ALASKA LEGISLATURE COMMITTEE FILES, 2005-2006 8672

11442 HOUSE HEALTH,EDUCATION & SOCIAL SERVICES

From: *Please **PRINT** the information below. This form **must be signed** by the sender.*

Mr. / Ms. / Mrs.	First name	M.I.	Last name	Jr. / Sr. / III
MR	CARL	D	BAKER	

Group affiliation (if applicable)	Daytime telephone number: 907 745 5650
Mailing address: P.O. Box 3131 PALMER, AK	Zip code: 99645
Residence (street) address if different from mailing address: 186 S. TATLOW PALMER AK	Zip code: 99645
Email address	Signature: Carl D Baker — Date: 1-24-06

To: Richard G Tubbs, Executive Director
Palmer Senior Citizens Center, Inc.
831 South Chugach Street
Palmer, Alaska 99645

Re: Letter of Support for the Palmer Senior Citizens Center

Dear Mr. Tubbs:

My wife and I visit the Senior center about four times a week. We participate in the commodities services and do other volunteer work as needed. We have lunch which is always well prepared and nutritious. This activity give us the opportunity to associate and help other seniors. As time passes we can see the need for a new and larger center. The present center is in need for some major repairs and has inadequate space for the staff. Storage space for supplies and records is definitly short. With the increase in population in the Palmer area a new and larger Senior Center is desperately needed.

Sincerely,

Carl D Baker

Age (optional): 66

Jan 19, 2004

To whom it may concern.

In reference to the need of a new senior housing center,

The need is going to be greater as time goes on due to more seniors seeking affordable housing and the general growth of the Mat-Su valley.

The normal growth of the area will more than double in the next 10 years or so and the addition of the new Mat-Su Hospital will encourage more seniors to reside in the Valley area.

The Mat-Su Valley being the size of West Virginia will require more police, fire & other forms of security. This can only be achieved with more housing and the sooner the better.

Time is of the essence as delay will make costs skyrocket.

Very truly yours -
C. T. Lieberman

Jan 26, '06

TO: Mr. Richard Tubbs,
Executive Director
Palmer Senior Center
S. Chugach St
Palmer, AK. 99645

FROM: Maryann Selle
P.O. Box 3217
Palmer, AK 99645

In Sept. 1994 I moved to Alaska. At that time I was 57 yrs old & had only spent 2 months in AK in the summer of 1970. I hitchhiked, walked the Chilkoot Trail, & saw a lot in 8 weeks — & liked what I saw! I had no friends or relatives here at that time. But that changed, primarily due to the Paws & Taws Square Dance Club, & the Senior Center. We set to building a home & came to the Center for midday meals instead of cooking in our camper at the construction site. We made friends quickly & realized what a valuable support net this facility provided when I had knee replacement surgery last year using a cane, crutches, & a walker. I couldn't drive til I healed up. Larry was Outside & the vans were my only means of shopping, keeping physio-therapy appointments two times a week, & going to the PSC for midday meals. Yes, I can cook — but you feel so weak after surgery that standing at a stove is a big drain on your energy reserves.

Now that I'm healed up, I'm very grateful for the support (meals, transportation & sociability) the Center provided during my convalescence. I look forward to the Sunday brunches & seldom miss one but only attend the weekday meals about twice a week.

I think outings are important, especially for seniors who have retired their driving privileges. They must feel awfully trapped. I would like to see more activities we can enjoy without spending too much on admissions & gasoline. The following are a few freebies I'd suggest:

1) visiting the Bird Rehabilitation Center in S. Anchorage - free

2) a free tour of the Russian Orthodox Church Museum downtown Anchorage

3) an evening tour of the Anchorage Cemetery in summer (sponsored by the Anch Tourist Office)

4) Beluga watching & visit to Girdwood - could be a picnic with a walk on Potters Marsh boardwalk trail.

5) Mother's Day at the Musk Ox Farm - free for Moms!

Probably some other attractions would be willing to give a reduced rate admission for a group of seniors. I'm thinking of the Eklutna

Church & Cemetery Tour of the Wasilla Original Townsite.

Another aspect of the Senior Center (besides sociability, meals, & transportation) is that it serves as an employment center for those interested in supplementing their incomes. We have an information specialist who helps with filing PFund applications, makes sure they're completed correctly, & if we didn't have a legal resource person worth her weight in gold, many of us would <u>never</u> have gotten around to updating our wills getting a power of attorney prepared or avoided the financial scams intended to entrap the unwary.

All this is done out of cramped, old offices that no longer are adequate for the increasing membership. The dining room is crowded, the kitchen inadequate as our membership increases. Housing in the Valley is so expensive & it will be a blessing when the new Senior Housing becomes a reality. Even though Larry & I have a beautiful home now, the day will come when we are no longer able to mow 1 acre of lawn & tend ¼ acre of garden, plow snow, & do the chore inherent in home maintenance & senior housing will be very welcome then.

I therefore heartily endorse the construction of a new Senior Housing along with a Center large enough to accommodate the surge of new seniors ~~that~~ will be eligible to use it. If money is available, I would ~~to~~ to see it include a swimming pool for exercise. Our high school pool is only available for lap swimming a few times a week & it is not in walking distance. Swimming is one of the best exercises for seniors because it is low impact activity. This can be a nominal charge - $2 per swim.

Another amenity that would enhance the quality of life at the Senior Housing would be an on-site barber/beauty shop. On the Palmer Wasilla Hwy opposite the Frontiersman there is a new beauty shop & tanning facility offering senior rates on Mondays - but non-drivers would not be able to get there without a taxi fare, which really drives the haircut price up!

However, this facility, "Body Elements", is very nice to their customers & I appreciate their accommodating us with reduced senior rates on Mondays.

If you're wondering what can be done with the present Sr Center, turn it into a Thrift Shop! They make money (believe it or not) while saving customers a pocket.

And by the way I talked to the manager at Lowe's in Wasilla last fall when they had

their big sale on Spring bulbs. Everything was half price! I bought tulips, daffodils, hyacinths, crocus, & narcissus (all 50% off) to force indoors for Spring blooms. Then I returned to Lowes the next week for more bargains! To my shock, all the unsold bulbs were thrown in the trash because the store needed space for poinsettas & Xmas decorations!

So I told them how much the Sr. Center would appreciate any unsold flowers or bulbs & that we have some very good gardeners & I'll bet we could even put a sign in the flowerbeds acknowledging their gift. So they said to check back for unsold bedding plants in Spring 2006 & for bulbs next fall; we could have the bulbs they'd normally throw out! That way we can save $ on landscaping a new facility as well!

Thank you for the opportunity to voice my opinion. It certainly is not too soon to plan on the expansion of our facilities as we are bursting at the seams in an old building that is probably not worth the $ to renovate. I think funds should be spent on new construction instead of trying to upgrade antiquated plumbing, electrical wiring & office facilities. Yours truly,

Margaret Stelle
742-5-1928

HB 436

ALASKA STATE LEGISLATURE

REPRESENTATIVE LES GARA

HB 436: Social Worker Caseloads
Sponsor Statement

The Child Welfare League of America (CWLA), a national children's organization recommends certain caseloads for social workers working in child protective services roles. House Bill 436 would bring Alaska's social workers into compliance with these standards.

Social workers are our front line resource in investigating child abuse and neglect cases, and assisting children in foster care. They provide an important service for some of the most vulnerable citizens of this state. When they are overburdened, cases go too long without being investigated, and in person visits become less frequent. Alaska has also experienced a high rate of turnover in the social worker profession, likely at least partially attributable to the high caseloads.

The Office of Children's Services (OCS) established caseload standards for each of their offices based on the CWLA standards and adjusted for the geographic area covered by each office. According to a 2005 research report, the majority of OCS social workers in Alaska had caseloads in excess of those standards. In Dillingham, the sole social worker handled 52 cases, when the caseload standard was 13. In Valdez, the sole social worker handles 30 cases, compared to the standard of 12.

HB 436 is a crucial first step toward protecting foster and neglected children in Alaska and I urge your support.

January-May: State Capitol • Juneau, AK 99801-1182 • (907) 465-2647 • Fax (907) 465-3518
June-December: 716 W. 4th Avenue • Anchorage, AK 99501• (907) 269-0106• Fax (907) 269-0109
Representative_Les_Gara@legis.state.ak.us

ALASKA STATE LEGISLATURE

REPRESENTATIVE LES GARA

HB 436: Social Worker Caseloads
Sectional Analysis

Section 1.

Amends the duties of the Department of Health and Social Services to include new social worker caseload standards.

Section 2.

Creates social worker caseload standards in line with national Child Welfare League of America standards.

For Anchorage, Mat Su, Fairbanks and Juneau the caseload standards are:

- -12 new active initial cases assessments
- -17 ongoing cases, and no more than 1 new case assigned per 6 ongoing cases.
- -10 ongoing active cases and 4 new active cases for initial assessment
- -15 children in foster care

For areas outside of Anchorage, Mat Su, Fairbanks and Juneau the caseload standards are the same, or what is necessary to comply with the Department's 2005 workload study.

These standards do not apply to the extent the department is unable, after diligent recruiting effords, to hire a sufficient number of social workers to meet the requirements.

Section 3.

The Department may adopt regulations for transition.

Section 4.

The Department may employ additional personnel as necessary to comply with this Act.

Sections 5 & 6.

Effective dates.

January-May: State Capitol • Juneau, AK 99801-1182 • (907) 465-2647 • Fax (907) 465-3518
June-December: 716 W. 4th Avenue • Anchorage, AK 99501• (907) 269-0106• Fax (907) 269-0109
Representative_Les_Gara@legis.state.ak.us

CWLA CHILD WELFARE LEAGUE OF AMERICA
Founded in 1920

Home Search

Recommended Caseload Standards

The following recommended caseload standards are excerpted from the CWLA Standards of Excellence for Child Welfare Services. The standards can be ordered by going to www.cwla.org/pubs or calling 800-407-6273.

The recommended caseload standards for child protective services are as follows (CWLA Standards of Excellence for Services to Abused or Neglected Children and their Families, Revised 1999):

Service/Caseload Type	CWLA Recommended Caseload/ Workload
Initial Assessment/ Investigation	12 active cases per month, per 1 social worker
Ongoing Cases	17 active families per 1 social worker and no more than 1 new case assigned for every six open cases
Combined Assessment/ Investigation and Ongoing Cases	10 active on-going cases and 4 active investigations per 1 social worker
Supervision	1 supervisor per 5 social workers

It should be noted that the caseload is based on new and active cases per month. In other words, new cases should not be added in a new month unless a comparable # of cases have been closed, assuming that the worker has a full caseload.

The recommended caseload standards for family foster care services are as follows (CWLA Standards of Excellence for Family Foster Care Services, Revised 1995):

Service/Caseload Type	CWLA Recommended Caseload/ Workload
Foster Family Care	12-15 children per 1 social worker
Supervision	1 supervisor per 5 social workers

The number of supervisees assigned to a given supervisor should be determined by the training and experience of both the supervisor and supervisees.

Background

Alaska State Legislature

House of Representatives

Session address:
Alaska State Capitol
Juneau, Alaska 99801-1182
1-888-465-2647 (toll free)
1-907-465-3518 (fax)

Interim address:
716 West 4th Avenue
Anchorage, Alaska 99501-2133
1-907-269-0106
1-907-269-0109 (fax)

Representative Les Gara

February 6, 2006

Tammy Sandoval
Deputy Commissioner
Office of Children's Services
P.O. Box 110630
Juneau, AK 99811
Via Fax to: (907) 465-3397

Dear Tammy:

I understand you are currently in the process of completing a workload study for social workers statewide. We appreciate the time you spent working with us, and with Senator Guess and Representative Dahlstrom last year to discuss this issue. As you know, we've pushed for a reduction in social worker caseloads since 2003.

In our conversations last year, we discussed waiting for the results of the workload study, and then introducing a bill to implement the recommended changes. Because of the bill introduction deadline of February 13th, we've decided to introduce the bill we wrote last year, but are committed to work with you to update it once the study is released.

Thank you again for your commitment to helping children in foster care and state custody. I look forward to working with you.

Best Regards,

Les Gara

cc: Rep. Nancy Dahlstrom
Sen. Gretchen Guess

E-mail: Representative_Les_Gara@legis.state.ak.us

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

OFFICE OF CHILDREN'S SERVICES

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110630
JUNEAU, ALASKA 99811-0630
PHONE: (907) 465-3170

February 28, 2006

Bill File

Honorable Representative Les Gara
Alaska State Legislature
State Capitol Building, Room 418
Juneau, Alaska 99801

Dear Representative Gara:

Thank you for the opportunity to meet with you and your staff on February 15th to discuss the Office of Children's Services (OCS) workload study and staffing needs.

During our meeting, you requested a current caseload count and suggested interest in a comparison to Child Welfare League of America (CWLA) caseload standards. As you probably know, the CWLA has different standards for different phases of child protective services case work. Since many of our workers do all phases of the work, calculating caseload standards based on CWLA definitions is not necessarily comparable for Alaska.

In our effort to understand the data we received from Hornby, Zeller, Inc., we learned that as of February 17th, ORCA reflected approximately 4,164 open cases statewide. Based upon the corresponding number of open cases per region and front-line workers in each region, the approximate average caseloads per worker are as follow:

Anchorage – 30; Northern – 16; Southcentral – 15; and Southeast – 15

We believe the high numbers of cases in the Anchorage region can be attributed to the fact that Anchorage has been more successful at closing their assessments and re-opening cases for in-home services when it has been determined that the family could benefit from further intervention. ORCA is currently reflecting a more realistic picture of the in-home cases for Anchorage staff, as compared to staff in any other region.

In an on-going effort strengthen the integrity of our data, I have requested that a statewide data clean-up effort will be complete by the end of March. I expect more accurate caseload numbers on April 1st. I have received a commitment from our workload study contractor to recalculate, using their workload formula, and I expect to have a more accurate count with which to better analyze our needs at that time.

As always, I truly appreciate your support.

Sincerely,

Tammy Sandoval

Tammy Sandoval
Deputy Commissioner

LEGISLATIVE RESEARCH REPORT

JANUARY 12, 2005

REPORT NUMBER 05.065

OFFICE OF CHILDREN'S SERVICES FRONT-LINE SOCIAL WORKERS AND THEIR CASELOADS

PREPARED FOR REPRESENTATIVE LES GARA

BY CHUCK BURNHAM, JOYCELYN WARD, AND ROGER WITHINGTON,
LEGISLATIVE ANALYSTS

You asked for information on the Office of Children's Services (OCS).[1] Specifically, you asked for a comparison of the OCS front-line Social Workers to their caseloads for FY2004 and FY2005. Further, you asked for an estimate of what the front-line Social Worker caseloads will be if Governor Murkowski's proposal for 31 new OCS workers is adopted for FY2006.[2] You also wanted to know how these caseloads compare to the caseload standards established by the Child Welfare League of America (CWLA).

Unfortunately, the OCS was unable to provide us with all of the specific information you requested. One of the principal reasons behind this inability is that the manner in which the OCS delivers child protective services does not precisely match the categories used by the Child Welfare League of America in calculating recommended caseload standards.[3] The CWLA views service delivery as three separate functions: initial assessment and investigation, ongoing cases, and foster family care. The CWLA does not appear to provide a caseload standard that "mixes" these functions--that is, a standard that assumes social workers perform multiple aspects of service delivery—which would more closely reflect the circumstances experienced by front-line Social Workers in many areas of Alaska. Further, some front-line Social Workers in Alaska license, or help in licensing, foster homes and residential care facilities. The CWLA standards do

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[1] Governor Murkowski reorganized the Alaska Department of Health and Social Services (DHSS) through Executive Order 108. Beginning on July 1, 2003, the duties of the Division of Family and Youth Services (DFYS) were merged with some duties formerly in the Divisions of Public Health and Medical Assistance, forming the Office of Children's Services (OCS). The OCS is responsible for Child Protective Services, Adoption, Foster Care, Family Services, Healthy Families Alaska, Infant Learning Program, WIC, and Behavioral Rehabilitation Services. Alaska Statutes 47.10, Children in Need of Aid, and 47.17, Child Protection, delineate most of Alaska's child protection laws.

[2] On November 29, 2004, the Alaska Department of Health and Social Services issued a press release indicating that Governor Frank Murkowski would request 34 new positions for the OCS in his FY2006 budget. On December 16, 2004, Governor Murkowski released his FY2006 budget proposal that included only 31 new employees for the OCS.

[3] The CWLA's caseload standards can be found at *http://www.cwla.org/newsevents/news030304cwlacaseload.htm*.

not account for these activities in their standard caseload. Additionally, during the initial assessment and investigation stage, some offices provide child protective services to families, but do not have custody of the child. Such situations fall under the OCS's "investigation" category but are viewed as "ongoing" by the CWLA. The sum of these limitations and inconsistencies make a direct comparison of the caseloads of the OCS front-line workers to the CWLA caseload standards problematic.

The OCS was able, however, to express the current caseloads of front-line Social Workers in a way that allows for a comparison of caseloads for FY2004 with those for FY2005, which we present in Tables 1 and 2 respectively.[4] Please use caution when interpreting these two tables as they measure only two service delivery components of the OCS: child protective service investigations and on-going services (cases in which the OCS has custody of a child, including children placed in Alaska pursuant to the Interstate Compact for the Placement of Children (ICPC)). The data the OCS provided to us does not reflect the activities of Social Workers associated with licensing or in-home services (cases in which a family receives services but no children are taken into state custody).

The OCS has 20 staff statewide who are responsible only for licensing activities and who are not front-line workers. Licensed Foster Homes are reviewed one year after they are first licensed and every two years thereafter. Licensing staff complete these reviews in addition to conducting the initial home studies. In small OCS offices, however, the front-line workers perform investigations, on-going case services, *and* licensing. Mike Lesmann, Program Coordinator with the Office of Children's Services, notes that although the OCS currently has some in-home cases, it does not have the resources to meet the demand for this type of service. The OCS estimates that they would need an additional 33 workers to meet the in-home case demand.[5]

Both Tables 1 and 2 base caseloads on *available* front-line, case-carrying staff. Please note, these figures do not include vacant positions, workers on long term leave such as Family Medical Leave Act, and newly hired workers who are in training and not yet carrying cases. Included are non-permanent case-carrying workers.[6]

Using FY2004 staffing levels, Table 1 calculates the caseloads of front-line Social Workers based on child protective service investigations and on-going case services active on August 2, 2004. Included in Table 1 are the following for each OCS office:

- The caseload standard,
- The number of cases per front-line worker
- The number of cases per worker in excess of the standard,
- The total number of front-line workers needed to meet the standard

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[4] Typically, "workload" is used to describe the aggregate of all duties assigned to social workers. "Caseload," by contrast, means the number of individual cases, or families, assigned to an individual social worker. Generally, "workload" is a measurement of time and effort and "caseload" is a measure of case volume.

[5] Mr. Lesmann can be contacted at 907-465-3548.

[6] At the time the OCS provided us with this data, they indicated that there were only two vacant front-line Social Worker positions statewide (a 3.3% vacancy rate for front-line workers). If filled, these vacant positions would reduce the number of front-line workers needed to meet the caseload standard to 38 in FY2004, 24 in FY2005, and 13 in FY2006. Please note that although we have not received the current front-line worker vacancy rate from the OCS, related material that we have received from the OCS implies the front-line worker vacancy rate is somewhat higher than 3.3%.

- The number of available front-line social workers, and
- The number of additional front-line workers needed to meet the standard.

As we noted, the typical caseload of many, though not all, front-line OCS Social Workers is comprised of a mix of investigation cases and ongoing cases (which the CWLA refers to as Foster Family Care cases). Although the CWLA standards do not precisely correspond to how the OCS delivers and accounts for its services, the OCS established its own caseload standards for each office based on the CWLA standard for providing Foster Family Care services (12 to 15 children per one Social Worker) and the geographic area covered by each office. In other words, the "Caseload Standard" provided in Tables 1 and 2 are generally based, in part, on CWLA standards.

Using FY2005 staffing levels, Table 2 also calculates the caseloads of the front-line Social Workers based on the child protective service investigations and on-going case services active on August 2, 2004. Included in the FY2005 calculation are 14 new front-line Social Worker positions.[7] The components and formulae in Table 2 are otherwise similar to those presented in Table 1.

As you can see by comparing the two tables, adding the 14 new workers in FY2005 reduced the overall average number of cases per front-line worker from 18 in FY2004 to 17 in FY2005. As Table 2 illustrates, the OCS still needs an additional 26 front-line workers to meet the established caseload standard.

On December 16, 2004, Governor Murkowski released his FY2006 budget proposal. This proposal includes the addition of 31 new employees for the OCS, 11 of whom are to be front-line Social Workers. According to Marcia Kennai, Deputy Commissioner, the OCS has not determined where these new employees will be located.[8] Ms. Kennai has indicated that the OCS plans to conduct a workload time study in the spring of 2005. Once this time study is analyzed, and if the positions are approved, she will distribute the new positions to the appropriate locations. Preliminarily, however, she anticipates that Anchorage will get at least three new positions (and one supervisor), and the other positions will be distributed to Kenai, Homer, Saint Mary's, Dillingham, and Bethel. According to our calculations, the OCS will still need an additional 15 front-line Social Workers to meet the caseload standards the OCS used in Tables 1 and 2.

As you will note from Tables 1 and 2, there are several OCS offices that appear to be overstaffed as indicated by a negative number in the "Number of Additional Front-Line Workers Needed to Meet Standard" column. This is one illustration of the limitations of the OCS's analysis. In an effort to provide a more complete picture, we contacted three Social Workers at the Juneau OCS office. Each of these three employees indicated that staff turnover rates, burdensome administrative functions, case complexity, and unpaid overtime work do not receive sufficient

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[7] The OCS created 26 new positions in the FY2005 budget; 14 of those positions are front-line case-carrying Social Workers. According to Debra Wahl, Administrative Manager for the OCS, as of December 8, 2004, not all of these positions had been filled.

[8] Marcia Kennai, Deputy Commissioner of the Office of Children's Services, 907-465-3191.

consideration in caseload calculations.[9] Administrative staff at the OCS also expressed similar concerns regarding the shortcomings of the current caseload accounting system.

In 2002, the CWLA published a "Research 2 Practice" report on the child welfare workforce in which many of these issues are discussed. We include a copy of this report as Attachment A.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[9] Of these three Social Workers, none had less than six years experience at OCS. One supervisor indicated that turnover had been "almost 100% since June" in her unit. One stated that he worked six hours overtime weekly, on a year-in, year-out basis.

Table 1: OCS Caseload on August 2, 2004, Using FY2004 Staffing Levels

Region	Office	Caseload Standard	Cases per Front Line Worker	Cases per Worker in Excess of Standard	Total Number of Front Line Workers Needed to Meet Standard	Number of Available Front Line Workers	Number of Additional Front Line Workers Needed to Meet Standard
Anchorage	**Anchorage**	**15**	**24**	**+ 9**	**87**	**55**	**+ 32**
South Central	**Region Total [a]**	**13.6**	**18**	**+ 4**	**56**	**42**	**+ 14**
	Bethel	13	13	- 0	10	10	- 0
	Kenai	14	24	+ 10	10	6	+ 4
	Mat-Su	14	12	- 2	10	11	- 1
	All Other SCRO [a]	13.1	23	+ 10	26	15	+ 11
	Aniak	12	22	+ 10	4	2	+ 2
	Cordova	14	13	- 1	1	1	- 0
	Dillingham	13	52	+ 39	4	1	+ 3
	Homer	14	39	+ 25	6	2	+ 4
	King Salmon	12	16	+ 4	1	1	+ 0
	Kodiak	14	9	- 5	1	2	- 1
	Seward	13	14	+ 1	1	1	+ 0
	St Mary's	12	27	+ 15	7	3	+ 4
	Unalaska	12	0	- 12	0	1	- 1
	Valdez	12	30	+ 18	3	1	+ 2
Northern	**Region Total [a] [b]**	**13.6**	**16**	**+ 2**	**42**	**36**	**+ 6**
	Fairbanks	15	17	+ 2	21	19	+ 2
	Nome [b]	13	13	+ 0	5	5	+ 0
	All Other NRO [a] [b]	11.4	16	+ 4	16	12	+ 4
	Barrow	13	20	+ 7	3	2	+ 1
	Delta	13	15	+ 2	2	2	+ 0
	Galena	12	12	+ 0	1	1	+ 0
	Fairbanks Bush	12	9	- 3	2	3	- 1
	Kotzebue [b]	13	23	+ 10	5	3	+ 2
	McGrath	12	11	- 1	1	1	- 0
Southeast	**Region Total [a]**	**14.8**	**10**	**- 4**	**18**	**25**	**- 7**
	Juneau	15	11	- 4	10	14	- 4
	Ketchikan	15	9	- 6	3	5	- 2
	All Other SERO [a]	14.1	10	- 4	4	6	- 2
	Craig	15	11	- 4	1	2	- 1
	Petersburg	13	9	- 4	1	1	- 0
	Sitka	14	10	- 4	1	2	- 1
	Wrangell	12	9	- 3	1	1	- 0
Statewide Total [a]		**14.6**	**18**	**+ 4**	**198**	**158**	**+ 40**

Notes: The OCS established caseload standards for each office based on the CWLA standard for providing Foster Family Care services (12 to 15 children per one Social Worker) and the geographic area covered by each office. These caseloads include investigations, children in legal custody or supervision, and children placed in Alaska pursuant to the Interstate Compact for the Placement of Children (ICPC). Cases involving in-home services (where no children are in legal custody) and licensing caseloads are not included in this table. All worker counts are based on front-line, case-carrying staff. The calculation for front-line, case-carrying staff excludes vacant positions, workers on long term leave such as Family Medical Leave Act, and new workers who are in training and not yet carrying cases. It includes non-permanent case-carrying workers.

(a) The caseload standard is weighted. The base caseload standard is 15, but the standard for an office may be adjusted based for the size of the geographic area served and the availability of transportation. Subtotals may not add to totals due to rounding.

(b) Workers employed by Kawerak in Nome and workers employed by Manilaq in Kotzebue, who provide child protective services are not counted in this analysis.

Sources: Mike Lesmann, Program Coordinator with the Office of Children's Services, 907-465-3548.

Table 2: OCS Caseload on August 2, 2004, Using FY2005 Staffing Levels

Region	Office	Caseload Standard	Cases per Front-Line Worker	Cases per Worker in Excess of Standard	Total Number of Front Line Workers Needed to Meet Standard	Number of Available Front Line Workers	Number of Additional Front Line Workers Needed to Meet Standard
Anchorage	**Anchorage**	**15**	**21**	**+ 6**	**87**	**62**	**+ 25**
South Central	**Region Total** [a]	**13.6**	**16**	**+ 2**	**56**	**47**	**+ 9**
	Bethel	13	11	- 2	10	12	- 2
	Kenai	14	24	+ 10	10	6	+ 4
	Mat-Su	14	11	- 3	10	12	- 2
	All Other SCRO [a]	13.1	20	+ 7	26	17	+ 9
	Aniak	12	22	+ 10	4	2	+ 2
	Cordova	14	13	- 1	1	1	- 0
	Dillingham	13	26	+ 13	4	2	+ 2
	Homer	14	26	+ 12	6	3	+ 3
	King Salmon	12	16	+ 4	1	1	+ 0
	Kodiak	14	9	- 5	1	2	- 1
	Seward	13	14	+ 1	1	1	+ 0
	St Mary's	12	27	+ 15	7	3	+ 4
	Unalaska	12	0	- 12	0	1	- 1
	Valdez	12	30	+ 18	3	1	+ 2
Northern	**Region Total** [a] [b]	**13.6**	**15**	**+ 1**	**42**	**38**	**+ 4**
	Fairbanks	15	15	+ 0	21	21	+ 0
	Nome [b]	13	13	+ 0	5	5	+ 0
	All Other NRO [a] [b]	11.4	16	+ 4	16	12	+ 4
	Barrow	13	20	+ 7	3	2	+ 1
	Delta	13	15	+ 2	2	2	+ 0
	Galena	12	12	+ 0	1	1	+ 0
	Fairbanks Bush	12	9	- 3	2	3	- 1
	Kotzebue [b]	13	23	+ 10	5	3	+ 2
	McGrath	12	11	- 1	1	1	- 0
Southeast	**Region Total** [a]	**14.8**	**10**	**- 4**	**18**	**25**	**- 7**
	Juneau	15	11	- 4	10	14	- 4
	Ketchikan	15	9	- 6	3	5	- 2
	All Other SERO [a]	14.1	10	- 4	4	6	- 2
	Craig	15	11	- 4	1	2	- 1
	Petersburg	13	9	- 4	1	1	- 0
	Sitka	14	10	- 4	1	2	- 1
	Wrangell	12	9	- 3	1	1	- 0
Statewide Total [a]		**14.6**	**17**	**+ 2**	**198**	**172**	**+ 26**

Notes: The OCS established caseload standards for each office based on the CWLA standard for providing Foster Family Care services (12 to 15 children per one Social Worker) and the geographic area covered by each office. These caseloads include investigations, children in legal custody or supervision, and children placed in Alaska pursuant to the Interstate Compact for the Placement of Children (ICPC) Cases involving in-home services (where no children are in legal custody) and licensing caseloads are not included in this table. All worker counts are based on front-line, case-carrying staff. The calculation for front-line, case-carrying staff excludes vacant positions, workers on long term leave such as Family Medical Leave Act, and new workers who are in training and not yet carrying cases. It includes non-permanent case-carrying workers.

(a) The caseload standard is weighted. The base caseload standard is 15, but the standard for an office may be adjusted based for the size of the geographic area served and the availability of transportation. Subtotals may not add to totals due to rounding.

(b) Workers employed by Kawerak in Nome and workers employed by Manilaq in Kotzebue, who provide child protective services are not counted in this analysis.

Sources: Mike Lesmann, Program Coordinator with the Office of Children's Services, 907-465-3548.

Attachment A

Child Welfare Workforce, Child Welfare League of America, September 2002, *http://www.cwla.org/programs/r2p/rrnews0209.pdf*

RESEARCH ROUNDUP
MOVING FROM RESEARCH TO PRACTICE
RESEARCH R2P to PRACTICE

September 2002

Child Welfare Workforce

Overview

According to the results of the Child Welfare League of America's (CWLA's) *2000 Membership Trends and Issues Survey*, public and private nonprofit agencies report that the greatest concerns for the child welfare field are the increasing number of children needing services and the lack of qualified staff.

No issue has a greater effect on the capacity of the child welfare system to effectively serve vulnerable children and families than the shortage of a competent and stable workforce. Without an adequate workforce, agencies are not able to adhere to national service and caseload standards, maintain a climate that supports the delivery of high quality services, or adopt evidence-based practices.

TRENDS

- The increasing number of children needing services and the lack of qualified staff affect children and families.
- Turnover often exceeds 50% per year in the child welfare field, and position vacancy rates often surpass 12%.

Nearly every American industry has experienced labor shortages at some time, but shortages in the helping professions are especially troublesome. Effectiveness in this area comes from increasing staff expertise, building rapport, and establishing stable, trusting relationships with children, families, and communities. These prerequisites for success are undermined by high turnover. Child welfare agencies experience turnover that frequently exceeds 50% per year. Position vacancy rates often surpass 12% (Drais-Parrillo, in press). The shortage of qualified workers affects these agencies at almost every level, including child and youth care staff, social workers, and support and administrative staff.

At the agency level, the current workforce crisis is evident in three ways. First, an insufficient number of qualified candidates are in the recruitment pool. Second, agencies are often unable to compete with other segments of the economy in terms of salary, benefits, and working conditions. Third, agencies are unable to retain workers.

These are not new challenges for child welfare agencies. In 1991, Helfgott reviewed literature and recommendations from child welfare leaders. It outlines many of the difficulties agencies report today. Items specifically cited as key challenges for staffing child welfare agencies were:

- increasingly complex demands for services and workloads,
- lack of resources for clients,
- insufficient training,
- inadequate financial compensation,
- safety and liability concerns, and
- poor physical and organizational working conditions.

In the past decade, these issues have not improved, and some have worsened. The cumulative effect on agency service provision is complex and will not respond to a quick fix. Some of the solutions are so obvious to many child welfare professionals that formal research seems unnecessary. The lack of progress in resolving these problems, continued negative public perception of the child welfare field, and an unwillingness to invest public resources in children, families, and those who work with them, however, demand a multifaceted approach.

Because an adequate workforce is fundamental to the delivery of services by child welfare agencies, CWLA's Research to Practice (R2P) Initiative has selected it as a focus area. The expectation is that bringing together a summary of the literature and the research efforts to date will provide agencies and advocates with the foundation to make productive decisions and changes, whether they are revising the workforce policies of a small work unit or of a statewide system.

Literature Review

Historical Perspective

What is now being termed the *workforce crisis* has its roots in public policy decisions made over the past 30 years. During the early years of the 20th century, the U.S. Children's Bureau, in cooperation with universities and local agencies, built a child welfare system staffed by people with professional social work educations (Schorr, 2000). As a result, the preferred standard for employment became the master's of social work degree (MSW). Child welfare came to be viewed as a prestigious specialty within the social work profession (A. Ellett, 1996; Leighninger & Ellett, 1993).

In 1962, at the federal level, child welfare merged with public assistance, which traditionally placed less emphasis on educational qualifications of staff. Later, increased recognition of child abuse led to passage of the Child Abuse Prevention and Treatment Act of 1974. The enactment of state child abuse and neglect reporting laws followed, leading to an avalanche of child abuse reports. There was no provision of adequate resources for the preparation and support of additional staff required to respond to the reports, however (A. Ellett & Millar, 1996; Leighninger & Ellett, 1998). Consequently, states moved quickly to reduce staff qualifications to hire enough employees (A. Ellett, 1996).

In the wake of this "deprofessionalization," agencies began to structure child welfare work differently, attempting to reduce its complexity and make it possible for people with fewer qualifications to adequately perform required tasks. These efforts are reflected in practices such as specialization, which causes families to be passed from one caseworker to another as they move through various agency programs, and the purchase of external clinical services that were formerly provided by internal agency staff (A. Ellett, 1996; Schorr, 2000).

Attempts to reform the system during the 1980s and 1990s were largely devoid of attention to the fundamental issues of workforce quality and quantity. Instead, efforts focused on external monitoring from courts and review bodies (O'Donnell, 1992). As a result, the child welfare work environment evolved into one characterized by lowered autonomy, heightened regimentation, and increased documentation (A. Ellett, 1996; Reagh, 1994; Schorr, 2000).

Issues in Workforce

The professional literature contains a substantial body of writing based on descriptive data and observations of trends in policy and practice over the past two decades. When this work is considered as a whole, seven major areas of concern emerge.

Staff Qualifications and Selection

A national study (Lieberman, Hornby, & Russell, 1988) revealed that only 28% of staff employed in public child welfare agencies had formal social work education. Recruitment and selection of qualified staff are hampered by the lack of accurate, realistic job descriptions necessary to ensure an applicant's understanding of the nature of the work and the knowledge, skills, and attitudes essential for competent performance (Pecora, Briar, & Zlotnik, 1989; Pecora, Whittaker, Maluccio, & Barth, 2000).

Work Environment and Support

Work environment includes both the physical setting that agencies provide and the resources made available to support the staff's multiple tasks and responsibilities. Child welfare practice settings are often deficient in both these areas (Pecora et al., 1989).

Perhaps the most important element of the work environment, however, is not the physical setting, but the organizational infrastructure, which includes such factors as supervision, level of organizational support, professional culture, autonomy, and flexibility. Many authors suggest that as child welfare work becomes more highly structured and regulated, it no longer has the flexibility and autonomy that characterizes a true profession (A. Ellett, 1996; Reagh, 1994). In addition, policies to which staff must conform are too often driven by external forces such as legislation and the courts. These policies are not consistent with the evidence supporting good practice (Malm, Bess, Leos-Urbel, Green, & Markowitz, 2001).

Workload

Unlike many other human service agencies, child welfare, at least in the public sector, has little ability to control work intake. Workers view high caseloads (often two to three times the amount recommended by CWLA standards (CWLA, 1991, 1995, 1997, 1998, 1999, 2000) and voluminous paperwork as the norm. Agencies are also subject to changes in legislation and policy that add to the duties associated with cases. A caseload standard, there-

fore, may be reasonable one year and unmanageable the next. The best examples of this are the increase in required documentation linked to the external reviews imposed by legislative changes and the time that caseworkers must spend in court or in meetings with review boards (C. Ellett, 1995; Malm et al., 2001; O'Donnell, 1992).

Salaries and Promotion Opportunities

Researchers point out that salaries in all areas of child welfare tend to be lower than in other jobs of comparable difficulty. As the need for social workers has expanded in other settings, this may discourage the best-qualified prospective employees from entering child welfare (Pecora et al., 1989). Agencies with a hierarchical organizational structure offer limited opportunities for promotion, and promotion typically requires that the caseworker move from direct service provision to management (C. Ellett, 1995).

Professional Development

Although professional development is valued by employees and can positively affect service delivery, both in-service training and continuing education opportunities are often greatly reduced or eliminated in times of fiscal shortfalls (Pecora et al., 1989). Even when continued learning opportunities are available, the mentoring and organizational support that staff need to transfer learning into performance may not be available (Alwon & Reitz, 2000). Furthermore, the regimented nature of work in many agencies discourages the exercise of judgment and decision-making that are critical to advanced skill development (Ewalt, 1991; Schorr, 2009).

Public Image and Professional Respect

The poor image of child welfare agencies has an adverse effect on morale and the ability of agencies to recruit and retain qualified employees (Ellett, 1995; Pecora et al., 1989). Lack of respect is shown in the attitudes of the public and the other professionals with whom child welfare staff must work each day. Staff reports of disrespectful treatment by judges and legal professionals suggest that the interface between agencies and the courts is an area of particular difficulty in this regard (C. Ellett, 1995; Malm et al., 2001).

Media coverage of child welfare agencies is often poorly researched and overly sensationalized. Such publicity, especially in the wake of a child death, may promote quickly designed changes in policy and legislation that are unsettling to staff and have unintended adverse consequences (Malm et al., 2001).

Personal Safety and Liability

Concerns about staff safety have grown over the past two decades as agencies report working with an increasingly needy and disturbed client population. Likewise, situations in which staff are placed in personal jeopardy as a result of civil litigation arising from their professional duties have increased (Alwon & Reitz, 2000).

Workforce Research

Empirical exploration of workforce issues has focused primarily on the identification of factors that are related to either employee performance or turnover and retention.

Performance

Social Work Education

Education is the variable that child welfare workforce researchers have explored most often in relation to performance. Several studies have found evidence that social work education, at either the bachelor's of social work (BSW) or MSW level, positively correlates with performance.

A study conducted in Maryland public child welfare agencies found an MSW to be the best predictor of overall performance as measured by supervisory ratings and employee reports of work-related competencies (Booz-Allen & Hamilton, 1987). A national study (Lieberman et al., 1988) that measured competencies related to 32 job-related

MOVING FROM RESEARCH TO PRACTICE

R2P encourages practitioners and agencies to make critical practice changes that reflect promising strategies and research findings featured in this Roundup. CWLA can provide comprehensive consultation on practice planning and implementation that can improve your agency's workforce status. Assistance is also available in establishing an evaluation component for existing programs or practices. R2P welcomes inquiries or information about your successful efforts to improve the child welfare workforce or other child welfare–related issues. Please send them to r2p@cwla.org.

For additional information about the R2P Initiative, visit www.cwla.org/programs/r2p. To further your understanding of CWLA's Workforce Initiative, visit www.cwla.org/programs/trieschman.

duties found that both MSW and BSW staff were better prepared for child welfare work than their colleagues without social work education. Research conducted with staff in Kentucky's public child welfare agency also revealed that staff with social work degrees scored significantly better on state merit examinations, received somewhat higher ratings from their supervisors, and had higher levels of work commitment than other staff (Dhooper, Royse, & Wolfe, 1990). A Nevada study (Albers, Reilly, & Rittner 3) showed that caseworkers who had a social work degree were significantly more likely to create a permanent plan for children in their caseloads within three years than their colleagues without social work education. In a study of professional staff in the public child welfare systems in Arkansas and Louisiana, Ellett (2000) found that social work education was associated with higher self-reported professional self-efficacy.

Much of the research on the effect of education has focused on the agency-university partnership programs that have been established over the past decade using federal funding provided by Title IV-E of the Social Security Act. Although there is variability in these programs, they generally aim to increase educational opportunities for agency staff to add to the pool of potential child welfare employees and enhance the relevance of curricula in schools of social work. Research to examine their effects found that students score significantly higher on measures of job-related competencies (Fox, Burn-ham, Barbee, & Yankeelov, 2000; Okamura & Jones, 1998). Graduates of the specialized child welfare program in New York State had higher levels of skills, confidence, and sensitivity to clients (Hopkins, Mudrick, & Rudolph, 1999).

WORKFORCE

- Less than a third of staff employed in public child welfare agencies have formal social work education.
- Salaries in public and private child welfare agencies are lower than in other comparable jobs.
- The increased regulation of public child welfare work, combined with external decisionmaking, make this an unattractive job setting for professionals.
- The poor image of child welfare agencies has an adverse effect on morale and the retention of qualified employees.
- Concerns about staff safety have grown over the past two decades.

Turnover and Retention

Social Work Education

Some research has also linked social work education to employee retention in child welfare. Russell (1987) found that agencies that require social work degrees experience lower turnover rates. A study conducted in Maine's public child welfare agency suggested that relevant education was related to retention (Bernotavicz, n.d.). Ellett (2000) found an association between social work education and self-reported intent to remain employed in child welfare.

Studies have also shown that graduates of specialized child welfare social work education programs are more likely to remain in child welfare and experience greater job satisfaction (Harrison, 1995; Okamura & Jones, 1998; Vinokur-Kaplan, 1991). Lewandowski (1998) found that BSW graduates of an agency-sponsored education program in Kansas tended to remain employed longer than MSWs. This finding may be linked to the case management nature of the public agency jobs, which do not allow MSWs to fully use the clinical and decisionmaking skills they learn in master's programs.

Personal Factors

A small body of research has also explored personal characteristics of staff in relation to turnover and retention. Anderson (1994) found that higher ratings on the Coping Strategies Inventory were associated with intent to remain in child welfare even in the presence of high levels of emotional exhaustion. Other researchers have found commitment, investment, and a sense of mission to be significantly related to retention (Bernotavicz, n.d.; Harrison, 1995; Reagh, 1994; Rycraft, 1994). Higher levels of professional self-efficacy and human caring are also associated with employee intent to remain (A. Ellett, 2000; C. Ellett, 1995).

Work Environment and Support

Other factors with a significant role in employee retention relate primarily to the organizational aspects of the environment. These include organizational support (Ellett, 2000; Midgely, Ellett, Noble, Bennett, & Livermore, 1994; Vinokur-Kaplan, 1991), supervision, and flexibility in job assignments (Bernotavicz, n.d.; Harrison, 1995; Rycraft, 1994; Samantrai, 1992; Texas Department of Protective and Regulatory Services, 2001). In studies that include staff interviews, supportive supervision is the most commonly cited variable

related to turnover and retention. Caseworkers differentiate supervisory support from that of the larger agency, and their comments suggest that they view it as more significant.

Workload

Some studies have found an association between lower workload and retention (CWLA, 2001; Samantrai, 1992; Winefield & Barlow, 1995). Workload is also cited as a negative factor in research exploring job satisfaction (Midgley et al., 1994). Staff report increased clerical work, preparation for court, and time in court as major factors increasing workload, leading to loss of time with clients and diminishing their satisfaction (C. Ellett, 1995; Malm et al., 2001).

Salary and Promotions

Research concerning the role of salary and promotional opportunities as factors in turnover and retention has had mixed results. In a 1984 study, Jayaratne and Chess found both salary and promotion to be significant factors in job satisfaction. A national survey of public and private agencies conducted by CWLA (2001), however, showed no relationship between these factors and retention.

FINDINGS

- Employees with higher social work education perform more positively.
- Agencies that require social work degrees experience lower rates of staff turnover.
- Lower workload is positively associated with staff retention.
- Social work education, supportive supervision, and job flexibility are positively associated with performance and retention.
- Agency-university partnerships can improve employee retention and performance.

Implications for Policy and Practice

A content analysis of workforce research reveals the strongest empirical support for social work education, supportive supervision, and job flexibility as factors positively associated with either performance or retention in child welfare.

Although the evidence related to educational qualifications is not unequivocal, it provides support for social work education as the best preparation for practice in child welfare. These findings tend to be most consistent with regard to graduates of specialized education programs offering enhanced child welfare content and internships in child welfare settings. Such agency-university partnerships have the potential to improve employee retention and performance.

There is evidence that at least for some jobs in child welfare, employees with BSWs may be better suited than those with master's degrees (Dhooper et al., 1990; Lewandowski, 1998). This finding may be related to the increased regimentation that has come to characterize child welfare jobs over the past 20 years. If agencies are to attract and maintain people with MSWs, they will need to create jobs that provide a greater degree of autonomy and make use of the employees' advanced skills.

The strength of supervision as a factor in retention across several studies suggests that agencies may benefit greatly from focusing resources on the support and development of supervisors. Valued supervision in child welfare takes the form of support and consultation rather than strict direction and monitoring (Rycraft, 1994). Accordingly, selection and training for supervisory positions should emphasize these qualities. The critical nature of this role also indicates that agencies may benefit from targeting supervisors for greater organizational support and devising ways for them to have greater input in decisionmaking.

Flexibility in job assignment allows employees to find the best fit between job expectations and their skills and aptitudes (Rycraft, 1994). The strength of this finding is encouraging because it is within the power of creative managers to provide greater flexibility in job description and assignment.

Implications for Future Research

Studies need to empirically establish the duties and competencies associated with child welfare work. Such research would provide the basis for developing job descriptions that more accurately depict job requirements and for setting and defending education standards (Pecora et al., 1989; Gambrill, 1997).

Researchers should explore the relationship between workforce factors, as staff qualifications, workload, and stability, and client outcomes. The effective deployment of resources is informed by studies that tie successful interventions to staff qualifications and workload (Pecora et al., 1989) and that compare the cost-effectiveness of external purchase of services with the provision of agency staff capable of performing these functions.

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Research to Practice

With the advice of program staff and leaders in the field, CWLA's Research to Practice (R2P) Initiative identifies well-researched, effective methods and practices in public and private agencies, both CWLA member agencies and others, that affect the lives of children, youth, families, and communities in a positive way.

Agency staff, an outside individual or group, or a university may have conducted the qualitative or quantitative research or evaluation component. R2P's goal is to support and promote the implementation of well-researched, evaluated methods. (See box on Research to Practice Levels of Rigor.)

CWLA disseminates information about these programs and practices, as well as strategies for implementation or replication, to its member agencies and the field through a variety of media, workshops, consultation, and development services.

Topics the R2P Initiative is initially exploring include youth development and mentoring, family reunification, workforce issues, behavioral health, brain research and early childhood development, and juvenile justice.

For further information, visit R2P's website at www.cwla.org/programs/r2p, or contact the R2P team by e-mail at r2p@cwla.org.

RESEARCH TO PRACTICE LEVELS OF RESEARCH RIGOR

Each program or practice included in the R2P Initiative has been identified as effective, with successes supported by a research component. R2P has developed four categories to describe the level of empirical support available. All programs and practices exist within an organizational context, with many factors that may influence outcomes.

Exemplary Practice

Research in this category has the following characteristics: a randomized study, a control group, posttests or pre- and posttests, effects sustained for at least one year, and multiple replications.

Commendable Practice

Research in this category has most of the following characteristics: a randomized or quasi-experimental study, a control or comparison group, posttests or pre-and posttests, follow up, and replication.

Emerging Practice

Research in this category has most of the following characteristics: a quasi-experimental study, a correlational or ex post facto study, posttest only, single group pre- and posttest, and a comparison group.

Innovative Ideas

Research in this category has most of the following characteristics: a case study, descriptive statistics only, and treatment group only.

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HB

442

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FAX TRANSMITTAL SHEET

TO: Leg Legal Terry Bannister 6650

FAX # 3027 **DATE** 3/21/06

# of PAGES (total): 11 w/cover

FROM:

____ **Representative Peggy Wilson**
____ **Jean Ellis**
____ **Becky Rooney**
__X__ **Linda Miller** - 3759
____ **Aaron Danielson**

COMMENTS:

Please incorporate the attached two amendments into a final CS for HB 442. The version adopted in G.

Thanks

Linda

24-LS1618\G.1
Bannister
2/24/06

AMENDMENT # 1

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: HB 442

Page 3, lines 24 - 26:

Delete "**or if the physician reasonably believes that the patient does not have a qualifying condition**"

Page 4, line 25, following "chapter;":

Insert "**or**"

Page 4, lines 27 - 31:

Delete "**or**

(D) because the health care provider or institution has a good faith belief that the condition requiring cardiopulmonary resuscitation or other resuscitative measures is not precipitated by a qualifying condition;"

24-LS1618\G.2
Bannister
2/28/06

AMENDMENT H 2

OFFERED IN THE HOUSE BY REPRESENTATIVE GARDNER

TO: HB 442

Page 1, line 4:

Delete "**of health care providers and institutions**"

Insert "**and discipline of health care providers, institutions, and facilities**"

Page 2, line 25, through page 3, line 10:

Delete all material.

Renumber the following bill sections accordingly.

Page 4, line 25, following "chapter;":

Insert "**or**"

Page 4, lines 27 - 31:

Delete "**or**

(D) because the health care provider or institution has a good faith belief that the condition requiring cardiopulmonary resuscitation or other resuscitative measures is not precipitated by a qualifying condition;"

Page 5, lines 3 - 12:

Delete all material and insert:

"*** Sec. 7.** AS 13.52.080 is amended by adding a new subsection to read:

(c) A health care provider, health care institution, or health care facility is not

subject to civil or criminal liability, or to discipline for unprofessional conduct, if a do not resuscitate order prevents the health care provider, health care institution, or health care facility from attempting to resuscitate a patient who requires cardiopulmonary resuscitation or other r suscitative measures because of complications arising out of health care being administered to the patient by the health care provider, health care institution, or health care facility. This subsection does not apply if the complications suffered by the patient are caused by reckless or intentional actions on the part of the health care provider, health care institution, or health care facility."

Renumber the following bill sections accordingly.

Page 6, line 4:

Delete "sec. 7"

Insert "sec. 5"

Amendment to A M E N D M E N T #2

OFFERED IN THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
TO: HB 442 Version G

BY Rep.Gardner
DATE 2/28/06

1 Amendment to Amendment #2
2 Page 2, line 7,

After "...patient are caused by" insert gross negligence, before "reckless".

• Bill with markings of proposed amendment by Gardner

24-LS1618\G

HOUSE BILL NO. 442

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE WEYHRAUCH

Introduced: 2/10/06
Referred: Health, Education and Social Services, Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act relating to the validity of advance health care directives, individual health care instructions, and do not resuscitate orders; relating to the revocation of advance health care directives; relating to do not resuscitate orders; relating to resuscitative measures; [redacted] relating to the liability of health care providers and institutions relating to an individual's capacity for making health care decisions; and providing for an effective date."

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

*** Section 1.** AS 13.52.010(k) is amended to read:

(k) An advance health care directive, including an advance health care directive that is made in compliance with the laws of another state, is valid for purposes of this chapter **if** [TO THE EXTENT THAT] it complies with [THE LAWS OF] this **chapter, regardless of where or when it was executed or communicated** [STATE].

*** Sec. 2.** AS 13.52.010 is amended by adding a new subsection to read:

(*l*) Notwithstanding the sample form provided under AS 13.52.300, an individual instruction that would be valid by itself under this chapter is valid even if the individual instruction is contained in a writing that also contains a durable power of attorney for health care and the durable power of attorney does not meet the witnessing or other requirements of this chapter.

*** Sec. 3.** AS 13.52.020(c) is amended to read:

(c) In the case of mental illness, an advance health care directive may be revoked in whole or in part at any time by the principal if the principal does not lack capacity and is competent. A revocation is effective when a competent principal with capacity communicates the revocation to a [THE ATTENDING] physician or other health care provider. The [ATTENDING] physician or other health care provider shall note the revocation on the principal's medical record. In the case of mental illness, the authority of a named agent and an alternative agent named in the advance health care directive continues in effect as long as the advance health care directive appointing the agent is in effect or until the agent has withdrawn. For the purposes of this subsection, a principal is not considered competent when

(1) it is the opinion of the court in a guardianship proceeding under AS 13.26, the opinion of two physicians, at least one of whom is a psychiatrist, or the opinion of a physician and a professional mental health clinician, that the principal is not competent; or

(2) a court in a hearing under AS 47.30.735, 47.30.750, or 47.30.770 determines that the principal is gravely disabled; in this paragraph, "gravely disabled" has the meaning given in AS 47.30.915(7)(B).

*** Sec. 4.** AS 13.52.060(d) is amended to read:

(d) Except as provided in (e), (f), and (i) [(e) AND (f)] of this section, a health care provider, health care institution, or health care facility providing care to a patient shall comply with

(1) an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and

(2) a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

* **Sec. 5.** AS 13.52.060 is amended by adding a new subsection to read:

(i) Notwithstanding the exception in (e) of this section for do not resuscitate orders, a health care provider may perform cardiopulmonary resuscitation or other resuscitative measures on a patient even if there is a do not resuscitate order for the patient if the condition requiring cardiopulmonary resuscitation or other resuscitative measures is precipitated by complications arising out of medical services being provided by the health care provider to the patient.

* **Sec. 6.** AS 13.52.065(a) is amended to read:

(a) **A** [AN ATTENDING] physician may issue a do not resuscitate order for a patient of the physician. The physician shall document the grounds for the order in the patient's medical file.

* **Sec. 7.** AS 13.52.065(f) is amended to read:

(f) A do not resuscitate order may not be made ineffective unless a physician revokes the do not resuscitate order**, a patient for whom the order is written and who has capacity requests that the do not resuscitate order be revoked, or the patient for whom the order is written is under 18 years of age and the parent or guardian of the patient requests that the do not resuscitate order be revoked. Any physician of a patient for whom** [. A REQUEST TO REVOKE] a do not resuscitate order **is written** may **revoke the do not resuscitate** [ONLY BE MADE BY THE PERSON FOR WHOM THE] order [IS WRITTEN OR,] if the person for whom the order is written **requests that the physician revoke the do not resuscitate order or if the physician reasonably believes that the patient does not have a qualifying condition** [IS UNDER 18 YEARS OF AGE, BY THE PARENT OR GUARDIAN OF THE PERSON].

* **Sec. 8.** AS 13.52.080(a) is amended to read:

(a) **A** [IF A] health care provider or health care institution **that acts** [MAKES REASONABLE EFFORTS, WITH A LEVEL OF DILIGENCE APPROPRIATE TO THE SERIOUSNESS AND URGENCY OF THE SITUATION, TO ENSURE THE

VALIDITY OF AN ADVANCE HEALTH CARE DIRECTIVE OR A PERSON'S ASSUMPTION OF AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR A PATIENT, A HEALTH CARE PROVIDER OR INSTITUTION ACTING] in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for

(1) providing health care information in good faith under AS 13.52.070;

(2) complying with a health care decision of a person based on a **good faith** [REASONABLE] belief that the person has authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;

(3) declining to comply with a health care decision of a person based on a **good faith** [REASONABLE] belief that the person then lacked authority;

(4) complying with an advance health care directive and [REASONABLY] assuming **in good faith** that the directive was valid when made and has not been revoked or terminated;

(5) participating in the withholding or withdrawal of cardiopulmonary resuscitation under the direction or with the authorization of a physician or upon discovery of do not resuscitate identification upon an individual;

(6) causing or participating in providing cardiopulmonary resuscitation or other life-sustaining procedures

(A) under AS 13.52.065(e) when an individual has made an anatomical gift; [OR]

(B) because an individual has made a do not resuscitate order ineffective under AS 13.52.065(f) or another provision of this chapter; [redacted]

(C) because the patient is a woman of childbearing age and AS 13.52.055 applies; or

(D) because the health care provider or institution has a good faith belief that the condition requiring cardiopulmonary resuscitation or other resuscitative measures is not precipitated by a qualifying condition; or

[redacted]

(7) acting in good faith under the terms of this chapter or the law of another state relating to anatomical gifts.

* **Sec. 9.** AS 13.52.100(c) is amended to read:

(c) An individual who is a qualified patient, including an individual for whom a physician has issued a do not resuscitate order, has the right to make a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures as long as the individual is able to make the decision. **Except as provided by AS 13.52.060(l), if** [IF] an individual who is a qualified patient, including an individual for whom a physician has issued a do not resuscitate order, is not able to make the decision, the protocol adopted under AS 13.52.065 for do not resuscitate orders governs a decision regarding the use of cardiopulmonary resuscitation and other life-sustaining procedures.

* **Sec. 10.** AS 13.52.150 is amended to read:

Sec. 13.52.150. Do not resuscitate orders and identification of other jurisdictions. A do not resuscitate order or a do not resuscitate identification executed, issued, or authorized in another state or a territory or possession of the United States **is valid** [IN COMPLIANCE WITH THE LAW OF THAT JURISDICTION IS RECOGNIZED] for the purposes of this chapter **if it complies with the laws of this state. A health care provider or health care institution may presume, in the absence of actual notice to the contrary, that** [. HOWEVER,] the do not resuscitate order or the do not resuscitate identification **complies** [MAY BE IMPLEMENTED ONLY TO THE EXTENT THAT THE IMPLEMENTATION DOES NOT CONFLICT] with the laws of this state**, regardless of where or when it was executed, issued, or authorized, and that the patient is a qualified patient**.

* **Sec. 11.** AS 13.52.390(7) is amended to read:

(7) "capacity," except in (9) of this section, means an individual's ability to receive and evaluate information effectively **and to make and effectively** [OR] communicate **health care** decisions [TO THE EXTENT NECESSARY TO MAKE MENTAL HEALTH TREATMENT DECISIONS];

* **Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF DO NOT RESUSCITATE ORDERS. A do not resuscitate order made under AS 18.12 before January 1, 2005, continues in effect under AS 13.52 unless the do not resuscitate order is made ineffective under AS 13.52.065(f), amended by [sec. 7] Sec 5 of this Act, or under another provision of AS 13.52.

*** Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECTIONS TO REGULATIONS ATTORNEY. The regulations attorney in the Department of Law shall

(1) replace in 7 AAC 16.010(d)(5) the reference to "an attending physician's DNR order" with "a DNR order by a physician of the patient";

(2) replace in 7 AAC 16.010(d)(5)(B) the reference to "attending physician" with "physician of the patient";

(3) delete in 7 AAC 16.010(g) "attending."

*** Sec. 14.** This Act takes effect immediately under AS 01.10.070(c).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 1, 2006

SUBJECT: CSHB 442(HES) relating health care matters
(Work Order No. 24-LS1618\F)

TO: Representative Peggy Wilson
Chair of House Health, Education and Social Services Committee
Attn: Linda

FROM: Theresa Bannister
Legislative Counsel

This memo accompanies a draft of the bill described above.

Amendment of AS 13.52.100(c). The amendments removed former sec. 9 from the bill. That section amended AS 13.52.100(c) to accommodate the proposed AS 13.52.060(i). Please consider whether sec. 9 needs to be reinserted to avoid a conflict with AS 13.52.060(i)

If I may be of further assistance, please advise.

TLB:med
06-181.med

Enclosure

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 10, 2006 **FURTHER REFERRALS: Judiciary**

Date of Committee Action: 2/28/06

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 442**

HOUSE BILL NO. 442 **HEALTH CARE DECISIONS**

"An Act relating to the validity of advance health care directives, individual health care instructions, and do not resuscitate orders; relating to the revocation of advance health care directives; relating to do not resuscitate orders; relating to resuscitative measures; relating to the liability of health care providers and institutions; relating to an individual's capacity for making health care decisions; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [X] CS *for* HB 442 (HES)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[X] Same Title [X] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	***FN#**	**Fiscal**	**Indet.**	**Zero**
HSS				X

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	**FN#**	**Fiscal**	**Indet.**	**Zero**

Signing with recommendations	**Printed Last Name**	**DP**	**DNP**	**NR**	**AM**
Gordon McInnis	CISSNA			✓	
Paul Seaton	Seaton	X			
Beth Gardner	Gardner	X			
[illegible]	[illegible]	X			
Chair: Peggy Wilson	WILSON	✓			
Chair:					

ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
FAX (907) 465-2273

Sponsor Statement for House Bill 442

Passage of the Health Care Decisions Act ("Alaska Act") in 2004, was an important step forward in modernizing and improving Alaska's health care laws for the terminally ill, their families, and loved ones. House Bill 442 makes minor changes to the Alaska Act in order to provide clearer direction to those implementing health care decisions.

Current law imposes a duty of investigation upon doctors when carrying out the health care directives of their patients. House Bill 442 amends the current statute to conform the language in the Alaska Act to Uniform Act language, thus requiring a doctor to act in "good faith" when time is often critical for their patients. The bill also substitutes the word "physician" for "attending physician", to clarify the intent that all physicians treating a patient adhere to the patient's advanced health care directives. Finally, House Bill 442 clarifies when CPR may be used, addresses the validity of orders from other jurisdictions, and indicates under what circumstances a Do Not Resuscitate order may be revoked.

The Health Care Decisions Act has been beneficial and important for all Alaskans in letting terminally ill patients have their wishes heard. House Bill 442 helps caregivers carry out those wishes.

LEGAL SERVICES

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MEMORANDUM February 13, 2006

SUBJECT: HB 442 relating to health care decisions
(Work Order No. 24-LS1618\G)

TO: Representative B e Weyhrauch
Attn: Jacqueline

FROM: Theresa Bannis r
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Amends AS 13.52.010(k) to state that an advance health care directive is valid under AS 13.52 if it complies with AS 13.52, no matter where or when it was signed or communicated.

Section 2. Adds a new subsection to AS 13.52.010. The new subsection states that an individual instruction that is valid under AS 13.52 is still valid even if it is contained in a writing with a noncomplying durable power of attorney for health care.

Section 3. Amends AS 13.52.020(c) to substitute "physician" for "attending physician" with regard to whom an individual may communicate a revocation of an advance health care directive.

Section 4. Amends AS 13.52.060(d) to add a new exception to the subsection's requirement that a health care provider, health care institution, or health care facility comply with individual instructions and certain health care decisions made by persons other than the patient. The new exception is found at bill sec. 5.

Section 5. Adds a new subsection to AS 13.52.060. The new subsection allows a health care provider to perform resuscitative measures, even if there is a DNR order, if the condition is caused by complications from medical services being provided by the provider.

Section 6. Amends AS 13.52.065(a) to remove the limitation that the physician who may issue a DNR order be the attending physician.

Section 7. Rewrites AS 13.52.065(f) to indicate under what circumstance a DNR order may be revoked.

Section 8. Amends AS 13.52.080(a) to impose a good faith requirement to the test for when a health care provider or a health care institution is not subject to liability or discipline for engaging in certain acts. Also, requires a good faith belief rather than reasonable belief in three of the identified acts. Adds two situations where the provider will not be liable under the main test in the subsection for causing or providing life-sustaining procedures.

Section 9. Amends AS 13.52.100(c) to add the exception established by AS 13.52.060(i) in bill section 5 to the subsection's direction as to when the DNR protocol will govern regarding the use of life-sustaining procedures.

Section 10. Amends AS 13.52.150 to change the conditions for when a DNR order or identification from another U.S. state, a territory, or a possession is considered valid and to establish a presumption of compliance.

Section 11. Amends the definition of "capacity" in AS 13.52.390(7) to include the ability to make and effectively communicate health care decisions.

Section 12. Provides that a DNR order made under former AS 18.12 continues to be effective under AS 13.52 unless it is made ineffective (for example, revoked) under AS 13.52.

Section 13. Directs the regulations attorney to make certain specified changes to the regulations relating to DNR protocol and identification.

Section 14. Gives this Act an immediate effective date.

If I may be of further assistance, please advise.

TLB:ljw
06-076.ljw

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB442-DHSS-DPH-02-17-06
( ) Publish Date:

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

Title: RELATING TO HEALTH CARE DIRECTIVES
RDU: Public Health
Component: Community Health/EMS Services

Sponsor: WEYHRAUCH
Requester: HOUSE (HES)
Component No.: 2078

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
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 (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This bill follows up on a comprehensive advance directives measure passed by the Legislature and signed into law in 2004. HB442 amends current law in several areas, including the validity of health care directives from other states, clarifying which physicians can issue or revoke health care directives on behalf of a patient, and revising provisions regarding do not resuscitate orders.

Though EMTs and other first responders in Alaska will have to be aware of changes enacted in this bill, there is no additional fiscal impact on the Department of Health and Social Services.

Prepared by: Richard Mandsager, M.D. Phone 465-3092
Division: Public Health Date/Time 02/17/2006
Approved by: Karleen Jackson, Commissioner Date 02/17/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

Testimony on House Bill 24-LS1618\G
"Health Care Decisions Act"

Thank you for the opportunity to provide testimony on the proposed refinements to AS 13.52.010 (k). We are indebted to Representative Weyhrauch and his colleagues in the legislature for taking the time to consider these proposed improvements to this law.
I am the practice administrator for a medical group of twenty-four anesthesiologists and a fellow in the American College of Healthcare Executives. I have served in healthcare administration for thirty-two years.
The medical group for which I work provides a minimum of five to seventeen physicians on call twenty four hours per day, seven days per week to serve the patients at Providence Alaska Medical Center. Responses to airway emergencies, "codes", cardiovascular emergencies, and other life threatening situations are frequent circumstances as we care for patients in operating rooms, cath labs, Labor and Delivery suites and operating rooms, intensive care units, emergency rooms, and many other areas of the medical center every day.
We do not pick our patients. We care for the patients regardless of means, clinical condition, origin, faith, race, gender, or ethical values. If patients wish to have 'do not resuscitate orders' or health care decisions to guide their care, we respect those wishes.
The changes proposed to this law help physicians to honor the decisions of patients and ethically respond to their clinical needs. It reduces the legal burden associated with the care of our patients by removing the requirement that we have knowledge of the laws of 49 other states prior to responding to our patients. It allows us to practice to a standard of "good faith" as we care for our patients. It allows us to respond to the wishes of our patients as they change their decisions during the course of their care. It helps us to match a patient with DNR wishes with a physician that can ethically honor those wishes.
For example, a patient electing surgery with anesthesia may, by the nature of the anesthesia, have their heart stop functioning or they may have a machine breathe for them in lieu of their own respiratory system's function. If the patient "codes" and their vital life support systems stop functioning, we are left with the dilemma of deciding if the problem is a byproduct of anesthesia, their physical problems, or the result of the surgery. This may leave us with the options of rescuing the patient, honoring a DNR order, or letting them die. If we let them die, we face the risk of heirs complaining of medical malpractice for the death. If we rescue the patient as we have been trained to do, we face fines and penalties for violating local laws and those of other states. In the vast majority of cases, the patients waive DNR orders during the peri-operative process. We need the clear capacity to have this dialogue with our patients and honor their desires waive a DNR and to survive surgery. If they chose to die in the peri-operative process, this needs to be clear so that we can honor those wishes absent risks of litigation and / or fines for doing so. They need a clear path to re-impose the DNR per their wishes after surgery. The changes to this law help us to achieve those goals.
Our patient care interactions are not always in a structured operating room environment.

Responses to emergencies are measured in very short periods of time with little time to decipher unique health care decisions versus clinical needs. Any changes to the law that make these processes more clear benefit the patients dependent upon the medical staff's responses and actions.

The proposed revisions to this law help us to care for our patients and reduce the diversion of physicians' attention to matters of law when they should be focused on the acute needs of patients. If decisions to rescue patients are to be affected by the law, it must have clear language and clear definitions. The proposed revisions to this law improve the language and definitions. They enhance our capacity to care for patients.

Sincerely,

James H Brooks, FACHE
Executive Director, PAAMG

HB

452

ALASKA STATE LEGISLATURE

Sponsor Statement

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Representative David Guttenberg

HB 452

"An Act establishing the Alaska Prescription Drug Task Force; and providing for an effective date."

Last year, Americans spent more than four times as much money on health care as on national defense. The Alaska Legislature's recent PERS/TRS debate focused attention on the rising cost of health care, but no pending bills address the high and rising cost of prescription drugs and the role those prices play in the bigger picture of health care.

Prescription drugs are the fastest growing component of health care expenditures. Those rising costs are imposing an ever-increasing economic burden on Alaskans. Our citizens should not have to choose between putting food on their tables or purchasing prescription drugs.

Pharmaceuticals are a vital component of health care in preventing and treating illness and helping to avoid more costly medical problems. However, rising costs have greatly reduced availability of prescription drugs. I began looking into the reasons why drug costs are rising and found some disturbing statistics:

- In 2003, nationwide spending on prescription drugs was $179.2 billion, almost 4½ times larger than the $40.3 billion spent in 1990;
- Between 1995 and 2002, the average increase for drug expenditures was 15% higher than for any other type of health expenditure;
- In 2001, nearly 1 in 4 seniors reported skipping doses or not filling prescriptions because of the cost;
- In 2002, 10 pharmaceutical companies amassed profits greater than the other 490 companies in the *Fortune 500* combined;

HB 452 will create a Prescription Drug Task Force within the Alaska Department of Health and Social Services. This Task Force will find ways to reduce the cost of prescription drugs and increase affordable access to prescription drugs for Alaskans.

Ten members representing various entities and business sectors will sit on the task force and will gather information from industry, government, citizens, and other sources.. Subsequent present reports to the Governor and to the Legislature will suggest actions to increase access to and reduce the cost of prescription drugs.

I urge your support of this bill.

Representative.David.Guttenberg@legis.state.ak.us
http://guttenberg.akdemocrats.org

ALASKA STATE LEGISLATURE

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Representative David Guttenberg
District 8

SECTIONAL ANALYSIS FOR HB 452

"An Act establishing the Alaska Prescription Drug Task Force; and providing for an effective date."

Section 1: Uncodified law adding a new section to state the Legislative findings and purpose

Section 2: Uncodified law adding a new section to establish the Alaska Prescription Drug Task force. The Task Force consists of ten members and sets out the guidelines for the duties and objectives of the task force. Sets the timeline for the reporting of the Task Force's findings to the Legislature and the Governor.

Section 3: Effective Date for Section 2.

Representative.David.Guttenberg@legis.state.ak.us
http://guttenberg.akdemocrats.org

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB452-DOLWD-WC-04-21-06**
() Publish Date:

Revision Date/Time (Note if correction):
Title: **Alaska Prescription Drug Task Force**

Department: **Labor and Workforce Development**
RDU: **Workers' Compensation**
Component: **Workers' Compensation**

Sponsor: **Representative Guttenberg**
Requester: **House HES**

Component Number: **344**

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: None
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

The task force is established in the Department of Health & Social Services and they have submitted a fiscal note to support all costs for this activity. The legislation is not expected to have a financial impact on the Department of Labor and Workforce Development.

Prepared by: **Paul F. Lisankie, Director** Phone: **465-6059**
Division: **Workers' Compensation** Date/Time: **4/21/06 10:25 AM**
Approved by: **Greg O'Claray, Commissioner** Date: **4/21/2006**
Agency: **Department of Labor and Workforce Development**

(Revised 9/7.. 05 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB452-DHSS-FMS-04-20-06
( ) Publish Date:
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: ESTABLISHING THE ALASKA PRESCRIPTION DRUG TASK FORCE

RDU: Departmental Support Services

Component: Commissioner's Office

Sponsor: GUTTENBERG

Requester: HOUSE (HES)

Component No.: 317

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	82.7					
Travel	16.5					
Contractual	10.0					
Supplies	5.0					
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**114.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	114.2					
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**114.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary	1					

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

This bill creates the Alaska Prescription Drug Task Force in DHSS and requires it to present its findings and recommendations to the Legislature by the 30th day of the 2007 legislative session. The bill requires the task force to meet at least three times and to hold public hearings, but it may meet more often. The 10 task force members are to serve without pay, but will be reimbursed for per diem and travel. Meetings can be held by teleconference; it is assumed the group would meet face-to-face at least twice and that two DHSS employees would also travel to staff the meetings. One non-perm position is required to staff the task force for FY07, and associated costs are itemized on page 2.

It is assumed the task force will disband after making its report.

(Continued on Page 2)

Prepared by: Janet Clarke — Phone 465-1630
Division: Finance and Management Services — Date/Time 03/01/2006
Approved by: Karleen Jackson, Commissioner — Date 04/20/2006
Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

PERSONAL SERVICES ($82.7)
One non-perm position would be needed for FY07 to coordinate the work of task force, perform research, write its final report and conduct needed followup - Health Planner II (Range 19 - $82.7)

TRAVEL ($16.5)
12 travelers are assumed:
$688 ea. ($600 airfare + $42 per diem + $26 car + $20 parking) times two meetings = $16,512

CONTRACTUAL ($10.0)
Office space for non-perm employee; telephone, computer usage and other centralized services costs, publication and distribution costs for report.

SUPPLIES ($5.0)
Personal computer for employee, miscellaneous office and publication supplies for employee and task force members.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 452
() Publish Date:

Revision Date/Time (Note if correction): 4/23/06 11:17 a.m.
Dept. Affected: Administration

Title: An Act establishing the Alaska Prescription Drug Task Force....
RDU: Centralized Administrative Services
Component: Retirement and Benefits

Sponsor: Representative Guttenberg, Kerttula
Requester: House Health, Education, and Social Services
Component No.: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation establishes a 10-member task force to consider strategies to manage the increasing costs of prescription drugs and to increase affordable access to prescription drugs for all state residents.

Participation on the Alaska Prescription Drug Task Force will have no fiscal impact on the Division of Retirement and Benefits.

Prepared by: Melanie Millhorn, Director
Phone 465-4408
Division: Retirement and Benefits
Date/Time 4/23/06 11:17 a.m.

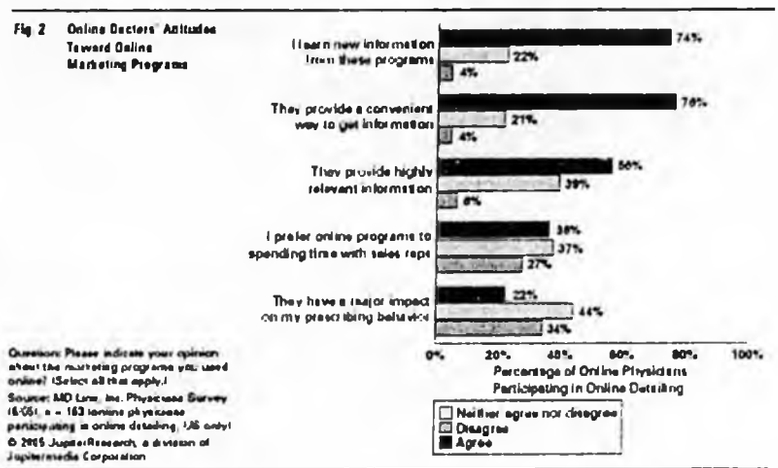
Approved by: Mike Tibbles, Deputy Commissioner
Date 4/24/2006
Agency: Department of Administration

(Revised 9/7/2005 OMB)

DETAILING

According to research from Health Strategies Group, "[t]he average primary care physician interacts with 28 sales representatives each week; the average specialist interacts with 14." While this represents a significant amount of time, 2 hours and 13 minutes a week in 2004 per doctor, this is 20% less time than in 1999, where doctors spent 2 hours and 46 minutes a week meeting with sales reps.[c]

DRUG REPS PER PHYSICIAN			
Year	Physicians (P)[a]	Detailers (D)[b]	Ratio D to P
2000	813,869	74,865	1 to 11
2002	853,187	93,612	1 to 9
2003	871,535	94,407	1 to 9
2004	884,974	101,531	1 to 9



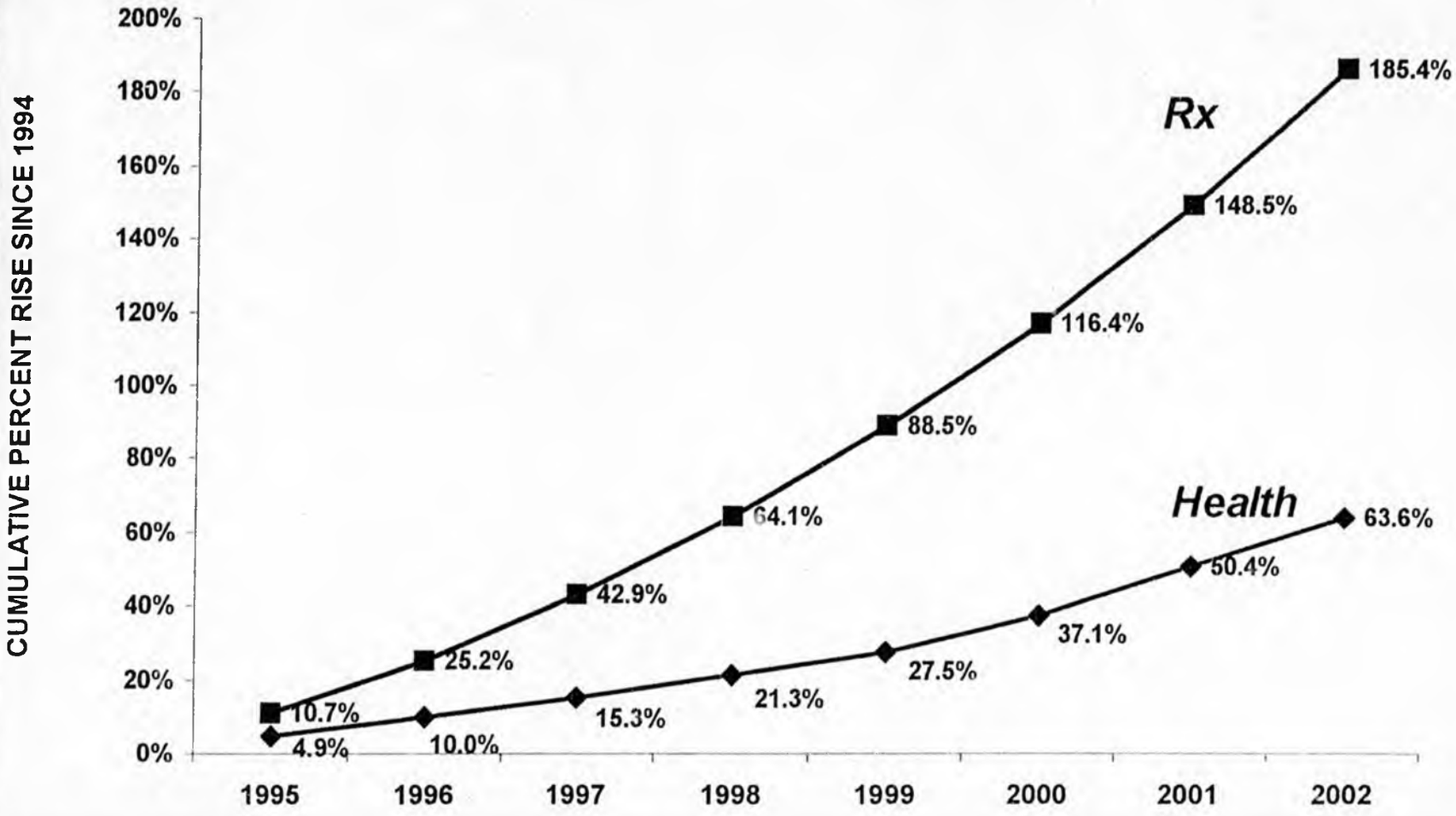
For a variety of reasons (e.g. time, professional concerns about information quality, online learning opportunities), 22% of doctors said they see fewer sales reps than in the past.[d] According to the table above, this does not appear to be due to a drop in the number of sales reps. It could be related to online detailing. Sixty-five percent of "online doctors"[e] participated in online detailing in 2005.[f] (See Figure 2)

Another way of looking at influence is to consider professional advertising expenditures per physician. The table at the right uses the cost of sales rep visits (excluding samples) to determine cost of all sales rep visits per physician.

COST OF SALES REP VISITS PER PHYSICIAN			
Year	Physicians[g]	Sales Rep Visit Cost ($)[h]	$ per Dr.
2000	813,869	5,137,000,000	$6311.83
2002	853,187	6,198,000,000	$7264.53
2003	871,535	6,938,000,000	$7960.47
2004	884,974	7,336,000,000	$8289.51

[a] American Medical Association. Available online at: http://www.ama-assn.org/ama/pub/category/12912.html.
[b] Matthew Arnold. "Flexible Forces." *Medical Marketing & Media*. November 2005.
[c] Ashley Mahoney. Rayna Herman. "2005 Access Report: The current state of pharma sales." *Pharmaceutical Representative*. July 1 2005.
[d] Monique Levy, Jupiter Research. *Online Marketing to Physicians: Evaluating Physicians' Responsiveness to Online Detailing*. September 1, 2005.
[e] Defined as physicians who use the internet for work-related activities. (Jupiter Research)
[f] Monique Levy, Jupiter Research. September 1, 2005.
[g] IMS Health. Total US Professional Promotional Spend by Type, 2004. Available online at: http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_49695992_75406357,00.html.
[h] Matthew Arnold. November 2005.

Rx SPENDING RISES MUCH FASTER THAN TOTAL HEALTH SPENDING, 1994 - 2002



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November 2005

Prescription Drug Trends

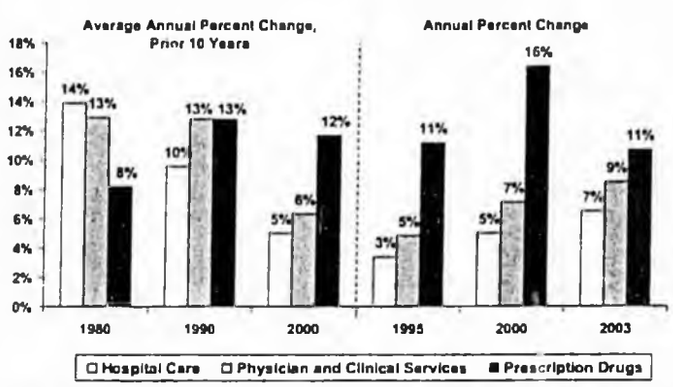
Overview

Prescription drugs are a vital component of health care in preventing and treating illness and helping to avoid more costly medical problems. However, rising costs and implementation of the new Medicare drug benefit have raised concerns about the affordability and availability of prescription drugs, prompting the need for a better understanding of the pharmaceutical market and for new approaches to rising costs.

Rising Expenditures for Prescription Drugs

Spending in the US for prescription drugs was $179.2 billion in 2003, almost 4½ times larger than the $40.3 billion spent in 1990. Although 2003 prescription drug spending was a relatively small proportion (11%) of national health care spending compared to spending for hospital care (31%) and physician services (22%), it was one of the fastest growing components, increasing at double digit rates from 1995 to 2003. From 2002 to 2003, national prescription spending increased 11%, compared to 7% for hospital care and 9% for physician services. However, the rate of increase in prescription spending has declined from a high of 20% in 1999, to 15% in 2002, and 11% in 2003 (Figure 1).[1]

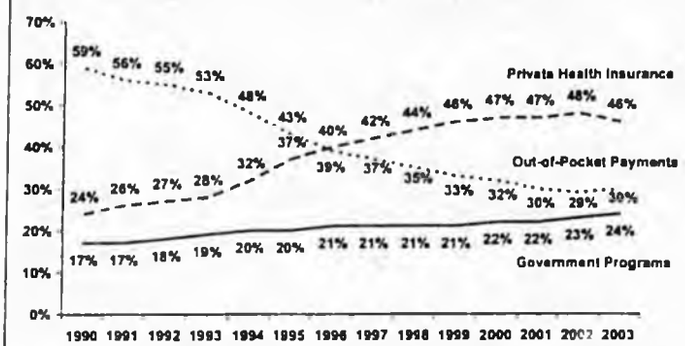
Figure 1: Annual Percentage Change in Selected National Health Expenditures, 1980-2003



Source: KFF analysis of National Health Expenditures data from Centers for Medicare & Medicaid Services at http://www.cms.hhs.gov/statistics/nhe/default.asp

The share of prescription drug expenses paid by private health insurance increased substantially over the past decade (from 24% in 1990 to 46% in 2003), contributing to a decline in the share that people pay themselves (from 59% in 1990% to 30% in 2003) (Figure 2). Private insurance spending for prescription drugs rose by 7% in 2003, much slower than the 16% increase in 2002.[2]

Figure 2: Percent of Total National Prescription Drug Expenditures by Type of Payer, 1990-2003



Note: Out-of-Pocket Payments includes direct spending by consumers for health care goods and services not covered by a health plan and cost-sharing amounts (coinsurance, copayments, deductibles) required by public and private health plans. It does not include consumer premium payments and cost sharing paid by supplementary Medicare policies, which are included in the Private Health Insurance category.

Source: KFF analysis of National Health Expenditures data from Centers for Medicare & Medicaid Services at http://www.cms.hhs.gov/statistics/nhe/default.asp

Factors Driving Increases in Prescription Spending

Three main factors drive increases in prescription drug spending: the increasing number of prescriptions (utilization), price increases, and changes in the types of drugs used.

- **Utilization.** From 1994 to 2004, the number of prescriptions purchased increased 68% (from 2.1 billion to 3.5 billion), compared to a US population growth of 12%. The average number of retail prescriptions per capita increased from 7.9 in 1994 to 12.0 in 2004.[3] The percent of the population with a prescription drug expense in 2002 was 61% (for those under age 65) and 91% (for those 65 and older).[4]

- **Price.** Retail prescription prices[5] (which reflect both manufacturer price changes for existing drugs and changes in use to newer, higher-priced drugs) increased an average of 8.3% a year from 1994 to 2004 (from an average of $28.67 to $63.59),[6] more than triple the average annual inflation rate of 2.5%.[7]

- **Changes in Types of Drugs Used.** Increases in prescription spending generally result from newer, higher-priced brand name drugs whose availability is affected by the research and development (R&D) activities of pharmaceutical manufacturers and government-supported research. Manufacturer R&D spending increased from $13.4 billion (17.3% of sales) in 1994 to an estimated $38.8 billion

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(15.9% of sales) in 2004.[8] New drug use is also affected by the number of new drugs (new molecular entities) approved by the US Food and Drug Administration, which has fluctuated over the past decade, with 21 approvals in 1994 and 36 approvals in 2004.[9]

Both prescription use and shifts to higher-priced drugs are affected by advertising. Manufacturers spent $11.9 billion for advertising in 2004 (excluding the $15.9 billion in retail value of drug samples), with $7.8 billion (66%) directed toward physicians and $4.0 billion (34%) directed toward consumers. Spending for direct-to-consumer advertising -- typically to advertise newer, higher-priced drugs -- was 15 times greater in 2004 than in 1994.[10]

From 1995-2002, pharmaceutical manufacturers were the nation's most profitable industry. In 2004, they ranked third, with profits (return on revenues) of 16%, compared to 5% for all Fortune 500 firms.[11]

Insurance Coverage for Prescription Drugs

Employers are the principal source of health insurance in the United States, providing coverage for 174 million (nearly 60%) of Americans in 2004.[12] About 60% of employers offered health insurance to their employees in 2005, and 66% of those employees took their employers' coverage. Others may have obtained coverage through a spouse. Nearly all (98%) of covered workers in employer-sponsored plans had a prescription drug benefit in 2005.[13]

The traditional Medicare program (the federal health program for the elderly and disabled) has not provided coverage for outpatient prescription drugs. About one-quarter (27%) of seniors age 65 and above, and one-third of poor (34%) and near-poor (33%) seniors, had no drug coverage in 2003.[14] That will change January 1, 2006 when, as authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare will begin a voluntary prescription drug benefit. To provide some assistance in the years prior to 2006, the law created a Medicare-endorsed discount card program to give beneficiaries greater access to negotiated discounts on their prescription drug purchases. The discount card program also included a temporary transitional assistance program that provided $600 per year in subsidies to low-income beneficiaries without drug coverage from other sources in 2004 and 2005.

Lack of drug insurance can have adverse effects. A 2005 survey found that uninsured adults (51%) are twice as likely as insured adults (25%) to say that they or a family member cut pills, did not fill a prescription, or skipped medical treatment in the past year because of the cost.[15] For seniors age 65+, the survey found that those with no drug coverage were more likely than those with drug coverage to not fill a prescription or to skip or take a smaller dose due to costs in 2003 (37% vs. 22%).

Private and Public Responses

Employer-sponsored health plans have responded to increasing prescription drug costs by establishing tiered cost-sharing formulas and increasing drug copayments. In 2005, about three-quarters (74%) of workers with employer-sponsored coverage had a cost-sharing arrangement with 3 or 4 tiers, over 2½ times the proportion in 2000 (27%). Copayments for nonpreferred drugs (those not included on a formulary or preferred drug list) have doubled from an average of $17 in 2000 to $35 in 2005. Copayments for preferred drugs (those included on a formulary or preferred drug list, such as a brand name drug without a generic substitute) increased by 69%, from $13 in 2000 to $22 in 2005.[16]

Medicaid is the joint federal-state program that pays for medical assistance to low income individuals and families. Outpatient prescription drug spending has steadily increased as a share of overall Medicaid spending from 5.6% in FY1992 to 13.4% in FY2003.[17] In a 2005 survey of 36 states + DC, all (100%) attempted to control drug costs by requiring prior authorization, 95% imposed limits on quantities dispensed per prescription, 92% required the use of generics, 81% charged limited copayments for prescription drugs, and 68% used preferred drug lists.[18] On January 1, 2006, drug coverage for those eligible for both Medicare and Medicaid will be shifted from Medicaid to Medicare as a result of the Medicare Modernization Act, although states will be required to provide payments to the federal government to finance this coverage.

Consumers are turning to a variety of methods to reduce their prescription costs, including requesting cheaper drugs or generic drugs from their physicians, using the Internet and other sources to make price comparisons, using over-the-counter instead of prescribed drugs, buying drugs in bulk and pill-splitting, using mail-order pharmacies, using pharmaceutical company or state drug assistance programs, and using Medicare discount drug cards.[19]

Drug importation has received attention as a way to address expensive drug prices in the US. Importation of pharmaceutical products from Canada using Internet orders and cross-border visits totaled $760 million in sales, or 0.3% of the total US market, in 2004.[20] An equivalent amount of prescription drugs is estimated to enter the US from the rest of the world, mostly through the mail and courier services.[21]

Proponents of permitting Americans to import drugs from Canada or other countries argue that prescription expenses have become a significant burden on families and third-party payers and that it is unfair to deny them access to the lower prices available abroad. Permitting importation also is seen as a way of reducing domestic prices, because manufacturers would be forced to lower their prices to compete with the lower costs of imported drugs. Opponents argue that it is difficult and costly to assure the safety of imported drugs. Opponents also argue that importation is likely to increases prices or reduce supply in countries exporting drugs to the US, so that manufacturers and foreign governments would likely take steps to limit exports to the US.

Outlook for the Future

Annual increases in US spending for prescription drugs are projected to rise from 10.7% in 2003 to 11.9% in 2004, and then decline to 9.7% in 2014. Increased spending due to increased prescription use by Medicare beneficiaries under the new Medicare Part D coverage is expected to be offset by increased availability and use of lower-cost generic drugs, more people covered under tiered copayment drug plans, fewer blockbuster drugs, and more drugs shifting to over-the-counter status.[22]

REFERENCES

[1] Centers for Medicare & Medicaid Services, National Health Accounts, at http://www.cms.hhs.gov/statistics/nhe/default.asp.

[2] Ibid.

[3] KFF calculations using data from IMS Health at www.imshealth.com and Census Bureau at http://www.census.gov. The number of prescriptions per capita (12.0 in 2004) differs from that at http://www.statehealthfacts.kff.org (10.7 in 2003) because the data come from different sources (IMS Health vs. Verispan).

[4] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, *2002 Compendium of Tables – Household Medical Expenditures*, at http://www.meps.ahrq.gov/MEPSNet/TC/TC15.asp?File=HCFY2002&Table=HCFY2002_PLEXP.

[5] Retail prescription prices reflect the prices paid by insured and uninsured patients, and do not reflect rebates, discounts, and other payments that in effect lower the cost of prescriptions.

[6] KFF calculations using data from National Association of Chain Drug Stores, "Industry Facts-at-a-Glance," at http://www.nacds.org, based on data from IMS Health.

[7] Consumer Price Index, US City Average, All items, from the Bureau of Labor Statistics at http://www.bls.gov.

[8] Pharmaceutical Research and Manufacturers of America, *Pharmaceutical Industry Profile*, various years, at http://www.phrma.org/publications; reflects data from PhRMA members only (approx. 80% of total R&D in 2004).

[9] US Food and Drug Administration at http://www.fda.gov/cder/rdmt/NMEapps93-04.htm; the 2004 figure includes new BLAs for therapeutic biologic products transferred from FDA's Center for Biologics Evaluation and Research to the Center for Drug Evaluation and Research.

[10] *Medical Marketing & Media*, "The IMS Health Report – Pressure Zone," May 2005, Fig. 7 and Fig. 9, at http://offlinehbpl.hbpl.co.uk/Misc/MMM/Features/MAY05%2036-50%20IMS.pdf; Kaiser Family Foundation, *Prescription Drug Trends, a chartbook*, July 2000, Ex. 3.13, at http://www.kff.org/rxdrugs/3019-index.cfm.

[11] *Fortune*, April 18, 2005, and earlier April Issues.

[12] US Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, August 2005, pp. 16 and 60, at http://www.census.gov/prod/2005pubs/p60-229.pdf.

[13] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, September 2005, Section 9, at http://www.kff.org/insurance/7315/index.cfm.

[14] DG Safran et al., "Prescription Drug Coverage And Seniors: Findings From A 2003 National Survey," *Health Affairs*, April 19, 2005, p. W5-160, at http://www.kff.org/medicare/med041905pkg.cfm.

[15] Kaiser Family Foundation/Commonwealth Fund/Tufts-New England Medical Center 2003 National Survey of Seniors and Prescription Drugs, Additional Charts and Tables, April 2005, Figure 3, at http://www.kff.org/medicare/med041905pkg.cfm.

[16] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, September 2005, Exhibits 9.1 and 9.2, at http://www.kff.org/insurance/7315/exhibits/index.cfm.

[17] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Prescription Drug Spending and Use*, June 2004, at http://www.kff.org/medicaid/7111a.cfm, with FY2003 data from *Medicaid and Outpatient Prescription Drugs*, March 2005, at http://www.kff.org/medicaid/1609-03.cfm; percentages include estimates of Medicaid managed care spending for prescription drugs.

[18] Kaiser Commission on Medicaid and the Uninsured, *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update*, October 2005, Fig. 3, at http://www.kff.org/medicaid/7381.cfm.

[19] D Herrick, National Center for Policy Analysis, *Shopping for Drugs: 2004*, NCPA Policy Report No. 270, October 2004, at http://www.ncpa.org/pub/st/st270.

[20] *Medical Marketing & Media*, "The IMS Health Report – Pressure Zone," May 2005, p. 45, at http://offlinehbpl.hbpl.co.uk/Misc/MMM/Features/MAY05%2036-50%20IMS.pdf.

[21] U.S. Department of Health and Human Services Task Force on Drug Importation, *Report on Prescription Drug Importation*, December 2004, p. ix, at http://www.hhs.gov/importtaskforce/Report1220.pdf.

[22] S Heffler et al., "U.S. Health Spending Projections For 2004-2014," *Health Affairs*, Web Exclusive, February 23, 2005, pp. W5-74 to W5-85; see http://www.cms.hhs.gov/statistics/nhe/projections-2004/proj2004.pdf.

For More Information:

In addition to the Kaiser Family Foundation reports in the Endnotes above, this Fact Sheet (#3057-04) and the following reports are available on the Foundation's website at http://www.kff.org: *Trends and Indicators in the Changing Health Care Marketplace* (#7031), *Prescription Drug Trends—A Chartbook Update* (#3112), *Medicare Prescription Drug Benefit Fact Sheet* (7044-2), *Resources on the Medicare Prescription Drug Benefit*, *Federal Policies Affecting the Cost and Availability of New Pharmaceuticals* (#3254), and *Current Trends and Future Outlook:Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits* (#7194). See also http://www.statehealthfacts.org for state-specific prescription drug utilization, sales, and average prices (under Health Costs & Budgets), and http://www.kaiserEDU.org (Prescription Drugs) for Issue Modules and a Tutorial on prescription drugs.

Paying the Price

The High Cost of Prescription Drugs for Uninsured Americans

October 2004

AkPIRG

Paying the Price

The High Cost of Prescription Drugs for Uninsured Americans

AkPIRG

October 2004

Acknowledgements

Written by Lindsey Johnson, Consumer Advocate with AkPIRG.

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To receive a copy of this report, visit our website or send a check for $20 made payable to AkPIRG at the following address:

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Table of Contents

Executive Summary

Millions of uninsured and underinsured Americans struggle to afford the medicines they need, even forgoing medically necessary drugs when prices are out of reach. When discussing the high cost of prescription drugs, politicians often focus on the financial burden carried by senior citizens. Unfortunately, high prescription drug prices are a problem for Americans of all ages, not just the elderly.

As prescription drug prices have increased, so has the number of uninsured and underinsured Americans. In 2003, 45 million Americans under the age of 65 did not have health insurance; millions more with health insurance lacked prescription drug coverage. Young adults (ages 19 to 34) accounted for 40% of the non-elderly, uninsured population in 2003. Meanwhile, the pharmaceutical industry continues to record enormous profits, often by blocking consumer access to equally effective but less expensive medication.

Uninsured consumers carry the full cost of overpriced prescription drugs. The federal government uses its buying power to negotiate lower prices for the drugs it purchases for its beneficiaries – such as veterans, government employees and retirees. In addition, consumers with health insurance coverage pay only a portion of the discounted price negotiated by their insurance company. Uninsured consumers, with no one to negotiate on their behalf, pay the highest prescription drug prices not only in America, but in the rest of the industrialized world as well.

In late summer of 2004, the National Association of State Public Interest Research Groups (PIRGs) conducted a survey of more than 400 pharmacies in 19 states across the country and Washington, DC to determine how much uninsured consumers are paying for 12 prescription drugs commonly used by adults under age 65. We then compared these prices with the prices the pharmaceutical companies charge one of their "most favored" customers, the federal government, and also with the prices paid by consumers in Canada.

Our survey showed that the uninsured pay a huge price for prescription drugs, especially when compared with the prices paid by the federal government and our neighbors to the north. Key findings include:

In Alaska:

- On average, uninsured consumers in Alaska pay 80% more than the federal government for 12 common prescription medications.

- Uninsured consumers in Alaska pay 80% more for Zithromax than the federal government pays for the same prescription. Zithromax is an antibiotic commonly used to treat pneumonia and other infections.

- On average, uninsured consumers in Alaska pay twice as much—109% more—for drugs purchased at their local pharmacy than they would pay if they purchased the same drugs from a Canadian pharmacy.

Nationally:

- Uninsured Americans pay 78% more on average for 12 common prescription drugs than the federal government pays for the

same medications. The price differences range from 41% more for Ambien, a sleep aid, to 162% more for Synthroid, which treats thyroid disorders.

• Many of the drugs featured in the PIRG survey treat chronic conditions – meaning that even small savings add up quickly. An uninsured person regularly taking Allegra to control his/her allergies, for example, would pay at least $1,120 for a year's supply. The federal government, on the other hand, would pay on average $657 for the same quantity of Allegra – a savings of $463.

• Uninsured Americans, on average, pay twice as much as Canadians—105% more—for nine of the common prescription medications we surveyed. The price differences range from 45% more for Norvasc, which treats high blood pressure, to 530% more for Premarin, a necessary hormone treatment for millions of women.

• An uninsured woman regularly taking Premarin would pay at least $465 for a year's supply in the United States. A woman purchasing her year's supply of Premarin from a Canadian pharmacy would pay just $74—a savings of $391.

The need for state and federal action to lower drug prices has never been greater.

Although federal lawmakers are aware that Americans pay the highest prescription drug prices in the world, they have yet to take substantive action to address the problem. Frustrated by inaction at the federal level, states across the nation are taking on the task of providing their uninsured and underinsured citizens with access to affordable prescription drugs. The state PIRGs support a range of strategies to lower the cost of prescription drugs that include:

State recommendations

- ✓ Creating prescription drug-buying pools at the state level that would allow businesses, the government and individuals of all ages to use their combined buying power to negotiate lower drug prices, similar to what the federal government and big HMOs do;
- ✓ Expanding the use of preferred drug lists (PDLs), which provide state governments with information about the most cost-effective treatment for a particular condition. State governments can use PDLs to make purchasing decisions that ensure patients get the most affordable and most effective treatment possible;
- ✓ Increasing scrutiny of pharmaceutical benefit managers, the pharmaceutical "middlemen" who manage the prescription drug care for millions of Americans under a veil of secrecy and often act against their clients' best interests;
- ✓ Regulating the marketing practices of pharmaceutical companies that drive up the prices of prescription drugs and encourage patients and doctors to favor the newest and most expensive drugs regardless of their effectiveness; and
- ✓ Providing consumers with immediate price relief by legalizing the importation of lower-priced prescription drugs from Canada and other countries with drug regulatory systems similar to ours as a stopgap measure until comprehensive reform passes.

Background: The High Cost of Prescription Drugs

American consumers pay too much for prescription drugs. In 2003, Americans spent $203.1 billion on prescription drugs, an increase of $20.4 billion from the previous year.[1] While some of that increase can be attributed to additional unit sales, skyrocketing prescription drug prices are the biggest driver of increased spending on prescription drugs. A study by Families USA, a non-profit advocacy group, found that prescription drug costs increased at more than three times the rate of inflation from January 2003 to January 2004.[2] AARP tracked prices for the 197 brand name drugs most widely used by seniors and found that they increased in price by 27.6% on average from 2000 to 2003, compared with a general inflation rate of just over 10%.[3] AARP also found that pharmaceutical companies actually increase their drug prices more than once a year; manufacturers increased the price of 106 of the 197 drugs most frequently used by senior citizens over the three-month period ending in March 2004.[4]

The Cost to Uninsured, Non-Elderly Americans

Both policy makers and non-profit advocacy groups often focus on the inordinate burden that prescription drug costs place on the elderly. Many seniors live on fixed incomes that increase only slightly with inflation. As prescription drug costs rise faster than the rate of inflation, health care consumes more and more of their limited annual incomes. In recognition of senior citizens' need for

Analysis: The Medicare Prescription Drug Benefit

Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act in late 2003. Unfortunately, the benefit created by the legislation provides only limited prescription drug coverage for most beneficiaries and does nothing to lower the overall price of drugs for all Americans.

Until private prescription drug plans become available in 2006, Medicare beneficiaries can enroll in an interim discount card program. Once a Medicare recipient selects a drug discount card, he or she is limited to the discounts available through that card for the next year. The companies selling the drug discount cards, however, can change the drug list and discounts at any time. Because enrollees have neither the freedom to change plans, nor the ability to predict prices, real competition between card providers does not exist. Drug card providers have little incentive to lower prices. Moreover, the legislation specifically prohibits Medicare administrators from negotiating drug prices with the pharmaceutical companies, which would have lowered both the cost to seniors for their medication and the overall cost of the program to taxpayers.

The Medicare legislation also does not address the cost of prescription drugs for non-Medicare recipients, including the millions of uninsured who are left to pay the full high price for their medication.

prescription drug coverage, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[5] Unfortunately, the benefit created by the legislation provides only limited prescription drug coverage for most beneficiaries (see box).

In addition to seniors, many non-elderly consumers are unable to afford their prescription drug medication. While Medicare beneficiaries have insurance that generally covers doctors and hospital care, increasing numbers of non-elderly (under 65 years of age) uninsured Americans struggle to pay for all of their health care. The number of non-elderly uninsured Americans grew to approximately 45 million in 2003, an increase of 1.4 million from 2002.[6] Young adults (ages 19 to 34) accounted for 40% of the non-elderly, uninsured population in 2003.[7]

Lacking health insurance is a tremendous barrier to obtaining needed health care. According to a survey conducted by Kaiser Family Foundation in 2003, 37% of uninsured people did not fill a prescription because of cost. Almost half (47%) of the uninsured postponed seeking any medical care because of cost.[8] Even after an uninsured person finally decides to seek medical care, that person is often unable to pay for the treatment that his or her doctor prescribes.

Having drug coverage does not necessarily translate into being able to afford prescription drugs; many plans require patients to make large co-payments or spend somewhere between $100 and $500 in deductibles before covering most services.[9] The more a person has to pay for a drug, the less likely he or she is to have it filled. A study published in the *Journal of the American Medical Association* found that increasing co-payments from $5 to $10 per prescription reduced consumer spending on drugs by 22%.[10] Co-payments have greatly increased as employers have looked for ways to cut rising health care costs.

Drug Prices Rise As Industry Thrives

The high price of prescription drugs has helped the pharmaceutical industry remain consistently profitable, even in a stagnant economy. In 2001, it ranked first of any industry in rates of return on equity, assets, or revenues.[11] Families USA, meanwhile, found that the pharmaceutical industry has been the most profitable industry in the United States for the past 10 years, and that it "was five-and-one-half times more profitable than the average for Fortune 500 companies."[12] Similarly, Public Citizen released a study finding that the combined profits for the 10 drug companies in the Fortune 500 ($35.9 billion) amounted to more than the profits for all the other 490 businesses put together ($33.7 billion) in 2002.[13]

The industry insists that its high prices are justified by the amount of money it must spend in researching and developing new medications. According to one industry source, the cost of research and development (R & D) averages $800 million or more for a single compound.[14] Another industry source suggests that out of 5,000 drugs under development, only five are likely to be tested in clinical trials and only one will be approved for patient use, meaning that industry must invest heavily in medicines that never turn a profit.[15] The inherent risks of R & D and the need to recover losses from failed trials both necessitate and justify the cost of its products, the argument continues. According to the industry, lowering prices will result in less investment in R & D and fewer new and innovative drugs on the market.

Yet R & D is actually a much lower priority for drug companies than they suggest. First, the government funds a substantial portion of the research and development required to produce any given medicine. One group has estimated that R & D can cost companies no more than $240 million per drug, once government-funded research and tax deductions are taken into account,[16] rather than the industry figure of $800 million. While $240 million is still a substantial sum of money, these figures suggest that the pharmaceutical industry's research and development expenses may be far lower than advertised.

In addition, despite the steep climb in the cost of prescription drugs, the Food and Drug Administration (FDA) approved only 17 new drugs in 2002, the fewest in a decade. Some suggest that this drop in new medications has prompted "companies to keep profits flowing the old-fashioned way: by charging more for their existing products."[17]

Furthermore, the pharmaceutical companies spent greater portions of their net revenue on marketing, advertising, and administrative costs than on R & D in 2001. In fact, one study found that eight major American pharmaceutical companies spent more than twice as much on marketing and administrative costs than on R & D. And in 2001, the major pharmaceutical companies put only 11% of their revenue into R & D, but counted 18% of revenue as profits.[18] Recent evidence also suggests that major drug companies spend a greater percentage of their money on buybacks of company stock and dividends to shareholders. Pfizer, the largest drug company in the world, spent 210% ($22.2 billion) more on stock buybacks and dividends than it did on research in the past 18 months.[19]

Drug Companies Exploit Loopholes to Delay Generic Competition

In response to concerns about the struggling generic industry and the pharmaceutical industry's frustration with the lengthy FDA approval process, Congress enacted the Drug Price Competition and Patent Term Restoration Act, commonly referred to as the Hatch-Waxman Act, in 1984. The legislation increased the number of generic drugs available to consumers by simplifying the approval process for generic companies. This provision increased the generic share of the prescription drug market from 20% at the time of enactment to nearly 50% of the current market.[20] Unfortunately, the legislation also gave the pharmaceutical industry a new set of weapons to delay the approval of generic equivalents.

In order to receive FDA approval to market a generic drug, the generic manufacturer must prove the brand-name drug's patent has either expired or is no longer valid. If the brand-name company retaliates with a lawsuit, which is common, FDA automatically delays the generic company's claim for 30 months while it investigates the dispute. The Hatch-Waxman Act also gave brand-name manufacturers the ability to submit patents on multiple aspects of the same drug, thereby extending the number of times the company can invoke the 30-month delay. Companies have filed patents on everything from the color of a capsule to the shape of a bottle, all in an attempt to extend their control over a specific brand-name drug. By filing new patents after the first lawsuit, then suing for infringement of those patents, brand name drug companies can obtain successive 30-month stays. Researchers have found that the average number of patents filed on brand-name medications has increased from 2 to 12 in the past 10 years.[21]

An additional six months of exclusive marketing rights can be extraordinarily profitable. When Wyeth Pharmaceuticals was granted an additional six months of exclusivity for its anti-depressant Effexor,[22] it earned an additional $72 million dollars.[23] By exploiting the legal loopholes created in the Hatch-Waxman Act, brand-name drug manufacturers have succeeded in maintaining monopoly rights to prescription drugs long after the original patent expired.

Drug Companies Engage in Collusion and Price Manipulation

In order to avoid the costly legal battles described in the previous section, some brand-name drug companies opt for a less expensive alternative. Rather than spend millions defending themselves against lawsuits, companies holding expired or invalid patents decide instead to cut their losses and make a deal with their competitors. The brand-name companies pay the generic manufacturer to postpone entry into the market, and they agree on a settlement. In June 2002, the Federal Trade Commission (FTC) challenged interim settlements for three drug products. In the challenges, the Commission alleged that "the brand-name drug company paid the first generic applicant not to enter the market, thereby retaining its (unused) 180-day marketing exclusivity and precluding the FDA from approving any eligible subsequent generic applicants."[24] The FTC found that the brand-name manufacturer and generic manufacturer were illegally colluding to prevent competition and preserve the drug's high price.[25]

Other lawsuits allege that some companies have systematically overcharged consumers for their medicines or waged misinformation campaigns against competitors. Wyeth-Ayerst Laboratories, for example, has been accused of maintaining a 99% monopoly over its estrogen supplement Premarin by waging a misinformation campaign about its generic competitor, Cenestin, to discourage consumers from purchasing the cheaper drug. Even as Wyeth-Ayerst worked to keep Cenestin off formularies—the list of medications covered by any given health plan—it continued to increase the price of Premarin.[26] Knoll Pharmaceuticals (now owned by BASF) also was accused of waging a misinformation campaign about generic competition for Synthroid, its drug to treat hyperthyroidism. Knoll maintained in both advertisements and communication with state and federal regulators, consumers, pharmacists, and the medical community that there was no "substitute for Synthroid" despite evidence in hand proving that the generic version of Synthroid was biologically equivalent and an effective substitute.[27]

Several state PIRGs have joined labor unions, senior citizen advocates and other consumer groups in litigation coordinated by the Prescription Access Litigation Project (PALP), challenging numerous unfair drug company price manipulation tactics. In July 2004, PALP announced a $29 million settlement with GlaxoSmithKline over charges that it used illegal tactics to maintain its patent on Augmentin, a popular antibiotic used in the treatment of a variety of common infections.[28]

Pharmacy Benefit Managers Use Deceptive Trade Practices

Pharmacy Benefit Managers (PBMs), the pharmaceutical "middlemen," arrange sales programs between drug manufacturers and health care plan providers (such as state health benefit programs, large businesses, and HMOs) seeking to reduce the cost of their prescription drug plans. PBMs provide pharmacy coverage to more than 150 million American consumers;[29] three PBMs—

Medco, Caremark and Express Scripts—currently control approximately 80% of the lucrative market. Overall, the nation's employers spend more than $70 billion through PBMs.[30] Despite the impact of PBMs on health care spending, tremendous secrecy surrounds how PBMs conduct business. Recent investigations charge that PBMs exploit their ability to negotiate secret deals and increase their revenues without passing cost savings on to clients.

In April 2004, 19 states settled deceptive trade practice claims against Medco Health Solutions, Inc. Medco is the nation's largest PBM, with 2002 net revenues of more than $32 billion and a network of 55,000 pharmacies.[31] The complaint alleged that Medco encouraged physicians and other prescribers to switch patients to different prescription drugs without disclosing that the switches benefited Medco by increasing rebates from drug manufacturers. The complaint also alleged that Medco misrepresented its actions by claiming that the switch would result in savings to both patients and health care plans.[32] In reality, the switches they encouraged often increased costs, primarily in follow-up doctor visits and tests. For example, Medco switched patients from certain cholesterol medications (such as Lipitor) to alternative treatments (such as Zocor), which required patients to pay for follow-up costs.[33] Medco paid $29 million to settle the deceptive trade allegations; $2.5 million to identifiable patients who incurred expenses related to a switch between cholesterol controlling drugs; and $6.6 million to states in fees and costs.

On August 4, 2004, the New York Attorney General's office announced it had filed suit against Express Scripts for "conducting elaborate schemes" that added millions of dollars in prescription drug costs to the state's health plan.[34] The lawsuit alleges that Express Scripts encouraged drug switches that increased its revenue at the expense of the health plan and its members. Specifically, Express Scripts would switch members from a brand name drug losing patent protection to another brand name drug, one not facing generic competition but made by the same manufacturer. The suit also charges that the company would induce physicians to switch a patient's prescription from one prescribed drug to another drug manufactured by a company paying Express Scripts for new prescriptions. The suit further alleges that Express Scripts disguised millions of dollars in rebates it received from drug manufacturers as various types of administrative fees when it should have passed the rebates onto the health plan.[35] Nineteen other states are currently investigating Express Scripts on similar charges.[36]

Drug Companies Limit Information on the Safety and Efficacy of Their Products

Often, several competing prescription drugs are available to treat one condition, such as depression or high cholesterol. However, consumers and doctors have few resources for determining which prescription is safest, most effective, and most affordable. Pharmaceutical companies frequently patent new prescription drugs that are either equivalent or less effective than less expensive options, such as drugs available in generic form, over-the-counter medication, or lifestyle changes. Unfortunately, pharmaceutical companies generally do not conduct head-to-head comparisons of drugs that treat the same condition; they prefer the less risky approach of competing through marketing, which encourages doctors and consumers to use the newest and usually most expensive treatments.

Not only do pharmaceutical companies discourage comparisons of drugs within the same class, they also control the dissemination and interpretation of their clinical trial results. In June 2004, the Attorney General of New York filed a lawsuit against GlaxoSmithKline, alleging that the company committed fraud by both concealing and failing to disclose negative information about its depression drug Paxil.[37] GlaxoSmithKline completed five studies on the use of Paxil in children; four failed to demonstrate that Paxil was more effective than a placebo and suggested a possible increased risk of suicidal behavior. Not only did GlaxoSmithKline fail to include this information in the "Medical Information Letter" it sent to physicians, it also failed to publish the negative clinical trial results.[38] GlaxoSmithKline reached a settlement with the State of New York that includes payment of $2.5 million as well as an agreement to publicly disclose information on clinical studies of its drugs.[39] In September 2004, an FDA advisory committee[a] concluded that the increased risk of suicidality in pediatric patients applied to all the drugs studied (Prozac, Zoloft, Remeron, Paxil, Effexor, Celexa, Wellbutrin, Luvox and Serzone) in controlled clinical trials. Shortly thereafter, FDA announced support for the advisory committee's recommendation to strengthen the warning label for antidepressant usage in children.[40]

[a] FDA uses advisory committees to gain expert advice about scientific and public health issues and/or regulatory decisions. On September 13-14, 2004, the Psychopharmacologic Drugs and Pediatric Advisory Committees held a joint meeting to consider the occurrence of suicidality in the course of treating pediatric patients with various anti-depressants. FDA is not required to follow the recommendations of its advisory committees; the agency announced a few days after the joint meeting that it "generally supports the recommendations." (From testimony of Dr. Robert Temple, Director of Medical Policy at FDA's Center for Drug Evaluation and Research, before the U.S. House Subcommittee on Oversight and Investigations, September 23, 2004.)

Around the same time, in September 2004, drug giant Merck announced a voluntary worldwide withdrawal of its blockbuster pain-relief drug, Vioxx. Merck stopped selling Vioxx after a long term study, financed by the company, showed that people taking the drug had more cases of heart attack, stroke or blood clot than people taking a placebo.[41] Since Vioxx went on the market in 1999, the prescription has been dispensed 84 million times.[42] Many experts in the medical field had raised questions about the safety of the medication for nearly four years; many others are raising similar questions about the FDA's failure to recall the drug in the face of this medical evidence. In 2000, a study by the *New England Journal of Medicine* found rates of heart attacks were higher in patients taking Vioxx than in patients taking an older drug. After that study, FDA required Merck to add a warning to Vioxx's label. Another study released by cardiologists in 2001 reiterated the findings of the 2000 study.[43] This news, combined with the high cost of Vioxx, caused some insurers to remove Vioxx and similar pain medications from their list of preferred drugs. Although an August 2004 French study found that high doses of Vioxx triple the rate of heart attack, FDA approved Vioxx for use in children just a few weeks later.[44] Merck continued to assert that the drug was safe—even as recently as three days before announcing its decision to withdraw the drug from the market.[45]

Drug Companies Spend Millions Lobbying to Maintain High Prices

In June 2004, Public Citizen released a report detailing the amount of money the drug industry—broadly defined as brand-name, generic and biotech drug makers, pharmacy benefit managers, distributors, and related advocacy groups—spent

lobbying Congress in 2003. According to the report, "the drug industry hired 824 individual lobbyists in 2003—an all-time high. That's more than eight lobbyists for each member of the U.S. Senate. In 2002, based on a more narrowly defined survey, the drug industry spent $91.4 million and hired 675 lobbyists."[46] Drug industry spending on lobbying in 2003 rose to a record $108.6 million; brand-name manufacturers alone spent nearly $80 million on lobbying, or 73% of the industry total. The Pharmaceutical Research and Manufacturers of America (PhRMA), the industry's leading trade association representing more than 40 brand-name drug companies, hired 136 lobbyists in 2003, 24 more than the previous year, and spent more than $16 million on direct lobbying before Congress, a 12.5% increase from the year before.[47] According to confidential budget documents, PhRMA does not confine its financial influence to federal decision-makers. For the fiscal year that began on July 1, 2003, PhRMA had budgeted $48.7 million for advocacy at the state level as well.[48]

Survey Findings

While the pharmaceutical industry is among the most profitable industries in the world, millions of uninsured and underinsured Americans struggle to afford the medicines they need, even forgoing medically necessary drugs when prices are out of reach. When discussing the high cost of prescription drugs, politicians often focus on the financial burden carried by senior citizens. Unfortunately, high prescription drug prices are a problem for Americans of all ages, not just the elderly.

The federal government uses its buying power to negotiate lower prices for the drugs it purchases for its beneficiaries – such as Veterans, government employees and retirees. Consumers with health insurance coverage pay only a portion of the discounted price negotiated by their insurance company. Unfortunately, 45 million uninsured Americans have no one doing the same on their behalf.

In late summer of 2004, the National Association of State Public Interest Research Groups (PIRGs) conducted a survey of more than 400 pharmacies in 19 states across the country and Washington, DC to determine how much uninsured consumers are paying for 12 prescription drugs commonly used by adults under age 65. We then compared these prices with the prices the pharmaceutical companies charge one of their "most favored" customers, the federal government, and the prices paid by consumers in Canada.

Our survey demonstrates that the uninsured pay unjustly high prices for prescription drugs in the United States—especially when compared with the prices paid by the federal government and our neighbors to the north. Tables 1 and 2 detail the results of our survey. Key findings include:

In Alaska:

• On average, uninsured consumers in Alaska pay 80% more than the federal government for 12 common prescription medications.

• Uninsured consumers in Alaska pay 80% more for Zithromax than the federal government pays for the same prescription. Zithromax—an antibiotic prescribed to treat various bacterial infections, such as pneumonia—is the most commonly dispensed antibiotic in America.

• On average, uninsured consumers in Alaska pay twice as much—109% more—for drugs purchased at their local pharmacy then they would pay if they purchased the same drugs from a Canadian pharmacy.

Nationally:

• Uninsured Americans pay 78% more on average for 12 common prescription drugs than the federal government pays for the same medication. The price differences range from 41% more for Ambien, a sleep aid, to 162% more for Synthroid, which treats thyroid disorders.

• Many of the drugs featured in the PIRG survey treat chronic conditions – meaning that even small savings add up quickly. An uninsured person regularly taking Allegra to control his or her allergies, for example, would pay on average $1,120 for a year's supply. The government, on the other hand, would pay only $657 for the same quantity of Allegra – a savings of $463.

• Uninsured Americans, on average, pay twice as much as Canadians—105% more—for nine of the common prescription medications we surveyed. The price differences range from 45% more for Norvasc, which treats high blood pressure, to 530% more for Premarin, a necessary hormone treatment for millions of women.

• An uninsured woman regularly taking Premarin would pay on average $465 for a year's supply. A woman purchasing her year's supply of Premarin from a Canadian pharmacy would pay $74—saving $391 a year.

Refer to Appendix A for a detailed breakdown of the average cost of these prescription drugs in all of the states and major metropolitan areas surveyed.