Survey

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ENews

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CAIRS

California Alliance of Information & Referral Services

CAIRS is an affiliate of AIRS

The 2-1-1 California Partnership is committed to making 2-1-1 available to all California residents

2-1-1 service is now active in Ventura, Los Angeles, Orange, Riverside, Santa Barbara, and San Diego counties. See the California Launch Press Release.

2-1-1 is an easy to remember telephone number connecting people with important community services.

Review the 2-1-1 State Plan (revised 1/2006) or review a two page summary of the plan.

A national cost benefit analysis estimates the net value to society of a national 2-1-1 system approaching *$130 million in the first year alone, and a conservative estimate of $1.1 billion over ten years.*
(University of Texas, 2004)

Benefits of a state-wide 2-1-1 system:

- **Community members benefit from simple access to services**
  - **One-number access to wide range of service information**
  - **Quality referrals eliminates the need for multiple calls, unneccessary trips**
  - **Expanded coverage, particularly in counties not currently served**

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Call 211 Help Starts Here

by I&R services

- **Taxpayers benefit from more effective access to information**
  - **Improved human services as professionals use 2-1-1 to connect clients to needed services**
  - **Updated public information can be disseminated quickly, such as for public health concerns**
  - **Less duplication as 2-1-1 reduces the need for other entities to develop, maintain, and operate new I&R systems or 800 numbers**
  - **Better planning and assessment 2-1-1 generates valuable information on community needs**

- **The whole community benefits from a stronger public safety system**
  - **Relieves 911 call volume, allowing for faster response to real emergencies**
  - **Centralized disaster response information**
    - **After the 9/11 terrorist attacks, 95 percent of all calls in Connecticut for mental health counseling, volunteering, and other services went to 2-1-1. New York, without a 2-1-1 system, created 400 new information lines, resulting in confusion and wasted resources.**
    - **During the 2004 hurricane season, thousands of Floridians turned to 2-1-1 for help**

Where does 2-1-1 exist?

2-1-1 is currently available to over 119 million people across the United States in 31 states, 40% of the U.S. population (www.211.org). California's first 2-1-1 services launched on February 11, 2005 in Ventura County. By the end of 2005, the Partnership projects that 2-1-1 will be available in 55% of Californians in 7 counties.

What is the 2-1-1 California Partnership?

The 2-1-1 California Partnership is a collaborative effort between the California Alliance of Information and Referral Systems (CAIRS) and United Ways of California (UWCA) to implement 2-1-1 service throughout the state. In 2005, the Partnership is developing a statewide business plan for 2-1-1 implementation.

To get all the latest 2-1-1 news, sign up for the 2-1-1 Action Update by sending your email address to Lynn Pesely at lpesely@yahoo.com.

2-1-1 California Partnership Statewide Planning
CAIRS Input to Standards
2-1-1 Status by County
2-1-1 Roll Out Plans by County - Chart
2-1-1 Roll Out Plans by County - 2-1-1 Map
Counties with Comprehensive I&R
Regional Meeting Presentation
Summary of Regional Meetings
Regional Meeting Detailed Notes
Regional Meetings -- Thoughts on 100% Coverage
Statewide Planning Update
Input to Business Plan by Component
April Stakeholder Meeting Notes
June Stakeholder Meeting Notes
Stakeholder Participants

2-1-1 Information Kit
2-1-1 Fact Sheet
2-1-1 Action Updates
2-1-1 Presentation by CAIRS (.ppt format)
CAIRS/UWCA MOU At-A-Glance

2005 CalNENA Conference 2-1-1 Presentation (.ppt format)

2-1-1 Tool Kit
2-1-1 Application Proof of Service Form
Butte County Update and Report
2-1-1 Service Provider Application
2-1-1 Endorsement Form
2-1-1 Service Provider Application at a Glance
Cost per Call Calculations
Application Checklist
Planning Checklist
Marketing 2-1-1
Telecommunications and Technology Primer

2-1-1 Costs and Benefits
2-1-1: A New Essential Link for Diasaster Information
National Benefit/Cost Analysis of Three Digit-Accessed Telephone Information and Referral Services; December 2004
50 Ways 2-1-1 Works
Maryland Study
Nebraska Study
San Diego First 5 Commission Study
Texas Study and Analysis
First 5 Funding for California 2-1-1/I&R's
New Mexico Study

Federal 2-1-1 Legislation
S 211 and HR 896 Co-Sponsor List
Sample Letter to Representatives
Sample Letter to Senators

2-1-1 Standards
CPUC final decision establishing procedures for implementing 2-1-1 dialing in CA
AIRS Standards for Professional I&R
Disability Access Standards
211 LA County Performance Goals
National 211 Benchmark Survey - conducted by 211 San Diego

NEWS:

- **San Francisco Chronicle, March 29, 2006 Social Services Available on New 211 Hotline**

United Way
of Anchorage

United Way • AIRS
2-1-1
Get Connected. Get Answers.

United Way

Connecting Alaskans with Services

Alaska Regulatory Commission Grants United Way use of 2-1-1 dialing code

The first step in finding help is knowing who to call. You know to dial 911 for emergencies and 411 for directory assistance. Soon, Alaskans will be able to dial 2-1-1 to connect to essential community health and human service resources.

On October 14, 2005, the Regulatory Commission of Alaska granted United Way of Anchorage approval to use the 2-1-1 dialing code on a statewide basis to provide a health and social services information and referral service within Alaska.

Within the year, many Alaskans in need of a food bank, help for an elderly parent, counseling in family crisis or childcare services will be able to dial this easy to remember telephone number or access information online via the internet and shortcut an often bewildering maze of health and human services agencies and programs.

"Help is out there," said Sue Brogan, project manager for Alaska 211. "It's figuring out how to get it that often keeps people from receiving the help they need. This vital service will also provide trending information on changing community needs which will allow social service agencies to proactively respond to newly emerging needs."

The goal is to have 2-1-1 call center operators available 24 hours a day, 365 days a year. These trained and accredited Information and Referral Specialists (I&R) will assess a callers' needs, access a continuously updated statewide database, and refer callers to the appropriate agencies and organizations who can help. A pilot 2-1-1 system covering Anchorage is expected to be 2007.

The improved well-being of Alaskans, enhanced public safety and crisis recovery efforts as well as cost savings for taxpayers, employers, and government are just some of the benefits expected from Alaska 2-1-1.

April 13, 2005

Honorable Representative Don Young
Alaska-At Large, Republican
2111 Rayburn HOB
Washington, DC 20515-0201

Dear Representative Young:

We are writing to ask you to support "The Calling for 2-1-1 Act" (S 211 and HR 895). The legislation has wide bipartisan co-sponsorships.

2-1-1 is a national telephone number for access to health and human services and volunteer opportunities. Today, 2-1-1 serves over 37% of U.S. residents and is a model public/private partnership. It is currently funded by state and local governments, United Ways and other non-profits, foundations, and corporate donations. Passage of this legislation would provide sustainable funding for nationwide availability. Once fully in place, 2-1-1 will be as well known and useful as 9-1-1 is for emergencies.

Thanks to the assistance of Senator Stevens, we are forming a statewide Alaska 2-1-1 line. This will grow from the few existing regional phone information lines and online information and referral databases. It will be operated by the United Way of Anchorage in partnership with the Alaska Department of Health and Social Services, the Municipality of Anchorage, other Alaska United Ways, and many others. This group is currently working together to create a single database of health and human services that will cover a majority of the state. We are also working with faith-based organizations to ensure that the many Alaska faith-based service providers are listed in the directory of services.

2-1-1 services will be extremely valuable in Alaska, particularly as rural residents travel to urban centers. The services can be tailored to local needs and provide referrals for basic and crisis human services needs. For examples, 2-1-1 can offer access to the following type of services:

- Core needs resources, such as food banks, clothing closets, shelters, rent assistance, and utility assistance.
- Physical and mental health resources, such as health insurance programs, Medicaid and Medicare, maternal health, medical information lines, crisis prevention, support groups, counseling, and drug and alcohol intervention and rehabilitation.
- Employment supports, such as financial assistance, job training, transportation assistance, and education programs.
- Support for older Americans and persons with disabilities, such as adult day care, Meals on Wheels, respite care, home health care, transportation, and homemaker services.

- Support for children, youth and families, such as childcare, after school programs, Head Start, family resource centers, summer camps and recreation programs, mentoring, tutoring, and protective services.
- Volunteer and donation opportunities.

2-1-1 systems have also proven to be invaluable during disasters and an asset for community planning.

We have a great collaborative start on this process in Alaska, but we are still a long way from making Alaska 2-1-1 a reality. Passage of S 211 and HR 896 will enable Alaska to garner the benefits that other communities with 2-1-1 capability have realized.

We urge you to support "The Calling for 2-1-1 Act."

Thank you for your consideration.

Sincerely,

Michele Brown
President
United Way of Anchorage

Ernie Hall
Chairman, Board of Directors
United Way of Anchorage

HCR

35

Health, Education and Social Services Committee

Alaska State Legislature

House of Representatives

Representative Peggy Wilson - Chair

House HESS Committee

AGENDA

Tuesday, March 28th 3:00 – 5:00 p.m. Capitol 106

+* HCR 35 Brain Injury Awareness Month: March 2006
+= HB 287 Medical Facility Certificate of Need
+ Bills previously heard/scheduled

Alaska State Capitol, Room 106 • Juneau, Alaska 99801
(907) 465-3759 phone • (907) 465-3175 fax

HOUSE HEALTH EDUCATION & SOCIAL SERVICES COMMITTEE PACKET

March 27, 2006

1	HCR 35 Brain Injury Awareness Month: March 2006
2	HB 287 Medical Facility Certificate of Need
3	Bills Previously Scheduled /Heard
4	
5	
6	

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. John Coghill
Rep. Peggy Wilson
Rep. Pete Kott
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

SPONSOR STATEMENT HCR 35
"A resolution relating to establishing March 2006 as brain injury awareness month,"
By House Judiciary Committee
Representative Lesil McGuire, Chair

Traumatic brain injuries often lead to sever disability or death. These injuries most often affect younger, more active people and are likely to have enduring physical, emotional, and financial costs.

Traumatic brain injury (TBI) is damage to the brain that results when the head is hit, strikes a stationary object, or is violently shaken. Depending on what area of the brain is injured, people with brain injuries may suffer from poor short-term memory and difficulty with organization concentration and judgment. Their personality may change. Family members say brain injury is one of the hardest disabilities to deal with because the survivors may look the same, but can be totally different. Alaska is the number one state, per capita, for brain injuries in the nation. Over 700 TBI's were reported in Alaska in 2003 and an estimated 12,000 Alaskans have suffered a traumatic brain injury.

This resolution is to draw awareness to traumatic brain injuries and support those that have suffered a traumatic brain injury, their families, and care providers.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HCR 35
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: BRAIN INJURY AWARENESS MO[illegible]TH:MARCH 2006
RDU
Component
Sponsor: JUDICIARY
Requester: HOUSE (HES)
Component No.

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 House Concurrent Resolution will have no fiscal impact on HSS.

Prepared by: Linda Miller
Phone 465-3759
Division
Date/Time 3/27/06 12:00 AM
Approved by: Rep. Peggy Wilson
Date 3/27/06 12:00 AM
Agency: House HESS Chair

(Revised 9/7/2005 OMB)

HJR

10

[redacted]OUSE COMMITTEE REPO[redacted]

(7)

Date Referred to Committee: February 14, 2005 **FURTHER REFERRALS: Finance**

Date of Committee Action: February 22, 2005

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HJR 10**

HOUSE JOINT RESOLUTION NO. 10 **FEDERAL MEDICAL ASSISTANCE REDUCTION**

Relating to a proposed reduction in the Federal Medical Assistance Percentage for Alaskans; and urging the United States Congress to take action to prevent the reduction.

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

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

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
Bill McGuire	Cissna	✓			
Con Bunde	Anderson	X			
Paul R Seaton	Seaton	✓			
Chair: Bert L Wilson	Wilson	✓			
Chair:					

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HJR10-DHSS-OCS-02-18-05
( ) Publish Date:

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

Title: FEDERAL MEDICAL ASSISTANCE REDUCTION
RDU: Children's Services
Component: Children's Medicaid Services

Sponsor: FINANCE
Requester: H HESS
Component No.: 2661

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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 (FY2005) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

If the current federal law is not changed, the FFY06 Federal Medical Assistance Payment (FMAP) for Medicaid Services will be 50.16%, down 7.42% from the 57.58% in FFY05. This decrease is more than twice that of the state with the next highest cut. While the federal government recognizes the high cost of living in Alaska by adding a 25% COLA to federal salaries, the federal government does not recognize the high cost of living when calculating federal payments. Alaska has the highest hospital inpatient cost per day and is in the top ranks of pharmacy costs. The reduction in FMAP will result in a loss of federal funds and an increase in state general funds of $53 million in FY06 and $73 million in FY07. Over the next 10 years the cost of the FMAP reduction is projected to exceed $900 million.

Prepared by: Marcia Kennai — Phone 907-465-3011
Division: Office of Children's Services — Date/Time 02/17/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 02/18/2005
Agency: Department of Health and Social Services

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. HJR10-DHSS-OCS-02-18-05

ANALYSIS CONTINUATION

Assuming the level of Children's Medicaid Services in FY06 will be the same as in FY05, the FMAP reduction will result in a $654.8 reduction in federal revenues for this component that will need to be supplanted by GF.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HJR10-DHSS-HCS-02-18-05
( ) Publish Date:

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

Title: FEDERAL MEDICAL ASSISTANCE REDUCTION
RDU: Health Care Services
Component: Medicaid Services

Sponsor: FINANCE
Requester: H HESS
Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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 (FY2005) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

If the current federal law is not changed, the FFY06 Federal Medical Assistance Payment (FMAP) for Medicaid Services will be 50.16%, down 7.42% from the 57.58% in FFY05. This decrease is more than twice that of the state with the next highest cut. While the federal government recognizes the high cost of living in Alaska by adding a 25% COLA to federal salaries, the federal government does not recognize the high cost of living when calculating federal payments. Alaska has the highest hospital inpatient cost per day and is in the top ranks of pharmacy costs. The reduction in FMAP will result in a loss of federal funds and an increase in state general funds of $53 million in FY06 and $73 million in FY07. Over the next 10 years the cost of the FMAP reduction is projected to exceed $900 million.

Prepared by: Dwayne Peeples — Phone 907-465-5830
Division: Health Care Services — Date/Time 02/17/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 02/18/2005
Agency: Department of Health and Social Services

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. HJR10-DHSS-HCS-02-18-05

ANALYSIS CONTINUATION

Assuming the level of Medicaid Services in FY06 will be the same as in FY05, the FMAP reduction will result in a $28,883.6 reduction in federal revenues for this component that will need to be supplanted by GF.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HJR10-DHSS-DBH-02-18-05
( ) Publish Date:
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: FEDERAL MEDICAL ASSISTANCE REDUCTION
RDU: Behavioral Health
Component: Behavioral Hlth Medicaid Svcs

Sponsor: FINANCE
Requester: H HESS
Component No.: 2660

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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 (FY2005) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal: ☐

POSITIONS

Full-time						
Part-time						
Temporary						

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

If the current federal law is not changed, the FFY06 Federal Medical Assistance Payment (FMAP) for Medicaid Services will be 50.16%, down 7.42% from the 57.58% in FFY05. This decrease is more than twice that of the state with the next highest cut. While the federal government recognizes the high cost of living in Alaska by adding a 25% COLA to federal salaries, the federal government does not recognize the high cost of living when calculating federal payments. Alaska has the highest hospital inpatient cost per day and is in the top ranks of pharmacy costs. The reduction in FMAP will result in a loss of federal funds and an increase in state general funds of $53 million in FY06 and $73 million in FY07. Over the next 10 years the cost of the FMAP reduction is projected to exceed $900 million.

Prepared by: Bill Hogan — Phone 465-3166
Division: Behavioral Health — Date/Time 02/17/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 02/18/2005
Agency: Department of Health and Social Services

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. HJR10-DHSS-DBH-0[illegible]-18-05

ANALYSIS CONTINUATION

Assuming the level of Behavioral Health Medicaid Services in FY06 will be the same as in FY05, the FMAP reduction will result in a $7,909.2 reduction in federal revenues for this component that will need to be supplanted by GF.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HJR 10
( ) Publish Date:

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

Title: FEDERAL MEDICAL ASSISTANCE REDUCTION
RDU: Senior and Disabilities Svcs
Component: Senior/Disabilities Medicaid Svc

Sponsor: FINANCE
Requester: H HESS
Component No.: 2662

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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 (FY2005) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

If the current federal law is not changed, the FFY06 Federal Medical Assistance Payment (FMAP) for Medicaid Services will be 50.16%, down 7.42% from the 57.58% in FFY05. This decrease is more than twice that of the state with the next highest cut. While the federal government recognizes the high cost of living in Alaska by adding a 25% COLA to federal salaries, the federal government does not recognize the high cost of living when calculating federal payments. Alaska has the highest hospital inpatient cost per day and is in the top ranks of pharmacy costs. The reduction in FMAP will result in a loss of federal funds and an increase in state general funds of $53 million in FY06 and $73 million in FY07. Over the next 10 years the cost of the FMAP reduction is projected to exceed $900 million.

Prepared by: Steve Ashman — Phone 907-465-3819
Division: Senior & Disabilities Services — Date/Time 02/17/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 02/18/2005
Agency: Department of Health and Social Services

Impact of FMAP Reduction on State Match
Projected Medicaid Expenditures
2005 to 2015
Funds in Thousands

STATE FISCAL YEAR

State Fiscal Year	Impact of FMAP Reduction on State Match
2005	$0
2006	$52,872,300
2007	$72,853,900
2008	$80,974,800
2009	$86,267,100
2010	$91,200,100
2011	$96,490,400
2012	$101,437,900
2013	$106,115,400
2014	$110,716,900
2015	$115,287,300
Total	$914,216,100

FEDERAL FISCAL YEAR

Federal Fiscal Year	Impact of FMAP Reduction on State Match
2005	$0
2006	$70,223,800
2007	$77,410,800
2008	$82,670,600
2009	$87,473,900
2010	$92,535,500
2011	$97,781,300
2012	$102,608,400
2013	$107,274,400
2014	$111,861,900
2015	$116,421,500
Total	$946,262,100

Announced FMAP *

Federal Fiscal Year	Title XXI FMAP	Title XIX FMAP
2005	70.31%	57.58%
2006	65.11%	50.16%
2007	65.00%	50.00%
2008	65.00%	50.00%
2009	65.00%	50.00%
2010	65.00%	50.00%
2011	65.00%	50.00%
2012	65.00%	50.00%
2013	65.00%	50.00%
2014	65.00%	50.00%
2015	65.00%	50.00%

Assumptions:

SFY2005 is from the Operating Budget; SFY2006 is from the Governor's Budget; SFY2007 to SFY2015 are actual quarterly claim payments (Jan. 1998-Dec. 2004) projected using a linear trend.

FFY2005 to FFY2015 are actual quarterly claim payments (Jan. 1998-Dec. 2004) projected using a linear trend.

The announced FMAP for FFY2007 and forward is assumed to be the minimum allowed rate.

No changes to program services or eligibility are included except a 39% reduction in pharmacy costs for Medicare Part D coverage beginning in 2006.

Past trends in inflation and population growth are expected to continue and are therefore already included in the projection. No additional adjustments are made.

Source: DHSS, FMS, Medicaid Budget Group, February 12, 2005

Impact of FMAP Reduction
Projected Medicaid Expenditures
2005 to 2015

Funds In Thousands

Announced FMAP	Title XXI	Title XIX
FFY2005	70.31%	57.58%
FFY2006	65.11%	50.16%
FFY2007 forward	65.00%	50.00%

STATE FISCAL YEAR

State Fiscal Year	Impact of FMAP Reduction on State Match	Keeping FFY05 FMAP				Using Announced FMAP				Announced FMAP (blended for SFY)	
		Total	% Fed	Federal	Match	Total	% Fed	Federal	Match	XXI FMAP	XIX FMAP
2005	$0	$1,059,719,600	67.7%	$717,615,700	$342,103,900	$1,059,719,600	67.7%	$717,615,700	$342,103,900	70.45%	57.78%
2006	$52,872,300	$1,075,280,600	65.7%	$706,991,400	$368,289,200	$1,075,280,600	60.8%	$654,119,100	$421,161,500	66.41%	52.02%
2007	$72,853,900	$1,226,852,500	64.3%	$789,364,300	$437,488,200	$1,226,852,500	58.4%	$716,510,400	$510,342,100	66.41%	52.02%
2008	$80,974,800	$1,313,480,700	63.6%	$834,897,900	$478,582,800	$1,313,480,700	57.4%	$753,923,100	$559,557,600	65.03%	50.04%
2009	$86,267,100	$1,391,945,400	63.6%	$884,773,000	$507,172,400	$1,391,945,400	57.4%	$798,505,900	$593,439,500	65.00%	50.00%
2010	$91,200,100	$1,471,540,900	63.6%	$935,366,900	$536,174,000	$1,471,540,900	57.4%	$844,166,800	$627,374,100	65.00%	50.00%
2011	$96,490,400	$1,556,901,100	63.6%	$989,625,100	$567,276,000	$1,556,901,100	57.4%	$893,134,700	$663,766,400	65.00%	50.00%
2012	$101,437,900	$1,636,731,700	63.6%	$1,040,368,400	$596,363,300	$1,636,731,700	57.4%	$938,930,500	$697,801,200	65.00%	50.00%
2013	$106,115,400	$1,712,203,300	63.6%	$1,088,341,000	$623,862,300	$1,712,203,400	57.4%	$982,225,700	$729,977,700	65.00%	50.00%
2014	$110,716,900	$1,786,450,100	63.6%	$1,135,535,100	$650,915,000	$1,786,450,100	57.4%	$1,024,818,200	$761,631,900	65.00%	50.00%
2015	$115,287,300	$1,860,195,600	63.6%	$1,182,410,500	$677,785,100	$1,860,195,600	57.4%	$1,067,123,200	$793,072,400	65.00%	50.00%
Total	$914,216,100	$16,091,301,500	64.0%	$10,305,289,300	$5,786,012,200	$16,091,301,600	58.4%	$9,391,073,300	$6,700,228,300	n/a	n/a

FEDERAL FISCAL YEAR

Federal Fiscal Year	Impact of FMAP Reduction on State Match	Keeping FFY05 FMAP				Using Announced FMAP				Announced FMAP	
		Total	% Fed	Federal	Match	Total	% Fed	Federal	Match	XXI FMAP	XIX FMAP
2005	$0	$1,064,112,000	63.6%	$676,389,700	$387,722,300	$1,064,112,000	63.6%	$676,389,700	$387,722,300	70.31%	57.58%
2006	$70,223,800	$1,157,503,300	63.6%	$735,752,700	$421,750,600	$1,157,503,300	57.5%	$665,528,900	$491,974,400	65.11%	50.16%
2007	$77,410,800	$1,249,046,400	63.6%	$793,941,000	$455,105,400	$1,249,046,400	57.4%	$716,530,200	$532,516,200	65.00%	50.00%
2008	$82,670,600	$1,333,915,400	63.6%	$847,886,900	$486,028,500	$1,333,915,400	57.4%	$765,216,300	$568,699,100	65.00%	50.00%
2009	$87,473,900	$1,411,417,600	63.6%	$897,150,300	$514,267,300	$1,411,417,600	57.4%	$809,676,400	$601,741,200	65.00%	50.00%
2010	$92,535,500	$1,493,088,100	63.6%	$949,063,100	$544,025,000	$1,493,088,100	57.4%	$856,527,600	$636,560,500	65.00%	50.00%
2011	$97,781,300	$1,577,731,700	63.6%	$1,002,865,800	$574,865,900	$1,577,731,700	57.4%	$905,084,500	$672,647,200	65.00%	50.00%
2012	$102,608,400	$1,655,617,700	63.6%	$1,052,373,000	$603,244,700	$1,655,617,700	57.4%	$949,764,600	$705,853,100	65.00%	50.00%
2013	$107,274,400	$1,730,905,000	63.6%	$1,100,228,500	$630,676,500	$1,730,905,000	57.4%	$992,954,100	$737,950,900	65.00%	50.00%
2014	$111,861,900	$1,804,925,600	63.6%	$1,147,278,800	$657,646,800	$1,804,925,600	57.4%	$1,035,416,900	$769,508,700	65.00%	50.00%
2015	$116,421,500	$1,878,495,800	63.6%	$1,194,042,800	$684,453,000	$1,878,495,800	57.4%	$1,077,621,300	$800,874,500	65.00%	50.00%
Total	$946,262,100	$16,356,758,600	63.6%	$10,396,972,600	$5,959,786,000	$16,356,758,600	57.8%	$9,450,710,500	$6,906,048,100	n/a	n/a

Assumptions:

SFY2005 is from the Operating Budget, SFY2006 is from the Governor's Budget, SFY2007 to SFY2015 are actual quarterly claim payments (Jan 1998-Dec 2004) projected using a linear trend

FFY2005 to FFY2015 are actual quarterly claim payments (Jan 1998-Dec 2004) projected using a linear trend

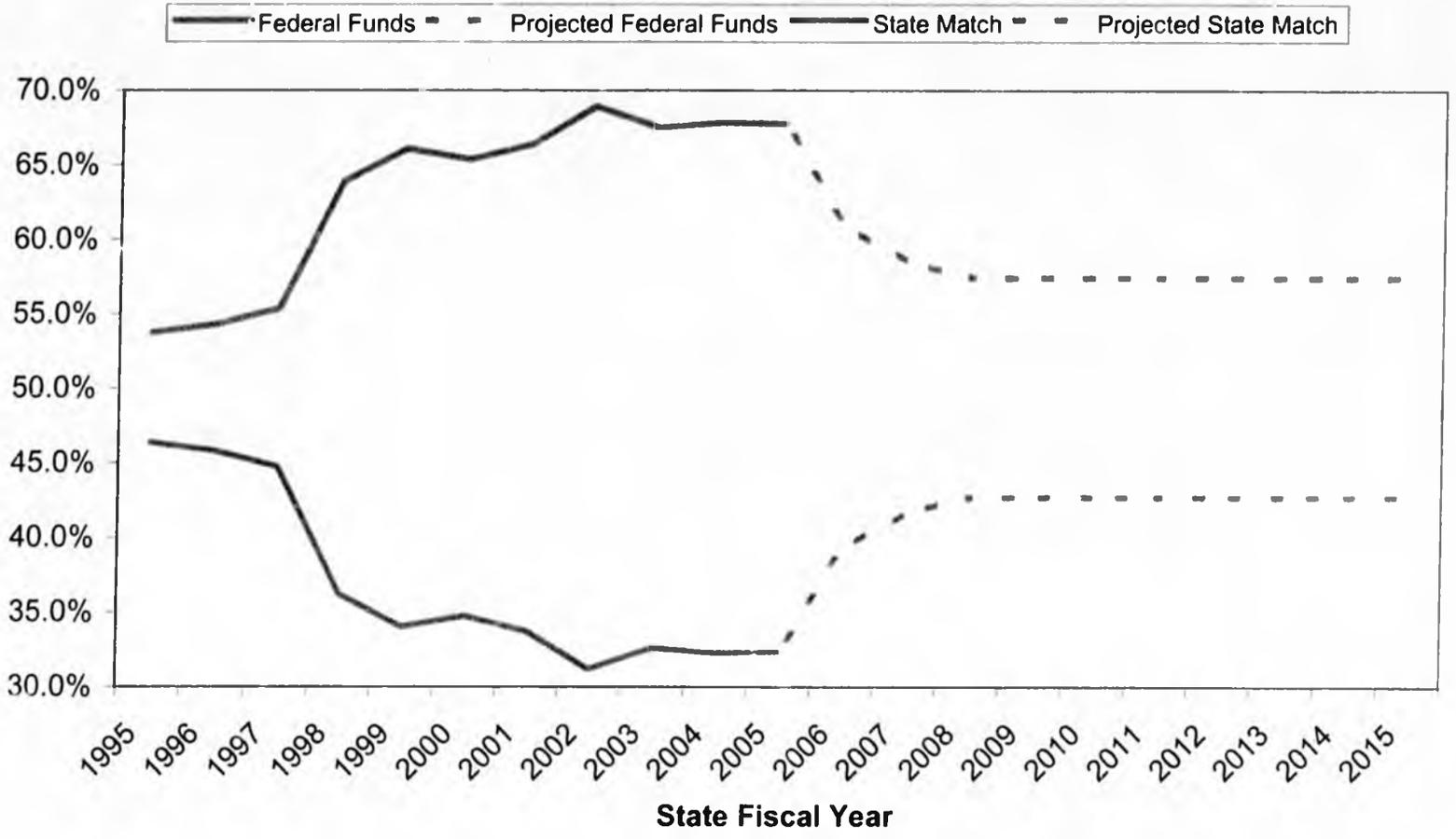
The announced FMAP for FFY2007 and forward is assumed to be the minimum allowed rate

No changes to program services or eligibility are included except a 39% reduction in pharmacy costs for Medicare Part D coverage beginning in 2006

Past trends in inflation and population growth are expected to continue and are therefore already included in the projection. No additional adjustments are made

Source: DHSS, FMS, Medicaid Budget Group, February 12, 2005

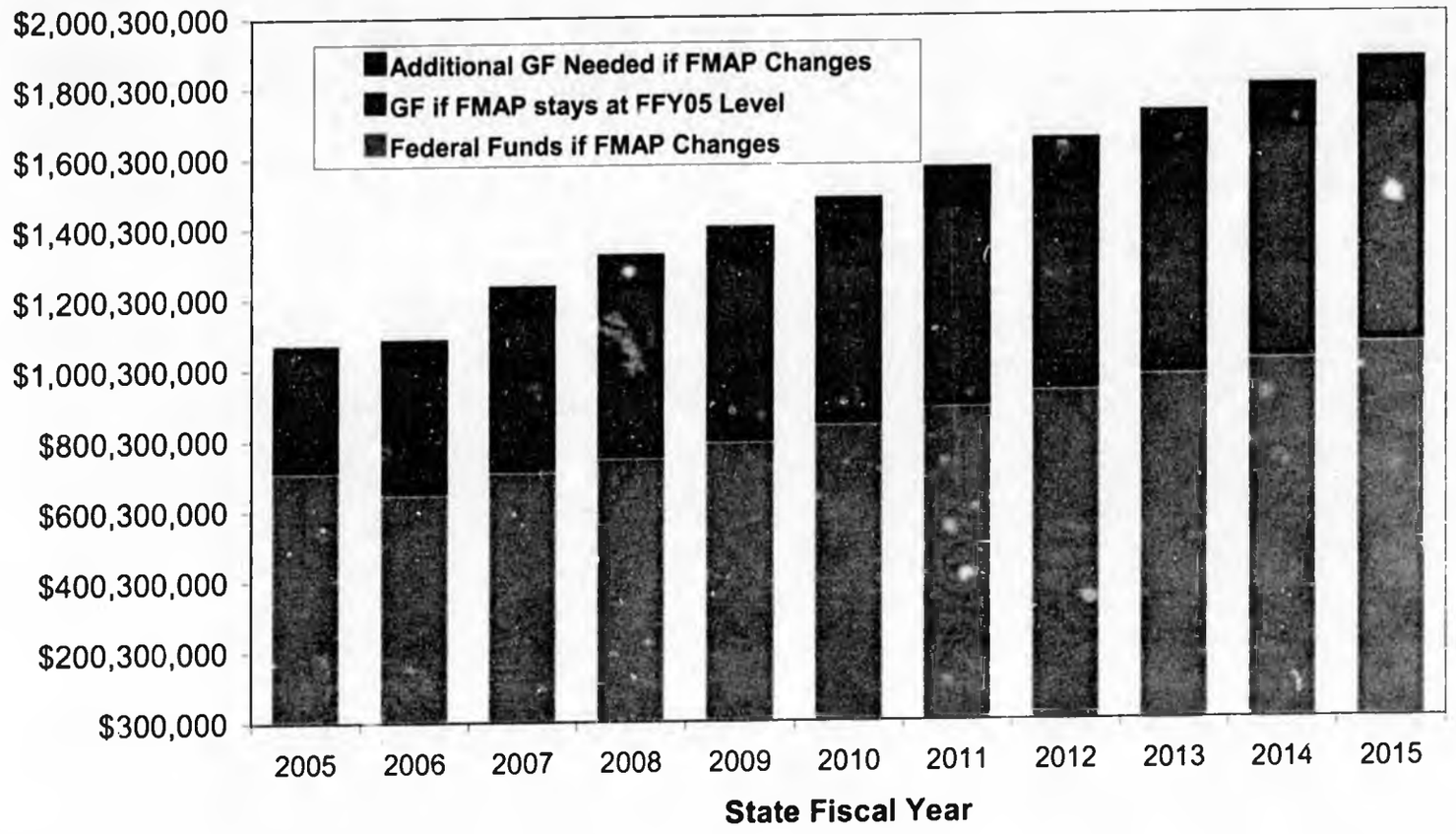
Percent of Total Medicaid Expenditures by Fund Source
SFY1995 to SFY2015



SFY1995 to SFY2004 are actual quarterly claim payments; SFY2005 is from the Operating Budget; SFY2006 is from the Governor's Budget; SFY2007 to SFY2015 are actual quarterly claim payments projected using a linear trend.

Source: DHSS, FMS, Medicaid Budget Group

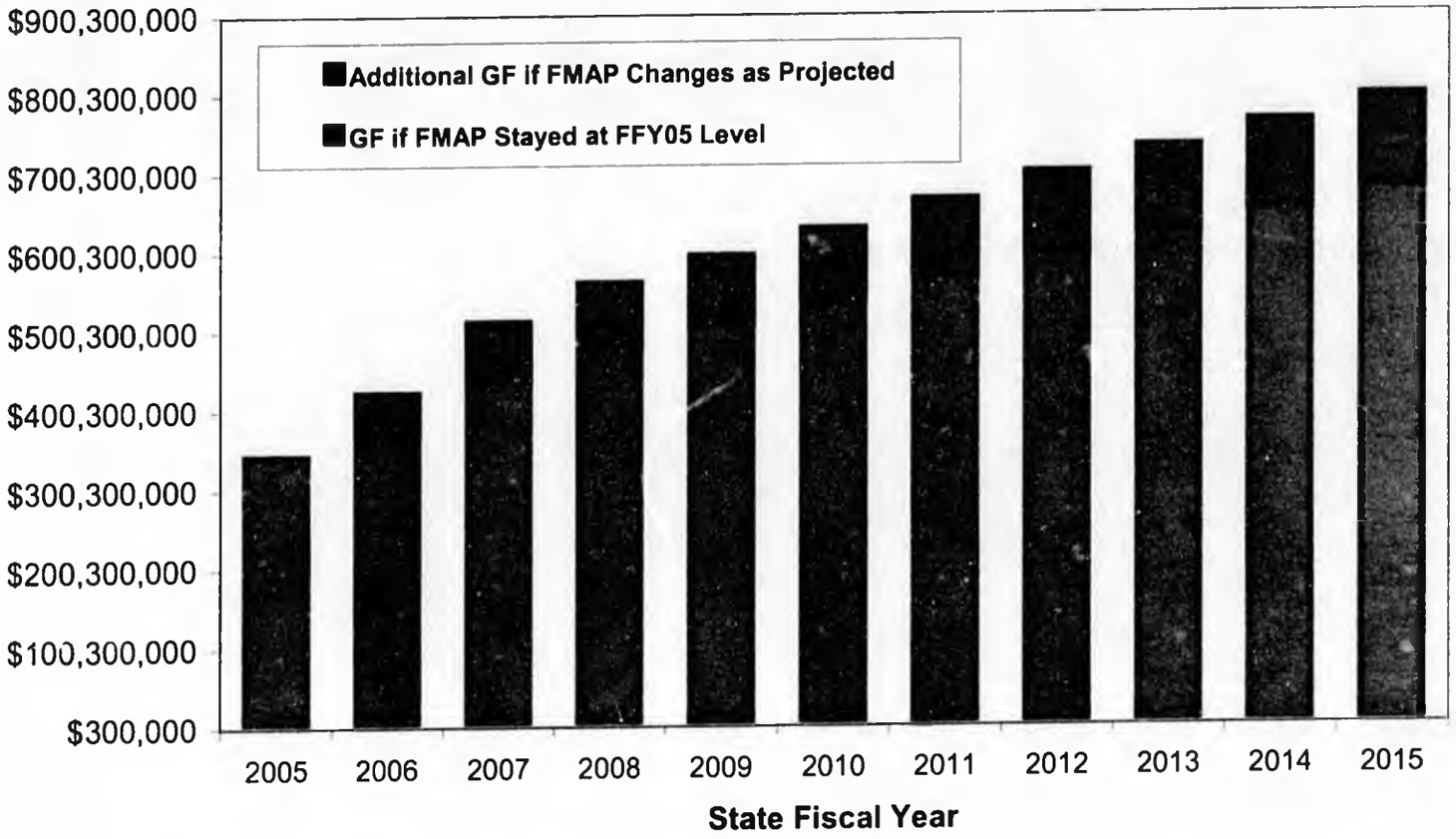
Impact of FMAP Reductions on General Funds
Projected Medicaid Expenditures by Fund Source
SFY2005 to SFY2015



SFY2005 is from the Operating Budget; SFY2006 is from the Governor's Budget; SFY2007 to SFY2015 are actual quarterly claim payments projected using a linear trend.
Source: DHSS, FMS, Medicaid Budget Group

Impact of FMAP Reductions on General Funds

Projected Medicaid General Fund Need
SFY2005 to SFY2015



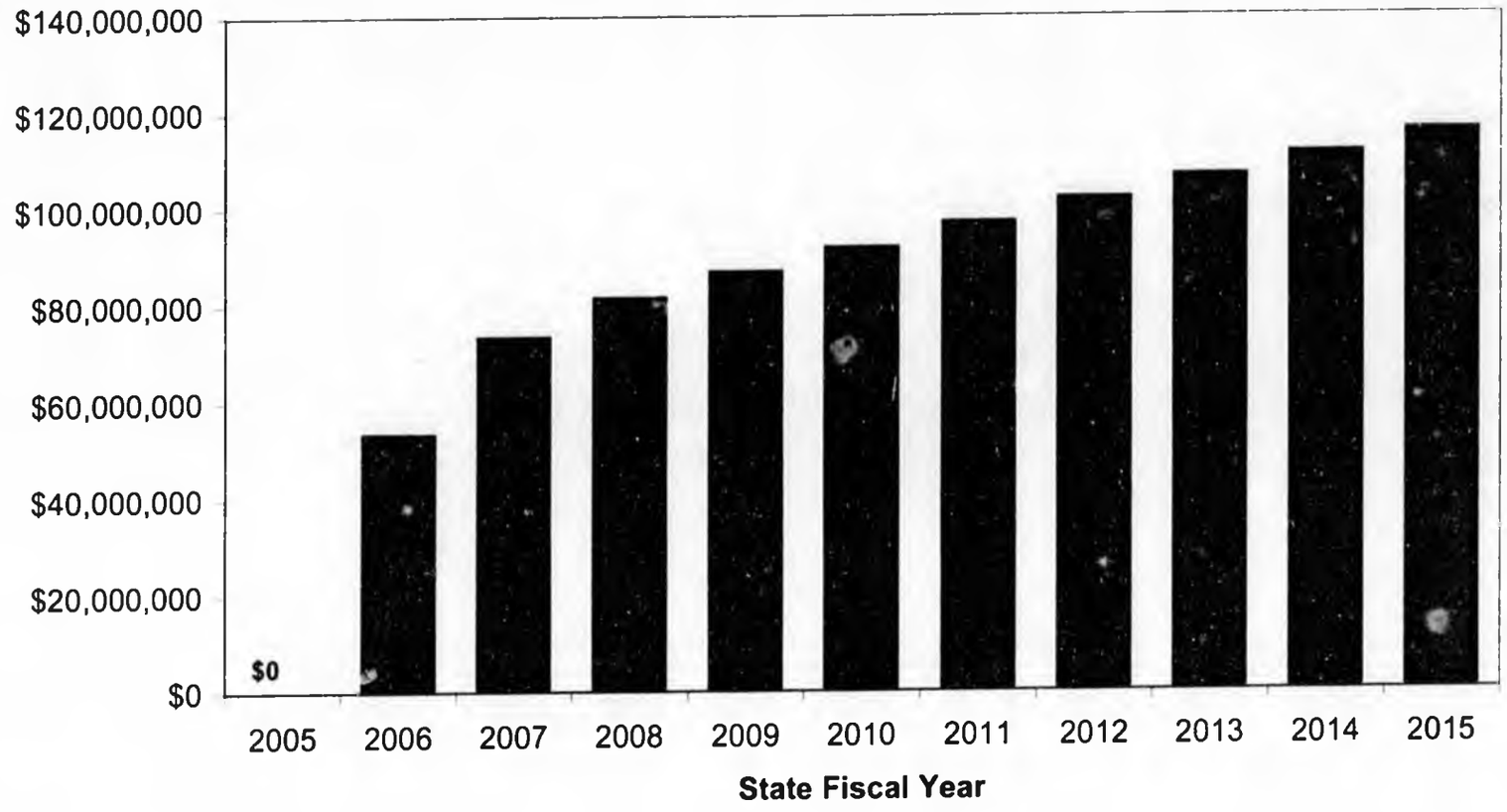
SFY2005 is from the Operating Budget; SFY2006 is from the Governor's Budget; SFY2007 to SFY2015 are actual quarterly claim payments projected using a linear

Source: DHSS, FMS, Medicaid Budget Group

Impact of FMAP Reductions on General Funds

Projected *Additional* General Funds Needed for Medicaid

SFY2005 to SFY2015



SFY2005 is from the Operating Budget; SFY2006 is from the Governor's Budget; SFY2007 to SFY2015 are actual quarterly claim payments projected using a linear trend.

Source: DHSS, FMS, Medicaid Budget Group

HJR

20

IOUSE COMMITTEE REPO

(7)
Date Referred to Committee: April 21, 2005 **FURTHER REFERRALS:**

Date of Committee Action: April 26, 2005

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HJR 20**

HOUSE JOINT RESOLUTION NO. 20 **PROSTATE CANCER DRUGS**

Urging the United States Congress and the United States Food and Drug Administration to assist in the prompt approval of new drug applications for the treatment of prostate cancer.

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____(_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] 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**
LCIS				✓

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

Signing with recommendations	**Printed Last Name**	**DP**	**DNP**	**NR**	**AM**
	Cissna	✓			
Berta Gardner	Gardner	X			
Tom Anderson	Anderson	X			
	McGuire				
Chair: Peggy Wilson	Wilson	X			
Chair:					

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HJR 20
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Legislature
Title "Urging the United States Congress and the United States Food and Drug Administration to assist..."
BRU Component: Legislative Council
Sponsor Representatives Gatto, Gruenberg
Requestor House HESS
Component: Council and Subcommittees
Session
Component No. 783

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES ( )	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
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 (FY2004) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation has zero fiscal impact on the Legislative Affairs Agency.

Prepared by: Karla Schofield, Deputy Director
Phone 465-6626
Division Administrative Services
Date/Time 4/25/05 1:32 PM

Approved by: Pamela Varni, Executive Director
Date 4/25/2005
Agency Legislative Affairs Agency

(Revised 9/2001 OMB)

Alaska State Legislature

SESSION ADDRESS:
Alaska State Capitol
Juneau, Alaska 99801
Phone: (907) 465-3743
1-800-565-3743
Fax: (907) 465-2381

INTERIM ADDRESS:
600 E Railroad Avenue
Wasilla, AK 99654
Phone : 907-376-2679
Fax: (907) 373-4745

Representative Carl Gatto

Date: 4/22/05

To: Representative Peggy Wilson
House Health, Education and Social Services Chair

From: Representative Carl Gatto

Re: Request for Scheduling – HJR 20

I respectfully request that the House Health, Education and Social Services Committee schedule a hearing for HJR 20 at your earliest convenience.

This bill urges the prompt approval of new, targeted drugs for the treatment of prostate cancer. None are currently approved.

Copies of the bill, sponsor statement, and backup materials are attached for your information.

Please feel free to contact Cody Rice at x3768.

Thank you for your consideration.

Representative_Carl_Gatto@legis.state.ak.us

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Alaska State Legislature

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Alaska State Capitol
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From: Representative Carl Gatto

Re: Request for Scheduling – HJR 20

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Representative Carl Gatto

SPONSOR STATEMENT

HOUSE JOINT RESOLUTION 20

"URGING THE UNITED STATES CONGRESS AND THE UNITED STATES FOOD AND DRUG ADMINISTRATION TO ASSIST IN THE PROMPT APPROVAL OF NEW DRUG TREATMENTS FOR THE TREATMENT OF PROSTATE CANCER"

HJR 20 recognizes the great cost to the United States, and Alaska, that prostate cancer creates in terms of lives lost, decreased productivity, and insurance claims. This bill would urge Congress and the FDA to pursue prompt approval of new, targeted drug treatments for prostate cancer. No targeted drugs are currently approved for the treatment of prostate cancer. Prostate is the second leading cause of cancer related death in men. It is time we looked seriously at targeted drugs specifically for prostate cancer.

Five Alaskans a day are expected to die from prostate cancer this year. We simply must find a way to lower this number through awareness, prevention, and effective treatment. This resolution serves each purpose by keeping the issue of prostate cancer in the forefront of Alaskans minds while seeking approval of drugs that may prove life saving for some and at least palliative for other, more dire, cases.

I urge your prompt and favorable action on this measure.

Representative_Carl_Gatto@legis.state.ak.us

HJR

30

Sponsor Statement
HJR 30

The growing cost of health care to every person, business and government in Alaska and the growing number of *under* or *un*insured citizens requires immediate relief. That relief will not come from the current proposed budget. The two billion dollars requested for FY07 HSS budget will be spent predominately on chronic health problems.

A large percentage of chronic health conditions come from poor habits, often chosen at a young age. Preventative health services, a way to stop the progressive damage from those habits, are not available for many. Bad health habits such as lack of exercise, overeating, drug/alcohol abuse, and smoking actually cost us all.

This complicated problem could be dealt with simply. A huge percentage of our costs (both financially and socially) are created by poor behavioral choices. Building healthy habits is not always easy, but often works best when we have the support of others.

This resolution, known as 'the Prevention Compact', is an invitation to Alaskan governments, organizations, and every man, woman and child in the state. All are invited to join in a statewide discussion, person-to-person and group-to-group, to share lessons and wisdom learned in preventing the increase of health risks. The idea is to get individuals and groups to develop their own strategies for promoting healthy habits and to share that knowledge in helping others develop theirs.

Good habits require nurturing and persistence. They can't be adopted and achieved overnight. The Prevention Compact dedicates the rest of the year 2006 for Alaskans to join the Compact. It sets 2007 as the year when hundreds or thousands of habits for health take hold.

This bill has no fiscal note because it relies totally on each member to make their own choice(s), and to share their own knowledge.

24-LS1557\F
Mischel
4/4/06

CS FOR HOUSE JOINT RESOLUTION NO. 30( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES CISSNA, Gruenberg, Kerttula, Moses

A RESOLUTION

Relating to public health and a prevention compact.

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

WHEREAS this state continues to lead the nation in negative health indicators, including tobacco use and alcohol abuse; and

WHEREAS state residents continue to rank poorly in rates of obesity and lack of physical activity compared to other states, and these negative indicators can lead to long-term illnesses, such as heart disease, diabetes, and other diseases that require costly and ongoing health care; and

WHEREAS the state ranks second in the nation in per capita public health costs; the state spent over $1,000,000,000 on health-related costs in 2005, and, despite these substantial expenditures on health care, the state still has a low ranking in the overall health of its population; and

WHEREAS, under the current system, the state's health care costs continue to rise, often resulting in lower expenditures for standard preventative health measures; and

WHEREAS the state must develop a health care strategy that provides opportunities to advance the quality and accessibility of health care so that the overall health of state

residents will be improved; and

WHEREAS the state has a high rate of uninsured residents who often cannot afford preventative health care programs or medical assistance when sick, and these behavioral patterns can result in a higher incidence of long-term illness that often leads to catastrophic levels of debt; and

WHEREAS the high number of uninsured residents in the state translates into poor physical and financial health; and

WHEREAS medical training in the state for health care providers is not sufficiently funded to produce qualified health care workers to occupy the many unfilled health care professional positions statewide; as a result, medical practitioners and health care workers are recruited from outside of the state to fill these positions, thus depriving the state's present and future health care workers of good careers and well-paying jobs; and

WHEREAS there is an increasing need for translators who can communicate with patients for whom English is a second language, and the lack of qualified translators creates barriers to receiving adequate medical treatment;

BE IT RESOLVED that the Alaska State Legislature invites state departments, all local governments, private and nonprofit businesses, and individuals to join in forming the Alaska 2007 Prevention Compact; and be it

FURTHER RESOLVED that each compact member may voluntarily craft and promote the member's own health preventative or curative initiative in the arena of the member's unique experience or interest, that the compact member's plans and efforts will be reported as voluntary presentations by private and public media and Internet websites, and that the method and content of the initiatives, as well as the method of promotion, will be at the discretion of each individual member.

COPIES of this resolution shall be sent to the Honcrable William Noll, Commissioner, Department of Commerce, Community, and Economic Development; the Honorable Marc Antrim, Commissioner, Department of Corrections; the Honorable Roger Sampson, Commissioner, Department of Education and Early Development; the Honorable Karleen Jackson, Commissioner, Department of Health and Social Services; the Honorable William Tandeske, Commissioner, Department of Public Safety; the Honorable Mark R. Hamilton, President, University of Alaska; Richard I. Mauer, Chair, State Board of Education

and Early Development; Elaine P. Maimon, Chancellor, University of Alaska Anchorage; Steve Jones, Chancellor, University of Alaska Fairbanks; John R. Pugh, Chancellor, University of Alaska Southeast; Douglas North, President, Alaska Pacific University; Stephanie Wheeler, Executive Director, Alaska Office of Faith-based Initiatives; Brenda Moore, Alaska Office of Faith-based Initiatives; the Honorable Stanley Mack, Mayor of the Aleutians East Borough; the Honorable Mark Begich, Mayor of the Municipality of Anchorage; the Honorable Michael Swain, Sr., Mayor of the Bristol Bay Borough; the Honorable David Talerico, Mayor of the Denali Borough; the Honorable Jim Whitaker, Mayor of the Fairbanks North Star Borough; the Honorable Fred Shields, Mayor of the Haines Borough; the Honorable Bruce Botelho, Mayor of the City and Borough of Juneau; the Honorable John Williams, Mayor of the Kenai Peninsula Borough; the Honorable Joe Williams, Mayor of the Ketchikan Gateway Borough; the Honorable Jerome Selby, Mayor of the Kodiak Island Borough; the Honorable Glen Alsworth, Sr., Mayor of the Lake and Peninsula Borough; the Honorable Timothy Anderson, Mayor of the Matanuska-Susitna Borough; the Honorable Edward Itta Sr., Mayor of the North Slope Borough; the Honorable Roswell Schaeffer, Sr., Mayor of the Northwest Arctic Borough; the Honorable Marko Dapcevich, Mayor of the City and Borough of Sitka; the Honorable Dave Stone, Mayor of the City and Borough of Yakutat; Paul Sherry, Chief Executive Officer, Alaska Native Tribal Health Consortium; Carolyn Crowder, Health Director, Aleutian/Pribilof Islands Association; Eben Hopson, Jr., Executive Director, Arctic Slope Native Association; Robert J. Clark, President and Chief Executive Officer, Bristol Bay Area Health Corporation; Patrick M. Anderson, Executive Director, Chugachmiut; Julie Bator, Health Director, Copper River Native Association; Lona Marioneax-Ibanitoru, Council of Athabascan Tribal Governments; Chris Devlin, Executive Director, Eastern Aleutian Tribes, Inc.; Karen Bachman-Carter, Health Administrator, Ketchikan Indian Community; Wendy Tisland, Health Director, Kodiak Area Native Association; Helen Bolen, President, Maniilaq Association; Rachel Askren, Metlakatla Indian Country; Wilson Justin, Executive Vice-President and Health Director, Mt. Sanford Tribal Consortium; Violet Rice, Health Director, Native Village of Eklutna; Casandra Trenton, Health Director, Native Village of Tyonek; Sarah Stokes, Health Director, Ninilchik Village Traditional Council; Joe Cladouhos, President and Chief Executive Officer, Norton Sound Health Corporation; Crystal Collier, Executive Director,

Seldovia Village Tribe; Ileen Sylvester, Vice-President, Executive and Tribal Services, Southcentral Foundation; Ken Brewer, Health Director, Southeast Alaska Regional Health Consortium; Josephine A. Huntington, Health Director, Tanana Chiefs Conference; Gene Peltola, President and Chief Executive Officer, Yukon-Kuskokwim Health Corporation; Benna Hughey, IHS Health Program Director, Valdez Native Tribe; David Talerico, President, Alaska Municipal League; Tim Bourcy, First Vice-President, Alaska Municipal League; Tim Beck, Second Vice-President, Alaska Municipal League; Joan Fisher, President, Alaska Primary Care Association, Inc.; Marilyn Kasmar, Executive Director, Alaska Primary Care Association, Inc.; Rod Betit, President, Alaska State Hospital and Nursing Home Association; Linda Fink, Vice-President, Alaska State Hospital and Nursing Home Association; Brian Saylor, President, Alaska Public Health Association; Don Smith, President, Alaska Academy of Physician Assistants; Ashley Marquardt, President-Elect, Alaska Academy of Physician Assistants; Cathy Giessel, Alaska Nurse Practitioner Association; Michael Ford, Legislative Liaison, Alaska Native Health Board; and the Honorable Ted Stevens and the Honorable Lisa Murkowski, U.S. Senators, and the Honorable Don Young, U.S. Representative, members of the Alaska delegation in Congress.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HJR 30
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: ALL
Title: Relating to public health and a prevention compact.
RDU: All RDUs
Component: All Components
Sponsor: Cissna, Gruenberg, Kerttula, Moses
Requester: Health, Education & Social Services
Component No.

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)*

Since participation is voluntary, any additional cost of participation in the Compact would be covered by the department's existing budget. As such, this legislation would not have a significant impact on any state agency.

Prepared by: John Boucher
Phone 465-4677
Division: Governor's Office of Management and Budget
Date/Time 3/29/2006 4:00pm
Approved by: Cheryl Frasca, Director
Date 3/30/2006
Agency: Governor's Office of Managment and Budget

SNAPSHOT

Alaska

Overall Rank: 30

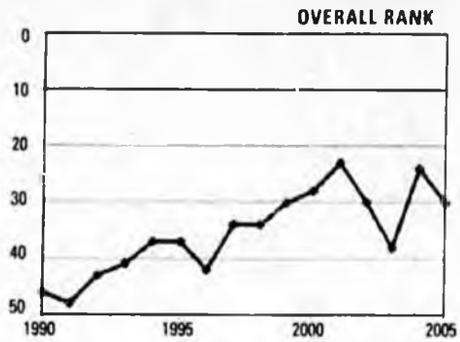
Change: 0

Strengths:
- High per capita public health spending
- Low percentage of children in poverty
- Low rate of cardiovascular deaths

Challenges:
- Limited access to adequate prenatal care
- Low immunization coverage
- High prevalence of smoking

Significant Changes:
- In the past year, the rate of uninsured population declined by 10%
- In the past year, immunization coverage decreased by 6%
- Since 1990, the incidence of infectious disease decreased by 83%
- Since 1990, the infant mortality rate declined by 39%

RANKING: Alaska is 30th this year; it was 24th in 2004.



STRENGTHS: Strengths include high per capita public health spending at $482 per person, a low percentage of children in poverty at 12.0 percent of persons under age 18, a low total mortality rate at 795.4 deaths per 100,000 population and a low rate of cardiovascular deaths at 275.1 deaths per 100,000 population.

CHALLENGES: Challenges include limited access to adequate prenatal care with 66.5 percent of pregnant women receiving adequate prenatal care, low immunization coverage with 75.3 percent of children ages 19 to 35 months receiving complete immunizations, a low high school graduation rate with 60.7 percent of incoming ninth graders who graduate within four years and a high prevalence of smoking at 24.8 percent of the population.

SIGNIFICANT CHANGES:
- In the past year, the rate of uninsured population decreased from 18.9 percent to 17.0 percent.
- In the past year, immunization coverage declined from 79.7 percent to 75.3 percent of children ages 19 to 35 months receiving complete immunizations.
- Since 1990, the incidence of infectious disease decreased from 92.2 to 15.9 cases per 100,000 population.
- Since 1990, the infant mortality rate declined from 10.6 to 6.5 deaths per 1,000 live births.

HEALTH DISPARITIES: In Alaska, the infant mortality rate varies from a low of 5.1 deaths per 1,000 live births for non-Hispanic whites to a high of 11.2 deaths for American Indians/Alaskan Natives. Cholesterol screening within the past five years is more extensive for non-Hispanic blacks, at 87.1 percent of the population age 18 and older, and less extensive for American Indians/Alaskan Natives, at 57.6 percent.

TEEN PREGNANCY: Births per 1,000 teenage females decreased 40.2 percent from 66.0 births in 1991 to 39.5 births in 2002. If this decline hadn't occurred, there would be an additional 9.4 percent of children under age 6 in poverty in 2002.

STATE HEALTH DEPARTMENT WEB SITE: health.hss.state.ak.us/

	2005		2004		1990	
	DATA	RANK	DATA	RANK	DATA	RANK
RISK FACTORS—PERSONAL BEHAVIORS						
Prevalence of Smoking (Percent of population)	24.8	42	26.2	46	34.3	47
Motor Vehicle Deaths (Deaths per 100,000,000 miles driven)	2.0	39	1.9	38	2.3	21
Prevalence of Obesity (Percent of population)	23.6	30	23.5	29	13.4	42
High School Graduation (Percent of incoming ninth graders)	60.7	42	60.7	42	73.6	33
RISK FACTORS—COMMUNITY ENVIRONMENT						
Violent Crime (Offenses per 100,000 population)	635⇑	44	563	39	455	29
Lack of Health Insurance (Percent without health insurance)	17.0⇓	38	18.9	44	17.6	40
Infectious Disease (Cases per 100,000 population)	15.9	24	15.3	20	92.2	47
Children in Poverty (Percent of persons under age 18)	12.0	11	11.2	8	16.6	18
Occupational Fatalities (Deaths per 100,000 workers)	10.1⇓	47	15.3	46	22.3*	48
RISK FACTORS—HEALTH POLICIES						
Per Capita Public Health Spending ($ per person)	$482⇑	2	$443	2	—	—
Adequacy of Prenatal Care (Percent of pregnant women)	66.5	47	64.7	46	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	75.3⇓	45	79.7	27	—	—
OUTCOMES						
Limited Activity Days (Days in previous 30 days)	2.0	16	1.7	7	1.8*	1
Cardiovascular Deaths (Deaths per 100,000 population)	275.1	5	289.4	7	345.6	5
Cancer Deaths (Deaths per 100,000 population)	198.0	16	191.8	7	203.6	31
Total Mortality (Deaths per 100,000 population)	795.4	8	799.4	9	876.4	23
Infant Mortality (Deaths per 1,000 live births)	6.5⇑	25	5.9	12	10.6	33
Premature Death (Years lost per 100,000 population)	8,119	35	8,147	36	9,304	41
OVERALL RANK		30		24		46

⇓ and ⇑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable.

The impact of lifestyle and prevention

First and foremost, this is an issue of individual responsibility. This means that each of us is ultimately responsible for our own health, how we eat, exercise and live. Nevertheless, many collective societal educational and social efforts can help further acceptance of this individual responsibility through application of sound health maintenance principles.

Our society is not used to facing the facts of collective issues. They are not part of the national or state non-Native psyche. Currently, the health care industry plugs holes in the dike that are the result of unhealthy lifestyles. We need to go way upstream and focus on prevention.

Fortunately, we can learn from the positive example of reduction of smoking in America. Much remains to be done. Today's limited but meaningful success is the result of a long-term effort that lasted over a generation. Extensive public education, warning labels, laws banning smoking in public places and a consistent message from the health care community ultimately resulted in societal changes that now appear to have gained a self-reinforcing life of their own.

1. **Plan a "walkable community."**
    a. Land use designed to facilitate walking and biking can encourage cardiovascular health. Maintaining safe municipal trail systems, seasonal bike paths, and cleared wintertime walkways permit citizens to practice healthful life habits year around.
    b. Enlightened city planning and architecture can promote a more active lifestyle.
    c. As public demand for exercise opportunities grow, their inclusion in real estate development and city planning can improve property values.

2. **The role of public health as community educator and provider.** Municipal health departments need to serve many more people than those who seek care at the clinic. Promoting wellness and healthful living habits to the entire community is an essential part of the public health mission. This portion of the mission needs to be funded adequately in the budget.

3. **The importance of physical education in the schools— (not a "frill")** It is important to teach children about the relationship between health, diet and exercise. Not every child will want to join a sports team, but learning to be responsible for their own health by incorporating physical activity into their daily lives is an important health lesson that cannot be ignored.

4. **Eliminate internal inconsistencies and conflicts between programs and objectives.** For example, eliminate financial incentives in schools to promote unhealthy foods. Provide a financial alternative to schools that have come to rely upon income from selling junk foods in the schools.

5. **Incentivize healthy behaviors through workplace activities.** Convince the Top 49 Alaska businesses to educate their employees on healthy lifestyles and offer healthful workplace activities. The Top 49 businesses would represent a large percentage of the Alaska population not already covered by Federal or Alaska Native health care systems. Encourage a **Top 49 Health Summit** to facilitate understanding and participation of these large Alaska businesses.

6. Develop intervention programs for **promoting the traditional rural diet.**

7. **Reconsider rural access to dentistry as part of the study.** Many rural communities lack a sufficient population to support construction of a simple dental facility to house a full time dental practice. The investment required to maintain a facility for use by an itinerant dentist would likely need to be made by the community, possibly partnering with the state. Lack of roads prevents the use of mobile dental clinics that are used in other remote locations worldwide.

8. **Reduce the critical shortage of facilities for alcohol and drug detox, and psychiatric facilities. The lack of services these facilities provide can increase costs in the long run.** Persons affected by alcohol and drug use, and the accidents they cause, account for a significant portion of the population needing care in hospital emergency rooms and psychiatric facilities. Yet Alaska has too few beds to treat those in need of drug and alcohol recovery. As a result we are forced to tolerate that burden of higher healthcare costs. Detox beds make good economic and health policy sense.

9. Find ways to incorporate **U.S Task Force on Preventive Health** recommendations into medical practices, schools, work environments and homes.

10. **Continue the Institute of Circumpolar Health Studies** to analyze common problems and look for solutions that will work for all circumpolar peoples. Similar environments and cultures may result in shared knowledge that can benefit those in northern latitudes. Many health issues in Alaska relate to weather, the environment, subsistence food quantity and quality, potable water and sanitation issues. These are issues shared by other circumpolar peoples. Alliances with other circumpolar countries, and organizations like the Institute for Circumpolar Health Studies may provide new insights in resolving some of these issues.

PF Dividends (line 25). This is spending to pay dividends to the residents of Alaska from a share of the Permanent Fund investment earnings. The dividend amount is based on the previous five-year average of PF statutory net income.

PF Inflation Proofing and Transfers (line 26). This spending is for the annual transfer from earnings to the Permanent Fund principal sufficient to offset the impact of inflation during the previous calendar year.

Table 1

Formula Programs
FY 05 Authorized vs. FY 06 Proposed
All Fund Sources

Agency	Program		FY 05 Authorized	FY 06 Proposed
DOA	Elected Public Officers Retirement System Benefits		1,493.9	1,493.9
	Unlicensed Vessel Participant Annuity Retirement Plan		75.0	75.0
		Subtotal	1,568.9	1,568.9
Education	Foundation Program*		776,852.3	624,313.6
	Pupil Transportation		53,557.2	54,093.2
	Boarding Home Grants		185.9	185.9
	Youth in Detention		1,100.0	1,100.0
	Special Schools*		6,945.3	7,894.7
		Subtotal	838,640.7	687,587.4
*Note: In FY 06, $62,058.4 Foundation funding and $425.1 Special Schools proposed in legislation separate from operating budget bill.				
DHSS	Alaska Temporary Assistance Program		44,771.8	41,071.8
	General Relief Assistance		1,499.0	1,355.4
	Adult Public Assistance		57,161.4	58,087.0
	Senior Care		14,711.1	7,719.4
	Permanent Fund Dividend Hold Harmless		15,949.9	12,884.7
	Child Care Benefits		46,003.1	47,288.1
	Tribal Assistance Programs		8,381.4	8,381.4
	Behavioral Health Medicaid Services		118,328.6	144,072.5
	Medicaid Services		649,258.2	671,732.1
	Medicaid School Based Admin Claims		6,239.3	6,239.3
	Catastrophic and Chronic Illness Assistance (AS 47.08)		1,471.0	1,471.0
	Subsidized Adoptions & Guardianship		19,732.9	21,711.6
	Foster Care Base Rate		10,322.5	10,245.9
	Foster Care Augmented Rate		2,126.1	2,126.1
	Foster Care Special Need		3,822.0	3,462.0
	Children's Medicaid Services		10,851.7	10,851.7
	Senior and Disabilities Medicaid Services		191,291.2	248,624.3
		Subtotal	1,281,921.2	1,297,324.3
DCED	National Program Receipts		15,830.0	15,830.0
	Fisheries Business Tax		1,600.0	1,600.0
	Alaska Energy Authority Power Cost Equalization		15,700.0	20,730.0
		Subtotal	33,130.0	38,160.0
DMVA	Retirement Benefits		1,996.8	2,053.8
		Total	2,077,257.6	2,226,694.4
		General Funds**	1,150,927.0	1,260,979.3
		Federal Funds	778,266.2	821,743.5
		Other Funds	148,064.3	143,971.6
**Notes: FY 06 includes $62,483.5 in legislation separate from the operating budget bill.				

FY2006 Budget Changes

FY06 Budget

The Department of Health and Social Services (DHSS) faced tremendous challenges in the last few years to provide a balance between reducing the reliance on state general funds and providing services to vulnerable populations.

In FY04 DHSS reduced general fund expenditures by $120 million in decrements and again in FY05 general fund reductions totaled $46.7 million. In over two fiscal years the department saved over $166 million. The reductions in the previous years were based on finding efficiencies, cost containment and refinancing so that services to clients would not have to be eliminated. Continuing to reduce general fund expenditures at the pace set in FY04 and FY05 would result in elimination of programs and cuts to services for vulnerable populations because efficiencies gained by the reorganization have been realized and there is little additional general fund savings that can now be taken in FY06.

In the FY06 budget the current Administration is not willing to sacrifice services to the poorest and weakest clients by eliminating programs. Our goal is to provide increases and enhance services that meet the outcomes established by the department. In addition, our emphasis in FY06 is to focus on continuing to fund treatment or prevention and early intervention as strategies rather than just high-end expenditures.

Proposed budget for 2006 compared to 2005

	2005	2006 Proposed
DHSS budget		
General Fund	**$ 530.6 million**	**$ 616.3 million**
Federal Funds	**935.2 million**	**989.8 million**
Other Funds	**212.5 million**	**206.1 million**
Total	**$ 1.678 billion**	**$ 1.813 billion**
Increased Federal revenue		**54.5 million**
Increased General Fund		**86.3 million**

Budget Strategies

Increases to maintain services: The Department recommends an increase of over $72 million in general funds to maintain the current level of service in a number of programs. Included in this are: 1) Increased fuel costs to 24 hour facilities, which will cost the department $121.5; 2) $2.7 million to maintain services for Fetal Alcohol Syndrome Diagnostic teams, Human Service Community Matching Grant program, the Alaska Poison Control service, the current Breast and Cervical Cancer screening program (an expansion is

adn.com
Anchorage Daily News

Alaska slips to 30th in ranking of nation's healthiest states

The Associated Press

(Published: December 12, 2005)

ANCHORAGE, Alaska (AP) - Limited access to prenatal care, low immunization rates and a high prevalence of smoking caused Alaska to drop six spots in a ranking of the nation's healthiest states released Monday.

Alaska was ranked 30th in the 2005 America's Health Rankings, issued annually by United Health Foundation with the American Public Health Association and Partnership for Prevention.

"I think the data is accurately represented," said Dick Mandsager, director of the state Division of Public Health. "The issues they highlignt are issues that we've been trying to raise attention to, too."

The report ranks states based on smoking rates, motor vehicle deaths, obesity rates, violent crime, health insurance coverage, poverty rates, public health spending and similar categories.

Minnesota was ranked as the healthiest state, followed by Vermont, New Hampshire, Utah and Hawaii.

Mississippi was named the least healthy state, with Louisiana, Tennessee, South Carolina and Arkansas rounding out the bottom five.

The survey dropped Alaska from 24th place last year because of a number of challenges.

A third of pregnant Alaska women have limited access to adequate prenatal care, the survey says.

It also cited Alaska's low immunization coverage, with 75.3 percent of children ages 19 months to 35 months receiving complete immunizations.

Other negatives cited by the study were Alaska's low high school graduation rate, with 60.7 percent of incoming ninth graders who graduate within four years, and Alaska's high smoking rate. The survey says one out of every four Alaskans light up.

The survey also noted health disparities in the state. For instance, the infant mortality rate varies from a low of 5.1 dates per 1,000 live births for non-Hispanic whites, to a high of 11.2 deaths for Alaska Natives/American Indians.

Mandsager said this is a "helpful reflector of where we are," and that "we need to pay attention to the health of the whole population of the state, whether you have insurance or not."

The survey also noted strengths for the state, including the high per capita public health spending at $482 per person. That ranked Alaska second in the nation behind Hawaii; the U.S. average was $162.

Other positives in the report included a low percentage of children in poverty, 12 percent.

The report noted that births per 1,000 teenage females decreased 20.2 percent, from 66 births in 1991 to 39.5 births in 2002. It notes that if this declined had not occurred, there would be an additional 9.4 percent of children under age 6 in poverty in 2002.

Other strengths noted in the report was a low total mortality rate of 795.4 per 100,00 population, and a low rate of cardiovascular deaths at 275.1 deaths per 100,000 population.

Print Page Close Window

HJR

31

IOUSE COMMITTEE REPO`

(7)
Date Referred to Committee: February 8, 2006 **FURTHER REFERRALS:**

Date of Committee Action: 2/22/06

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HJR 31**

HOUSE JOINT RESOLUTION NO. 31 **FETAL ALCOHOL SPECTRUM DISORDERS DAY**

Relating to designating September 9, 2006, as Fetal Alcohol Spectrum Disorders Awareness Day.

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

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	CISSNA	✓			
Berta Gardner	Gardner	X			
Vic Kohring	Kohring	X			
Chair: Peggy Wilson	Wilson	✓			
Chair:					

ALASKA STATE LEGISLATURE

REPRESENTATIVE BRUCE WEYHRAUCH

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
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Sponsor Statement for House Joint Resolution 31

House Joint Resolution 31 designates September 9, 2006 Fetal Alcohol Spectrum Disorders Awareness Day. Fetal Alcohol Spectrum Disorders are the single largest cause of mental retardation in Alaska and are one hundred percent preventable.

International FAS Awareness Day was first observed on September 9, 1999. It began when a small group of adoptive and foster parents of children afflicted with FAS and Fetal Alcohol Effect (FAE) came together on the Internet to ask this compelling question, "What if a world full of FAS and FAE parents all got together on the ninth hour of the ninth day of the ninth month of the ninth year and asked the world to remember that during the nine months of pregnancy a woman should not consume alcohol?"

The designation of FASD Awareness Day is intended to focus attention on the high cost of Fetal Alcohol Spectrum Disorders to our state and the ease of prevention. Currently, more American babies are born with FAS than with Down Syndrome, Muscular Dystrophy, and HIV combined. The simple fact is no alcohol consumed during pregnancy has been established safe for the fetus. If women do not drink any alcohol during their nine months of pregnancy, alcohol-related birth defects would be eliminated.

We ask Alaskans to come together at 9:09 am on September 9, 2006 for a "pregnant pause" to reflect on preventing FASD's and also to remember throughout the year to continue to reach for the goal of eradicating Fetal Alcohol Spectrum Disorders.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HJR 31
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected:
Title: Fetal Alcohol Spectrum Disorders Day
RDU
Component
Sponsor: Representative Bruce Weyrauch
Requester: House Health Education & Social Services
Component No.

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	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

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

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

POSITIONS

Full-time	0	0	0	0	0	0
Part-time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

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

Prepared by: Linda Miller
Phone 465-3759
Division: House HESS Committee Aide
Date/Time 3/1/06 10:00 AM
Approved by: Representative Peggy Wilson
Date 3/1/2006
Agency: Chair, House HESS Committee

(Revised 9/7/2005 OMB)

FAS Awareness Day 2005

September 9th, 2005

in Anchorage / in Kenai / in Juneau / in Fairbanks / FAS Websites

International Fetal Alcohol Syndrome Awareness Day is September 9th!

This year in Juneau there will be increased FAS/FASD awareness during the first week of September as the Fetal Alcohol Spectrum Disorder Community Advisory Group's Outreach and Training Committee works on spreading the word on FASD prevention and awareness, including radio interviews, public service announcements, outreach and education, poster contests and much more.

On the morning of Friday, September 9th I invite you to join community members on the Capitol steps at 8:45am, where proclamations from the mayor and governor will be read, and a concordance of local bells will ring at 9:09am, followed by a minute of reflection. A walk of support will then occur from the Capitol to Marine Park and back.

We hope to see you there.

FASD Websites

For more information on FAS(FASD) and hints on how you or your agency can participate in FASD awareness on FAS Day and every day, here are a few websites of interest:

- http://www.fasworld.c /home.html
- http://www.fasworld.com/symbol.html
- http://www.fasstar.com/
- http://www.faslink.org/
- http://www.come ver.to/FASCRC/

FASDAY in Anchorage:

The Anchorage Council on FASD is coordinating a variety of events on and during the week leading up to International FAS Awareness Day. ON 9/6 and 9/8 Peer Outreach Youth involved in the Alaska Youth and Parent Foundation will be distributing FAS knots and wristbands and FASD prevention information in local malls and transit centers. Several businesses in Anchorage are showcasing FASD prevention messages on their electronic reader boards during the month of September.

ON 9/9, local and state officials will share their comments with members of the community at the Town Square, local churches will join with the town Square participants in ringing bells at 9:09, dance groups will perform, a young mother with FASD will tell her story and a poem about the tragedy of FASD will be read. Local programs working in the field will share information about their various programs. Refreshments donated by local businesses will be served during this event. Many coffee kiosks and cafes will attach FASD prevention message stickers to their cups

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and at least one restaurant will be providing free non-alcoholic beverages to pregnant women that day. These businesses will also use the napkins and or placemats with prevention messages provided by the state office of FAS.

FAS Day in Kenai:

The Kenai Peninsula will hold a ceremony the morning of September 9th on the bluff overlooking the mouth of the Kenai River. We will begin with the Heartbeat of Mother Earth drummers, followed by a moment of silence and the ringing of the bell. There will be special music, a mayoral proclamation, and a few words of wisdom from experts in the field of FASD (a physician and a parent.)

FAS Day in Juneau

View the flyer.

FAS Day in Fairbanks

ACCA in conjunction with RCPC and our FAS Advisory Board planned and is having a BBG at Frontier Park for parents and children who have either rec'd our services or want to know more about us. We will have games for children and a table 'womaned' by Maureen Harwood with info for adults. BBQ will start at 5:30. In addition the Fairbanks North Star Borough Assembly passed a resolution during their Aug 18th meeting declaring Sept 9 local FAS Awareness Day. They distributed copies of the resolution to our local legislators and to the Governor Frank Murkowski.

International Fe
Syndrome (FAS) A

When: Friday, September 9th at 8:45 a.m.
Where: The Capitol steps
What: Show your support by walking from the Capitol steps to the Marine Park and back
Who: You, Governor Murkowski, Mayor Botelho, families, youth, students, and professionals

* Make the world aware that no amount of alcohol
* Make the world aware of the millions of people normally, because their brains - and often their bo before they were born.
* We want our governments to invest in informatio women with alcohol addiction problems, and their ties, special education, and other support for indiv

September 9th

FASWORLD

the international alliance promoting the awareness of Fetal Alcohol Syndrome and related disorders

presents

HOW TO DO FAS DAY

Online Manual for International FAS Awareness Day 2000

Prepared by Bonnie Buxton, Brian Philcox, and Teresa Kellerman
co-founders of FASWORLD, an international aliance formed
to raise global awareness about the dangers of drinking alcohol during pregnancy
and the special needs of individuals affected by prenatal exposure to alcohol.

Vivien Lourens of Cape Town, South Africa with daughter Tisha, FAS

Children of Kim Meawasige, FAS Day volunteer in Toronto

Children at Queen of Apostles School in Toledo, Ohio

"I have read that the oscillation of butterfly wings in Brazil may set off storms in Texas."
--Janette Turner Hospital, The Last Magician

1. What is FAS Day?

FAS Day is the short name for International Fetal Alcohol Syndrome Awareness Day, which was observed for the first time on September 9, 1999, with a "Minute of Reflection" at 9:09 a.m.

It came about because a number of people on the online support group "FASlink" were feeling frustrated about the lack of awareness by professionals and the general public about FAS.

We were trying to figure out how to make the world more aware that woman should not drink in pregnancy - and also inform the world that millions of people throughout the world are suffering from brain damage caused by alcohol before they were born.

Twenty volunteers from around the world began working together to build awareness, and by September 9 we had 80 volunteer coordinators. On September 9, 1999, events were held in communities across Canada and the U.S., and in South Africa, New Zealand, Germany, and Sweden. We also had individual volunteers in Australia and Italy. All of this was accomplished with volunteers and no financial resources.

Our international butterflies really did cause a storm. The event generated enormous local media and on September 10, 1999, we decided to do it again in 2000 - only bigger and better!

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2. What is the Bell Concordance?

(From the Oxford English Dictionary)*Concordance: 1. The fact of agreeing or being concordant; agreement, harmony...4. An agreeable or satisfactory blending of musical sounds or notes; harmony.)*

On Sept.9, 1999, bells around the world marked the "magic minute" at 9:09 a.m., and we named this ringing of bells, "The FAS Bell Concordance." It was so successful that other organizations have picked up this term and copied it!

Bells ranged from the historic 56-bell carillon in Cape Town, South Africa, to tiny bells rung by school children in Toledo, Ohio, and wind chimes and rain sticks in Sioux-Lookout, Ontario.

More bells and carillons will ring in 2000.

3. Why observe FAS Day?

FAS Day provides an opportunity to build awareness and understanding of FAS in your own community. Newspaper, radio and TV reporters who would otherwise be indifferent to the FAS story become interested when we provide a reason for them to inform the public.

In 1999, our volunteers found that the months leading up to FAS Day, and the weeks and months afterward also helped them to build important permanent contacts in their community -- with professionals, politicians, local government agencies, media -- and, most important, other families who had also been knowingly or unknowingly struggling with FAS. The effects of FAS Day lasted well past the day itself, and many of us will be building on last year's contacts as we plan this year's events.

Yeah, but....

It's difficult when you are the only person in your community who seems to know anything about FAS. If you're a parent, you're burned-out and reeling from crisis to crisis because of your child's problems. Yet, a number of people in this situation did manage to set off some ripples of awareness.

For example:

Carol Ann Allen in Cape May, New Jersey - adoptive mom of five children with FAS -- and Carlyn Graham hosted a successful open house in Carol's home. Carol Ann and Carlyn managed to get a state proclamation from the Governor of New Jersey along with a civic proclamation.

Another parent, Claudia Barker in Bastrop, Texas, wondered what on earth she could do for FAS Day. She got in touch with Double Arc in Austin, intrigued a number of energetic Texans, and on September 9, found herself speaking to a group of teachers at a FAS Day event in San Antonio -- held as a result of her involvement. One of Claudia's recruits, parent Marlo Kaskoto, took on the job of getting a Texas state proclamation, numerous civic proclamations, and the ringing of the carillon ringing at University of Texas at 9:09 on FAS Day. Having made many excellent personal contacts as a result of her work, Claudia wrote on September 10, "FAS Day did way more for me than I did for FAS Day."

Trudy House of Hastings, Nebraska, managed to get a state proclamation from Governor Mike Johanns, and found herself on the steps of the governor's mansion being interviewed by the media.

Frances Brown on the tiny island of Kitkatla, a isolated native community in northern British Columbia, planned a community breakfast on September 9, and as a result the island's children held a protest March on December 9, urging their parents not to drink over the Christmas holidays.

Shiona Watson in the small community of Acton, Ontario, captivated ninth-graders at a local high school and managed to place a story in the local newspaper.

4. Some Worldwide Events on FAS Day '99

Here are some more events as FAS Day moved around the world -- - feel free to

borrow ideas.

Aukland, NZ: Breakfast for FAS supporters, Minute of Reflection bells ringing in nearby Mt. Albert Methodist Church. Events also held in Wellington, Hamilton and Invercargill.

Cape Town, South Africa: program outside historic 37-bell War Memorial Carillon, which rang when Nelson Mandela was released from prison.

Kiel, Berlin, Flensburg and Hamburg, Germany: posters, buttons, info stand in town centre; information evening for Social Services, teachers, physicians; famous restaurant giving free nonalcoholic drinks to pregnant women all day long.

Iqualuit, Nunavut, Canada: events included church bells, art exhibit featuring soapstone carving donated by famous artist Ookpik Pitseolak, showing drinking mother with baby in Aamouti@ (parka hood.)

Toronto, ON, Canada: program inside Metropolitan United Church included international lullabies on church carillon, native drum singer/elder offering prayer in English and Ojibwa, keynote address by Dr. Carolyn Bennett, federal Member of Parliament.

Sioux Lookout, ON, Canada: program in local park featuring sharing circle, prayer by First Nations elder, Minute of Reflection with wind chimes and rain sticks.

Kenora, Keewatin, Jaffrey Melick, ON, Canada: poster distribution to doctors= offices, three-level curriculum offered to teachers.

Toledo, OH, U.S.A.: Day-long activities included hot-air balloon with words on it, AFAS: THE HIDDEN PLAGUE@ and matching yellow AHidden Plague@ T-shirts.

Minneapolis, MN, U.S.A.: 9:09 a.m. bells included two carillons, City Hall, three cathedrals, two other churches, followed by large rally and speeches outside State Courthouse.

San Antonio, TX, U.S.A.: Day-long information program for teachers and others concerned with FAS, included presentations from FAS Day volunteers, Claudia Barker, and Dr. Bob Clayton.

Austin, TX, U.S.A.: program built around the 56-bell Kniker Carillon at University of Texas.

Tucson, AZ, U.S.A.: 9:09 a.m. bells at St. Augustine Cathedral; outdoor program featuring two young people who struggle daily with FAS.

Lakeland, AB, Canada: five communities participated in day-long events, including poster blitz, mall display, bars offering Apregnant pause@ nonalcoholic drinks for pregnant women, church bells ringing, junior high school students making FAS Knots, proclamations in all five communities.

Red Deer, AB, Canada: all-day mall displays, use of FAS brochures as place-mats in local restaurants.

Brooks, AB, Canada: A 9-block walk to symbolize the 9 months of pregnancy, with Atrimester@ information provided every three blocks. At the end of the walk the handouts were assembled into a picture of a healthy bouncing baby.

HJR

33

Amendment #1 - passed 3/23/06

Amendment to HJR33 by Senator

Page 2 line 9
delete "and" after hospitals
insert "with"

Page 2 line 17
delete [redacted] "possibly"
insert "United States Department of Veteran Affairs doctors and hospitals are not easily accessible"

ALASKA STATE LEGISLATURE

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Legislative Council

Member:
Community and Regional Affairs
Judiciary
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REPRESENTATIVE PETE KOTT
DISTRICT 17 – EAGLE RIVER

Sponsor Statement
For
House Joint Resolution 33

Urging the Alaska Department of Health and Social Services to seek authority and funding from the United States Department of Veterans Affairs to establish a system of allowing Alaska veterans treatment in both public and private Alaska Facilities.

With approximately 72,000 veterans that call our great state home, I believe that Alaska's veterans deserve top quality health care in their own communities. Currently forced to seek medical treatment with U.S. Veteran's facilities, many of these heroes have to leave their communities and even go outside of Alaska. Many millions of dollars have been spent in airfare alone in order to get Alaskan's treatment when the treatment and facilities are available in state. This policy is costly and inefficient, and it disrupts Alaskans' lives.

House Joint Resolution 33 urges the United States Department of Veterans' Affairs to authorize funding and management to establish a system whereby Veterans can seek treatment from medical facilities other than that of the U.S. Military and Veteran's Affairs doctors and hospitals, many of which are available in the State of Alaska. This would give veterans a greater choice and flexibility for healthcare and increase the interaction between the Department and Military and Veterans Affairs doctors and the public and private medical facilities in the state thus, significantly reducing medical costs and increasing efficiency for veterans' medical care. This system would support the use of a veteran's medical identification card as an insurance card for medical billing to the U.S. Department of Military and Veteran's Affairs.

The passage of HJR 33 will give veterans a choice, and will allow them local access to quality healthcare.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1 ****CORRECTED****
Bill Version: HJR 33
(H) Publish Date: 3/3/2006

Revision Date/Time (Note if correction):
Dept. Affected:
Title: Supporting In-State Med.Care for Vets
RDU
Component
Sponsor: Representative Kott
Requester: House Mil & Vet Affairs Committee
Component No.

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)*

Prepared by: Nancy Manly, Committee Aide
Phone 907-465-2794
Division: House Special Committee on Military and Veterans' Affairs
Date/Time 3/23/06 11:36 AM
Approved by: Representative Lynn
Date 3/23/2006
Agency: Chairman

(Revised 9/23/2004 OMB)

COMMITTEE COPY

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HJR 33
(H) Publish Date: 3/3/2006

Revision Date/Time (Note if correction):
Dept. Affected:
Title: Supporting In-State Med.Care for Vets
RDU
Component
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Component No.

Expenditures/Revenues (Thousands of Dollars)

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OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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						
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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 (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

Prepared by: Nancy Manly, Committee Aide
Phone 907-465-2794
Division: House Special Committee on Military and Veterans' Affairs
Date/Time 3/3/06 10:22 AM
Approved by: Representative Lynn
Date 3/3/2006
Agency: Chairman

(Revised 9/23/2004 OMB)

ALASKA VETERANS FOUNDATION

VA/AK VETERANS HEALTH CARE CONCEPTS/working DRAFT (RD) 2 5 06

This is a working draft of ideas/concepts crafted by Ric Davidge and a small working group toward defining solutions to the ongoing structural (service and funding) issues within our federal veterans' health care system in Alaska. The ultimate re-crafted solution(s) may have application in other states with Alaska functioning as a demonstration project. NOTHING in this working paper is final nor does it represent the position of the Foundation or the other participants in this discussion. This paper is only necessary due to the complexity of these issues. We find it easier to outline things on paper so that there is clearer understanding by all parties as to

Structural Problems:

1. Veterans Heath Care funding is not annually assured based on either our nations moral obligation to the men/women who have been injured in service or retired after 20 plus years of honorable service. Funding levels are politically negotiated within the context of annual budgets and political agendas without regard to veteran health care need/demand or the quality of service. Recent General Accounting Office reports requested by the leadership of both the House and Senate veterans program oversight committee have highlighted the structural nature of these problems.
2. The old system of federal hospitals, for veterans or even when combined with active duty military medical facilities is no longer efficient or capable of meeting the location, medical, or mental health needs of our veterans and their families. This is especially true with regional federal medical service centers that require significant patient and employee travel and other support costs that could be far more efficiently turned directly into medical service through existing privately provided hospital and clinical services.

Moral Imperatives:

1. In the face of continued efforts by our federal government to reduce or otherwise restrict the levels and categories of medical care for our veterans at a time of growing demand by old and new veterans for services, why should not a state, especially the richest state per capita in America with the highest per capita number of veterans, step up to ensure that its veterans receive adequate and appropriate care in their community?
2. The quality and certainty of veteran care must not be a partisan issue. It is an American obligation to those few citizens willing to step forward and answer the call to stand guard for America. If our federal government is politically unwilling or financially unable to provide adequate care for its veterans, then we/Alaskan's must step up to this obligation for Alaska's veterans.

Veterans Care at existing private Alaskan hospitals and clinics

1. In years past veterans in Alaska were treated at private health care facilities with VA employees working within these facilities. Even today close to $40 million is spent annually by the VA through local hospitals and clinics.
2. This allows veterans, connected under the VA Health Care Program, to receive services for either service related injuries or other health needs at any hospital or clinic in Alaska.
3. The VA ID card should work just like an insurance card. The veteran shows the card when paying the bill (co-pay levels established). The medical service provider then bills the state program. The state pays the provider within 30 days of receiving the bill consistent with a negotiated reimbursement schedule for the procedure/service. The state then bills the VA for

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reimbursement consistent with a negotiated reimbursement schedule with the VA which is adjusted annually based on cost and service demand.

4. Alternatively, some argue that our veterans should be "covered" by an established healthcare insurance company at the level of care selected by the veteran and/or their family. Appropriate co-pay agreements could be structured based on the veteran's income level, however for any veteran with a service connected disability any related medical services for that disability must be fully covered. Veterans who have retired after 20 or more years of honorable service would receive full coverage possibly minus an appropriate co-pay based on income.
5. Reimbursement schedules must be negotiated between the hospitals and clinics, the state, and the VA. Any medical provider that wants to participate must be "certified" by the state and/or VA to participate in the program. This is really no different then existing VA programs for some services and third party insurance procedures.
6. Alaska VA receipts from third party billings ("other insurance" - insurance companies used by veterans now treated at VA clinics/hospitals) should be transferred to a state program for veterans' health care as a federal grant similar to what is done at the Indian Health Service. This sets up a potential federal matching strategy for state veterans' health care. (may require federal law or regulatory changes. Look at IHS or Public Health Service third party receipts programs for comparables. Also look at VA authorization to run "demonstration projects" in states.)
7. This program will require state legislation to set up (authorize) the program, allow receipt of federal funds, receipt of billings from medial providers, reimbursement payments to medical service providers, and approval of some range of reimbursement schedules as can be negotiated and annually adjusted and provided in regulations.
8. The state's reimbursement schedule should be the same or greater then the VA schedule.
9. The state is in a far more powerful position to negotiate with the federal VA for an appropriate reimbursement schedule for Alaskan communities then are individual medical service providers.
10. Based on increased efficiencies within the overall Alaskan based medical services industry, new economies of scale should push reductions in the cost of services. (the more beds filled the lower cost per bed, the more clients seen the lower cost per client)

Why should the State of Alaska put itself in the middle?

1. Alaskans (National Guard and Reserve) are becoming more and more involved in fighting our wars. Even if these troops are federalized, the state has a moral and ethical obligation to ensure that its veterans receive appropriate medical services after leaving active duty.
2. When an Alaskan who likely is fully employed in his/her civilian life and has a personal or family health insurance program linked to that job, is federalized/deployed - he/she will likely loose his/her income from this nonmilitary employment for years, suffer a sig. ificant loss of annual income, unable to pay the premiums for this private health insurance and his/her employer will likely not continue employer co-payments as the employee is gone - resulting in a loss of personal health insurance for the soldier and/or family. Then when the Alaskan returns to private life they will likely have to start their health insurance all over again but NOT be able to apply any new private insurance to any military related injury or illness (known or unknown at the time) as it would be considered a "preexisting condition" under any new private insurance. If the veteran is n connected" to the VA Health Care program to cover these "service related" costs – he/she is SOL. This is not in Alaska's best interest.
3. This program should ensure that Alaska's veterans receive adequate health care OUTSIDE of the current federal appropriations processes. A process that, regardless of need, continues to reduce the per-veteran level of federal services and the per-veteran level of programmatic federal funds compared to the growing level of need from the veterans in Alaska.
4. Alaska should explore new medical service concepts for veterans that are far more cost effective then the building of new VA hospitals/clinics especially in areas of Alaska with small populations that do not enable the levels of medical service efficiencies essential to compete in this market.
5. Alaska could be a pilot project in the evolution of new national approaches to more efficient medial insurance/services for veterans In fact, we may not be reinventing the wheel here, we may just be returning to an approach that some years past provided services in this manner.

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Questions for the VA/AK:

1. How many Alaskan veterans are sent out of state for medical/mental health services? What is the average number of Alaskans per year over the past ten years?
2. How much does the VA spend annually (in air fare, taxi, hotel, meals) to send veterans outside for medical/mental health services? ***ANSWER: $2,057,222 for airfare alone in 2004.***
3. What medical/mental health services/treatments are veterans receiving outside of Alaska?
4. What is the total cost/value of these "outside" medical services to the VA annually?
5. If these services are available in Alaska, why does the VA send the veteran out of state?
6. Does the VA provide any family assistance to spouses/families to be close to a veteran when sent out of state for medical services? Is there some gradation based on seriousness of condition?
7. How many veterans in Alaska are classified as having a service related PTSD claim? How many of them receive regular treatment in Alaska? How many receive treatment outside of Alaska?
8. How many veterans are served annually instate at VA clinics and hospitals?
9. What is the total cost of medical services (do not include VA Administration) provided by VA in Alaska? ***ANSWER: $38,681,991 in part.***
10. How many veterans receive medical services at private or other than VA facilities in Alaska annually?
11. What is the total cost of medical services received by veterans in Alaska at other than VA facilities?
12. What is the nature of these medical services?
13. What is the cost per patient ratio for VA medical services in Alaska?
14. How many facilities in Alaska currently have reimbursement schedules with the VA?

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Problems Solved

1. Maximizes use of existing underutilized Alaskan hospital services/beds increasing the operational efficiency of existing facilities allowing lower service fees especially in rural areas.
2. The emotional cost to veterans and their families when the veteran is separated by thousands of miles (now sent outside of Alaska) for treatment. Veterans can be treated in Alaska allowing families to be by their side during these difficult times. This is often a critical component of a patient's recovery during medical or mental health care.
3. The cost [significantly reduced travel (air fare, hotel, taxi, meals) expenses] of providing services to veterans should be reduced overall with the retention of veterans in Alaska for medical care.
4. New expensive Veterans Hospitals and clinics will not have to be built and operated by the federal government.
5. The existing Military/VA Hospital at Elmendorf can revert to active duty service only. Elmendorf will not have to adjust their fence/perimeter to put this hospital outside of the existing security zone. Saving money, time, manpower, and enhancing on base security while at the same time providing services to veterans in a far more friendly way. This action is also responsive to the general desire of veterans to receive their medical services within their community.
6. Veterans will be allowed/enabled to use existing private facilities based on cost and quality of service.
7. No additional land will need to be developed for new hospitals in areas with little land available.
8. Existing VA Clinic employees could shift to other medical service providers, but should remain under VA employment status as their principle area of service is veterans within those facilities.
9. The VA Clinic could be relocated to an existing medical campus such as Providence or Alaska Regional rather than moved to Elmendorf providing better professional services integration within the medical communities that exist. Additional efficiencies may be realized with the consolidation of all VA services at one medical campus (now five (5) commercial spaces are under "fair market value" lease by the VA in Anchorage alone).
10. Existing medical service providers who offer services in demand by veterans can enhance their practices and increase their cost efficiencies.
11. Veterans are allowed to "shop" for their service related medical care/services based on quality of service and, with existing co-payment requirements, cost. They are empowered in their choice of medical services whereas currently they are given no service or service that may not be at the same level or in their community or state.
12. Services can be responsive to demand within established health service markets.

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News Flash

Congressman Lane Evans wants full accounting from VA on FY07 budget

House Committee on Veterans Affairs – Democratic Office
Lane Evans Ranking Democratic Member
333 Cannon House Office Building
Washington, DC 20515

http://veterans.house.gov/democratic/welcome.htm

FOR IMMEDIATE RELEASE: February 15, 2005
CONTACT: Geoffrey Collver 202/225-9756

Early Indicators Warn of Possible Shortfalls at VA ... Again

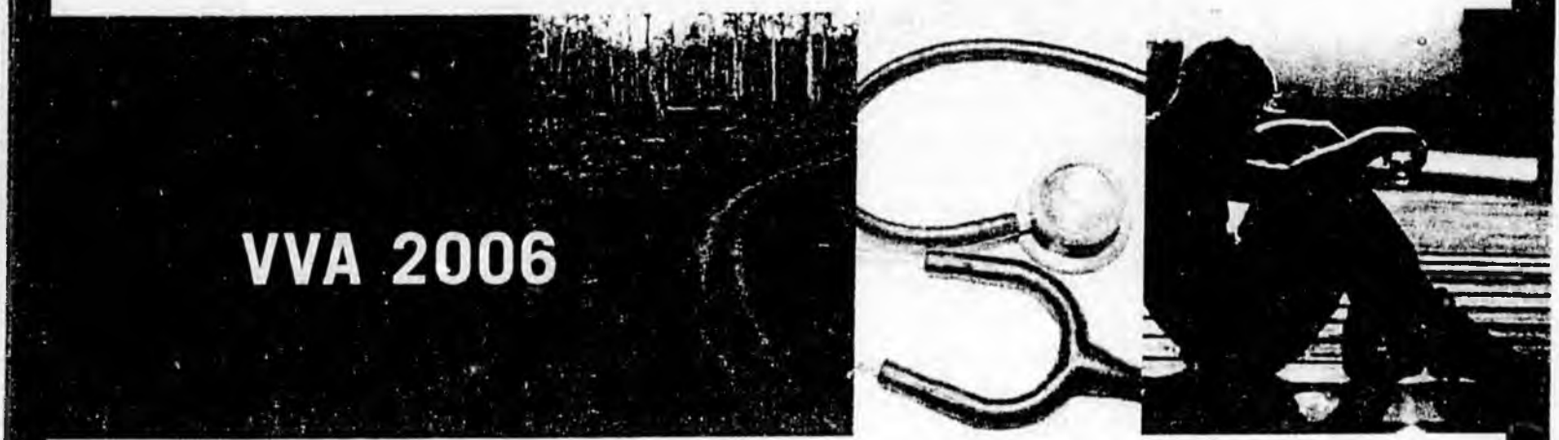
Washington, DC - Rep. Lane Evans (D-IL), ranking Democrat on the House Veterans Affairs Committee, warned that the problem of chronic underfunding of veterans' health care is again causing budget shortfalls at Department of Veterans Affairs (VA) hospitals and clinics across the nation. Evans and Rep. Michael Michaud (D-ME), ranking Democrat on the Health Subcommittee, have called upon the Secretary of the Department of Veterans Affairs, in a joint-letter sent today, to provide a full and accurate accounting of current shortfalls.

"I am distressed by reports of $500,000 to $18 million shortfalls we are hearing from VA medical facilities across the nation from Seattle, Washington to West Palm Beach, Florida, from White River Junction, Vermont to San Diego, California," said Evans.

In response to Rep. Michaud's questions at the February 14, 2006, Committee hearing on the VA health care budget, VA officials conceded to shortfalls at some facilities. While denying a system-wide problem, VA officials revealed that VA was planning to notify Congress that it needed to shift money around in its medical care program accounts to cover gaps in funding. VA officials also acknowledged regional health care networks might be transferring funds between networks to cover funding gaps. In their letter to the Secretary, Representatives Evans and Michaud warned, "These actions are early warning indicators that something is amiss with VA's funding for FY 2006."

Rep. Filner (D-CA), a Senior Member on the House Veterans' Affairs Committee, representing San Diego, urged early action. "Veterans' health care needs real funding. In the short-run, transferring funds may camouflage the shortfall but it does not rectify the underlying problem," said Filner.

VVA 2006



LEGISLATIVE AGENDA & POLICY INITIATIVES

VIETNAM VETERANS OF AMERICA®

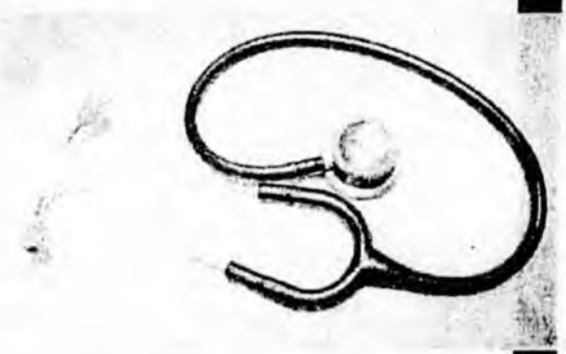
In Service to America

There are other issues of concern that warrant the attention of Congress and the American people. What follows are VVA's legislative priorities in these areas.

Veterans' Health Care

- When the VA cannot provide the highest quality care within a reasonable distance or travel time from a veteran's home and in a timely manner, the VA has a duty to provide care via a fee-basis provider of choice for service-disabled veterans.

- VVA is committed to protecting and advancing the rights to access VA health care programs and services for all veterans who meet the definition set forth in Title 38, U.S. Code, and shall continue our efforts to ensure that clinicians at VA medical facilities take a military history as a matter of course for all veterans currently in or entering the VA health care system.



- To better provide health care for women veterans, VVA will seek legislation or regulation to re authorize the biennial Report of the Advisory Committee on Women Veterans, with submission to the Secretary of Veterans Affairs for response, and to members of Congress; and VVA shall seek legislation to provide contract care, for up to 14 days post-delivery, for infants born to women veterans who receive delivery benefits through the VA.