.

By the early '80s, the time had come.

But before starting a study involving 1,400 volunteers, hundreds of staff members, and millions of dollars, researchers wanted to be sure that it was practical. So from 1983 to 1985, researchers in 21 centers conducted a trial run. They recruited 278 people age 13 to 39 who had had type I diabetes for 1 to 15 years.

All volunteers received top-notch diabetes care. Half the volunteers stayed on standard therapy—up to two insulin injections each day and urine tests for glucose. Half went on intensive therapy. They used either multiple daily injections of insulin or an insulin pump, worked closely with a health-care team, and monitored blood glucose levels at least four times a day, to keep their blood glucose levels as close to normal as they could.

And...it worked. The volunteers were dedicated. Their quality of life didn't suffer. People in the standard treatment group kept the average control they had before going on the study. People in the intensive therapy group got tighter control. The difference in blood sugar control between the groups was big enough to be scientifically meaningful.

This pre-study also highlighted two bad effects of intensive therapy. People in the intensive therapy group gained more weight and had three times as many episodes of severe low blood sugar as the people in the standard treatment group.

The increase in episodes of low blood sugar worried the researchers, and they analyzed the problem. They found that people with a history of severe low blood sugar reactions were at higher risk for future problems. So, for the full-scale trial, people with a history of severe low blood sugar reactions were screened out.

In 1985, the full-scale trial started. Study centers were added, for a total of 29. The people from the feasibility study stayed on, and more volunteers were recruited. By 1989, the last volunteer had entered the study, and 1,441 people were in the trial that was finally to answer the long-debated question: Will tight control prevent or delay complications?

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States that have enacted Diabetes Insurance Coverage

State	Date Signed	Governor Signing the Bill
Wisconsin	1987	Tommy Thompson (Republican)
New York	1993	Mario Cuomo (Democrat)
Minnesota	1994	Arne H. Carlson (Republican)
Florida	6/95	Lawton Chiles (Democrat)
New Jersey	1/96	Christine Todd Whitman (Republican)
West Virginia	4/1/96	Gaston Caperton (Democrat)
Maine	4/2/96	Angus S. King (Independent)
Oklahoma	4/17/96	Frank Keating (Republican)
Rhode Island	5/15/96	Lincoln Almond (Republican)
New Mexico	3/19/97	Gary E. Johnson (Republican)
Arkansas	4/11/97	Mike Huckabee (Republican)
Indiana	4/16/97	Frank O'Bannon (Democrat)
Maryland	4/29/97	Parris N. Glendening (Democrat)
Vermont	5/6/97	Howard Dean (Democrat)
Washington	5/7/97	Gary Locke (Democrat)
Texas	5/9/97	George W. Bush (Republican)
Tennessee	5/30/97	Donald Sundquist (Republican)
North Carolina	6/25/97	James B. Hunt, Jr. (Democrat)
Nevada	6/30/97	Robert J. Miller (Democrat)
New Hampshire	7/1/97	Jeanne Shaheen (Democrat)
Missouri	7/1/97	Mel Carnahan (Democrat)
Louisiana	7/10/97	Mike Foster (Republican)
Connecticut	8/5/97	John G. Rowland (Republican)
Georgia	4/6/98	Zell Miller (Democrat)
Kentucky	4/15/98	Paul Patton (Democrat)
Colorado	4/17/98	Roy Romer (Democrat)
Arizona	5/11/98	Jane Hull (Republican)
Kansas	5/13/98	Bill Graves (Republican)
Illinois	8/13/98	Jim Edgar (Republican)
Pennsylvania	10/16/98	Tom Ridge (Republican)
Virginia	3/5/99	James Gilmore, III (Republican)
South Dakota	3/17/99	Bill Janklow (Republican)
Iowa	4/28/99	Thomas J. Vilsack (Democrat)
Nebraska		Mike Johanns(Republican)
South Carolina	5/27/99	(passed, pending governor signiture)

Since 1995, the American Diabetes Association has led successful efforts in 35 states to pass legislation requiring state-regulated health insurance plans to provide coverage for diabetes supplies and self-management education as part of basic coverage (at no additional cost). The Association's strategic plan calls for passage in all 50 states by the year 2003. We are well ahead of this goal. If your state has not yet passed legislation and you want to help, sign up to be a Delegate for Diabetes and begin to receive the *Diabetes Advocate*.

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DIABETES STATISTICS FOR Alaska

Total Number with Diabetes	36,698.00
Number Diagnosed with Diabetes	24,073.89
Number Undiagnosed with Diabetes	12,624.11
Number of Children with Diabetes	338.37
Number Aged 65 and Older with Diabetes	6,189.94
Number on New Cases of Diabetes	1,866.00
Number of Deaths each year caused by Diabetes	438.14
Number of Amputations each year caused by Diabetes	156.48
Number of new cases of Blindness each year caused by Diabetes	Between 28.17 and 56.33
Number on Dialysis or Receiving a Kidney Transplant	231.11
Annual Economic Cost of Diabetes	Indirect $125,984,674.38 Direct $103,078,369.94 Total $229,063,044.32

Click here to return to American Diabetes Month Operational Guide

Return To Intranet Homepage

SUMMARY OF STUDIES RELEVANT TO DIABETES INSURANCE REFORM LEGISLATION

I. Milliman & Robertson (M&R) study done for American Diabetes Association found the following:

- "Studies have shown that people with diabetes often do not receive adequate care and education..."
- "Lack of reimbursement from health insurance plans for education and supplies may be a deterrent for adequate care."
- Studies show "...decreases in health care utilization for people with diabetes receiving appropriate education and access to supplies."
- The Maine Diabetes Control Project concluded "...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."
- 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 compared to a control group."
- A 63% reduction in emergency room visits was seen as a result of Rhode Island's Diabetes Outpatient Education Program for insulin-using diabetics."
- The Diabetes Control and Complications Trial 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%.
- The United Kingdom Prospective/Diabetes Study showed that vigorous treatment of Type II diabetes will have similar results to the DCCT
- "The most likely scenario shows $917 in annual savings," *after* adding in additional costs.

I. "Abstracts of Articles Regarding Access to Diabetes Education, Equipment & Supplies" Related to increased diabetes education shows:

- Better health as measured by A1c values, length of stay in hospitals, readmissions, self-evaluations, and weight loss.
- Cost savings associated with diabetes education programs including one with Medicaid patients that lowered costs from $5,271 to $3,533.
- Improvements are better when a diabetes program rather than a general medical program deliver education.

Related to costs, the abstracts show:

- Medical care costs increase significantly with each 1% rise in A1c above 7%
- Short-term economic benefits from education
- Preventative strategies are not being used because of an assumption that they are too costly

II. 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 costs of 0.1% of premium.

III. 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 concluded 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."

V. Studies by insurance and/or corporation commissions in Maine, Wisconsin and New Mexico found negligible administrative costs to insurers from implementation of this legislation.

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*.

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.

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.

ALASKA STATE LEGISLATURE

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REPRESENTATIVE LISA MURKOWSKI
Government Hill • Elmendorf • East Anchorage

RECEIVED
FEB 23 2000

To: Representative Norman Rokeberg

From: Representative Murkowski

Date: 02/23/00

Re: House Bill 298

Please schedule House Bill 298, "An Act requiring health care insurers provide coverage for treatment of diabetes," for a hearing in the Labor & Commerce Committee as soon as possible.

HB 298 represents a means to promote better health and lower health care costs for Alaskans. 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 for diabetics is the key to quality care. 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. HB 298 promotes better health and ultimately lower healthcare cost for Alaskans.

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REPRESENTATIVE LISA MURKOWSKI
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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.

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSHB 298 (HES)

Revision Date/Time (Note if correction) _____
Dept. Affected Community & Economic Development

Title An Act requiring that health care insurers provide coverage for treatment of diabetes.
BRU Insurance

Sponsor Reps. Murkowski, Brice, Phillips
Component Insurance

Requester H (L&C)
Component No. 354

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: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
There is no fiscal impact on this component.

Prepared by: Robert A. Lohr
Division Insurance
Phone 269-7900
Date/Time 3-2-00 3:13 PM

Approved by Commissioner Deborah B. Sedwick
Agency Community & Economic Development
Date 3-9-00

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FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSHB 298 (HES)

Revision Date/Time
Dept. Affected: Administration
Title: An Act requiring that health care insurers provide coverage for treatment of Diabetes
BRU: Centralized Administrative Services
Component: Retirement and Benefits
Sponsor: Representative Murkowski
Requester: Labor and Commerce
Component No.: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURE	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 (1029 P/E Retire)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

The State's health plans provide the coverage required under this bill. This legislation has no fiscal impact.

Prepared by: Guy Bell, Director
Phone: 465-4471
Division: Retirement and Benefits
Date/Time: 3/6/00 3:17 PM
Approved by Commissioner: Robert Poe, Jr.
Date: 3/6/00
Agency: Department of Administration

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FISCAL NOTE

Bill Version: CSHB 298 (HES)
(H) Publish Date: 2/28/00

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Revision Date/Time (Note if correction) _____
Dept. Affected Community & Economic Development
Title An Act requiring that health care insurers provide coverage for treatment of diabetes.
BRU Insurance
Component Insurance
Sponsor Reps. Murkowski, Brice, Phillips
Requester H (HES)
Component No. 354

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)*
There is no fiscal impact to this component.

Prepared by: Robert A. Lohr
Phone 269-7900
Division Insurance
Date/Time 2-22-00 4:48 PM
Approved by Commissioner Deborah B. Sedwick
Date 2-22-00
Agency Community & Economic Development

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COMMITTEE COPY

American Diabetes Association.

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

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.

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 longer-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."

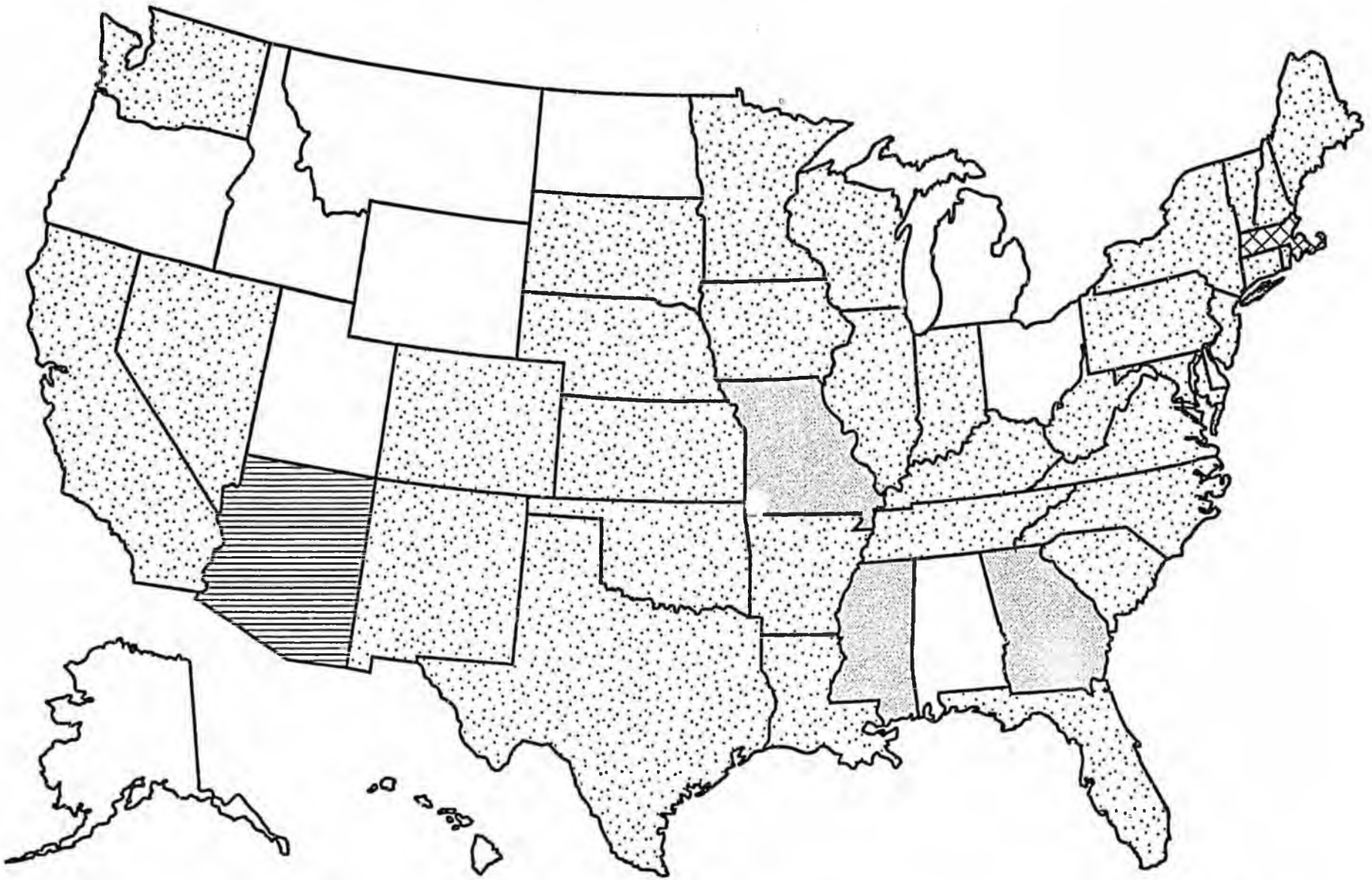
- The Congressional Budget Office (CBO) analyzed the potential costs of a package of Medicare preventive services and determined that if Medicare pays for diabetes education and blood test strips, the Federal government will begin to save money after three years. Congressional Budget Office, "Preliminary 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."

Coverage of Diabetes Self-Management Education by Health Insurance

(Revised October 1999)



State	Coverage/Type	When	Citation	Pending HB/SB	Rulemaking	Comments
AL	No	—	—	SB 20	—	Local efforts to achieve passage in 1999
AK	No	—	—	—	—	Pending legislation would authorize optional coverage
AZ	Equip. & Supply	1998	ARS 20-826(P)	No	—	No Education coverage; Applies only to policies that cover diabetes
AR	Education, Equip. & Supply	1997	Ark.Code Ann. §§23-61-108, 25-15-203	—	Adopted	Education beyond one visit could be difficult to obtain— possibly subject to purchase of a rider
CA	Education, Equip. & Supply	1999	S.1367.51 Health & Safety Code S.10176.61 Insurance Code	—	—	Defined list in legislation as to what items are covered. Diabetes education and medical nutrition therapy to be provided by appropriately licensed or registered health professionals. Education and MNT must have a physician order/prescription when teaching on proper use of equipment, supplies or medication. Additional education and MNT must be "medically necessary" and have a physician order/prescription. Effective January 1, 2000.
CO	Education, Equip. & Supply	1998	CRS 10-16-102 CRS 10-16-104	—	—	Effective July 1, 1998, for all policies originated or renewed thereafter. Education may be provided by any professional w/ expertise in diabetes.
CT	Education, Equip. & Supply	1997/ 1999	Public Act 97-268 CS 38a-469	—	—	1999 amendment adds coverage for self-management education effective January 1, 2000. Limited to 10 hours upon diagnosis, an additional 4 hours on a significant change of condition or treatment and an additional 4 hours when treating for newly developed techniques or treatments. Coverage for supplies remains unchanged.
DE	No	—	—	Yes	—	—
FL	Education, Equip. & Supply	1996	s.627.408, F.S. s.641.31, F.S.	—	Yes/See Comments	Comprehensive Diabetes Medical Practice Guidelines, ver. 1/16/98. Free publication available by calling 850/414-7300
GA	Optional/Education, Equip & Supply	1998	COG 33-24-59.1 (Act 806 '98)	—	—	Requires insurers to make coverage available. Education must be provided in that coverage. Insurance Commissioner to create rules & regulations. Effective July 1, 1998.
HI	No	—	—	—	—	Attempting to negotiate coverage with state's major insurer/MCO
IA	Education, Equip & Supply	1999	IACS 514C 14	—	—	Places specific limits on when a person with diabetes can receive covereage for education services. Limits coverage to one 10 hour initial program with annual 1 hour followup. Effective July 1, 1999.
IL	Education, Equip & Supply	1998	215 ILCS 5/356w	—	—	Effective January 1, 1999. No coverage for insulin pumps. Cap of 3 visits for education & MNT upon diagnosis and 2 additional visits for significant change of condition or treatment. Education to be provided by a physician or a licensed, registered or certified healthcare professional with expertise in diabetes management to whom physician refers.
IN	Education, Equip. & Supply	1997	IC 27-8-14.5 et.seq. PL 190-1997	—	—	Education to be provided by a licensed, registered or certified healthcare professional with specialized training in the management of diabetes. HMO/MCO may limit access to participating providers.
ID	No	—	—	—	—	—
KS	Education, Equip. & Supplies	1998	KSA 98 Supp. 40-32(?)	—	—	Effective January 1, 1999. Education may be provided by/at an ADA approved program or by a CDE. RD may provide MNT
KY	Education, Equip. & Supplies.	1998	KRS 17A-304	—	—	Effective July 15, 1999. Education must be provided by a "healthcare professional" with expertise in diabetes
LA	Education, Equip. & Supplies	1997	SB 405	—	—	Permits education by any licensed healthcare professional having completed a program accredited by their professional licensing board
MD	Education, Equip. & Supplies	1997	ACOM 15-822	—	—	Education/MNT provided through a program supervised by an appropriately licensed, registered or certified healthcare provider whose scope of practice includes diabetes education or management
ME	Education, Equip. & Supplies	1995	Chap. 592 L.1995	—	—	Education standards and providers designated by state's Diabetes Control Program
MA	Insulin & Syringes	1995	—	H.2030 & H.2911 S.656	—	Seeking grass roots support for passage in the 1999 legislative session
MI	No	—	—	S.261 & 262/ H.4395	—	A key state. Business interests have developed a coalition of large employers and labor organizations to oppose this bill.
MN	Education, Equip. & Supplies	1994	MNS 62A.45	—	—	Education must be provided by a licensed healthcare professional in a program consistent with ADA standards
MO	Optional/Education, Equip. & Supplies	1997	MRS §376.385 Chap. 376, L.1997	—	—	Medicaid program requires providers to be CDE, RD, or RPh with certification in diabetes. Missouri Medicaid Bulletin, Vol. 21, No. 1 Aug. 1998. No regulation regarding health or insurance contracts.
MS	Optional/ Education, Equip. & Supplies	1998	—	—	—	Effective January 1, 1999. Annual limit of $250 on education and medical nutrition therapy. Must be CDE or RD.
MT	No	—	—	—	—	—
NE	Education, Equip. & Supplies	1999	LB 99	—	—	Education to be provided through ADA recognized program or CDE. Education benefit limited to $500 bi-annually. Effective October 1, 1999.
NV	Education, Equip. & Supplies	1997	NRS 695B 127 NRS 695C 127	—	—	Education and MNT covered without limitation on new diagnosis or change in condition. No guidance on who performs services.
NH	Education, Equip. & Supplies	1997	Title 37, §415:6-e, §415:18-f,§420-A :17-a,§420-B:8-k.	—	—	Education & MNT may be provided by licensed, registered, or certified healthcare professional with expertise in diabetes
NJ	Education, Equip. & Supplies	1995	NJPS 17B:26-2 et seq.	—	—	Education maybe provided by a RD, CDE or pharmacist with certification by State Board of Pharmacy.
NM	Education, Equip. & Supplies	1996	NMSA 59A-22-41	—	—	Education may be provided by licensed, registered, or certified healthcare professional with expertise in diabetes.
NY	Education, Equip. & Supplies	1993	Ch. 378, L. 1993 A.1335-c	—	NYCRR 60-3.1 (Spplys & Equip)	Education may be provided by a RN or RD who is a CDE.
NC	Education, Equip. & Supplies	1997	NCGS §58-51-61, §58-65-91, §58-67-74	—	Guidelines adopted from ADA Stds. of care	Education may be provided by a physician or healthcare professional designated by a physician. Insurer or HMO/MCO may designate who is to provide education services.
ND	No	—	—	None	—	—
OH	No	—	—	SB 147	—	—
OK	Education, Equip. & Supplies	1996	OSL 1996, C. 125	—	Title 310:590	Education to be provided by licensed healthcare provider with recent, verifiable CE training or CDE . Regulations provide comprehensive standards for content and record keeping requirements.
OR	Education	?	ORS 743.704	—	—	Statute expired, however most policies still contain the coverage. Education may be provided by healthcare professionals (physician, nurse, dietitian, pharmacist) who are knowledgeable about the disease. Limited to one program every three years.
PA	Education, Equip. & Supplies	1998	S.633 Ins. Co. Law	HB 656	—	Education may be provided by a physician or an appropriately licensed and certified healthcare provider.

State	Coverage/Type	When	Citation	Pending HB/SB	Rulemaking	Comments
RI	Education, Equip. & Supplies	1996	RIS §27-18-38 §27-19-35, §27-20-30, §27-41-44	———	———	Education may be provided by a physician or an appropriately licensed and certified healthcare provider.
SC	Education, Equip. & Supplies	1999	SCC 38-71-46	———	———	Education to be provided by CDE or a program approved by DISC or the SC-DCP. Benefits and service levels tied to HCFA regulations for education provided under Medicare, part B. DISC to create standards of care. Effective January 1, 2000.
SD	Education, Equip. & Supplies	1999	Chapters 58-17, 58-18B, 58-38, 58-40, 58-41	———	———	Education may be provided by a licensed health care provider who meets the academic requirements of NCBDE, and has completed a course in diabetes education and training, or is a CDE. Education must be based upon a program recognized by the ADA or with an approved curriculum.
TN	Education, Equip. & Supplies	1998	Tenn. Statutes §56-7-2605	———	———	Education & MNT may be provided by physicians, nurses, dietitians or pharmacists who complete a diabetes patient management program recognized by the Am.Council on Pharma.Ed. & the state bd. of pharmacy or other licensed healthcare providers that have expertise as determined by the insurance carrier.
TX	Education, Equip. & Supplies	1997	Texas Ins. Code Art.21.53G	———	28TAC §§ 21.2601-21.2607	Education to be provided by licensed, registered, or certified healthcare practitioner.
UT	No	——	———	Yes	———	———
VA	Education, Equip. & Supplies	1999	COVA 38.2-3418.8	———	———	Education to be provided by a licensed, registered, or certified, healthcare practitioner. Rules implementing article are being developed. Effective July 1, 1999
VT	Education, Equip. & Supplies	1997	Title 8, VSA § 4089c	———	———	Education & MNT to be provided by a certified, registered, or licensed healthcare professional with specialized training in the education & management of diabetes. Access may be limited to provider panel.
WA	Education, Equip. & Supplies	1997	RCW §§ 41.05, 48.20, 48.21, 48.44, 48.46 (Ch.276, L. 1997)	———	———	Diabetes education may only be provided by healthcare providers with expertise in diabetes. Does not apply to employer benefit plans when the employer also offers self-insuring plans that do not cover diabetes education. Does not apply to "State Basic Health Plans" or to policies issued on & after July 1, 2001. Sunsets July 1, 2002.
WI	Education, Equip. & Supplies	1986	§632.895(6) Wisc. Statutes	———	———	No statutory direction as to provision of services. Check with state insurance regulators
WV	Education, Equip. & Supplies	1996	WVC §§33-15C-1, 33-16-16	———	Regulation 114 Series 52	Education may be provided by CDE or other licensed healthcare professional with expertise in diabetes. MNT by RD or licensed nutritionist.
WY	No	——	———	None	———	———

AMERICAN ASSOCIATION OF DIABETES EDUCATORS
100 West Monroe Street, Suite 400, Chicago, IL 60603 • 312/424-2426 • 312/424-2427 fax

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.

ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501
(907) 274-0827 FAX: (907) 272-0292

February 28, 2000

Representative Lisa Murkowski
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Representative Murkowski:

On behalf of the Alaska Nurses Association I would like to offer our support of HB 298. We understand that this bill will require health insurance companies in Alaska to provide coverage for equipment, supplies, training and education considered necessary by health care providers for individuals with diabetes.

Diabetes affects over 30,000 Alaskans and is one of the most commonly occurring chronic diseases. Without proper monitoring, treatment and education, the resulting complications often lead to blindness, amputations, kidney failure, strokes, health disease and extended hospitalizations. Nurses witness firsthand the effects of poor treatment on a daily basis. This myriad of complications and accompanying costs are often avoidable through education regarding proper nutrition, exercise, medication, and blood sugar monitoring.

Education is one of the hallmarks of quality care for individuals with diabetes. Health care providers supply individuals with diabetes the information as well as the skills needed to perform ongoing self-care behaviors. This knowledge may assist the diabetic to make important life style changes that are necessary to avoid long-term complications from this disease. Given proper education the diabetic assumes his/her role as an active participant in the treatment plan.

Research has demonstrated that individuals who receive appropriate health education as well as access to adequate supplies utilize less health care. This translates to savings for the insurance industry. We strongly urge you to pass this legislation that we believe will not only promote better health but ultimately lower costs for health care.

Sincerely yours,

Jackie Pflaum, Chair
Legislative Committee

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

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

Representative Lisa Murkowski
Alaska State Legislature
State Capitol Room 406
Juneau, AK 99801-1182

February 23, 2000

Dear Representative Murkowski,

I am writing to ask for your continued support of diabetes insurance reform legislation in Alaska. This legislation, HB 298, will ensure that Alaskans have access to diabetes medications, equipment and education which are vital for the successful management of diabetes and the prevention of costly diabetes related complications. As of December 1999, 37 states had passed essential diabetes insurance reform legislation. Please show ALL Alaskan's with diabetes that their health matters by supporting this very important legislation.

My family has a very long history of diabetes in our relatives. My grandfather died in kidney failure as a result of diabetes complications. My mother has had diabetes for fifteen years. She checks her blood sugar levels and takes insulin shots 3 or more times every day. Thanks to her perseverance, health care coverage and a certified diabetes educator providing the necessary instruction and follow-up she thus far has been able to avoid the devastating complications that she watched her father suffer and die with. Oh and yes, I also have diabetes.

Diabetes affects at least 30,000 Alaskans. It is the leading cause of kidney failure, blindness, nerve damage and limb amputations. Diabetes is also a major cause of heart disease and strokes. Because the cause of death is usually listed as fatal heart attack, or massive stroke, or chronic heart failure, most people are unaware that diabetes was the underlying factor.

Often retirees whose one pleasure left in life is reading, are no longer able to because they have lost their vision. Young people in their 20's and 30's are attached to dialysis three or more days a week until maybe a kidney transplant becomes available; (insurance will pay for that transplant surgery and rehabilitation). Many Alaskans are **never educated or given appropriate follow up** care because they their insurance won't cover the cost of their insulin or medication, blood sugar testing supplies or education and health care examinations. The financial costs of dialysis treatments for one month for one person in kidney failure exceed the financial costs of routine lab tests, diabetes medication and equipment for blood sugar testing, routine office visit with their physician and diabetes educator for one person **per Year!** This does not make any sense.

Employed, hard working Alaskans are often the very people who suffer the most because they don't qualify for programs such as Medicare or Medicaid which provide benefits for people with diabetes. Studies have shown that people who can obtain reimbursement for diabetes education and equipment are able to successfully self-manage their disease and dramatically reduce the incidence of diabetes related health problems. Not only will this dramatically reduce the financial and emotional burden of Alaskan's but also health care costs in Alaska.

Thank you for considering support of this important legislation.

Sincerely,

Kathy L. Jacques

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

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Letter from Julie A. Burns to Representative Murkowski

I am writing to ask for your support of diabetes insurance reform legislation in Alaska. This legislation, House Bill 298 and Senate Bill 276 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, including my 17-year-old son.** 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. Patients 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 costs can be significantly reduced** when people with diabetes have access to supplies and patient education. Some insurance plans in our state do not 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 our life on a daily basis: Please read the attached letter stating just some of the daily affects that diabetes has on our family. Some of you may have seen this particular letter in and e-mail a week or so ago, but I received only a few responses. I feel as though my family's daily trials in life either did not effect some of you, or you feel that this is not an important issue. I feel as though it is a very important issue.

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

Sincerely,
Julie A. Burns

Letter from Julie A. Burns to Representative Murkowski

My 16-year-old son has had diabetes for over 5 years. I am lucky in the respect that he is a bright young man that realizes how important taking care of his health is. This disease seems to be particularly hard on the youth, they are at the age where peer pressure and acceptance is the most important part of life. Having the extra responsibility of checking your blood sugar often, taking shots several times each day, watching what you eat, avoiding situations where you may accidentally get cut or hurt, totally avoid getting sick, having to say no thank you to that delicious looking chocolate birthday cake, having to drink awful diet pop while your friends are having Root Beer Floats, and having to go to the doctor for every single sign of a cold. And these are just a few of the trials that those with diabetes face each and every day. Not to forget the nagging of parents, family, friends reminding you each and every day that you need to take care of this and that years worth of strict diet and taking care of yourself will pay off in the years to come.

I have been fortunate enough to have had health insurance through out all of this, but this still is a very expensive and frustrating thing to deal with. My insurance company does have co-pay for prescriptions, but this still runs us $50-$80 each month for insulin (the amount of insulin used changes each day, plus most diabetics use two types of insulin). Plus you need to use test strips to check you blood between 6-8 times each day (a box of 50 costs around $40) as you can see it not cheap to keep your blood sugars in check. Insurance does help pay for these, but you have to purchase them, fill out mounds of forms, send it in, and wait for the insurance company to pay you. They think you should check your sugars only 1-2 times a day so they fight with you and MAYBE you will get back about half of what you should, we all get tired of the fight and just except their offer and go on with life.

I have been a single parent through most of this and financially it is hell taking care of all this, plus all of the regular part of life. Add a second child into the equation who doesn't get any extras because all of the extra $$ goes for medical necessities, it soon has just a little jealousy and hate going on. The guilt that I feel is in no way measurable, like any parent you try to spend dollar for dollar on one child as you do on the other and it just does not add up. You try not to take into consideration that you just spent $200.00 on diabetic supplies and doctors fees and then spend what is left equally between two wonderful kids. They both get shortchanged. My 10 year-old daughter's desires have been put on the back burner more often than any parent would like to admit. Then don't forget how guilty the one with diabetes feels when they realize that they are the reason there is no going to the movies, that old bike will just have to do for one more year, and forget the thought of a vacation. We went 4 years without seeing family in Montana.

Lets not forget doctors office visits, you soon realize that you head off everything before it gets out of hand, if not you could EASILY end up in the emergency room and we all know how expensive that is. We spent 12 hours in the emergency room several years ago and it was not fun for any one especially my son. It started out as a simple bout of the flu, all the regular symptoms that we all have experienced. I stayed home from work AGAIN. We were taking blood sugars often and small doses of insulin (8-12 shots instead of 1-2 during the day), normal behavior for a sick diabetic. When you cannot keep anything down, not even water well things go wrong especially with a diabetic. Within an hours time Chris went from being just sick, to me not being able to wake him up and when I finally did I couldn't keep him awake. His blood sugar was low, temperature over 102, dehydrated, and a very sick young man in a very short period of time. This was not a fun situation for anyone, and the sad part of this is it can happen so quickly. If I had not been home to take care of him this could have been a fatal situation, and this is a real threat for all those who have this disease.

I spend almost every day of my vacation and sick leave on these types of situations. If I or either of my children even have a cold we stay home and get better, we get right in to the doctors office even for the small things because it is not worth the risk of repeating another ER visit. I have been lucky in the respect that my past employers do seem to be understanding about staying home for sickness, but not very understanding when I asked for a couple days off without pay to visit with family that came to town. I do understand, but it is just another one of those frustrating things that seem to nip you in the butt at every turn.

Education is the key to a healthy diabetic, not only does the diabetic need the education so does the entire family. My new husband is slowly learning, but it is frustrating when things come up that he does not understand. Even the most logical thing to a diabetic is not logical if you do not understand the disease. My husband can not stay home from work so that I can go to work when Chris is sick, not because he does not want to, but because he does not feel comfortable doing so. He was in on our last emergency room venture and he and I had only been together for a couple months. Needless to say he is very leery about those kinds of responsibilities and I myself do not feel comfortable with putting this kind of responsibility on any one. The education here is so limited, and to go out of town or state is outrageously expensive. Not only is it a nightmare to convince the insurance company that they should pay for the diabetic to attend classes, but that the whole family needs the education. Add the cost of travel, room and board, time of from school and work, plus the cost of the education classes. No wonder so few go to the education classes, even though they would pay for them selves several times fold. There are new breakthroughs and new ideas concerning this disease each year that I personally feel that it should be mandatory for people to get the education. If insurance companies would push this one preventative measure they would save so much money in the long run, not to mention the health of the diabetic.

If there was a facility or even an educator that was available to give education classes that was up to date, one that was not just the office visit to tell you that your 3 month A1C needs to be lower and that it would make such a difference. Our personal family doctor is not an expert in diabetes, but he tries and he is always willing to work with us and he always makes time for us. We recently asked him about an insulin pump, he was unfamiliar with it, but sent us to someone that is very knowledgeable on them. Don Novotney works at BRH (not as a diabetic consultant, which is what he should be doing). He has given us more education and help than any one has. I worked with the company making the diabetic pump for over a month, if Disetronic had not known exactly how to work through all of the paper work and the red tape we still would not have this wonderful new device. The representative we had knew exactly what the insurance company needed and worked with all involved to accomplish the required paperwork. This paperwork seemed to be redundant and just a lot of red tape in hopes that it would discourage you from filing a claim.

I recently quit my job and lost our primary insurance carrier. It has taken my ex-husband and myself 4 full days each of making calls, filling out forms, answering very stupid questions, trying to get our sons diabetic needs taken care of. And that was only to convince his secondary carrier that they were now the primary. At this time they still are not completely taken care of and the frustration level is at its peak, but at least I am not working and have the time to call them again and again and again.

I am not bitter and I am not trying to make you feel sorry for my family, I am mearly trying to convey how hard and frustrating diabetes is on every one in the family. It may be only one person in my family that has to deal with the disease on a daily basis for the rest of his life, but it has an effect on us all. I am fortunate enough to have the ability to deal with this and teach my children how to deal with this. I feel very sorry for those who are in the same situation that do not have the insurance coverage that I have. All of this has made us a very close family. It is frustrating at times, it is a financial nightmare, and it certainly does not seem fair at times, but it can be made easier if legislation is passed to protect those of us that deal with this on a daily basis. I could go on and on and on, with ideas, stories of frustration, pain, anger and even a few of great pride. Please look hard at what you can do to make things easier and more efficient for those of us that deal with this dreadful disease on a daily basis.

Thank you for your time and your attention to this very important matter. I am not an eloquent speaker or writer but I do know that this is an important matter that truly does need your time and attention. You have the ability to make things better for all of those who deal with diabetes on a daily basis, please do not hide behind closed minds. If you have been fortunate enough, to have not had to fight with insurance companies I am as jealous as a person could be. It has become a constant battle for us, and seeing a little glimmer of light at the end of a tunnel is worth sending letters like this to everyone.

Julie Burns