

147 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

WHITE PAPER

The Position of Vietnam Veterans of America On Health Care Funding For *All* Veterans

July 2003





Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

July 2003

Dear Friends and Colleagues,

This White Paper makes the argument for what Vietnam Veterans of America (VVA) and other Veterans Service Organizations (VSOs) have been advocating for too long: the need to shift the funding of the VA's medical operations from a discretionary to an obligatory model at an appropriate level of funding. We believe the time for Congress and the President to address and rectify this situation is now, while another generation of American troops is fighting a new, global war that doesn't promise a swift conclusion.

It is our hope that all the VSOs and all Americans will unite and push for enactment of legislation to restore the base funding for VA medical operations; and to bring a measure of sanity to how veterans health-care is funded so that we can turn our attention to how to improve that care and introduce greater accountability and efficiencies into the system.

We look forward to working with our fellow veterans and with members of Congress who believe that this is the right thing to do and the right time to do it.

We welcome your comments and your support.

Sincerely,

A handwritten signature in cursive script that reads "Thomas H. Corey".

Thomas H. Corey
National President



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EXECUTIVE SUMMARY

The highest legislative priority of Vietnam Veterans of America is the institution of obligatory, or assured, funding for medical operations at the VA based on the per capita use of the veterans health-care system (including long-term care) at the 1996 level of funding, indexed for medical inflation.

The debate of the past several years has been whether to fund the veterans health-care system at a very inadequate level or a grossly inadequate level. This debate needs to end. We must give more than lip service to the health-care mandates set forth in law, and by the will of the American people, to care for those who have borne the battle.

In the mid-1990s, the VA health-care system welcomed higher income, non-disabled veterans, with the caveat that these enrollees pay a nominal co-payment. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health-care system. Congress endorsed this initiative and enacted Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996.

Because the law did not mandate a level of funding, it established an annual enrollment process and categorized veterans into "priority groups" to manage enrollment. Last year, the system hemorrhaged, and Secretary Principi had to make a difficult call. Overburdened by an influx of enrollees, the VA did not have the financial resources to provide care for all who chose to enroll. The Secretary then temporarily suspended new enrollments of Priority 8 veterans. This suspension, which went into effect January 17, 2003, will continue through Fiscal Year 2004. Although this decision is to be reviewed annually, many fear that Priority 8 veterans have been effectively banished from the health-care system as the VA, with no promise of an infusion of supplemental appropriations, refocuses on its "core mission" of serving veterans "with service-connected disabilities, the indigent, and those with special health care needs."

The VA is not assured adequate funding that complies with Public Law 104-262. This law, undermined by years of flat-line budgeting by Congress and by medical inflation, effectively strained the VA system beyond capacity and rendered the VA unable to respond adequately to the needs of veterans who have chosen to use its health-care system. Access to this care is their right as veterans, and that right is being abrogated.

To adequately serve all of those who seek its services, the VA needs \$28.5 billion in hard, appropriated dollars in FY 04. Using a very conservative methodology and government figures, some \$36 billion should have been appropriated for VA medical operations in FY 04. To restore the eroded funding base would take a four-year "off-budget" restoration plan of \$8-10 billion. To avoid future funding crises, Congress must go beyond the rhetoric of considering whether the current discretionary-funding model needs to be replaced by an obligatory system of funding indexed both to per capita costs of treatment and medical inflation. Congress and the President must not pass the buck any longer. They must grapple with the issues keeping the compact between our government and our veterans at the forefront of debate, and they must enact legislation that will ensure a consistent, predictable, and appropriate level of funding for VA medical services.

T*he willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the Veterans of earlier wars were treated and appreciated by their nation.*

– George Washington

INTRODUCTION

Americans have long held that health care for veterans is a national obligation, part of the covenant between the American people, through our democratically elected representatives and agencies of government, and the men and women who have pledged to defend the Constitution and the cherished principles of our nation. Because those who render military service pledge not only their loyalty but their life, knowing that they may be called to combat, understanding that they may give up their life, this covenant is more profound than a legal contract. Now, at a time when a new generation of our sons and daughters is on the front lines defending America's interests, it is our obligation as citizens of a generous and compassionate society to ensure that the funding to care for the injuries, illnesses, and disabilities they may suffer is assured and not relegated to a "discretionary" appropriation of inadequate proportions.

Those who serve during times of war or conflict, particularly those who are deployed to a war zone, return home changed. Many are seared psychologically. Some are wounded or maimed by the weapons of modern warfare. Yet just as they have fulfilled their obligation to their country – to all of us – it is our collective obligation to do all that we can, through the appropriate agencies of government, to restore as much as possible each veteran who has been lessened physically, psychologically, or economically; and all that we can individually and through our communal and religious institutions to heal each veteran who has been lessened spiritually.

All Americans committed to justice for veterans understand that the annual budget battles in Congress do little to inspire confidence that we will do right by our veterans. Budgets and appropriations are, of course, a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does "discretionary" funding for the care of men and women who defend our country say about America? Which is more important: the pet highway construction projects of a powerful member of Congress or adequate funding for veterans health care? What does the "temporary"

trriage of veterans classified as "Priority 8" say about the state of the VA health-care system? Beyond political platitudes, what legislation will the administration and the congressional leadership debate and enact to eliminate the uncertainty in funding veterans' health care?

The debate over the past several years has been whether to fund VA medical operations at a very inadequate level or a grossly inadequate level. The flat-lined budgets passed by Congress and signed by the President during the mid- and late-1990s so eroded the base funding for health care that the VA is hard-pressed to meet the mandate of its mission. This annual debate needs closure. It is time to act to ensure a consistent, predictable, and appropriate level of funding that will give more than lip service to the mandates for health care set forth in law, and by the will of the American people, for those who have borne the battle in the fertile fields of Europe, the islands of the South Pacific, the rice paddies and jungles of Southeast Asia, the sands of Kuwait and Afghanistan and Iraq, and the myriad peacetime confrontations of the Cold War.

BACKGROUND

The Department of Veterans Affairs, the second largest of the 15 Cabinet departments, is the largest integrated health-care provider in the nation, with 163 medical centers, more than 900 outpatient clinics, 180 nursing homes and domiciliaries, and 206 Vet Centers divided into 21 Veterans Integrated Service Networks administered under the aegis of the Veterans Health Administration.

In the mid-1990s, the leadership of the VA, with the bi-partisan support of Congress, embarked on a significant shift in policy. They opened the VA health-care system to non-indigent, non-disabled veterans, with the caveat that these enrollees pay a nominal co-payment. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health-care system. Congress and the President endorsed this initiative, enacting Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, which gave the VA the legal authority to do what it had proposed.

The new law reaffirmed the VA's mandate to provide care for its core constituency: service-connected disabled veterans, indigent veterans, and others such as ex-prisoners of war and veterans who had been exposed to environmental hazards, toxic substances, and radiation. It also required that the VA provide "for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness)."

However, even though the new law was predicated on the assumption that the VA would be reimbursed from Medicare as well as from third-party collections from private insurers for the services it provided, a provision of the law stipulated that "hospital care and medical services shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes." The law gave the Secretary of Veterans Affairs the authority and responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding, or a standard of care, it did establish an annual enrollment process and categorized veterans into "priority groups" to manage enrollment (see Appendix, an explanation of these priority groups).

A confluence of events and conditions served to swell the roster of those who sought service at the VA. Outreach to veterans who had never considered care in VA facilities was stimulated by the fissures and faults of a national health-care system that does a terrible job of containing costs. Double-digit inflation priced health insurance beyond the reach of millions of Americans. The soaring costs of prescription drugs – and the unavailability of a drug program in Medicare – caused veterans to flock to the VA. The

Veterans' Millennium Health Care and Benefits Act of 1999 further increased demand by expanding benefits. Because funding of VA medical operations is not based on per capita usage, the VA's resources shrunk while enrollment was soaring. Caseloads ballooned. Waits for appointments to see physicians lengthened from several weeks to several months. Veterans using the system were frustrated by a system that had bogged down.

Last year, VA Secretary Principi had to make a difficult call. The system did not have the financial resources to provide care for all who chose to enroll. Confronted by dire fiscal realities, the Secretary created a new category, Priority 8, for prioritizing medical care in the VA system. ("Priority 8" is comprised of veterans who agree to pay specified co-payments and whose income and/or net worth is above the VA means-test threshold and the HUD geographic index.)

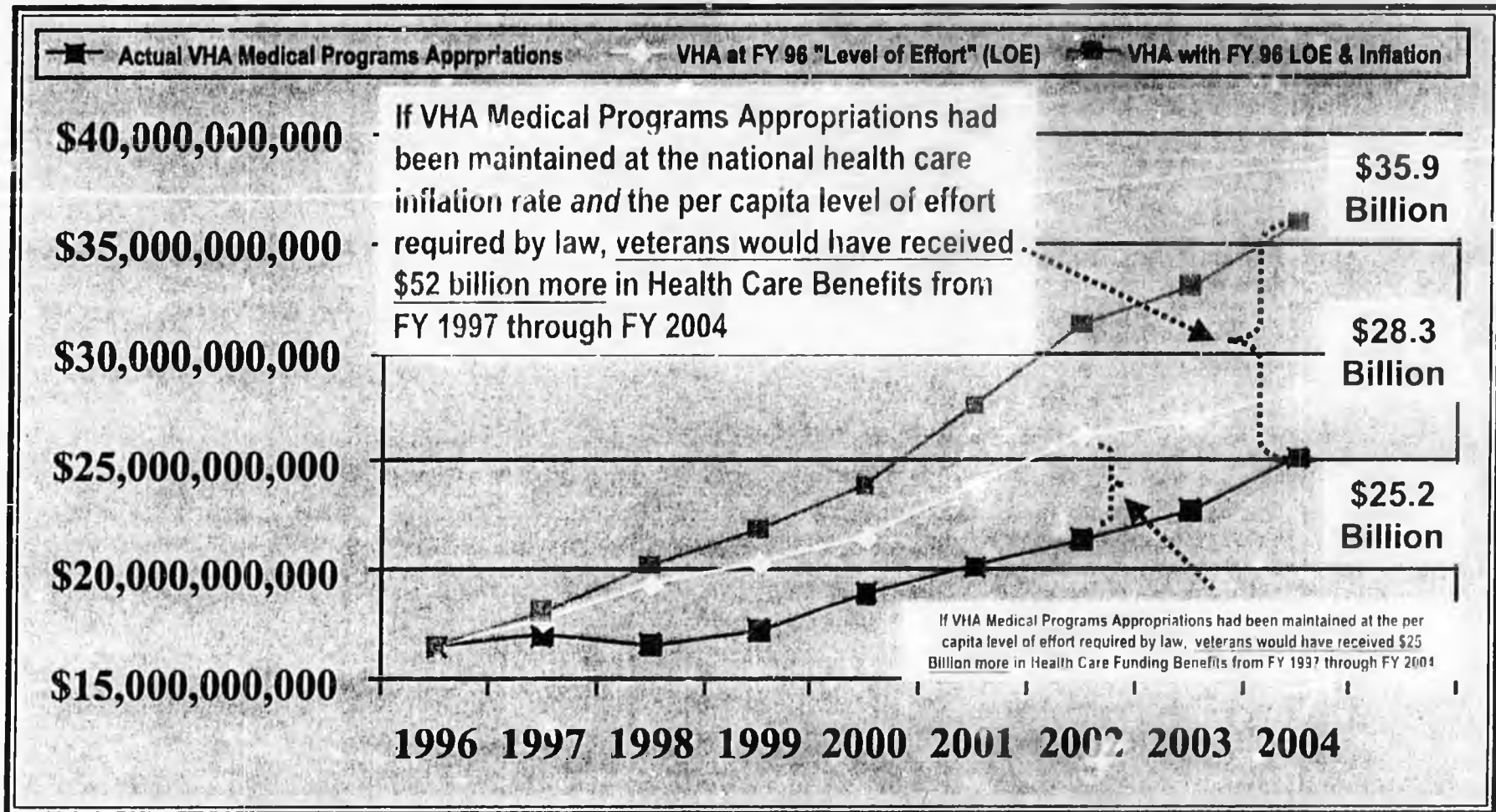
The Secretary then temporarily suspended new enrollments of veterans in that category. This suspension, which went into effect January 17, 2003, will continue through Fiscal Year 2004 (which runs from October 1, 2003, through September 30, 2004). While this decision is to be reviewed on an annual basis, many fear that Priority 8 veterans have been effectively banished from the health-care system as the VA, with no promise of an infusion in supplemental appropriations, refocuses on its "core mission" of serving veterans "with service-connected disabilities, the indigent, and those with special health care needs."

How did it come to pass that Secretary Principi felt compelled to take so drastic an action as suspending registration and access for Priority 8 veterans? Part of the answer lies in how the system is funded. The VA is not assured adequate funding that enables it to comply with the provisions of Public Law 104-262, which mandates that funding for health care meet the "level of care" provided by the VA in 1996. While recent increases to the VA health-care budget have been reasonable, the law has been effectively undermined by years of flat-line budgeting during the mid- to late-1990s. The situation has been compounded by the eroding effects of medical inflation, straining the VA system beyond capacity and rendering the VA unable to respond adequately to the needs of veterans who have chosen to avail themselves of its health-care system. This is their right as veterans, and that right is being abrogated.

The following graphs illustrate the problem. While enrollment in the VA system has increased by almost 120 percent since 1996 – from some 3.4 million to more than 7.0 million projected in FY 2004 – Veterans Health Administration (VHA) per capita expenditures have decreased over the same period by 30 percent (Graph 2, page 6). The ratio of patients to licensed practical nurses has shot up more than 100 percent, while the ratio of patients to registered nurses had grown by 67 percent (Graph 3, page 7). Likewise, the doctor-patient ratio has increased by almost 60 percent (Graph 4, page 8). While this situation is exacerbated by an increase in Priority 7 and 8 veterans, in fact more Priority 1–6 veterans entered the system over the same period (Graph 5, page 9).

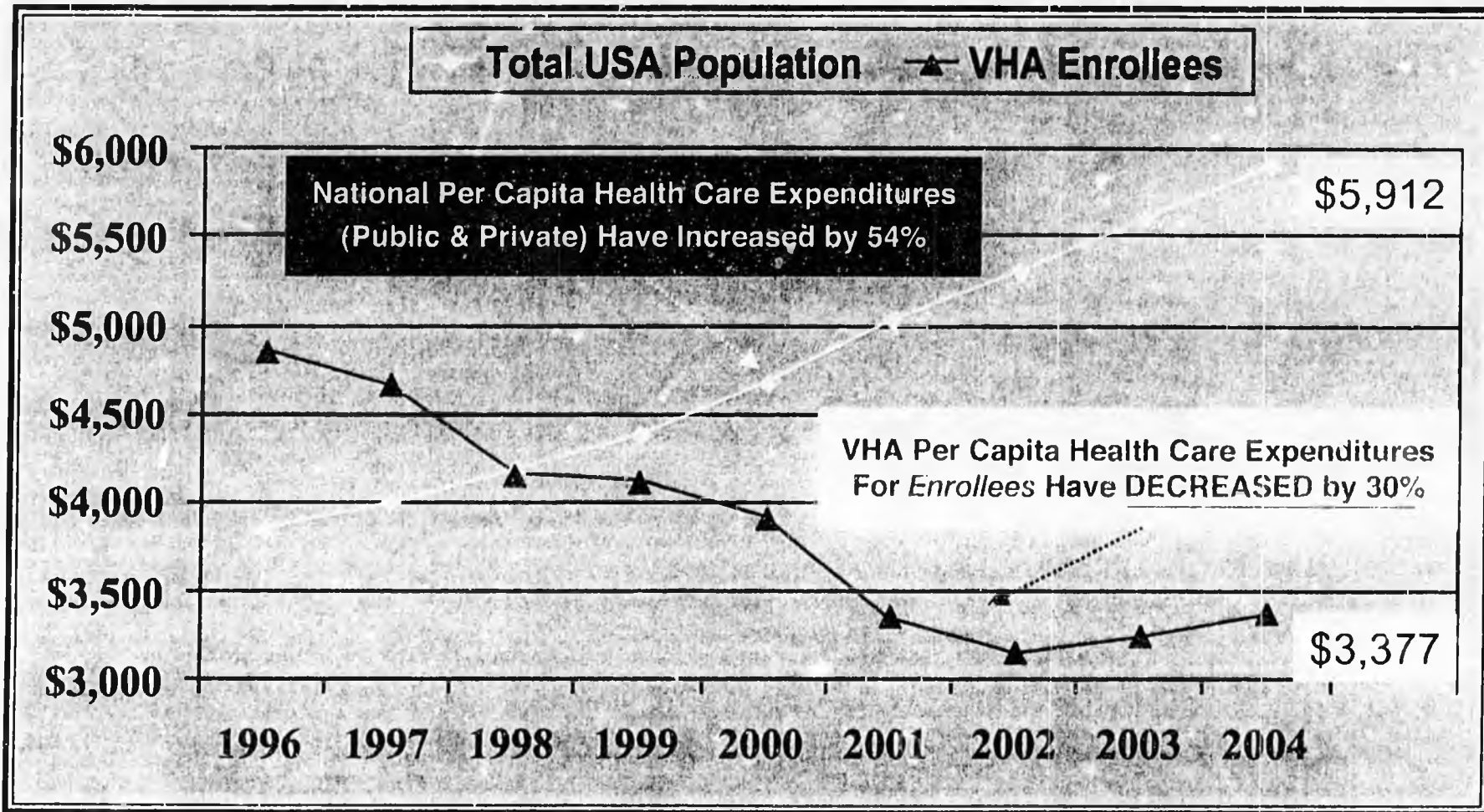
Perhaps most telling is Graph 1 (page 5): Had the level of funding mandated by law been met – and the law requires that funding for the VA's medical operations match the "level of effort" in Fiscal Year 1996 – this funding would be hovering at \$36 billion for FY 04. The debate would reflect this higher figure. In order for the VA to serve all veterans who are eligible and who seek care at VA facilities, VA officials have acknowledged that, beyond the \$1.7 billion they anticipate collecting in third-party billings in FY 2004, they will need at least \$28.5 billion in hard, appropriated dollars to re-open the medical system to all eligible veterans in FY 04.

VHA Medical Programs "Should Spend" Budget



Sources: (VHA Medical Program Appropriations) - VHA Appropriations history/projections were e-mailed from the Veteran's Administrations Central Office (VACO) on 2-04-03.
 (VHA at FY 96 "Level of Effort" Budget Line) - Data derived by multiplying the FY 96 Per Capita "Level of Effort" (\$5,633) by the number of VHA Users. FY 96-98 VHA Users are a VVA estimate. FY 99-04 VHA Users came from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04.
 (VHA at FY 96 LOE & Inflation Budget Line) - Health care inflation figures for each FY were faxed to VVA from the Centers for Medicare and Medicaid Services (CMS) Actuarial Offices, and can be viewed for 1998-2004 at www.cms.gov/statistics/mhe/projections-2002/r1.asp. The CMS data are conservative because they do not reflect price inelasticity accounted for in the slightly higher health care inflation figures of the Consumer Price Index (patients cannot as easily substitute lower cost drugs/treatments as in other sectors)

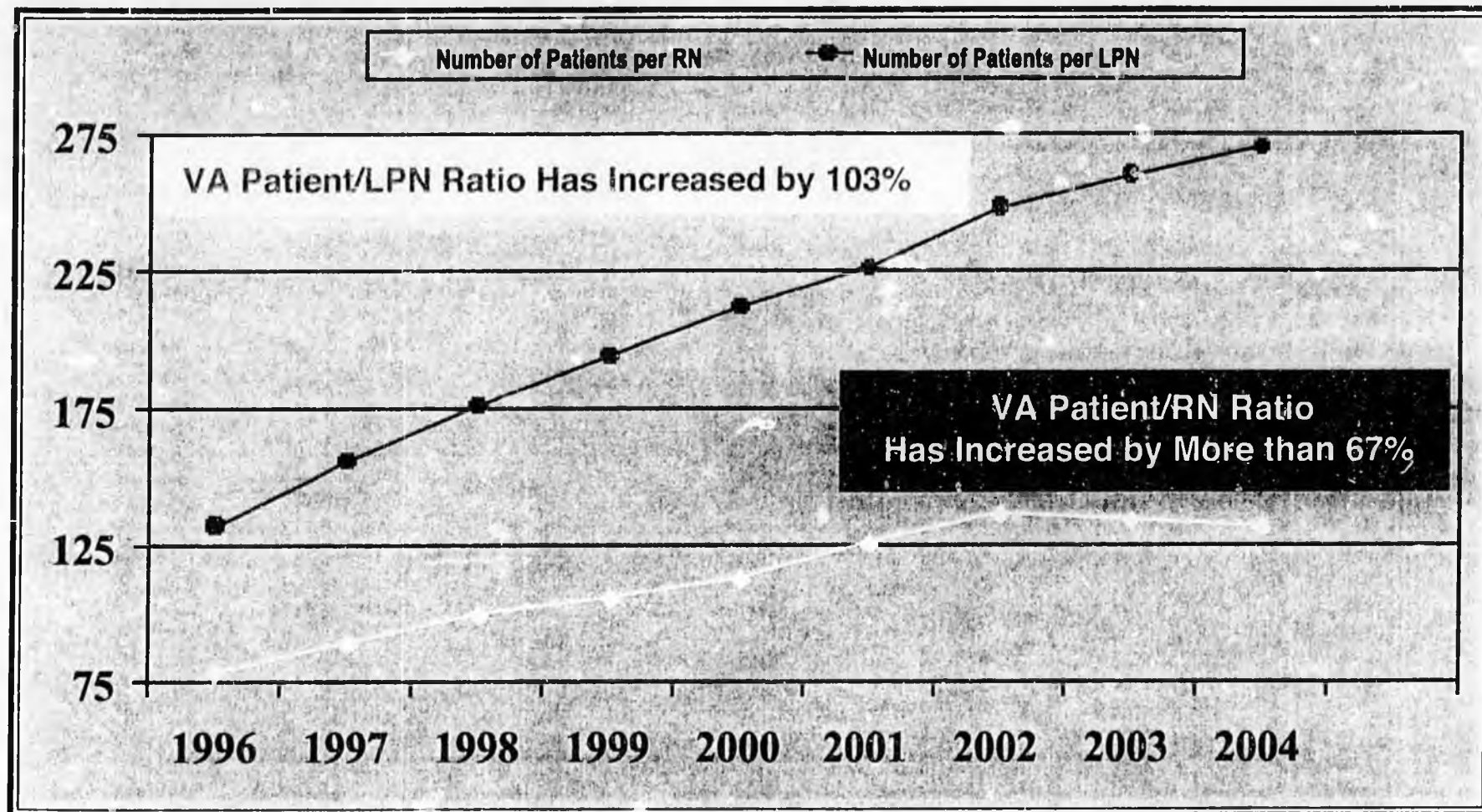
Annual Per Capita Health Care Expenditures



Sources: (National Health Care) - Per Capita Expenditures are derived from the Centers for Medicare and Medicaid Services data found at <http://www.cms.gov/statistics/nhe/>, the "nhegdp01.zip" file (2nd table at bottom of web page). Projections for FY 02-04 are based on the average 5.5% per capita growth rate from FY 96-01.

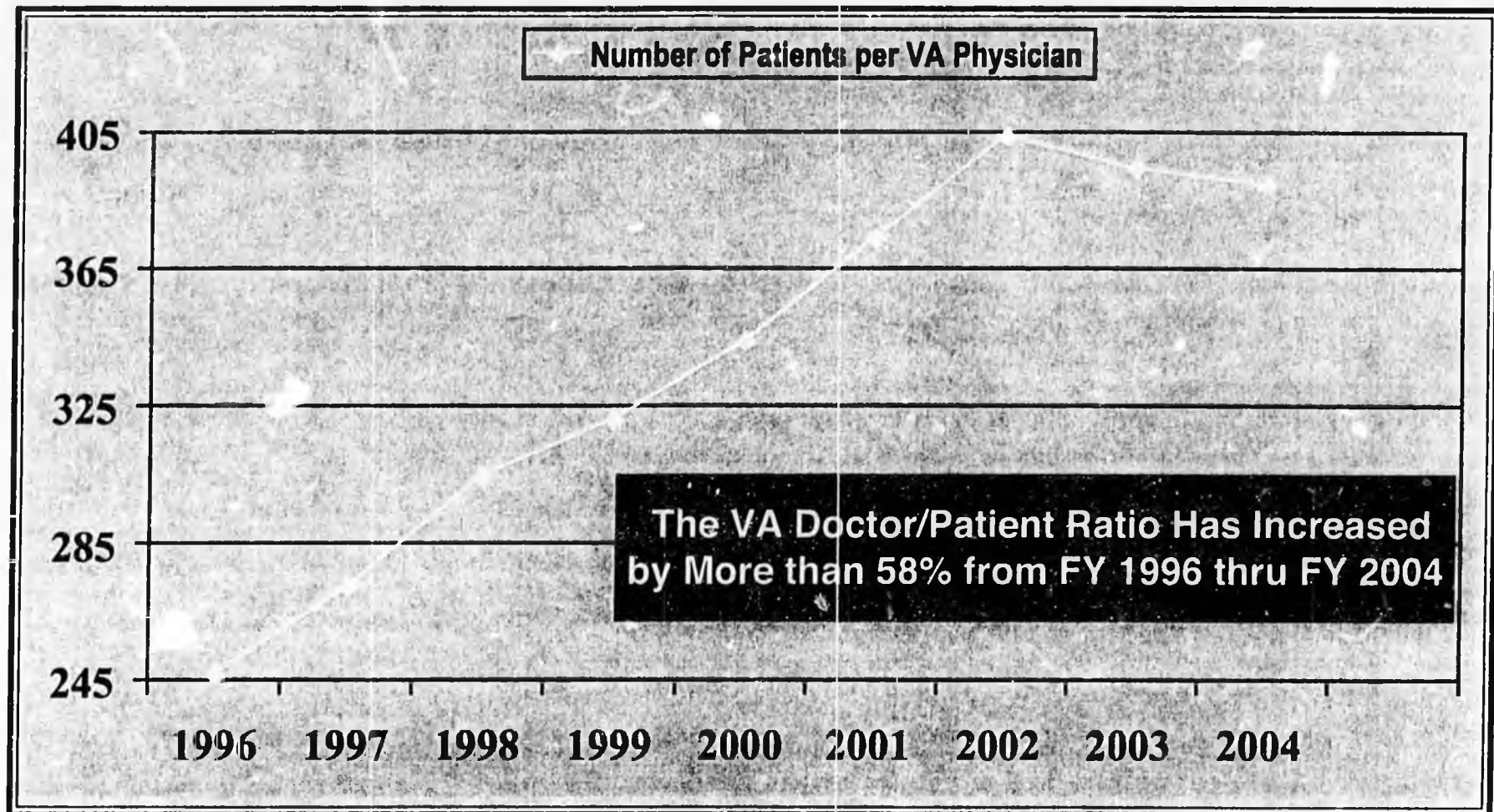
(VHA) - Enrollee Per Capita Expenditures are derived by dividing FY 96-04 VHA Appropriations by the number of VHA enrollees. FY 96-98 are estimates based on the 16% enrollee/user difference in FY 99. FY 99-04 actual and projected enrollees are from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04. VHA Appropriations history and projections were e-mailed to VVA from the Veterans Administration Central Office (VACO) on 2-04-03.

VA Nurse/Patient Ratio



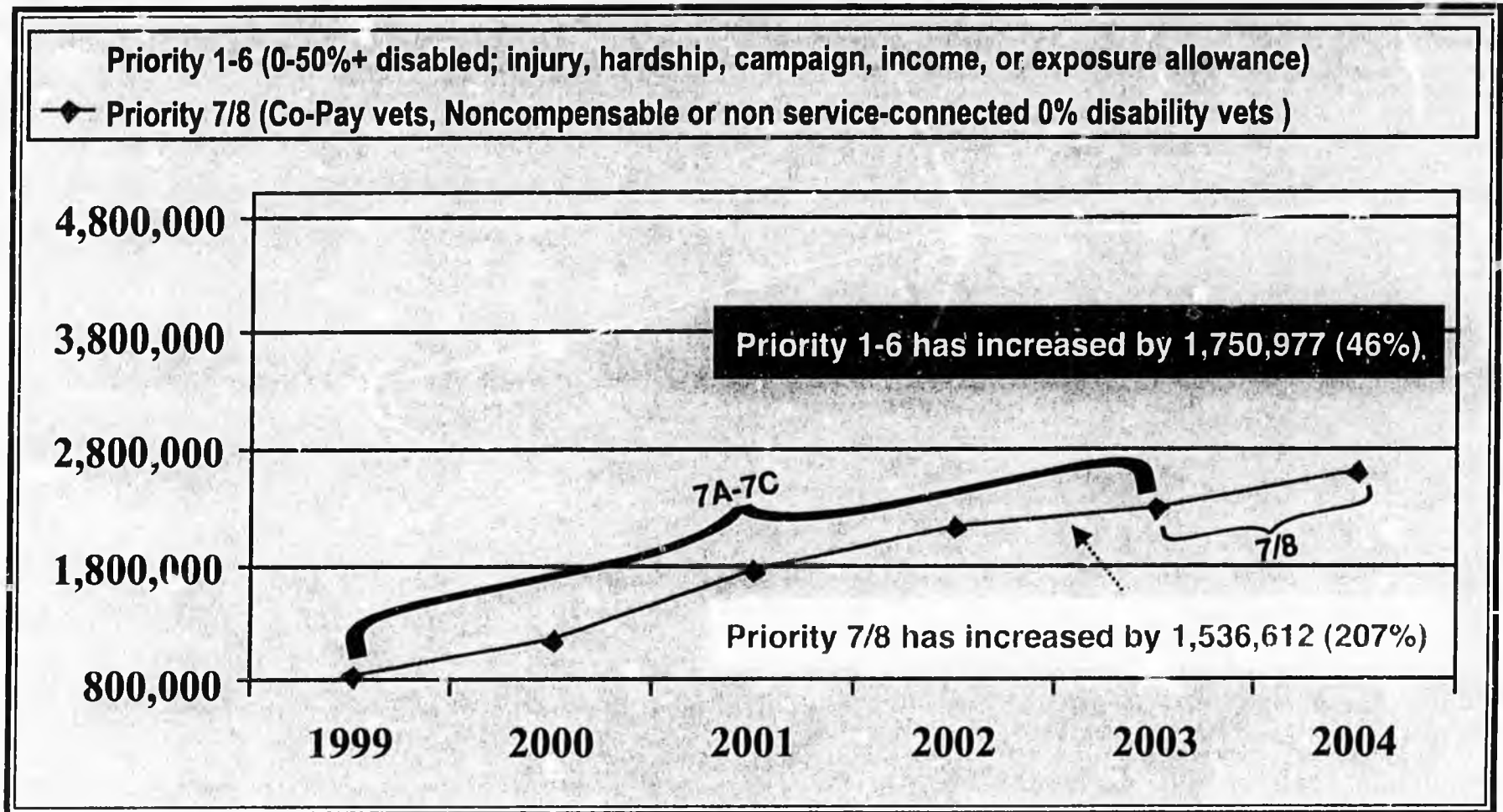
Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03

VA Doctor/Patient Ratio



Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.

Total VHA Enrollee Growth (by Priority and FY)



Sources: FY 99-02 data are from an Excel file e-mailed to VVA from the VHA Policy and Forecasting office titled "enrollees and pts fy99-04 by priority.xls." FY 03 & 04 estimates are from the same office and utilize the full demand figures. 7A-7C are previous designations for the current priority 7 and 8 categories.

VVA's POSITION

The highest legislative priority of Vietnam Veterans of America is the institution of obligatory, or assured, funding for veterans' health care, funding that is based on the per capita use of the veterans' health-care system (including long-term care) at the 1996 level of funding, indexed for medical inflation. Why the "accepted" level of care at the rates expended in FY 96? Because that's when the law was passed, even though FY 96 was not at the time considered a banner year for medical appropriations by anyone familiar with the process.

VVA initially acknowledged that for the VA to adequately minister to the core groups eligible to receive care at its facilities, the course of action taken by Secretary Principi, while wrenching, was justified and even necessary – but only as a stopgap, temporary palliative. It was the only reasonable action he could take to stanch the hemorrhaging of the system and prevent its collapse. VVA strongly opposes making this exclusion of Priority 8 veterans permanent. VVA has asked that Congress direct that the VA use numbers for its future planning and projection purposes that include provision of services to Priority 8 veterans.

VVA is gratified that the hue and cry raised by veterans service organizations is finally being heard by Congress. Several measures are being considered that would, if a bill is finally enacted, restructure the way medical operations of the VA are funded and effectively remove the annual uncertainty over the VA's budget for health care. The time for serious consideration of these measures is now. A government that can afford to outlay billions for a war against terrorism can find the funding, and reconfigure the funding mechanism, to help heal the veterans of this war and the wars that preceded it.

With funding uncertainties removed, the VA leadership could focus on implementing measures to create a true veterans health-care system, a system in which every veteran who enrolls would be given a full physical examination that would include a comprehensive military health/medical history, a psychosocial workup, and the drawing of blood samples.

This history would provide an epidemiological baseline to help measure future health conditions not only for a particular veteran but potentially for others with whom (s)he served. When an extensive epidemiological database is finally compiled, it can serve as an invaluable tool for physicians. With more information about a patient's military background, a doctor would know to test for particular conditions, parasites, and toxic exposures that may already be adversely affecting the health of that veteran. Such a database could reveal whether others who served in the same outfit reported similar conditions. It would not only help a doctor render an accurate diagnosis and establish an effective treatment plan, it would enable the VA to more effectively identify occupational illnesses and diseases that may be connected to a veteran's military service. Such a database, if accessible to private physicians – and the vast majority of veterans are not enrolled in the VA health-care system – can inform these medical professionals about potential health issues in their patients.

ADJUSTING the FUNDING BASE for VA MEDICAL OPERATIONS

VVA believes, however, that in addition to restructuring the way in which the medical operations of the VA are funded, an adjustment to the base funding must be made.

The percentage increases appropriate for VA medical operations from FY 2002 to FY 2003, and the proposed increase from FY 2003 to FY 2004, are reasonable, even generous. However, the base upon which these increases are predicated is inadequate. The "should-spend" budget illustrated by Graph 1 on page 5 illustrates why. VA officials acknowledge they require an infusion of \$1.2 billion over and beyond

the amount appropriated by Congress for FY 04 to reopen the system to Priority 8 veterans. This translates to an appropriation of \$28.5 billion in FY 04. And the VA needs \$8-10 billion more to effectively comply with the law and meet the 1996 "level of effort" for veterans' health care. Using very conservative figures for medical inflation, funding of the VA's medical operations should be some \$36 billion for FY 04.

Congress must revisit this issue and consider ways to right this wrong as part and parcel of any move to rework the way the VA health-care system is funded. Whether additional funding is on-budget or off-budget, or whether these additional funds are "discretionary," "mandatory," "assured," or "obligatory," the funding base for the veterans health care must be restored to the proper level, starting the next fiscal year.

TOWARD REAL ACCOUNTABILITY

VVA has long maintained that managerial accountability goes hand-in-hand with obligatory funding. The entire VA system warrants continued management systems reforms, the prime goal of which must be to ensure the accountability of senior managers.

The VA's focus on accountability concentrates on providing incentives to senior managers, rewarding those who perform their jobs adequately with annual bonuses that average almost \$11,000. There are few, if any, sanctions imposed on those managers who demonstrate incompetence or recalcitrance to do what they are paid to do. It is useful to note that a VISN director and a director of a VA Medical Center received bonuses greater than \$10,000 for several years even after lice had been found in the bodies of veterans under their care.

While many very fine managers who are able leaders and dedicated public servants are employed by the VA, there are others who don't feel compelled to act in the manner of true public servants. Rarely if ever is a senior manager denied a bonus, even in instances in which that manager is known to have ignored directives or deliberately misled top officials at the VA.

While there is a legitimate need to make significant adjustments in the compensation for critical health-care workers, the current use of "merit bonuses" has been corrupted. Merit bonuses must be just that: bonuses for merit and achievement above and beyond that which is required. The current mode does a disservice to the many fine VA physicians and administrators who deserve more competitive pay and bonuses for truly outstanding performance. The system of rewards and punishment must be adjusted to sanction those who do a poor job or are not fully open and honest with appointed or elected officials.

To ensure accountability, the VA must develop a modern financial tracking system and standardize its financial systems so that the costs at one medical center can be easily tracked and compared to similar expenditures at other VA medical centers. Similarly, VA must develop a real-time Management Information System (MIS) to track how many clinicians or specialists are available at each medical center at any given time. VVA believes that the VA must subscribe to the old military adage that "a unit does well which the commander checks well."

CONCLUSION

We as a nation can and must do better for our veterans. Funding for veterans' health care has been woefully inadequate for years. As Dr. Linda Spoonster Schwartz, then chair of VVA's National Veterans Healthcare Committee (and currently Commissioner of Veterans Affairs for the State of

Connecticut) testified before Congress: "The lack of a consistent, reliable budget has, in essence, obstructed VA's capacity to respond to the changing needs of the health-care system, to efficiently grow, to acquire competent personnel and maintain a viable service infrastructure." And as the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans has concluded: "Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner. . . . Full funding should occur through modification to the current budget and appropriation process by using a mandatory funding mechanism, or by some other change in the process that achieves the desired goal."

VVA believes it is imperative to enact legislation that would mandate obligatory funding for veterans' health care. Such legislation would make moot the issue of eligibility of Priority 8 veterans to receive medical services from the VA. Making veterans' health-care funding obligatory would eliminate the annual uncertainty about funding levels that has prevented planners at the VA from meeting the needs of the growing number of veterans seeking treatment. An assured, steady funding stream would enable the VA to concentrate on achieving accountability for performance from senior managers and building a system that is not only cost-effective and cost-efficient, but truly contributes to the mission of restoring veterans who have been lessened physically through injury or illness or the psychic wounds of war, or economically by virtue of military service.

To rectify past injustices, the system must be funded at a level that will enable Secretary Principi to re-open the VA health-care system to new enrollees who may be classified as Priority 8. It is imperative that at least \$28.5 billion (in addition to projected third-party payments of \$1.7 billion) be appropriated by Congress for VA medical operations for FY 04.

VVA and other VSOs believe it is disingenuous for our government to promise health care to veterans and then fail to provide adequate funding. Rationed health care must only be a temporary expedient as Congress moves toward an obligatory funding model. We endorse the proposition that "by including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our nation's sick and disabled veterans." We expect our government to respect the covenant and honor its commitment and our obligation to those who have placed life and limb in harm's way.

APPENDIX

EXPLANATION OF PRIORITY GROUPS 1-8

The following is taken from the VA Web site, www.va.gov.

In October 1996, Congress passed Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996. This legislation paved the way for the creation of a Medical Benefits Package - a standard enhanced health benefits plan available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services.

VA places a priority on improved veteran satisfaction. Our goal is to ensure that the quality of care and service you receive is consistently excellent, in every location, in every program. Under the Medical Benefits Package, VA offers you, the veteran, a comprehensive health care plan that provides the care you need.

What are the Priority Groups?

Once you apply for enrollment, your eligibility will be verified. Based on your specific eligibility status, you will be assigned a priority group.

The priority groups are as follows, ranging from 1-8 with 1 being the highest priority for enrollment. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans.

As of January 17, 2003, VA is not accepting new Priority Group 8 veterans for enrollment (veterans falling into Priority Groups 8e and 8g.)

Priority Group 1

- Veterans with service-connected disabilities rated 50 percent or more disabling

Priority Group 2

- Veterans with service-connected disabilities rated 30 percent or 40 percent disabling

Priority Group 3

- Veterans who are former POW's
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0 percent disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6

- Compensable 0 percent service-connected veterans
- World War I veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
 - exposure to herbicides while serving in Vietnam; or
 - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
 - for disorders associated with service in the Gulf War; or
 - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

Priority Group 7

Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index

- Subpriority a: Noncompensable 0 percent service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0 percent service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Priority Group 8

Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and the HUD geographic index

- Subpriority a: Noncompensable 0 percent service-connected veterans enrolled as of January 16, 2003, who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, who have remained enrolled since that date
- Subpriority e: Noncompensable 0 percent service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

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Additional Support for HJR 33



March 23, 2006
Testimony before the State House
HJR 33

My name is Ric Davidge and I serve as President of the Vietnam Veterans of America, Chapter 904 – the Anchorage Chapter and the largest in Alaska. I also serve as President of the Alaska Veterans Foundation, Inc. a statewide veteran service organization that serves Alaskan War Veterans. And I serve as Vice Chairman of the Anchorage Military & Veterans Affairs Commission.

In 1965 I was a medic with the First Air Cavalry in Vietnam and served honorably for 6 years.

Why do we have this resolution before you and just what does it really do?

I assume you have, in your packet, a copy of the most recent "Talking Paper" that we update regularly about the problems Alaskan veterans face in securing appropriate healthcare. This paper is an open ended discussion of problems that continue to come to light as our working group, made up of a wide range of veterans, VA employees, politicians of both political parties, and medical service professionals, wrestles with the challenges of meeting the moral and legal obligations of our community in the provision of healthcare for our veterans. We would be delighted to add any of you to the email tree we have set up on this issue so that you and your staff are kept informed of any developments. There is much to learn.

As our talking paper points out, the health care of Alaska's veteran's faces serious and difficult structural problems in securing the funding authorized by federal law but not appropriated because veteran healthcare has become a partisan football. Veteran healthcare like so many other federal programs is politically "negotiated," regardless of need, every year unlike healthcare provided to our poor, our homeless, our elderly, and even our illegal aliens. Are not our war veterans at least as deserving as these groups when it comes to healthcare? Are not the men and women who voluntarily stand guard for America worth at least as much to our community?

The other day a member of our legislature said to me, "You know veterans are really just another welfare group." This Alaskan of prominence never served in the military, and clearly does not understand that healthcare for veterans is not "welfare" but the moral, ethical, and legal obligation of our people and our leaders for the service and sacrifices we faced to ensure your liberties. We are only asking for what was promised and appropriate.

As a community of veterans we are tired of all the talk. We are tired of all the political promises. We are tired of receiving healthcare based on "administrative convenience" rather than appropriate care at home. We are tired of being shipped outside of our communities and our state to receive healthcare available right here at home. We are tired and we are angry.

So, why are we here before the State Legislature asking you to direct the Commissioner of Health and Social Services to "talk" to the Veterans Administration about what the state might be able to do to help Alaskan veterans? Yes, that's all we are asking is that our legislature recognize this problem, one that will likely not be solved in Washington DC as it should, but that will continue to harm, even destroy the lives of Alaskan veterans and their families. **72,000 veterans** have chosen to be Alaskans. The highest per-capita in the nation. When extended to their immediate families, we estimate that at least **150,000**

Alaskans are directly affected by veteran policies. We should be proud that this many veterans choose to live in Alaska. And now our Alaskan guard and Reserves face the largest and longest active duty deployments in combat in our state's history. But as a state, what are we – what is Alaska doing to ensure they receive the healthcare they have earned when they come home?

We don't have all the answers, but we are gathering lots of the questions. We have asked the VA to provide the facts and figures identified in the last page of our talking paper. This is something our legislature and our state government can help us with, and this resolution will facilitate that and more.

We have talked about veteran healthcare, but let's now look at some of the other implications of current VA policies on our Alaskan based medical services industry. We are told for example that the VA spent over \$2 million in air fare alone to send veterans out of state for healthcare. We know that at least most of these medical services are available not only in Alaska but often in the veteran's home community. We are told that over \$17 million of healthcare services were provided veterans outside of Alaska. With all other costs considered, that's over \$20 million in healthcare services that are taken out of our economy.

We know of prominent Alaskan doctors who have recently lost their significant veteran client base as their patients are now sent out of state. We know of Alaskan based hospitals, now losing money because the services they built to serve a particular medical need in their community, including long-term veteran patients, are no longer economically viable due to the loss of these patients causing other Alaskan patients to assume these losses. So, there are serious economic implications to VA policies that now ship more and more Alaskan veterans outside for medical services. Certainly if these services are not available in Alaska one can understand this. But when they are here, and the veterans are currently being served here in their home communities, there are other "costs" associated with these policies. Taking a veteran away from his/her family at a critical and vulnerable time, is clearly not in the best interests of our veterans, their families, or of Alaskans as a community.

So, we are asking our State Legislature to direct the Commissioner of Health and Social Services to "talk" with the VA and see if there is something we in Alaska can do to better serve our veterans. That's all.

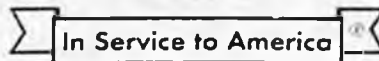
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"Never will one generation of veterans abandon another." That is the motto of the Vietnam Veterans of America and the Alaska Veterans Foundation. Please remember that when we came home, not only did our nation, and our communities dishonor our service, most national veteran service organizations refused us membership. That is why the Vietnam Veterans of America was chartered by Congress.

We have stood guard for America and human liberty in the jungles and deserts of our world when you, our elected officials, have asked us to do so. We now stand before you and ask for your help. Help to ensure we receive the healthcare we have earned, is morally and ethically appropriate, and consistent with what is in the best interests of our families, our state, and our nation.

Thank you very much for your time and consideration.

Ric Davidge, President



February 17, 2006

Alex Spector, Director
Alaska VA Healthcare System
2925 DeBarr Road
Anchorage, Alaska 99508

Director Spector:

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From this forum an informal working group was set up by some of the participants that includes veterans, VA employees, politicians, hospital and medical clinic interests, etc. Although this working group does not have a leader per se, in an effort to give form to the chatter and get things down on paper, I've stepped forward to provide this service.

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I'm certain you are aware of the continuing controversy of Congressional funding or rather the lack thereof for Veteran Health Care. The competing efforts of the Republicans and Democrats may, from time to time, align with the current administration. But, the bottom line, as expressed by our national office, Vietnam Veterans of America, on behalf of the nine national veterans organizations last year, is that Congressional appropriations have not kept up with the needs of veterans. If you do not have a copy of the White Paper produced by the VVA last year that has some excellent graphic analysis of funding trends, I can get you one or you can access it on their web site www.vva.org.

As part of the discussion of the working group, we have tried to identify critical FACTS or DATA or questions that may or may not provide a basis for understanding the "Alaskan" situation. Those questions are contained in the last page of the Talking Paper that I've enclosed for you.

We would appreciate your timely response to these sixteen questions. If they are presented by us in a manner that is not productive to the gathering of data or information, please let us know. If you have questions about these questions, we are also most open to your thoughts.

Thanks for your attention to this ongoing debate;

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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 Health Care funding is not annually assured based on either our nation's moral obligation to the men/women who have been injured in service or who have 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 or the quality of service.

2006 General Accounting Office reports requested by the leadership of both the Congressional House and Senate veteran's program oversight committees highlight the structural nature of these problems. Problems that can not be solved by opposing political parties, but by new ideas.

2. The old system of federal veterans hospitals, 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 Alaska's veterans and their families. This is especially true with regional federal medical service centers that require significant patient and employee travel (out of state and within Alaska) with significant support costs that could be far more efficiently turned directly into medical service through existing Alaskan 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 (72,000), step up to ensure that its veterans - Alaska's 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 voluntarily 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 Alaskan hospitals and clinics. Our program extends this proven method and captures even more efficiencies while keeping our veterans at home for medical service.
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3. In our program the VA ID card works just like an insurance card. The veteran shows the card when paying the bill and the VA portion is billed, according to an approved schedule, is billed to the state. The state then bills the VA for reimbursement. The state pays the provider within 30

- days of receiving the bill, again consistent with a negotiated reimbursement schedule for the specific procedure or service.
4. Alternatively, some argue that our veterans should be "covered" by an established national 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 would be fully covered. The insurance company bills the VA for reimbursement for all service related medical treatments. Veterans who have retired after 20 or more years of honorable service would receive full coverage possibly minus appropriate co-pay based on income.
 5. Reimbursement schedules would be negotiated between the hospitals and clinics and the state. The state would negotiate with the VA. Any medical provider that wants to participate must be "certified" by the state to participate in the program. This is really no different then existing VA programs for some services and third party insurance procedures except that the state is a payer.
 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 in the Department of Health and Social Services 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 block grant for state veterans' health care. (this 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 in Alaskan hospitals the lower the cost per bed, the more clients seen in a clinic the lower cost per client)
 11. We effectively eliminate the need for a separate, with its own heavy administrative costs, federal medical service program in Alaska and push all of the efficiencies directly into the private sector where they are far more efficient.

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 Alaska's troops are federalized, the state has a moral and ethical obligation to ensure that Alaska's veterans receive adequate and appropriate medical services after leaving active duty.
2. When an Alaskan (guard or reserve), 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 most likely loose his/her income from this nonmilitary employment for years, suffering a significant 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 their family. Then when the Alaskan returns to private life they will likely have to start their health insurance all over again in a new job, 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. We know that all service related injuries are not immediately evident upon separation from active duty. If the veteran is not "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 or the existence of federal laws, 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 our veterans, old and new, in Alaska.
4. Alaska should explore new medical service concepts for veterans that are far more cost effective than 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 medical 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.

Problems Solved

1. Maximizes use of existing underutilized Alaskan hospital services/beds increasing the operational efficiency of existing private facilities allowing lower service fees especially in rural areas.
2. By bringing back into Alaska's economy the tens of millions of "lost dollars" for medical service now required by the VA outside of Alaska we can inject this significant cash flow through our existing private hospitals and clinics close to the homes of Alaskan veterans.
3. 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.
4. 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, and closer to their homes, for medical care.
5. New expensive Veterans Hospitals and clinics will not have to be built and operated by the federal government causing a drain on existing private hospitals and clinics.
6. 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 and efficient way. This action is also responsive to the general desire of veterans to receive their medical services within their community.
7. Veterans will be allowed/enabled to use existing private facilities based on cost and quality of service in Alaska and in their own communities.
8. No additional land will need to be developed for new hospitals in areas with little land available.
9. Existing VA Clinic employees could shift to other medical service providers, but should remain under VA employment (if they choose) status as their principle area of service is veterans within those facilities.
10. 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 can 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).
11. Existing medical service providers who offer services in demand by veterans can enhance their practices and increase their cost efficiencies.
12. 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.
13. Services can be responsive to demand within established local or state health service markets.

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. How much does the VA spend annually (in air fare, taxi, hotel, meals) to bring veterans from outside of Anchorage to Anchorage for some level of medical services?
4. How often are Alaskans flown in for medical services only to find out that the service is not available because the VA doctor (often flown in from out of state) is not available?
5. What medical/mental health services/treatments are veterans receiving outside of Alaska?
6. What is the total cost/value of these "outside" medical services to the VA annually? **ANSWER: \$17,000,000 in outside healthcare. Number not yet verified in writing.**
7. If these services are available in Alaska, why does the VA send the veteran out of state?
8. 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?
9. 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?
10. How many veterans are served annually in state at VA clinics and hospitals?
11. What is the total cost of medical services (do not include VA Administration) provided by VA in Alaska? **ANSWER: \$38,681,991 in part.**
12. How many veterans receive medical services at private or other than VA facilities in Alaska annually?
13. What is the total cost of medical services received by veterans in Alaska at other than VA facilities?
14. What is the nature of these medical services?
15. What is the cost per patient ratio for VA medical services in Alaska?
16. How many facilities in Alaska currently have reimbursement schedules with the VA?

Library

Additional Support for HJR 33



In Service to America

March 23, 2006
Testimony before the State House
HJR 33

My name is Ric Davidge and I serve as President of the Vietnam Veterans of America, Chapter 904 – the Anchorage Chapter and the largest in Alaska. I also serve as President of the Alaska Veterans Foundation, Inc. a statewide veteran service organization that serves Alaskan War Veterans. And I serve as Vice Chairman of the Anchorage Military & Veterans Affairs Commission.

In 1965 I was a medic with the First Air Cavalry in Vietnam and served honorably for 6 years.

Why do we have this resolution before you and just what does it really do?

I assume you have, in your packet, a copy of the most recent "Talking Paper" that we update regularly about the problems Alaskan veterans face in securing appropriate healthcare. This paper is an open ended discussion of problems that continue to come to light as our working group, made up of a wide range of veterans, VA employees, politicians of both political parties, and medical service professionals, wrestles with the challenges of meeting the moral and legal obligations of our community in the provision of healthcare for our veterans. We would be delighted to add any of you to the email tree we have set up on this issue so that you and your staff are kept informed of any developments. There is much to learn.

As our talking paper points out, the health care of Alaska's veteran's faces serious and difficult structural problems in securing the funding authorized by federal law but not appropriated because veteran healthcare has become a partisan football. Veteran healthcare like so many other federal programs is politically "negotiated," regardless of need, every year unlike healthcare provided to our poor, our homeless, our elderly, and even our illegal aliens. Are not our war veterans at least as deserving as these groups when it comes to healthcare? Are not the men and women who voluntarily stand guard for America worth at least as much to our community?

The other day a member of our legislature said to me, "You know veterans are really just another welfare group." This Alaskan of prominence never served in the military, and clearly does not understand that healthcare for veterans is not "welfare" but the moral, ethical, and legal obligation of our people and our leaders for the service and sacrifices we faced to ensure your liberties. We are only asking for what was promised and appropriate.

As a community of veterans we are tired of all the talk. We are tired of all the political promises. We are tired of receiving healthcare based on "administrative convenience" rather than appropriate care at home. We are tired of being shipped outside of our communities and our state to receive healthcare available right here at home. We are tired and we are angry.

So, why are we here before the State Legislature asking you to direct the Commissioner of Health and Social Services to "talk" to the Veterans Administration about what the state might be able to do to help Alaskan veterans? Yes, that's all we are asking is that our legislature recognize this problem, one that will likely not be solved in Washington DC as it should, but that will continue to harm, even destroy the lives of Alaskan veterans and their families. **72,000 veterans** have chosen to be Alaskans. The highest per-capita in the nation. When extended to their immediate families, we estimate that at least **150,000**

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So, we are asking our State Legislature to direct the Commissioner of Health and Social Services to "talk" with the VA and see if there is something we in Alaska can do to better serve our veterans. That's all.

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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 Alaska's troops are federalized, the state has a moral and ethical obligation to ensure that Alaska's veterans receive adequate and appropriate medical services after leaving active duty.
2. When an Alaskan (guard or reserve), 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 most likely loose his/her income from this nonmilitary employment for years, suffering a significant 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 their family. Then when the Alaskan returns to private life they will likely have to start their health insurance all over again in a new job, 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. We know that all service related injuries are not immediately evident upon separation from active duty. If the veteran is not "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 or the existence of federal laws, 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 our veterans, old and new, in Alaska.
4. Alaska should explore new medical service concepts for veterans that are far more cost effective than 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 medical 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.

Problems Solved

1. Maximizes use of existing underutilized Alaskan hospital services/beds increasing the operational efficiency of existing private facilities allowing lower service fees especially in rural areas.
2. By bringing back into Alaska's economy the tens of millions of "lost dollars" for medical service now required by the VA outside of Alaska we can inject this significant cash flow through our existing private hospitals and clinics close to the homes of Alaskan veterans.
3. 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.
4. 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, and closer to their homes, for medical care.
5. New expensive Veterans Hospitals and clinics will not have to be built and operated by the federal government causing a drain on existing private hospitals and clinics.
6. 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 and efficient way. This action is also responsive to the general desire of veterans to receive their medical services within their community.
7. Veterans will be allowed/enabled to use existing private facilities based on cost and quality of service in Alaska and in their own communities.
8. No additional land will need to be developed for new hospitals in areas with little land available.
9. Existing VA Clinic employees could shift to other medical service providers, but should remain under VA employment (if they choose) status as their principle area of service is veterans within those facilities.
10. 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 can 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).
11. Existing medical service providers who offer services in demand by veterans can enhance their practices and increase their cost efficiencies.
12. 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.
13. Services can be responsive to demand within established local or state health service markets.

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. How much does the VA spend annually (in air fare, taxi, hotel, meals) to bring veterans from outside of Anchorage to Anchorage for some level of medical services?
4. How often are Alaskans flown in for medical services only to find out that the service is not available because the VA doctor (often flown in from out of state) is not available?
5. What medical/mental health services/treatments are veterans receiving outside of Alaska?
6. What is the total cost/value of these "outside" medical services to the VA annually? **ANSWER: \$17,000,000 in outside healthcare. Number not yet verified in writing.**
7. If these services are available in Alaska, why does the VA send the veteran out of state?
8. 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?
9. 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?
10. How many veterans are served annually instate at VA clinics and hospitals?
11. What is the total cost of medical services (do not include VA Administration) provided by VA in Alaska? **ANSWER: \$38,681,991 in part.**
12. How many veterans receive medical services at private or other than VA facilities in Alaska annually?
 3. What is the total cost of medical services received by veterans in Alaska at other than VA facilities?
14. What is the nature of these medical services?
15. What is the cost per patient ratio for VA medical services in Alaska?
16. How many facilities in Alaska currently have reimbursement schedules with the VA?

HJR

36

ALASKA STATE LEGISLATURE

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Session:
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**REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2**

SPONSOR STATEMENT HJR 36 "Taiwan: World Health Assembly"

The World Health Organization (WHO) was created as a way to promote to the highest possible level the general health and wellbeing of all people in the world. This Resolution urges the U.S. Congress to endorse Taiwan's efforts to become an Observer at the World Health Assembly (WHA). This would allow Taiwan to have immediate firsthand information that they can use to promote the health of their people, as well as contribute to international health activities supported by WHO. With a population of 23 million, there is an appropriate need for Taiwan to be included as an Observer to these vital discussions.

SARS and the current strain of avian influenza originated in the East Asian region of the world and threatens the health of all people, regardless of political borders. The information that Taiwan could gather from the World Health Assembly could allow further information, identification, and prevention of more widespread outbreaks of these two potentially pandemic diseases. The strides and achievements that Taiwan has made in the fields of public health can be enhanced by their admission as an Observer to the World Health Organization.

I ask for your support of HJR 36 to encourage the World Health Assembly's acceptance of Taiwan as an Official Observer.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: HJR 36
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: _____
 Title Taiwan: World Health Assembly RDU _____
 Component _____
 Sponsor Representative Peggy Wilson
 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
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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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 4/18/06 8:00 AM
 Approved by: Representative Peggy Wilson Date 4/18/2006
 Agency Chair, House HESS Committee

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[Taken Questions](#)

Office of the Spokesman

Washington, DC

March 20, 2002

[Taken Question from March 20, 2002 Daily Press Briefing](#)

Taiwan: Senate Bill on Observer Status at the World Health Organization

Question: What is the State Department's view on the Senate's adoption of HR 2739, a bill to authorize the Department to initiate a plan to endorse and obtain observer status for Taiwan at the May 13-17 World Health Assembly?

Answer: The Department supports the overall goal of Taiwan's participation in the work of the World Health Organization (WHO) and has long worked closely with Taiwan authorities to advance that objective. We have urged the World Health Organization and its members to find appropriate ways for Taiwan to participate. We will continue to do so.

U.S. policy is to support Taiwan's membership in international organizations where statehood is not an issue. In those organizations in which it cannot be a member, we support finding ways for Taiwan's voice to be heard.

Released on March 20, 2002

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United States Department of State

Washington, D.C. 20520

JAN 27 2006

Dear Mr. Andrews:

Thank you for your letter of December 16, 2005 regarding Taiwan's participation in international efforts to combat avian influenza.

Consistent with our close but unofficial relations with Taiwan, the U.S. Government has made every effort to include Taiwan in the international battle against highly pathogenic avian influenza and a potential influenza pandemic. We have engaged with representatives from Taiwan in the Asia-Pacific Economic Cooperation (APEC) forum – where Taiwan, as a member, has participated fully in a number of meetings on the subject – and have supported Taiwan's bid to obtain observer status in the World Health Assembly. With strong U.S. backing, Taiwan was able to send its CDC director, Steve Kuo, and other experts to represent Taiwan at WHO meetings on avian influenza in Geneva (November 7-9, 2005) and in Tokyo (January 12-13, 2006). Regrettably, China's Ministry of Foreign Affairs rebuffed our attempts to include Taiwan at this week's International Pledging Conference on Avian and Human Pandemic Influenza in Beijing, maintaining that only foreign states, multilateral organizations and NGOs would be invited.

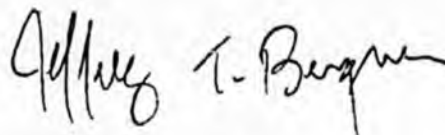
Regarding the International Partnership on Avian and Pandemic Influenza (IPAPI), the Department of State determined that the Partnership could most effectively meet U.S. objectives by ensuring the participation of countries most affected by avian influenza, including the People's Republic of China. However, the United States ensures that Taiwan is fully briefed on all Partnership activities, and we cooperate with Taiwan to identify other areas in which Taiwan can bring its considerable public health resources to bear in the fight against pandemic influenza.

The Honorable
Robert E. Andrews,
House of Representatives.

The U.S. Government will continue to support Taiwan's participation in key international meetings dedicated to fighting avian influenza and to engage with Taiwanese officials through bilateral meetings and workshops. Events such as a meeting between senior staff members of HHS and Steve Kuo to discuss continuing U.S.-Taiwan cooperation on influenza research, as well as a workshop currently under discussion on poultry farming and veterinary aspects of avian influenza to be sponsored jointly by USDA/APHIS and Taiwan's quarantine authorities, attest to the ongoing nature of our commitment.

We share your resolve to ensure that Taiwan is included in the international effort to halt the spread of highly pathogenic avian influenza. Please do not hesitate to contact us if we can be of further assistance in this or any other matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey T. Bergner". The signature is written in a cursive, flowing style.

Jeffrey T. Bergner
Assistant Secretary
Legislative Affairs

Dr. Lee Jong-wook

January 30, 2006

Director General, WHO

Avenue Appia 20

1211 Geneva 27

Switzerland

Dear Director General Lee:

We hope that this letter finds you and your staff well as you face a variety of global health concerns, including avian flu. The current prospect of an avian flu epidemic merits the full involvement of the entire international community. It also serves as another forceful reason for Taiwan's meaningful and effective participation in the activities of the World Health Organization.

The avian flu has struck China and Southeast Asian countries, including Thailand, Vietnam and Indonesia. Commerce between Taiwan and its neighboring countries puts it at risk for importing the virus from an infected area. Taiwan currently employs more than 300,000 foreign workers from Southeast Asia. In 2004, 1.5 million Taiwanese people visited Southeast Asian countries while a half million people from Southeast Asia visited Taiwan. Almost 4 million people from Taiwan visit China annually. Taiwan is also an important transit point for migratory birds, which are the main carriers of the avian flu virus. Approximately one million migratory birds annually pass through Taiwan or reside in Taiwan during the winter season.

Taiwan has thus far been free of the H5N1 strain of the avian flu virus, but is seriously at risk. A less virulent strain of avian flu, H7N3, was found in the droppings of migratory birds in Taiwan. Further, on October 14, 2005, a vessel from China was discovered with 1,037 smuggled pet birds on board. Among the 46 birds randomly selected for tests, 8 were found H5N1 positive. The consequences are unthinkable if the vessel had not been discovered in time.

Taiwan has taken measures to combat bird flu within its borders, but effective efforts will require the engagement of the entire region and the world. It is disturbing that Taiwan has not been given full access to the Global Outbreak Alert and Response Network (GOARN), the Global Influenza Program (GIP), the Global Early Warning and Response System (GLEWS), and the Global Influenza Surveillance System (GISN).

Diseases know no borders. Taiwan cannot afford to be the missing link in this international battle against the avian flu. Even more importantly, the global community cannot afford to leave Taiwan out.

We in the US Congress have passed numerous resolutions supporting Taiwan's WHO participation, and the US government is on record in support of Taiwan's WHO observer status.

We sincerely hope that you will show the leadership necessary to advance this matter. And we will pay close attention to WHO actions in this regard.

Sincerely,

HENRY HYDE

TOM LANTOS

Chairman

Ranking Democratic Member

駐西雅圖台北經濟文化辦事處
Taipei Economic and Cultural Office in Seattle

2001 Sixth Avenue, Suite 2410
Seattle, Washington 98121
Tel (206) 441-4586 Fax : (206) 441-4320

March 28, 2002

The Honorable Brian Porter
Speaker of the House
State of Alaska
716 W. 4th Suite 300
Anchorage, AK 99501-2133

Dear Speaker Porter:

I am writing to solicit your support for Taiwan's participation in the annual summit of the World Health Assembly (WHA), the highest decision-making body of the World Health Organization (WHO), in May 2002 in Geneva, Switzerland.

Taiwan has made substantial achievements in the field of public health and has demonstrated a willingness to provide technical and financial assistance to international aid and health activities supported by the WHO. During the last seven years, Taiwan has contributed \$100 million to 78 countries. A WHO membership is vital to Taiwan since it will gain access to the latest information on epidemics and diseases. While Taiwan has been able to indirectly acquire health information, it is often a case of "too little, too late." For instance, the deaths of those 80 children in Taiwan in 1998 might have been prevented with early-warning reports. To prevent such a tragedy from ever recurring, Taiwan would like to participate in the WHO, even only as an observer.

To echo Taiwan's bid for observer status at the WHA, US House of Representatives passed a bill, H.R. 2739, in December 2001 urging the US to push for Taiwan's participation in the coming WHA annual conference in May 2002. A bill, identical to the one adopted by the House, was unanimously passed by the U.S. Senate on March 19, 2002.

駐西雅圖台北經濟文化辦事處
Taipei Economic and Cultural Office in Seattle

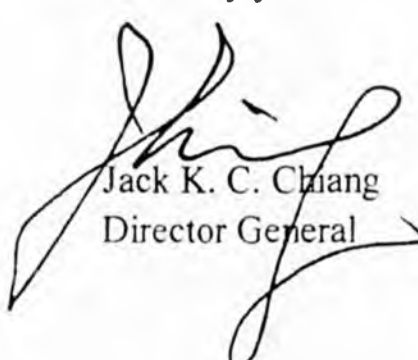
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Indeed, support for Taiwan's participation in the WHO is fairly strong in the United States. For instance, the Nevada State Legislature, South Carolina State Legislature and Georgia State House of Representatives have already passed resolutions supporting for Taiwan's WHO bid. Considering the fact that the state of Alaska and Taiwan are enjoying an amicable and beneficial relationship, I hereby respectfully urge you to show your support for Taiwan's participation in the upcoming WHA annual conference by passing a resolution. If you think there is no possibility to propose a resolution for now, I hope you can write letters to President Bush, Secretary of State Colin Powell and Secretary of Health and Human Services Tommy Thompson to push for Taiwan's bid, preferably with endorsement by your colleagues.

Enclosed please find the bill H.R. 2739 and the resolutions passed by Nevada, South Carolina and Georgia State Legislature for your reference. Please do not hesitate to contact me if you have any questions. Thank you for your great support. I look forward to hearing from you.

With best regards,

Sincerely yours,


Jack K. C. Chiang
Director General

Calendar No. 330

107TH CONGRESS
1ST SESSION**H. R. 2739**

IN THE SENATE OF THE UNITED STATES

DECEMBER 20 (legislative day, DECEMBER 18), 2001

Received; read twice and referred to the Committee on Foreign Relations

MARCH 19, 2002

Reported by Mr. BIDEN, without amendment

AN ACT

To amend Public Law 107-10 to authorize a United States plan to endorse and obtain observer status for Taiwan at the annual summit of the World Health Assembly in May 2002 in Geneva, Switzerland, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. AMENDMENTS TO PUBLIC LAW 107-10.

4 (a) FINDINGS.—Section 1(a) of Public Law 107-10
5 (115 Stat. 17) is amended by adding at the end the fol-
6 lowing:

1 “(12) On May 11, 2001, President Bush stated
2 in his letter to Senator Murkowski that the United
3 States ‘should find opportunities for Taiwan’s voice
4 to be heard in international organizations in order to
5 make a contribution, even if membership is not pos-
6 sible’, further stating that his Administration ‘has
7 focused on finding concrete ways for Taiwan to ben-
8 efit and contribute to the WHO.’.

9 “(13) On May 16, 2001, as part of the United
10 States delegation to the World Health Assembly
11 meeting in Geneva, Switzerland, Secretary of Health
12 and Human Services Tommy Thompson announced
13 to the American International Club the Administra-
14 tion’s support of Taiwan’s participation in the activi-
15 ties of the WHO.”.

16 (b) PLAN.—Section 1(b)(1) of Public Law 107-10
17 (115 Stat. 17) is amended by striking “May 2001” and
18 inserting “May 2002”.

 Passed the House of Representatives December 19,
2001.

Attest:

JEFF TRANDAHL,
Clerk.

107TH CONGRESS
1ST SESSION

H. R. 428

AN ACT

Concerning the participation of Taiwan in the World Health
Organization.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. CONCERNING THE PARTICIPATION OF TAIWAN
2 IN THE WORLD HEALTH ORGANIZATION
3 (WHO).

4 (a) FINDINGS.—The Congress makes the following
5 findings:

6 (1) Good health is a basic right for every citizen
7 of the world and access to the highest standards of
8 health information and services is necessary to help
9 guarantee this right.

10 (2) Direct and unobstructed participation in
11 international health cooperation forums and pro-
12 grams is therefore crucial for all parts of the world,
13 especially with today's greater potential for the
14 cross-border spread of various infectious diseases
15 such as AIDS.

16 (3) Taiwan's population of 23 500,000 people is
17 larger than that of $\frac{3}{4}$ of the member states already
18 in the World Health Organization (WHO).

19 (4) Taiwan's achievements in the field of health
20 are substantial, including one of the highest life ex-
21 pectancy levels in Asia, maternal and infant mor-
22 tality rates comparable to those of western countries,
23 the eradication of such infectious diseases as chol-
24 era, smallpox, and the plague, and the first to be rid
25 of polio and to provide children with free hepatitis
26 B vaccinations.

1 (5) The United States Centers for Disease Con-
2 trol and its Taiwan counterpart agencies have en-
3 joyed close collaboration on a wide range of public
4 health issues.

5 (6) In recent years Taiwan has expressed a will-
6 ingness to assist financially and technically in inter-
7 national aid and health activities supported by the
8 WHO.

9 (7) On January 14, 2001, an earthquake, reg-
10 istering between 7.6 and 7.9 on the Richter scale,
11 struck El Salvador. In response, the Taiwanese gov-
12 ernment sent 2 rescue teams, consisting of 90 indi-
13 viduals specializing in firefighting, medicine, and
14 civil engineering. The Taiwanese Ministry of Foreign
15 Affairs also donated \$200,000 in relief aid to the
16 Salvadoran Government.

17 (8) The World Health Assembly has allowed ob-
18 servers to participate in the activities of the organi-
19 zation, including the Palestine Liberation Organiza-
20 tion in 1974, the Order of Malta, and the Holy See
21 in the early 1950's.

22 (9) The United States, in the 1994 Taiwan Pol-
23 icy Review, declared its intention to support Tai-
24 wan's participation in appropriate international or-
25 ganizations.

1 (10) Public Law 106-137 required the Sec-
2 retary of State to submit a report to the Congress
3 on efforts by the executive branch to support Tai-
4 wan's participation in international organizations, in
5 particular the WHO.

6 (11) In light of all the benefits that Taiwan's
7 participation in the WHO can bring to the state of
8 health not only in Taiwan, but also regionally and
9 globally, Taiwan and its 23,500,000 people should
10 have appropriate and meaningful participation in the
11 WHO.

12 (b) PLAN.—The Secretary of State shall initiate a
13 United States plan to endorse and obtain observer status
14 for Taiwan at the annual week-long summit of the World
15 Health Assembly in May 2001 in Geneva, Switzerland,
16 and shall instruct the United States delegation to Geneva
17 to implement that plan.

18 (c) REPORT.—Not later than 14 days after the date
19 of the enactment of this Act, the Secretary of State shall

- 1 submit a written report to the Congress in unclassified
- 2 form containing the plan required under subsection (b).

Passed the House of Representatives April 24, 2001.

Attest:

Clerk.

SHOW YOUR SUPPORT

TAIWAN
WORLD HEALTH ORGANIZATION
OBSERVER STATUS CANDIDATE

TAIWAN
WORLD HEALTH ORGANIZATION
OBSERVER STATUS CANDIDATE



DISEASE KNOWS NO BORDERS

DISEASE KNOWS NO BORDERS

TAIWANS CONTRIBUTIONS

23 MILLION PEOPLE AT RISK

ENTRY TO THE WHO IS URGENT

BENEFITS TO INTERNATIONAL
COMMUNITY

SHOW YOUR SUPPORT

The World Health Organization is the United Nations organization for health. Taiwan has been excluded from this organization for over three decades, during which, the problems of globally orientated disease have become increasingly serious.



A recent amendment to the WHO constitution stresses on the point universal application. If all humans are to be considered, Taiwan must be included in the World Health Organization.

NAME:
NATIONALITY:
EMAIL:

Sign Petition

Good health is a fundamental right of all humans and the basis of developing a high quality of life. Taiwan has a population of over 23 million, greater than over three quarters of current WHO member states. This population requires access to the latest disease outbreak information and other assistance provided to WHO member states. In return, Taiwan has much to offer the international community.



Diseases do not recognize borders, nor can they differentiate between WHO member states and non-WHO members.

TAIPEI TIMES

Published on TaipeiTimes

<http://www.taipeitimes.com/News/editorials/archives/2006/03/15/2003297488>

Editorial: Grant Taiwan WHO observer status

Wednesday, Mar 15, 2006, Page 8

Last week, the World Health Organization's (WHO) official Web site, which includes Taiwan as part of China, mistakenly showed Taiwan as being affected by bird flu. After protests from Taiwan's Ministry of Foreign Affairs and members of the US Congress, the WHO on Monday distinguished between Taiwan and China, and excluded Taiwan from the infected area on its map.

That the WHO corrected the mistake immediately, pushing aside political considerations, testifies to the organization's professional attitude, and deserves praise. But the incident is yet another warning to Taiwan and the international community. To avoid similar incidents in the future, Taiwan should work to gain the right to attend the World Health Assembly (WHA) in May. The WHO should stop procrastinating and allow Taiwan observer status.

If the WHO had not made the prompt corrections, Taiwan would have been listed as a bird flu-infected area, dealing a serious blow to the tourism, trade and animal foods industries -- despite the fact that not one instance of bird flu has been discovered here. It would also have damaged Taiwan's international image and intensified pressure on the nation's health authorities and the psychological pressure on the general public. This highlights the difference in interests between the two sides of the Taiwan Strait.

Although China claims that Taiwan is part of its territory, border restrictions between the countries remain in place, and the exchange of people, air traffic and goods between the two sides is more strictly controlled than between other countries. The disease prevention measures on each side of the Taiwan Strait are separate, and there are also clear differences in the quality of these measures. Political issues should not be confused with public health issues.

With the whole world under the threat of bird flu, excluding Taiwan from the international network to prevent the spread of infectious diseases may well make it the weak link in the disease prevention chain. This violates the Taiwanese people's fundamental right to medical information. It also weakens the international health network. With Taiwan located so close to China, an area affected by bird flu, the WHO should bolster disease prevention measures by allowing Taiwan to participate in technical discussions. This would prevent a repeat of the SARS crisis, during which Taiwan stood alone.

The WHO's international contagious disease report and response mechanism still excludes Taiwan. Although we can obtain the information via a third party such as the US, direct access to such information from the WHO would be more efficient and reduce the time lag, helping Taiwan to fulfill its responsibility to put in place preventive measures.

Last year, Taiwan strongly supported the addition of the words "universal application" to the International Health Regulations. Last year China also signed a memorandum of understanding with the WHO agreeing to the principle that preventive measures against epidemics have no national boundaries. It also agreed to Taiwan's participation in an avian flu conference in Tokyo. Nevertheless, it barred Taiwan from a similar conference held in Beijing. A country that shows such enmity to Taiwan should not be allowed to become its guardian.

The WHO's basic function is to guarantee global health, and it should operate on the basis of professionalism and international cooperation. Its considerations should exclude political questions such as national sovereignty and focus on health matters. It should therefore grant Taiwan observer status.

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Home >In Focus >More Issues

Latest WHO Bid Gets Support In Washington

Several members of both the U.S. House of Representatives and Senate recently tabled bills that would authorize the secretary of state to propose a resolution on the floor of the forthcoming World Health Assembly (WHA) in support of Taiwan's latest bid to participate in that conference as an observer.

On Feb. 10, Co-chair of the Congressional Taiwan Caucus (CTC) Rep. Sherrod Brown led three other members of the pro-Taiwan group--Reps. Steve Chabot, Robert Wexler and Dana Rohrabacher--in introducing H.R. 3793, a bill concerning Taiwan's participation in the World Health Organization (WHO).

Established in April 2002, the CTC explores ways of strengthening U.S.-Taiwan relations in accordance with the Taiwan Relations Act. The group presently consists of 126 members from the House of Representatives.

"The secretary of state is authorized to initiate a United States plan to endorse and obtain observer status for Taiwan at the annual week-long summit of the World Health Assembly in May 2004 in Geneva, Switzerland; to instruct the United States delegation to Geneva to implement that plan; and to introduce a resolution in support of observer status for Taiwan at the summit of the World Health Assembly," reads the bill, which was referred to the Committee on International Relations.

It was the first time that a bill was introduced to authorize such a resolution at the WHA. The previous bills, tabled annually since 1999, merely urged the secretary of state to develop a strategy to help Taiwan secure observer status at the health summit, and U.S. representatives generally accomplished this by speaking in favor of the island nation on the sidelines of the assembly.

"Good health is important to every citizen of the world," the bill reads, adding that access to the highest standards of medical information and services, and participation in international health-related events, is important for the enhancement of public health.

Taiwan is denied entry into the world health body largely due to obstruction from China. This is despite the increasing risk of cross-border infection by severe epidemics, as evidenced by last year's outbreak of Severe Acute Respiratory Syndrome (SARS), which started in China and spread throughout the world, causing 73 deaths in Taiwan alone. This year the island nation is being threatened by the outbreak of avian flu now ravaging much of Asia.

"The SARS and avian influenza outbreaks illustrate that disease knows no boundaries and emphasize the importance of allowing all people access to the WHO," the bill reads. "As the pace of globalization quickens and the spread of infectious disease accelerates, it is critical that all people, including the people of Taiwan, be given the opportunity to participate in international health organizations such as the WHO." The bill referred to Taiwan's achievements in the field of health as "substantial." Those mentioned in the statement included one of the highest life expectancy levels in Asia, the eradication of cholera and smallpox, and becoming the continent's first country to wipe out polio and provide children with hepatitis B vaccinations.

The bill also cited Taiwan's contribution to the world community as one reason the island democracy and its people deserve "appropriate and meaningful participation in the WHO." For example, Taiwan sent two rescue teams consisting of 90 members specializing in firefighting, medicine and civil engineering to El Salvador after a devastating earthquake hit the Central American country in January 2001.

In addition to donating US\$200,000 in aid to the Salvadoran government, Taipei also pledged US\$1 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria in December 2002 in response to an appeal from the United Nations and the United States for resources to curb the spread of HIV/AIDS, the bill said.

Two days after the introduction of the bill in the House of Representatives, Sen. George Allen, co-chair of the Senate Taiwan Caucus, led 10 senators in introducing a similar bill numbered S. 2092 in the Senate. "It would be tantamount to medical malpractice to continue to exclude Taiwan from participation in the assessment, treatment and cure of SARS and other dangerous diseases in the world," opined Allen.

The government of Taiwan began pushing for participation in the WHO as an observer in 1997 with a view to

safeguarding the health and well-being of its people, despite China's efforts to block this. However, most countries that do business with the communist giant have adopted a "one China" policy, which makes Taiwan's continued efforts to obtain observer status extremely difficult in the absence of worldwide backing.

To sidestep the thorny "one China" problem and thus avoid the sovereignty dispute with China, Taiwan started two years ago promoting the idea of joining the world body as a "health entity." According to Deputy Foreign Minister Michael Kau, who devised the strategy, there are already precedents for non-state entities becoming WHA observers. Palestine and the Order of Malta, for example, are considered "quasi-state entities," while the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies enjoy observer status as "nongovernmental organizations." Although Taiwan's efforts have thus far been in vain, its never-say-die spirit has gradually evoked some response. In recent years, a few governments and international medical bodies, including the European Parliament and Japan, have voiced their support.

On May 11, 2001, U.S. President George W. Bush stated in a letter to Sen. Lisa Murkowski that the United States "should find opportunities for Taiwan's voice to be heard in international organizations in order to make a contribution, even if membership is not possible," adding that his administration has "focused on finding concrete ways for Taiwan to benefit and contribute to the WHO." The Commission of the World Medical Association (WMA) passed a resolution in October 2001 calling on the WHO to grant Taiwan observer status. Likewise, the E.U. Parliament passed a similar resolution the following March, urging the commission and member states to support Taiwan's bid for WHA participation. The E.U. resolution reads, in part, "Taiwan's experience in dealing successfully with important health issues at home can be of benefit not only regionally but also globally." "America's work for a healthy world cuts across political lines. That is why my government supports Taiwan's efforts to gain observership status at the World Health Assembly," indicated Tommy Thompson, secretary of the U.S. Department of Health and Human Services, in a speech at the WMA in May 2002. "We know this is a controversial issue, but we do not shrink from taking a public stance on it. The people of Taiwan deserve the same level of public health as citizens of every nation on Earth, and we support them in their efforts to achieve it," he said.

The U.S. health secretary also voiced support of Taiwan at an official WHA meeting last May. "The need for effective public health exists among all peoples. That's why the United States has strongly supported Taiwan's inclusion in efforts against SARS and beyond," said Thompson in a speech at the assembly's second plenary session. "If we are truly serious about stopping this disease in its tracks, then we cannot ignore millions of people who are at risk. One lesson of SARS is that public health knows no borders--and no politics."

Source: GIO(2004/03/24 17:05:35)

Find this article at: <http://english.www.gov.tw//e-Gov/index.jsp?catid=18&recordid=52681>

SB

42

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: SB 42
 (S) Publish Date: 1/31/05

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title Naturopathic Medicine Task Force RDU Occupational Licensing (117)
 Component Occupational Licensing
 Sponsor Seekins
 Requester Senate Labor and Commerce Component No. 2360

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					

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()	0.0					
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
TOTAL	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)

This legislation establishes in the legislative branch a Task Force on Naturopathic Scope of Practice. The Task Force is terminated on February 1, 2006. New funds are not required by the department to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager Phone (907) 465-2144
 Division Occupational Licensing Date/Time 1/21/05 6:12 PM
 Approved by: Edgar Blatchford, Commissioner Date 1/21/2005
 Agency Commerce, Community & Economic Development

ALASKA STATE SENATE



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Senator_Ralph_Seekins@legis.state.ak.us

Senator Ralph Seekins
District D

MEMORANDUM

Date: February 14, 2005

To: Office of Representative Wilson

From: Senator Ralph Seekins

Re: Request for Hearing of SB 42

AS for BS

Attached please find Senate Bill 42 along with a concomitant sponsor statement and zero fiscal note.

Senate Bill 42 extends the reporting & termination dates for a task force gathered to study naturopathic scope of practice issues. This bill, known as SB 306, was passed during the 23rd Legislature. The task force was unable to complete its work within the time frame provided for in SB 306. Therefore SB 42 simply extends the time allowed for completion.

I respectfully request this bill be scheduled in the Health, Education and Social Services Committee at your earliest convenience. Thank you.

ALASKA STATE SENATE



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Senator Ralph Seekins
District D

Senate Bill 42 Sponsor Statement

“An Act extending the reporting date for and the termination date of the Task Force on Naturopathic Scope of Practice.”

During the 23rd Legislative session SB 306 established a task force to examine various elements and aspects relating to naturopathic physicians' scope of practice. By statute the task force was charged with addressing:

1. comparable educational and training levels of naturopaths and medical doctors;
2. the use of legend or prescription drugs by naturopaths with respect to scope of practice;
3. non-pharmacological treatments by naturopaths including minor surgery;
4. collaborative protocols and agreements between naturopaths and medical doctors;
5. joint liability issues between collaborating practitioners; and,
6. other issues of relevance.

SB 306 established that the task force would consist of nine voting members. These are as follows:

1. Alex Malter, MD representing the Alaska State Medical Association;
2. Richard Holm, RPh representing the Alaska Pharmacist Association;
3. Robert Breffeilh, MD representing the Alaska State Medical Board;
4. Cathy Giessel, MSN FNP-CS representing Nurse Practitioners;
5. Jason Harmon, ND representing licensed Naturopaths;
6. Scott Luper, ND representing licensed Naturopaths;
7. Rick Urion, Director of the Division of Occupational Licensing,
8. Lesil McGuire, Alaska State Representative for District 28; and,
9. Ralph Seekins, Alaska State Senator for District D.

The task force was unable to complete its business within the time parameters specified in SB 306. Consequently, SB 42 extends the task force's charge into 2005. In fact, SB 42 is identical to the previous bill except for the report and termination dates which have been changed to December 1, 2005 and February 1, 2006, respectively.

SB

48

24-LS0708\X

Mischel

5/5/06

HOUSE CS FOR CS FOR SENATE BILL NO. 48(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): SENATORS DAVIS, Huggins, Cowdery, Guess, French, Seekins, Elton, Kookesh, Wagoner, Therriault, Ben Stevens

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to recommending or refusing psychotropic drugs or certain types of**
2 **evaluations or treatments for children."**

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

4 *** Section 1. AS 14.30 is amended by adding new sections to read:**

5 **Article 2A. Psychiatric and Behavioral Evaluations and Treatments.**

6 **Sec. 14.30.171. Prohibited actions.** (a) Except as provided in AS 14.30.172 -
7 14.30.176, school personnel may not, unless otherwise authorized by law or a specific
8 policy adopted by a governing body of a school district,

9 (1) recommend to a parent or guardian that a child take or continue to
10 take a psychotropic drug as a condition for attending a public school;

11 (2) require that a child take or continue to take a psychotropic drug as a
12 condition for attending a public school, except when, in the opinion of the child's
13 treating physician,

14 (A) the medication is necessary for the mental health of the

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child; or

(3) the child poses a risk of harm to self or others without the medication;

(3) conduct a psychiatric evaluation of a child;

(4) recommend a specific licensed physician, psychologist, or other health specialist to a parent or guardian for a child;

(5) recommend that a parent or guardian seek or use for a child

(A) a psychotropic medication; or

(B) a psychiatric or psychological treatment; or

(6) make a report of suspected child abuse or neglect to authorities, including the Department of Health and Social Services, based solely on the fact that a parent or guardian refuses to give signed consent for

(A) the administration of a psychotropic drug to a child; or

(B) a psychiatric, psychological, or behavioral treatment of a

child.

(b) As used in this section, "school personnel" means persons employed by a public school or school district to work in a public school, except for a person who holds a special services type C certificate issued under AS 14.20 that qualifies the person to be employed to provide related services to students, as described in regulations adopted by the board.

Sec. 14.30.172. Communication not prohibited. (a) Nothing in AS 14.30.171 may be construed to prohibit school personnel from

(1) consulting or sharing classroom-based observations with parents or guardians regarding a student's academic and functional performance, behavior in the classroom or school, or regarding the need for evaluation for special education or related services as long as school personnel do not make an assertion or recommendation that violates AS 14.30.171; or

(2) exercising their authority relating to the placement within the school or readmission of a child who may be or has been suspended or expelled for a violation of a school disciplinary and safety program adopted under AS 14.03.160, AS 14.30.045, or AS 14.33.110 - 14.33.140.

1 (b) Nothing in AS 14.30.171 may be construed to prevent teachers or other
2 school personnel from complying with the requirements of AS 47.17.020 or from
3 filing a report to authorities if a child poses a serious and imminent risk to the child's
4 or another person's safety.

5 **Sec. 14.30.174. Compliance with federal education law.** (a) Notwithstanding
6 AS 14.30.171(a)(3) and (5), a behavioral or mental health professional working within
7 a public school system may, in compliance with federal education law or applicable
8 state law,

9 (1) recommend, but not require, a psychiatric or behavioral health
10 evaluation of a child;

11 (2) recommend, but not require, psychiatric, psychological, or
12 behavioral treatment for a child; and

13 (3) conduct a psychiatric or behavioral health evaluation of a child
14 with the consent of the child's parent or guardian.

15 (b) In this section,

16 (1) "behavioral health professional" means a person who has a master's
17 degree in psychology, social work, counseling, or a related field with specialization or
18 experience in working with children experiencing behavioral, physical, and emotional
19 disabilities, and is working within the scope of the person's training and experience;

20 (2) "federal education law" means 20 U.S.C. 1400 - 1487 (Individuals
21 with Disabilities Education Act), 20 U.S.C. 7101 - 7143 (Safe and Drug-Free Schools
22 and Communities Act of 1994), 29 U.S.C. 794 (nondiscrimination under federal grants
23 and programs), and 42 U.S.C. 12101 - 12213 (equal opportunity for individuals with
24 disabilities);

25 (3) "mental health professional" has the meaning given in
26 AS 47.30.915.

27 **Sec. 14.30.176. List of community resources.** Notwithstanding
28 AS 14.30.171(a)(4), a school district may make available to an interested parent or
29 guardian a list of community resources, including mental health services if the list
30 conspicuously states the following: "This list is provided as a resource to you. The
31 school neither recommends nor requires that you use this list or any of the services

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provided by individuals or entities on the list. It is for you to decide what services, if any, to use and from whom you wish to obtain them."

Sec. 14.30.177. Violations. Each school board shall adopt a policy that provides for disciplinary action against a person employed by the school district for a violation of AS 14.30.171 - 14.30.176.

Sec. 14.30.179. Definition. In AS 14.30.171 - 14.30.179, "public school" means a school operated by publicly elected or appointed school officials in which the program and activities are under the control of those officials and that is supported by public funds.

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Senator Bettye Davis

Senate Bill SB 48

"An Act relating to recommending or refusing psychotropic drugs as a treatment for children and to the evaluation and treatment of children with behavioral or psychological problems."

Sponsor Statement

The use of psychiatric drugs in our nation's schools has more than doubled in the first half of the last decade and continues to escalate. There are documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline, which may be related to a variety of causation. There is also parental concern regarding the issue of diagnosis and medication and their impact on student achievement.

In it's simplest terms this bill basically states that a public school may not deny any student access to programs or services simply because the parent of the student has refused to place the student on psychotropic medications, get a psychiatric evaluation or seek psychiatric or psychological treatment for a child.

It also spells out what communications are allowed, who can do evaluations and the protections a parent or guardian has against being reported to OCS simply because they disagree with psychotropic medications.

Provisions to allow behavioral, psychological or psychiatric screening by those qualified to do so, with parental consent are preserved.

Communication between school employees on behavioral and learning issues concerning the child are preserved.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: CSSB 48(HES)
 (S) Publish Date: 4/13/06

Revision Date/Time (Note if correction): _____ Dept. Affected: Education & Early Development
 Title: *An Act relating to recommending or refusing RDU: Teaching & Learning Support
psychotropic drugs . . . Component: Student and School Achievement
 Sponsor: Davis
 Requester: HESS Component No.: 2796

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	*	*	*	*	*	*

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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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	*	*	*	*	*	*

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)

HB 48 describes specific actions and communications in which school personnel may or may not engage related to psychiatric and behavioral evaluations and treatments. School personnel are prohibited from recommending or requiring that a child take or continue to take a psychotropic drug as a condition for attending school; conducting a psychiatric or behavioral evaluation of a child; recommending a specific physician, psychologist or other health specialist to a parent or guardian; recommending that the parent take a specific course of medical or psychiatric action, and reporting suspected child abuse or neglect based solely on whether a parent or guardian refuses to consent to a course of medical, psychiatric, psychological, or behavioral treatment or evaluation.

Costs for school districts to implement provisions of this bill are indeterminate.

Prepared by: Barbara Thompson, Director
 Division: Teaching & Learning Support
 Approved by: Karen Rehfeld, Deputy Commissioner
 Agency: Education & Early Development

Phone: 465-8727
 Date/Time: 3/31/06 12:30 p.m.
 Date: 03/31/2006

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 2
 Bill Version: CSSB 48/HES
 (S) Publish Date: 4/13/06
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title REFUSING PSYCHOTROPIC DRUGS AND TREATMENTS FOR CHILDREN

RDU Children's Services

Component Front Line Social Workers

Sponsor DAVIS

Requester SENATE (HES)

Component No. 2305

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						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2006) cost: _____

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB 48 proposes to accomplish three major things: 1) prohibit public schools from recommending mental health services and/or psychotropic medication for students; 2) prohibit public schools from reporting suspected abuse or neglect if the only concern is that a parent or guardian refuses to consent to proper mental health treatment for a child; and, 3) prohibit the DHSS from taking custody based solely on a parent or guardian's refusal to consent to proper mental health treatment for a child. There would be no fiscal impact to the department.

Prepared by: Tammy Sandoval, Deputy Commissioner
 Division: Office of Children's Services
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone: 465-3191
 Date/Time: 03/31/2006
 Date: 03/31/2006

Journal Text for SB48 in the 24th Legislature

Full Journal

04-26-2006

Senate Journal

2949

SB 48

Senator Bunde requested that the reconsideration on CS FOR SENATE BILL NO. 48(HES) "An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children" be taken up. The bill was before the Senate on reconsideration.

Senator Bunde moved that the bill be returned to second reading for the purpose of a specific amendment, that being Amendment No. 1. Without objection, the bill was returned to second reading.

Senator Bunde offered Amendment No. 1:

Page 3, following line 21:

Insert a new section to read:

"Sec. 14.30.175. At risk students. Notwithstanding AS 14.30.171(3) and (5) and 14.30.174(a), a principal or other person in charge of a public school who reasonably believes that a student is at risk of causing harm to self or others, may require a psychiatric or behavioral health evaluation of a child."

Senator Bunde moved for the adoption of Amendment No. 1. Senator Davis objected.

The question being: "Shall Amendment No. 1 be adopted?" The roll was taken with the following result:

CSSB 48(HES)
Second Reading
Amendment No. 1

YEAS: 6 NAYS: 14 EXCUSED: 0 ABSENT: 0

Yeas: Bunde, Green, Stedman, Stevens G, Therriault, Wilken

Nays: Cowdery, Davis, Dyson, Ellis, Elton, French, Guess, Hoffman, Huggins, Kookesh, Olson, Seekins, Stevens B, Wagoner

and so, Amendment No. 1 failed.

04-26-2006

Senate Journal

2950

CS FOR SENATE BILL NO. 48(HES) was automatically in third reading on reconsideration.

The question to be reconsidered: "Shall CS FOR SENATE BILL NO. 48(HES) "An Act relating to recommending or refusing psychotropic drugs or certain types of evaluations or treatments for children" pass the Senate?" The roll was taken with the following result:

CSSB 48(HES)
Third Reading - On Reconsideration

YEAS: 16 NAYS: 4 EXCUSED: 0 ABSENT: 0

Yeas: Cowdery, Davis, Dyson, Ellis, Elton, French, Guess, Hoffman, Huggins, Kookesh, Olson, Seekins, Stedman, Stevens B, Stevens G, Wagoner

Nays: Bunde, Green, Therriault, Wilken

Therriault changed from "Yea" to "Nay".

and so, CS FOR SENATE BILL NO. 48(HES) passed the Senate on reconsideration and was referred to the Secretary for engrossment.

Bill Root:

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SB 48

Similar Legislation

Available Bills

Category	Bill #	Summary	Status
Children	<u>AK SB 0048</u>	PSYCH. EVALUATION/TREATMENT FOR STUDENTS	introduced
Children	<u>FL HB 0209</u>	Contains the following provisions: 1) A recipient of state funds shall not require a student to be prescribed or administered any psychotropic medication as a condition of such student receiving educational or school-based services; 2) A psychotropic medication shall not be administered to a student on school premises except by a licensed health care professional and in compliance with HIPPA; and 3) A school or school district personnel shall not initiate, or make a referral for, diagnosis or treatment of a student for any disorder listed in the Diagnostic and Statistical Manual of Mental Disorders or in ICD-10.	passed house committee
Children	<u>FL SB 1090</u>	Minors/Psychotropic Medication	passed senate committee
Children	<u>FL SB 1766</u>	School Students/Psychotropic Med	introduced
Children	<u>GA SR 0128</u>	Mental Health Screening; urge GA Congressional Delegation to oppose	introduced
Children	<u>NH HB 0240</u>	relative to psychotropic drugs and child protection.	passed house committee
Children	<u>NM S.JM 0052</u>	STUDY PRESCRIPTION DRUGS FOR CHILD BEHAVIOR	enacted
Children	<u>NY AB 1132</u>	Directs the commissioner of education to establish rules and regulations prohibiting school personnel from recommending psychotropic drugs for children.	introduced
Children	<u>NY AB 5043</u>	Restricts recommendations for psychotropic drugs.	introduced
Children	<u>NY SB 2900</u>	Directs the commissioner of education to establish rules and regulations prohibiting school personnel from recommending psychotropic drugs for children.	introduced
Children	<u>PA HB 0591</u>	An Act amending the act of March 10 1949 (P.L.30 No.14) known as the Public School Code of 1949 prohibiting school officials or employees from recommending that a child use psychotropic or sympathomimetic drugs.	introduced
Children	<u>TN HB 0580</u>	Students - Prohibits school personnel from recommending psychotropic drugs such as Ritalin to treat elementary and secondary school students for behavioral concerns. - Amends TCA Title 49 Chapter 6 Part 50.	hearing held
Children	<u>UT HB 0042</u>	Prohibits school personnel from making certain medical recommendations for a minor, including the use of psychotropic drugs; prohibits consideration of a petition for removal of a minor and removal of a minor from parental custody based on a parent's refusal to consent to the administration of psychotropic drugs.	passed house & senate
Children	<u>VT HB 0074</u>	PSYCHOTROPIC DRUGS AND SPECIAL NEEDS SERVICES FOR CHILDREN	introduced
Children, Medications Access, Mental Health	<u>NY AB 5885</u>	Authorizes and directs the department of health to conduct a study on drugs prescribed for school-age children with ADD.	introduced

Fight For Kids Day

1999-2003

» Bills and Resolutions

U.S. BILLS & RESOLUTIONS INTRODUCED OR PASSED AGAINST COERCIVE PSYCHIATRIC LABELING & DRUGGING OF CHILDREN

In 1999, the Colorado State Board of Education passed a precedent-setting Resolution that asked school personnel to use academic rather than drug solutions to resolve problems with behavior, attention and learning. Since then, state legislatures, school boards and national organizations have responded to the need to protect children from arbitrary and forced psychiatric labeling and drugging, and to monitor the prescription rate of stimulants and other psychiatric drugs for children.

In 2001, two precedent-setting laws were passed in Connecticut and Minnesota that prevent school personnel from coercing or recommending that parents drug their children, especially as a requisite for remaining in class. Laws have also been necessary to protect parents against criminal charges being threatened or laid if they refuse to put their child on a mind-altering psychiatric drug.

1999: The Colorado State Board of Education resolution stated, "*There are documented incidents of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline which may be related to lack of academic success; and be it resolved that the State Board of Education encourage school personnel to use proven academic and/or classroom management solutions to resolve behavior, attention, and learning difficulties....*"

2000: The Texas State Board of Education Resolution recommended, "*that programs such as tutoring, vision testing, phonics, nutritional guidance, medical examinations, allergy testing, standard disciplinary procedures, and other remedies known to be effective and harmless, be recommended to parents as their options....*"

2001: Four laws were passed in the states of Connecticut, Minnesota, North Carolina and Utah, and the Hawaii legislature passed a Resolution. The Connecticut law prohibited school personnel from recommending the use of psychotropic drugs for any child.

2002: Illinois and Virginia passed laws with similar protections provided in Connecticut's law. Illinois' law required school boards to adopt and implement policy prohibiting disciplinary action being taken against parents or guardians for refusing to administer, or consenting to administer, a psychotropic or stimulant drug. The law in Virginia directed the Board of Education to develop and implement policies prohibiting school personnel from recommending the use of psychotropic drugs for any student. The National Foundation of Women Legislators (NFWL) passed a resolution calling on the federal government to pass regulations or laws in relation to schools receiving federal funds that protect children from being wrongly diagnosed and stigmatized as mentally disordered and forced onto psychotropic drugs as a requirement of their education. The American Legislative Exchange Council (ALEC) also proposed two pieces of model legislation, one against schools coercing parents to drug their children (or recommending drugs) and the other against invasive psychological testing and questionnaires.

2003: A federal bill was introduced—HR 1170—which states that as a condition of receiving federal funds under any program or activity administered by the U.S. Secretary of Education, each state shall develop and implement policies and procedures prohibiting school personnel from requiring a child to obtain a prescription for substances covered by

section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) as a condition of attending school or receiving services. [Covers those psychotropic drugs which are generally subject to special provisions because of their potential for abuse and dependence. They are grouped into five "Schedules" based on their abuse potential. Schedule I means those drugs that have a high abuse potential and no accepted medical use in the United States such as heroin, LSD, and mescaline; Schedule II means those drugs with a medical use that have the highest potential for abuse or drug dependence such as Ritalin, Concerta (methylphenidate), Dexedrine, morphine and cocaine; Schedules III-V includes those drugs that have an accepted medical use and lower degrees of potential for abuse and dependence such as vicodin, valium and over-the-counter cough medicines with codeine.] HR 1170 was passed by the House, by an overwhelming margin of 425 votes to one, on May 21, 2003. It is now with the Senate Committee on Health, Education, Labor and Pensions.

An amendment was also added to House of Representatives Bill 1350, the "Improving Education Results for Children with Disabilities Act of 2003," that amends and reauthorizes the Individuals with Disabilities in Education Act. The amendment reads, "PROHIBITION ON PSYCHOTROPIC MEDICATION," and essentially uses similar wording to that in HR 1170, but covering special education. HR 1350 passed the House on April 30 and was received in the Senate and referred to the Committee on Health, Education, Labor, and Pensions May 1, 2003.

On a state level, fifteen states introduced 24 bills and/or resolutions in 2003. These were Alaska, California, Colorado, Hawaii, Indiana, Kentucky, Massachusetts, Michigan, New Hampshire, New York, North Carolina, Oregon, Texas, Vermont and West Virginia. Colorado enacted a law on June 5, 2003, requiring school boards to adopt a policy prohibiting school personnel from recommending or requiring the use of a psychotropic drug for any student.

1999:

State	Description	Introduced	Active	Passed
Colorado State Board of Education Resolution	Resolution promoting the use of academic solutions to resolve problems with behavior, attention and learning in the classroom.	10/99	PASSED	11/11/99
National Black Caucus Of State Legislators	Resolution strongly urges a national examination of the use of psychotropic drugs and their effects on children.	12/01/99	PASSED	12/03/99

2000:

State	Description	Introduced	Active	Passed
Georgia R 1079	The General Assembly of Georgia creates the Commission on Psychiatric Medication of School-Age Children, to investigate the usage and effects of psychiatric drugs on children and to provide recommendations for improved monitoring of	02/16/00	PASSED	05/01/00

	the prescription rate of these drugs.			
<u>Texas</u> State Board of Education Resolution	Resolution urging local school personnel to use proven academic and/or management solutions to resolve behavior, attention and learning difficulties such as exams, tutoring, phonics, vision testing, etc., known to be effective and harmless.	11/01/00	PASSED	11/03/00
<u>Washington</u> HB 2912	An act relating to the use of psychiatric "medication" by children in state custody, and tracking the number of children being diagnosed and placed on psychiatric "medications."	01/21/00	PASSED	03/24/00

2001:

State	Description	Introduced	Active	Passed
<u>Connecticut</u> AB 5701	Prohibits school personnel from recommending the use of psychotropic drugs for any child. A parent or guardian refusing to administer, or consenting to administer, a psychotropic or stimulant cannot be grounds for a child to be taken into the custody of the Dept. of Child and Family Services.	01/12/01	PASSED	06/28/01
<u>Hawaii</u> SC Resolution 92	Requests the Department of Health and Department of Education jointly to research and examine non-"medication" alternatives for dealing with children who have learning and behavioral difficulties.	03/14/01	PASSED	04/12/01
<u>Minnesota</u> HB 478	Parents' refusal to give stimulant drugs to a child does not constitute educational neglect. States that a child does not have to take such drugs as a condition for re-admission to school after having been suspended. Also establishes a study and report system on the number of children in the	02/01/01	PASSED	05/01/01