ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

11155 SENATE JUDICIARY

SENATOR FRED DYSON

SB 30
SECTIONAL ANALYSIS (Version S)

"An Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency."

Section 1 FINDINGS language describes the interests and intentions of the Legislature's intervention in this issue. Interests include regulating medical practice, protecting the life and health and choices of pregnant women, and clarifying a physician's requirements to obtain inform consent, which will in turn, conserve legal and judicial resources.

Section 2 directs the Department of Health and Social Services to develop a website designed to assist a pregnant woman with her reproductive choices. This pamphlet will provide resources for women to use in order to make and implement these decisions. The material will include information specific to geographic region, adoption services, counseling, abortion, clinics, medical assistance benefits, requirements for doctors who performs abortions, the father's liability, fetal development, and medical risks/rewards for each procedure option.

Section 3 adds that abortion may not be performed unless informed consent is obtained, as outlined in Section 4. This elevates 12 A.A.C. 40.070 to statute.

Section 4 adds civil liability for a person who performs or induces an abortion without meeting the informed consent provisions. A doctor who prints the website's information and distributes it to the pregnant woman is not liable under this section.

Section 5 states the terms of qualification for consent to an abortion to be informed and voluntary. Medical emergency, as defined in this section, bypasses the informed consent requirements. The pregnant woman or her parent/guardian/etc. will certify the requirements in writing as met. Voluntary informed means: at least 24 hours before the procedure, in an individual and private and confidential setting, the physician will provide information on the women's individual circumstances including the physician's name, gestational estimation of the pregnancy, and the nature and risks of the procedure and its alternatives, and the availability of the website's information.

Section 6 adds to the current abortion reporting law. In preparing the report, the state registrar must require whether or not the pregnant woman received the website's information.

Section 6 provides severability of this legislation.

During Session (January-May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 FAX
During Interim (June-December): 10928 Eagle River Road • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 FAX
Senator.Fred.Dyson@Legis.state.ak.us • www.akrepublicans.org

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB 30(HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: INFORMED CONSENT FOR ABORTION
BRU: State Health Services
Component: Maternal, Child, & Family Hlth

Sponsor: DYSON
Requester:
Component No. 290

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	20.0					
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	20.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
1002 Federal Receipts						
1003 GF Match						
1004 GF	20.0					
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	20.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2003) cost:
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)*

This bill requires that information be prepared and made available via the Internet, to every woman seeking an abortion, on the medical risks of abortion, pregnancy, and where services can be sought, by geographic region. The Department of Health & Social Services already produces, procures and disseminates a range of materials regarding how to have a healthy baby and ways to keep the baby safe and healthy after birth. In addition, the Department maintains a 24-hour referral line for services. Ensuring the intent of this bill is addressed will require resources for the production of the additional informational materials on abortion.

CONTRACTUAL: $20.0 for a professional services contract in Year 1 for the production and posting of the web-based materials required under this bill.

Prepared by: Doug Bruce, Director — Phone 465-3090
Division: Public Health — Date/Time 04/16/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 04/17/2003
Agency: Department of Health and Social Services

(Revised 9/2002 OMB)

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB 30(HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: INFORMED CONSENT FOR ABORTION
BRU: State Health Services
Component: Bureau of Vital Statistics

Sponsor: DYSON
Requester:
Component No. 961

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	30.0					
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	30.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
1002 Federal Receipts						
1003 GF Match						
1004 GF	30.0					
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	30.0	0.0	0.0	0.0	0.0	0.0

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

POSITIONS

POSITIONS	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Full-time						
Part-time						
Temporary						

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

This bill would add a requirement to the report of Induced Termination of Pregnancy (ITOP) program that the Bureau of Vital Statistics (BVS) collect and record data on whether or not each reported patient requested and received a written copy of information on reproductive options required to be maintained on the Internet.

CONTRACTUAL: $30.0 in GF for contractual service costs would be required in Year 1 (one-time costs) to provide for 1) a contract to revise the BVS ITOP computer program ($20,000); 2) to produce, print and distribute revised ITOP reporting forms to providers throughout Alaska ($2,000); and 3) to contract for the drafting of regulations to implement AS 18.50.245(e) ($8,000).

Prepared by: Doug Bruce, Director
Phone 465-3090
Division: Public Health
Date/Time 04/16/2003
Approved by: Joel S. Gilbertson, Commissioner
Date 04/17/2003
Agency: Department of Health and Social Services

Subject: **SB-30 North Carolina Version**
Date: Fri, 25 Apr 2003 08:49:31 -0800
From: "Haase, Donald J." <HaaseDJ@alyeska-pipeline.com>
To: "'brian_hove@legis.state.ak.us'" <brian_hove@legis.state.ak.us>,
"'senator_ralph_seekins@legis.state.ak.us'" <senator_ralph_seekins@legis.state.ak.us>,
"'senator_scott_ogan@legis.state.ak.us'" <senator_scott_ogan@legis.state.ak.us>,
"'senator_Gene_Therriault@legis.state.ak.us'" <senator_Gene_Therriault@legis.state.ak.us>

Dear Judiciary Committee,

North Carolina is attempting to pass a bill similar to SB-30. I thought you might be interested in the polling data they are using.

Source: North Carolina Right to Life; April 24, 2003

A CNN/USA Today/Gallup
poll dated January 2003 reported that 78% of those polled favor a "law requiring women seeking abortions to wait 24 hours before having the procedure done." The same poll showed 88% supporting a "law requiring doctors to inform patients about alternatives before performing the procedure." A Wirthlin December 2002 poll asked, " In light of recent medical advances such as in-utero surgery and 3-D ultrasound technology, which reveals the unborn child's body and facial features in detail, are you in favor of restoring legal protection for unborn children?" 68% of those polled said "yes": 44% strongly and 24%, somewhat. Only 25% said "no": 13%, somewhat and 12%, strongly. 7% did not know.

The Abortion-Woman's Right to Know (H998) requires that 24 hours before a pregnant woman receives an abortion, she is told the name of the physician who will perform the abortion, the medical risks involved for the particular abortion procedure she will have, the medical risks in carrying her child to term, and the probable gestational age of her unborn child at the time when the abortion is to be performed. If the doctor uses an ultrasound in the performance of the abortion, then he is to offer the woman the option of viewing the ultrasound image of her unborn child. She must be told if the person performing the abortion does NOT have hospital privileges or malpractice insurance.

Additionally, the pregnant woman is offered additional information which includes fetal development and alternatives to abortion. The legislation does provide for medical emergencies and for civil remedies.

From: The Pro-Life Infonet <infonet@prolifeinfo.org>
Reply-To: Steven Ertelt <infonet@prolifeinfo.org>

DNA and CODIS Update

May 2003

Chris Beheim 269-5743
State Crime Laboratory

Biological Testing at the Alaska Crime Laboratory

- 1982 Blood and Semen Identification
- 1987 ABO Typing 1 in 20
- 1992 DQ-alpha Typing 1 in 100
- 1996 Polymarker Typing 1 in 1000
- 1999 STR Typing
  1 in 2,111,000,000,000,000,000

STR
Short Tandem Repeat

1997 13 Core Loci Selected by FBI

Consistent Technology to Allow Comparisons

Alaska's DNA Registration System

- AS 44.41.035 Directs DPS to establish a DNA registration system
- Individuals convicted of a felony crime against a person after January 1, 1996 must provide a blood or oral sample
- Burglary added as a qualifying conviction in September 2001

CODIS

Combined DNA Index System

- Convicted Offender
- Forensic (crime scene evidence)

CODIS

- IDENTIFY SUSPECTS

  Compare DNA profiles from unknown crime scene evidence to convicted offender DNA profiles obtained locally and nationally.

- LINK CASES

  Compare unknown DNA profiles collected as evidence from various crime scenes.

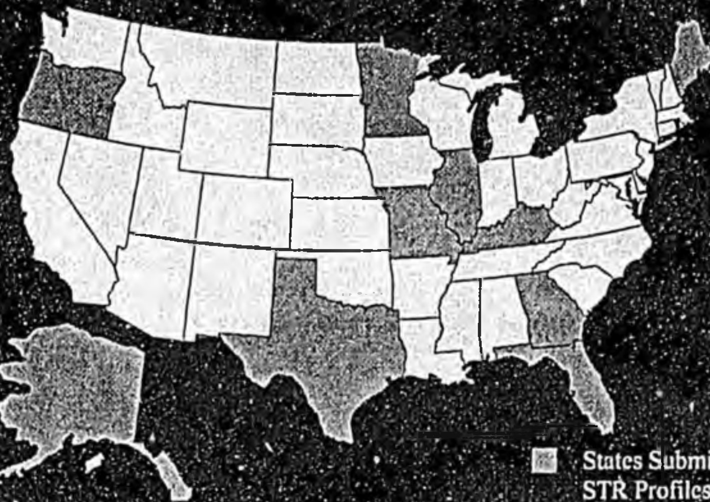
CODIS

- State DNA Index System
- National DNA Index System (NDIS)
  NDIS opened October 13, 1998

National DNA Index System

States Submitting STR Profiles to NDIS

October 1999 - 10 States



NDIS Status
October 1999

- 20,155 Offender STR profiles
- 1,722 Forensic STR profiles

- 10 States

CODIS Laboratories
January 2002

NDIS Status
January 2003

- 1,266,351 Offender STR profiles
- 42 States, 2 Federal Laboratories and Puerto Rico

Alaska CODIS Database
April 30, 2003

- 3,243 Convicted offender STR profiles
- 312 Forensic STR profiles
- 165 "no suspect" forensic STR profiles
  - 17 Homicides
  - 91 Sexual Assaults
  - 48 Burglaries
  - 9 Miscellaneous

Alaska CODIS Hits

April 30, 2003

30 Total Hits

15 Offender to Case

15 Case to Case Hits

40 Investigations Aided

Should Alaska's Database Law be Expanded?

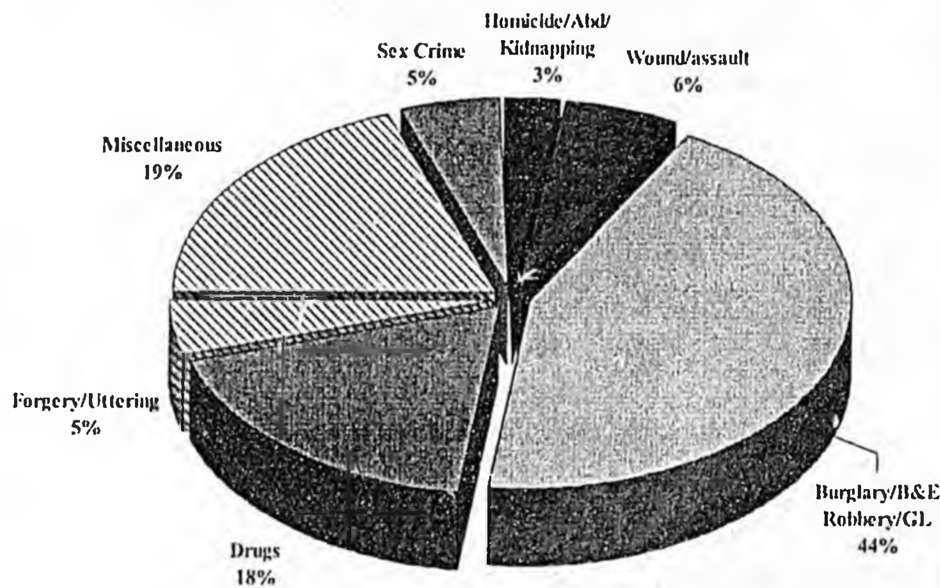
- 40 State & Federal database laws retroactive
- 26 States collect from all Felons
- Collect from all Registered Sex Offenders
- Increase penalty for refusing
- Increase penalty for unauthorized disclosure

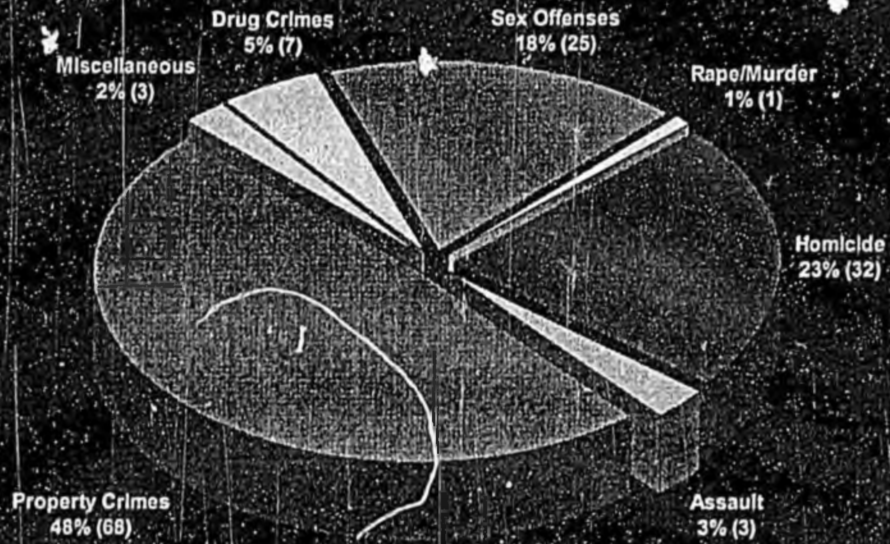
Virginia's DNA Database

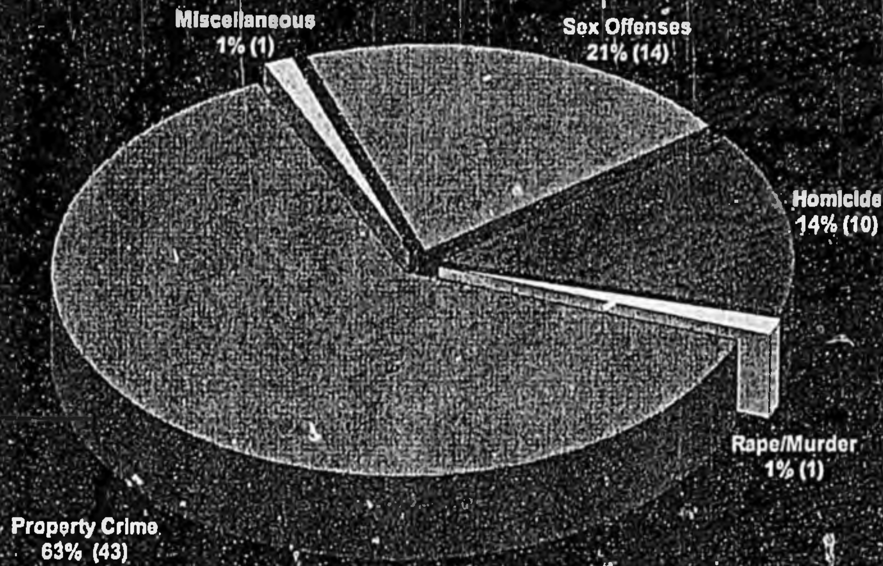
- 1998 5 cold hits
- 1999 74 cold hits
- 2000 178 cold hits
- 2001 308 cold hits
- 2002 445 cold hits

Crimes Solved/Assisted by Type

Sex 266
Sex/Homicide 12
Homicide 125
B+E/Burglary/GL/Robbery 618
Miscellaneous 120




Virginia's "Cold Hits" on the DNA Database
Drug Possession Only to Type of Crime Solved
Drug Crimes
5% (7)
Sex Offenses
18% (25)
Miscellaneous
2% (3)
Rape/Murder
1% (1)
Homicide
23% (32)
Property Crimes
48% (68)
Assault
3% (3)
* Numbers as of October 31, 2002


Virginia's "Cold Hits" on the DNA Database
Forgery to Type of Crime Solved
Miscellaneous
1% (1)
Sex Offenses
21% (14)
Homicide
14% (10)
Rape/Murder
1% (1)
Property Crime
63% (43)
* Numbers as of October 31, 2002

Virginia's DNA Database

- 82 % of "hits" would have been missed if the Databank was limited to only violent offenders
- Approximately 38% of violent crimes solved were perpetrated by individuals with previous property crime convictions
- DNA Databases are most effective with inclusion of all felons and applied to all forms of cases

Virginia DNA Database

1998	26,090	Samples	30	Hits
2003	191,017	Samples	1,131	Hits

Alaska DNA Database

2003	3,555	Samples	30	Hits

Why Expand Offender Databases?

- Catch More Criminals
- Exonerate the Innocent
- Protect Public Safety
- Very Cost Effective

2003 Congressional Budget As Passed Congress Feb. 14 2003

✓ Crime Lab Improvement Program (CLIP)	$40.538 M
✓ Coverdell Forensics Science Improvement	$ 5.0 M
✓ Committed non-DNA "Soft" Earmarks	($30.14 M)
⇨ **Funds Remaining for non-DNA Grants**	**$15.39 M**
✓ DNA Backlog Elimination Act	$36.0 M
✓ Committed DNA "Soft" Earmarks	($ 7.9 M)
⇨ **Funds Remaining for DNA Grants**	**$28.1 M**
Convicted offender $15 million	
Unsolved Casework $13.1 million	

✓ $4 million to the FBI for four regional mitochondrial DNA labs

President Bush's Proposed 2004 Budget

DNA Provisions

President / Attorney General "DNA Initiative"

- ✓ $232.6 Million for FY 2004
- ✓ Continued funding for five years
- ✓ Total commitment of over $1 billion

Safeguards of DNA process

- Laboratories performing analyses are accredited
- Lab procedures are strictly controlled and reviewed
- All hits to convicted offenders are confirmed
- CODIS computers and lines are very secure
- DNA profiles provide no health or genetic information

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Alaska Civil Liberties Union

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Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

To: Senate Judiciary Committee
From: Jennifer Rudinger, Executive Director
Date: Friday, May 2, 2003

Re: (CS)HB 49: DNA collection from persons convicted of a felony

The Alaska Civil Liberties Union opposes (CS)HB 49 and respectfully urges this Committee to put an end to the progressive expansion of DNA collection by the government. DNA collected from one person not only reveals personal information about that individual (much of which has nothing to do with serving the needs of law enforcement), but it also reveals very personal information about that individual's blood relatives. Unlike fingerprinting, which *only* reveals information that can be used for identification purposes, DNA gives the government control over a great deal of personal, private information about anyone related to the sample source. Therefore, expansion of the government's power to collect DNA from its citizens – even people convicted of crimes – should not be taken lightly. (CS)HB 49 proposes to invade the privacy of innocent people, and the government's only justification is that anyone convicted of a felony *might* later commit violent crimes in which they leave DNA evidence at the crime scene.

To give the Committee some background, DNA testing and profiling are becoming increasingly more common. States across the country and the federal government are expanding the scope of their DNA data banks as scientific knowledge about the content of this genetic material is growing by leaps and bounds.

In October 1998, the FBI opened a national database that brings together the DNA records from all 50 states and the federal government into one centralized system, known as CODIS (Combined DNA Index System). If this trend is allowed to continue, the most intimate and personal information about each individual could routinely become a matter of public record, to be used and abused at the state's discretion.

Initially, these DNA storehouses were created to house information about convicted sex offenders exclusively. The argument was that sex offenders were especially prone to recidivism, typically left DNA evidence at the crime scene, and hence, were important to identify. Whether or not that argument was sufficient, we were assured at the time that only convicted sex offenders would be tested, and the information gleaned from these tests would be used by law enforcement officials strictly for identification purposes.

But it is often the case that information initially collected for one, limited purpose is before long used for many other purposes. Slowly and inexorably, the pool of people being tested, and the range of uses for the data, has been expanding, raising grave

concerns for personal privacy. In just a decade, law enforcement officials across the country have gone from advocating collection of DNA from only convicted sex offenders, to all violent offenders, to all burglars, to all persons convicted of any crime, to all juvenile offenders. In many states, the DNA record is maintained even if a conviction is overturned.

Louisiana has gone a step further. A parrish in Louisiana collects DNA data from everyone *arrested* for certain felonies -- before they have been convicted. In Louisiana, this record can be kept even if the person is found innocent. Former U.S. Attorney General Janet Reno asked the National Commission on the Future of DNA Evidence to look into the possibility of applying this concept across the country. In December 1998, New York City Police Commissioner Howard Safir jumped on the bandwagon, proposing the same idea. And New York's former Mayor Rudy Giuliani not only voiced his support for the proposal, but went so far as to say that he would support the collection of DNA samples from all babies at birth, giving the city a genetic database of all its citizens.

The collection of DNA samples and the creation of DNA data banks have legitimate and vital medical, scientific and forensic purposes. Research can lead to treatments and even cures for many genetic diseases. DNA can prove that an individual was at the scene of a crime. It can also prove the innocence of a suspect, preventing terrible miscarriages of justice. DNA can even be used to correct wrongful convictions based upon an erroneous identification (although law enforcement and prosecutors seem decidedly less enthusiastic about this use).

But it is equally clear that there is tremendous potential for abuse. The vast amount of information to be gleaned, the incredible longevity of DNA samples, and the ease with which DNA databases can be shared and accessed raise grave privacy, equality and due process concerns. Though DNA has been touted as a high-tech equivalent to fingerprints, this comparison is dangerously misleading. Where fingerprints can be used for identification purposes only, DNA samples (the actual blood, saliva or hair) can provide insight into a breathtaking wealth of singularly private information -- information about a person's ethnicity, family relationships, family history and the likelihood of getting some 4,000 genetic conditions and diseases. This information belongs to each individual, not the government. Further, geneticists are constantly increasing the database of information that can be gleaned from DNA -- some even claim that there are genetic markers for "criminal tendencies," sexual orientation, substance abuse, etc. The possibilities -- and thus the dangers -- are endless.

Today, the growing law enforcement databases raise the immediate specter of widespread discrimination. Given the over-targeting of Alaska Natives, African Americans, Latinos and other minorities within the criminal justice system nationwide, the government will have the disproportionate power to track millions of people of color.

Now the sponsor of (CS)HB 49 wants the Alaska Legislature to expand DNA sampling to include convicted felons, including felony shoplifters, felony DWI, felony weapons violations and forgery. This will help identify more violent criminals in the

future, proponents say. Claiming that this is a minor and necessary expansion of the present system, proponents ask, "What's the harm?"

Because genetic information pertains not only to the individual whose DNA is sampled, but to everyone who shares in that person's blood line, potential threats to genetic privacy posed by their collection extend well beyond the millions of Americans whose samples are currently on file. Moreover, there is no requirement in (CS)HB 49, in the Alaska Statutes, or in federal law that the DNA sample from which genetic information is taken ever be destroyed. This allows for the future possibility that all of the information could be used in other ways that we cannot even anticipate.

There is a long and unfortunate history of despicable behavior by governments toward people whose genetic composition has been considered "abnormal" under the prevailing societal standards of the day. While the FBI states that this information will be used for limited forensic purposes, the history in our country is that information compiled for one purpose will be used for another. For example, Social Security numbers were initially intended only for use as an aid tracking social security payments but are now a universal identifier. Another example, Census records created for general statistical purposes were used to round up innocent Japanese Americans and place them in internment camps during World War II.

Your constituents throughout Alaska are concerned about the government's ever-increasing control over their personal information, and their concerns cross party and ideological lines. The Alaska Civil Liberties Union fields inquiries virtually every week regarding the government's demand for personal information – Social Security numbers, Census information, background checks, DNA and genetic information, etc. Almost every week, Alaskans voice concerns that the government cannot be trusted to keep this information confidential or to limit its use to the initial purpose for which it is given. And we agree. Your constituents are right.

In conclusion, (CS)HB 49 does not "only" affect convicted felons – it affects their relatives, who are law-abiding citizens innocent of any crime. And the government's proposed justification for collecting DNA from such a broad array of people just doesn't fly in Alaska – we do not take DNA from people who have never committed a violent crime on the theory that someday they *might* commit a violent crime. If so, where will this end?

Please end it here and now. Please do not pass (CS)HB 49 out of Committee. But in the alternative, if you are going to expand the government's collection of people's DNA as broadly as this bill requires, please make two important changes to the bill to protect Alaskans' civil liberties and to address the privacy concerns raised by your constituents who contact the AkCLU daily:

1. **The bill should be amended at Section 7(f)(2) to delete the words "law enforcement purposes including" so that it reads only "criminal investigations and prosecutions;".** This section is intended to impose limits on what law enforcement can do with our DNA, to prevent abuses and to safeguard our privacy. But the phrase "law enforcement purposes including criminal investigations and prosecutions" imposes no real

limitations. This is analogous to saying "the alphabet including the letters H and Q." There are 24 other tools in that arsenal covered by the word "alphabet," and the fact that they are not listed does not mean that they may not be used. If there are other "law enforcement purposes" being authorized besides criminal investigations and prosecutions, the Legislature ought to know exactly what they are before authorizing this massive expansion of our DNA database. The current law gives law enforcement carte blanche to decide for itself what purposes it deems to be law enforcement purposes, and this does not allow for the Legislature or the people to hold law enforcement accountable for their use of our DNA.

2. **The bill should be amended to require the destruction of the DNA sample (the drop of blood, saliva or the strand of hair) within a reasonable period of time post-conviction, after the DNA has been coded and entered into the law enforcement database.** This does not mean that the data will be removed from the database. The identification markers would remain in the database permanently, as is currently the case. But once a person has been convicted and their DNA is entered into the database, there is no compelling justification for law enforcement to retain the actual samples forever. These samples contain the sensitive, private information not only about the sample source but also everyone related to that person by blood – and these relatives are innocent of any crime! The government should not have indefinite access to information about innocent people's genetic make-up. If the sample source were destroyed, this would go a long way toward alleviating Alaskans' concerns about personal privacy and the potential for future misuse of our DNA.

Thank you very much for your consideration of this important matter. Please feel free to contact me if you wish to discuss this further. I can be reached in Anchorage at 258-0044 or by email at akclu@alaska.net.

MAY - 7 2003

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary Com.
Committee name

Committee on SB30, dated 5-3-03
Bill/Subject

17 PAGES

Double Sided

Legislative Information Office
600 E. Railroad Avenue
Wasilla, Alaska 99654

Signed: Karen Vosburgh
Testifier

AK. Right to Life 3400 Spenard Ste. 4 Anchorage, AK. 99503
Representing (Optional)

PO Box 1847 Palmer, AK 99645
Address

907-746-6727
Phone number

Karen Vosburgh

From: "Steven Ertelt" <ertelt@prolifeinfo.org>
To: "Pro-Life Infonet" <infonet@prolifeinfo.org>
Sent: Tuesday, April 23, 2002 11:08 PM
Subject: [Infonet-List] Pro-Life Infonet 4/24/02 #2694

Today's Headlines:

New Study Finds Abortion Risks Higher Than Expected
Media Bias on Adult Stem Cell Research Continues

From: The Pro-Life Infonet <infonet@prolifeinfo.org>
Reply-To: Steven Ertelt <infonet@prolifeinfo.org>
Subject: New Study Finds Abortion Risks Higher Than Expected
Source: The de Veber Institute; April 23, 2002

New Study Finds Abortion Risks Higher Than Expected

Toronto, CA -- Abortion complications are seriously underreported, leaving women who undergo abortion largely unaware of the range of physical and psychological risks they face, according to a new study by a Canadian bioethics institute.

Breast cancer, pelvic infection, infertility, life-threatening ectopic pregnancy, and subsequent premature births - with higher rates of children born with cerebral palsy - were found to be associated with abortion in a comprehensive review of the world medical literature. Abortion complications were not limited to physical health. While abortion is often regarded as a cure for the depression and stress of a crisis pregnancy, the study found that women are more likely to commit suicide after abortion than after giving birth to a child.

Current abortion rates of 114,000 in Canada and 1.4 million in the U.S. underscore the magnitude of this potential public health issue.

" In the absence of this knowledge, how can a woman give her informed consent to an abortion?" asks Ian Gentles, history professor at York University in Toronto, and one of the authors of the study entitled Women's Health after Abortion: The Medical and Psychological Evidence, published by the deVeber Institute, a nonprofit bioethics and social

research group based in Toronto. Elizabeth Fox-Genovese, Emory University professor of humanities and women's studies, calls the findings "compelling", and says the study "makes overwhelmingly clear [that] women who seek abortions in the United States and Canada are not even told of the risks they are running."

The study calls for a more accountable system of risk assessment where research data accurately reflect the true risks of abortion to their future health and fertility.

Key abortion risks

An extensive review of the world medical literature reveals abortion is associated with:

* Suicide risk

A woman's risk of suicide is up to 6 times higher after abortion than after giving birth to a child, according to three large worldwide studies.

Gissler M et al. Suicides after pregnancy in Finland 1987-94: register linkage study. British Medical Journal 1996 Dec. 7;313(7070):1431-4.

* Breast cancer

27 worldwide studies, including 13 U.S. studies, show the risk caused by the unprotected internal estrogen exposure a woman receives after an abortion. A young woman who aborts her first pregnancy nearly doubles her lifetime risk of developing breast cancer.

Daling JR et al. Risk of breast cancer among young women: relationship to induced abortion. Journal of the National Cancer Institute 1994 Nov(2);86(21):1584-92.

* Immediate complications

Pain, bleeding, infection, perforated uterus, and occasional death occur at rates higher than usually reported. True rates are often underestimated by inadequate hospital diagnostic coding. Such as deaths caused from an abortion are categorized under "maternity" death.

Heisterberg L, Kringelbach M. Early complications after induced first-trimester abortion. Acta Obstetricia et Gynecologica Scandanavica,1987;66(3):201-4.

* Infertility, prematurity, cerebral palsy

Subsequent infertility, life-threatening ectopic pregnancy, and premature delivery of subsequent children - which increases the risk of cerebral palsy 38 times in the earliest premature babies.

Escobar GJ et al. Outcome among surviving very low birthweight infants: a meta-analysis. Archives of Disease in Childhood 1991;66:204-211.

To order the study from the deVeber Institute visit the website: http://deveber.org/publications2.html#launch

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The Pro-Life Infonet is a daily compilation of pro-life news and information. To subscribe, send the message "subscribe" to: infonet-request@prolifeinfo.org. Infonet is sponsored by Women and Children First (http://www.womenandchildrenfirst.org). For more pro-life info visit http://www.prolifeinfo.org and for questions or additional information email ertelt@prolifeinfo.org

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From: The Pro-Life Infonet <infonet@prolifeinfo.org>
Reply-To: Steven Ertelt <infonet@prolifeinfo.org>
Subject: Media Bias on Adult Stem Cell Research Continues
Source: National Review; April 23, 2002

Media Bias on Adult Stem Cell Research Continues
by Wesley Smith

[Pro-Life Infonet Note: Wesley Smith Smith is the author of Culture of Death: The Assault on Medical Ethics in America. His next book will be A Consumer's Guide to Brave New World, a discussion of the business, science, and morality of human cloning.]

The pattern in the media reportage about stem cells is growing very wearisome. When a research advance occurs with embryonic stem cells, the media usually give the story the brass-band treatment. However, when

John Kindley J.D.

Biography | ABC Facts | Dr. Weldon's letter | Executive Summary

Wisconsin Law Review | Litigation | Links | Wisconsin

Author of 'The Fit Between the Elements for an Informed Consent Cause of Action and the Scientific Evidence Linking Induced Abortion with Increased Breast Cancer Risk,' 1998 Wisconsin Law Review, Pages 1595-1644.

The above article was distributed in August 1999 to every member of the House of Representatives by U.S. Rep. Dave Weldon, R-Fla., a physician who described it in an accompanying letter as making a "persuasive case for the potential legal liability of abortion providers who do not inform women about the prospect of increased risk for breast cancer following an induced abortion." An Executive Summary of this article as well as the complete article are posted on this site.

Scientists have long suspected that the hormonal disruption that occurs when a woman's pregnancy is artificially interrupted leaves the breasts with an abnormally high number of cells vulnerable to cancerous mutation. The first American study on abortion as a risk factor for breast cancer was published in 1981 and reported that abortion "appears to cause a substantial increase in risk of subsequent breast cancer." Almost two decades later, thirteen out of fourteen American studies bear out this early warning, but to this day women considering abortion are still not informed about this significant health threat.

In fact, the Red River Women's Clinic, an abortion provider in Fargo, North Dakota, was until recently not only failing to warn women about the abortion-breast cancer link, but actually distributing to prospective customers a pamphlet that included the following false statement: "Anti-abortion activists claim that having an abortion increases the risk of developing breast cancer and endangers future childbearing. **None** of these claims are supported by medical research or established medical organizations." (Emphasis in original.)

I am lead counsel in a suit filed in December 1999 to enjoin this clinic from its false advertising. This suit was brought on behalf of women considering abortion and the general public, and thus seeks prospective relief rather than money damages. A woman who has already had an abortion, without being told that it would increase her risk of breast cancer, may be able to sue the abortion provider for compensatory and/or punitive damages, even if she has not yet developed breast cancer. Indeed, women in several states are now considering suing their abortion providers for failing to warn them about the abortion-breast cancer link.

It is time for the American people to decide for themselves whether the evidence is such that it warrants disclosure. As noted by Marcia Angell, M.D., executive editor of the New England Journal of Medicine, it is a "false belief that medical research is somehow too

complex to be understood by nonscientists." I am convinced that once juries have the opportunity to hear fully both sides of this scientific controversy they will agree that women had a right to know about this evidence decades ago.

Please e-mail me with any questions or suggestions, especially if you:

1. know a woman who has had an abortion and might need a referral to a medical malpractice attorney in her state;
2. know an attorney who might be interested in taking cases based on the cause of action outlined in my law review article;
3. would like to help raise necessary funding for the costs of pending litigation;
4. are interested in spreading the word about these health and legal issues and would like to order informational materials for this purpose.

John Kindley is a Wisconsin licensed attorney. While the information on this site is about legal issues, it should not be construed as legal advice.

You may contact me at jkindley@johnkindley.com
Phone: (608) 294-6936
This page was last updated on 03/11/00

Fri, Aug 30, 2002 9:30 AM

From: Elliot Institute News <dreardon@mine4ever.net>
Reply-To: Larry Wilson <lwilson@xc.org>
To: Elliot Institute News <ei-news@ds.xc.org>
Date: Tuesday, August 27, 2002 7:51 PM
Subject: Abortion Elevates Women's Mortality Rate, New Study Shows

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ABORTION MAY INCREASE WOMEN'S MORTALITY RATE

New Study Shows Women's Death Rate Following Abortion Much Higher than Previously Known

Springfield, IL A study published in the latest issue of the Southern Medical Journal reveals that women who have abortions are at significantly higher risk of death than women who give birth. This finding contradicts the widely accepted opinion that abortion is safer than childbirth.

Researchers examined death records linked to Medi-Cal payments for births and abortions for approximately 173,000 low income Californian women. They discovered that women who had abortions were almost twice as likely to die in the following two years and that the elevated mortality rate of aborting women persisted over at least eight years.

During the eight year period studied, women who aborted had a 154 percent higher risk of death from suicide, an 82 percent higher risk of death from accidents, and a 44 percent higher risk of death from natural causes.

This is the second major record-based study to link abortion to elevated mortality rates. In 1997, a study of women in Finland sent a tremor of worry through family planning agencies when it revealed that in the first year following an abortion, aborting women were 252 percent more likely to die compared to women who delivered and 76 percent more likely to die compared to women who had not been pregnant.

This new study confirms the trend found in Finland. It is also the first American study to use a uniform and objective standard for associating deaths with prior abortions and births.

Critics of abortion have long complained about the inaccuracies of abortion mortality figures. There are no federal or state regulations requiring the reporting of abortion complications. Indeed, the international standard for identifying cause of death does not even provide a means for identifying surgical abortion as a cause of death.

Another recently published Elliot Institute study using the California data reveals that aborting women also seek more subsequent mental health care. A third Elliot Institute study, published last January in the British Medical Journal, reveals that subsequent long-term clinical depression is more common

karen vosburgh

From: Adam Jezek <adamj@ifrl-pac.com>
To: IFRL Subscription List <listmaster@ifrl-pac.com>
Sent: Wednesday, April 25, 2001 8:23 AM
Subject: IFRL Newsletter Vol 010425 A -- Special Report: Abortion Deaths - Baby and Mother

Illinois Federation For Right to Life Daily News
Date: Wednesday, April 25th, 2001
Volume: 010425 A

The report below has been split up into 5 separate sections, the information is great. I have visited sites all over the internet investigating deaths due to LEGAL abortions. Here is a summary of what I have found. Please take a few moments and read it, and then spread it. The normal news stories will be reported on a later newsletter (Vol 010425 B)

In this issue:
Special Report: Abortion Deaths - Baby and Mother

Part 1: Death by Abortion
Part 2: Illinois Abortion Deaths
Part 3: Aborted Women: Silent No More
Part 4: Abortion Is Not The Answer
Part 5: Sources

Special Report: Abortion Deaths - Baby and Mother
Part 1: Death by Abortion

According to one medical study, "An unfortunate aspect of this procedure is the vast number of complications." The immediate life threatening conditions are heavy bleeding and infection. A British medical journal reports the following.

1. 17% of the patients lost over 500 ml of blood and 9.5% needed transfusions. (Source: 1)

2. 27% suffered infections and fever above 100.4(o), lasting more than 24 hours. (Source: 2)

3. Cervical lacerations occurred in 4.2%. (Source: 3)

4. Perforation of the uterus occurred in 1.2%. (Source: 4)

The article concludes, "This emphasizes that the termination of pregnancy is neither as simple nor as safe as some advocates of abortion would have the public believe. Moreover, the incidence of such complications as infertility, recurrent miscarriages, premature labor, ruptured uterus or emotional manifestations cannot be assessed at this stage."

The womb during pregnancy is designed to protect the new life growing there. During an abortion the mouth of the womb, the cervix, is forcibly stretched open. This can tear the cervix, making the woman far more likely to miscarry her next pregnancy.

The powerful suction used in first trimester abortion can scar the uterus, resulting in scarred fallopian tubes, tubal pregnancies or sterility. It can also cause placenta previa. If an abortionist is too gentle with the suction tube he will leave behind parts of the unborn child or placenta - causing infection. If he is too forceful he will tear a hole in the uterus and an emergency hysterectomy may be needed.

Several medical studies of legal abortion are summarized below.

* 4% of women having legal abortions will suffer from a damaged cervix. (Source: 6)

* 5-10% will become sterile. (Source: 7)

* Legalized abortion has resulted in:
a.) a 300% increase in first trimester miscarriages of later pregnancies. (Source: 8)
b.) a 400% increase in second trimester miscarriages of later pregnancies. (Source: 9) Medical - Journal of the [illegible]
c.) a 200% increase in premature births. (Source: 10)
d.) a 700% increase in placenta previs. (Source: 11) American Journal of Obstetrics - Gynecology
e.) a 200% increase in tubal pregnancies. (Source: 12) British Medical Journal

One study estimates that one fourth of all aborted women will not be able to have a normal pregnancy again. After so many women have experienced abortion in this country, any feminist who fails to acknowledge the extent of abortion trauma can justly be accused of indifference to women's pain.

Journal of the American Medical Association

(Source: 13)

More and more, health researchers are noting a dramatic rise in sterility, tubal pregnancies and placenta previa.13 Vanderbilt University Medical Center noted an increase in placenta previa, a condition in pregnancy where the placenta covers the opening of the womb. This can lead to great blood loss to the mother during labor. It can cause death of the mother and death of the baby. Doctors on staff looked into the increase of this condition and found its cause to be the increase of legal abortions. The study concluded that aborted women were 7-15 times more likely to get placenta previa in later pregnancies. (Source: 14)

A doctor in private practice reported on 54 abortion patients ranging in age from 15-19. One of the ghastly stories included that of a 17-year-old girl who experienced bleeding and pain every day after a suction abortion. After four days she went into her bathroom and passed recognizable parts of her unborn child into the toilet. She then fainted and developed severe hysteria. (Source: 15)

Abortion advocates claim that things were worse wnen abortion was illegal. Some have claimed that 5,000 to 10,000 women died each year from illegal abortions. These unsubstantiated figures were advanced first by Dr. F. J. Taussig and then by Dr. Bernard Nathanson when he was co-founder of the National Abortion Rights League. Other abortion advocates admit that these figures are totally false and were used to make abortion acceptable to the public. (Source: 16)

The annual reports on vital statistics reveal the following.

* In 1965 there were 235 deaths from all abortions (legal, illegal and spontaneous). (Source: 17)

* In 1966 this number dropped to 189, in 1967 it was 160 deaths. (Source: 18)

* In 1968 there were 55 deaths from illegal abortions. (Source: 19)

* In 1972 (one year before Roe vs. Wade) there were 48 deaths from illegal abortions. In 1973 there were 33 deaths from induced abortions. (Source: 20)

David Reardon, author of Aborted Women: Silent No More (Loyola University Press, 1987), carefully tabulates statistics from the U.S. and Europe and finds a distressing portrait of female loss and pain. In three studies he

cites, ectopic pregnancies increase after abortion 200%, 300%, as much as 800%. For every 100,000 ectopic pregnancies, there are 300 rupture/hemorrhage deaths. Ironically, abortion advocates distort these figures to prove that pregnancy is dangerous.

Reardon's book further exposes the lie that abortion is safer than childbirth. It is no surprise that abortion providers have tried to set our minds to rest by providing the political push to eliminate uniform legal requirements for reporting abortion related deaths. In the years when there was an accurate reporting procedure, Oregon reported 14 deaths per 100,000 legal abortions, compared with 8 maternal deaths per 100,000 live births. Maryland reported 40 deaths per 100,000 abortions, compared to 23 maternal deaths per 100,000 live births. In Sweden and Denmark, abortion mortality rates are twice the maternal death rate and conditions are safer there.

Here are some specific cases of women who died from their legal abortions:

1. Women's Care Center in Miami killed four mothers and their babies from 1979-83. (Source: 21)

2. In Los Angeles, a 16-year-old Hispanic girl bled for five hours during an abortion of her six-month-old unborn baby and died of cardiac arrest. Her family filed a lawsuit against Dr. Edward Allred, charging that her death resulted from negligence caused by his anti-Hispanic bigotry documented in local newspapers. (Source: 22)

3. Dr. James Franklin of Denver left parts of an unborn child inside a 26-year-old patient. When she went home she was packed with gauze and was bleeding profusely. She died two days later of a massive infection. (Source: 23)

"Nearly 80% of the women surveyed believed they were denied information or were actively misinformed by their counselors prior to their abortions ... nearly 50% complained that they were not told about fetal development."

- David Reardon

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On the IFRL Web Site at: http://www.ifrl.org/newstory/667

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Linda languished and died after an abortion performed New Years Day.

Kathleen Gilbert
Kathleed bled to death from a perforated uterus after her abortion.

Sylvia Moore
On New Years Eve, abortionist Arnold Bickham called the dying Sylvia "lazy" when she was too weak from hemorrhage to stand up after her abortions. He literally shoved her out the clinic doors to bleed to death.

Dorothy Muzorewa
Dorothy's husband didn't even know about her abortion. He came home to find her dead in a blood-spattered apartment.

Legalization was supposed to stop women from dying. The experiment failed. (Source: 31)

On the IFRL Web Site at: http://www.ifrl.org/newstory/668

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Just visit either of the IFRL Web Sites at: http://www.ifrl.org or http://www.ifrl-pac.com

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Part 3: Aborted Women: Silent No More

The emotional impact of abortion can be as crippling as the physical risks. Some women never bring their grief or guilt to the surface, yet it still affects them. One study of these emotional effects found, "Unresolved feelings of grief, guilt and loss may remain long after an abortion." (Source: 24)

Women may try to artificially numb the intense pain through drinking or drugs. Many go through unexplained depressions and often the relationship with the father of the baby is destroyed.

Women Exploited By Abortion (WEBA) was formed to help women overcome being silenced by their shame and to illuminate the reality of abortion as an assault on women at every level of their existence. WEBA is also a refuge and a source of spiritual and emotional healing where members turn their

pain and loss into personal growth and compassion for others.

Nancy Jo Mann, Founder of WEBA, remembers her saline abortion in Aborted Women: Silence No More: "For two hours I could feel her struggling inside me. But then as suddenly as it began she stopped. Even today I remember her very last kick on my left side. She had no strength left. Despite my grief and guilt I was relieved that her pain was finally over. But I was never the same again. The abortion killed not only my daughter, it killed a part of me."

The following accounts are of women that WEBA has helped. (Source: 25)

* Cindy, 28, was hospitalized for psychiatric disturbances numerous times in the four years following her legal abortion. Four of those times followed serious suicide attempts.

* Terry, 36, has a recurring nightmare in which a child cries out to her in a pleading voice, reaching with tiny arms, until the scalpel falls, leaving only bloody nubs still reaching.

* Lynda was 15 when her mother dragged her, begging and crying, into the abortion mill. She was sedated and her mother signed Lynda's name to a consent form. Lynda has never been emotionally stable enough to return to high school.

* Debbie became pregnant as a result of rape. Following her abortion she suffered complications which culminated in a hysterectomy. Worse than her physical trauma was the realization that, "the man who raped me took a few minutes of my life, but I took my baby's entire life ... I perpetuated the worse crime. How I wish there had been one person who had offered love, support and encouragement."

* Karen Sullivan experienced nightmares, depression and suicidal thoughts the months and years after her abortion. She remembers: "During the abortion I looked down and saw the bits and pieces of my baby floating in a pool of blood. When I screamed, "I killed my baby!" the counselor told me, "Shut up." Today she wonders, "Since when has death become good for us?"

Can the brutality of abortion be a benefit for pregnant teens? Reardon found that those for whom abortion seems therapeutically "indicated," i.e. victims of rape or incest, women too young or poor or troubled, seem to be the ones who suffer most from the trauma of abortion. This finding lays to rest the assumption that legal abortion might be tragic but necessary in the hard

cases.

On the IFRL Web Site at: http://www.ifrl.org/newstory/669

Doing some research? Try searching the IFRL Databases.
Just visit the IFRL Web Sites at http://www.ifrl.org or
http://www.ifrl-pac.com
The IFRL has hundreds of Pro-Life articles, stories and facts stored online waiting for you.

Part 4: Abortion Is Not The Answer

Abortion proponents often claim that a woman denied an abortion may attempt suicide. However, suicide among pregnant women has always been extremely rare. In Ohio there were only two maternal suicide deaths from 1955-1963.26 >From 1938-1958, over 13,500 Swedish were denied abortion. Only three committed suicide. (Source: 27)

While maternal suicide is rare, women often attempt suicide after an abortion. A pediatric journal warned pediatricians to be on the lookout for young teenage girls who attempt suicide after legal abortion.28 In 1981, Meta Uchtman, regional director of Cincinnati Suiciders Anonymous testified before the Cincinnati City Council, "Of over 4,000 that were seen by our group, 1,800 or more had had abortions. (Source: 28)

An American psychiatric journal recorded cases of women who suffered complete disintegration of personality after a legal abortion. (Source: 29)

Another claim we hear is that most women who are refused access to legal abortion will get abortions elsewhere, either out of the country or illegally. This is not true. In Canada, of 6,000 women who were denied abortion, only 13% of them got abortions anyway. The vast majority decided to keep their children. The study found that there were no major psychological problems associated with the women or children they gave birth to. (Source: 30)

Many good, well-intentioned people support abortion because of what the media and the pro-abortionists have been saying: "That it is good for women, that legal abortion is safe, illegal abortion is unsafe, that women will get

abortions anyway", etc.

This nation has been deceived and many of those who are committed to legal abortion do not know all of the facts.

On the IFRL Web Site at: http://www.ifrl.org/newstory/670

Questions, comments, ideas? Drop the editor a line. E-mail him at: adamj@ifrl-pac.com
Need more information on an article? Just ask, info@ifrl-pac.com

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Part 5: Sources:

Pro-life people are not taking the easy way out. Brave and generous behavior can be stressful. Being right does not ensure personal peace.

Nobody should make moral judgments purely on the basis of the resultant pleasure or pain. Abortion is wrong not because it will bring pain, though it will. Protecting human life is right because it preserves what God creates for His eternal purpose.

Information for this Report taken from...

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7 Thomas Hilgers, MD, Induced Abortion, A documented Report (1976).
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9 Medical Journal of Australia (6/2/79), pp. 479-80.
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26 "Maternal Deaths Involving Suicide," Ohio State Medical Journal (December 1966) p. 1294.
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31 Life Dynamics' "Tombstone Project"
32 About.com

Some Reporting by Media House International

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Their Own Words

Editor: The chair of the Maryland Religious Coalition for Abortion Rights (Rev. Matthew McNaught, letters, Feb. 3) should consult Planned Parenthood's 1990-1993 three-year plan.

Its authors note recent studies which have "shown that the incidence of post-procedural trauma for abortion clients may be as high as 91 percent of all cases."

They then acknowledge that "recent unpublished reports from the Alan Guttmacher Institute indicate that the scope of the problem may have been accurately tabulated in these studies." The rest of the document indicates that Planned Parenthood intends to try to defuse this "volatile political dilemma" by proving that it's not abortion but the pro-life movement that is creating this trauma.

Planned Parenthood is right in calling post-abortion trauma a "volatile . . . dilemma," but it's a dilemma of the heart and mind — not merely a "political" game-piece in the abortion wars.

The Roman Catholic Church has reached out to grieving aborted women for years and years through "Project Rachel" post-abortion counseling.

And no matter how much the country's largest abortion provider, Planned Parenthood, and the Religious Coalition for Abortion Rights try to wish away post-abortion trauma because it's bad for abortion politics, our experience counseling thousands of women tells us it will not go away until abortions are no more.

Helen M. Alvare.
Washington.

The writer is director of planning and information for the National Conference of Catholic Bishops' Secretariat for Pro-Life Activities.

MORNING SUN 3/[illegible]

Baltimore Sun newspaper

Alaska State Legislature

Please enter into the record my testimony to the Judiciary Committee
Committee name

Committee on SB 30, dated 5-2-03
Bill/Subject

The creation of an unplanned pregnancy equally involves two people, a male and female. Yet, in effect, SB 30 only holds the female accountable. Until ~~[illegible]~~ public policy imposes comparable restrictions on male sexual behavior, abortion-restrictive policies on women are discriminatory.

When I say "No" on SB 30, that doesn't really mean "maybe."

Signed: Barbara McDaniel
Testifier

Representing (Optional)

PO Box 520324 Big Lake, Ak 99652
Address

373-6977
Phone number

MAY - 7 2003

Alaska State Legislature

Please enter into the record my testimony to the S. Jud
Committee name

Committee on SB30, dated 5/2/03
Bill/Subject

I strongly endorse SB30!
I feel the women of alaska have
been victimized, as well as the unborn
baby, who perhaps would have lived
if the mother (and parents of the
pregnant women) had known the true
implications of the abortion procedure!
Speaking as a "former fetus", I of
course would wish abortion to be
totaly out lawed, except in cases of
medical emergency -

Signed: Eileen O Johnson
Testifier

the unborn
Representing (Optional)

501 KMK GOOSE BAY Rd.
Address

WASILLA ALASKA 99654
Phone number
907-373-1139

LEGISLATIVE AFFAIRS AGENCY
Fairbanks Legislative Information Office
119 N. Cushman St. Suite 101
Fairbanks, Alaska 99701

MAY - 7 2003

Please enter into the record our testimony concerning *"A Woman's Right to Know" SB 30* and *HB 292* on 2 May 2003...

We support these informed consent bills which are just common sense. People who consider themselves to be pro-choice are opposing these bills even though the bills would provide an informed choice. How can a woman make a choice whether or not to abort her preborn baby if it is not required that she have access to the information necessary before she makes the choice including a period of time to think about her choice.

Within all other surgeries there is a requirement to sit down and provide the information, the risks, a second opinion, and time to decide, but, this has not been required with abortion, an invasive surgery with great risks. And so-called pro-choicers do not want the woman to know her risks, etc. but to move forward blindly.

The risks of abortion have been researched and documented in many sources. The following is by Dr. Burns, D.O., Dr. Carroll, M.D. and Dr. Graeser, D.O. This information is documented at http://www.ohiolife.org/ The title of their research is "You're Considering an Abortion...What Can Happen to You?" There are complications that have happened and can happen with an abortion including injury and death. Some of the injuries are bladder injury, bowel injury, laceration of the cervix, perforation of the uterus, retained products of conception, severe-rapid bleeding. Complication rates increase with younger, teen-age women. However, younger women who carry their babies to term have better births than older women if they get proper care. They can then adopt out the baby and be physically healthier.

Post-abortion syndrome is difficult to measure yet has caused havoc within families. Although pro-choicers and doctors deny this, frequently after an abortion, women suffer a range of mental and psychological problems. These may include recurrent dreams of the abortion experience, avoidance of emotional attachment, relationship problems, sleep disturbances, guilt about surviving, memory impairment, hostile outbursts, suicidal thoughts and actions, depression and substance abuse. These problems may occur days to years later.

Sterility and abnormal deliveries have occurred after abortions as effects on future pregnancies. I have personally known people who have aborted their babies and can no longer bear children. One of the most serious aftereffects of abortion is the later occurrence of breast cancer. Pro-choicers and many doctors have been in denial concerning this but the documented evidence is increasing. Many women have died, others are waiting for this cancer to materialize. The medical problem is with the interruption in the pregnancy causing the mammary glands to stop growing, but material is leftover due to the interruption from abortion. With a miscarriage or natural birth, the body would naturally dissolve the tissue. Within this tissue cancer can occur. Women who have aborted have significantly higher rates of breast cancer later in life. Breast cancer has risen by 50% in America since abortion became legal in 1973.

Dr. Warren Hern, a world renowned abortionist states: ***"In medical practice, there are few surgical procedures given so little attention and so underrated in its potential hazards as abortion. It is the commonly held view that complications are inevitable."***

Sincerely,

Jonathan and Ruth Ewig
2325-30th Avenue
Fairbanks, AK 99701
Phone/fax: 907-452-5538.

Margaret Seeley
#142
3875 Geist Road, Suite E
Fairbanks, AK 99709

TESTIMONY RE. S.B. 30 ENTITLED "A WOMAN'S RIGHT TO KNOW"

I would like to express my support for S.B 30 regarding informed consent. A woman and, especially young girls, must be provided both with complete information and time to think before undergoing an abortion. Any woman experiencing an unplanned and unwanted pregnancy is naturally in a very vulnerable emotional and mental state. Many women are pressured by their boyfriends, friends, or family into *"getting rid of the problem"* by undergoing a hasty abortion. This may solve the immediate "problem" of the unwanted child, but it may also result in long-term emotional and/or physical problems for the young woman.

Having an abortion is very serious business. It is a decision that should never be made in ignorance, fear or haste. Woman have a right to know all the possible consequences of such a serious matter.

Please vote yes on S.B. 30, A woman's right to know."

Sincerely,

Margaret Seeley

LEGISLATIVE INFORMATION OFFICE
PO Box 1189
Room 221, Jarvis Office Center
Delta Jct., AK 99737
Phone: 895-4236 Fax: 895-5017

MEMORANDUM

DATE: May 2, 2003
TO: Senate Judiciary Committee

FROM: Elizabeth A. Sarver eas
Legislative Information Officer

SUBJECT: Testimony for Senate Judiciary Committee

Please accept the enclosed original(s) of written testimony for the House State Affairs committee hearing that was scheduled for 05/02/03.

Copies of this testimony were transmitted by fax on 05/02/03.

Thank you.

Enclosures: 2

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary
committee name

committee on SB 30, dated 5/2/03.
bill/subject

SB30 is about empowering women to make informed choices. It is about respecting a woman's intelligence enough to give her the tools necessary to make an educated choice. Many women must resort to making the decision about having an abortion based on outside pressure rather than revelatory information. This pressure may come from a variety of sources, but it often comes from within the medical profession itself. I have heard many stories of women being coerced by members of the medical profession into having an abortion.

SB30 puts this very important decision back into the hands of the ones it most effects. I doubt there is any other medical procedure which we administer, while purposely withholding knowledge that would insure the patient is as informed as possible on the scietific facts, medical hazards, and emotional and psychological risks of the procedure. Anyone truly concerned about women's rights should be fighting for the support of this bill.

Thank you,
Ruth Abbott
Delta Jct.

Signed: Ruth A. Abbott
Testifier

Representing (Optional)

HC 60 Box 4225 Delta Jct. AK
Address
(907) 895-2002
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary
committee name

committee on SB30 / Informed consent, **dated** 5/2/03.
bill/subject

I want to urge you to vote for SB30. Even tho' this may be called the information age - not all of us know about medical procedures. I'm a housewife - never did want to go to medical school, but if I need a doctor's help with something I expect to be told all the angles and options. In fact 5 years ago my OB doctor saw a spot on my skin that concerned him so much that right then he himself escorted me to see another doctor in the building. Then he went out to the parking lot to bring my husband up and the second doctor wouldn't let us leave until we signed a paper saying we understood how serious skin cancer could be. They did not assume I knew about skin cancer but took the time to educate me a little. Ultimately, the patient makes the final choice and how much better if she can make an informed one?

Again, I urge you to pass SB30. Thank-you

Signed: Linda Bowdre
Testifier

Representing (Optional)

P.O. Box 1048 Delta Jct. AK
Address

895-4328
Phone No.

SB

41

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN

MEMORANDUM

To: Senator Ralph Seekins, Chair
Senate Judiciary Committee

From: Senator Lyda Green
Sponsor, SB 41

Date: March 25, 2003

Re: Request to Schedule SB 41 in Senate Judiciary Committee

This memo is to request a hearing of Senate Bill 41, an act relating to medical care and crimes relating to medical care, in the Senate Judiciary Committee at your earliest convenience. Attached are a copy of CSSS SB 41(HES) and a packet of background material.

I have also attached a work draft of a blank committee substitute (version S) that I would appreciate being considered by the Judiciary Committee for discussion. The changes proposed in this work draft are intended to address concerns expressed to my office by both the public and other state agencies.

Included in the packet is an MS Word document that tracks the changes between CSSS SB 41(HES) and the work draft of the blank committee substitute (version S). This document is offered so committee members can easily see the proposed changes.

Please contact my aide, Traci Carpenter at 465-3841, if she can be of assistance. Thank you for your consideration.

23-LS0204\S
Lauterbach
3/21/03

CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): **SENATORS GREEN, Taylor, Dyson, Ben Stevens, Ogan, Cowdery, Seekins, Wagoner, Wilken**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to medical care and crimes relating to medical care, including medical**
2 **care and crimes relating to the medical assistance program, catastrophic illness**
3 **assistance, and medical assistance for chronic and acute medical conditions."**

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

5 *** Section 1.** AS 17.30.080(b) is amended to read:
6 (b) A person who violates (a) of this section, or who otherwise manufactures,
7 distributes, dispenses, or conducts research with a controlled substance in the state
8 without fully complying with 21 U.S.C. 811 - 830 (Controlled Substances Act), and
9 regulations adopted under those sections, is guilty of misconduct involving a
10 controlled substance under AS 11.71.010 - 11.71.070 in the degree appropriate to the
11 circumstances as described in those sections. **Upon filing a complaint, information,**
12 **presentment, or indictment charging a medical assistance provider with**
13 **misconduct involving a controlled substance under AS 11.71.140 - 11.71.190, the**
14 **attorney general shall, in writing, notify the commissioner of health and social**

1 **<u>services of the filing.</u>**

2 * **Sec. 2.** AS 17.30.080 is amended by adding new subsections to read:

3 (c) Upon receiving a notice from the attorney general under (b) of this section,
4 the commissioner of health and social services shall immediately undertake a review
5 of all unpaid claims or requests for reimbursements attributable to services claimed to
6 have been provided by the person charged.

7 (d) In this section,

8 (1) "claims" has the meaning given in AS 47.05.290;

9 (2) "medical assistance provider" has the meaning given in
10 AS 47.05.290;

11 (3) "medical purpose" means a purpose that is solely medical as
12 opposed to any other purpose, that is reasonably necessary for treatment of a person's
13 illness, injury, or physical or mental health, and that is provided by a practitioner while
14 acting within the usual course of professional practice or research and in accordance
15 with a standard of care generally recognized and accepted within the medical
16 profession in the United States;

17 (4) "practitioner" has the meaning given in AS 11.71.900.

18 * **Sec. 3.** AS 47.05 is amended by adding new sections to read:

19 **Article 2. Medical Care Programs.**

20 **Sec. 47.05.200. Annual audits.** (a) The department shall annually contract
21 for independent audits of a statewide sample of all medical assistance providers in
22 order to identify overpayments and violations of criminal statutes. The audits
23 conducted under this section may not be conducted by the department or employees of
24 the department. The number of audits under this section each year, as a total for the
25 medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75 percent of
26 all enrolled providers under the programs, adjusted annually on July 1, as determined
27 by the department, except that the number of audits under this section may not be less
28 than 75. The audits under this section must include both on-site audits and desk audits
29 and must be of a variety of provider types. The department may not award a contract
30 under this subsection to an organization that does not retain persons with a significant
31 level of expertise and recent professional practice in the general areas of standard

1 accounting principles and financial auditing and in the specific areas of medical
2 records review, investigative research, and Alaska health care criminal law. The
3 contractor, in consultation with the commissioner, shall select the providers to be
4 audited and decide the ratio of desk audits and on-site audits to the total number
5 selected.
6 (b) Within 90 days after receiving each audit report from an audit conducted
7 under this section, the department shall begin administrative procedures to recoup
8 overpayments identified in the audits and shall allocate the reasonable and necessary
9 financial and human resources to ensure prompt recovery of overpayments unless the
10 attorney general has advised the commissioner in writing that a criminal investigation
11 of an audited provider has been or is about to be undertaken, in which case, the
12 commissioner shall hold the administrative procedure in abeyance until a final
13 charging decision by the attorney general has been made. The commissioner shall
14 provide copies of all audit reports to the attorney general so that the reports can be
15 screened for the purpose of bringing criminal charges.
16 (c) Each fiscal year, the state's share of recovered overpayments obtained
17 because of the required contract audits under this section shall be deposited with the
18 commissioner of revenue under AS 37.10.050 and separately accounted for by the
19 commissioner of administration under AS 37.05.142. The legislature may appropriate
20 a portion of the estimated balance in the account to the department to pay for the
21 annual audits described in this section.
22 (d) As a condition of obtaining payment under AS 47.07 and AS 47.08 and for
23 purposes of this section, a provider shall allow
24 (1) the department reasonable access to the records of medical
25 assistance recipients and providers; and
26 (2) audit and inspection of the records by state and federal agencies.
27 (e) This section does not preclude the department from performing audits that
28 are allowed or required under other laws.
29 **Sec. 47.05.210. Medical assistance fraud.** (a) A person commits the crime
30 of medical assistance fraud if the person
31 (1) knowingly submits or authorizes the submission of a claim to a

1 medical assistance agency for property, services, or a benefit with reckless disregard
2 that the claimant is not entitled to the property, services, or benefit;
3 (2) knowingly prepares or assists another person to prepare a claim for
4 submission to a medical assistance agency for property, services, or a benefit with
5 reckless disregard that the claimant is not entitled to the property, services, or benefit;
6 (3) except as otherwise authorized under the medical assistance
7 program, confers, offers to confer, solicits, agrees to accept, or accepts property,
8 services, or a benefit
9 (A) to refer a medical assistance recipient to a health care
10 provider; or
11 (B) for providing health care to a medical assistance recipient if
12 the property, services, or benefit is in addition to payment by a medical
13 assistance agency;
14 (4) does not produce medical assistance records to a person authorized
15 to request the records;
16 (5) knowingly makes a false entry in or falsely alters a medical
17 assistance record;
18 (6) knowingly destroys, mutilates, suppresses, conceals, removes, or
19 otherwise impairs the verity, legibility, or availability of a medical assistance record;
20 or
21 (7) violates a provision of AS 47.07 or AS 47.08 or a regulation
22 adopted under AS 47.07 or AS 47.08.
23 (b) Medical assistance fraud under (a)(1), (2), or (3) of this section is
24 (1) a class B felony if the portion of the claim or claims submitted in
25 violation of (a)(1) or (2) of this section, or the value of the property, services, or
26 benefit that is in violation of (a)(3) of this section, is $25,000 or more;
27 (2) a class C felony if the portion of the claim or claims submitted in
28 violation of (a)(1) or (2) of this section, or the value of the property, services, or
29 benefit that is in violation of (a)(3) of this section, is $500 or more but less than
30 $25,000;
31 (3) a class A misdemeanor if the portion of the claim or claims

1 submitted in violation of (a)(1) or (2) of this section, or the value of the property,
2 services, or benefit that is in violation of (a)(3) of this section, is less than $500.
3 (c) Medical assistance fraud under (a)(4), (5), or (6) of this section is a class A
4 misdemeanor.
5 (d) Medical assistance fraud under (a)(7) of this section is a class B
6 misdemeanor.
7 **Sec. 47.05.220. Notice of charges.** Upon the filing of a complaint,
8 information, presentment, or indictment charging a medical assistance provider with a
9 crime under AS 47.05.210, the attorney general shall, in writing, notify the
10 commissioner of the filing. Upon receiving notice from the attorney general under
11 this section, the commissioner shall immediately undertake a review of all unpaid
12 claims or requests for reimbursements attributable to services claimed to have been
13 provided by the person charged.
14 **Sec. 47.05.230. Determination of value; aggregation of amounts.** In
15 AS 47.05.210, whenever it is necessary to determine the value of property, that value
16 shall be determined in accordance with AS 11.46.980. In determining the degree or
17 classification of a crime described under AS 47.05.210, amounts involved in criminal
18 acts committed under one course of conduct, whether from the same person or several
19 persons, shall be aggregated.
20 **Sec. 47.05.240. Exclusion from medical assistance programs.** (a) The
21 commissioner may exclude an applicant to or disenroll a medical assistance provider
22 in the medical assistance program in AS 47.07 or AS 47.08, or both, for a period of up
23 to 10 years after unconditional discharge on a conviction
24 (1) for medical assistance fraud under AS 47.05.210 or misconduct
25 involving a controlled substance under AS 11.71; or
26 (2) in a court of the United States or a court of another state or
27 territory, for a crime with elements similar to the crimes included under (1) of this
28 subsection.
29 (b) After a period of exclusion under (a) of this section, an applicant may not
30 participate in a medical assistance program under AS 47.07 or AS 47.08 until the
31 applicant establishes to the commissioner by clear and convincing evidence that t'

1 applicant possesses all required licenses and certificates and is qualified to participate.
2 **Sec. 47.05.290. Definitions.** In AS 47.05.200 - 47.05.290,
3 (1) "benefit" has the meaning given in AS 11.81.900;
4 (2) "claim," in addition to its usual meaning, also means a request for
5 payment for medical assistance services attempted to be provided, provided, or
6 claimed to have been provided to another, whether the request is in an electronic
7 format or paper format or both, made or submitted by a person or an organization that
8 is or claims to be a medical assistance provider;
9 (3) "commissioner" means the commissioner of health and social
10 services;
11 (4) "department" means the Department of Health and Social Services;
12 (5) "falsely alters" has the meaning given in AS 11.46.580;
13 (6) "knowingly" has the meaning given in AS 11.81.900;
14 (7) "makes a false entry" has the meaning given in AS 11.56.820;
15 (8) "medical assistance agency" means the department, an agency of
16 the department, and an agent, contractor, or designee of the department or of one of its
17 agencies that performs one or more of the activities of the department or an agency of
18 the department;
19 (9) "medical assistance program" means a program under AS 47.07 or
20 AS 47.08;
21 (10) "medical assistance provider" or "provider" means a person or
22 organization that provides, attempts to provide, or claims to have provided services or
23 products to a medical assistance recipient that may qualify for reimbursement under
24 AS 47.07 or AS 47.08 or a person or organization that participates in or has applied to
25 participate in a medical assistance program as a supplier of a service or product;
26 (11) "medical assistance recipient" means a person on whose behalf
27 another claims or receives a payment from a medical assistance agency, without
28 regard to whether the individual was eligible for benefits under a medical assistance
29 program;
30 (12) "medical assistance record" means records required to be kept by
31 state or federal law or regulation regarding claims to a medical assistance agency;

1 (13) "organization" has the meaning given in AS 11.81.900;
2 (14) "person" has the meaning given in AS 11.81.900;
3 (15) "property" has the meaning given in AS 11.81.900;
4 (16) "reckless disregard" means acting recklessly, as that term is
5 defined in AS 11.81.900;
6 (17) "services" means a health care benefit available to a medical
7 assistance recipient, including health care benefits provided, attempted to be provided,
8 or claimed to have been provided to another, by a medical assistance provider, or
9 "services" as defined in AS 11.81.900;
10 (18) "unconditional discharge" has the meaning given in
11 AS 12.55.185.
12 * **Sec. 4.** AS 47.07.010 is amended to read:
13 **Sec. 47.07.010. Purpose.** It is declared **by the legislature** as a matter of
14 public concern that the needy persons of this state **who are eligible for medical care**
15 **at public expense under this chapter should seek only** [RECEIVE] uniform and
16 high quality [MEDICAL] care **that is appropriate to their condition and cost-**
17 **effective to the state and receive that care**, regardless of race, age, national origin, or
18 economic standing. **It is equally a matter of public concern that providers of**
19 **services under this chapter should operate honestly, responsibly, and in**
20 **accordance with applicable laws and regulations in order to maintain the**
21 **integrity and fiscal viability of the state's medical assistance program, and that**
22 **those who do not operate in this manner should be held accountable for their**
23 **conduct. It is vital that the department administer this chapter in a manner that**
24 **promotes effective, long-term cost containment of the state's medical assistance**
25 **expenditures while providing medical care to recipients.** Accordingly, this chapter
26 authorizes the **department** [DEPARTMENT OF HEALTH AND SOCIAL
27 SERVICES] to apply for participation in the national medical assistance program as
28 provided for under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act).
29 * **Sec. 5.** AS 47.07.074(a) is amended to read:
30 (a) As a condition of obtaining payment under AS 47.07.070, a health facility
31 shall allow

1 (1) the department and the commission reasonable access to the
2 [FINANCIAL] records of medical assistance **recipients and providers**
3 [BENEFICIARIES]; and
4 (2) audit and inspection of **the** [FINANCIAL] records by state and
5 federal agencies.

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SS SB 41 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: MEDICAL CARE AND MEDICAID FRAUD
BRU: Medical Assistance Admin
Component: Health Purchasing Group

Sponsor: GREEN
Requester:
Component No. 243

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	66.5	65.7	66.9	68.1	69.4	70.7
Travel						
Contractual		1,024.9	1,045.4	1,066.3	1,087.6	1,109.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	66.5	1,030.6	1,112.3	1,134.4	1,157.0	1,180.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

Fund Source	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
1002 Federai Receipts	49.9	818.0	834.2	850.8	867.8	885.0
1003 GF Match	16.6	272.6	278.1	283.6	289.2	295.0
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0

Estimate of any current year (FY2003) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Full-time	1	1	1	1	1	1
Part-time						
Temporary						

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

This bill creates more accountability from providers, recipients, and the Department of Health and Social Services (DHSS) in the administration of the Medicaid and CAMA programs, primarily through provider audits. The department is ordered to contract for independent financial audits in order to identify overpayments and criminal violations. This bill establishes named criminal acts for medical assistance fraud and corresponding degrees of felony or misdemeanor crimes. This bill provides for disenrollment of a health care provider for fraud or misconduct involving a controlled substance.

Prepared by: Kevin Henderson
Phone 465-5821
Division: Medical Assistance
Date/Time 03/17/2003
Approved by: Joel S. Gilbertson, Commissioner
Date 03/17/2003
Agency: Department of Health and Social Services

(Revised 9/2002 OMB)

FISCAL NOTE
FN #

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CS SS SB 41 (HES)

ANALYSIS CONTINUATION

ESTIMATED EXPENDITURES

The department has limited experience with contracting for provider audits. Audits for which DHSS has contracted in the past did not include the search for illegal activity required by this bill. Factoring in our limited experience, we make the following assumptions:

The .75% sample of all enrolled providers required by this bill means at least 75 providers would have to be audited each year. We estimate that two of the provider audits would be medical facilities, which require a more complex audit. The remaining 73 providers chosen by the contractor would be a cross section of provider types who exhibited characteristics that indicate recovery was likely.

To estimate the cost of an audit, we started with the historical cost of both facility and non-facility audits and increased that amount by 50%. This increase is to compensate for the added requirements of this bill, including the search for illegal activity, using a contractor with attorney staff, and the higher cost of short term contracting with a firm large enough to complete the complexity and number of audits required. The FY04 base cost of a facility audit is $26,100 per audit and there would be at least 2 of these completed per year. The base cost of a non-facility audit is $13,050 and there would be at least 73 of these per year.

DMA would require one full-time auditor (Range 16) to coordinate the non-facility audits, assist in management of the contract, and coordinate fair hearings as a result of DMA recovery enforcement. Additional administrative costs of equipment, supplies, office space, travel, etc are factored in.

Expenditures are anticipated to grow at an annual rate of 2%. Federal Medicaid match is calculated at 75%.

FISCAL NOTE
FN #

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CS SS SB 41 (HES)

ANALYSIS CONTINUATION

ESTIMATE OF RECOVERIES

Of the 75 providers audited each year, we estimate that 75% of them will result in a claim for recovery. We estimate a 1 to 2 ratio of audit costs to recoveries. Historically, for every 1$ of the cost of an audit we recovered $2.

Annual growth in recovery of Medicaid and CAMA is estimated at 4%, which is a balance between inflationary growth in medical costs and a reduction in the frequency of provider violations and related recoveries as the program matures. We anticipate no recovery in FY04, because that year will be needed to develop, advertise, and award a contract for audit and recovery functions. In addition, some regulations changes will be needed in order to make a clear distinction between rate-setting audits and financial/misconduct audits.

Estimated recovery is shown below:

FY04	FY05	FY06	FY07	FY08	FY09
$0	$1,567.5	$1,630.2	$1,695.4	$1,763.2	$1,833.8

Section 3: AS 47.05.200(c) requires recovered overpayments obtained because of an audit to be deposited with the Department of Revenue.

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 41
() Publish Date:

Revision Date/Time (Note if correction):
Title "An Act relating to medical care and crimes relating to medical care, including . . . medical assistance program."
Sponsor Senator Green
Requester Senate HESS Committee

Dept. Affected: Law
BRU Criminal Division; Civil Division
Component Criminal Appeals/Special Litigation; Human Services
Component No. 2203;2208

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)

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
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
Check 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)*
This bill establishes new crimes specifically addressing Medicaid fraud, including misconduct involving the prescription and dispensing of controlled substances. The bill further requires a specified percentage of financial/misconduct audits be performed by the Department of Health and Social Services each year.

The Department of Law does not anticipate many new cases will result from the criminal provisions contained in the bill and so does not anticipate a fiscal impact.

Prepared by: Joan M. Kasson Phone (907) 465-5370
Division Attorney General's Office Date/Time 2/25/03 12:10 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General Date 2/25/2003
Agency Department of Law

(Revised 9/2002 OMB)

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN

SENATE BILL 41
SPONSOR STATEMENT

An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program

Since 1999, the costs of the Medicaid program have risen throughout the nation at an average rate of 11 percent per year. Alaska's Medicaid program has averaged annual increases of 20 percent, or more than $100 million per year, bringing the total projected program costs in FY2004 to just under $1 billion ($695 million in federal funds and $289 million in state funds).

Factors such as increased participant enrollments, increased use of health services, and the increasing costs of pharmaceuticals and long-term care are the greatest contributors to the rise in Medicaid program costs. While we have limited ability to contain these cost factors, we can control program integrity by targeting waste and fraud.

Nationally, the error rate of overpayments in the Medicare program is 7 percent, a number that could be inferred to the Medicaid program as well. In addition, the commonly held perception of the amount of fraud committed against the Medicaid program nationwide is 10 percent. Whether these two numbers are inclusive of one another or should be compounded, they represent a sizeable amount of spending -- between $70 and $170 million -- in Alaska's Medicaid program on activities that are, at best, questionable and at worst, criminal.

To preserve the integrity and fiscal viability of Alaska's Medicaid program, the system should be held to rigorous controls and frequent scrutiny. Relevant laws should be in place to prosecute those who commit fraud and abuse related to medical care. Alaska has no specific health care criminal theft statutes. Currently, in order to prosecute those who commit Medicaid fraud, prosecutors must use criminal statutes related to actions coincidental to the misconduct. Alaska theft statutes require proving the conduct was intentional, a very high standard to meet for a crime where there is no crime scene or physical evidence. Consequently, there have been relatively few prosecutions. Senate Bill 41 provides the legal tools for the fiduciaries of the Medicaid program to establish program integrity and maintain maximum fiscal control.

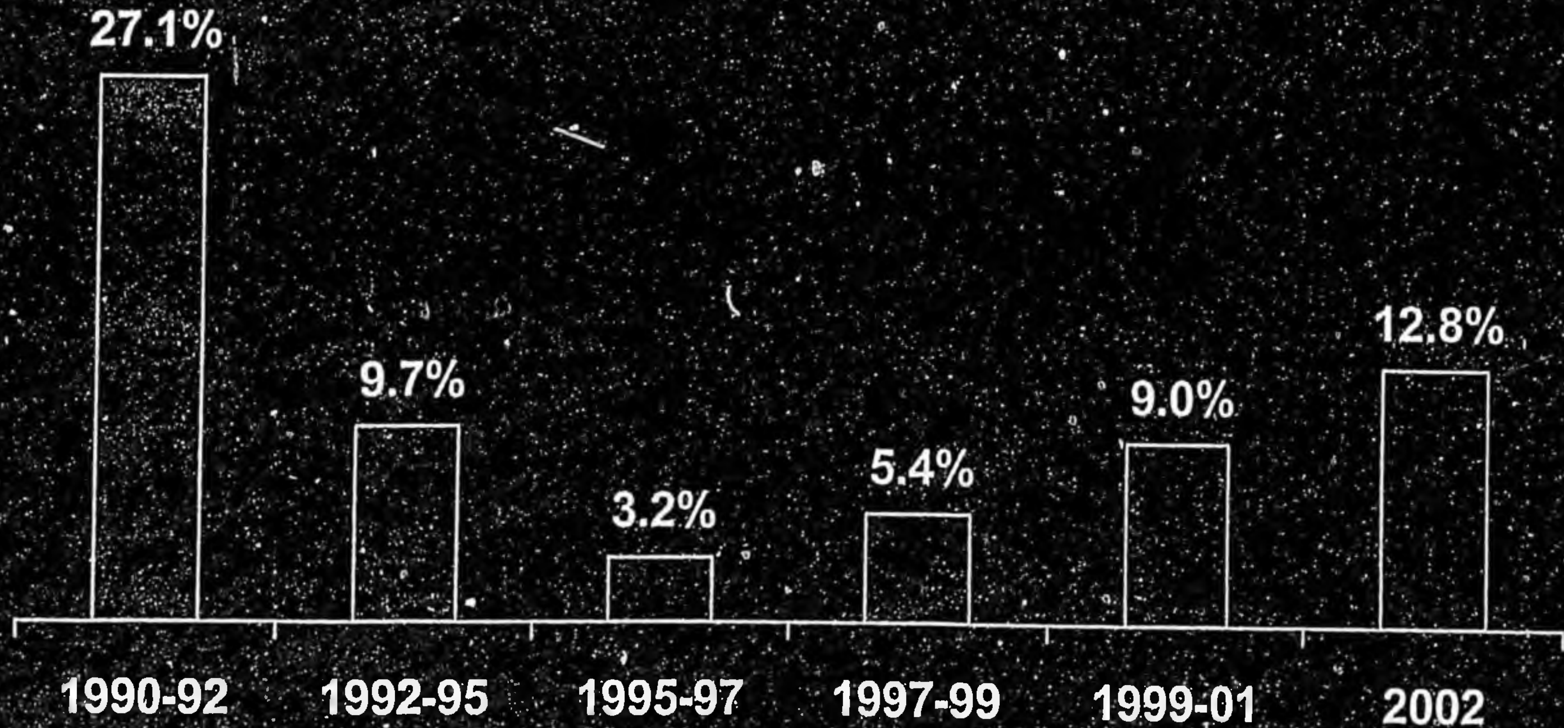
The legislation establishes three specific crimes of misconduct involving Medicaid services, defines the actions constituting those crimes, and classifies the type of crime committed as either a felony or a misdemeanor. It clarifies the circumstances under which controlled substances may be prescribed. It requires independent financial audits to identify errors, overpayments, and criminal violations made to, or by, Medicaid providers and requires administrative action within 90 days of receipt of each audit. It completes the loop between the Department of Health and Social Services and the Department of Law by requiring copies of all audits be provided to the Attorney General and by directing the Attorney General to notify the Department of Health and Social Services of any charges of misconduct filed against a Medicaid provider. Such notice requires the Department to suspend payment to, and undertake a complete review of, that provider. Finally, Senate Bill 41 provides that financing of the audits may be made from the recovery, due to the audits, of misspent funds.

It is vital that the State of Alaska administer its Medicaid program in a manner that ensures effective, long-term cost containment while providing medically necessary services to its intended recipients. Medicaid providers must operate honestly, responsibly and in accordance with the law. Those who do not should be held accountable. Senate Bill 41 provides the State with the means to better implement this philosophy.

Figure 13

Average Annual Growth Rates of Total Medicaid Spending

Annual growth rate:



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 20012002: Health Management Associates surveys for the Kaiser Commission on Medicaid and the Uninsured.

KAISER COMMISSION ON
Medicaid and the Uninsured

ALASKA MEDICAID PROGRAM EXPENDITURES ~ RECENT HISTORY							
Numbers and Language							
	Actuals FY98	**Actuals FY99**	**Actuals FY00**	**Actuals FY01**	**Actuals FY02**	**Enacted FY03**	**Projected FY04**
Medical Assistance							20% increase
Medicaid	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
General Purpose	129,731.2	131,522.9	145,514.7	152,791.1	192,921.5	173,294.8	207,953.8
Federal	231,329.7	261,315.7	307,508.4	387,431.9	461,846.9	579,552.0	695,462.4
Other	5,475.6	2,850.9	17,685.9	43,670.6	38,911.3	67,189.7	80,627.6
Total	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
% Increases from Prior Year		7.95%	18.96%	24.05%	18.80%	18.22%	20.00%
Total Medicaid Expenditures FY 99 - FY 02:				2,143,971.8			
Average annual increase between FY 99 and FY 02				20.60%			

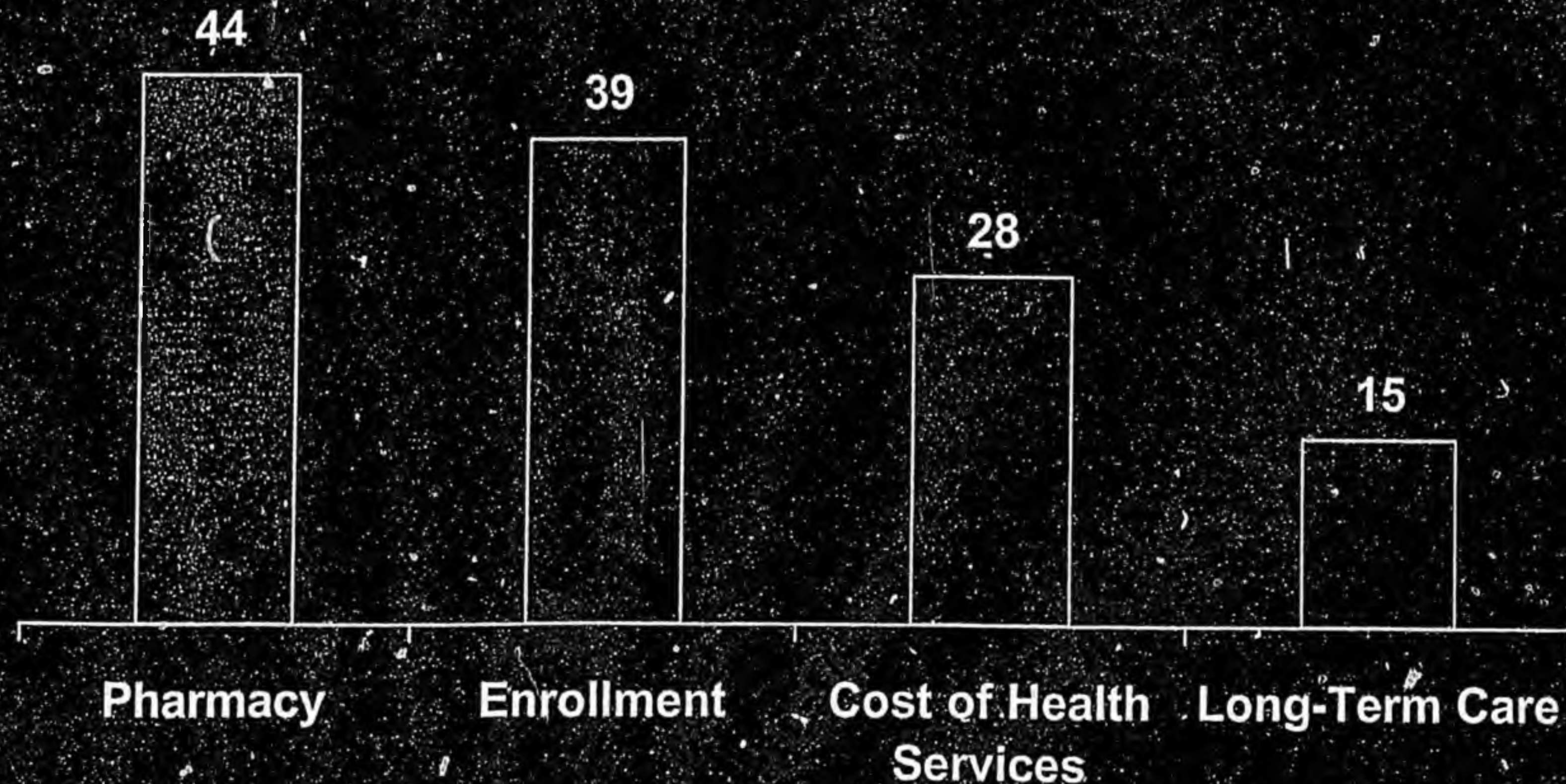
Source: figures obtained from Legislative Finance Division
Presented by T. Carpenter of Senator Green's staff

2/24/2003

Figure 15

Factors States Reported as Among the "Top Three" Increasing Medicaid Spending

Number of states reporting:

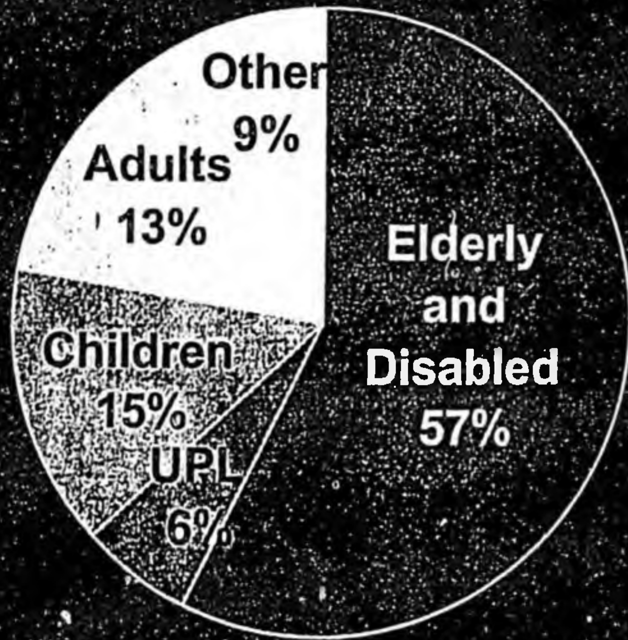


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

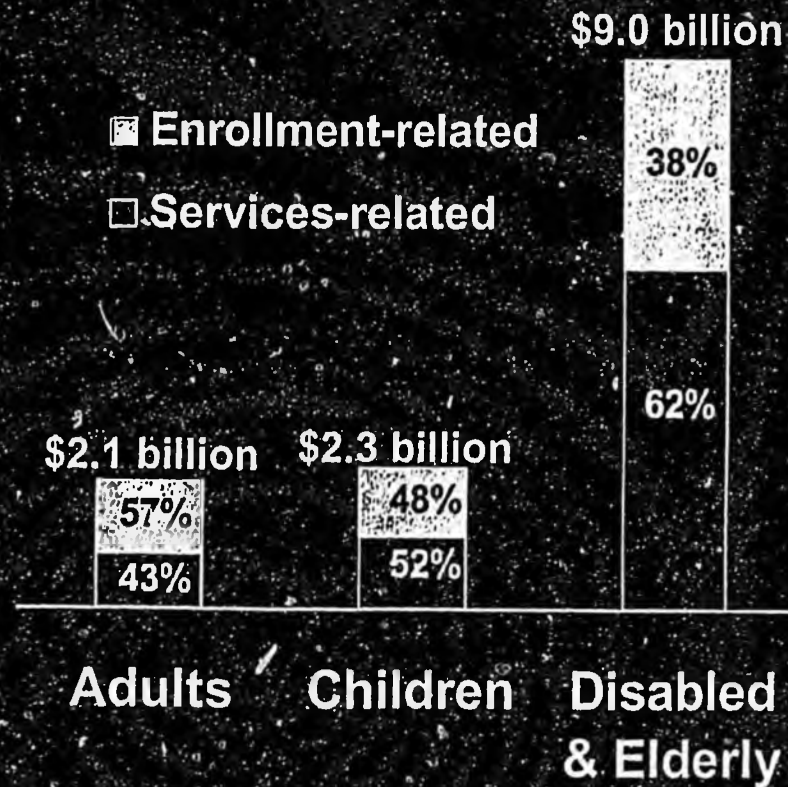
Figure 16

Sources of Growth in Federal Medicaid Expenditures, 2001-2002



Total Increase = $15.7 billion

Factors Behind Expenditure Growth for Beneficiaries

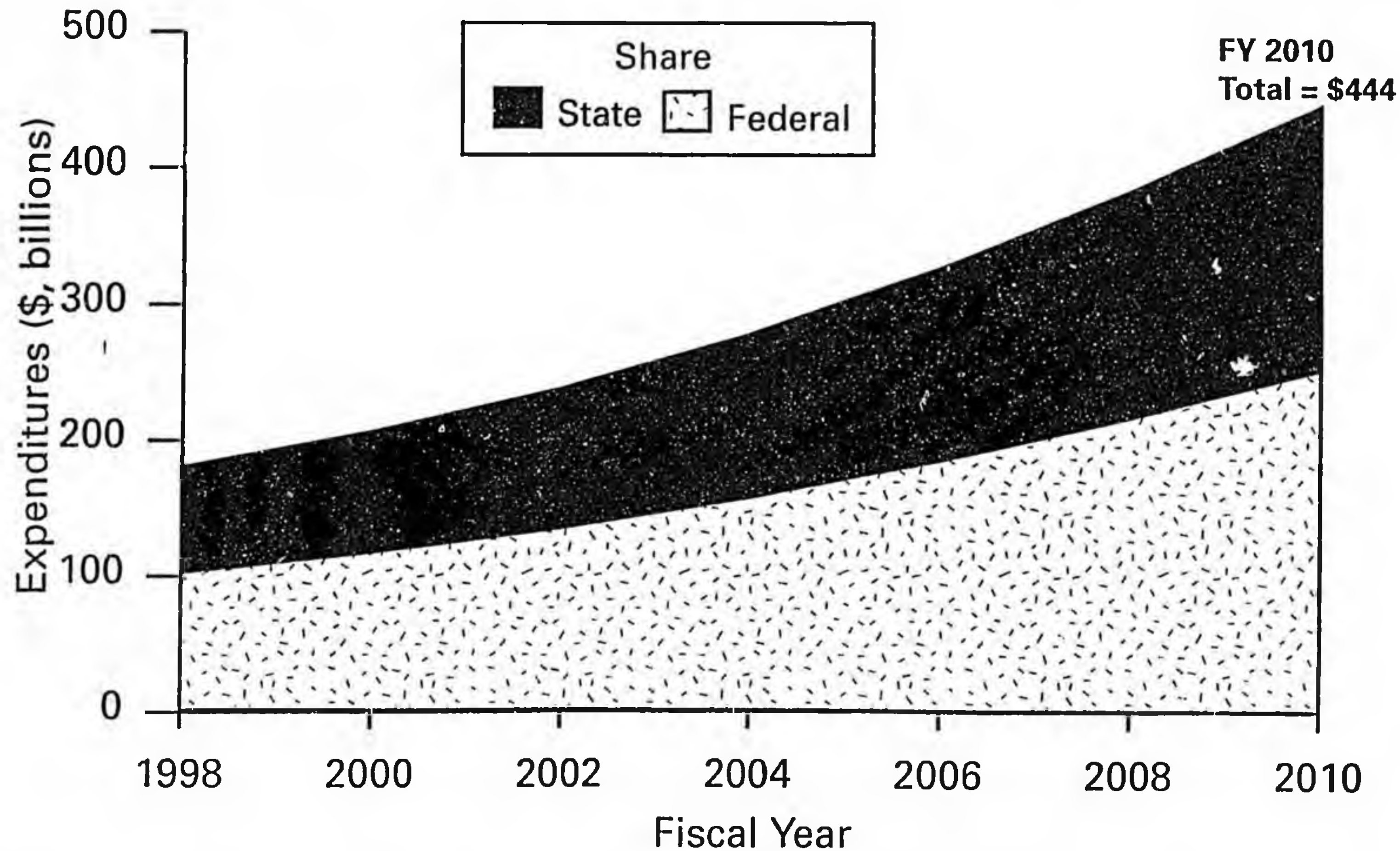


SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 2.5 Projected Medicaid Expenditures, Fiscal Years1998-2010

Spending is projected to grow to $444 billion in FY 2010.

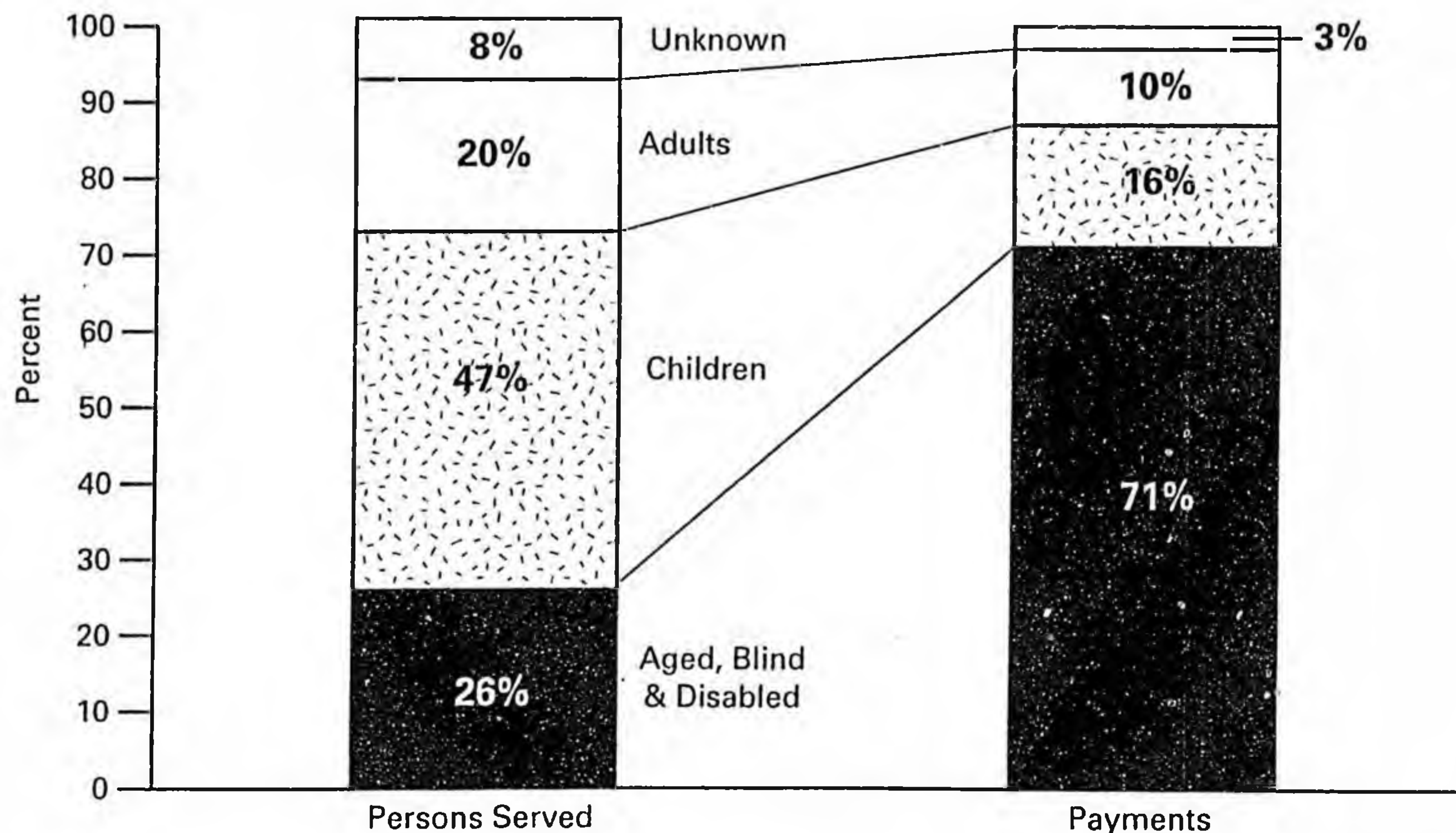


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors — case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal terms.

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 2.10 Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 1998

Payments for the elderly, blind and disabled account for 71 percent of total payments.

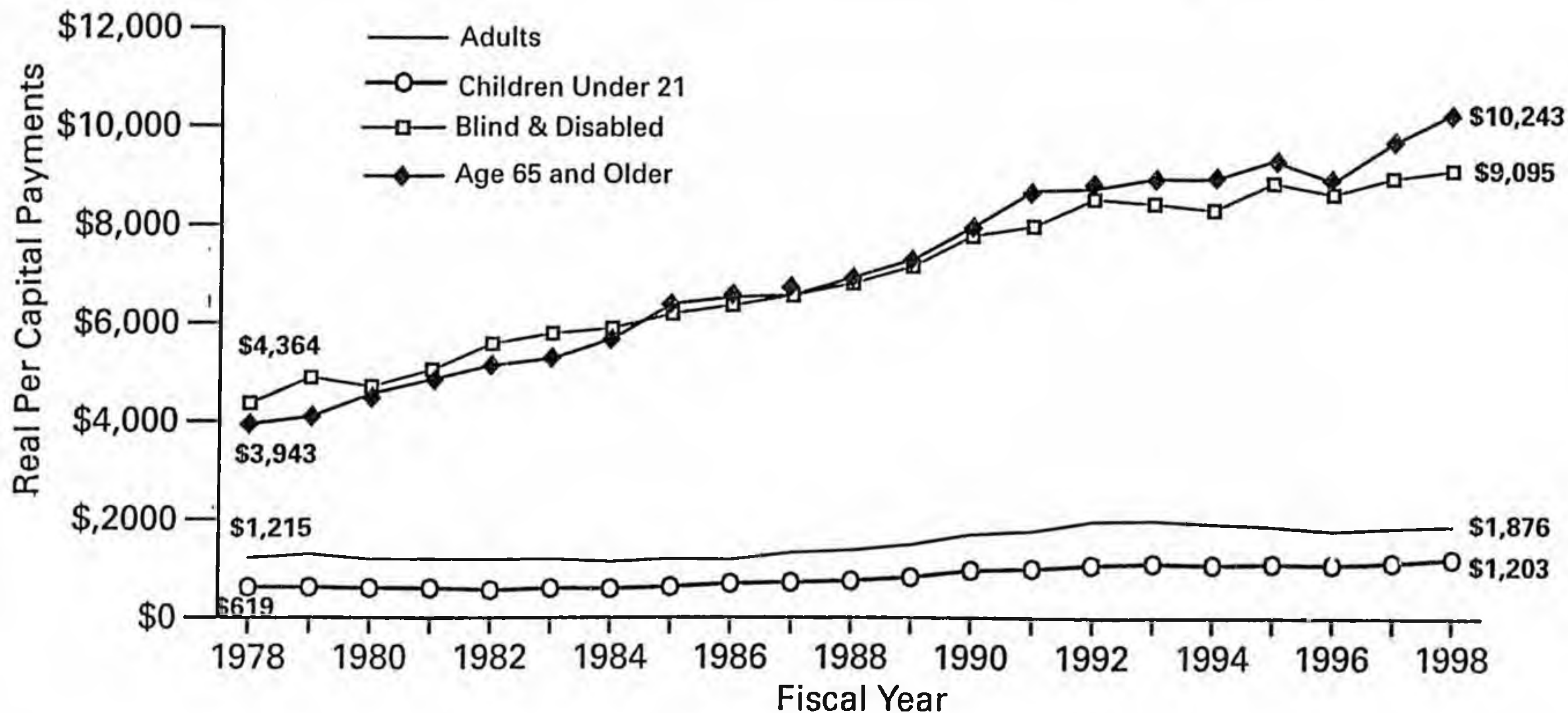


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare); (3) disabled children are included in the aged, blind & disabled category shown above.

Source: HCFA-2082.

Figure 2.12 Average Real Medicaid Payments per Person Served, Fiscal Years 1978-1998

Per capita payments for the elderly, blind and individuals with disabilities more than doubled while per capita payments for children and adults had modest growth rates.



Note: (1) Data shown above are expressed in 1998 dollars; (2) for FY 1998 "payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments; (3) the term "adults" as used above refers to a category of non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

ALASKA STATE LEGISLATURE

SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE

Health Care and Welfare Subcommittee Hearing

Mat-Su Legislative Information Office

November 8, 2001

9:00 a.m.

See pp. 37-49
Testimony of S. Branchflower

MEMBERS PRESENT

Senator Lyda Green, Chair
Senator Bettye Davis

MEMBERS ABSENT

Senator Jerry Ward

OTHER LEGISLATORS PRESENT

Senator Robin Taylor
Representative Fred Dyson
Representative Sharon Cissna

SUBCOMMITTEE CALENDAR

The future of health care costs and welfare reform in Alaska.

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Mr. Dennis Dunn
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Kenai, AK 99611

ACTION NARRATIVE

TAPE 01-47, SIDE A
Number 001

CHAIRWOMAN LYDA GREEN called the Senate Health, Education & Social Services Subcommittee meeting to order at 9:00 a.m. Present were Senators Davis, Taylor, and Chairwoman Green. Chairwoman Green announced that the subcommittee is meeting to consider in what direction Alaska should go regarding Medicaid coverage and possible legislation. She noted that priorities regarding services to be covered under Medicaid have changed since the events of September 11. She pointed out that one item on the agenda today is rural health care. When looking through the budget last year, Senate Finance Committee members noticed there would be a budget item to provide a service at the state level that other groups were providing. They tried to find as many funding sources coming into rural health care sites to get them aligned and not duplicative. She asked a representative

from the Denali Commission to present to the committee.

MR. KRAG JOHNSON, the Alaska Legislature's staff representative on the Denali Commission, introduced Joel Neimeyer, the Commission's rural health expert. He distributed an update on Denali Commission activities to committee members and the public. The update contains a generalized list of projects the Denali Commission has been working on and funding levels for those projects. He noted Mr. Neimeyer came to the Denali Commission after 17 years with the Indian Health Service and has worked with the Alaska Native Tribal Health Consortium.

MR. JOEL NEIMEYER, program manager for the Health Facilities Program, informed the committee that since September of 1999, he has been working with the Denali Commission on infrastructure, originally with rural energy projects. When the health care program started developing, it was consuming so much time he became the Health Facilities Program Manager.

CHAIRWOMAN GREEN asked Mr. Neimeyer if he spent all 17 years with the Indian Health Service (IHS) in rural Alaska.

MR. NEIMEYER said all but three years, which he spent in Western Washington. He noted that he would address four bullets issues, one being the role of the state and federal government, the Denali Commission and Native non-profit health corporations in rural health care.

First, the Denali Commission was created by federal legislation in 1998 to look at training, economic development, and infrastructure development. The legislation allows the Commission to work with many different partners in many different areas. The legislation established an administrative cap at 5 percent, which does not allow the Commission to run its own program. That cap forces the Commission to find partners who are .lready doing the work and have the same mission.

CHAIRWOMAN GREEN asked who a typical partner would be.

MR. NEIMEYER said that varies by interest. In the Denali Commission's health care program, its two primary partners are the State of Alaska and the Alaska Native Tribal Health Consortium. In the Commission's rural energy program, it primarily partners with the Alaska Energy Authority and the Alaska Village Electric Authority. He said in 1999, Congress passed legislation [P.L. 105-277] that amended the Denali Commission act and focuses it particularly on health care programs. It gives the Commission the authority to plan, design

and construct hospitals, mental health facilities, elder care, childcare, and primary care facilities.

MR. NEIMEYER said one of the first things the Denali Commission did when that legislation passed was to put together a steering committee to do a needs assessment of primary care. Its original partners were the Alaska Native Tribal Health Consortium and Indian Health Service. The goal of the needs assessment was to quantify what the primary care needs are across the state. They chose to look at 288 communities without an in-patient care facility at the hospital and more than 20 year-round residents. The study results determined a need for $253 million to address primary care facilities statewide.

CHAIRWOMAN GREEN asked him to describe some typical communities identified in the study.

MR. NEIMEYER stated that some communities have no health clinics, but many have very small clinics. The Steering Committee found that many clinics were built based upon available funds from HUD community development block grant funds and State of Alaska community development block grant funds. The Steering Committee found the small facilities restrict the amount of health care programs offered in the community so that health care access is restricted by capital funds, not by health program services that can be offered. The Steering Committee decided to change its perspective and requirement of a community for primary care services based upon geographic isolation and population size.

When the Steering Committee put together the needs assessment, it found that it could not compare the health care needs of large and small communities and felt it was unfair to make communities compete with one another. The outcome was to develop three funding processes as demonstrated in the following chart. Large clinics work for communities with a population larger than 750 or communities that serve as a sub-regional clinic or a multi-community clinic. Small clinics work in communities where that clinic is a "stand alone" clinic for that community. The third funding process is for the repair or renovation of existing clinics.

MR. NEIMEYER pointed out that none of the Denali Commission's projects to date have required a Certificate of Need but that will be incorporated into the program in case one is needed.

Where the Commission goes with funding these projects will be guided by the Health Care Steering Committee. That Committee was organized in early 2000 and is made up of four agencies: the

Denali Commission, the IHS, the Alaska Native Tribal Health Consortium and the State of Alaska. Over time, more partners were added: the Alaska Primary Care Association, the Alaska Mental Health Trust, the University of Alaska and the Alaska Native Health Board. The Steering Committee took on the responsibility for developing the Request for Proposals process for capital funding of health care facilities. Recently, the Committee was restructured so that it takes a more policy advisory role and less of a work-group function. Karen Perdue will represent the University of Alaska.

CHAIRWOMAN GREEN asked for a description of the Alaska Primary Care Association.

MR. NEIMEYER explained that it is a non-profit member organization made up of about 40 or 50 members, located in Anchorage.

MR. NEIMEYER informed the subcommittee that Karen Pearson is the chair of the Steering Committee.

CHAIRWOMAN GREEN noted the presence of Senator Taylor.

MS. KAREN PEARSON informed the committee that the primary role of the Alaska Primary Care Association (APCA) is to support its membership, which is made up predominantly of the rural community health centers and the two larger ones in Fairbanks and Anchorage. The APCA helps them to do joint purchasing and to help with board development.

CHAIRWOMAN GREEN asked if the APCA has any members from the private sector.

MR. NEIMEYER said several decisions were made about who would have a seat on the Steering Committee, one being that each seat would be filled by a representative from a statewide organization. The concern was that if a regional organization was selected, other regional organizations would fear that funds would be steered toward that region. The Steering Committee gives advice to the seven commissioners on the Denali Commission about what the Commission should be doing in the health care arena. The Steering Committee gets its advice from the seven member organizations.

CHAIRWOMAN GREEN asked how a conflict of interest is avoided if the Steering Committee is funding organizations that belong to it.

MS. PEARSON said that is a question the Steering Committee has grappled with and was partly responsible for the restructuring of the board. She pointed out the State of Alaska, University of Alaska and Native Health Board will not receive funding and all members work very hard to be cognizant of that issue.

MR. NEIMEYER said once decisions are made, it has to find partners because it has a 5 percent limit on administrative costs.

CHAIRWOMAN GREEN asked for an explanation of the administrative costs.

MR. NEIMEYER said administrative costs include utilities, staff, and whatever else it takes to run an operation. To put projects on the ground in rural Alaska takes more than five percent, so the Steering Committee finds partners to help. In the health care arena, the State (the Department of Health and Social Services - DHSS) is the pre-award partner. Ms. Pearson and her staff assist the Steering Committee in getting the RFPs out and in putting together evaluation teams to review the applications. Once the decision has been made about what projects should be funded, the Steering Committee works with its post-award partner, the Alaska Native Tribal Health Consortium (ANTHC), on small clinic projects and repair projects. The ANTHC represents the Steering Committee's interests in the individual communities. The Steering Committee found that many of the proposals for large clinics are from large organizations.

CHAIRWOMAN GREEN asked for an example of a large organization.

MR. NEIMEYER replied that the Steering Committee funded a large clinic through the Yukon Kuskokwim Corporation (YKC). YKC has a health facility manager, professional engineer, and several staff who run the project. The Steering Committee funded SEARHC projects in Angoon and Haines, who also have health facilities managers and contracting departments, so they are capable of putting the projects on the ground. The Steering Committee entered into agreements with those organizations for the large clinic funding. Routinely, small clinics are built in smaller communities.

CHAIRWOMAN GREEN asked if Mr. Neimeyer is referring to the large clinic in Kotzebue.

MR. NEIMEYER said he was not and that, in general, a small clinic is about 1,500 to 2,500 square feet. Large clinics are 2,500 to 10,000 square feet.

CHAIRWOMAN GREEN asked if, in general, a clinic is a 24-hour, overnight stay facility.

MR. NEIMEYER said they are not. He explained that ANTHC represents the regional health corporations, such as YKC and the Tanana Chiefs Conference (TCC). When the Steering Committee selected ANTHC, it required ANTHC to agree to represent all communities in the state that the Denali Commission funds.

CHAIRWOMAN GREEN asked if ANTHC was pre-ordained to participate from the beginning.

MR. NEIMEYER said it was not. The Steering Committee looked into what different organizations could be program partners and everything pointed to ANTHC as being the organization most ready to take on this work. ANTHC agreed to serve all communities that the Steering Committee recommends projects in.

CHAIRWOMAN GREEN asked if they are audited regularly.

MR. NEIMEYER said they are; they fall under the federal single audit act so they are monitored regularly. He said this past fiscal year, the Steering Committee put 12 projects on a fast-track process; ANTHC represented the Steering Committee on those projects. Mr. Neimeyer told the committee that if the Denali Commission decides to expand its program to include health facilities other than primary care facilities, such as hospitals, it will have to explore the question of who to partner with.

CHAIRWOMAN GREEN asked if totally different standards would apply to a hospital program.

MS. PEARSON said that is correct and that is the reason the Denali Commission has not gone into that arena. The Denali Commission is only looking at communities that do not have a hospital. Primary care includes, in addition to physical care, mental health and substance abuse services. With the maturation of this process, communities are thinking about their total primary care needs.

CHAIRWOMAN GREEN asked if the Haines clinic, a one-person outfit, is an example of a primary care health care facility. She pointed out that managing a one-person clinic is a very stressful job.

MS. PEARSON said the Haines clinic is an example of a primary care facility. The Steering Committee is approaching the design of these facilities in a systematic way that focuses on physical

care first, but will build a one-person mental health facility so that residents will have total access to primary care.

CHAIRWOMAN GREEN asked Ms. Pearson if her participation is outside of her job at the Division of Public Health so that she wears two hats.

MS. PEARSON said that is correct.

CHAIRWOMAN GREEN asked Ms. Pearson how she considers both perspectives when she works on the division's budget.

MS. PEARSON said she believes it was a wise decision on the part of the Denali Commission to have the director of the Division of Public Health chair this group because to have the facility development work happen separate from the question of how to pay for services would not have worked well. All participants do the planning for the facilities and the services together in a coordinated fashion.

CHAIRWOMAN GREEN stated that she would like to have a follow-up session, perhaps in April, to update the committee on the impact of the Steering Committee's work on the budget.

ME. NEIMEYER continued his presentation. For projects managed by ANTHC, communities have six funding-construction options. A community, regional health corporation or ANTHC can manage a project using a force account or by contract. If a community wants to take the lead, it can, if it can demonstrate that it has the ability to do so. The Steering Committee has found that when it partners with ANHTC, it receives quarterly status reports, it manages the funds, and it has engineers in the field. In fiscal year 2000, the Steering Committee put $1,000,000 into four demonstration projects and learned to have the construction plans in hand and to do site control. Those lessons were applied in fiscal year 2001, when the Steering Committee had $20 million to spend. In fiscal year 2002, the Steering Committee has committed $12.5 million for small clinics. It plans to have $20 to $30 million so it is developing mechanisms to select projects.

TAPE 01-47, SIDE B

MR. NEIMEYER explained that the Steering Committee had to devise a way to translate services to square footage. Emergency Medical Services categories are used; the first of three being an isolated community, which includes most of the 288 communities, and the two highway communities. Based upon isolation and population, the Steering Committee decided how large a facility

should be. For example, a community relatively close to a large urban center with a hospital and other health care service was deemed to not need as much space as a community far from an urban center. The Steering Committee designated clinic sizes as small, medium and large within the small clinic program. A small clinic is 1500 square feet, a medium is 2000 square feet, and a large clinic is 2500 square feet. The Steering Committee found, when developing these guidelines, access to inpatient services became a much more important factor in the health care needs of larger communities. For that reason, the Steering Committee created two categories so that those communities would have to compete individually and demonstrate their service delivery needs.

CHAIRWOMAN GREEN asked Ms. Pearson if any of the Division of Public Health's budget is used for the administrative costs of the Denali Commission.

MS. PEARSON said it does not. The Steering Committee worked out an arrangement whereby it has about $300,000 that it can tap into as needed for support activities. It has worked very hard to dovetail this program with programs already in place, which is why the Denali Commission asked the division to be the pre-award partner. The division administers a lot of grants every year and has a process established that can easily be duplicated. Ms. Pearson noted that during the past year, the Steering Committee worked very hard, with support from Senator Stevens' office, to access federal community health money (Section 330 money). While the Steering Committee was successful in partnering with certain clinics to get money directly to communities, it was also successful in persuading the federal Health Resource Services Administration (HRSA) that the State of Alaska needs an ongoing stream of funds to ensure that communities get the necessary support to compete for Denali Commission dollars or for other federal dollars. The Steering Committee received $250,000 for that purpose. That will support the additional work it takes to support the Denali Commission without using any state funds.

SENATOR TAYLOR referred to the Denali Commission's needs assessment, which projects a need for $253 million, and asked if that amount will provide a full clinic in every community in the state.

MR. NEIMEYER said that amount will provide a full clinic in 288 communities. He pointed out that communities with fewer than 20 year-round residents and communities with hospitals are not on the Commission's "radar screen."

SENATOR TAYLOR asked if communities are expected to participate

in the needs assessment.

MR. NEIMEYER said there is a required cost share match in legislation of 25 or 50 percent, depending on the economic status of the community and the Steering Committee has found that to be a barrier to getting communities funded.

There was no further testimony from, or questions for, Mr. Neimeyer.

Number 958

MS. CYNTHIA NAVARRETTE, President and CEO of the Alaska Native Health Board (ANHB), stated that Sally Smith, the ANHB Chair, was unable to present to the committee today because of a schedule conflict. She clarified that the ANTHC is a member organization of ANHB, which is a privately owned, non-profit organization. It advocates on behalf of health organizations throughout the state of Alaska. ANHB was established in 1968 with the sole purpose of promoting the spiritual, physical, mental, social and cultural well-being and pride of Alaska Native people. The Board of Directors include Alaska Native regional and village health providers from across the state. In most cases, these organizations are the only health care providers in the communities and, in fact, they not only serve Native people but they serve all community members. She informed the committee she would present her testimony in four parts: an overview of the Alaska Native health system; an overview of the funding providing to operate the programs, functions, activities and services; an overview of Medicaid; and the effects of the IHS beneficiaries in the use of the Medicaid program.

Overview of The Alaska Native Statewide Health Care Delivery System

The heart of the Alaska Native Health System is the 468 Community Health Aides working in 178 village clinics throughout rural Alaska. The IHS beneficiaries in remote villages do not have daily access to physician care. They rely on the medical attention of the Health Aide.

There are six regional hospitals operated by the following Native regional organizations: Maniilaq, Inc. located in Kotzebue, Yukon-Kuskokwim Health Corporation located in Bethel, Norton Sound Health Corporation located in Nome, Bristol Bay Area Health Corporation located in Dillingham, Arctic Slope Native Association located in Barrow, and Southeast Alaska Regional Health Consortium located in Sitka.

The Alaska Native Health Care Delivery System consists of both consortiums and individually operated service units. A typical consortium infrastructure includes village clinics, possibly several sub-regional clinics, and a regional hospital. The rural health organizations typically serve areas as sole community providers. They may also serve the entire population, regardless of race.

The Alaska Native Medical Center (ANMC) is located in Anchorage and provides essential tertiary care, acute care and specific statewide health services for all Indian Health Service beneficiaries. The Alaska Native Tribal Health Consortium and Southcentral Foundation jointly manage the facilities that provide the full continuum of care within the Alaska Native Health Campus.

The Alaska Native Health System reflects levels of care available within the village, the regional hospitals, and the Alaska Native Medical Center (ANMC), located in Anchorage. The Medivac is essential to receive the next step up of care from the village to the regional hospital. If the case is deemed serious enough, a Medivac can be directed from the village straight to ANMC. There are Medivac call-outs from regional hospitals to ANMC, and also from ANMC to more specialized hospitals in the lower-48.

Overview of Funding

With the construction of the new Alaska Native Medical Center and the Primary Care Center, there is a perception that Alaska Native Health Services are amply funded. The reality is that the system is significantly under-funded. Indian people have long experienced disproportionately low health status and a large gap in health care resources compared to other Americans. Recently, Congress requested a health status and resource deficiency report for each Indian tribe or service unit. The IHS charged a Level of Need Funded (LNF) Workgroup to develop the necessary methodology. This report, published April 2001, states that Alaska is only funded at 61% of the total need compared to the Federal Employee Health Benefits Package. It is important to know that the Medicaid reimbursement funding is included in this percentage.

Overview of Medicaid

The Medicaid Program is not out of control. It is a large cost in every state, second only to public schools. To save the Alaska Legislature money by reducing the Medicaid Program would actively harm people receiving care - either by eliminating services for adults, or cutting reimbursement to providers, which will reduce access. Medicaid provides insurance to individuals and families that have no other access to health care services. Reducing the program would be a huge detriment to the health of Alaskan

citizens.

Additionally, there is the economic impact that would be imposed on private health care providers to consider. Seventeen percent of the employees within the private sector are funded due to the Medicaid Program. Realistically, Medicaid within the State of Alaska is not a comparatively generous program. Other states in our nation provide more services and that should be the direction in which the Alaska Legislature heads as well.

The Effects of IHS Beneficiaries' Use of the Medicaid Program

IHS beneficiaries are a large user of the Medicaid Program. However, the fiscal reality this imposes on the Medicaid Program is not what one would think. The State of Alaska receives 100% reimbursement from the federal government for IHS beneficiaries that utilize Medicaid. This results in broader user access to a non-IHS beneficiary population. Additionally, the IHS beneficiary who utilizes the Medicaid Program actually has a positive impact on our State's economy. The federally reimbursed dollars create jobs in the private health care sector that may not be otherwise available.

The Alaska Native Health Care Delivery System encourages the Alaska State Legislature not to cut the Medicaid Program and lower the wellness of Alaskans for the benefit of fiscal conservation.

MS. SANDRA MIRONOV, health administrator for the Yukon Kuskokwim Health Corporation, made the following comments. Last spring, the Legislature had some questions about a budget request unit and how the money was used. A budget request unit is direct funding from the State of Alaska to different organizations across the state. It was established about 20 years ago to develop services in rural areas to provide better access to Alaskans that had no services. She noted that she distributed to members an overview of the Yukon Kuskokwim Health Corporation's (YKHC) use of the budget request unit and testimony from consumers in the region, prepared for the Legislature last April.

She provided the following highlights of the handouts. The budget request unit currently funds about one-third of the services of all mental health and substance abuse services in the region provided by YKHC. It also funds a significant portion of our community health services and the health aide program. It is the core of YKHC's services. Page 2 contains a graph showing how much of the actual services are covered by Medicaid that are provided in the region. The YKHC's concerns about the budget request unit are that if this funding was cut from the state budget, YKHC would be put at a very unfair disadvantage in a