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11120 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

"(C) DURATION.—An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved applicant or the deemed approved demonstration program meets the requirements of this section.

"(d) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement—

"(A) any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under the medicaid program; and

"(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.

"(2) ACCOUNTING INFORMATION.—The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

"(e) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that a tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.".

(b) CONFORMING AMENDMENTS.—(1) Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended by adding at the end the following:

"(e) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).".

(2) Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended by adding at the end the following:

"(d) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see

section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).".

25 USC 1645 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2000.

Effective dates. 25 USC 1645 note.

SEC. 4. TECHNICAL AMENDMENT.

(a) IN GENERAL.—Effective November 9, 1998, section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645(e)) is reenacted as in effect on that date.

(b) REPORTS.—Effective November 10, 1998, section 405 of the Indian Health Care Improvement Act is amended by striking subsection (e).

Approved November 1, 2000.

LEGISLATIVE HISTORY—S. 406:

HOUSE REPORTS: No. 106–818, Pt. 1 (Comm. on Resources).
SENATE REPORTS: No. 106–152 (Comm. on Indian Affairs).
CONGRESSIONAL RECORD:
Vol. 145 (1999): Sept. 15, considered and passed Senate.
Vol. 146 (2000): Oct. 17, considered and passed House.

○

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

CDC Fact Sheet

The National Breast and Cervical Cancer Early Detection Program

The **National Breast and Cervical Cancer Early Detection Program** helps low-income, uninsured, and underserved women gain access to lifesaving early detection screening programs for breast and cervical cancers.

Many deaths from breast and cervical cancers—which will occur disproportionately among women who are uninsured or underinsured—could be avoided by increasing cancer screening rates among all women at risk. Mammograms and Papanicolaou (Pap) tests are underused by women who have less than a high school education, are older, live below the poverty level, or are members of certain racial and ethnic minority groups.

Studies show that early detection of breast and cervical cancers saves lives. Timely mammography screening among women aged 40 or older could prevent 15% to 30% of all deaths from breast cancer. Detection and treatment of precancerous lesions found during a Pap test can actually prevent cervical cancer, as well as find cervical cancer at an early stage when it is most curable.

Mammography is the best available method to detect breast cancer in its earliest, most treatable stage—an average of 1 to 3 years before the woman can feel the lump. Women aged 40 years of age and older should have routine mammograms every 1 to 2 years.

Cervical cancer screening using the Pap test detects not only cancer but also precancerous lesions. Women should begin getting a Pap test with the onset of sexual activity, but no later than 18 years of age.

The Facts

Breast Cancer

Except for skin cancer, breast cancer is the most commonly diagnosed cancer among American women.

—

It is second to lung cancer as the leading cause of cancer-related death.

—

In 2002, an estimated 203,500 new cases will be diagnosed among women.

—

In 2002, an estimated 39,600 women will die of this disease.

—

If detected early, the 5-year survival rate for localized breast cancer is 96%.

Cervical Cancer

The incidence of invasive cervical cancer has gone down significantly over the last 40 years, in large part because of screening for and treatment of precancerous cervical lesions.

—

In 2002, an estimated 13,000 new cases will be diagnosed.

—

In 2002, an estimated 4,100 women will die of this disease.

—

Routine screening for cervical cancer can prevent the disease.

Source: American Cancer Society, *Cancer Facts and Figures 2002.*

CDC SAFER·HEALTHIER·PEOPLE™

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

CDC Activities Target Early Detection

To help improve access to early detection screening for breast and cervical cancers for underserved women, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which created the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This program, currently funded at $192.6 million, provides both screening and diagnostic services, including

- Clinical breast exams
- Mammograms
- Pap tests
- Surgical consultation
- Diagnostic testing for women whose screening outcome is abnormal

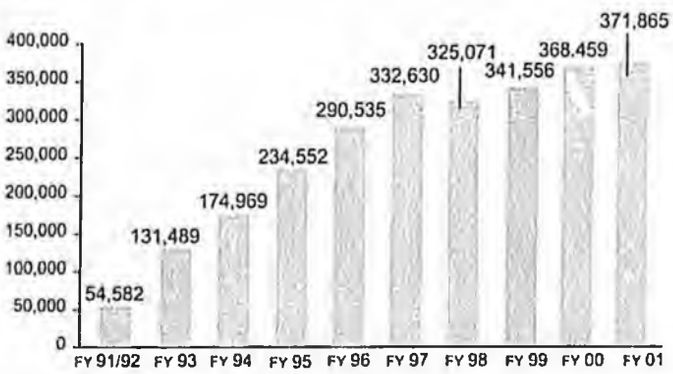
Over the last 12 years, the Program has grown and is now in all 50 U.S. States, 6 U.S.Territories, the District of Columbia, and 14 American Indian/Alaska Native organizations.

To date, it has

- Screened almost 1.5 million women.
- Provided more than 3.5 million screening exams.
- Diagnosed more than 9,000 breast cancers; 48,170 precancerous cervical lesions; and 831 cervical cancers.

The NBCCEDP is improving health care for underserved women through outreach, public and professional education, improved access to services, diagnostic evaluation, case management, treatment services, and quality assurance measures. Examples of the Program's work are provided in the following sections.

Number of Women Served by the NBCCEDP, 1991–2001



Total number of women ever served = 1,440,455.
Served indicates that a woman received at least one Program Pap, mammogram, or clinical breast exam in the fiscal year.
Source: Minimum Data Elements through 09/30/2001 paid with NBCCEDP funds, National Breast & Cervical Cancer Early Detection Program.

Coalitions and Partnerships: Reaching Underserved Women

CDC funds a network of partners to develop interventions that increase access to and use of screening services among underserved women. Many state programs have joined with nontraditional partners, including Native American tribal leaders, councils on aging, and church groups to offer education and outreach in community settings. The range of community partners and intervention strategies has expanded screening services to women on American Indian reservations and in rural and inner-city areas. For example—

With added support from Avon and the Susan G. Komen Foundation, the South Puget Intertribal Planning Agency's Native Women's Wellness Program has steadily increased its outreach to women in the five tribal communities in Washington state. Native American outreach workers and tribal health care providers have built a level of trust with the women in the community and are highly respected among this group. Their work continues to steadily increase the number of women screened through this program.

Public Education and Outreach: Eliminating Barriers to Access

The NBCCEDP supports a variety of organizations to develop and implement effective outreach programs. These programs help women overcome barriers to screening, including fear of a cancer diagnosis, lack of transportation and child care, linguistic and cultural differences, and lack of physician referral. With CDC's leadership, significant progress has been made in teaching women about the benefits of screening and early detection. For example—

California Department of Health's Every Woman Counts Program launched the nation's first statewide Asian language breast cancer hotline, providing information in Chinese (Mandarin and Cantonese dialects), Korean, and Vietnamese languages (English and Spanish were already offered). A public awareness campaign "Every Woman Counts...Every Year!" ran radio and print public service announcements in Mandarin, Cantonese, Korean, and Vietnamese publicizing the available hotline. The number of calls to the hotline increased more than 200%.

Professional Education: Enhancing Health Care at the Source

Through professional education services, the NBCCEDP's state, territorial, and tribal programs educate a wide range of health care professionals—including physicians, nurses, radiology technologists, and cytologists—on the key roles they play in the early detection of breast and cervical cancers. For example—

Alabama's Breast and Cervical Cancer Early Detection Program (ABCCEDP) produces multiple professional education conferences by satellite every year. In September 2001, they aired a video conference on the Alabama Medicaid Breast and Cervical Cancer Treatment Program. The satellite broadcast reached hundreds of health professionals with information about the treatment program. The ABCCEDP continues to receive inquiries for information on this broadcast.

Screening, Tracking, Follow-Up, and Case Management

The NBCCEDP provides national guidance on screening tec. .iques, diagnostic skills, and case management to ensure current techniques and best practices are used. Case management consists of making sure a woman is screened, rescreened, accesses appropriate follow-up care if she has an abnormal test result, and receives appropriate treatment if she is diagnosed with cancer. Case managers also may help women navigate the health care system (e.g., make sure transportation is available, work with physicians to obtain free or reduced-cost services). For example—

Case managers with the Missouri Department of Health and Senior Services' Breast and Cervical Cancer Control Program (BCCCP) collaborate with organizations to provide resources and support for individuals and their families affected by breast cancer. In one instance, a case manager helped a woman who was unemployed and depressed and who needed chemotherapy. The BCCCP case manager sought help from several organizations, including the Breast Cancer Foundation of the Ozarks, which paid the woman's rent and utilities for 3 months. The American Cancer Society provided a wig and other types of support. The woman finished treatment and is doing well in her own home. Through the work of the Missouri BCCCP case manager, the woman received much needed support during a difficult time.

Quality Assurance for Screening and Follow-Up

Health agencies that participate in the NBCCEDP use mammography facilities certified by the American College of Radiology and Cytology and laboratories that follow the Clinical Laboratory Improvement Amendments of 1988. CDC provides screening and diagnostic guidelines to all programs and helps them evaluate their clinical services. With CDC's guidance, all programs develop strategies to ensure that all women receive the best care possible. For example—

Oregon's Breast and Cervical Cancer Early Detection Program has created a database that tracks and documents communication between state and local providers to ensure that women needing diagnostic evaluation receive quality care. Annual chart reviews are done to validate data previously reported to the state by local providers. The Oregon Program has also developed a case management handbook that provides standardized guidance information on the expectations and basic elements of case management. This helps to ensure the consistency and quality of services provided throughout Oregon's decentralized state health care system.

Enhancing Treatment Services

In 2000, the Breast and Cervical Cancer Treatment and Prevention Act was passed to help provide treatment to women enrolled in the NBCCEDP and who are diagnosed with a breast or cervical cancer or precancer. This landmark legislation gives states the option to provide Medicaid coverage for treatment services to women enrolled in the NBCCEDP who have been diagnosed with cancer or precancerous lesions. CDC's partnership with the Centers for Medicare and Medicaid Services has helped states receive approval from the U.S. Department of Health and Human Services for the Medicaid option in their state. (For a current list of approved states, see the NBCCEDP Web site at http://www.cdc.gov/cancer/nbccedp/law106-354.htm.)

CDC's Research Activities

CDC conducts research to develop more effective strategies to improve the communication, education, outreach, and outcomes of its breast and cervical cancer control activities. Examples include the following:

- ***Mammography Rescreening Rates and Risk Factor Assessments***—This four-state study is designed to obtain scientifically valid and statistically precise estimates of mammography rescreening rates among the NBCCEDP enrollees and identify factors that influence rescreening behavior. The study also looks at why women do not return for rescreening. Data collection is complete and data analysis is underway. Results are expected in early 2003.

- ***Breast Cancer Data Quality and Patterns of Care Study***—This study will sample female patients in seven states and the District of Columbia who received a diagnosis of localized breast cancer in 1997 and 1998 to determine quality of data collected and patterns of care (PoC) received. It will compare data newly collected from medical records with data routinely collected for central cancer registries. Information on the first course of treatment, health insurance type, stage of cancer at diagnosis, and other data will be compared. Results from CDC's PoC are expected by December 2005. This study is part of the larger CONCORD study, which is looking at differences in cancer survival between the United States, Canada, and European countries.

- ***Case-Control Study of Mammography Efficacy***—This is an adjunct to a large, multi-center, case-control study of risk factors for breast cancer among women aged 35 to 64 years of age. This part of the study is designed to assess the efficacy of screening mammography. Because the assessment of efficacy depends on the accuracy of women's self-reported mammography histories, an initial validation study to compare self-reported mammography history with provider records has been done. CDC is working with the University of Pennsylvania on this project.

- ***Cervical Cancer Screening Policy: Clinical and Economic Outcomes***—This study will conduct quantitative evaluation of cervical cancer screening policies and practices involving low-income women enrolled in the NBCCEDP. Decision-analysis, cost-effectiveness, and cost-utility modeling will be done using the NBCCEDP data. CDC is working with the University of California.

- ***2000 National Health Interview Survey***—An analysis is being done of year 2000 National Health Interview Survey cancer data on breast cancer screening among American women. This CDC survey collects information from a representative sample of U.S. women. The data provide important insights into differences in breast cancer screening practices in different populations.

- ***Economic Barriers to Preventive Cancer Screening***—This study will use data from the Behavioral Risk Factor Surveillance System to look at how income, insurance status, and the perception of cost as a barrier to medical care affects the probability of getting screened for breast and cervical cancers. The study will also look at the role of the NBCCEDP in changing behaviors of uninsured women toward accessing breast and cervical cancer screening services.

Future Directions

By raising awareness about the importance of early detection and providing access to screening services, the NBCCEDP is estimated to reach approximately 18% of women 50 years of age and older who are eligible for the Program. CDC will continue working with an array of partners to increase access to breast and cervical cancer early detection and treatment services, to develop effective strategies to improve rescreening rates among women enrolled in the program, and to implement proven public education and outreach strategies to improve access to screening for women who have rarely or never been screened. Research will continue to develop innovative strategies to ensure timely and high quality clinical services and access to treatment for women with a cancer or precancer diagnosis.

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Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

FAQs

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

On January 4, 2001, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) provided initial guidance to State Health Officials to assist with implementing the provisions of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). The new option allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

Below are the first series of answers that respond to some of the questions about the BCCPTA. CMS and CDC are committed to providing timely responses to important issues and will release additional guidance as needed and as it becomes available.

ELIGIBILITY

Question 1. What are the eligibility requirements for the new optional eligibility group for women who need treatment for breast or cervical cancer?

Answer. In order to qualify under this new optional category, a woman must meet the following eligibility requirements (As mandated by PL 106-354.):

1. The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);

2. She does not otherwise have creditable coverage, as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of the PHS Act (42 U.S.C. 300gg(c)); and she must not be described in any of the mandatory Medicaid categorically needy eligibility groups; and

3. She is under age 65.

Question 2. Must a woman be uninsured for a specific length of time before she may be found eligible for Medicaid under this new option?

Answer. No. There are no requirements imposed by federal law that there be a waiting period of prior uninsurance before a woman can become eligible for Medicaid under this new option, and no authority for states to impose such requirements. In addition, if she were insured but her creditable coverage were to end, the woman could become immediately eligible for coverage under Medicaid assuming she satisfied all other eligibility criteria.

Question 3. What is meant by the term "creditable coverage"?

Answer. The term "creditable coverage" is defined under the new Act to have the same meaning as "creditable coverage" for purposes of HIPAA. A woman having the following types of coverage would be considered to have creditable coverage and would, therefore, be ineligible for the new Medicaid option:

- A group health plan
- Health insurance coverage - *benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.*
- Medicare
- Medicaid
- Armed forces insurance
- A medical care program of the Indian Health Service (IHS) or of a tribal organization
- A state health risk pool

Question 4. Are there any circumstances where a woman with creditable coverage could be eligible for the new Medicaid option?

Answer. Yes. While the new option requires that a woman is "not otherwise covered under creditable coverage," we read that requirement to refer to creditable coverage for treatment of breast or cervical cancer (in light of the immediately preceding requirement referring to that treatment). There may be limited circumstances where a woman has creditable coverage, as defined above in Question 3, but she is not actually covered for treatment of breast or cervical cancer. For example, if a woman has creditable coverage but is in a period of exclusion (such as a preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer, she is not considered covered for this treatment. If a woman who has creditable coverage exhausts her lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer, she is not considered covered for this treatment. In these types of circumstances, the woman may be eligible for the new Medicaid option, assuming that she meets all other eligibility criteria.

(NOTE: The reference to "not otherwise covered" in the eligibility criteria for this new group is different than under the State Children's Health Insurance Program (SCHIP) eligibility criteria. While the statute also provides that a child is ineligible for SCHIP if covered by a group health plan or health insurance coverage, unlike the new Medicaid option the SCHIP eligibility exclusion is not connected to coverage for a specific condition.)

(Question 37 addresses the treatment of creditable coverage that may be available/unavailable to American Indians and Alaska Natives (AI/AN) through a medical care program of the IHS or AI/AN tribal organization.)

Question 5. Is a woman who has limited coverage, such as limited drug coverage or limits on the number of outpatient visits or high deductibles, eligible for the new Medicaid option?

Answer. No. In order to qualify for this new Medicaid option, a woman must not be otherwise covered under creditable coverage. According to the HIPAA rules defining creditable coverage, most health insurance, including insurance that may have limits on benefits or have high deductibles, is considered creditable coverage. However, there are certain types of coverage that are not considered creditable coverage. A woman who may have one of these types of coverage may be eligible for the new Medicaid option assuming that she meets all other eligibility criteria:

- Limited scope coverage such as those which only cover dental, vision, or long term care.

- Coverage for only a specified disease or illness.

Question 6. What does it mean that an individual not have "attained age 65"? What if she turns age 65 during her period of coverage?

Answer. The statute uses the term "attained age 65". A woman attains age 65 on the date of her 65th birthday. If the woman turns age 65 during her period of coverage her eligibility will terminate as of the date of her birthday. Her coverage may continue to the end of the month or quarter to the extent that it is the usual and customary practice of the state to pay for coverage through a capitated payment on a monthly or quarterly basis. Similarly, to the extent that it is usual and customary for payment to be due at the onset of a particular service, such as payment for inpatient hospital services upon admission to the hospital, she is entitled to the full service. Further, at attainment of age 65, the state must explore other categories of Medicaid coverage and should assist the individual to continue coverage under Medicare.

Question 7. Who is considered to have been "screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program?"

Answer.

1. Women are considered screened under the CDC program if their clinical services were provided all or in part by CDC Title XV funds. CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the National Breast and Cervical Cancer Early Detection Program.

In addition, CDC allows Title XV grantees the flexibility to extend the definition of screened under the CDC program to include one or both of the following two options:

2. Women who are screened under a state Breast and Cervical Cancer Early Detection Program in which their particular clinical service was not paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds, and the service was within the scope of a grant, sub-grant or contract under that state

program and the CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

3. Women who are screened by any other provider and/or entity and the CDC Title XV grantee has elected to include screening activities by that provider as screening activities pursuant to CDC Title XV. For example, if a family planning or community health center provides breast or cervical cancer screening or diagnostic services to low-income women, but does not receive funds from the CDC Title XV grantee to support these services, the CDC Title XV grantee would have the option of including these providers' screening activities as part of their overall screening program. The CDC Title XV grantee may require any provider deemed part of the overall screening program to follow program guidelines.

The programs operating in states under the CDC program will provide Medicaid agencies with verification that a woman was screened under the CDC program. A list of state contacts for the CDC National Breast and Cervical Cancer Early Detection Program can be found at web site: http://www.cdc.gov/cancer/nbccedp/contacts.htm.

Question 8. Does a woman have to have been screened for both breast and cervical cancer and found to be in need of treatment before she can be found eligible for Medicaid?

Answer. No. A woman does not have to have been screened for both breast and cervical cancer as a condition of eligibility for Medicaid. Either screen would satisfy the screening requirement.

Question 9. What is meant by the term "need treatment"?

Answer. The term "need treatment" means that, in the opinion of the woman's treating health professional that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the physicians plan-of-care, women who are determined to require only routine monitoring services for a precancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

Question 10. Is there any income test under Medicaid for women under this new eligibility group?

Answer. No. There are no Medicaid income or resource limitations imposed by federal law for this new Medicaid eligibility group, and no authority for states to impose such limitations.

Question 11. Can a state impose Medicaid asset /eligibility standards on women whose eligibility is based on this new option?

Answer. No. Asset related questions would be appropriate as part of the Medicaid application process only to the extent necessary to determine if the individual is otherwise eligible for Medicaid.

Question 12. Can a state limit Medicaid eligibility to certain subcategories of women (e.g., women of a certain age, certain geographic residences, or with certain types of cancers or disease severity)?

Answer. No. States must cover all eligible women and may not limit coverage to sub-populations.

ELIGIBILITY PERIOD

Question 13. If a state elects to expand Medicaid eligibility to include this new optional group, what is the effective date of the coverage available to this group?

Answer. Medicaid eligibility can be effective as early as the first day of the quarter in which the state Medicaid agency submits an approvable state plan amendment to HCFA and the state implements the expansion or a later date specified in the state plan amendment.

Question 14. When does a woman's eligibility under this new option begin?

Answer. A woman's eligibility for coverage under this new option begins up to three months prior to the month in which she applied for Medicaid, if as of this earlier date, she would have met relevant eligibility requirements under the state plan (including having been screened and diagnosed).

Question 15. When would a woman's eligibility under this new option end?

Answer. A woman determined eligible under this option would continue to be eligible as long as she is receiving treatment for breast or cervical cancer, is under age 65, and is not otherwise covered under creditable insurance coverage. A state may presume that a woman is receiving such treatment during the duration of the period established by her treating health professional in her plan of care. If that period extends beyond a year (or a shorter period at state option), the state must confirm eligibility consistent with standard Medicaid redetemination requirements. Care and services under this new option should be consistent with optimal standards of practice for items and services available under the state plan. The state may use utilization management techniques such as prior approval to monitor care and ensure that it is medically necessary and used efficiently.

Question 16a. Is a woman limited to one period of eligibility? What happens if a woman goes through treatment for breast or cervical cancer, and then two years after treatment is completed has a recurrence and needs treatment for breast or cervical cancer again?

Answer. No. A woman is not limited to one period of eligibility. A new period of eligibility and coverage would commence each time a woman is screened under a CDC program and found to need treatment for breast or cervical cancer, and meets all other eligibility criteria.

Question 16b. If a woman is treated for breast or cervical cancer during her first period of eligibility and is subsequently determined to have cancer that has spread to other parts of her body, would she be covered?

Answer. Yes. If the recurrent metastasized cancer is either a known or presumed complication of breast or cervical cancer, and the women is still in her first period of eligibility, i.e., she is still receiving treatment for the initial breast or cervical cancer diagnosis, she would continue to be eligible for additional treatment. If, however, her first treatment period is over and her Medicaid eligibility has been terminated, she must be screened again under a CDC program and found to be in need of treatment for breast or cervical cancer.

COVERAGE

Question 17. What is the scope of coverage under this option?

Answer. During the period of eligibility, a woman is entitled to full Medicaid coverage as specified in the state plan. Coverage is not limited to treatment of breast or cervical cancer (including a precancerous condition).

Question 18. Can states employ utilization management techniques to determine coverage limits and if so, are there relevant practice standards that can be used to assist states to carry out utilization management activities?

Answer. Yes. As is the case with Medicaid coverage in general, states may use administrative methods, such as prior review and approval requirements, to ensure that care and services furnished to women under this new option are medically necessary. Care and services furnished under this new option should be, to the maximum extent possible, consistent with optimal standards of practice. Such practice guidelines are located at the National Guideline Clearinghouse, Agency for Health Care Research and Quality: http://www.ahrq.gov.

Question 19. May a state cover experimental treatments?

Answer. Yes. States may cover experimental treatments although they are not required to do so. Routine covered costs associated with the experimental intervention may also be covered.

PRESUMPTIVE ELIGIBILITY

Question 20. What is presumptive eligibility?

Answer. Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time before full Medicaid applications are filed and processed, based on a determination by a Medicaid provider of likely Medicaid eligibility. States have the option to use the presumptive eligibility procedure to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical

cancer. Election of presumptive eligibility provides states the opportunity to offer immediate health care coverage to women likely to be Medicaid eligible, before there has been a full Medicaid eligibility determination.

Question 21. Is presumptive eligibility mandatory for this group?

Answer. No. Presumptive eligibility is a state option.

Question 22. When does presumptive eligibility begin?

Answer. Presumptive eligibility begins on the date that a qualified entity determines that the woman appears to meet the eligibility criteria for this new Medicaid option. Federal financial participation (FFP) is allowed for services provided during this presumptive eligibility period regardless of whether the woman is later found eligible for Medicaid.

Question 23. When does presumptive eligibility end?

Answer. Presumptive eligibility ends on the earlier of the following two dates: the date on which a formal determination is made on the woman's application for Medicaid; or, in the case of a woman who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins.

For example, if a woman is found presumptively eligible on April 1 and files her application before May 31, her presumptive eligibility would continue until her eligibility is determined. If the woman fails to apply, her eligibility would cease on May 31.

Question 24. Which types of entities can be a qualified entity for purpose of presumptive eligibility?

Answer. State Medicaid agencies can certify entities that are eligible for payments under the state's Medicaid program that the state determines are capable of making presumptive eligibility determinations. A certified entity can enroll women who appear to be eligible in Medicaid on a temporary basis.

Question 25. What if the entity does not participate in Medicaid as a health provider or on some other basis? For example, what if a community volunteer group wants to make presumptive eligibility services?

Answer. If the entity receives payment as either a provider or administrative contractor under the state Medicaid plan, the entity could be qualified as long as the Medicaid agency also determines that the entity is capable of making presumptive eligibility determinations.

Question 26. Can presumptive eligibility determinations be performed at outstationed eligibility locations? Can the full application be filed at an outstationed site?

Answer. Yes. States are generally required to have outstation locations at federally qualified health centers and disproportionate share hospitals. At its option, a state may expand the types of entities that are used in its outstationing program. Outstation activities may be performed by state eligibility workers, by employees of a provider or contractor, or by volunteers.

If a state that arranges with an entity to perform outstation functions determines that the entity is capable of making presumptive eligibility determinations, the state can expand its agreement with the entity to make presumptive determinations for women applying under this new category. In addition, the state can use the outstation location to accept full Medicaid applications from presumptively eligible women. Outstation workers who are not public employees of the agency that makes eligibility determinations can only do initial processing of full Medicaid applications.

For example, a state has an agreement with its federally qualified health centers (FQHC) to conduct outstationing activities. The health centers also are part of the state's early detection coalition under Title XV and offer both cervical cancer and breast cancer screening. A state that adopts presumptive eligibility may enter into an agreement with the FQHCs to make presumptive eligibility determinations and perform outstationed enrollment activities for presumptively eligible women.

Question 27. Must a full Medicaid eligibility determination be completed in order to establish presumptive eligibility?

Answer. No. Presumptive eligibility is designed to permit temporary Medicaid coverage while a complete eligibility determination is conducted. Presumptive eligibility permits rapid access to health care for women found through screening to need cancer treatment. To streamline this process, at the point that presumptive eligibility is being determined, a presumptive eligibility provider need to determine only that the woman has been screened under the state's breast and cervical cancer detection program (as defined by the state) and needs treatment, is under age 65, and has neither Medicaid nor any other form of individual or group health insurance. For women who meet these rapid criteria, coverage on a presumptive basis can begin. The state will provide qualified entities with application forms and information on how to assist such individuals in completing and filing such forms. This will enable the qualified entity to assist a presumptively eligible woman in applying for formal coverage and to help her collect and provide the state agency with needed information to determine eligibility, including income and resource information, and other information related to residency and legal status.

Question 28. Are state administrative expenditures for a presumptive eligibility program eligible for a federal match?

Answer. Yes. Expenditures for presumptive eligibility activities, including payments to the qualified entity for the administrative costs of making presumptive determinations and providing application assistance would be allowable administrative costs under Medicaid and federal financial participation would be available at the 50% rate. Expenditures for providing services to presumptive eligibles under this category are eligible for the enhanced federal matching rate.

Question 29. Can provider taxes or donations be used to support the state share of a presumptive eligibility program?

Answer. Provider taxes that meet the requirements of §1903(w) of the Social Security Act may be used to support the state share of a presumptive eligibility program. Furthermore, §1903(w) of the Act provides an exception to the otherwise restrictive rules governing provider-related donations, by considering as permissible provider donations made by a hospital, clinic, or similar entity for the direct costs of state or local agency personnel who are stationed at the facility to determine eligibility of individuals for Medicaid or to provide outreach services to eligible Medicaid individuals. Thus, under the statutory exception, donations made by a hospital, clinic, or similar entity to cover the direct costs of a state or local agency worker stationed at such facility could be used to support the state share of a presumptive eligibility program. It must be noted that this exception applies to the costs of state or local agency workers (i.e., outstationed state employees) and is not applicable to costs incurred by provider personnel. Under the latter arrangement, an in-kind donation made by the provider would be subject to the very restrictive bona fide provider-related donation statutory provisions and would more than likely not be considered a permissible source of state share." Donations by health providers to cover the direct costs associated with presumptive eligibility would be permissible as a form of Medicaid outreach in accordance with the requirements of 42 C.F.R. §433.66 (b)(2). A state could report these provider donations as a state expenditure for purposes of claiming the federal administrative match.

Question 30. Must a state enter into presumptive eligibility agreements with all entities that are eligible to receive federal payments under Medicaid and are capable of carrying out presumptive eligibility services?

Answer. No. A state may select among qualified presumptive eligibility providers. However, CMS and the CDC encourage states to elect presumptive eligibility as a means of promoting access to rapid coverage, which is essential to treatment. Furthermore, we encourage states that elect to use presumptive eligibility to make decisions about presumptive eligibility sites through closely coordinated efforts among the state Medicaid agency, the state agency that administers the early detection program, and community breast and cervical cancer coalitions. This will best ensure the availability of presumptive eligibility and enrollment assistance at a sufficient number of locations to ensure that the purposes of this Act are achieved.

Question 31. Were a state to offer presumptive eligibility, would the state be required to do so on a statewide basis?

Answer. Yes. Presumptive eligibility is part of the state plan and must be made available on a statewide basis.

CITIZENSHIP AND ALIENAGE

Question 32. Does this new eligibility option amount to a "federal means tested public benefit"?

Answer. Yes. Medicaid is a federal means tested public benefit.

Question 33. Are qualified aliens and non-qualified aliens eligible for the new Medicaid option?

Answer. The usual rules which govern citizenship and alienage apply to the new optional Medicaid eligibility group. In general, to be eligible for Medicaid an individual must either be a citizen or a qualified alien (See the web site http://www.aspe.hhs.gov/hsp/immigration/restrictions-sum.htm for a definition of "qualified alien" and a discussion of the restrictions on immigrants receiving federal public benefits, including Medicaid, and for a list of exceptions to these restrictions). Many qualified aliens who arrived in the United States after August 21, 1996 are barred from receiving Medicaid for 5 years beginning with their date of entry with a qualified alien status. The 5-year bar does not apply to certain refugees, asylees, and certain other groups. Otherwise eligible qualified aliens who are subject to the 5-year ban as well as otherwise eligible non-qualified aliens may receive Medicaid coverage for treatment of an emergency medical condition but not including organ transplants and transplant-related services.

Women who do not meet the immigration-related eligibility criteria may still be able to receive Medicaid coverage related to an "emergency condition", other than services related to an organ transplant. Section 1903(v) of the Act permits states to obtain federal match for services related to an "emergency medical condition" when furnished to an otherwise eligible individual.

Question 34. What does the term "emergency medical condition" mean?

Answer. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy; (B) serious impairment of bodily functions, or (C) serious dysfunction of any bodily part.

Question 35. Would treatment for breast and cervical cancer (including treatment for a precancerous condition) be classified as coverage for an "emergency medical condition?"

Answer. Breast or cervical cancers may be identified at various stages. Some women in need of treatment for breast or cervical cancer will have an emergency medical condition. As with other examples of emergency medical conditions, medical judgement and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.

TREATMENT OF TERRITORIES

Question 36. Does the new law apply to the United States territories?

Answer. Yes. Territories that operate Medicaid programs (Puerto Rico, Virgin Islands, American Samoa, Guam and the Northern Marianas Islands) may choose this new option. However, federal payments to those territories are capped by statute. To the extent that these territories already receive the maximum federal payment permitted, the new law would not result in any additional federal funding. If the cap on federal payments has not been reached, federal funds at the enhanced matching rate could be available for the new eligibility group.

TREATMENT OF AMERICAN INDIAN AND ALASKA NATIVE (AI/AN)WOMEN

Question 37. Since medical care furnished by the Indian Health Service (IHS) or AI/AN tribal organizations is treated as "creditable coverage" under the PHS Act, how does this affect AI/AN women?

Answer. Medical care programs of the IHS or of a tribal organization is creditable coverage under §2701(c) of the PHS Act; however not all AI/AN women are covered under such programs (in this case, for breast or cervical cancer treatments). Some AI/AN women may not have access to coverage under such programs at all: for example, women who do not live on a reservation or near an IHS facility. States are encouraged to work with IHS and tribal organizations to ensure that AI/AN women screened under the CDC program who lack such coverage are enrolled in Medicaid.

Furthermore, some AI/AN women who have creditable coverage through IHS may not be covered under that creditable coverage *(refer to questions 3 through 5 for a detailed explanation of creditable coverage)* with respect to treatment for breast or cervical cancer. If the State eligibility worker (or the qualified entity that performs presumptive eligibility) determines that the AI/AN woman lacks coverage for breast and cervical cancer treatment through the IHS or tribal organization, that AI/AN woman can be included in the new Medicaid eligibility group. Such a determination should be based on a documented refusal or inability by IHS or tribal organization to provide (or continue to provide) treatment for breast or cervical cancer. States should consult and work with IHS and tribal organizations to understand when such a determination is appropriate, and to streamline documentation requirements.

Question 38. What type of coordination should states engage in with the IHS and tribes and tribal organizations?

Answer. States should ensure that the IHS and tribal health programs that participate in the CDC early detection program are fully involved in the planning process regarding implementation and coordination between the state's early detection program and the expanded Medicaid eligibility option.

Question 39. Are the HIS or tribal health programs administered by Indian tribal organizations eligible to receive Medicaid payments for the breast and cervical cancer treatment they furnish to Medicaid-eligible women?

Answer. Yes. IHS and tribal health programs would be eligible for payment for covered services to the same extent as they would be eligible for payment for any other covered Medicaid service.

FEDERAL FINANCIAL PARTICIPATION

Question 40. What level of enhanced FFP is available to states that elect to add coverage under this option? How can a state find out what its enhanced match rate will be?

Answer. The federal matching rate for the new eligibility group is equal to the enhanced federal medical assistance percentage (FMAP) used in the State Children's Health Insurance Program (SCHIP) (described in §2105(b) of the Act. That rate is published annually in the Federal Register, and is posted on the web site at http://aspe.os.dhhs.gov/health/fmap.htm.

Question 41. When is the enhanced federal matching rate available for Medicaid expenditures on the new eligibility group?

Answer. The new law has an effective date of October 1, 2000. In order to be eligible for payment under this new Act, a state or territory must submit a state plan amendment (SPA) electing this optional categorical needy eligibility group and/or to provide presumptive eligibility. A SPA can be effective back to the first day of the quarter in which it is submitted. Funding for this group would be available back to the effective date of the SPA. Attached is a state plan preprint that should be used by states electing these new options.

Question 42. What level of FFP is available to States for providing case management as a medical service under the BCCPTA? What level of FFP is available to States for providing case management as an administrative activity?

Answer. State Medicaid expenditures are generally claimed under two categories: medical assistance (that is, medical services) and administrative expenditures. The federal matching rate for medical assistance expenditures, referred to as the federal medical assistance percentage (FMAP), is generally the same for all types of medical services, but varies by state in accordance with a statutorily prescribed formula. The FFP for States' administrative expenditures is the same for all States, but varies by the type of administrative expenditure.

Under the BCCPTA, covered medical services provided to the new eligibility group, including the service of case management, are matched at an enhanced FMAP. That rate is published annually in the Federal Register, and is posted on the web site at http://aspe.os.dhhs.gov/health/fmap.htm.

Question 43. Is there any aggregate upper limit on the availability of federal funds for this new eligibility group?

Answer. No. This is a Medicaid benefit and there is no aggregate upper limit on the federal funds available to furnish coverage to individuals eligible under this new eligibility group.

Question 44. What financial obligations for medical assistance will a state incur under the Act?

Answer. A state is responsible for its share of covered medical assistance consistent with the enhanced federal matching rate. Because the enhanced federal matching rate is significantly higher than the standard Medicaid federal matching rate, a state's financial responsibility for expansions authorized by the BCCPTA will be significantly lower than under the standard program. States will be able to obtain access to the enhanced federal matching in advance of actual expenditures, pursuant to the normal Medicaid funding mechanism.

Question 45. Can Medicaid require cost sharing from women eligible in the new eligibility group?

Answer. Yes, for non-pregnant women over age 20, but cost sharing is limited to deductibles, coinsurance copayments or similar charges that do not exceed the nominal amounts set forth in federal Medicaid regulations. Under these requirements, for non-institutional services, any deductible cannot exceed $2.00 per month per family for each period of Medicaid eligibility, coinsurance may not exceed 5 percent of the payment the state makes for the services, and the maximum copayment for a single service would be $3.00. For institutional services, cost sharing may not exceed 50 percent of the payment made by the state for the first day of institutional care. Only one of these types of charges can be imposed for each service, and there must also be a cumulative maximum amount for all deductible, coinsurance or copayment charges.

Question 46. If a state were to impose cost-sharing requirements (to the extent permitted under Medicaid law and regulation) on individuals in this new eligibility group, would cost sharing amounts count toward the state share?

Answer. No. Beneficiary cost sharing is not considered part of the state match for expenditures under Title XIX but an applicable credit that reduces state expenditures. Beneficiary cost-sharing revenues collected by the state must be applied to offset, that is to reduce overall federally matchable Medicaid expenditures. Such revenues effectively reduce both the state and federal shares of allowable Title XIX expenditures, and both state and federal governments would be credited with their respective share of these cost sharing funds. Cost sharing collected and retained by providers would not count as expenditures or revenues to the state.

For example, if the total expenditure for a beneficiary is $20,500 and the state collects $500 in cost sharing, the expenditure allowable for Title XIX purposes would be $20,000. If the state's enhanced FMAP was 65%, the federal government would pay the state $13,000 and net state responsibility would be $7,000.

Question 47. How will states report their expenditures related to the new law?

Answer. CMS is currently revising the form HCFA-64, Medical Assistance Expenditures by Type of Service for the Medical Assistance Program, to include a new Column (e) specifically dedicated to reporting these expenditures. We are currently reprogramming the MBES/CBES

automated reporting system (Medicaid Budget Expenditure System/State Children's Health Insurance Program Budget Expenditure System) to incorporate this change. We expect this change to be completed in time for the states to use this in reporting their first quarter fiscal year 2001 expenditure report which is due January 30, 2001. We will also be sending detailed reporting instructions to the states.

APPLICATION AND ENROLLMENT

Question 48. What are the basic elements of an application under this new option? How simple can it be?

Answer. The basic elements of an application under this new option can be simple. The individual must provide a social security number and information about her health insurance and citizenship/alienage status. The application must notify the individual about her rights and responsibilities and must be signed. No verification is required under federal law except alien status if the woman is not a citizen. The application must contain sufficient information to determine if an individual is described in the mandatory Medicaid categorical eligibility groups. However, the application could be structured to avoid asking for unnecessary information. If, for example, an individual is not pregnant, does not have dependent children, and is not disabled, no additional income or asset information needs to be collected, since the woman has no relationship to one of the mandatory categorical eligibility groupings. If the information on the application indicates that the individual is not likely to be in a mandatory Medicaid group, the state does not have to perform a full determination for those groups. However, if a short application that is expressly designed for this new option would not collect enough information to allow the state to actually determine her eligibility under all other mandatory Medicaid coverage groups, the application must say so and must inform the woman of her right to file a full application.

Question 49. Must there be a written application?

Answer. Yes. Medicaid requires that there be a written application and that the final determination be made by the agency which determines Medicaid eligibility. An outstationed enrollment provider that performs outstationing functions for this newly eligible category of women can receive and initially process applications but cannot make the final determination. However, the final determination can be made at the outstationed enrollment provider site if it is done by a State employee from the agency that makes Medicaid eligibility determinations.

Question 50. How quickly must the application be processed?

Answer. Applications must be processed within 45 days, barring unusual circumstances.

Question 51. What if a woman who applies is determined not to meet the qualifications of this new option?

Answer. If the information on the application is sufficient to determine her eligibility under some or all relevant categories, the state must make this determination before denying coverage. If the application does not permit a determination under all relevant categories, the applicant must be notified and given the opportunity to submit the additional information required to make a determination under other categories.

GENERAL STATE IMPLEMENTATION

Question 52. Is the expansion of Medicaid eligibility authorized by the new law mandatory or optional for states?

Answer. The new Medicaid eligibility group is optional for states.

Question 53. If a state wishes to expand Medicaid eligibility to include the new eligibility group authorized by the new law, what is the state required to do? Must a state plan amendment be submitted? What must the state do to add presumptive eligibility for the group?

Answer. In order to be eligible for payment under this new Act, the state or territory must submit a state plan amendment electing this optional categorical eligibility group and/or providing presumptive eligibility. Attached is a state plan preprint that should be used by states electing these new options.

Question 54. Can states offer targeted case management for women with breast and cervical cancer?

Answer. Yes. A state can develop a targeted case management program under its Medicaid state plan for women with breast and cervical cancer. Such a program would be designed to assist the target population in accessing needed medical, social, educational, and other services. States can find additional information on targeted case management at §1915(g) of the Act and §4302 of the state Medicaid Manual. States also may wish to consult the National Association of Social Workers' Standards for Social Work Case Management, June, 1992, or the Case Management Society of America's Standards of Practice for Case Management, 1995.

Question 55. Can a state require a beneficiary under this benefit to enroll in a managed care organization or managed care entity?

Answer. Yes. By electing in its state plan to do so, a state may require beneficiaries to enroll in managed care arrangements to obtain coverage. To the extent consistent with usual and customary practices, a state could contract with full-service managed care organizations or managed care entities that specialize in the management of breast and cervical cancer patients and receive payments on a global basis. Those arrangements must ordinarily permit eligible individuals a choice of managed care entities. Furthermore, such arrangements must either include the full range of Medicaid coverage, or must be coordinated with other arrangements to furnish beneficiaries the full range of Medicaid coverage.

In the event that a state decides to use managed care arrangements for breast and cervical cancer patients, we urge state Medicaid agencies and state health agencies to collaborate in developing standards and contractual specifications for participation by either full service or specialty MCOs. At a minimum, such standards should address the following issues: enrollment; scope of coverage; case management; provider network capabilities; geographic and service timeline access; cultural competence and language access; quality improvement; data; and external review. MCOs that participate in breast and cervical cancer treatment must meet all standards applicable to MCOs under the Medicaid program.

Question 56. Is breast reconstructive surgery a covered service under the new Medicaid option?

Answer. Reconstructive breast surgery may be provided as an optional service under the Medicaid program. If a state elects this option, women eligible for breast cancer treatment through the new Medicaid option can receive breast reconstructive surgery as defined in the state's Medicaid plan.

Question 57. Are men diagnosed with breast cancer eligible for this Medicaid benefit?

Answer. No. Title XV (Public Law 101-354) precludes men from being eligible to receive screening and/or diagnostic services through the CDC NBCCEDP; therefore, men may not be considered screened under the program.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Alaska Statistics

Sen. Davis

Report to the Legislature
In Accordance with Chapter 33, SLA 2001
By the Department of
Health and Social Services

OVERVIEW OF THIS REPORT

AS 47.07.020(b) requires that the Department of Health and Social Services report to the Legislature by the 30th day of the Second Regular Session of the Twenty Third Alaska State Legislature on the following matters:

1. **Factors associated with the onset of breast or cervical cancer;**
2. **Information from Alaska-specific sources regarding risk factors associated with the onset of breast or cervical cancer;**
3. **Recommendations about behavioral actions that may reduce the occurrence or likelihood of these types of breast or cervical cancer;**
4. **Costs per person paid for by the State associated with treatment assistance, and total medical costs per person, whether paid for by the State or not.**

This report addresses these requirements.

DETAILED INFORMATION

AS 47.07.020(b), Section 2 (1): The environmental, behavioral, or genetic factors that have been associated with the onset of breast or cervical cancer in peer-reviewed clinical studies published in periodical medical literature that have postulated an association between one or more of these factors and an increase in the incidence of breast or cervical cancer.

An extensive literature search was conducted in 2002 and updated in early 2003 to comply with Section 2 (1). The text below summarizes the information from documents referenced at the end of this report. These documents describe the risk and protective factors generally agreed upon by the majority of scientists and medical practitioners, thus representing sound modern scientific research practices. This list does not include any factors generally agreed to be inconclusive or controversial.

Breast Cancer

Most scientists agree that these **risks and associated factors** increase the odds of having breast cancer.

- Increasing age: Women over age 50 have a higher risk of breast cancer and it continues to increase with age. Age is the only identifiable risk factor in the majority of cases diagnosed.
- Younger than average age at menarche: Women who had their first period at an early age have a higher risk of breast cancer.
- Older age at first birth: Women who give birth to their first child at a later age have a higher risk of breast cancer. The risk increases incrementally with age.
- Older than average age at menopause: Women who go through menopause later have a higher risk of breast cancer.
- Number of births: Women who have fewer than 2 children have a higher risk of breast cancer *but a lower risk of cervical cancer.*
- Post-menopausal hormones: Women who take post-menopausal hormones for an extended period of time have a higher risk of breast cancer.
- Benign breast disease: Women who have benign breast conditions, especially hyperplasia have an increased risk of breast cancer.
- Family history: Women who have a mother or sister with breast cancer have a higher risk of the disease, especially if the relative was diagnosed at a young age.
- Known genetic predisposition: Genetic mutation is proven in only 5-10% of cases.
- Significant radiation exposure: "Significant" exposure would be considered repeated chest X-rays in childhood or radiation therapy for cancer as in leukemia.

Protective factors:

- Breast feeding: Women who breast feed for at least one year combined over all pregnancies have a lower risk of breast cancer.
- Weight: Women who maintain a healthy weight have a lower risk of breast cancer, especially if they are post-menopausal.
- Exercise: Women who exercise regularly or who perform manual labor have a lower risk of breast cancer.
- Alcohol: Women who have less than 1 drink a day have a lower risk of breast cancer (This association has been shown to be weak).
- Eating vegetables: Women who eat at least 3 servings of vegetables a day have a lower risk of breast cancer (This association is believed to be weak and nonspecific).

Cervical Cancer

Most scientists agree that these **risks and associated factors** increase the risk of cervical cancer:

- Smoking cigarettes: Women who smoke have a higher risk of cervical cancer.
- Sex at an early age: Women who have sex for the first time at an early age have a higher risk of cervical cancer. "Early age" normally refers to puberty, when there is rapid cellular division of the cervix making it vulnerable to infection. Because numerous factors can affect the onset of pubertal changes (e.g., ethnicity, weight,

amount of physical exercise) "early age" can vary widely in a population. Sexual molestation or abuse must not be overlooked or minimized when considering age of first vaginal intercourse.

- Sexually transmitted disease or infection: Women exposed by their partners to sexually transmitted disease or infection have a higher risk of cervical cancer, especially if infected by specific virulent strains of the human papillomavirus (HPV).
- Number of births: Women who give birth to two or more children have a higher risk of cervical cancer *but a lower risk of breast cancer.*
- Poor nutrition: Dietary deficiencies, especially of folates, and Vitamins A, C, & E contribute to risk. (This is considered a weak associated factor).

Protective factors:

- Pap smears: Women who have regular Pap smears have a lower risk of cervical cancer. This test finds cells that may turn into cancer. If the cells are found early, a woman can be treated for a pre-cancerous condition before cervical cancer develops.
- Limited number of sexual partners: Women with few sexual partners in their lifetime have a lower risk of cervical cancer.
- Condoms and diaphragms: Women who utilize barrier methods of contraception every time they have sex, have a lower risk of cervical cancer, even though these methods do not always protect against HPV.
- Nutritional supplementation: Therapeutic levels of beta carotene, folates, and Vitamins A & E have been found helpful in reversing CIN.

AS 47.07.020(b), Section 2 (2): Summary information from the Alaska Cancer Registry and other Alaska-specific sources available to the department regarding risk factors for breast and cervical cancer.

The Alaska Cancer Registry and the American Cancer Society/Alaska concur with the factors listed above as presented in peer-reviewed medical periodicals. There are no additional or differing Alaska-specific risk factors for women and the incidence or prevalence of breast or cervical cancer.

AS 47.07.020(b), Section 2 (3): Recommendations, if any, about behavioral actions that may reduce the occurrence or likelihood of these types of breast or cervical cancer.

Experts generally agree that most breast cancer risk factors relate to cumulative lifetime exposure to estrogen, both endogenous (produced or synthesized within the body) and exogenous (introduced from outside the body, such as from food sources). Alterations of these factors are associated with both risks and benefits. While experts agree that the following activities may reduce the occurrence or likelihood of breast cancer, it is imperative to note that only about one-third of women diagnosed with breast cancer have any acknowledged risk factor. Without clear knowledge of risk and cause, it is difficult to isolate preventive activities. Research continues, but the lack of hard data on risk

reduction must be mentioned here. Nonetheless, activities thought to reduce the risk of breast cancer include:

1. Maintaining a healthy body weight
2. Consuming 5 servings a day of fruits and vegetables
3. Not smoking
4. Getting regular exercise
5. Getting regular mammograms. "Regular" has been defined by the National Cancer Institute as women in their 40's being screened every 1-2 years with mammography; women aged 50 and over being screened every year; and women who are at higher risk than average should seek expert medical advice about whether they should begin screening before age 40 and the frequency of screening.
6. Treating high-risk women with Tamoxifen. "High-risk" women (women with hyperplasia or who test positive for the breast cancer gene) participating in research trials using the drug Tamoxifen prophylactically have demonstrated a reduced incidence of cancer than would otherwise be expected. Tamoxifen has no prophylactic benefit for non-high-risk women.

Cervical cancer rates are higher among older women; however, cervical intraepithelial neoplasia (CIN), the precursor lesion to cervical cancer, most often occurs among younger women. Experts agree that infection with certain strains of HPV is one of the strongest risk factors for cervical cancer and CIN. Experts also agree that one of the most important things women, especially younger women, can do to reduce their risk of cervical cancer is to receive regular screening with a Pap test. Early detection and treatment of CIN is nearly 100% effective in stopping progression to cervical cancer.[3] Thus, activities thought to reduce the risk of cervical cancer include:

1) Getting regular Pap smears
2) Postponing initial sexual activity and limiting the number of sexual partners
3) Engaging in safe sexual activity

Programs that Provide Information to the Public in Support of these Recommendations

The Department of Health and Social Services houses numerous programs that address these preventive activities and educate the public about reducing risk factors to improve overall health.

Breast Cancer prevention and education services by state programs

Breast & Cervical Health Check (BCHC)

Housed in the Section of Maternal Child & Family Health, BCHC encourages all women to receive appropriate breast screening. BCHC-eligible women (as determined by age and income) are actively assisted in receiving screening through a wide network of medical providers. BCHC reimburses providers and radiologic facilities for breast screening and diagnostic services.

"Take Heart Alaska" and "Eat Smart Alaska"

These programs are housed in the Section of Community Health and Emergency Medicine (CHEMS) of the Dept. of Health and Social Services. They promote a preventive approach to chronic disease by emphasizing heart health and advocating for individual and community-based commitment to healthier lifestyles and nutritious dietary choices. CHEMS services seek to improve access to preventive services for all Alaskans.

The Family and Community Nutrition Program

The Section of the Maternal, Child & Family Health Program (MCFH) houses the Family and Community Nutrition Program (FCNP). It works primarily toward reducing dietary risk for chronic diseases among Alaskans. FCNP also works on other nutrition issues affecting Alaskans, such as food access and availability.

The Alaska Diabetes Prevention and Control Program

Located in the Section of Epidemiology, the Diabetes Program works to reduce the burden of diabetes (Type II Diabetes is caused by sedentary lifestyle) by providing public education and information, developing community based diabetes programs, and translating research into clinical practice by providing professional education programs. Research now indicates that Type II diabetes can often be preventable by improved general nutrition, maintenance of normal weight, and adequate physical activity, things which also reduce risk for many other chronic diseases, including cancer.

"5 A Day for Better Health"

This MCFH program is part of a nationwide nutrition campaign to encourage Americans to eat 5 or more servings of fruits and vegetables every day for better health. The "5 A Day" campaign distributes recipes, brochures and other materials throughout Alaska promoting integration of more fruits and vegetables into every day's diet. In rural Alaska, the campaign has been adapted to become "The Alaskan Way to 5 A Day" and promotes canned and frozen fruits and vegetables consumption as well as appropriate traditional Native foods.

The Alaska Tobacco Prevention and Control Program

The Tobacco Prevention and Control Program strives to reduce the overall mortality and morbidity caused by active tobacco use, passive exposure to tobacco, and the effects these two factors have in Alaska. Located in CHEMS, the program cooperates with local communities, statewide partners, and national organizations, to eliminate exposure to environmental tobacco smoke, promote cessation among youth and adults, reduce initiation among youth, and identify and eliminate disparities.

Alaskans Promoting Physical Activity

This CHEMS program strives to improve health fitness and quality of life for all Alaskans by influencing policies, physical and social environments, and personal behaviors through health promotion, education, and advocacy efforts.

Cervical Cancer prevention and education services by state programs

Breast & Cervical Health Check (BCHC)

BCHC is housed in the Section of Maternal Child & Family Health and encourages all women to receive appropriate screening. It assists BCHC-eligible women (as determined by age and income) to receive screening through BCHC, providing payment for professional services and laboratory fees. In addition to those Pap smears provided by BCHC clinicians throughout the state (5,000 per year), the Section of Public Health Nursing provides an additional 6,000 Pap screenings annually Public Health Centers statewide.

The Teen Abstinence Education Program

Housed in the Section of Maternal, Child & Family Health, the Teen Abstinence Education Program supports sexual abstinence as a positive and healthy choice for teens through support for abstinence education in six school districts – Juneau, Sitka, Mat-Su, Kodiak, Fairbanks and Kenai. This abstinence education training is offered to high school peer educators, who then deliver a series of five lessons to junior high students. To make the most of limited dollars, the training is offered to the largest school districts in the state. The Anchorage School District has chosen not to avail themselves of this opportunity as school staff have stated that other curricula and activities currently offered promote abstinence. Unfortunately, this program has suffered loss of staff due to funding reductions in 2002.

Family Planning Program

Family planning services are provided to sexually active teens and low-income women at Alaska Public Health Centers. Services provided include: a comprehensive medical history and physical examination (with breast examination and Pap smear), counseling regarding abstinence and methods of contraception, and information about reducing the risk of sexually transmitted infections. Approximately 3000 breast examinations and 6000 Pap tests were provided in 2002. Family planning clinics also participate in the CDC-funded National Infertility Prevention Project and offer pregnancy services such as preconceptional counseling, pregnancy testing and prenatal referral.

Sexually transmitted disease (STD) program

The Section of Epidemiology provides case surveillance of STDs to monitor trends and detect potential outbreaks; provides information, technical assistance, and other capacity building services to educators, members of the public, medical and other health service providers; and (in collaboration with Public Health Laboratory) provides screening for STDs in Public Health Centers and private non-profit agencies statewide. The diagnosis of HPV infection is primarily a clinical one: a physician diagnoses and may treat HPV if detected at examination. Because HPV infection is not vaccine-preventable, there is no State-funded prevention activity against HPV except general education on STD reduction.

Other sources of data and information: In addition to the above-noted programs, CHEMS maintains the Behavior Risk Factor Surveillance System. The System provides information on behavioral risks in Alaska and data for interventions to reduce risky behaviors. The Alaska Cancer Registry maintains a listing of newly diagnosed cancer cases and pertinent data about that cancer.

AS 47.07.020(b), Section 2 (4): To the extent that the information is available to the department in the billings submitted for assistance under Section 1 of this Act, the cost per person paid for by the State under Section 1 of this Act during the fiscal year preceding the date of the report and total medical costs per person for the fiscal year preceding the date of the report, whether paid for by the State or not; the information provided in the department's report under this paragraph shall be provide separately for each person who received assistance under Section 1 of this Act, but the information shall be presented in a manner that does not allow identification of this person.

Medicaid payments for this program for the period July 1, 2001 – June 30,, 2002 totaled $584,364. This amount includes both state general fund dollars and federal dollars. The federal dollars amounted to 70.4% of the total paid amount, or $411,382--- state general fund dollars equaled 29.6%, or $172,982.

See next page for specific dollar amounts per individual case.

Breast and Cervical Cancer Program
Financial Information 7/1/01 to 6/30/02

Recipient	Total Billed Amount	Total Paid Amount
1	$607.85	$521.86
2	$1,000.00	$431.24
3	$103,976.45	$57,634.03
4	$167,962.79	$95,514.37
5	$3,689.50	$3,051.88
6	$3,868.19	$2,481.74
7	$89,341.14	$23,453.92
8	$3,892.80	$1,897.29
9	$107.99	$105.99
10	$18,077.14	$7,528.94
11	$111,821.87	$40,247.08
12	$7,908.40	$4,202.43
13	$9,056.84	$5,593.44
14	$1,186.00	$1,029.88
15	$64,425.77	$19,440.81
16	$4,460.65	$2,140.69
17	$283.00	$274.23
18	$22,396.87	$6,252.46
19	$7,161.44	$4,077.21
20	$89,491.26	$43,505.59
21	$75.00	$53.11
22	$2,656.90	$1,464.04
23	$14,331.23	$6,541.00
24	$35,066.34	$14,874.27
25	$57,944.39	$23,881.07
26	$1,463.00	$670.49
27	$87,539.39	$51,549.83
28	$2,759.81	$1,352.08
29	$10,279.25	$3,078.70
30	$1,472.78	$1,055.61
31	$79,668.14	$23,883.43
32	$2,978.11	$1,718.94
33	$130,680.02	$49,033.26
34	$1,352.00	$568.26
35	$533.99	$422.57
36	$56,311.67	$21,193.02
37	$7,239.45	$4,897.84
38	$96,747.95	$37,306.64
39	$2,574.75	$1,064.50
	$11,624.84	$10,692.60

40		
41	$1,651.00	$482.20
42	$1,350.00	$431.24
43	$10,667.92	$7,116.45
44	$2,758.29	$1,647.99
Total	**$1,330,442.17**	**$584,364.19**

*This data represents Medicaid claims only.

Documents used in compiling this report:

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Vogel, V. (2001). Reducing the risk of breast cancer with Tamoxifen in women at increased risk. *Journal of Clinical Oncology*, 19(90001):87-92.

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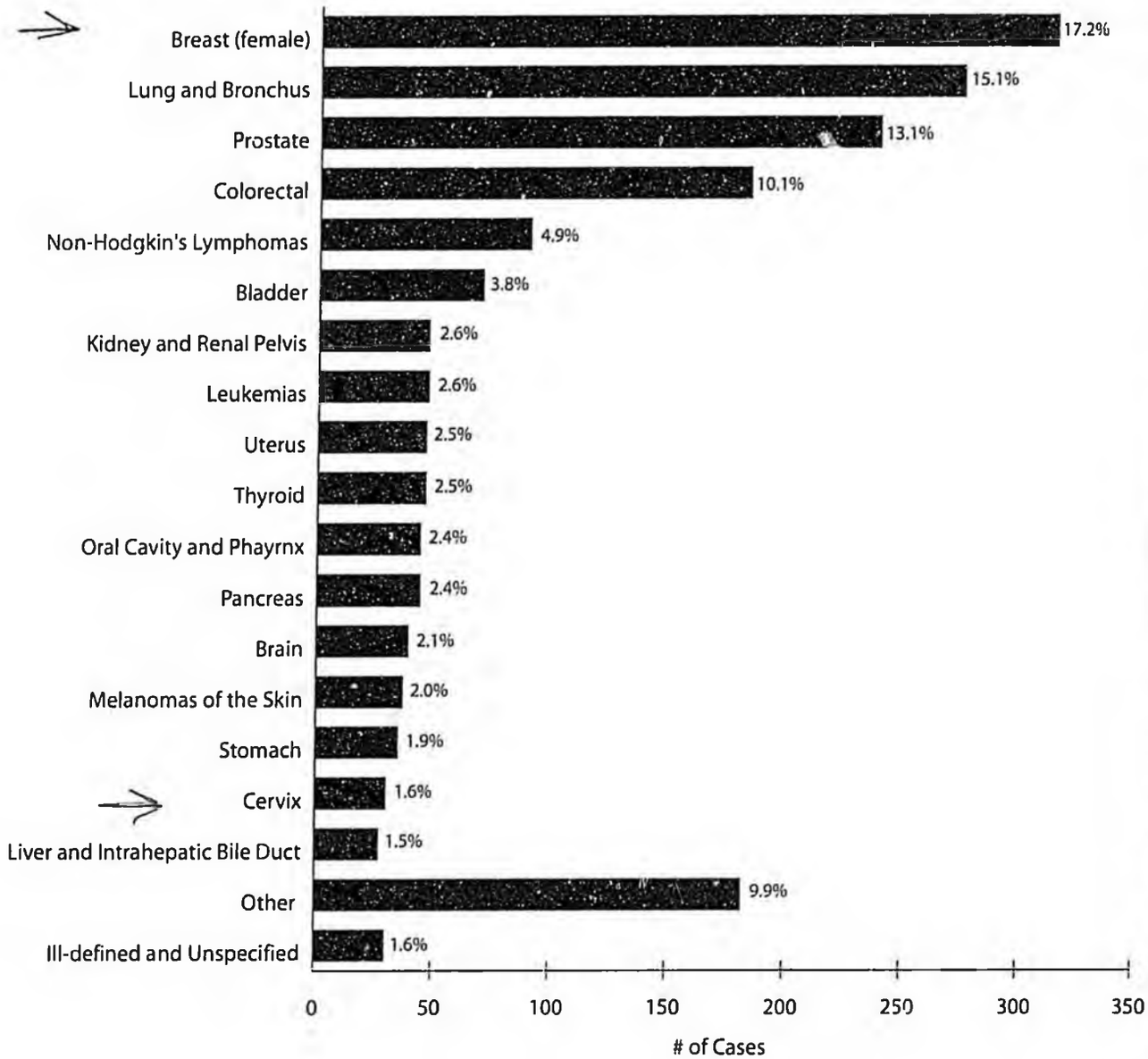
Highlights

The Alaska Cancer Registry is pleased to release its *1998 Annual Report,* which provides statewide cancer statistics for both incidence and mortality. Highlights from findings from this report are summarized below:

- During 1998, there were 1,827 new cases of invasive cancers diagnosed among Alaska residents. The 1998 age-adjusted incidence rate was 413.5 new cases per 100,000 residents.
- Cancers of the breast, lung and bronchus, prostate, and colorectal accounted for 55.7% of all newly diagnosed 1998 cancers in Alaska residents.
- The incidence rate for all cancers in Alaska was 16% higher for males than females.
- The five most commonly diagnosed cancers among Alaska men, which consisted of 63.5% of total male cancers, were: prostate (26.3%), lung (16.9%), colorectal (8.9%), urinary bladder (6%) and non-Hodgkin's lymphoma (5.4%).
- The five most commonly diagnosed cancers among Alaska women, which consisted of 68.3% of total female cancers, were cancers of the breast (34.4%), lung (13.2%), colorectal (11.2%), uterus (5%) and non-Hodgkin's lymphoma (4.5%).
- Of all the cancers diagnosed in 1998, 85.4% were in Alaskans 45 years of age or older; 65.4% were in Alaskans 55 years of age or older.
- In 1998, a total of 649 Alaska residents died as a result of cancer (25.2% of all Alaska resident deaths). Cancer was the leading cause of death in Alaska. The 1998 age-adjusted mortality rate for Alaska residents was 161.7 cancer deaths per 100,000 residents.
- The mortality rate for all cancers was 28% higher for males than females.
- Lung cancer was the most common cause of cancer death among Alaskans. There were 195 lung cancer deaths in 1998, or 30% of all cancer deaths. Lung cancer was the leading cause of death among both men (30.9%) and women (29.1%).
- Of the total cancer deaths, 77% were of Alaskans 55years of age or older; 54.5% were of Alaskans 65 years of age or older.

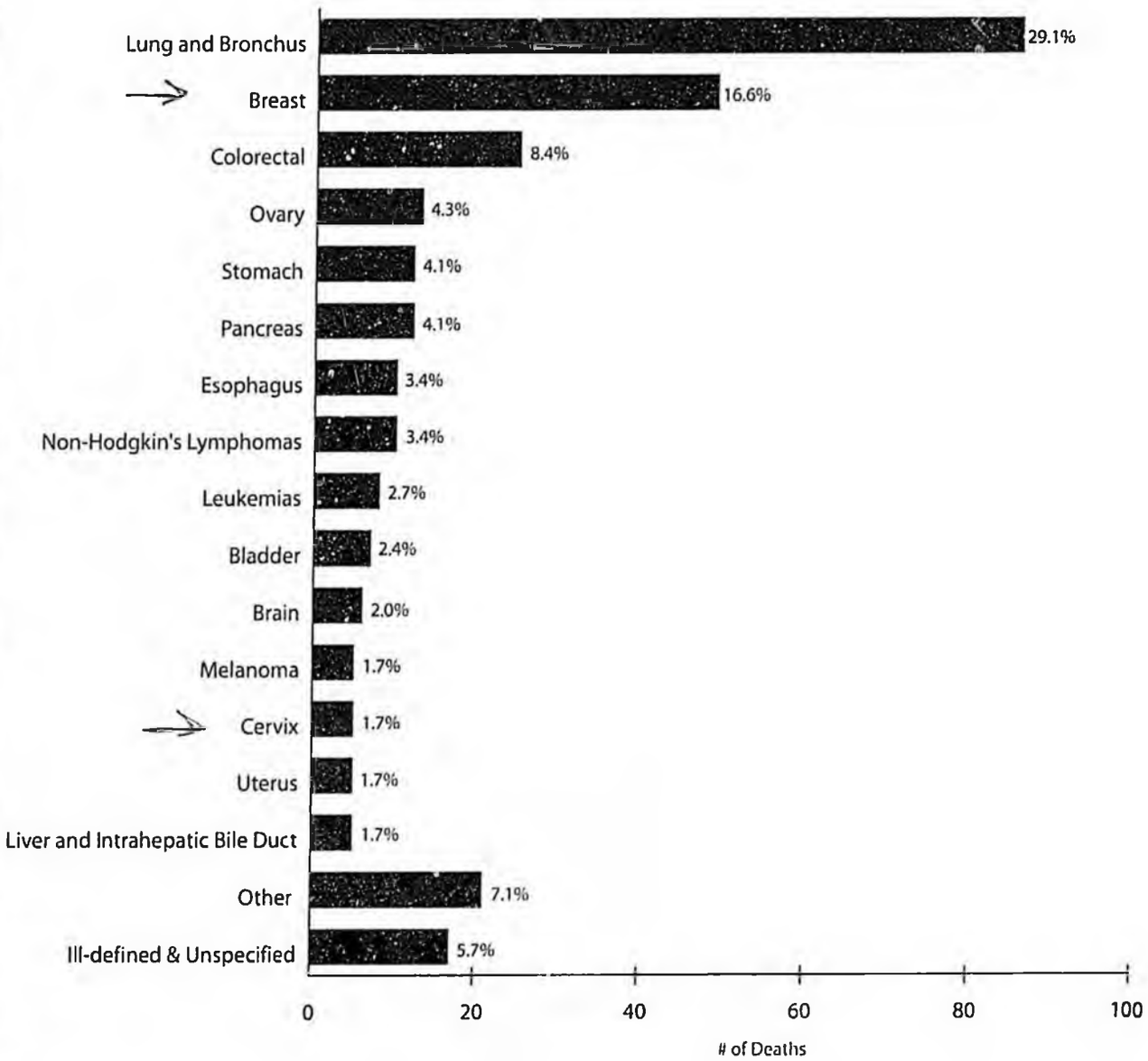
Percent of Cancer Cases by Site

1998 Invasive Cancer Cases (n=1827) - Alaska Residents



Percent of Female Cancer Deaths by Site

1998 Female Cancer Deaths (n=296) - Alaska Residents



Breast (female)

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 codes C50.0 - C50.9, and excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 174.0 - 174.9.

1998 Alaska Residents
Incidence and Mortality Summary by Sex
rates per 100,000 population age-adjusted to 1970 U.S. population

Incidence	Female
In situ cancer	66
Invasive cancer	315
Incidence rate*	122.1
1998 U.S. rate*	118.1

*Excludes in situ cases

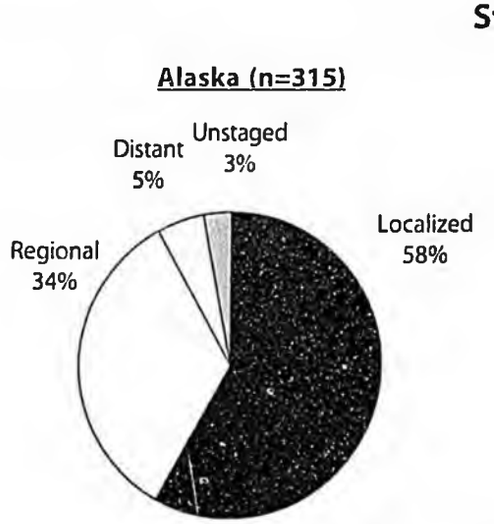
Mortality	Female
Deaths	49
Mortality rate	21.3
1998 U.S. rate	22.7

Invasive Breast Cancer by Borough/Census Area

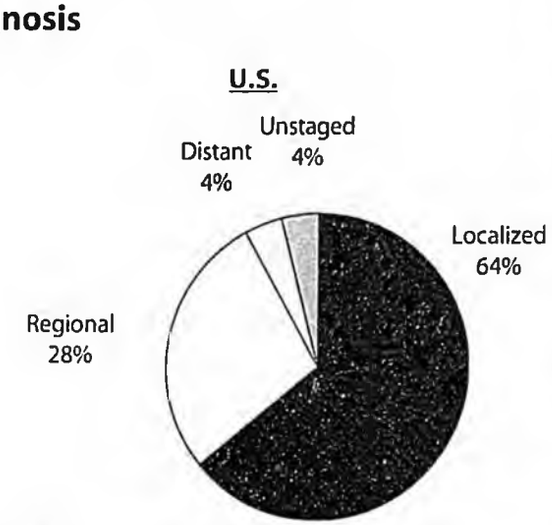
Aleutians East	1	Kenai Peninsula	26	Skagway-Hoonah-Angoon	0
Aleutians West	3	Ketchikan Gateway	8	Southeast Fairbanks	7
Anchorage	144	Kodiak Island	11	Valdez-Cordova	5
Bethel	3	Lake and Peninsula	0	Wade Hampton	0
Bristol Bay	0	Matanuska-Susitna	30	Wrangell-Petersburg	4
Denali	2	Nome	4	Yakutat	0
Dillingham	5	North Slope	1	Yukon-Koyukuk	5
Fairbanks North Star	38	Northwest Arctic	0	Unknown	0
Haines	1	Prince of Wales-Outer Ketchikan	0		
Juneau	12	Sitka	5		

Stage at Diagnosis

Alaska (n=315)



U.S.



5 year Survival (U.S., 1998)
All Stages 85.5% Localized 96.4%

Cervix

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 codes C53.0 - C53.9,and excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 180.0 - 180.9.

1998 Alaska Residents
Incidence and Mortality Summary by Sex
rates per 100,000 population age-adjusted to 1970 U.S. population

Incidence	Female
Invasive cancer	30
Incidence rate	10.1
1998 U.S. rate*	7.5

*Excludes in situ cases

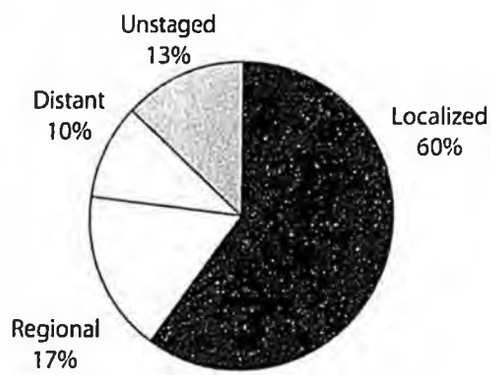
Mortality	Female
Deaths	5
Mortality rate	1.6
1998 U.S. rate	2.5

Cervical Cancer by Borough/Census Area

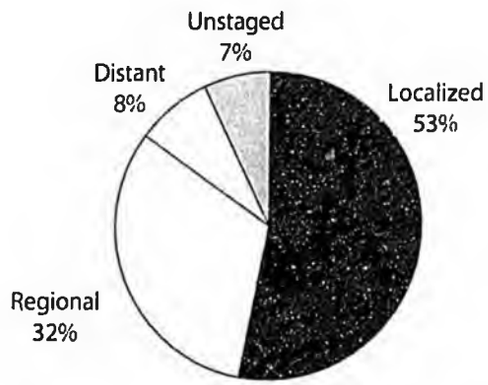
Aleutians East	**0**	**Kenai Peninsula**	**0**	**Skagway-Hoonah-Angoon**	**1**
Aleutians West	**0**	**Ketchikan Gateway**	**2**	**Southeast Fairbanks**	**1**
Anchorage	**10**	**Kodiak Island**	**3**	**Valdez-Cordova**	**0**
Bethel	**0**	**Lake and Peninsula**	**0**	**Wade Hampton**	**1**
Bristol Bay	**0**	**Matanuska-Susitna**	**3**	**Wrangell-Petersburg**	**2**
Denali	**0**	**Nome**	**0**	**Yakutat**	**0**
Dillingham	**0**	**North Slope**	**0**	**Yukon-Koyukuk**	**0**
Fairbanks North Star	**3**	**Northwest Arctic**	**1**	**Unknown**	**0**
Haines	**0**	**Prince of Wales-Outer Ketchikan**	**3**		
Juneau	**0**	**Sitka**	**0**		

Stage at Diagnosis

Alaska (n=30)



U.S.



5 year Survival (U.S., 1998)
All Stages 69.9% Localized 91.9%

Table 1. Age Distribution of Invasive Cancers - Alaska, 19988

	All Ages	45-49		50-54		55-59		60-64		65-69		70-74		75-79		80-84		85+	
Site of Cancer	#	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Liver and Intrahepatic Bile Duct	27	4	14.8	2	7.4	3	11.1	4	14.8	2	7.4	6	22.2	1	3.7	1	3.7	1	3.7
Liver	23	4	17.4	1	4.3	3	13.0	3	13.0	2	8.7	5	21.7	1	4.3	1	4.3	1	4.3
Intrahepatic Bile Duct	4	0	0.0	1	25.0	0	0.0	1	25.0	0	0.0	1	25.0	0	0.0	0	0.0	0	0.0
Gallbladder	5	0	0.0	0	0.0	0	0.0	1	20.0	1	20.0	2	40.0	0	0.0	0	0.0	0	0.0
Other Biliary	5	0	0.0	1	20.0	1	20.0	1	20.0	0	0.0	1	20.0	1	20.0	0	0.0	0	0.0
Pancreas	44	1	2.3	4	9.1	7	15.9	8	18.2	9	20.5	6	13.6	2	4.5	0	0.0	3	6.8
Retroperitoneum	1	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Peritoneum, Omentum and Mesentery	3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0	0	0.0
Other Digestive Organs	4	0	0.0	0	0.0	0	0.0	0	0.0	1	25.0	0	0.0	1	25.0	1	25.0	0	0.0
Respiratory System	297	14	4.7	27	9.1	32	10.8	41	13.8	55	18.5	53	17.8	43	14.5	10	3.4	6	2.0
Nose, Nasal Cavity and Middle Ear	3	0	0.0	0	0.0	0	0.0	0	0.0	2	66.7	0	0.0	0	0.0	0	0.0	0	0.0
Larynx	13	1	7.7	2	15.4	4	30.8	1	7.7	0	0.0	1	7.7	3	23.1	0	0.0	0	0.0
Lung and Bronchus	275	13	4.7	24	8.7	28	10.2	39	14.2	52	18.9	52	18.9	38	13.8	9	3.3	6	2.2
Pleura	6	0	0.0	1	16.7	0	0.0	1	16.7	1	16.7	0	0.0	2	33.3	1	16.7	0	0.0
Trachea, Mediastinum and Other Respiratory Organs	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Bones and Joints	3	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Soft Tissue including Heart	18	1	5.6	0	0.0	0	0.0	2	11.1	0	0.0	2	11.1	1	5.6	0	0.0	0	0.0
Skin excluding Basal and Squamous	46	6	13.0	4	8.7	7	15.2	6	13.0	4	8.7	4	8.7	2	4.3	0	0.0	0	0.0
Melanomas of the Skin	37	5	13.5	3	8.1	6	16.2	5	13.5	4	10.8	1	2.7	2	5.4	0	0.0	0	0.0
Other Non-Epithelial Skin	9	1	11.1	1	11.1	1	11.1	1	11.1	0	0.0	3	33.3	0	0.0	0	0.0	0	0.0
Breast	318	69	21.7	41	12.9	37	11.6	31	9.7	18	5.7	23	7.2	20	6.3	19	6.0	3	0.9
Female Genital System	105	15	14.3	21	20.0	8	7.6	10	9.5	7	6.7	7	6.7	4	3.8	4	3.8	4	3.8
Cervix	30	5	16.7	4	13.3	2	6.7	1	3.3	0	0.0	2	6.7	0	0.0	0	0.0	2	6.7
Corpus and Uterus, NOS	46	6	13.0	9	19.6	4	8.7	7	15.2	6	13.0	4	8.7	3	6.5	2	4.3	0	0.0
Corpus	46	6	13.0	9	19.6	4	8.7	7	15.2	6	13.0	4	8.7	3	6.5	2	4.3	0	0.0
Uterus, NOS	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ovary	24	3	12.5	8	33.3	2	8.3	1	4.2	0	0.0	1	4.2	0	0.0	2	8.3	1	4.2
Vagina	1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0
Vulva	3	1	33.3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0
Other Female Genital Organs	1	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Table 2-c. Female Cancer Incidence and Mortality by Site - Alaska, 1998

	INCIDENCE					MORTALITY				
Site of Cancer	# of Cases	Rate per 100,000	95% CL Lower	95% CL Upper	94-98 US Rate	# of Cases	Rate per 100,000	95% CL Lower	95% CL Upper	94-98 US Rate
Other Biliary	4	n/c	n/c	n/c	0.9	1	n/c	n/c	n/c	0.4
Pancreas	16	7.2	4.0	12.2	7.8	12	5.9	3.0	10.6	7.2
Retroperitoneum	0	n/c	n/c	n/c	0.4	0	n/c	n/c	n/c	0.1
Peritoneum, Omentum and Mesentery	1	n/c	n/c	n/c	0.7	0	n/c	n/c	n/c	0.2
Other Digestive Organs	2	n/c	n/c	n/c	0.3	0	n/c	n/c	n/c	0.1
Respiratory System	126	**62.7**	51.9	75.1	44.0	88	**44.5**	35.5	55.2	35.0
Nose, Nasal Cavity and Middle Ear	2	n/c	n/c	n/c	0.4	1	n/c	n/c	n/c	0.1
Larynx	2	n/c	n/c	n/c	1.4	1	n/c	n/c	n/c	0.5
Lung and Bronchus	121	**60.6**	50.0	72.9	43.5	86	**43.6**	34.6	54.2	34.3
Pleura	1	n/c	n/c	n/c	0.3	0	n/c	n/c	n/c	0.1
Trachea, Mediastinum and Other Respiratory Organs	0	n/c	n/c	n/c	0.1	0	n/c	n/c	n/c	0.1
Bones and Joints	1	n/c	n/c	n/c	0.8	1	n/c	n/c	n/c	0.3
Soft Tissue including Heart	12	4.3	2.1	8.2	2.2	2	n/c	n/c	n/c	1.2
Skin excluding Basal and Squamous	14	**4.5**	2.3	8.3	12.1	5	2.3	0.7	5.7	1.8
Melanomas of the Skin	11	**3.3**	1.5	6.6	11.7	5	2.3	0.7	5.7	1.5
Other Non-Epithelial Skin	3	n/c	n/c	n/c	1.2	0	n/c	n/c	n/c	0.3
Breast	315	122.1	108.0	137.7	114.3	49	21.3	15.5	28.9	24.2
Female Genital System	105	41.1	33.1	50.6	47.1	24	11.3	7.1	17.3	14.1
Cervix	30	10.1	6.6	15.2	7.7	5	1.6	0.5	4.5	2.7
Corpus and Uterus, NOS	46	19.9	14.3	27.1	21.9	5	3.0	1.0	7.0	3.3
Corpus	46	19.9	14.3	27.1	21.0	1	n/c	n/c	n/c	1.7
Uterus, NOS	0	n//c	n/c	n/c	0.3	4	n/c	n/c	n/c	1.6
Ovary	24	**8.5**	5.3	13.4	14.5	13	6.2	3.2	10.9	7.5
Vagina	1	n/c	n/c	n/c	0.6	0	n/c	n/c	n/c	0.2
Vulva	3	n/c	n/c	n/c	1.7	0	n/c	n/c	n/c	0.3
Other Female Genital Organs	1	n/c	n/c	n/c	0.6	1	n/c	n/c	n/c	0.2
Male Genital System	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Prostate	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Testis	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Penis	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Other Male Genital Organs	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Urinary System	28	12.0	7.8	17.9	14.0	9	4.2	1.9	8.4	4.1
Urinary Bladder	15	6.8	3.7	11.7	7.6	7	3.7	1.5	7.9	1.7
Kidney and Renal Pelvis	13	5.2	2.7	9.4	6.6	2	n/c	n/c	n/c	2.3
Ureter	0	n/c	n/c	n/c	0.3	0	n/c	n/c	n/c	0.1
Other Urinary Organs	0	n/c	n/c	n/c	0.2	0	n/c	n/c	n/c	0.0

Bold numbers indicate rate differrent than U.S. rate.
Note: Rate is not calculated (n/c) where number is less than 5.

Table 3-b. Cancer Mortality by Race for Selected Sites - Alaska, 1996-1998

	Total			White			AK Native			Asian-Pacific Islander			Black			
Site of Cancer	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	1994-98 U.S. Rate
All Sites	167.3	(1,915)	159-175	163.8	(1,423)	155-173	217.2	(389)	119-306	80.6 *	(46)	57-113	203.4	(54)	148-274	166.2
Stomach	6.4 **	(79)	5-8	3.9 ***	(32)	2-5	18.8 *	(39)	13-26	n/c	(6)		n/c	(<5)		4.0
Colorectal	15.3	(166)	13-18	13.5 **	(110)	11-16	26.9 *	(47)	19-36	n/c	(<5)		n/c	(7)		16.9
Pancreas	8.9	(101)	7-11	8.3	(72)	6-10	14.7 *	(26)	9-22	n/c	(<5)		n/c	(<5)		8.3
Lung	51.7	(572)	47-56	50.1	(429)	45-55	66.3 *	(112)	54-80	19.8 *	(11)	9-41	74.6	(19)	43-122	48.7
Breast (female)	21.6	(143)	18-26	22.6	(109)	18-28	21.1	(24)	13-32	n/c	(<5)		n/c	(7)		24.2
Prostate	15.8 *,2	(68)	12-22	17.4	(55)	13-24	13.6	(10)	6-26		(0)		n/c	(<5)		23.7
Non-Hodgkin's Lymphoma	6.7	(81)	5-8	7.4	(67)	5-10	5.2	(10)	2-10	n/c	(<5)		n/c	(<5)		6.9

Unknown race = 3 deaths

Rates per 100,000 population age-adjusted to 1970 U.S. population

* Significantly different from U.S. and Alaska

** Significantly different from U.S.

*** Significantly different from Alaska

Note: Rate is not calculated (n/c) where number is less than 10
Cells with fewer than 5 cases are not presented.

Table 4-a. Cancer Incidence by Borough/Census Area for Selected Sites Alaska, 1996-1998

	All Cancers Combined			Lung			Colorectal			Breast			Prostate			Non-Hodgkin's Lymphoma		
	Rate per 100,000	(# of) Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of) Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI
U.S. 1994-1998	400.5			56.1			43.9			114.3			142.0		16.1			
Alaska, 1996-1998	409.7	(5,242)	397-421	67.5**	(780)	62-72	45.1	(527)	41-49	118.1	(864)	109-127	129.0	(673)	124-145	17.0	(238)	15-19
Aleutians East	233.3	(10)	99-2,893	n/c	(<5)			(0)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Aleutians West	454.5	(34)	268-760	154.7**	(10)	62-377	n/c	(5)		n/c	(5)		n/c	(<5)		n/c	(<5)	
Anchorage	411.3	(2,133)	392-431	61.9	(290)	54-70	40.2	(189)	34-47	127.5	(388)	114-142	152.0***(293)		134-172	18.3	(107)	14-22
Bethel	245.2*	(72)	190-312	45.3	(12)	23-80	73.4**	(20)	44-115	60.9	(10)	28-118	n/c	(<5)		n/c	(<5)	
Bristol Bay	n/c	(5)		n/c	(<5)			(0)			(0)			(0)			(0)	
Denali	389.3	(15)	179-872	n/c	(<5)			(0)		n/c	(6)		n/c	(<5)		n/c	(<5)	
Dillingham	454.3	(40)	317-641	n/c	(9)		n/c	(9)		n/c	(6)		n/c	(<5)		n/c	(<5)	
Fairbanks North Star	416.3	(607)	380-454	65.4	(83)	51-82	43.7	(57)	32-58	119.9	(97)	95-150	116.8	(74)	90-152	13.1	(24)	8-21
Haines	382.1	(29)	252-574	n/c	(5)		n/c	(<5)		n/c	(<5)		n/c	(5)		n/c	(<5)	
Juneau	386.3	(275)	339-438	59.6	(37)	41-83	28.9	(18)	16-47	100.1	(48)	72-138	148.3	(42)	105-204	17.2	(11)	8-32
Kenai Peninsula	436.1	(491)	396-479	96.4*	(101)	78-118	31.0***	(34)	21-44	121.6	(73)	94-155	134.3	(68)	103-175	17.7	(21)	10-29
Ketchikan Gateway	404.4	(168)	343-475	70.4	(28)	46-105	31.0	(14)	16-56	95.8	(22)	58-154	121.8	(21)	74-192	n/c	(5)	
Kodiak Island	530.1*	(129)	433-646	85.3	(18)	47-146	64.2	(13)	32-120	258.1*	(32)	170-387	158.2	(17)	89-273	n/c	(<5)	
Lake and Peninsula	378.2	(14)	202-670	n/c	(<5)		n/c	(<5)		n/c	(<5)			(0)			(0)	
Matanuska-Susitna	462.3*	(515)	420-508	61.4	(67)	47-80	54.5	(54)	40-73	132.9	(82)	103-169	126.8	(62)	95-170	26.3**	(29)	17-40
Nome	370.6	(75)	288-471	88.4	(15)	49-148	83.0*	(17)	46-138	n/c	(9)		n/c	(<5)		n/c	(<5)	
North Slope	305.3	(43)	213-433	n/c	(8)		74.3	(10)	32-156	n/c	(5)		n/c	(<5)			(0)	
Northwest Arctic	349.5	(41)	246-489	n/c	(6)		99.5*	(11)	48-191	n/c	(<5)		n/c	(<5)		n/c	(<5)	
Prince of Wales-Outer Ketchikan	388.6	(56)	277-541	n/c	(9)		151.6*	(14)	77-276	n/c	(<5)		n/c	(6)		n/c	(<5)	
Sitka	376.0	(92)	300-467	66.0	(15)	36-113	67.7	(17)	38-114	n/c	(8)		104.6	(10)	48-204	n/c	(<5)	
Skagway-Hoonah-Angoon	334.4	(35)	226-485	n/c	(<5)		n/c	(<5)		n/c	(6)		n/c	(6)		n/c	(<5)	
Southeast Fairbanks	429.0	(61)	319-570	n/c	(6)		n/c	(<5)		n/c	(9)		n/c	(9)		n/c	(<5)	
Valdez-Cordova	407.3	(103)	326-505	52.3	(13)	26-97	54.9	(12)	26-103	126.9	(18)	69-220	164.7	(19)	97-271	n/c	(6)	
Wade Hampton	358.3	(43)	256-497	120.1**	(13)	63-218	n/c	(5)		n/c	(<5)		n/c	(<5)			(0)	
Wrangell-Petersburg	365.7	(75)	285-467	72.5	(14)	39-130	n/c	(<5)		131.3	(16)	73-237	135.2	(12)	69-251	n/c	(<5)	
Yakutat	974.0*	(15)	505-1,872	n/c	(<5)			(0)		n/c	(<5)		n/c	(<5)			(0)	
Yukon-Koyukuk	384.0	(60)	290-500	n/c	(6)		105.3*	(16)	59-175	n/c	(7)		n/c	(8)		n/c	(<5)	

Unknown Borough/Census Area = 6 cases.

Rates per 100,000 population age-adjusted to 1970 U.S. population.

*Significantly different from U.S. and Alaska.

**Significantly different from U.S.

***Significantly different from Alaska.

Notes: Rate not calculated (n/c) where number is less than 10.

Cells with fewer than 5 cases are not presented.

Table 4-b. Cancer Mortality by Borough/Census Area for Selected Sites Alaska, 1996-1998

	All Cancers Combined			Lung			Colorectal			Breast			Pancreas		
	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI
U.S. 1994-1998	166.2			48.7			16.9			24.2			8.3		
Alaska, 1996-1998	167.3	(1,915)	159-175	51.7	(572)	47-56	15.3	(166)	13-18	21.6	(143)	18-25	8.9	(101)	7-11
Aleutians East	n/c	(9)		n/c	(<5)			(0)		n/c	(<5)			(0)	
Aleutians West	n/c	(7)		n/c	(<5)			(0)		n/c	(<5)		n/c	(<5)	
Anchorage	166.4	(754)	154-179	49.0	(216)	42-56	14.1	(58)	10-18	20.7	(60)	15-27	7.4	(34)	5-10
Bethel	161.4	(44)	116-219	53.4	(14)	29-91	n/c	(7)		n/c	(<5)		n/c	(<5)	
Bristol Bay	n/c	(<5)		n/c	(<5)			(0)			(0)			(0)	
Denali	n/c	(<5)		n/c	(<5)			(0)			(0)			(0)	
Dillingham	161.6	(13)	83-295	n/c	(<5)		n/c	(<5)			(0)			(0)	
Fairbanks North Star	154.6	(197)	132-180	44.0	(53)	32-59	9.4	(12)	4-18	31.0	(22)	18-49	14.3	(15)	8-24
Haines	138.6	(10)	65-281	n/c	(5)			(0)			(0)		n/c	(<5)	
Juneau	158.4	(102)	127-194	48.8	(29)	32-71	n/c	(8)		n/c	(<5)		n/c	(9)	
Kenai Peninsula	205.7	(216)	178-237	68.4*	(73)	53-87	20.0	(19)	11-32	35.4	(19)	20-57	10.2	(10)	4-20.1
Ketchikan Gateway	127.0	(52)	94-170	36.0	(14)	19-63	n/c	(7)		n/c	(<5)		n/c	(<5)	
Kodiak Island	123.1	(26)	76-193	n/c	(9)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Lake and Peninsula	n/c	(8)		n/c	(<5)			(0)			(0)		n/c	(<5)	
Matanuska-Susitna	168.5	(177)	143-198	50.4	(53)	37-67	12.0	(13)	6-23	26.9	(14)	14-47	8.7	(10)	4-18
Nome	210.0	(39)	147-291	86.3	(15)	47-145	n/c	(5)			(0)		n/c	(<5)	
North Slope	186.9	(21)	110-302	n/c	(7)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Northwest Arctic	212.7	(27)	135-328	n/c	(6)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Prince of Wales-Outer Ketchikan	112.1	(16)	58-212	n/c	(<5)		n/c	(<5)			(0)			(0)	
Sitka	119.7	(27)	78-178	n/c	(9)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Skagway-Hoonah-Angoon	133.8	(13)	69-245	n/c	(<5)		n/c	(<5)		n/c	(<5)			(0)	
Southeast Fairbanks	198.7	(20)	119-315	n/c	(<5)		n/c	(<5)			(0)			(0)	
Valdez-Cordova	153.2	(32)	102-223	n/c	(9)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Wade Hampton	228.8	(25)	146-350	91.1	(10)	42-182	n/c	(<5)			(0)			(0)	
Wrangell-Petersburg	169.2	(34)	116-245	53.2	(10)	25-106	n/c	(<5)		n/c	(<5)		n/c	(<5)	
Yakutat	n/c	(7)		n/c	(<5)			(0)			(0)			(0)	
Yukon-Koyukuk	193.1	(28)	127-283	79.3	(10)	35-139	n/c	(<5)		n/c	(<5)		n/c	(<5)	

Unknown Borough/Census Area = 6 deaths.

Rates per 100,000 population age-adjusted to 1970 U.S. population.

*Significantly different from U.S. and Alaska.

Notes: Rate not calculated (n/c) where numbers are less than 10.

Cells with fewer than 5 deaths are not presented.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Press Releases

United States Department of Health Human Services

News Release

FOR IMMEDIATE RELEASE
Wednesday, Jan. 29, 2003

Contact: HHS Press Office
(202) 690-6343

HHS TO PROPOSE INCREASED FUNDING FOR CANCER SCREENING

President Bush will propose a $10 million increase in funding for breast and cervical cancer screening to help low-income and underserved women, HHS Secretary Tommy G. Thompson said today.

The proposed increase is for the National Breast and Cervical Cancer Early Detection Program, administered by Centers for Disease Control and Prevention (CDC), which provides screening services, including clinical breast examinations, mammograms, pelvic examinations and Pap tests, to underserved women. It also funds post-screening diagnostic services, such as surgical consultation and biopsy, to ensure that women with abnormal results receive timely and adequate referrals.

"Together, breast and cervical cancer take the lives of more than 40,000 American women each year," Secretary Thompson said. "These deaths occurred disproportionately among low-income women and women who belong to racial or ethnic minorities. By increasing screening rates for at-risk women, we can save lives."

HHS' fiscal year 2004 budget will request an additional $10 million for this program, bringing the total requested funding to $211 million. The additional funding would allow the program to provide an additional 32,000 procedures, for a total of 562,000 procedures. The increase also will support efforts to increase education and outreach programs for women and health care providers, to improve quality assurance measures for screening and to improve access to screening and follow-up services.

In addition, HHS has approved Medicaid plan amendments for 49 states and the District of Columbia that allow their state Medicaid programs to provide health coverage to women without health insurance who are diagnosed with cancer through the free CDC screening program. This coverage helps to ensure that women receive appropriate care and treatment as quickly as possible, when the odds for a successful recovery are greatest.

The National Breast and Cervical Cancer Early Detection Program was established by the Breast and Cervical Cancer Mortality Prevention Act of 1990. Since its creation, the program has provided more than 3 million screening examinations and diagnosed more than 12,000 breast cancers and 800 invasive cervical cancers. The program operates in all 50 states, the District of Columbia, six U.S. territories and 12 American Indian and Alaska Native organizations.

More information about the CDC screening program is available at http://www.cdc.gov/cancer/nbccedp/. Details about this Medicaid option are available at http://www.cms.hhs.gov/bccpt/.

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Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

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Anchorage, AK

Dave Steward / KTUU

Breast cancer survivor Denise Otter says the program helped enormously.

Group fights for Medicaid cancer funding

Joy Mapaye

Anchorage, Alaska, Jan. 26 - A local advocacy group for breast cancer is fighting to keep Medicaid funding for Alaska's breast and cervical cancer treatment program. It's funding that ends this summer.

That funding is scheduled to end this June, which is why the group says it's trying to get the word out as quickly as possible. What's at stake is a treatment program that allows low-income Alaskan women with breast cancer or cervical cancer to get access to Medicaid funds for treatment.

Candidates for the program have been screened and diagnosed, by a Centers for Disease Control screening program to get the funds. From July 2001 to June 2002, Medicaid paid treatment costs for 44 women.

Federal funds make up about 70 percent of this money, with the state chipping in about 30 percent. Last year, the total amount Alaska spent on funding was about $175,000.

"It's helped me enormously," said breast cancer survivor Denise Otter. "I've used the program for a month, before I was eligible with insurance through my employer."

"This program allows low-income women, who have been diagnosed through the screening program, to get that treatment quickly," said Carla Williams, the president of Alaska Breast Cancer Advocacy Partners.

The group says an estimated 69 women will qualify and need breast cancer treatment in fiscal year 2003.

There are two bills in the Legislature to help restore funding, one in the House and one in the Senate. It's still early for those bills so the group is just waiting to see what happens.

Web posted Thursday, January 16, 2003

Women's increased cancer coverage to end

Democrats file bills to make coverage permanent

By TIMOTHY INKLEBARGER
JUNEAU EMPIRE © 2003

A program providing breast and cervical cancer treatment for women who lack health insurance could come to an end this year unless the Legislature extends the program.

A bill passed in 2001 took advantage of a federal program extending Medicaid coverage of breast and cervical cancer. That program increased the income limit from 72 percent of the federal poverty rate to 250 percent.

The program provides about 70 percent funding from the federal government.

In fiscal year 2002, 44 of 54 eligible recipients took advantage of the program for a total cost of $584,364, according to the state Department of Health and Social Services. The state pitched in about $174,300.

Then-Gov. Tony Knowles filed a bill in 2001 to take advantage of the federal program, calling it "must have" legislation. But it hit a snag in the Senate with lawmakers who opposed expanding Medicaid and choosing diseases that are eligible for coverage.

The bill was stalled by Wasilla Republican Lyda Green, former chairwoman of the Senate Health and Social Services committee.

At the time, then-U.S. Sen. Frank Murkowski, an Alaska Republican, sent a letter to all Alaska lawmakers calling on them to support the bill.

"I recognize that there are concerns about creating disease-specific Medicaid eligibility categories. However, this legislation deals with a thoroughly unique set of circumstances ... and should not be viewed as a precedent for extending Medicaid body-part by body-part," Murkowski wrote.

The bill was approved by the committee, but Green placed a two-year sunset on the program, which is set to expire this June.

Green, a survivor of breast cancer, told The Associated Press in March of 2001: "These are not easy decisions. These are very, very tough policy calls."

She did not return calls to the Empire by its midday deadline today.

Bills have been prefiled by Democrats in the House and the Senate to make the coverage permanent. It is uncertain whether any lawmakers will oppose the measure. Similar bills introduced last session to remove the sunset did not make it to a floor vote.

Sen. Fred Dyson, an Eagle River Republican, will sit as chairman of the Senate Health and Social Services Committee this session. While serving in the state House in 2001, Dyson was one of five Republican lawmakers in the 40-member body who voted against the bill. Dyson was unavailable for comment for this article.

Murkowski's support in 2001 for providing coverage, however, could persuade lawmakers who oppose expanding Medicaid.

Murkowski spokesman John Manly said he was unsure if the governor supported such a bill but added: "In light of the governor's and first lady's interest in this issue over the years ... I anticipate that he will be in support of this bill."

Rep. Beth Kerttula, a Juneau Democrat and co-author of the House bill to make the program permanent, said she expects that most Democrats and many Republicans in the House will sign on to the bill.

As the recently appointed minority whip of the House, Kerttula has the responsibility to line up the vote within the Democratic caucus.

Meanwhile, breast and cervical cancer advocacy groups in Alaska are gearing up for a heavy lobbying effort on the issue this session.

Carla Williams, president of the Anchorage-based Alaska Breast Cancer Advocacy Partners, said the group plans trips to the Legislature and will engage in a postcard-writing campaign to elected officials.

The organization plans to send out hundreds of postcards across the state calling on people to support the bill.

"Discontinuing treatment would be devastating for those women who are trying to get well and fight this disease," Williams said.

Timothy Inklebarger can be reached at timothyi@juneauempire.com.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Positive Support

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

Preamble: State Scorecard
(as of January 27, 2003)

Purpose

National Breast Cancer Coalition (NBCC) grassroots advocates played a pivotal role in the enactment of the Breast and Cervical Cancer Treatment Act (P.L. 106-354). This important legislation established a program, available to all states, that provides breast and cervical cancer treatment coverage to low-income, uninsured women.

States must take certain steps to "opt into" the new treatment program in order to participate. This state scorecard tracks the steps that states have taken to implement it. The scorecard also describes the Act and explains where the policy idea behind the law came from; how the law was enacted; what states generally need to do to participate in the program; and what work still needs to be done.

This scorecard is a snapshot of state action as it stands at the moment.

The Act

On October 24, 2000, the Breast and Cervical Cancer Treatment Act (P.L. 106-354) was signed into law. This Act gives states the option of providing Medicaid coverage to low-income, uninsured women, under 65 years of age, who have been screened and diagnosed through the Breast and Cervical Cancer Early Detection Program (BCCEDP), and are in need of breast or cervical cancer treatment. Each state that opts in receives an enhanced match from the federal government, equal to its Children's Health Insurance Program match, which will help fund 65%-83% of the total program cost. Participating states may choose to extend a presumptive eligibility procedure to applicants in order to facilitate prompt enrollment and immediate access to treatment.

Origin of the Policy

For years, NBCC was concerned that the Breast and Cervical Cancer Mortality Prevention Act (PL 101-354) authorized the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide free screening services for low-income women with no health insurance, but failed to cover any treatment. As a result, many women diagnosed with cancer under the NBCCEDP found themselves scrambling to find ways to pay for their treatment. Over the years, volunteers helped these women find treatment coverage through charitable contributions, but this system was often unreliable and rapidly deteriorating.

The idea for a potential solution to this problem came from the National Breast Cancer Coalition through its grassroots network. NBCC recognized the need for women diagnosed through the NBCCEDP to gain access to guaranteed treatment and suggested Medicaid as a possible source to cover the cost of their treatment. This idea launched what was to become the Breast and Cervical Cancer Treatment Act.

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

The Road to Enactment

From 1997 until the Treatment Act became law, NBCC focused its efforts on implementing a treatment component for the federal screening program. From developing the strategy, successfully urging the Administration to include funding for the bill in the President's fiscal year 2001 budget, persuading an overwhelming majority of members of Congress to cosponsor the Breast and Cervical Cancer Treatment Act, convincing Committees to hold hearings and markups, to persuading Congressional leaders to bring the bill to the floor, NBCC led the fight to bring this law to life.

While rapid state action and overwhelming support in Congress (the bill passed 421-1 in the House of Representatives, and unanimously in the Senate) may suggest that the steps above were accomplished easily, that is far from the case. Rather, passage of this important Act was an uphill battle. It took four long years to get this bill passed, and during that time NBCC's grassroots faced many setbacks – some that seemed insurmountable. NBCC's success in ensuring that low-income women diagnosed with breast cancer have access to the treatment they deserve demonstrates the power of strategic and tireless grassroots advocacy.

Process for State Participation in the Treatment Program

Since the bill was signed into law, NBCC's attention and efforts have been focused on working with individual states to ensure that they take up the new Medicaid option. NBCC's grassroots network has been working with their Members of Congress, Governors, state legislators, CDC's Early Detection Program officials, and State Medicaid Directors on engaging states in the implementation process. This far-reaching initiative has revealed that while the key steps in the process are similar for all states, no two states share the same story.

Any state that elects to participate in the new Medicaid option, and if so desired, the presumptive eligibility option, must submit an amended state Medicaid plan to the Center for Medicare and Medicaid Services (CMS) (formerly called the Health Care Financing Administration) for its approval. Only when a state's amended state Medicaid plan is approved by CMS has it completed the steps it needs to receive its enhanced federal share of payment for program costs.

In addition, all states must provide funding to cover the state share of program costs. Most states will need to appropriate new funding, while a few states may initially be able to use funding already allocated to the state health or Medicaid Department.
For some states, an amendment to the state Medicaid plan and the allocation of funding are the only requirements to participate in the new option. States that opt in this way are considered to have opted in administratively, since the Governor could approve the policy without having to sign authorizing legislation that would need to pass through the state legislature. However, most states must enact authorizing legislation in order to opt in to the treatment program.

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

State Action

In only a year since the enactment of the Treatment Act, almost every state has committed to adopting the treatment option. Many public policy and public health officials, and leaders in local and national healthcare communities have commented that this progress is unique. For example, the Federal Funds Information for States (FFIS) noted that states were taking on the Medicaid option at "a historically rapid rate," and attributed this phenomenon partly to "coordinated efforts by breast cancer survivors and their allies to persuade state officials to adopt it." The National Breast Cancer Coalition's incredible grassroots advocates have been credited numerous times as the primary leaders of this effort.

To date, United States Department of Health and Human Service's Secretary Tommy Thompson has approved **48** states' proposals to amend their state Medicaid plans to expand coverage to uninsured women diagnosed with breast or cervical cancer. NBCC commends Secretary Thompson and the CMS officials for their support and strong encouragement to the states to participate in the Treatment Program.

NBCC applauds the many states that quickly implemented the treatment program. The Coalition urges other states to follow suit so women will access to the treatment option as soon as possible.

Continuing Efforts

It is important that, while we celebrate the passage of the Breast and Cervical Cancer Treatment Act and the rapid progress we are making in encouraging state participation in this program, we do not lose sight of the fact that this is only a first step. While the Breast and Cervical Cancer Treatment Act provides coverage for underserved women screened who qualify for the NBCCEDP, there are many other women who still do not have access to early detection and treatment services. We must continue to work together to ensure that all women who are diagnosed with breast cancer have access to the high quality treatment they deserve.

NBCC's grassroots advocates will remain diligent in their efforts to ensure that if a state has opted into the program, the program continues to thrive in future years, and that cuts are not made to the critical treatment benefits the women in that state will now receive.

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

Steps that states must take to participate ("opt into") the Treatment Program:
There are two ways for a state to begin implementation of the Treatment Program. A state can either enact authorizing legislation or opt in administratively. In either case, states must also allocate funding for their share of program costs. Next, all states must submit an amended Medicaid plan to the Center for Medicaid and Medicare Services (CMS) (*formerly called the Health Care Financing Administration (HCFA)*) for its approval. These amended plans inform CMS how a state will run the Treatment Program. Finally, upon CMS approval of its state plan amendment, a state may begin participating in the Treatment Program.

(1) Legislation enacted = legislation authorizing participation in the Treatment Program passed in the state legislature and was signed by the governor.

Funding approved = the state has allocated funding for its share of the Treatment Program costs. To see the amount and source of the funding allocated by the state, look in either the authorizing legislation or within the general budget bill.

(2) Amended plan submitted = the state submitted an amended state Medicaid plan to CMS for its approval.

(3) Participating in treatment program = CMS approved the state Medicaid plan amendment. Therefore, the state has completed all steps required to accept the new Medicaid option and can begin participating in the Treatment Program.

State	(1) Legislation enacted/ funding approved	(2) Amended plan submitted	(3) Participating in treatment program
Alabama	✓	✓	✓
Alaska	✓	✓	✓
Arizona	✓	✓	✓
Arkansas	✓	✓	✓
California	✓	✓	✓
Colorado	✓	✓	✓
Connecticut	✓	✓	✓
Delaware		✓	✓
Florida	✓	✓	✓
Georgia	✓	✓	✓
Hawaii	✓	✓	✓
Idaho	✓	✓	✓
Illinois	✓	✓	✓
Indiana	✓	✓	✓
Iowa	✓	✓	✓
Kansas	✓	✓	✓
Kentucky	✓	✓	✓
Louisiana	✓	✓	✓
Maine	✓	✓	✓
Maryland	✓	✓	✓
Massachusetts	✓		
Michigan	✓	✓	✓
Minnesota	✓	✓	✓
Mississippi	✓	✓	✓
Missouri	✓	✓	✓
Montana	✓	✓	✓
Nebraska	✓	✓	✓
Nevada	✓	✓	✓
New Hampshire	✓	✓	✓
New Jersey	✓	✓	✓
New Mexico	✓	✓	✓
New York	✓	✓	✓
North Carolina	✓	✓	✓
North Dakota	✓	✓	✓
Ohio	✓	✓	✓
Oklahoma	✓		
Oregon	✓	✓	✓
Pennsylvania	✓	✓	✓
Rhode Island	✓	✓	✓
South Carolina	✓	✓	✓
South Dakota	✓	✓	✓
Tennessee			✓
Texas	✓	✓	✓
Utah	✓	✓	✓
Vermont	✓	✓	✓
Virginia	✓	✓	✓
Washington	✓	✓	✓
West Virginia	✓	✓	✓
Wisconsin	✓	✓	✓
Wyoming	✓	✓	✓

Nancy Murkowski

Nancy Gore Murkowski is a life-long Alaskan. Born in Nome, where her father was the Federal Judge for the Territory of Alaska, she was raised in and attended school in Ketchikan. She attended Willamette University in Salem, Oregon, and graduated with a Bachelor of Arts degree from San Jose State University in California.

In 1974, Nancy helped found the Breast Cancer Detection Center of Alaska in Fairbanks, which provides free- or low-cost breast examinations and mammograms for women throughout Alaska. She has been an active fundraiser for that Center, hosting eight charity fishing tournaments to aid the facility. (See below) In 1998, she won the sixth annual Action for Cancer Awareness Award from the Cancer Research Foundation of America for her efforts. She was the 1996 recipient of the Georgetown University Lombardi Cancer Center's "Symbol of Caring" award for her work in this area, is a member of the Congressional Families for Breast Cancer Awareness, and is Honorary Chair of the Alaska Breast Cancer Coalition. She also serves on the Executive Board of the Congressional Families for Cancer Awareness Foundation.

Nancy and Frank Murkowski have been the Honorary Alaska State Chairmen of the Red Ribbon Campaign, an anti-drug abuse program, for several years. She is a former Chairman for the Congressional Families for Drug Free Youth.

Nancy is also a member of the Senate Spouses Red Cross Unit and the Pioneers of Alaska, Auxiliary 4. An active fundraiser in the Washington, D.C. area, she was Chairman for the 1997 March of Dimes gala in Washington, was Chairman for the 1993 Ambassadors Ball to benefit the National Multiple Sclerosis Society in Washington, Co-Chairman of the CARE Ball for 2000 and 2001 and was a member of the Medical Affairs Development Council at the University of Washington.

Nancy and Frank have a home in Fairbanks, six children and 12 grandchildren.

Breast Cancer Detection Center of Alaska

Frank and Nancy Murkowski are pioneers in efforts to fight cancer in Alaska.

In 1974, Mrs. Murkowski was one of three women who formed the non profit Breast Cancer Detection Center of Alaska, first housed in an old bank building donated by the senator when he was President of Alaska National Bank of the North in his hometown of Fairbanks. Initially, the center, from a single X-ray machine, provided low- or no-cost mammograms for anyone who could visit the northcentral Alaska location. Initially the center provided about 2,000 mammograms a year to women from up to 80 Alaska villages.

Eight years ago, the Murkowskis sponsored their first charity fishing tournament to raise money, first to replace the center's aging X-ray machine, and in later years to buy a mobile van and equip it with a new X-ray machine -- the Mollie -- so that women on the road system in central Alaska could obtain mammograms. And then two years ago the event raised enough money to buy a third (mobile) machine -- the Sophie - that can be packed in air freight crates and resembled to allow mammogram testing in tiny Alaska villages served only by small commuter airlines.

The Murkowskis in the event's first eight years have raised more than $1.8 million, more than $1.6 million for the operation of the Fairbanks center. The center now serves about 2,500 women a year in more than 81 villages throughout the state. In years when the event has raised more than $250,000 for the Fairbanks center, excess money has been donated to cancer and health groups statewide. The following groups have received donations from the event: 2002 -- Sunshine Health Clinic of Talkeetna, $20,000; Providence Hospital in Anchorage, $25,000 and the Southeast Alaska Cancer and Wellness Foundation of Juneau, $20,000; 2001 -- the ACS Mammogram Assistance Program, $20,000; the First City Council on Cancer in Ketchikan, $25,000; the Hospice Home Care of Juneau, $10,000; 2000 -- Ketchikan General Hospital, $20,000; Bering Straits Womens Group, $5,000; and Craig Community Foundation, $3,000.

Frank and Nancy Murkowski in 2001 also donated $80,000 for detection and treatment of breast cancer and other forms of cancer in Alaska -- money derived not from the Waterfall fishing event, but was raised during the celebration of Murkowski's 20th anniversary in the U.S. Senate in February 2001 in Anchorage. The money was donated to both Providence Foundation to be used in providing cancer treatments for those in need at Providence Alaska Medical Center in Anchorage and to the Breast Cancer Detection Center of Alaska in Fairbanks.

The Murkowskis say they work so hard to raise money to fight breast cancer because Alaska has the second highest breast cancer death rate in the nation -- about 50 women every year. With one in eight women diagnosed with breast cancer in Alaska yearly -- about 200 new cases a year -- early detection is especially vital. And early detection is especially difficult in Alaska where most of the state's 228 rural villages have clinics that contain no mammogram X-ray equipment.

Prostate Cancer Testing

The Senator and Nancy Murkowski in 1999 also served as honorary leaders in an effort to encourage men to have prostate cancer examinations and women to have breast cancer exams.

The effort, centered around Father's Day observances, noted that Prostate cancer is one of the most treatable cancers when detected early and is one of the easiest cancers to detect through regular screenings. Nevertheless, prostate cancer is the second leading cancer killer of American men and will affect one in every five men sometime in their lifetime. In Alaska, according to the American Cancer Society, 200 men and women were diagnosed with prostate and breast cancer in 1998, with the diseases claiming nearly 50 men and 100 women in 1998.

Frank Murkowski urged Alaskans, especially men over age 50, to get a prostate exam, which includes both a PSA (prostate specific antigen test) and a digital rectal exam yearly. He also urged women over age 40 to have mammograms every year or two, while women 50 and over are urged to have the exams yearly. Legislative Changes:

In 1998, Senator Murkowski sponsored legislation, with former Sen. Al D'Amato, R-N.Y., that allowed physicians and not insurance companies to determine the length of stay for breast cancer mastectomy patients in hospitals. The bill, that was included in the final appropriations bill for that year, also ensured that mastectomy patients could have access to reconstructive surgery and the right for additional consultations with doctors to be covered by health insurance.

Prior to the bill, Murkowski said, some HMOs and other insurance plans didn't adequately cover reconstructive surgery nor were allowing long enough stays in the hospital after the operations. At the time, some companies required doctors to discharge mastectomy patients within 24 hours of surgery. The bill overrode that requirement. It also required companies nationwide to pay for secondary consultations often needed since patients should receive pathology, radiology and

oncology consults prior to and after mastectomies.

The bill also required coverage for breast reconstruction which was vital because many women could not afford the roughly $15,000 cost of reconstructive surgery following mastectomies without adequate insurance benefits. Nationwide, before the change only 23 percent of women with breast cancer were undergoing full reconstructive surgeries after mastectomies -- only 3.4 percent of the women in Alaska being able to afford the costs.

The Senator accomplished that legislation after winning additional money from the military's medical budget for breast cancer medical research in prior years.

In 2000, Murkowski also co-authored the Breast and Cervical Cancer Prevention and Treatment Act that passed that year. The measure guarantees that low-income women across the nation, including in Alaska, who were diagnosed with breast or cervical cancer under a special federal screening program created years earlier will receive follow-up medical treatment under the states' Medicaid programs, if needed.

The law actually changes the income formulas for women under the Medicaid program -- the program that provides health care nationwide for low income people -- to allow states to extend Medicaid coverage to slightly higher income poor women diagnosed with cancer under the 1990's federal screening program. The change, which involved adding $200 million in federal Medicaid funding nationwide to pay for the formula change, had the effect of helping thousands of low-income women get medical care for the cancer found during the screening program, including 42 women in Alaska.

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FRANK H. MURKOWSKI
ALASKA

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April 26, 2001

The Honorable Senator Rick Halford
President, Alaska State Senate
State Capitol
Juneau, AK 99801-1182

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

Dear Senator Halford and Representative Porter:

As you know, I have traditionally given great deference to the work of Alaska's state legislature, and it is not my custom to become involved with its activities. I believe it is my duty to respond to the state's concerns and calls for help--rather than to interject myself into internal debates. However, the needs of a small number of Alaskan women force me to diverge from my common practice. It is a very important priority for me to see that Alaska Senate Bill 38, extending Medicaid coverage to a few uninsured low income Alaskan women with breast or cervical cancer, is passed by the legislature before the end of this legislative session.

In 1990, Congress recognized the importance of screening and early detection--establishing the National Breast and Cervical Cancer Early Detection Program. This program provided screenings to uninsured, low income women across the country. Unfortunately, for those women who were diagnosed with cancer, the program failed to provide insurance coverage that would have allowed them to receive medical treatment.

Last year, Congress enacted the Breast and Cervical Cancer Prevention and Treatment Act, legislation I co-wrote. This law fulfilled Congress' 1990 commitment to the victims of these cancers by permitting states to extend Medicaid coverage to cover the costs of treating these illnesses which, untreated, are almost always fatal. We will continue to help lower-income, uninsured women access needed preventive health care services. But now our commitment will not stop with a screening. If problems are found, the federal government will work with the state to provide necessary treatment services to women facing cancer diagnoses. But to accomplish this, the state legislature must adopt SB 38. For this, I need your

immediate help.

I recognize that there are concerns about creating disease-specific Medicaid eligibility categories. However, this legislation deals with a thoroughly unique set of circumstances. The new Medicaid eligibility category is specifically linked to a unique and existing federal screening program, and should not be viewed as a precedent for extending Medicaid eligibility body-part by body-part. Additionally, Medicaid coverage would only be available during the period in which the individual requires breast or cervical cancer treatment.

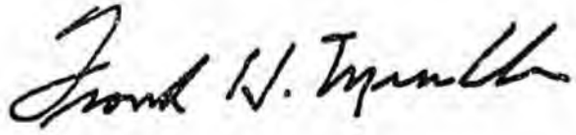
As you know, I am very sensitive to the costs associated with the Medicaid program in Alaska. In 1997, I was able to change the federal government's Medicaid formula to enable the state to bear a smaller share of Medicaid costs. This saved the state approximately $100 million over three years. Just last year, I won an additional $200 million of federal dollars--a 20 percent increase above the previous adjustment--to expand our state's Medicaid program over the next five years. As a result, In FY 2002 alone, the state will receive an additional $40 million from my legislation.

The cost of extending Medicaid coverage to the estimated 42 eligible women diagnosed under the CDC program in 2002 will be $175,800, as the federal government will pay for 70.17% of total expenditures. In light of these facts, I strongly believe that the state can afford to extend Medicaid coverage to these women--and can use these additional funds to accomplish this goal.

We must work quickly to ensure that the state extends coverage to these women. We have the money, and there certainly is a need. While this is a small segment of Alaska's population, it is our duty to heed their call for help. It must be recognized that Alaskan women have the second highest rate of breast cancer in the nation. With such an epidemic in our state, I would hate for Alaska to stand out as one of the few states that fail to provide this life-or-death benefit.

Please feel free to call me or my staff if we can provide you with any additional information or to discuss the merits of this legislation. Together, we can ensure that needy women in Alaska receive the care and coverage they deserve.

Sincerely,



Frank H. Murkowski
United States Senator

cc: All Members of the Alaska State Legislature

FRANK H. MURKOWSKI
ALASKA

COMMITTEES:

RANKING MEMBER
ENERGY AND NATURAL RESOURCES

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May 20, 2002

Mr. Richard A. Benavides
Legislative Aide
Office of Senator Bettye Davis
State Capitol
Juneau, AK 99801-1182

Dear Richard:

Thank you for contacting me regarding the Breast and Cervical Cancer Act. I appreciate your interest in seeing that this program continues.

In December of 2001, we did amend the original law to extend the benefit to Native women. Otherwise, no other changes were made or are planned to be made.

Thank you again for contacting me and for all that you are doing for Alaska.

Sincerely,

Frank H. Murkowski
United States Senator

Alaska State Legislature

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Senator Bettye Davis

Sectional Analysis
Senate Bill 17

Section 1. Adds a new group of persons who are eligible for medical assistance under AS 47.07, known as the "Medicaid" program. The new group is confined to persons who are eligible for coverage under the specified federal law.

Section 2. Repeals the temporary law (sec.1, ch.33, SLA 2001) that added the same new group to coverage in the year 2001. The 2001 legislature put an application deadline in the 2001 law: two years after the effective date of the session law, which was June 26, 2001. That means that, after June 26, 2003, there can be no new applicants for Medicaid coverage for persons with breast or cervical cancer who are eligible under the specified federal law under unless the application period is extended by amending ch. 33, SLA 2001, or by passage of a bill like SB 17, which puts the new eligible group in the permanent statutes without an expiration date for either applications or for coverage. However, the coverage even under SB 17 is not necessarily permanent. State coverage of this group would expire if the federal law, 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII), is repealed or expires. Note the qualifying phrase at the end of section 1 of this bill ("...who are eligible for coverage under 42 U.S.C. [etc.]." If a person would no longer be covered under this federal law, they would no longer be covered under this state law.

Section 3. Provides that persons already covered under the temporary program enacted in 2001 do not have to reapply as new applicants under SB 17, but their cases would be subject to regular eligibility review on the same basis that the situations of other Medicaid recipients are subject to review.

Section 4. Keeps in place the regulations adopted for the temporary program enacted in 2001, subject to future amendment of the regulations by DHSS.

Section 5. Gives this Act an immediate effective date so that there would probably be no gap between the application deadline in ch. 33, SLA 2001 [June 26, 2003] and the effective date of SB 17.

SB

25

GARY WILKEN
SENATOR
West Fairbanks

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MEMORANDUM

TO: Senator Fred Dyson, Chairman
Health, Education and Social Services Committee

FROM: Senator Gary Wilken

DATE: February 5, 2003

RE: Senate Bill 25 – AHFC Loans to Educators

I respectfully request that Senate Bill 25, *AHFC Loans to Educators*, be scheduled for a hearing before the Senate Health, Education, and Social Services Committee.

Senate Bill 25 establishes a teacher's housing loan program within the Alaska Housing Finance Corporation (AHFC) for teachers, counselors, and administrators who are required to be certificated. The new teacher-housing loan offered through AHFC requires no down payment and may only be used for owner-occupied housing.

The recruitment and retention of qualified public school teachers is paramount to the operation of a successful K-12 educational program. Unfortunately many school districts are experiencing a shortage of experienced, talented teachers and spend thousands of dollars to recruit the necessary workforce. The new housing loan program will provide school districts with a tool to encourage new teachers to come to their district and remain in their community.

Thank you for your cooperation and assistance in scheduling a hearing.

GARY WILKEN
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SPONSOK STATEMENT

Senate Bill 25
AHFC Loans to Educators

Senate Bill 25 establishes a teacher's housing loan program within the Alaska Housing Finance Corporation (AHFC) for teachers, counselors, and administrators who are required to be certificated. The new teacher-housing loan offered through AHFC requires no down payment and may only be used for owner-occupied housing.

This legislation will provide Alaska school districts with a tool to help to attract and keep qualified public school teachers. The recruitment and retention of a qualified workforce is paramount to the operation of a successful K-12 educational program. Unfortunately many school districts are experiencing a shortage of experienced, talented teachers and spend thousands of dollars to recruit the necessary educators. The proposed new housing loan program provides an incentive for trained teachers, counselors, and administrators to enter into the profession and settle down in local communities.

In addition, Senate Bill 25 addresses one of the concerns highlighted in the October 2001 *Committee Report on the Statewide Teacher Shortage* by the House Special Committee on Education. This report stated education professionals testified that one reason for the statewide teacher shortage is because teacher housing is too expensive or even nonexistent. Senate Bill 25 will help facilitate educators to obtain the necessary financing to purchase a home by eliminating the requirement of a down payment. Senate Bill 25 makes a small, but positive step towards ensuring that Alaska school districts have the best, stable workforce possible.

Please join me in endorsing and passing Senate Bill 25.

February 5, 2003

Senate Bill 25 – AHFC Loans to Educators

IT'S ABOUT RECRUITMENT AND RETENTION!

Why??

- *Teacher Housing: Current Issues and Challenges*
  Alaska House Finance Corporation Draft White Paper

Statements of Support

- Guest Opinion article by Rep. Con Bunde
  Fairbanks Daily News-Miner, October 30, 2001

- Anchorage School District
  Committee Report on Statewide Teacher Shortage
  By the House Special Committee on Education, Oct. 22-24, 2001

- *2000 Alaska Statewide Educator Supply and Demand Report*
  by Alaska Teacher Placement, University of Alaska Fairbanks
- *No Dream Denied* by the National Commission on Teaching

Other States' Actions

- Alaska Council of School Administrators Bulletin Excerpt

- *School Board News* Article, January 28, 2003

Provided by Gary Wilken
February 10, 2003

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Teacher Housing: Current Issues and Challenges
DISCUSSION DRAFT
November 27, 2002

The State of Alaska has 55 school districts with 8,206 teachers serving over 132,000 students. Of these school districts, 19 serve rural and remote communities. Retention of staff in these areas has generally been difficult due to a variety of factors including community acceptance, salary, and quality of life. However, one issue that is becoming increasingly important to school administrators in these communities is teacher housing. The villages and rural towns served by these districts often have a limited supply of adequate and affordable housing. Administrators report that many teachers in rural districts live in substandard housing and often are doubled-up with other households because of a lack of supply.

In a preliminary analysis of the state of teacher housing, AHFC contacted 19 rural and "rural-hub" school districts and asked them 10 questions about teacher housing. Responses were received from 12 school districts. Of the 12 districts who responded over half identified teacher housing as an important issue. Three districts identified it as the highest priority. Seven of these districts own single family and multifamily housing that they lease to teachers. The North Slope and the Lower-Kuskokwim school districts reported the bulk, 277 units or 75% of the total number reported. A smaller number of districts, 5, do not own but manage units, 70 total.

In addition to owning and managing units, rural school districts may choose to use the private market. In communities like Bethel and Dillingham, the school provides a rental subsidy, typically specified in the teacher contract that pays a portion of a private rental unit cost. In smaller communities, the district may lease units from the tribal entity, borough, or local corporation. However, the school district is most likely to operate as the owner and manager of teacher rental housing. Very few districts mentioned homeownership. Only two districts noted that they had a handful of teachers purchase homes.

The most pressing issue in the districts was affordability. Seventy-five percent of the districts indicated that it is difficult for a first-year teacher to afford to either purchase or rent a home. Supply and quality were also rated as important but to a lesser degree (55 and 45% respectively). Another issue raised was land-availability. Districts reported that it is difficult to acquire land in small communities, especially in villages. One district, Annette Island, reported that the

tribe controlled the land and that any development needed to be approved by the village council.

To what extent do these issues contribute to loss of teachers? District personnel estimated that anywhere from 4% - 30% of their teachers leave every year because of housing issues. For these districts this equates to a loss of 133 teachers a year. The percentage of teachers who decide not to accept positions in each district because of problems with housing is close to 8% or 152 teachers. One district, Lower Kuskokwim indicated that for every successful teacher applicant there are six that decide not to work in the district, roughly half of these are due to housing factors. It's important to note that the numbers reported reflect the opinion of administrators, not teachers, and not all districts keep track of these numbers.

What do districts report they need to address teacher housing problems? The answer depends on the district. Some district superintendents have concluded that attrition due to housing is a problem but have decided not to get into the business of developing or providing housing. Other districts have taken an active role in housing, both developing and managing housing. Fifty-percent of districts indicated that providing more rent subsidy would help address the problems of teacher housing. Forty-two percent indicated that better financing, including downpayment assistance, would help. Forty-two percent also indicated that land acquisition would be helpful. In terms of housing production, district personnel estimated that they would need an additional 27 multifamily and 144 single family units to address their current problems with teacher housing.

Current AHFC Programs Could Address the Teacher Housing Problem

Through the refinement or modification of three existing AHFC financing programs it may be possible to address some of the barriers to the development of teacher housing:

- *AHFC Multifamily Development Long Term Take-out Loans* - Districts may be able to develop more units of multifamily housing with affordable rents.
- *AHFC Rural Loan Program* – The utilization of this program which has been more specifically targeted toward teachers could increase from marketing efforts, and/or modification of some of the statutory limitations on the program.
- *AHFC Interest Rate Reduction Programs* – By combining the rural loan program with an interest-rate reduction program, the program could enhance affordability for teachers who want to own their own home.

Current Challenges May Make It Difficult for AHFC Programs to Assist All School Districts

For some districts, AHFC programs in their current form may not be enough because of the following issues:

- It is unknown what the capacity of each district is to develop multifamily housing and what the demand would be for such units.
- In smaller communities, the ability to acquire land may make multifamily development difficult.
- Many teachers work in rural areas for less than three years and community resistance often makes it difficult for teachers to establish roots in the community.
- School districts have expressed reluctance in constructing new housing in communities where there is already wide disparity in housing quality between community residents and teachers.
- Lack of quality supply may serve as a disincentive to homeownership.
- It is unknown what the demand for homeownership is without demographic and financial data on teachers in the rural school districts.

Case Studies

To better illustrate the challenges of rental and homeownership development in rural Alaska, the following profiles are provided:

Rental Development Example

Based on market rents there is not sufficient income to support debt for the total development cost. The gap may be reduced by changing loan terms or gap financing through development subsidies for land, site work, infrastructure or general construction cost:

24 unit project in Kotzebue, three eight plexes, two story wood frame construction.

Estimated Development Cost:	$184,000 per unit or $4,428,000 .
Potential Rents:	1 Bed - $1,000
	2 Bed - $1,200
	3 Bed - $1,400
Operating Expenses:	$5,500 per unit/year
Estimated Loan Amount:	$1,800,000 at 5.5%, 30 year term

Estimated Funding Gap (Dev. Cost - Loan): $2,628,000

Starting Teacher Salary in Kotzebue:	$42,000
30% of Monthly Income for Rent:	$1,030

Using 30% as a measure of affordability, the starting teacher in Kotzebue would be able to afford only a one bedroom unit at the rents above.

Homeownership Example

Under AHFC's rural loan program, a starting teacher in Kotzebue would not make enough income to qualify for a new 1,500 square foot single family home in Kotzebue. The gap may be reduced through land donation, down payment assistance, lowering the interest rate, or subsidizing the cost of construction if the cost of the home exceeds the appraised value, or self-help programs.

Cost of New Single Family Home: In Kotzebue, 1500 sq ft.	$200,000
Starting Teacher Salary	$ 42,000
30% of Monthly Income for Mortgage:	$ 1,030
Loan amount at 5.5%, 30 year term:	$190,000
Downpayment requirement (5%):	**$ 10,000**
PITI Monthly Payment Requirement: (Includes MI at 95% LTV)	$ 1,346

Estimated Funding Gap: -$316 per month

Recommendations

Combining existing AHFC mortgage loan programs with new initiatives will address many of the challenges that rural school districts currently face. Specific recommendations include:

- Educating rural school districts about AHFC homeownership programs so that teachers who are interested in homeownership can take advantage of AHFC's favorable interest rates. (AHFC's current rural interest rate is 5%; additionally, assuming the loan meets the qualifications, there is the possibility of reducing the interest rate even further through the options of IRRLIB and EEIR.

- Explore the possibility of offering down-payment assistance to teachers. Such assistance may make homeownership possible in rural areas that have problems with affordability. (With regards to down payment, other

than a veteran's or FHA insured loan, a lower down payment would require a change to statutes).

- Promote AHFC's Multifamily Development Programs to school districts who want to develop their own housing. AHFC already has a long term take-out program in its direct lending multi-family program; wherein, if a project is marginal because of the market interest rate, a portion of the loan can be structured into an arbitrage soft second at 1.5% or an option that has not been used before is that, similar to IRP.LIB and EEIRR programs, the interest rate can be bought down. A cash-flow problem may arise during the off-school year in the event the teachers leave the community for that time; thus, reducing the cash flow available to pay expenses and debt service.

- Promote home ownership programs with the private sector

- Promote housing development partnerships between school districts and local housing authorities. With these partnerships local communities may be more effective in developing new housing stock for both teachers and community residents. Such collaboration may result in the upgrade of community infrastructure and address the community resentment issues that often arise when only new teacher housing is being constructed in the community. These partnerships could also overcome the land availability issue that school districts often face when attempting to develop housing in native village areas.

- Partner marketing efforts with the USDA, Denali Commission, Rasmusson Foundation and other potential partners to address issues of infrastructure development and down payment assistance.

- Promote the development of housing for both teachers and non-teachers so that the inventory of available housing units could be increased. In many areas that lack housing stock, the free market system simply cannot flourish and perform in a normal fashion because there is nothing to buy or sell.

- In some areas it may be unrealistic to promote homeownership for teachers, and a multifamily development approach would be more successful. In those areas that could support single-family ownership, incentives will probably be necessary to encourage people to participate.

- 100% Loan-to-value ratio would eliminate the need for down payment with a manageable risk exposure.

- Development grants for construction lending, or subsidized capital financing.

Looking for answers to shortage

Guest Opinion

By REP. CON BUNDE

Research has shown that an excellent teacher is a vital factor in a student's academic success. Unfortunately, school districts all over the country are experiencing a severe shortage of quality teachers, especially in the areas of math, science, special education, foreign languages and support-service positions such as school counselors, speech-language pathologists and nurses. Districts are also having difficulty keeping the teachers they do have, due to factors such as retirement and job dissatisfaction. Regrettably, Alaska is sharing in these problems.

Over 30 years ago, when my wife and I began teaching in Anchorage, the school district recruited about 300 teachers every year, and virtually all were hired from outside Alaska. Salaries were high compared to those in the Lower 48. Now, estimates put Alaska's average teacher salaries at sixth or seventh out of the 50 states. A decade ago, 30 new teachers were required for a new school and the district received thousands of applications. This year, schools statewide started the school year with 80 teaching vacancies. Thirty positions still remain vacant.

Teacher retention is just as important as recruitment, and it is just as much of a problem. In some rural districts, there is 30 percent to 50 percent teacher turnover each year. In the Anchorage School District, 52 percent of those who left the classroom last year did so in the first four years of their teaching career.

As chair of the House Special Committee on Education, I recently conducted hearings around the state to investigate the specific causes of these problems and to identify ways the state Legislature can help districts recruit and retain excellent teachers. The committee visited school districts in Kodiak, the Matanuska-Susitna Borough, Anchorage and Kotzebue. We also held a statewide teleconference.

Education professionals testifying before the committee said there were several reasons for the state teacher shortage:

- First-year teachers feel unprepared for the challenges they encounter in real classrooms;
- Alaskan school districts are unable to compete with the salaries, benefits and incentives provided by districts down south;
- Rising health insurance costs are eating away at school and family budgets;
- Salaries are inadequate to support the cost of living in rural areas;
- Adequate housing can be too expensive or nonexistent;
- Teachers are dropping their certifications in high-need areas due to the high cost of renewal;
- Qualified teachers from other states find it too expensive and time consuming to apply for jobs in Alaska.

While those testifying were clear about the problems, they were also eager to offer suggestions on how to enhance teacher recruitment and retention, including:

- Improving teacher preparatory programs to better equip new teachers for the challenges of today's schools;
- Supporting effective mentoring programs for new teachers, both for professional skill and cultural awareness;
- Expanding mentoring programs for new teachers in more districts;
- Streamlining the certification process, repeal duplicative fees and paperwork;
- Establishing a student loan forgiveness program;
- Hiring more Alaskans;
- Instituting a state health insurance pool for all teachers to increase benefits and lower costs;
- Working with Alaska Housing Finance Corp. to provide low-interest housing;
- Hiring retired teachers as substitutes and full-time teachers, and as mentor teachers;
- Increasing salaries;
- Making the state's teachers exam, the Praxis, more effective to help more people become eligible for certification;
- Working to increase respect for the education profession.

Every state in the nation is trying to solve its teacher shortage in creative ways. Alaska must remain competitive in this very important market, support our teachers, and ensure that every student has an excellent teacher.

It has been invaluable for the Education Committee to hear from those "in the trenches," and I am grateful to the education professionals and community members who shared their ideas with the committee. These hearings provided an important framework for further discussion and new legislation next session.

Con Bunde, a Republican from Anchorage, heads the Alaska House of Representatives' Special Committee on Education.

Fairbanks Daily News-Miner
October 30, 2001

Anchorage School District
Resolution on Teacher Recruitment and Retention:

The Anchorage School District urges the Alaska Legislature to develop strategies to attract and retain education professionals.

Rationale:

- Alaska's colleges and universities supply about 30% of our state's annual demand for new teachers.
- More than two-thirds of new teachers come from out-of-state.
- A national shortage of teachers and administrators forces Alaska to compete with other states for an ever-shrinking pool of applicants.
- Other states are offering teachers signing bonuses, down payment on homes, mortgage subsidies, and student loan repayment plans.
- As a result, Alaska needs to consider strategies for attracting and retaining qualified educators.

These strategies might include:

ASD Resolution #183	Aligning vesting in the Teacher Retirement System (TRS) with vesting in the Public Employees Retirement System (PERS). Currently, it takes 8 years to vest in TRS, but only 5 years to vest in PERS.
ASD Resolution #183	Providing student loan forgiveness to offset high needs areas such as special education and related services
ASD Resolution #183	Providing housing subsidies for teachers in both rural and urban areas.

2000
ALASKA STATEWIDE EDUCATOR SUPPLY AND DEMAND REPORT

By
Melissa Hill

ALASKA TEACHER PLACEMENT
UNIVERSITY OF ALASKA FAIRBANKS

PO Box 756880
Fairbanks Alaska 99775
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January 2001

This table shows the 2000 positions filled by each district. The total district staff numbers are included in this table to help the reader keep the turnover percentages in perspective. An 8-10% turnover is normal for natural attrition. In any given year, Alaska's rural sites can experience resignations from up to 47% of their staff. This high turnover can be due to many reasons, but one of the main reasons seems to be poor housing and harsh living conditions. The number of first year teachers being hired increases each year. Are they being given the support needed for success? The University of Alaska Fairbanks is seeking a post-hiring course for first year teachers. Courses such as these in addition to Alaskan Native Studies are essential to teacher retention rates. Many rural sites do not have adequate funding to give them the resources for success.

Positions Filled by Districts

District	New Hires Admin	New Hires Teacher	Total Staff	District Turnover	District	New Hires Admin	New Hires Teacher	Total Staff	District Turnover
Alaska Gateway	0	6	42	14%	Kodiak	0	23	221	10%
Aleutain Region	0	2	6	33%	Kuspuk	2	14	52	31%
Aleutians East	1	16	43	40%	Lake & Pen	0	24	67	36%
Anchorage	12	215	3477	7%	L. Kuskokwim	4	71	335	22%
Annette Island	1	5	35	17%	Lower Yukon	5	48	164	32%
Bering Strait	3	58	201	30%	Matanuska	6	85	910	10%
Bristol Bay	2	2	28	14%	Nenana	2	12	33	42%
Chatham	2	9	30	37%	Nome	3	11	60	23%
Chugach	0	3	16	19%	North Slope	6	53	231	26%
Copper River	0	8	52	15%	NW Arctic	6	49	199	28%
Cordova	2	3	38	13%	Pelican	1	1	4	50%
Craig City	0.5	9	37	26%	Petersburg	0	6	54	11%
Delta	0	0	65	0%	Pribilof	2	4	13	46%
Denali	0	5	36	14%	Sitka	2	7	128	7%
Dillingham	2	15	51	33%	Skagway	2	12	14	100%
Fairbanks	1	48	1087	5%	Southeast Is.	0	3	25	12%
Galena	1.5	9	75	14%	Southwest R.	0	5	97	5%
Haines	0	0	36	0%	St. Mary's	7.5	28	20	178%
Hoonah	1	3	25	16%	Tanana	0	1	10	10%
Hydaburg	0	5	12	42%	Unalaska	1	6	36	19%
Iditarod	3	14	51.5	33%	Valdez	2	11	73	18%
Juneau	5	25	407	7%	Wrangell	0	6	36	17%
Kake	1	3	15	27%	Yakutat	1	7	19	42%
Kashunamiut	1	6	26	27%	Yukon Flats	7	16	42	55%
Kenai	6	39	737	6%	Yukon Koyukuk	1	15	85	19%
Ketchikan	2	13	168	9%	Yupiit	3	23	42	62%
Klawock	0	0	18	0%	SESA	0	3	21	14%

Average Turnover for the following:	
URBAN DISTRICTS	7%
RURAL DISTRICTS	20%
ALL DISTRICTS	12%

History of District Turnover

District	1997 Total Staff	1997 Total Turnover	1998 Total Staff	1998 Total Turnover	1999 Total Staff	1999 Total Turnover	2000 Total Staff	2000 Total Turnover	Average Turnover
Alaska Gateway	48	31%	45.25	24%	40.5	4%	42	14%	15%
Aleutian Region	4	0%	9.5	33%	9.5	42%	6	33%	19%
Aleutians East	36	57%	37	15%	41.5	32%	43	40%	26%
Anchorage	3009	7%	3100	15%	3143	9%	3477	7%	8%
Annette Island	39	17%	37	16%	34.3	3%	35	17%	9%
Bering Strait	172	35%	198.5	24%	202	35%	201	30%	24%
Bristol Bay	29.75	0%	28	7%	28	3%	28	14%	3%
Chatham	33	29%	29	26%	27	10%	30	37%	16%
Chugach	17.5	0%	17	6%	12	8%	16	19%	4%
Copper River	46.97	28%	48.5	11%	48.5	11%	52	15%	13%
Cordova	34.5	21%	41	5%	35.3	10%	38	13%	9%
Craig City	31	17%	30	23%	33	15%	37	26%	14%
Delta/Greely	50	0%	75	11%	68	4%	65	0%	4%
Denali	30	15%	33	11%	30.5	24%	36	14%	13%
Dillingham	51	10%	54	34%	51	19%	51	33%	16%
Fairbanks	1044.33	0%	1065	10%	1129	8%	1087	5%	5%
Galena	34	24%	56	48%	70	36%	75	14%	27%
Haines	30.8	19%	11.7	23%	37	7%	36	0%	12%
Hoonah	25	0%	20	11%	21.5	4%	25	16%	4%
Hydaburg	15	28%	10	57%	12	50%	12	42%	34%
Iditarod	42.25	34%	47	39%	51	31%	51.5	33%	26%
Juneau	276.35	18%	371.7	10%	381	21%	407	7%	12%
Kake	17	0%	17.6	17%	16.6	23%	15	27%	10%
Kashunamiut	21	29%	27	33%	27	35%	26	27%	24%
Kenai	668	12%	730.5	8%	733	11%	737	6%	8%
Ketchikan	141.2	10%	165	13%	170.7	11%	168	9%	9%
Klawock	21.5	0%	18.5	6%	18.5	5%	18	0%	3%
Kodiak	199.95	0%	209	11%	216	15%	221	10%	7%
Kuspuk	51	38%	56	22%	56	31%	52	31%	23%
Lake & Peninsula	56.5	54%	69	36%	73	36%	67	36%	32%
Lower Kuskokwim	298.5	17%	329	16%	327	22%	335	22%	14%
Lower Yukon	170	26%	181	23%	162	13%	164	32%	16%
Matanuska	736.15	9%	872	4%	869	13%	910	10%	7%
Nenana	13	24%	17	47%	25	27%	33	42%	25%
Nome	58.5	15%	63.5	16%	65	21%	60	23%	13%
North Slope	204.25	35%	237	23%	234	27%	231	26%	21%
Northwest Arctic	152	22%	170	30%	186	29%	199	28%	20%
Pelican	5	55%	5	0%	4	31%	4	50%	22%
Petersburg	55.5	0%	54	18%	54	9%	54	11%	7%
Pribilof	21.5	37%	15	38%	13.5	15%	13	46%	23%
Sitka	121	10%	129	12%	133	11%	128	7%	8%
Skagway	13	0%	14	40%	14	14%	14	100%	14%
Southeast Island	29	26%	27	9%	27	35%	25	12%	18%
Southwest	72	25%	91	30%	92	26%	97	5%	20%
St. Mary's	13	12%	15.5	13%	12	39%	20	178%	16%
Tanana	11	0%	11	25%	11	36%	10	10%	15%
Unalaska	32.6	27%	34	24%	34	25%	36	19%	19%
Valdez	69.5	0%	67	13%	68	10%	73	18%	6%
Wrangell	41.2	0%	38	16%	39	15%	36	17%	8%
Yakutat	16	20%	18	35%	19	35%	19	42%	23%
Yukon Flats	53	30%	48	25%	45	25%	42	55%	20%
Yukon Koyukuk	58	36%	63	37%	73	19%	85	19%	23%
Yupiit	38	0%	37	41%	38	47%	42	62%	22%
SESA	21.6	15%	18.5	11%	19	6%	21	14%	8%

No Dream Denied

A Pledge to America's Children

NATIONAL COMMISSION ON TEACHING AND AMERICA'S FUTURE

HON. JAMES B. HUNT JR.,
CHAIRMAN

THOMAS G. CARROLL, Ph.D.,
EXECUTIVE DIRECTOR

SUMMARY REPORT

National Commission on Teaching and America's Future, Washington, DC

WHY DOESN T EVERY CHILD HAVE QUALITY TEACHING?

If we know that high quality teaching makes a difference, why isn't every child in America getting it? The conventional wisdom is that we lack enough good teachers. But, the conventional wisdom is wrong. ***The real school staffing problem is teacher retention.*** Our inability to support high quality teaching in many of our schools is driven not by too few teachers entering the profession, but by too many leaving it for other jobs. The ability to create and maintain a quality teaching and learning environment in a school is limited not by teacher supply, but by high turnover among the teachers who are already there—turnover that is only aggravated by hiring unqualified and underprepared replacements who leave teaching at very high rates.[5] The extensive evidence for these assertions is laid out in the next section. That evidence paints a disquieting picture.

In the mistaken belief that teacher supply is the core problem, quality teaching is too often compromised in an effort to recruit a sufficient quantity of teachers to fill classrooms. The results: standards for entry into the profession are lowered; quality teacher preparation is undercut; licensure becomes a bureaucratic barrier to be side-stepped, instead of a mark of quality; and the mythology that "anyone can teach" gains more ground with each fall's round of stop-gap hiring. Today, thousands of unqualified individuals are in classrooms across the nation, hired because state laws and district policies are ignored in the name of meeting immediate needs of schools that appear to face "shortages." But the real problem is that these schools are unable to retain a sufficient number of teachers with the proper credentials. We have mistaken the symptom for the problem.

ACSA
Alaska Association of Elementary Schools Principals
Alaska Association of Secondary School Principals
Alaska Association of School Administrators
Sponsor of the Alaska Staff Development Network

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Alaska Council of School Administrators

Excerpt from the *ACSA Education Bulletin* January 2000 Issue

Where are the Teachers?

WE NEED A MORE POWERFUL MAGNET!

By Darroll Hargraves, Executive Director, ACSA

What's the problem? What's getting the attention?

Interesting isn't it? During the past few years, public attention has been focused on funding, construction, standards, and testing. Each of these issues is important. However, whenever superintendents get together to talk about immediate and future concerns, another issue tops the agenda—the need to recruit, hire, and keep certified and qualified teachers and administrators.

The recent announcement by the University of Alaska that a five-year program will be required for certification will further reduce the number of Alaskans to fill positions in our schools.

Alaska is not alone. In fact, teacher shortages are entering a critical stage across the nation. U.S. Secretary of Education Richard Riley consistently expresses a concern about the ability of our schools to attract the very brightest and best into education careers. As student enrollments continue to climb nationally, demand is outstripping supply at a time when the hurdles are being lifted even higher. For example, the shortage is becoming even more acute because many states are increasing their standards for teachers and some are requiring them to have majors in the subjects they teach or to pass qualifying tests. The recent announcement by the University of Alaska that a five-year program will be required for certification will further reduce the number of Alaskans to fill positions in our schools.

Salaries have not kept pace with what talented people can make outside the classroom. A recent Quality Counts 2000, 50-state survey, conducted by *Education Week*, found that one in five college graduates who began teaching in 1993-94 left within three years. The brightest novice teachers, as measured by their college-entrance exams, were the most likely to leave, the study revealed.

There was a time, not so long ago, when Alaska was a magnet for educators.

What's at stake here? The immediate concern for many educators is having excellent teachers in the classroom—preparing students to pass exit exams that are looming in their future. Even more importantly, they are concerned about preparing students for life in the 21st century.

There was a time, not so long ago, when Alaska was a magnet for educators. Our salaries were the highest in the nation. Our recruiters could promise adventure, good hunting and fishing, and a lifestyle that attracted exceptional talent. Let's face it. What worked in the past is not getting us the number and level of certified, qualified educators we need today and will need in the future.

While average teacher salaries in Alaska are still above the national average, we are now caught in what the *New York Times* calls a bidding war. That war has spread from coast to coast, and we are not winning. In fact, we are being out-maneuvered as never before. Take, for example, the incentives being offered in several states. California is offering $10,000 interest-free loans for buying a home, $30,000 bonuses for attaining advanced certification, and $11,000 to repay college loans. In Texas, $2,000 signing bonuses are becoming commonplace. Southern states such as Florida, Georgia and Mississippi have districts paying bonuses of up to $6,000 to retain quality teachers.

As crises show signs of becoming catastrophes, some state legislatures and state departments of education have gotten the ball rolling on bringing retired teachers and administrators back into the system. Those early retirement incentives that were sold, in some case as a way to remove the "dead wood" are now looking more like they've caused a "brain drain."

Salaries are a major problem, both for teachers and administrators. Alaska's largest districts provide an example of how noncompetitive our salaries are. These districts have budgets, enrollments, numbers of employees, physical plants, and demands comparable to large districts outside the state that are paying their superintendents nearly double. In fact, an Alaska board member recently admitted to the media that their superintendent is underpaid and speculated that if the present superintendent left and had to be replaced, it would require an additional $50,000. Even that level of an increase would be low compared to salaries paid in comparable districts outside.

Granted, we need to pay attention to standards, facilities, and a number of other critical issues. At the same time, let's not forget that our ability to attract and keep outstanding teachers and administrators is basic to everything we hope to accomplish. Alaska needs a constant flow of quality, certifiable educators. While the problem may not be completely solved during this session of the Legislature, we simply must make sure that it receives the attention it deserves. The future of our kids depends on it.

Teachers in Santa Fe get help in buying homes

In an effort to curb the exodus of teachers from high-cost Santa Fe, N.M., the school board has set aside $600,000 to help teachers buy homes.

The average teacher salary in Santa Fe is $34,635, while the median price of a house is $268,000. Starting teachers earn $26,414.

In addition to the district's contribution, a collaboration of the New Mexico Mortgage Finance Authority, Neighborhood Reinvestment Corp., and Neighborhood Housing Services hopes to raise $1.3 million.

A pilot program launched by Neighborhood Housing Services in 1999 helped 25 teachers buy homes with down payment assistance and helped seven teachers make home repairs, says Executive Director Michael Loftin.

The new program will help teachers find affordable apartments in Santa Fe, as well as provide $10,000 to $15,000 to help teachers with down payments. Teachers buying their first home in Santa Fe could get a zero percent, deferred-mortgage loan, which must be repaid when they sell.

Loftin also hopes to offer teachers workshops on home buying, low-interest home-improvement loans, and rental discounts for apartments.

"Santa Fe is an expensive city in a poor state," says school board President Marcy Litzenberg. "We know this is only a drop in the bucket, but for the teachers who take advantage of it, it may make all the difference in the world whether or not they stay in Santa Fe."

Contact: Joanne Ferguson, public information officer, (505) 467-2028. ■

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 25
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Revenue
Title: AHFC Loans to Educators
BRU: Alaska Housing Finance Corp.
Component: Operations
Sponsor: Senator Wilken
Requester: Senate HESS Committee
Component No.: 110

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
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--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2003) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

SB25 authorizes AHFC to establish a housing loan program for teachers. Although loans may be made at 100 percent loan-to-value (i.e. no down payment requirements), no financing plan, source of funds or subsidy is identified in the legislation. As such, market-rate bonds will have to be issued to finance the program, and the loans offered will have the same interest rate as existing AHFC mortgage programs.

As written, SB25 is not anticipated to significantly impact AHFC budget numbers and loan authorizations, since loan rates will be roughly the same as loans currently offered.

Prepared by: Bryan Butcher
Phone 330-8445
Division: Alaska Housing Finance Corporation
Date/Time 2/11/03 6:56 AM
Approved by: Larry Persily, Deputy Commissioner
Date 2/11/2003
Agency: Department of Revenue

(Revised 9/2002 OMB)

ASSOCIATION OF ALASKA SCHOOL BOARDS

Advocates for Alaska's Youth

Position Paper

In Support of SB 25 AHFC Loans for Educators

The Association of Alaska School Boards (AASB) supports legislation that will help attract and retain teachers in Alaska. Creating a teacher housing loan program within the Alaska Housing Finance Corporation to provide loans with no down payment for certificated staff will assist us in meeting that goal. SB 25 makes a positive step towards ensuring that Alaska school districts have the best, stable workforce possible.

AASB recognizes that the greatest factor affecting the ability of students to master Alaska's student performance standards is the quality of the teacher who delivers classroom instruction to students. Compounding this concern is a shortage of qualified teachers, administrators and paraprofessionals. Issues such as educator recruitment, distribution, preparation and focused in-service, substandard housing and, in some areas, the inability to purchase a home, continue to impact the supply and retention of qualified teachers.

Housing, in particular, has been identified as a long-standing barrier to retaining quality educators. Time and again, educators point to the lack of quality housing, expensive housing, or even nonexistent housing, as a contributing factor in their decision about whether or not to settle and establish roots in a community.

An influx of educators new to the profession and educators new to Alaska, coupled with a sagging economy, has further elevated the issue of affordable, quality housing for educators.

While the state has recently increased efforts to attract educators from both conventional and non-traditional sources and to more effectively prepare teachers, the full promise of these efforts has yet to reach most school districts. AASB supports increased opportunities for improved access to quality housing in both urban and rural settings for those educating Alaska's public school students.

316 West 11th Street, Juneau, Alaska 99801-1510 • Tel. 907-586-1083 fax: 907-586-2995 Email: aasb@aasb.org

AMENDMENT

OFFERED IN THE SENATE SENATOR DYSON

TO: SB 25

Page 1, line 6:

Delete "public"

Page 1, lines 7 - 10:

Delete all material.

Insert "to purchase housing. A loan made under this program may be used only for owner-occupied housing. The loan may be made only to an individual who is employed in a

(1) public or private elementary or secondary school in the state that complies with all student testing and assessment requirements of the Department of Education and Early Development; and

(2) teaching, counseling, or administrative capacity and is required to be certificated to hold the position."