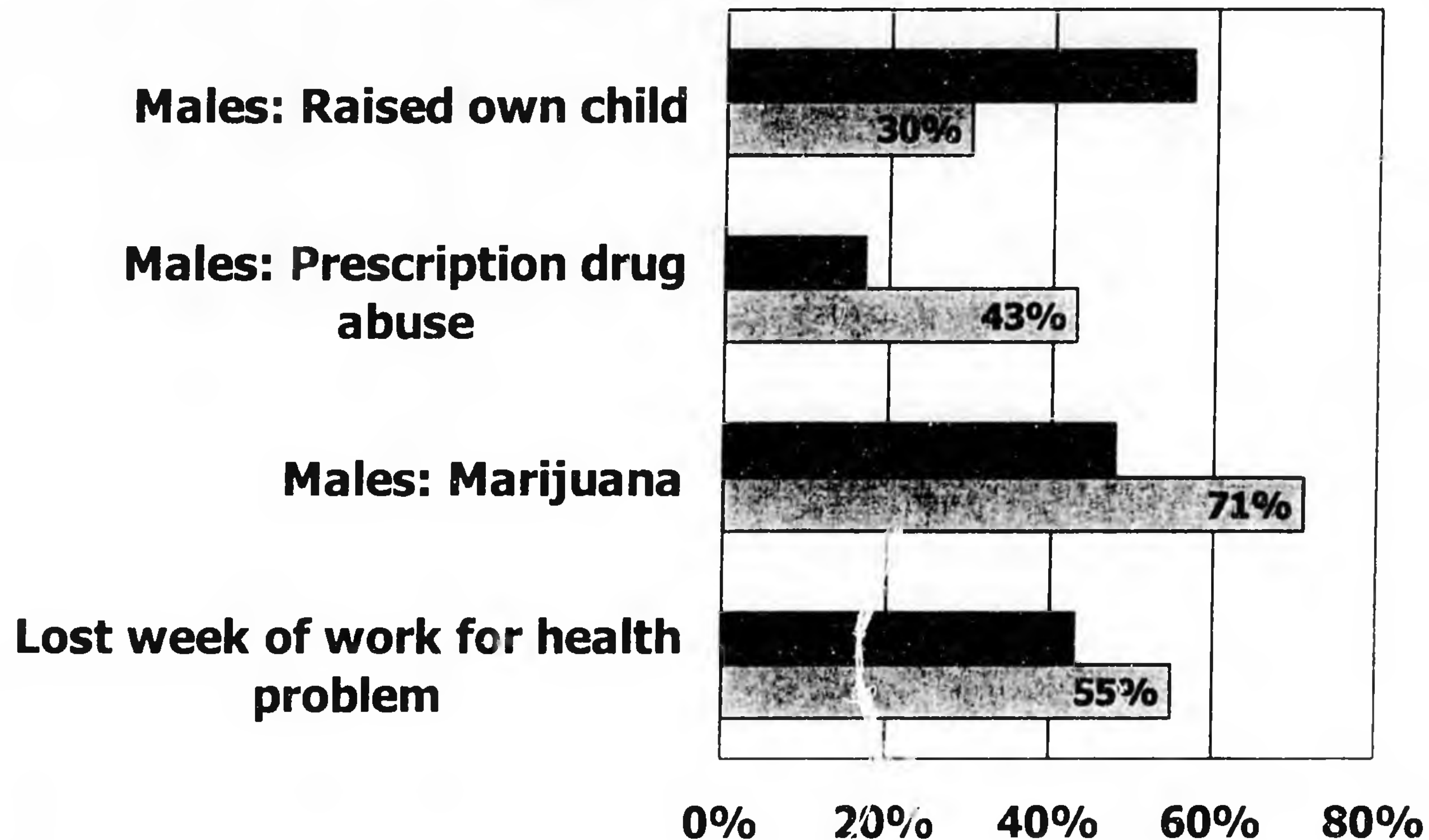
12137 HOUSE HESS

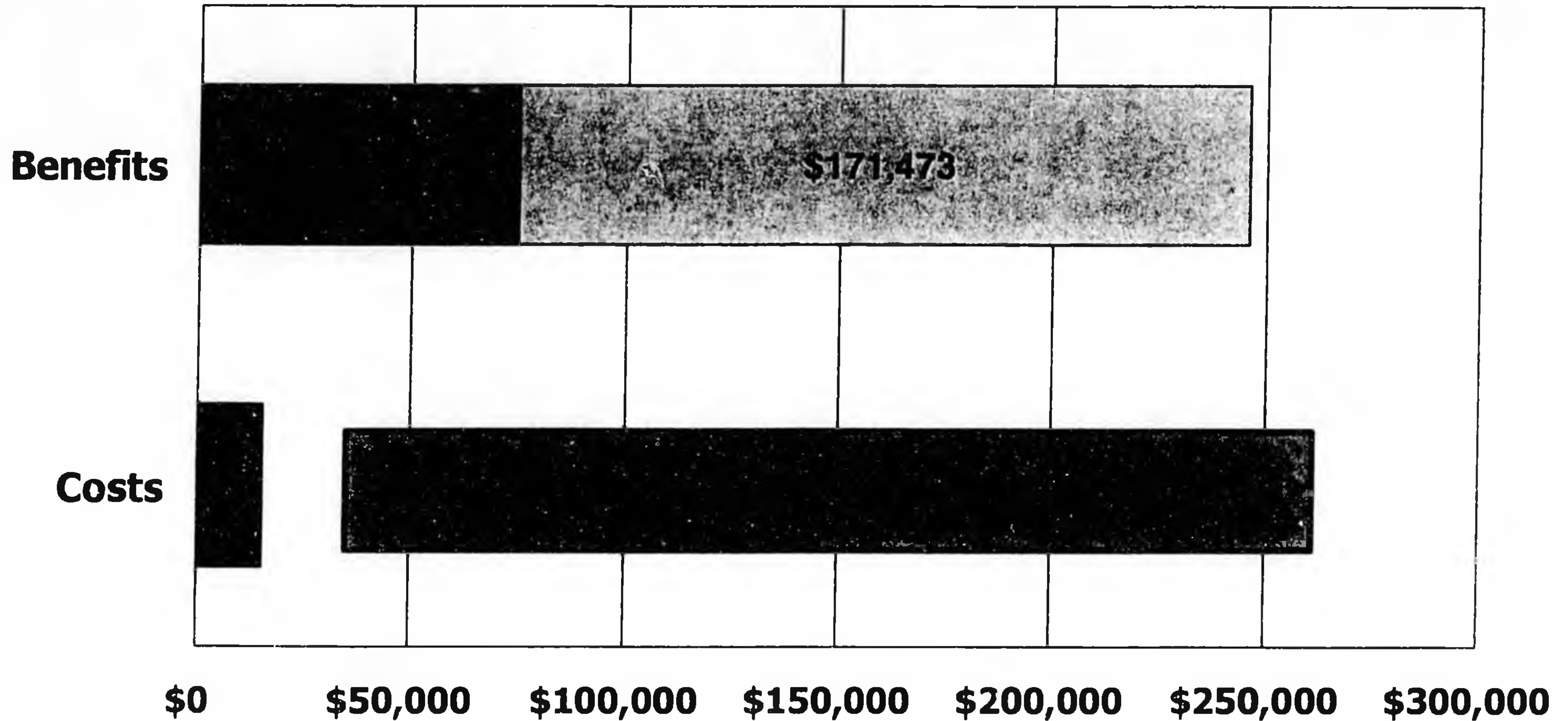
Better health and family relations



Large return on investment

(Per participant in 2000 constant dollars discounted 3% annually)

Welfare Education Earnings Taxes paid Crime



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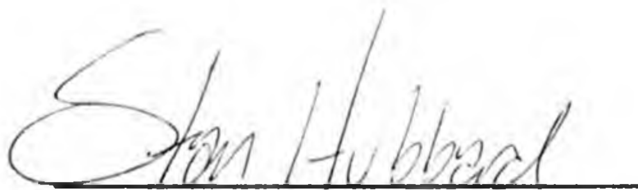

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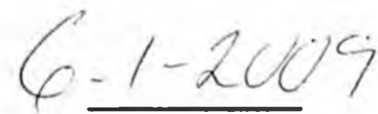

Date

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SJR

1

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
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Senator Bettye Davis

SJR 1 " Relating to reauthorization of federal funding for children's health insurance; and encouraging the Governor to support additional funding for and access to children's health insurance."

Sponsor Statement

SJR 1 Medical Assistance for Children, states that the Alaska State Legislature urges our Congressional delegation to work diligently to achieve a timely reauthorization of the State Children's Health Insurance Program and to continue federal medical assistance percentages (or FMAP) for the Denali KidCare program.

Denali KidCare is Alaska's version of the State Children's Health Insurance program or SCHIP which was created in 1997 and is slated for reauthorization this year. It has been and continues to be a successful federal-state partnership, now covering over 4 million low-income children and enjoying bipartisan support. However, in the upcoming federal fiscal year, 17-18 states, among them Alaska, are projected to have insufficient federal SCHIP funding to sustain their existing SCHIP programs.

According to various estimates by the Centers for Medicare and Medicaid Services, the Congressional Research Service and other independent analysts, these states will face an estimated $800 to $950 million in total funding shortfalls in 2007. Here in Alaska that shortfall could total over $12 Million.

Without additional federal funding to avert these shortfalls, Alaska, along with other states may have to reduce their SCHIP enrollment, placing health insurance coverage nationally for over *500,000* low-income children at risk. States may also be forced to enact harmful changes to their SCHIP programs, such as curtailing benefits, increasing beneficiary cost-sharing or reducing provider payments.

Congress has acted in the past to address SCHIP shortfalls successfully and can do so again.

To that end, just this last Friday, February 23rd, a bipartisan group of lawmakers announced their proposal to extend health insurance to an additional 9 million children in the US. Backed by a broad consumer and industry coalition, the Healthy Kids Act of 2007 would authorize $50 billion over five years to expand the SCHIP and Medicaid program. The proposal would also provide $10 billon for refundable tax credits to help families with annual incomes of up to 350 percent of the federal poverty level (FPL) purchase health insurance that covers children if they are not eligible for SCHIP.

We ask your support of SJR 1 to add the Alaska State Legislature to the many voices urging our delegation and the rest of Congress to enact legislation immediately that provides additional funding to ensure that all states have sufficient federal funding to sustain their existing SCHIP programs in FY 2007.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SJR 1
() Publish Date:

Revision Date/Time (Note if correction):
Title: SJR 1Medical Assistance for Children
Sponsor: Senator Davis
Requester: (S) Health, Education & Social Services Committee

Dept. Affected:
RDU
Component
Component No.

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2007) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

Prepared by: (S) HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE Phone 465-3822
Division Date/Time
Approved by: /s/ Senator Bettye Davis, Chair Date 2/25/2007
Agency

(Revised 9/18/2006 OMB)

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Revised February 22, 2007

FOURTEEN STATES FACE SCHIP SHORTFALLS THIS YEAR TOTALING OVER $700 MILLION

By Edwin Park and Matt Broaddus

New estimates, based on the latest available data, show that 14 states face federal funding shortfalls this year in the State Children's Health Insurance Program. These states lack sufficient federal funding to maintain current enrollment levels through the end of fiscal year 2007. The shortfalls in these states total more than $700 million. (The Congressional Research Service has produced very similar estimates.)

The 14 states are Alaska, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Rhode Island and Wisconsin.

These figures reflect the shortfalls that remain after the effect of a provision enacted in December 2006 is taken into account. Shortly before adjourning in December, Congress approved legislation (H.R. 6164) that contained a modest provision to delay the onset of the shortfalls. Under the SCHIP provision of H.R. 6164, some unspent federal SCHIP funds from prior fiscal years will be distributed to seven of the 14 states and will delay the shortfalls until early May.

Congress will need to act expeditiously to enact further SCHIP legislation that provides additional funding to address the substantial shortfalls that remain. Otherwise, the affected states will be forced to scale back their SCHIP programs, placing several hundred thousand low-income children at risk of losing health care coverage, unless these states can come up with sufficient new state funds to fully plug the holes.

In fact, the state of Georgia, which faces an estimated shortfall of $124 million, has already announced that effective March 11, it will bar any new children from enrolling in the program. Georgia will thereby cut the number of children that it insures through the program, since children who leave the program (as their families' incomes rise or when children exceed the program's age limit) will no longer be replaced with newly participating children.

The SCHIP Provision Enacted in December 2006

The SCHIP provision of H.R. 6164 was intended to partially address the fiscal year 2007 SCHIP funding shortfalls. It altered the scheduled redistribution of unspent fiscal year 2004 SCHIP funds, and targeted those unspent funds entirely on states that face shortfalls in 2007. These unspent 2004 funds will be redistributed among the shortfall states on a monthly basis, with the funds being allocated among these states in the order in which the states otherwise would encounter shortfalls.

H.R. 6164 Would Restrict Use of SCHIP Funds for Parents by Shortfall States in 2007

H.R. 6164 includes a restriction on the use of the unspent fiscal year 2004 and 2005 funds that will be redistributed to shortfall states. Shortfall states that cover low-income parents through SCHIP and that receive some of the reallocated 2004 and 2005 funds will be able to use those funds for coverage of parents only at the regular federal Medicaid matching rate, which is about 13 percentage points lower, on average, than the SCHIP matching rate. This will have the effect of artificially reducing the size of the shortfall in these states — by reducing their projected need for *federal* SCHIP by about $24.7 million and increasing the amount of *state* funds that these states will have to provide by the same amount.

If this restriction were *not* applied, three of the seven states that are projected to face shortfalls first — Illinois, New Jersey and Rhode Island — would still face shortfalls of $24.7 million through early May. To the extent these three states address those shortfalls by reducing coverage of parents, the loss of coverage is likely not only to cause many of the parents losing coverage to become uninsured but also to affect children's coverage. An extensive body of research demonstrates that covering low-income parents increases enrollment in public programs among eligible children. Scaling-back SCHIP coverage of parents consequently would be likely also to result in reduced coverage for low-income children in these states.[*]

[*] See Leighton Ku and Matthew Broaddus, "Coverage of Parents Helps Children Too," Center on Budget and Policy Priorities, October 20, 2006.

Under H.R. 6164, a portion of the SCHIP funds originally allocated in *fiscal year 2005* that remain unspent after March 31, 2007 also will be redistributed to shortfall states (again, in the order in which these states encounter shortfalls). Here, too, the funds will be redistributed on a monthly basis, until they are depleted.

The SCHIP provision of H.R. 6164 will provide an estimated $271.3 million to the seven shortfall states that are expected to face shortfalls first — Alaska, Georgia, Illinois, Maryland, Massachusetts, New Jersey and Rhode Island.[1] (The other shortfall states will *not* receive any funds under H.R. 6164.) This should postpone the onset of shortfalls in these seven states until early May 2007.[2] The total amount of funds made available to shortfall states under H.R. 6164 will, however, be only about one-fourth of the amount needed to fully close the 2007 shortfalls, and a projected shortfall of $744.4 million will remain among the 14 shortfall states.[3] (See Table 1 for the estimated remaining fiscal year 2007 shortfalls in each of the 14 states.) The Congressional Research Service has issued nearly identical estimates.[4] This remaining shortfall is equivalent to the annual, average cost of covering approximately 510,000 children under SCHIP in 2007.

[1] Our estimates are derived from the Center on Budget and Policy Priorities' SCHIP financing model and incorporate states' final SCHIP spending estimates from November 2006. The $271.3 million figure includes a projected $146.9 million in unspent 2004 funds and a projected $124.4 million in unspent 2005 funds.

[2] Shortfall states that provide SCHIP coverage to parents are likely to experience limited shortfalls *prior* to early May, see the box on this page.

[3] Taking into account the restriction in H.R. 6164 on parents' coverage, which artificially reduces the size of the shortfall by $24.7 million (see the box on page 2), the remaining shortfall will be reduced from $744.4 million to $719.7 million.

[4] See Chris Peterson, "SCHIP Provisions of H.R. 6164 (NIH Reform Act of 2006)," Congressional Research Service, Updated December 13, 2006 and Chris Peterson, "Funding Projections and State Redistribution Issues," Congressional Research Service, Updated January 30, 2007. CRS estimates that H.R. 6164 will provide $271.3 million to six shortfall states, leaving a remaining shortfall of $744.5 million in fiscal year 2007. Both the $271.3 million figure and the $744.5 million figure are virtually identical to our estimates. CRS, however, has somewhat different estimates then we do of the effect of the restriction on the use by shortfall states of redistributed SCHIP funds for parents.

A Stop-Gap Measure

Passage of the SCHIP provision of H.R. 6164 in December 2006 was a welcome development, but H.R. 6164 is only a stop-gap measure. To close the remaining shortfall, Congress will need to act.

If Congress does not do so, the 14 shortfall states will have to cut their SCHIP programs — by reducing eligibility, shrinking enrollment, scaling back benefits, increasing cost-sharing and/or cutting payments to health care providers — unless these states can come up with the additional funds themselves. One of the shortfall states, Georgia, has already announced an enrollment freeze.

As noted, effective March 11, the Georgia SCHIP program (known as PeachCare for Kids) will no longer enroll any additional eligible children.[5] Since some portion of the children currently on the SCHIP program leave it each month (because their family income rises or they "age out" of the program), the effect of the freeze will be to reduce the overall number of low-income children that the program insures and, correspondingly, to increase the number of children in the state who are uninsured. Georgia also may consider reducing the income eligibility limit for children and eliminating coverage for services such as dental care.[6] In shortfall states that cut their programs, significant numbers of SCHIP beneficiaries will be at risk of losing some or all of their coverage unless Congress acts swiftly to ensure no state faces a SCHIP funding shortfall this fiscal year.

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[5] Bill Hendrick, "PeachCare to halt new sign-ups," *Atlanta Journal-Constitution*, February 9, 2007.

[6] Bill Hendrick, "Legislature 2007: Tightened PeachCare eligibility proposed," *Atlanta Journal-Constitution*, February 10, 2007.

TABLE 1

14 States Projected to Face Federal SCHIP Financing Shortfalls in 2007

STATE	Federal SCHIP Funding Shortfall Not Counting H.R. 6164	Remaining Shortfall After H.R. 6164 Redistribution*
Nation	$1,015,763,000	$744,448,000
Alaska	$13,475,000	$12,130,000
Georgia	$128,473,000	$124,163,000
Illinois	$365,460,000	$247,253,000
Iowa	$15,047,000	$15,047,000
Maine**	$539,000	$539,000
Maryland	$79,446,000	$60,744,000
Massachusetts	$139,145,000	$85,409,000
Minnesota	$15,763,000	$15,763,000
Mississippi	$23,713,000	$23,713,000
Missouri	$3,339,000	$3,339,000
Nebraska	$80,000	$80,000
New Jersey	$178,595,000	$122,620,000
Rhode Island	$49,851,000	$30,811,000
Wisconsin	$2,837,000	$2,837,000

* Includes both the regular redistribution of unspent federal SCHIP funds from states' 2004 SCHIP allotments and the accelerated redistribution of a portion of states' unspent federal SCHIP funds from their 2005 SCHIP allotments. States receive redistributed funds as they experience shortfalls.

Shortfalls are further reduced artificially by an additional $24.7 million because, if states use the redistributed funds for coverage of parents, they will receive only the lower Medicaid matching rate as opposed to the enhanced SCHIP matching rate. The following states are affected: Illinois ($14.7 million), New Jersey ($7.5 million), and Rhode Island ($2.5 million). This additional $24.7 million reduction is not reflected in this table.

** State officials have indicated to CBPP staff that Maine's SCHIP spending in fiscal year 2007 could be significantly higher than under the state's most recent estimates submitted to the Centers for Medicare and Medicaid Services. Maine's shortfall could be as high as $6.5 million in 2007.

Source: Center on Budget and Policy Priorities' SCHIP financing model, based on a model created by the Office of the Actuary at the Centers for Medicare and Medicaid Services. The model incorporates SCHIP provisions of the Deficit Reduction Act, states' November 2006 estimates of federal SCHIP funding needs for federal fiscal year 2007, and the fiscal year 2007 state allotments announced by CMS in August 2006.

[illegible] February [illegible] 2007

States Spend Funds Meant for Children on Adults

[illegible] Percent of Enrollees in "Children's" Program are Adults

Filed As: Health Care

The upcoming debate over health insurance for children will send a strong signal about the direction that the health policy debate will take in the new Congress.

The State Children's Health Insurance Program must be reauthorized this year or it will expire. And some states are running out of money and have their hands out to Washington for more.

When Congress created SCHIP 10 years ago, it set up the program in a new way. Instead of making it an open-ended entitlement to benefits for recipients, like Medicare and Medicaid, it created block grants to the states, capping expenditures at $40 billion over the last decade.

The states are not accustomed to this discipline. Several of them ran over their allotments last year, and the Republican Congress appropriated another $283 million. So far this year, 14 states have over-committed and face shortfalls of a total of $745 million. The Democratic Congress is ready to appropriate the money.

(You have to wonder what kind of parents they would be. "I've run out of allowance money, Dad." "Oh that's okay, son. Here's some more.")

The new congressional leadership signaled early on that they would like to expand SCHIP to cover every eligible child, but the price tag is a whopping $60 billion over the next five years.

Senate Finance Committee Chairman Max Baucus must figure out where to get the extra money, and in the meantime will try to tack the shortfall appropriation onto another bill this spring.

Would it surprise you that six of the nine states that GAO surveyed which have over-spent their allotments were states that cover adults through their State Children's Health Insurance programs? In Minnesota, 87% of total SCHIP enrollees in 2005 were adults, and 66% in Wisconsin. In Arizona, 56% of those enrolled in SCHIP were adults, yet the state has one of the highest rates of uninsured children in the nation at 16%. Where is the outrage?

Of the 6.[illegible] million people enrolled in SCHIP in 2005, more than 10 percent (639,000) were adults, according to the Government Accountability Office. And those 639,000 were from just nine states where GAO could get data.

"Adults accounted for an average of 55 percent of enrollees in the shortfall states, compared with 24 percent in the nonshortfall states," according to GAO.

It seems that Congress could benefit from a few guidelines before moving forward.

* Cover Kids First. As the GAO points out, covering adults is not the point

Sea[illegible]

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of SCHIP, and it means that funds are being "diverted from the needs of low-income children." The Congress tried last year to put the brakes on more states adding adults to the program, but it needs to make a firm statement that the program is for kids.

* Cover low-income kids first. Fourteen states use SCHIP to cover kids who live in families with incomes above 200% of poverty, or annual incomes of $41,300. New Jersey covers kids up to 350% of poverty - which means taxpayer subsidized health care for kids whose parents make more than $72,000 a year!

New Jersey is a shortfall state

* Don't crowd out private coverage. A National Bureau of Economic Research Study looked at the first five years of experience with SCHIP in 2002 and found that "perhaps as much as half of the new SCHIP enrollment was offset by declining private coverage." In other words, a free or mostly-free government program was taking the place of private coverage. And that leads to

* Give parents the option to put their kids on their own policies. If a parent has the option of a policy at work that could cover dependents for relatively little, why leave this money on the table? The original SCHIP legislation made it an option to turn the SCHIP benefit into a premium assistance stipend, but the administrative process is so cumbersome that only a few states have been able to succeed in doing this. Lightening the administrative burden is essential. It's inexpensive to add children to family policies, but by making the process too difficult, private money is left on the table, and the taxpayer picks up the full tab

* Create new purchasing pool options for families. Congress could take President Bush up on his offer to use some of the money that is currently being sent to the states for uncompensated care to create new state purchasing pools. This could make it much simpler for states to administer a premium assistance program, and could allow working families without other sources of coverage to buy in as well

Private competing plans that meet the benefits test could compete to offer coverage to families, paid for by SCHIP's premium assistance, employer contributions, and worker payments. The structure of the Federal Employees Health Benefits Program (and the vision, but not the reality, of the Massachusetts Connector) could be a model

* Get the subsidies right. States have an incentive to add more of their citizens to SCHIP because they are paid more by the federal government for doing so. That's because the funding formulas for SCHIP are upside down. SCHIP was designed to cover kids whose families make too much to qualify for Medicaid but not enough to afford private coverage. But the federal government matches state spending at a higher percentage for higher-income SCHIP kids than for lower-income Medicaid children. What is wrong with this picture?

The federal government pays an average of [illegible]% of SCHIP costs but only 59% of Medicaid costs. This is bad policy. The federal government should provide a higher match rate for covering kids in the poorest families, and the match should scale back as their family's income rises

It makes no sense, for example, for New Jersey to get an SCHIP match rate of 65% for adding adults to SCHIP but only [illegible]% for adding kids into Medicaid. Is it any wonder that New Jersey is expanding its SCHIP program? It's all about incentives

To protect the ability of SCHIP to serve needy low-income children and to

preserve the program's core purpose of covering children, states should receive a Federal match rate that reimburses them at a higher rate for adding lower-income children to the program, with the match scaling back as they expand the program to higher-income children. And adults should not be on the children's program

It's up to Congress now to decide whether this program will run out of control or inject real discipline and bring it back to its core purpose.

posted by Grace-Marie Turner | 15:50 PM | 0 comment

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SJR

3

ALASKA STATE LEGISLATURE

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Co-chair
Joint Armed Services Committee

Member
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SENATOR BILL WIELECHOWSKI

SPONSOR STATEMENT
SJR 3

"A resolution relating to the effect of Medicare rates on senior citizens' access to healthcare; and urging the United States Congress to increase Medicare rates for Alaska."

Approximately 55,000 Alaskans rely on the federal Medicare Program to meet their health care needs. Unfortunately this program is increasingly letting down some of Alaska's most vulnerable citizens.

Many Alaska physicians say Medicare pays less than 50% of what it costs them to treat their patients. As a result, an alarming number of doctors are refusing to accept new Medicare patients, and many are terminating existing patients, leaving a growing number of senior and disabled Alaskans without access to medical care.

The American Medical Association calls the Medicare reimbursement formula "broken beyond repair." It reports that in 2008 Alaska will lose $8 million in federal payments to doctors as a result of cuts in Medicare reimbursement rates and projects a loss of $240 million between 2008 and 2015.

The Military Officers Association of America says Medicare reimbursement rates are also hurting military beneficiaries' access to care since military health insurance is linked to Medicare reimbursement rates.

SJR 3 calls on Congress and the U.S. Department of Health and Human Services to address this crisis by rewriting the formulas used to develop Medicare reimbursement rates for Alaska. It also urges Congress to address inequities in physician reimbursement that are leading to the collapse of the primary care system and limiting seniors' access to those physicians best qualified to coordinate their care.

I urge you to join me in helping disabled and senior Alaskans by supporting SJR 3.

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Anchorage Daily News

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Fewer primary care doctors take Medicare

By ROSEMARY SHINOHARA
Anchorage Daily News
(Published: February 18, 2007)

Henry Taylor had problems finding a doctor. By the time the 77-year-old finally located a physician who accepted Medicare, his cancer was beyond help. He is one of 55,000 Alaskans who are enrolled in the federal health insurance entitlement. *(Photo by BOB HALLINEN / Anchorage Daily News)*

After Henry Taylor's doctor moved to Homer, Taylor, who is 77, needed two things: an Anchorage physician to prescribe drugs for diabetes and other ailments, and relief for his aching back.

He didn't realize his lungs were quietly killing him. He didn't find out until it was too late because he is on Medicare, and doctor after doctor refused to see him.

There's a crisis in health care for Alaska's older residents: Few primary care doctors take new patients on Medicare, the federal insurance program for people 65 and older.

The crisis is not new, but evidence indicates it is worsening.

Alaska is short of primary care doctors in general. And many of them say they can afford to treat only limited numbers of Medicare patients, if any, because the rates are too low -- often less than half what a doctor normally charges.

Henry Taylor and daughter Pat Cochran talk about his problems finding a doctor. "I call myself 'Medicareless Henry,'" he joked. *(Photo by BOB HALLINEN / Anchorage Daily News)*

"When you get close to 23 to 25 percent of your visits from Medicare patients, you're going bankrupt," said Dr. Bruce Kiessling of Primary Care Associates, the largest primary care group in the state. "We do not take new Medicare, not at all."

Primary Care keeps existing patients who age into Medicare.

Once retired people turn 65, Medicare rules, even if a person has private insurance as well. Doctors must charge Medicare patients no more than Medicare allows. Medicare pays 80 percent of the allowed charge, after an annual deductible is met. The patient or private insurance picks up the rest.

About 55,000 Alaskans are enrolled in Medicare.

Some doctors opt out of Medicare altogether and patients are responsible for payments. Kiessling's office did that for a time.

"You can't blame the providers for not wanting to see us because the federal government is paying so little," said Janet Mischler, 67, a retired nurse. "A lot of people don't go (to the doctor) unless it's really bad."

Medicare represents a significant share of federal spending, and the government wants to hold costs as low as possible. The president's upcoming budget anticipates that payments to doctors will be cut at least 8 percent next year, The New York Times reported recently.

Anchorage residents on Medicare seem to have a harder time finding primary care doctors than in most of the country, although many say they don't have a problem getting in to see specialists like cardiologists or lung doctors.

Some Alaskans report they go Outside to get their general checkups because it's easier.

Doctors say there's such a big disparity between what Medicare allows for a service and what Alaska doctors charge non-Medicare patients partly because it costs more to practice medicine here.

Dr. Richard Neubauer, an internist who often speaks out on Medicare, said overhead is higher. There are no big outside forces, such as huge corporations or unions, that can impose their will on the medical establishment and drive down costs, Neubauer said.

The state's congressional delegation persuaded Congress that Alaska doctors needed special rates during 2004 and 2005. Alaska won a temporary boost of more than 50 percent in Medicare payments, according to a report at the time from the Alaska State Medical Association.

The delegation tried and failed to get that boost extended. The rates dropped in January 2006, and remain flat for 2007.

Those in the trenches of senior health care in Alaska say Medicare clients have more trouble than ever getting in to a general practitioner.

"It's gotten worse and worse and worse," said Rita Hatch of the Older Person's Action Group. She surveys Anchorage doctors' offices daily to see who's taking new Medicare patients and finds hardly any. "It's the most serious problem seniors are facing right now," Hatch said.

People seeking new doctors call Anchorage Neighborhood Health Center with two messages, said Dr. Tom Hunt, the center's medical director: My doctor dropped me, or, more commonly, I moved my mother into town. Or we just moved in, and this is the ninth doctor I called.

Anchorage Neighborhood Health is a nonprofit corporation that serves a lot of uninsured patients but is open to everyone. However, the center offers only limited advance appointments.

Hatch advises callers to use an advanced nurse practitioner instead of a doctor, because nurse practitioners are more accessible.

Anna Bell Stevens, 77, goes to a nurse practitioner. It works well, until she needs a doctor, she said. When she had pneumonia several years ago, she went to a small clinic near her house in Turnagain on a Saturday.

"When the lady saw I was past 65, she said, 'We're not taking Medicare patients.' I am dying, practically, and they wouldn't see me. There is something wrong with a system when you cannot walk into a doctor's office and pay for being seen. To me, it's just absolutely wrong."

Technically, a person can choose to pay out-of-pocket for services, and ask the doctor not to bill Medicare. But in practice, Medicare beneficiaries say, places that aren't taking new Medicare patients often won't see them, regardless.

Mary Ann Lindbeck, 82, secured a doctor for her husband, who has since died, by breaking down in her doctor's office.

"I was trying to get Ed in there. The office nurse was saying, 'We aren't taking any more, we can't.' And I burst into tears. (Her doctor) came by, looked at me, and said, 'What's the matter with you?' "

Henry Taylor, who lives in South Anchorage with daughter Pat Cochran and a Boston bull terrier that licks everything that moves, relies on his sense of humor in a grim situation.

"I call myself 'Medicareless Henry,'" he joked.

After the doctor Taylor had been seeing moved to Homer, Taylor drifted from one untenable arrangement to the next.

Though he lives off O'Malley Road, Taylor started seeing a doctor at the Acute Family Medicine Clinic in Eagle River because they would take him. Effective January 2006, that doctor wrote patients that the clinic would no longer bill or receive payments from Medicare -- they were opting out altogether.

Then Taylor went to an urgent care clinic but had to wait sometimes for hours before they could get to him. With his back problems, that was a struggle.

Sometimes a doctor's willingness to take new Medicare patients changes from day to day.

Taylor's daughter had contacts at AARP and elsewhere, and moved fast whenever she got word a doctor might be taking Medicare patients.

"I probably called two or three dozen," Cochran said.

Taylor got a tip that a 77-year-old semi-retired doctor might see him, and in November he finally got a comprehensive exam. That's when they discovered he had advanced lung cancer.

Outside Alaska, Medicare clients mostly report adequate access to doctors, says a 2006 study by the Government Accountability Office, a congressional watchdog agency. But the GAO survey found twice as many Alaskans reported major difficulty signing on with a doctor than the national average.

The government has an interest in keeping health costs down, so if the system is working well, Congress is unlikely to raise reimbursement rates.

Why is it such a problem here?

Dr. Neubauer said medical care is more expensive to deliver here than in other states.

A recent study done for the University of Alaska and the state Department of Health and Social Services documented a growing shortage of doctors here compared with the national average, and cited a need for even more than we have as the population ages. The large Baby Boom generation starts turning 65 in 2011, just four years from now, and is expected to strain the health care system further.

With enough primary care doctors, the Medicare population would be spread around and the system would be more workable, Neubauer said.

U.S. Sen. Lisa Murkowski, R-Alaska, secured a seat on the Senate Health, Education, Labor and Pensions Committee partly to work on improved Medicare coverage in Alaska, she said in an interview.

Murkowski said she'll push aggressively to get higher reimbursement rates, and thinks colleagues are coming to recognize that Alaska's situation is different. "Our facts are just that much more extreme."

Murkowski has scheduled a Senate Health Committee hearing in Anchorage Feb. 20 to allow doctors to explain how the Medicare rates affect their practices, and members of the public to share their experiences.

For Henry Taylor, any help with Medicare will come too late.

He is getting treatment, but there is no hope for a cure.

"They said from the beginning, 'We cannot save your life,'" said his daughter, Cochran. "It's in both lungs. It's inoperable. It's in his bones."

Which leaves Taylor and Cochran wondering whether his outlook could have been better, with more timely treatment.

Daily News reporter Rosemary Shinohara can be reached at rshinohara@adn.com or 257-4340.

How it works

Here's an example of what Medicare pays in Alaska, compared with what doctors and nurse practitioners charge other patients:

At Health Works Family Medical Clinic in Eagle River, an established patient on the most common visit would be charged $121, said office manager Renee Blakely. Medicare allows $59.70.

If someone comes in with a list of problems, and takes an hour, the charge would be $281, said Blakely. Medicare pays $122.07.

Speak out

U.S. SEN. LISA MURKOWSKI will hold a hearing on the shortage of primary care physicians in Alaska, particularly in rural areas. The hearing by the Senate's Health, Education, Labor and Pensions Committee begins at 9 a.m. Tuesday at Loussac Library.

Medicare at a glance

Medicare is health insurance for people 65 and older, and for people younger than that with certain disabilities.

- **MEDICARE PART A** covers hospital care, and everyone gets it free.

- **PART B** covers services of doctors and nurse-practioners. It is optional, and costs money -- $93.50 per month for those who make $80,000 or less. If you don't take Part B when you are first eligible, it can cost more.

- **PART D** is the new, optional, prescription drug coverage. Beneficiaries choose from among a variety of available plans that cost different amounts. There can also be a penalty for joining late.

HOW DOCTORS GET PAID:

1. ASSIGNMENT: You assign Medicare to pay your doctor directly. If a doctor accepts assignment, the doctor agrees to collect only the amount Medicare approves.

2. NO ASSIGNMENT: Your doctor may accept Medicare but not accept assignment. In that case, the doctor may charge more than the Medicare-approved amount. But still, doctors are generally limited to charging a maximum of 15 percent more.

Source: Centers for Medicare & Medicaid Services

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Web posted Sunday, February 25, 2007

Diagnosis: Alaska's shortage of doctors a growing problem

By Melissa Campbell
Alaska Journal of Commerce

Dr. Ross Tanner, president-elect of the Alaska State Medical Association, right, sitting next to Dr. Harold Johnson, director of Alaska Family Practice Residency, and Dr. Richard Neubauer, internal medicine, left, testifies during a Feb. 20 Health, Education, Labor, and Pensions Committee field hearing, chaired by Sen. Lisa Murkowski, R-Alaska, in Anchorage. AP PHOTO/Al Grillo

Alaska's health care system is nearing a crisis stage, with rising costs, lower reimbursement rates, a shortage of doctors and few methods to entice caregivers to work in the state, doctors and health care advocates told Sen. Lisa Murkowski.

Chairing a field hearing of the Senate Health, Education, Labor and Pensions Committee on Feb. 20, the state's junior senator heard from people who have trouble finding doctors and from doctors who tried to explain why that is.

She also heard ideas on how the federal government could help ease the situation.

Health care is a major concern nationwide. In Alaska, the cost of health care is roughly 70 percent higher when compared to the Lower 48, adding to the financial burden.

Last year, Americans spent $1.9 trillion on health care, Murkowski said. That's more than was spent on food or housing, and four times the amount spent on national defense. By 2015, that figure is estimated to balloon to nearly $4 trillion. Alaskans spend more than

$5 billion a year on health care, a figure that is also expected to increase in coming years.

Those rising figures are largely attributed to an aging population — assuming that the older one gets, the more often he needs to see a doctor, and the more medications he'll need to take. In 20 years, some 20 percent of the U.S. population will be 65 years old or older, Murkowski said.

In Alaska, the number of those older than 65 is expected to increase from 43,000 to 124,000 between 2005 and 2025.

At the same time, experts predict a national shortage of 200,000 physicians, with a shortage of nearly 400 in Alaska. About a third of the nation's doctors are nearing retirement age, while for the past quarter-century, medical schools have kept enrollments virtually flat.

Murkowski read off several messages from constituents detailing their troubles in finding a doctor to accept a new Medicare patient, either themselves or a family member. Some said they had made more than 100 calls to doctors in the Anchorage area and were turned down.

One was speaker Carl Berger, of the Lower Kuskokwim Economic Development Council in Bethel. Berger just turned 65 and entered into the Medicare system. His doctor of 20 years retired, and Berger can't find a general practitioner to take him as a patient.

"Lucky for me I have a heart condition," he said. "I'm able to see another doctor. But what doctor would want to see me if he get reimbursed only 40 percent of his costs?"

Speaker Frank Appel, of the Alaska Commission on Aging, recently got a letter from his doctor of 15 years saying that once Appel reaches 65, he'll have to find a new doctor.

"I believe the challenge faced by seniors and others who can't find a doctor is intolerable," Murkowski said at a Commonwealth North health care discussion held later that afternoon. "This is not a new problem, but I think people believe that it's not going to happen to me. I think people should realize that turning 65 is one of those things that happens after 64. We must help current physicians stay in the practice of medicine and increase our health care work force."

Rita Hatch, a volunteer with the Older Persons Action Group, a senior advocacy organization, said she does an ongoing survey of Anchorage doctors who accept new Medicare patients. There are currently about 20 doctors on her list.

The Anchorage Neighborhood Center is the only facility taking new patients, and it is being overwhelmed.

Doctors said they are reimbursed only 40 percent of their actual costs for services provided to Medicare patients. That doesn't cover their overhead costs.

"It seems like we are the bad guys," said Dr. Ross Tanner,

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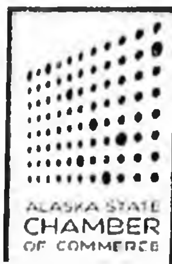

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president-elect for the Alaska State Medical Association. "But for me to remain financially soluble, I have to be paid for what I do."

He added that a plumber or engineer would not be asked to take a reduction in their fees, but that's exactly what the federal government demands when doctors treat Medicare patients.

"It's not a greed thing," he said. "I don't have a bunch of money that I go home and roll around in every day. I am the cheapest thing that Medicare could spend their money on. I am cheaper than the emergency room or any specialist."

Everyone agreed that efforts in recruitment and education need to be stepped up, but those are costly programs.

The annual cost of recruiting doctors to Alaska is more than $24 million, said Karleen Jackson, commissioner of the state Department of Health and Social Services. The average cost to hire a physician surpassed $74,000.

Medical school can cost from $125,000 in a public school to $200,000 in a private college. That's a huge debt load for a young person, Tanner said.

Alaskans have the lowest acceptance rate of applicants entering into medical school. And those entering into school now won't be ready to open their own practices for at least seven years.

Alaska needs 59 new doctors each year to approach national levels of doctor to population ratios. But Alaska has no medical school, is limited on the number residency students it can train and is limited on the number of students it can enroll into a Washington state medical school program.

That means that a number of Alaskans who want to become a doctor will have to train Outside. Statistics show that doctors practice within 100 miles of where they trained.

So how to make it better?

Doctors offered several suggestions:

- Enact federal legislation to fix the Medicare payment system to reflect the higher Alaska costs. *
- Enact legislation to provide tax credits for young doctors to practice in "frontier" states, like Alaska.
- Enact legislation to revamp the funding for residencies.
- Develop programs to help medical students with the debt garnered to attend medical school.

Alaska is already involved in programs that have helped train Alaskans to be doctors or to bring doctors to Alaska, including the University of Washington Medical School Partnership, known as WWAMI, for the Northwest states that are involved in the partnership. Lawmakers are working to expand the number of slots allowed for Alaskans to enter into the program.

On the federal level, Murkowski and Sen. Ted Stevens continue to work for higher Medicare and Medicaid reimbursements for Alaska providers. Earlier this year, Alaska's senators introduced the Rural Physician Relief Act, a bill that provides tax incentives for doctors to practice in rural areas.

Soon, Murkowski will introduce the Physician Shortage Elimination Act, which will double the funding for the National Health Service Corp., a program dedicated to meeting the needs of the underserved. Some 80 percent of the applicants to the program are turned away each year.

The bill will allow rural and underserved residency programs to expand by removing barriers that prevent programs from developing rural training rotations, and will create programs that target disadvantaged youth in rural areas by creating a pipeline into health care careers. The bill also offers grants to community health centers to expand residency programs.

Melissa Campbell can be reached at melissa.campbell@alaskajournal.com.

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Medicare's physician payment update formula: The facts

The Congressional Budget Office recently forecast that Medicare physician payment rates would be reduced by 10 percent in 2008 under current law. The 2006 Medicare Trustees report predicts cumulative reductions in Medicare physician payment rates of nearly 40 percent by the year 2015. These successive annual reductions are due to a statutory formula governing annual Medicare payment updates that is broken beyond repair and must be replaced.

It is critical that a permanent, long-term replacement for this payment formula be identified as it is producing disastrous effects. In addition to generating the forecast 40 percent pay cuts by 2015, the formula:

- Has kept average 2007 Medicare physician payment rates about the same as they were in 2001
- Has prevented physicians from making needed investments in staff and health information technology to support quality measurement
- Punishes physicians for participating in initiatives that encourage greater use of preventive care in order to reduce hospitalizations
- Has led to a budget baseline that is widely viewed as unrealistic and that has driven policymakers to enact short-term interventions that have increased the duration of cuts and the cost of a long-term, permanent solution

The law provides for Medicare physician payment rates to be updated each year:

- The initial element in each year's update calculation is the Medicare Economic Index or MEI, a conservative government index of practice cost inflation.
- The update is then adjusted up or down from MEI based on the sustainable growth rate or SGR.
- The SGR was created by Congress in the Balanced Budget Act of 1997 as a target rate of growth in Medicare spending for physician services.
- The key factors in setting the SGR are Gross Domestic Product (GDP) growth, changes in law and regulation, Medicare enrollment and price changes.
- If expenditures exceed the SGR targets, then annual physician payment updates are less than annual increases in practice cost inflation.

There are several **fatal flaws in the SGR:**

- Utilization of physician services grows more rapidly than GDP, so using GDP as the standard for utilization growth in the SGR means that the target is always set too low.
- The "law and regulation" factor has not been appropriately adjusted to reflect new Medicare coverage policies, such as macular degeneration treatment and implantable cardiac defibrillators. Omitting the costs of such treatments from the SGR targets increases the likelihood of pay cuts.
- None of the factors in the SGR recognize Medicare spending due to technological advances, shifts from care being provided in hospitals to being provided in physician offices and other medical practice trends. Services that may save money for the Medicare program as a whole or improve quality, therefore, can still lead to cuts in Medicare physician payment rates.
- Spending for Part B drugs has been improperly included in the SGR calculations and is growing much more rapidly than physician services. As a result, drug spending consumes an ever-increasing share of a target that is already too low, increasing the likelihood of SGR-driven pay cuts. The American Medical Association (AMA) continues to call for the Administration to remove drug spending from its SGR calculations.

Continued on next page...

Surveys have shown that **SGR-driven pay cuts would hurt seniors' access to physician care:**

- The Medicare Payment Advisory Commission has found that increasing numbers of Medicare beneficiaries report "big problems" finding new primary care and specialist physicians. The Commission is concerned that Medicare pay cuts will worsen patient access problems.
- AMA surveys of physicians have found that nearly half would have to decrease or stop accepting new Medicare patients if payments were cut.
- The Military Officers Association of America states SGR pay cuts would significantly damage military beneficiaries' access to care under TRICARE, as TRICARE payments are linked to Medicare rates.
- The congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020. Medicare cuts will exacerbate this shortage by making medicine a less attractive career.

Physician services have extended patients' lives and improved seniors' quality of life, despite a significant rise in chronic disease among the elderly:

- The Centers for Disease Control reported 50,000 fewer deaths in 2004, the biggest single-year reduction in mortality since the 1930s.
- An August 2006 *Health Affairs* article by Kenneth Thorpe and David Howard found that "[v]irtually all of the growth in spending from 1987 to 2002 can be traced to the twenty-percentage-point increase in the share of Medicare patients receiving medical treatment for five or more conditions during a year."
- Medical advances added about a half year to seniors' life spans between 1999 and 2002 alone. Deaths from heart and cerebrovascular disease have been falling by about 3 percent a year in recent years and the cancer death rate over the last decade has fallen by about 1 percent a year.
- An August 2006 *New England Journal of Medicine* article by David Cutler et al. concluded that, "although medical spending has increased over time, the return on spending has been high… concern about high medical costs needs to be balanced against the benefits of the care received."
- Utilization of physician services is not the cause of the Medicare program's financial predicament, and cuts in physician payment rates are not the way to improve Medicare's financial sustainability.

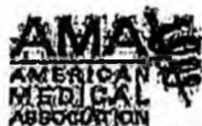
The time has come to replace the Medicare update formula with a new approach that will provide adequate financing for physician services.

Support legislation in 2007 to stop Medicare physician payment cuts triggered by the SGR and replace it with a formula that provides annual updates that reflect increases in physician practice costs.

IMPACTS OF MEDICARE PHYSICIAN PAY CUTS IN ALASKA

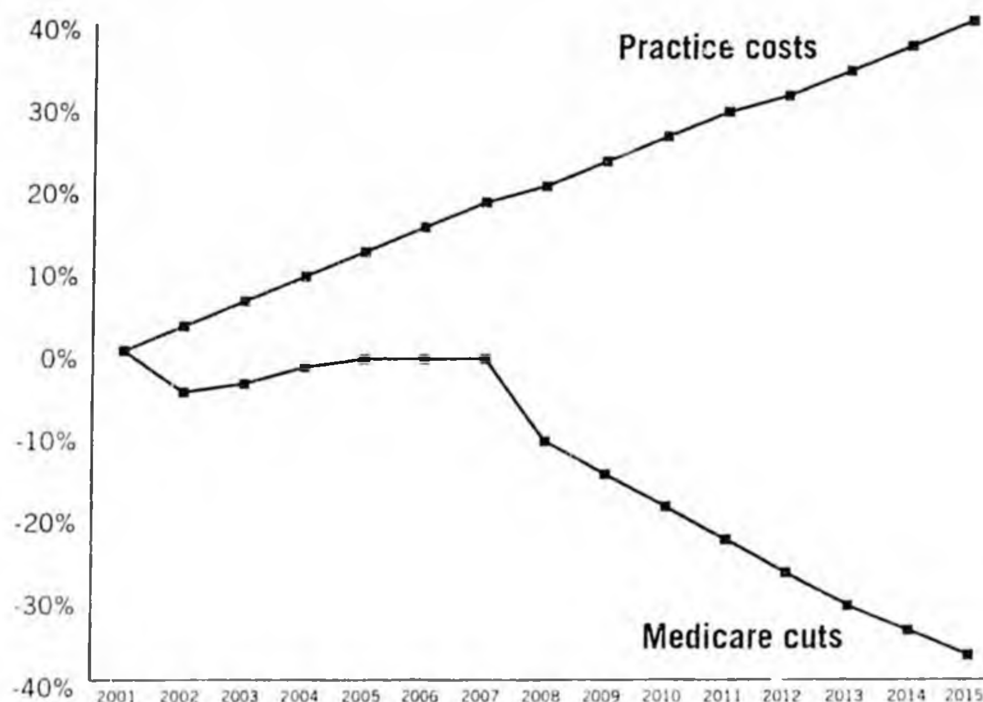
- Alaska will lose $8 million in health care funds due to the projected 10% negative update in 2008, and the state will lose $240 million by 2015 due to 8 years of SGR cuts.
- (,969 employees, 47,519 Medicare patients and 78,803 TRICA E patients in Alaska will be affected by these cuts.
- Compared to the rest of the country, Alaska, at 232 practicing physicians per 100,000 populatior has a below-average ratio of practicing physicians to population, even before the cuts take effect.
- 43% of Alaska's practicing physicians are over 50, an age at which surveys have shown many physicians consider reducing their patient care activities.

Note: The special Alaska GPCI which added $27 million per year for 2004 and 2005 expired on 1/1/06. So, the additional loss will really be more than the $240 million cited above.



Future bleak for seniors, baby boomers. Medicare to cut payments as boomers enter the program

Without congressional intervention, Medicare will slash physician payments nearly 40 percent over eight years beginning in 2008, while practice costs increase almost 20 percent. These cuts come at a time when Medicare payments to physicians already lag far behind the cost of caring for seniors. In 2010, the leading edge of the baby-boom generation will start enrolling in Medicare, with enrollment growing from 43 million in 2010 to 49 million by 2015.



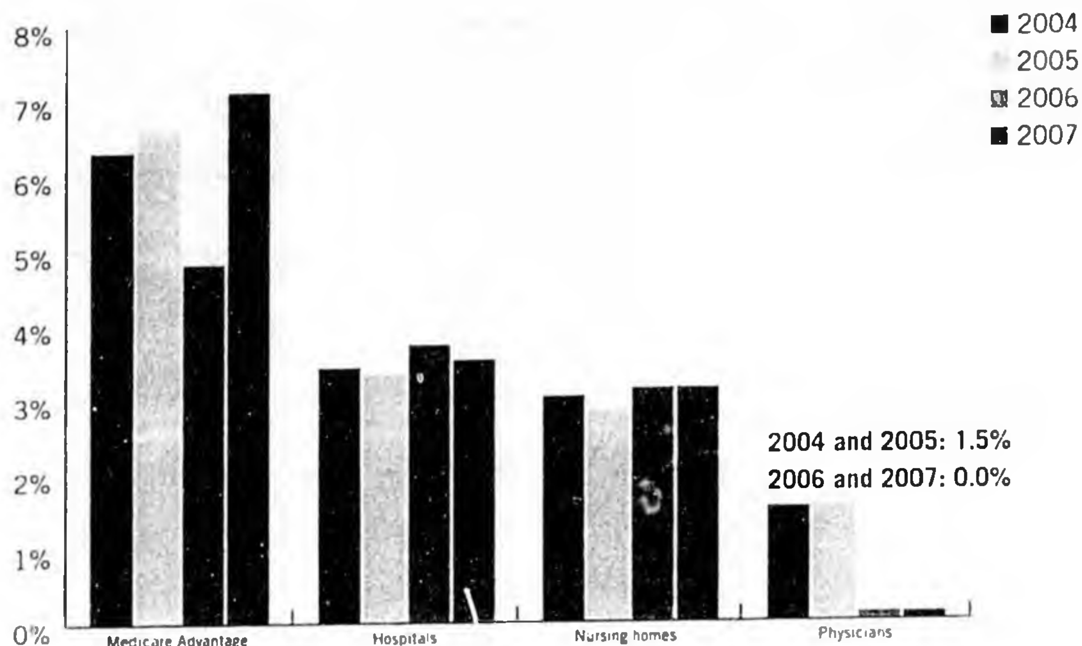
Sources: Physician cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment updates are from the 2006 Medicare Trustees report, with adjustments for 2008 to reflect the Congressional Budget Office analysis of the "Tax Relief and Health Care Act of 2006." Any change in pay that may result from use of the $1.35 billion "physician assistance and quality initiative fund" for 2008 is not included.

Support legislation in 2007 to stop Medicare physician payment cuts triggered by the SGR and replace it with a formula that provides annual updates that reflect increases in physician practice costs.

American Medical Association
February 2007

Physicians vs other providers: 2004-2007 Medicare payment updates

Physicians received below-inflation updates in 2004 and 2005 and zero percent updates in 2006 and 2007, while other Medicare providers' payment updates have kept pace with their costs.



Source Centers for Medicare & Medicaid Services final announcements.

Support legislation in 2007 to stop Medicare physician pavment cuts triggered by the SGR and replace it with a formula that provides annual updates that reflect increases in physician practice costs.

American Medical Association
February 2007

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

March 16, 2007

Senator Bill Wielechowski
State Capitol, Room 115
Juneau, Alaska 99801

Subject: Support Letter for Senate Joint Resolution No. 3

Dear Senator Wielechowski:

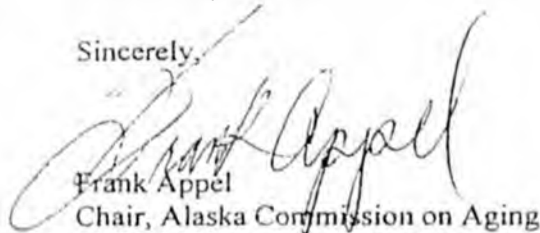
On behalf of the Alaska Commission on Aging and more than 43,000 Alaskans age 65 and older, we support your Senate Joint Resolution No. 3 that calls on Congress and the U.S. Department of Health and Human Services to revise Medicare physician reimbursement rates for Alaska, to improve access to health care for older Alaskans We hope that this resolution will lend support to our Congressional delegation's efforts to improve rates for Alaska so that older Alaskans will not be denied health care.

Over the past year the Alaska Commission on Aging has increasingly received alarming reports from older Alaskans enrolled in Medicare who are being denied medical services by primary care physicians because the Medicare reimbursement rate for these services is less than what doctors would receive from private payment or other insurance carriers. Some older Alaskans are having difficulty locating any provider in their area who will take new Medicare patients.

During our initial investigation of this problem, we have learned that physician refusal of Medicare patients is a situation unique to Alaska because the physician's cost of providing patient services in Alaska exceeds their Medicare reimbursement rate. If left unattended, the problem of physician refusal of Medicare patients will intensify over the next few years as the population of Medicare-eligible older Alaskans grows at a rate of 5% to 6% annually and the number of practicing physicians decreases as the result of an aging workforce.

Thank you for sponsoring this important legislation. Please feel free to call on the Alaska Commission on Aging should you have questions or when your legislative efforts require research and analysis of this issue or others that affect the quality of life of older Alaskans.

Sincerely,



Frank Appel
Chair, Alaska Commission on Aging

Denise Daniello
Executive Director, ACoA

Retired Public Employees of Alaska, APEA/AFT
Anchorage Office
3310 Arctic Blvd., Suite 200, Anchorage, Alaska 99503
Phone (907) 274-1703, (800) 478-9992, Fax 907-277-4588

April 5, 2007

Alaska State Senators
State Capitol
Mailstop 3100
Juneau, AK. 99801-1182

RE: Senate Joint Resolution No. 3

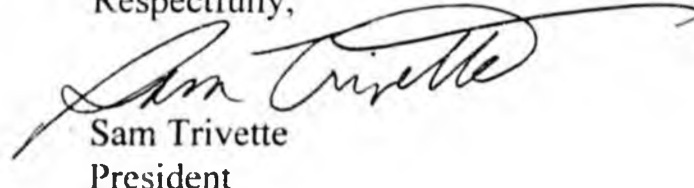
Dear Senator Bill Wielechowski:

Retired Public Employees of Alaska represents thousands of public employee retirees around Alaska. One of our members contacted us in tears last year when after making almost 30 calls to try to see physician in the Anchorage area, she still could not find a doctor that would take Medicare. Many Alaska doctors will not take any Medicare patients because of the low Medicare reimbursement rate in Alaska. If a doctor will not bill Medicare, the State retiree insurance will pay nothing, and the retiree must pay every penny of the costs out of pocket. If this problem is not fixed, it will drive many of our older retirees out of Alaska to the lower 48 where most doctors still take Medicare.

The University of Alaska's research paper by the Institute of Social and Economic Research released in September 2006 shows that seniors in Alaska spend **$1.46 BILLION annually** in the Alaska economy. We want our seniors to remain in Alaska, and having health insurance that will help pay medical bills is critical.

Please pass SJR 3 that will help our seniors get the Medicare coverage they paid for in their working years so they can remain in Alaska.

Respectfully,



Sam Trivette
President

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Your Retirement Years

SJR

11

Support Assured Funding for Veterans Health Care

Today's soldiers…
are tomorrow's veterans

THE PARTNERSHIP FOR
Veterans Health Care
BUDGET REFORM

The Partnership for Veterans Health Care Budget Reform

Representing America's Veterans

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Washington, DC 20006
(202) 861-2700
www.legion.org

AMVETS (American Veterans)
4647 Forbes Blvd.
Lanham, MD 20706
(301) 459-9600
www.amvets.org

Blinded Veterans Association
477 H Street, N.W.
Washington, DC 20001
(202) 371-8880
www.bva.org

Disabled American Veterans
807 Maine Avenue, S.W.
Washington, DC 20024
(202) 554-3501
www.dav.org

Jewish War Veterans of the USA
1811 R Street, N.W.
Washington, DC 20009
(202) 265-6280
www.jwv.org

Military Order of the Purple Heart of the U.S.A., Inc.
5413-B Backlick Road
Springfield, VA 22151
(703) 642-5360
www.purpleheart.org

Paralyzed Veterans of America
801 18th Street, N.W.
Washington, DC 20006
(202) 872-1300
www.pva.org

Veterans of Foreign Wars of the United States
200 Maryland Avenue, N.E.
Washington, DC 20002
(202) 543-2239
www.vfwdc.org

Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910
(301) 585-4000
www.vva.org

This We Believe

Americans are once again deployed around the world, answering our nation's wartime call to arms. Like so many brave men and women who honorably served before them, these soldiers are fighting to preserve freedom, liberty and security. Many have already made the ultimate sacrifice. Also, like those who fought before them, today's veterans deserve the respect of a grateful nation when they return home.

Unfortunately, without urgent changes in health care funding, our new veterans will soon discover their battles are not over. They will be forced to fight to preserve a health care system designed specifically to meet their unique needs. They will inherit an ongoing struggle to ensure that America fulfills its promise to make the veterans health care system accessible to all veterans who need it.

The Partnership for Veterans Health Care Budget Reform—The American Legion, AMVETS (American Veterans), Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Heart of the U.S.A., Inc., Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, and Vietnam Veterans of America—is united in the belief that no veteran should be forced to fight for the care he or she has earned by virtue of his or her military service.

We believe it is time to guarantee health care funding for all veterans who need medical care. Health care rationing must end. It is time the promise is kept.

Many sick and disabled veterans are forced to wait six months or longer for an appointment in a Department of Veterans Affairs (VA) facility. The VA must have a predictable, reliable funding stream to meet the specialized health care needs of veterans.

Access to quality health care for veterans has been compromised in recent years by budget shortfalls, rising medical costs and dramatically increased demand for care. The current funding formula, in which the VA must compete with other agencies for scarce budget dollars, must be replaced. The only way the VA can fulfill its mission is for Congress to guarantee the direct funding it needs to operate.

The men and women who are currently deployed must be assured the VA health care system will be there for them when they need it—now and in the future. Congress should be mindful of George Washington's words: "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their nation."

Support Assured Funding for Veterans Health Care

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THE PARTNERSHIP FOR

Veterans Health Care

BUDGET REFORM

Today's VA

The Department of Veterans Affairs (VA) is the largest integrated health care system in the United States and has four critical health care missions:

- To provide health care to veterans
- To educate and train health care personnel
- To conduct medical research
- To serve as a backup to the Department of Defense and support communities in time of emergency

The VA operates 157 hospitals, with at least one in each of the 48 contiguous states, Puerto Rico and the District of Columbia. It operates more than 850 ambulatory care and community-based outpatient clinics, 132 nursing homes, 42 residential rehabilitation treatment programs and 88 home-care programs. More than 193,000 employees support the VA health care system.

The VA provides a wide range of specialized services to meet the unique needs of veterans including spinal cord injury and dysfunction care and rehabilitation, blind rehabilitation, traumatic brain injury care, post-traumatic stress disorder treatment, amputee care and prosthetics programs, mental health and substance abuse programs, and long-term care programs. These services are incomparable resources that often cannot be duplicated in the private sector.

The VA also manages the largest medical education and health professions training program in the United States. VA facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,200 colleges and universities. These affiliations foster first-rate health care and state-of-the-art medical science. Each year, about 81,000 health professionals are trained in VA medical centers. More than half of the physicians practicing in the United States today received some of their professional education in the VA health care system.

The VA also conducts research on some of the most critical health issues today. VA researchers have played key roles in

developing the cardiac pacemaker, the CT scan, the radio-immune assay technique and improvements in artificial limbs. The first liver transplant in the world was performed by a VA surgeon. VA clinical trials established the effectiveness of new treatments for tuberculosis, schizophrenia and high blood pressure. Because three out of four VA researchers are practicing physicians, their research often immediately benefits patients. Functional electrical stimulation, a technology using controlled electrical currents to activate paralyzed muscles, is being developed at VA clinical facilities and laboratories. Through this technology, paraplegic patients have been able to grasp objects, stand, and even walk short distances. VA contributions to medical knowledge benefit all Americans.

VA has proven it provides cost-effective, high quality, comprehensive health care services to our nation's veterans. In a study published in the *New England Journal of Medicine*, May 29, 2003, "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," researchers found dramatic improvements in the quality of care to veterans after the system-wide reengineer g in the mid-1990s, and that care in VA was significantly better than that in the Medicare fee-for-service program.

Furthermore, in the Nugent study, "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," published in the *Medical Care Research and Review*, Decembe 2004,

The Federal Budget

The entire federal budget is divided between discretionary and direct programs.

Discretionary programs are those programs which the Administration and Congress control through the budget and appropriations process. VA medical care is a discretionary program.

Direct programs are often referred to as entitlements, because all recipients of these funds meet specific criteria and are entitled to payments. Social Security, Medicare, Medicaid, VA compensation and pension, and congressional salaries are direct programs and receive guaranteed appr priations.

Currently, nearly 90 percent of all federal health care spending is already guaranteed (direct or mandatory) spending.

researchers concluded that the VA is able to provide a richer benefit package at lower cost than veterans would be able to obtain through the private sector under the Medicare fee-for-service program.

Even though the VA is unquestionably a success story, Congress typically provides an annual discretionary appropriation for veterans health care that falls far short of actual needs. To ensure health care programs and services are readily accessible for veterans, funding needed over the years has not kept pace with medical inflation, let alone the increased demand for services. The enrollment for VA medical care increased 134 percent between fiscal years 1996 and 2004; funding, however, only increased 34 percent during the same period when adjusted to 1996 dollars.

Who Uses the VA Health Care System?

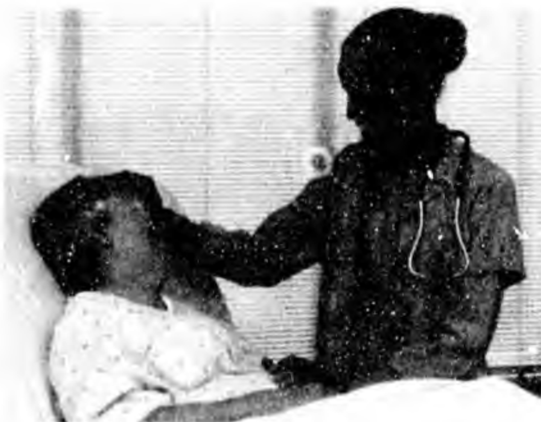
In fiscal year (FY) 2004, the VA provided care to more than 5.1 million patients, including approximately 100,000 homeless veterans, more than 20,000 veterans with catastrophic spinal cord injuries and nearly 100,000 veterans diagnosed with post-traumatic stress disorder. These veterans fall into one of eight categories:

- **Priority Group 1:** Veterans with service-connected disabilities rated 50 percent or more.
- **Priority Group 2:** Veterans with service-connected disabilities rated 30 or 40 percent.
- **Priority Group 3:** Veterans who are former POWs or were awarded a Purple Heart, veterans with disabilities rated 10 and 20 percent and veterans awarded special eligibility for disabilities incurred in treatment.
- **Priority Group 4:** Veterans receiving aid and attendance or housebound benefits and veterans determined by the VA to be catastrophically disabled, although some may be responsible for co-payments.
- **Priority Group 5:** Veterans who are determined to be unable to pay the expenses of needed care.
- **Priority Group 6:** All other eligible veterans not required to make co-payments. This includes veterans of the Mexican border period or World War I; veterans seeking care solely for certain conditions associated with exposure to radiation, for any illness associated with combat service in a war after the Gulf War or during a period of hostility after November 11, 1998, for any illness associated with participation in tests conducted by the Defense Department as part of Project 112/Shipboard Hazard and Defense; and veterans with zero percent service-connected disabilities who still receive compensation.
- **Priority Group 7:** Nonservice-connected veterans and noncompensable zero percent service-connected veterans with income above the VA's national means test threshold and below the VA's geographic means

test threshold based on the Department of Housing and Urban Development (HUD) index.

- **Priority Group 8:** Nonservice-connected veterans and zero percent noncompensable service-connected veterans with incomes above the HUD index who agree to pay co-payments. In January 2003, the VA closed enrollment to all new Priority Group 8 veterans seeking enrollment due to insufficient resources.

The VA is also obligated to provide two years of free health care to veterans who served in Iraq and Afghanistan. Every active-duty servicemember, Reservist or National Guard member who serves in a theater of combat operations is eligible for the full range of VA care for injuries or illnesses he or she believes is related to combat service. Veterans who enroll with VA under this authority will retain enrollment eligibility even after their two-year post discharge period ends under current enrollment policies.



Funding Reform Is Needed Now

Early in his first term, President Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. In its final report, the Task Force targeted health care funding reform as critical to the success of any VA-DoD collaboration of services. The Task Force also identified a significant mismatch between the demand for VA services and the availability of adequate funding which, if left unresolved, would delay veterans' access to care and threaten the quality of care provided.

In Recommendation 5.1, the Task Force noted:

> *The federal government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal.*

In January 2003, the Secretary of Veterans Affairs suspended the enrollment of Priority 8 veterans because of insufficient resources to accommodate all eligible veterans seeking care and treatment from the VA. These veterans, the Task Force stated, "do not know from year to year whether they will have access to VA care, and as an organization, the VA cannot effectively plan or budget, given this uncertainty." Declaring the situation regarding Priority 8 veterans unacceptable, the Task Force

recommended that the President and the Congress should work together to resolve the status of this group.

Although the Secretary of Veterans Affairs suspended the enrollment of Priority 8 veterans initially as a "temporary" measure, VA planning documents do not assume that Priority 8 veterans will ever be permitted to enroll in the system. And as resources continue to precipitously decline and more veterans are seeking health care services, veterans from other priority groups may also be barred from the system.

It is clear the current method of funding VA medical care is flawed. We strongly urge the Administration and Congress to act on the recommendations of the Task Force, and to reform the method for funding veterans health care to ensure a predictable and reliable funding stream. Providing health care to our nation's sick and disabled veterans is part of the cost of national defense and should be a top priority for our government.

Frequently Asked Questions

Does direct funding create a new entitlement?

- No. Direct funding neither creates an individual health care entitlement nor changes the VA's current mission, eligibility requirements, or medical benefits package.
- Direct funding only changes the way funds are provided for VA health care.

Will direct funding result in runaway costs?

- No. The Secretary of Veterans Affairs will retain the right to make an annual enrollment decision based on available resources.
- Although eligibility reform opened the VA health care system to all veterans, the vast majority of veterans choose other health care options.
- Direct funding will ensure that the VA receives a reliable, predictable, and consistent funding stream to provide timely, high-quality health care.

Will Congress lose oversight if direct funding of the VA health care system is instituted?

- No. As with other direct funded federal programs, Congress would retain oversight of VA programs and health care services.
- The VA will still be accountable to Congress for how its funds are spent and how well its health care programs are managed.
- Currently, almost 90 percent of federal health care spending is direct rather than discretionary. Only funding for active duty military, Native Americans, and veterans health care are left to the discretion of Congress.

Care for veterans who have served our nation with honor—and who are by law eligible to receive medical care from the VA—must be considered part of the continuing cost of the national defense. Congress must institute a rational, reliable means of funding the medical operations of the VA. What is needed is a mechanism that will enable every VA facility to provide quality care to sick and disabled veterans in a timely, cost-effective manner.

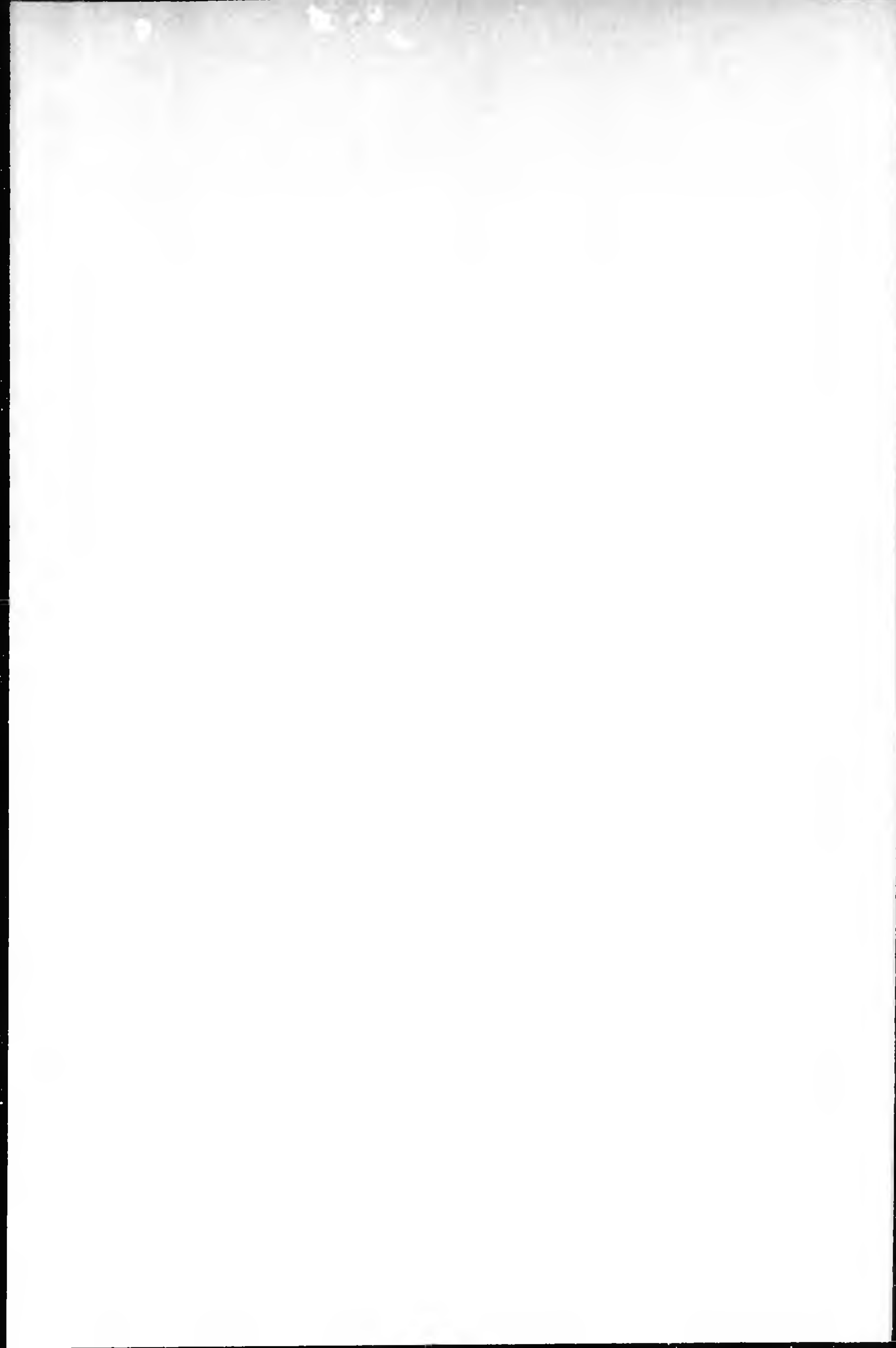
Providing for the health care needs of veterans should not be pitted against the needs of military families, or costs of a strong national defense. Caring for veterans is an American responsibility.

Open discussion on budget reform by our elected officials is necessary to determine a viable long-term solution to the VA's funding crisis. The time to act is now.

Supporting Documents

- *FY 2004 Performance and Accountability Report* – Office of the Budget, Department of Veterans Affairs. (November 2004)
- *Final Report 2003* – The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. (May 2003)
- *A System Worth Saving* – The American Legion. (September 2003)
- *The Independent Budget for Fiscal Year 2006* – AMVETS, DAV, PVA, and VFW. (February 2005)
- White Paper: *The Position of Vietnam Veterans of America on Health Care Funding for All Veterans* – Vietnam Veterans of America. (July 2003)
- White Paper: *America's Health Care Crisis: Where Does Veteran's Health Care Stand?* – Disabled American Veterans. (2005)

Notes



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Disabled American Veterans
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www.dav.org

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HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 13, 2008 **FURTHER REFERRALS: HES**

Date of Committee Action: February 26, 2008

The HOUSE SPECIAL COMMITTEE ON MILITIARY AND VETERANS' AFFAIRS considered: **SJR 11**

SENATE JOINT RESOLUTION NO. 11 **SUPPORTING U.S. VETERANS' HEALTH CARE**

Supporting federal funding for veterans' health care and urging the United States Congress to ensure adequate funding for veterans' health care.

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

[ ] attach amendments
[ ] add new referral to ___________Committee
[ ] Letter of Intent___________Committee

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

***NEW* FISCAL NOTES**
*Assigned by Chief Clerk's Office

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

***PREVIOUS* FISCAL NOTES**

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

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	Kawasaki	X			
[signature]	LeDoux	X			
Anna I. Fairclough	Fairclough	X			
[signature]	Dahlstrom	X			
R L Buch	Buch	X			
Chair: [signature]	ROSES	X			
Chair:					

ALASKA STATE LEGISLATURE

Co-chair, Joint Armed Services Committee
•
Senate Resources Committee
•
Senate Judiciary Committee
•
Senate Transportation Committee

Session
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SENATOR BILL WIELECHOWSKI

SJR 11 – Supporting Adequate Funding for Veteran's Health Care
Sponsor Statement

We owe our veterans a debt of gratitude that can never fully be repaid. One of the things we can, and must, do for our veterans is to honor the promises we have made to them. This starts with providing those veterans with access to the quality health care they deserve.

The press has documented the neglect of Walter Reed Army Medical Center, and former Secretary of Veterans Affairs Anthony Principi has publicly stated that the Department of Veterans Affairs has been struggling to provide health care to the rapidly rising number of veterans who require it.

As the state with the largest per capita number of veterans, it is essential that we send a clear signal of our commitment to care for our military personnel both on active duty and as veterans. While our legislature tries to do all we can for our vets and returning soldiers, our federal government has the primary responsibility of meeting the needs of our veterans. We need to call on Congress, as a state, to adequately fund critical veteran services.

We respectfully request the Alaska State Legislature to support this resolution to provide adequate federal funding for veterans' health care. Thank you.

ALASKA STATE COUNCIL

Senator Bettye Davis, Chair
Senate Health, Education, and Social Services Committee
February 4, 2008 Hearing on SJR11

Madame Chairwoman and Members of the committee:

Senator Wielechowski, Senate Chairman of the House/Senate Joint Committee on Military and Veterans Affairs, introduced **Senate Joint Resolution 11** in support of federally assured funding for veterans healthcare at our request. In Congress, **HB 2514** enacting "assured funding" is in the House Veterans Affairs Committee and has 115 cosponsors. We request your full and impassioned support of **SJR11**. This is an important official statement by Alaska to its veterans and especially those injured while standing guard for America. In passing SJR11 you join over tw .nty other states formally speaking out on this critical issue. We also hope you will carry this resolution to your respective national legislative organizations and ask for a similar national resolution by them as well.

Under the leadership of Vietnam Veterans of America, in 2004, the nine national Veteran Service Organizations, for the first time, came together and agreed that the highest priority for veterans across the nation was moving veteran healthcare funding from the "discretionary" budget to an assured funding mechanism. Following this historic agreement these nine national veteran organizations called on Congress to pass a federal law changing the manner of funding for veterans healthcare. All previous bills have failed on partisan votes. Frankly, we were surprised given the historic support a wide majority of veterans give to candidates, but that is changing. We believe that veteran healthcare should not be a partisan issue. It is the moral obligation of our nation, a "contract" signed with the blood of those willing to stand guard for America.

What are the key questions in the minds of legislators when they consider this issue?

1. **Does direct funding create a new entitlement?**

No. Direct funding neither creates an individual health care entitlement nor changes the VA's current mission, eligibility requirements, or medical benefits package. Remember these are "earned" rights.

2. **Will direct funding result in runaway costs?**

No. The Secretary of Veterans Affairs will retain the right to make an annual priority enrollment decision based on available resources. The vast majority of our veterans choose other healthcare options, although many may also be registered with the VA, they do not use its programs or facilities.

3. **Will Congress lose oversight if direct funding of the veterans healthcare system is instituted?**

No. As with other direct funded federal programs, Congress will retain oversight of VA programs and healthcare services. The VA will still be accountable to Congress for how its funds are spent and how well its healthcare programs are managed. Almost 90% of federal healthcare spending is direct

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rather than discretionary. Only funding for our active duty military, Native Americans, and veterans healthcare are left up to the annual partisan battles. Veteran healthcare should not be a partisan issue. These are "earned" rights by men and women injured while standing guard for America.

4. Why should the Alaska State Legislature support this resolution?

Alaska has just less than 80,000 veterans, the highest per capita number of veterans in America. [74,500 according to the 2000 US Census] We have already identified over $1 Billion in **annual** federal revenue to Alaska's veterans and their families, and this does not include military retirement, National Guard, reserve, active duty, or military contracts in Alaska. Stated simply, **it is in the financial best interest of Alaska** to ensure federal funding for veteran healthcare. Otherwise our state and local governments will have to cover, in many cases, the costs of medical services to our veterans.

Americans believe this is a "contract" a moral obligation of our nation to those who voluntarily step forward to stand guard for America. We MUST honor this service, we must care for those injured while in service, and we must honor the contract because if we don't fewer Americans will be willing to step up to that line of defense for America.

Unfortunately both of our national political parties have played the smoke and mirrors game on veteran healthcare funding. Claims of significant increases in funding are not fully honest, as most of these increases fail to keep up with medical cost inflation and new demands as a result of the war we are now engaged in. These reports do not honestly report on the whole VA healthcare system nor candidly place this care in the context of our overall national healthcare needs or system costs.

One of the greatest problems in Alaska is that **we do not know where our veterans are**. VVA supports a volunteer group of private retired military pilots and planes that go into rural Alaska to find our veterans and "connect" them to the services they legally are due. The VA is currently serving less than 20% of our veterans. We continue to ask for state legislation (previously introduced in the House as **HB44**) allowing the voluntary registration of all Alaskan veterans though the Permanent Fund Application form. This way the Alaska Department of Military and Veterans Affairs and our Congressionally Chartered Veteran Service Organizations can find and advise our veterans on their and their families, legal rights. If we could but double the percentage of Alaskan veterans served to 40%, we would significantly increase the annual federal injection of funds and services far beyond the current $1 Billion each year veterans generate to our economy. Please consider this additional legislative item soon. **It's in Alaska's best interest** and in the best interest of thousands of our veterans and their families.

With the recent national media attention to the problems of military and veteran healthcare highlighted by a part of the facility at Walter Reed Hospital, now is the time to act. Our nation's political will is poised to correct this historic failure of our government to honor its commitments to veterans.

We are asking state legislatures, national legislative organizations, the National Conference of Mayors, the National Governor's Association and any other national organization that cares about veterans to pass a simple resolution calling for Congress to act on assured funding for veteran healthcare.

We ask you to join Senator Wielechowski, the nine national Veteran Service Organizations, and more than 20 other states across America, in calling upon Congress to change the way veteran healthcare is funded. It is time we honored the "contract" and assured funding for veteran healthcare. Our veterans deserve nothing less.

We want to thank the staff of the Alaska State Legislature's Joint Military and Veterans Affairs Committee Chairs who helped craft this resolution for Alaska and are delighted with its introduction.

It is an honor,

Ric Davidge
Alaska State Council President
Vietnam Veterans of America

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February 26, 2008

Chairman Roses and Members of the Committee
House Special Committee on Milit ry and Veterans Affairs

According to the latest statistics, Alaska now has almost 80,000 veterans which, as you know, is the highest per capita in the United States. But under Federal and State privacy laws we are not longer able to find them and inform them of the rights and services they've earned.

Since the introduction last year of HB44 by Rep Guttenberg, Dahlstrom, Kerttula, & Lynn requiring the Permanent Fund Board include the question: "Are you an American Veteran?" on the PFD Dividend Application form we have done some homework.

We have met with the Governor's Advisory Council, staff of the AK Dept of Mil and Vet Affairs, and a number of Members of the House and Senate to examine the few concerns that have been raised. We believe that with a committee substitute, such as we have suggested, we have resolved these issues; mainly of list confidentiality. We respectfully request your consideration of the substitute language suggested and move this bill forward.

This is not just an act that will benefit our veterans and their families. This act is in the economic best interest of Alaska. Veterans annually generate over $1 Billion in funds and services to our state's economy - that with the VA serving less than 20% of our veterans. This small act enables our Alaska Department of Military and Veterans Affairs to locate and communicate with our veterans and their families. Every year Congress scolds the VA for its failure in "outreach" but this is honestly unfair, given all the restrictions now. In Alaska we have a unique means to accomplish this, by putting this simple question on the annual PFD Dividend Application. Then we can inform our veterans and their families of their rights to access services they earned.

VETERAN ECONOMIC VALUE TO ALASKA

- VA home loans represent **over half a billion** to our economy every year. (FY05 $584M 3,500 homes)
- Military retirement payments account for over **$165 Million** in direct cash to Alaskan families each year.
- Compensation for disabled terans adds **$97.2 Million** every year to our economy. (FY05 = 12,000 AK veterans w in-service connected disabilities. FY06 it will be well over $100 Million, 300 AK veterans received non-service connected pensions $2.2 Million)
- VA medical services, provided in Alaska represent **over $103 Million** in FY05.
- VA Education benefits 1,300 Alaska veterans totaling **$11 Million**.
- VA Survivor dependent benefits **$6.2 Million** in FY05

As you can see an increase of just 20% in the levels of service provided Alaska's veterans would have a significant positive economic impact on our state and these deserving families.

Thank you for your consideration of this important legislation.

Ric Davidge
State Council President

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

A revamped method of funding veterans' health care is the highest legislative priority of VVA. What is needed is a new mechanism to assure, or guarantee, funding of the VA's health care operations, one that will ensure VA planners of a predictable, reliable, sufficient, sustainable – and timely – funding stream. Such an innovation will not diminish congressional oversight, nor will it lead to spiraling costs. (What leads to higher expenditures is twofold: medical inflation and an influx of eligible veterans who choose to use the VA system for their health-care needs.)

More than 7 million of our nation's 23 million veterans are on the VA rolls. Some receive disability compensation for wounds or conditions incurred or exacerbated during or as a result of their military service. More than 5 million use the VA health care system as their provider of choice – or of last resort. Veterans whose income places them below the poverty line have few options; however, they are lucky to be served by a system that provides, for the most part, good to excellent care. Many others, who are so-called higher income veterans, have no medical insurance but are denied access to VA healthcare by the current administration as a matter of policy and by the fact that Congress has not allocated enough resources to take care of all who have earned the right to health care -- who were promised health care as a condition of their service. Still other veterans receive care privately but often cannot afford the prescription medications they need; for them, the VA prescription drug service is a godsend. And there are those who choose to avail themselves of the VA health care system because of the quality of care it provides, and they were fortunate enough to get into the system before the administration closed the door to these "Priority 8" veterans – more than half a million of them, it has been estimated, since 2003.

It is incumbent upon all of us to work together to continue to improve what is the largest integrated health care system in the country. We must ensure that the VA has the funding it needs to meet its mandate, to fulfill the promise of President Abraham Lincoln "To care for him who shall have borne the battle, and for his widow, and his orphan." To this end, we must work together to fashion a formula to fund the VA's health care operations – because the current discretionary method of funding is, in effect, arbitrary.

VVA believes, in concert with The Partnership for Veterans Health Care Budget Reform, that a fair funding formula can be arrived at, one that won't bust the budget, one that recognizes our nation's obligations to veterans and is indexed to medical inflation and the per capita use of the VA health care system.

A revamped funding mechanism for veterans' health care is one of a trio of overarching issues that we believe Congress must address. We know that many of your colleagues are less than enthusiastic about pouring dollars into a system that often cannot account for how this money is spent. There have been repeated instances of hundreds of millions of dollars dedicated to specific purposes, e.g., mental health or hepatitis C, that have been swallowed by VISN budgets with nary a trace, and the VA cannot or will not say what has happened to this taxpayer money.

VVA has long maintained that measures to **ensure accountability** must be built into any method of funding the VA health care system. An infusion of funding alone is a recipe for failure, and we do not endorse simply throwing dollars at a problem. Controls are needed to convince managers that it is in their best interest to do the job right the first time. Yes, give bonuses to key managers and others whose work shines; but also employ real sanctions when the job is not done right.

The Partnership for Veterans Health Care Budget Reform

Representing America's Veterans

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February 22, 2008

The Honorable Tim Johnson
136 Senate Hart Office Building
Washington, D.C. 20510-4104

Dear Senator Johnson:

On behalf of The Partnership for Veterans Health Care Budget Reform, we would like to take this opportunity to thank you for introducing S. 2639, the Assured Funding for Veterans Health Care Act.

Your bill would shift VA medical care from a discretionary to a mandatory funding status and provide VA sufficient, timely, and predictable funding to better address the needs of all veterans who require VA health care, including our newest generation of veterans returning from Iraq and Afghanistan.

For years The Partnership has argued that the current budget process fails to serve veterans. It is impossible for VA to properly plan for an upcoming fiscal year when so much uncertainty surrounds the passage of its appropriations bill and the level of health care funding it will receive. In an era of funding all government programs through continuing resolutions, Congress has been forced to confront VA health-care funding shortages with emergency or supplemental appropriations totaling nearly $3 billion for fiscal years 2005 and 2006, and $5.5 billion for fiscal years 2007 and 2008.

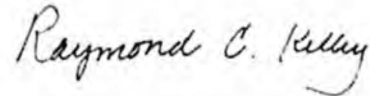
Although welcomed, temporary funding supplements provided by Congress in urgent circumstances have forced VA medical facilities to restrict services provided to veterans, delay hiring of new clinical staff, institute local and regional freelance policies to restrict eligibility and care, and impose a variety of questionable—and potentially hazardous—cost-cutting measures just to make ends meet. Despite recent funding increases for VA health care, today's budget process itself has basically paralyzed VA officials from more properly managing, planning and operating the VA system.

The time is now for all of us—Congress, the Administration, and the veterans' community—to come together to resolve the inherent problems involved in funding VA health care. We all must work together to find a long-term solution to provide VA with health care funding that is sufficient, timely, and predictable.

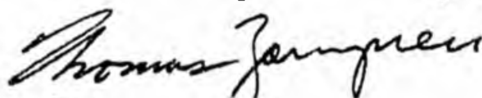
Again, we appreciate your strong advocacy and unwavering support on this important issue.

Sincerely,

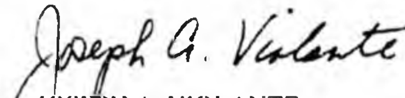
STEVE ROBERTSON
Legislative Director
The American Legion



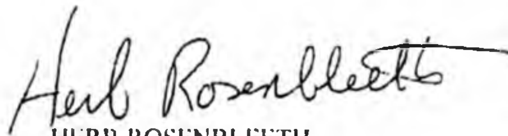
RAYMOND C. KELLEY
National Legislative Director
AMVETS (American Veterans)



THOMAS ZAMPIERI
Director of Government Relations
Blinded Veterans Association



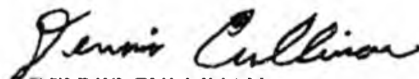
JOSEPH A. VIOLANTE
National Legislative Director
Disabled American Veterans



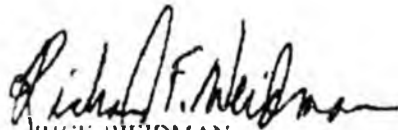
HERB ROSENBLEETH
National Executive Director
Jewish War Veterans of the USA

HERSHEL GOBER
National Legislative Director
Military Order of the Purple Heart of the USA, Inc.

CARL BLAKE
Legislative Director
Paralyzed Veterans of America



DENNIS CULLINAN
Legislative Director
Veterans of Foreign Wars of the United States



RICK WEIDMAN
Director of Government Relations
Vietnam Veterans of America, Inc.

IMMEDIATE RELEASE

February 13, 2008

Contact:
Mokie Pratt Porter
301-585-4000, Ext. 146

VA Budget Proposal Short by $3 Billion

(WASHINGTON, DC) – "The annual exercise of debating the merits of the President's proposed budget is flawed," said John Rowan, National President of Vietnam Veterans of America, before the Senate Committee on Veterans' Affairs. "Medical Center directors should not be held in limbo as Congress adjusts this budget and misses, yet again, the start of the fiscal year.

"These public servants can be more effective and efficient managers if they are able to properly plan for the funding needed to care for their patients. We ask that you consider an immediate alternative to the broken system we currently have," Rowan said.

Rowan characterized as "inadequate" the FY'09 request for $2.34 billion more than the FY'08 appropriation. This "barely keeps up with inflation" and "will not allow the Department of Veterans Affairs to continue enhancing its physical and mental health care services for returning veterans, restore needed long-term care programs for aging veterans, or allow working-class veterans to return to their health care system."

To accommodate these goals, Rowan said, VVA recommends an increase of $5.24 billion over FY'08. Of this amount, $1.3 billion should be dedicated to restoring access to Priority 8 veterans who were "temporarily" barred from entering the system five years ago.

Rowan condemned the proposed budget for again attempting to tax "higher income" veterans with an annual fee and for nearly doubling the co-payment for prescription drugs. "This is further evidence," Rowan said, "of the attempt to rid the system of as many "higher income" veterans as possible."

Rowan was skeptical that the President's budget will provide resources "to virtually eliminate the patient waiting list by the end of 2009." He voiced concern that the budget will provide adequate resources "to deal with the flood of troops and veterans returning to our shores and presenting with a range of mental health issues."

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

Honorable Bob Roses, Chair
House Military and Veterans Affairs Committee
State Capitol, Room 416
Juneau, Alaska 99801

and

Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
State Capitol, Room 403
Juneau, Alaska 99801

February 25, 2008

Re: Support of SJR 11 *Supporting U.S. Veterans' Health Care*

Dear (H)MVA Chair, Representative Roses, and (H)HESS Chair, Representative Wilson and Members of Your Respective Committees,

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans and is strongly in support of SJR 11 *Supporting U.S. Veterans' Health Care.* Many of the veterans in Alaska reside in medically underserved areas; with the current funding levels and criteria for VA sponsored health care, many of our Alaskan veterans do not have adequate primary care access. When the medical condition is not service-related and does not exceed a certain degree of disability, these veterans in outlying areas have primarily three choices: 1) cover their own expenses to fly in to Anchorage or Fairbanks to access VA care; 2) go without care; or 3) access services at a non-VA clinic, very likely to be one of the 124 Community Health Center (CHC) sites in the state.

For those veterans who opt for the third choice above, often, the CHC does not receive reimbursement because the veteran did not file the necessary paperwork in advance. The CHC typically eats the cost. The APCA is working at this time with the Alaska VA Health Care System to increase access for all the veterans who live in areas outside of the vicinity of the VA clinics, including all the veterans who have gone without but need care and all those who have had limited care because of the cost of travel.

It is very important that Congress adequately fund VA health care so that veterans from every corner of Alaska have appropriate access – all veterans, those returning from the current conflict with pressing issues as well as those who served previously and are experiencing increasing health care needs as they age.

The Alaska Primary Care adamantly supports SJR 11 and appreciates the Alaska State Legislature working to promote health care access for veterans throughout the state by passing this important resolution in order to communicate this priority to the U.S. Congress.

Supporting health care for Alaska's veterans,

Regan Mattingly	Shelley S. Hughes	Marilyn Kasmar
State Affairs Coordinator	Government Affairs Director	Executive Director

Alaska Primary Care Association
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Anchorage, AK 99503

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ALASKA STATE LEGISLATURE

Co-chair, Joint Armed Services Committee
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Senate Resources Committee
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Senate Judiciary Committee
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Senate Transportation Committee

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SENATOR BILL WIELECHOWSKI

February 26, 2008

Representative Peggy Wilson, Chair
House Health, Education and Social Services Committee
Room 403, State Capitol
Juneau, Alaska 99801

I respectfully request a hearing on SJR 11, a resolution supporting federal funding for veterans' health care and urging the United States Congress to ensure adequate funding for veterans' health care.

This simple resolution expresses gratitude for and recognizes the sacrifices made by veterans who suffer from medical and mental problems resulting from injuries sustained while serving in the U.S. Armed Forces. It urges the United States Congress to increase funding for veteran's health care in light of the funding inadequacies that exist today.

SJR 11 recently passed the Senate unanimously. It has the support of the Alaska chapter of Vietnam Veterans of America, the Alaska Veterans Foundation, the Anchorage chapter of the Military Order of the Purple Heart, the Alaska chapter of Veterans of Modern Warfare, and the Alaska Veterans Business Alliance.

Thank you for your speedy consideration of this request.

Sincerely,

Senator Bill Wielechowski

Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910 • Telephone (301) 585-4000
Main Fax (301) 585-0519 • Advocacy (301) 585-3180 • Communications (301) 585-5245 • Finance (301) 585-5542
World Wide Web: http://www.vva.org

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

A revamped method of funding veterans' health care is the highest legislative priority of VVA. What is needed is a new mechanism to assure, or guarantee, funding of the VA's health care operations, one that will ensure VA planners of a predictable, reliable, sufficient, sustainable – and timely – funding stream. Such an innovation will not diminish congressional oversight, nor will it lead to spiraling costs. (What leads to higher expenditures is twofold: medical inflation and an influx of eligible veterans who choose to use the VA system for their health-care needs.)

More than 7 million of our nation's 23 million veterans are on the VA rolls. Some receive disability compensation for wounds or conditions incurred or exacerbated during or as a result of their military service. More than 5 million use the VA health care system as their provider of choice – or of last resort. Veterans whose income places them below the poverty line have few options; however, they are lucky to be served by a system that provides, for the most part, good to excellent care. Many others, who are so-called higher income veterans, have no medical insurance but are denied access to VA healthcare by the current administration as a matter of policy and by the fact that Congress has not allocated enough resources to take care of all who have earned the right to health care – who were promised health care as a condition of their service. Still other veterans receive care privately but often cannot afford the prescription medications they need; for them, the VA prescription drug service is a godsend. And there are those who choose to avail themselves of the VA health care system because of the quality of care it provides, and they were fortunate enough to get into the system before the administration closed the door to these "Priority 8" veterans – more than half a million of them, it has been estimated, since 2003.

It is incumbent upon all of us to work together to continue to improve what is the largest integrated health care system in the country. We must ensure that the VA has the funding it needs to meet its mandate, to fulfill the promise of President Abraham Lincoln "To care for him who shall have borne the battle, and for his widow, and his orphan." To this end, we must work together to fashion a formula to fund the VA's health care operations – because the current discretionary method of funding is, in effect, arbitrary.

VVA believes, in concert with The Partnership for Veterans Health Care Budget Reform, that a fair funding formula can be arrived at, one that won't bust the budget, one that recognizes our nation's obligations to veterans and is indexed to medical inflation and the per capita use of the VA health care system.

A revamped funding mechanism for veterans' health care is one of a trio of overarching issues that we believe Congress must address. We know that many of your colleagues are less than enthusiastic about pouring dollars into a system that often cannot account for how this money is spent. There have been repeated instances of hundreds of millions of dollars dedicated to specific purposes, e.g., mental health or hepatitis C, that have been swallowed by VISN budgets with nary a trace, and the VA cannot or will not say what has happened to this taxpayer money.

VVA has long maintained that measures to **ensure accountability** must be built into any method of funding the VA health care system. An infusion of funding alone is a recipe for failure, and we do not endorse simply throwing dollars at a problem. Controls are needed to convince managers that it is in their best interest to do the job right the first time. Yes, give bonuses to key managers and others whose work shines; but also employ real sanctions when the job is not done right.

ALASKA STATE COUNCIL

Representative Bob Roses, Chairman
House Military and Veterans Affairs Committee
REF: SJR11

Chairman Roses:

Senator Wielechowski, Senate Chairman of the House/Senate Joint Committee on Military and Veterans Affairs, introduced **Senate Joint Resolution 11** in support of federally assured funding for veterans healthcare at our request. In Congress, **HB 2514** enacting "assured funding" is in the House Veterans Affairs Committee and has 115 cosponsors. Additionally, a major new GI Bill is being crafted that will also address assuring veteran healthcare funding.

We request your full and impassioned support of **SJR11**. This is an important official statement by Alaska to its veterans and especially those injured while standing guard for America. In passing SJR11 Alaska will join over twenty other states formally speaking out on this critical issue. We also hope you will carry this resolution to your respective national legislative organizations and ask for a similar national resolution by them as well.

Under the leadership of Vietnam Veterans of America, in 2004, the nine national Veteran Service Organizations, for the first time, came together and agreed that the highest priority for veterans across the nation was moving veteran healthcare funding from the "discretionary" budget to an assured funding mechanism. Following this historic agreement these nine national veteran organizations called on Congress to pass a federal law changing the manner of funding for veterans healthcare. All previous bills have failed on partisan votes. Frankly, we were surprised given the historic support a wide majority of veterans give to candidates, but that is changing. We believe that veteran healthcare should not be a partisan issue. It is the moral obligation of our nation, a "contract" signed with the blood of those willing to stand guard for America.

The Partnership for Veterans Health Care Funding Reform has published a small booklet that we would like to provide you and the members of your committee prior to the hearing. With your agreement we would like to send you the appropriate number of copies as soon as possible.

What are the key questions in the minds of legislators when they consider this issue?

1. **Does direct funding create a new entitlement?**

   No. Direct funding neither creates an individual health care entitlement nor changes the VA's current mission, eligibility requirements, or medical benefits package. Remember these are "earned" rights.

2. **Will direct funding result in runaway costs?**

   No. The Secretary of Veterans Affairs will retain the right to make an annual priority enrollment decision based on available resources. The vast majority of our veterans choose other healthcare options, although many may also be registered with the VA, they do not use its programs or facilities.

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(907) 222-6945 fax (907) 222-6933 Email: ricdavidge.ak@gci.net

3. **Will Congress lose oversight if direct funding of the veterans healthcare system is instituted?**

No. As with other direct funded federal programs, Congress will retain oversight of VA programs and healthcare services. The VA will still be accountable to Congress for how its funds are spent and how well its healthcare programs are managed. Almost 90% of federal healthcare spending is direct rather than discretionary. Only funding for our active duty military, Native Americans, and veterans healthcare are left up to the annual partisan battles. Veteran healthcare should not be a partisan issue. These are "earned" rights by men and women injured while standing guard for America.

4. **Why should the Alaska State Legislature support this resolution?**

Alaska has just less than 80,000 veterans, the highest per capita number of veterans in America. [74,500 according to the 2000 US Census] We have already identified over $1 Billion in **annual** federal revenue to Alaska's veterans and their families, and this does not include military retirement, National Guard, reserve, active duty, or military contracts in Alaska. Stated simply, **it is in the financial best interest of Alaska** to ensure federal funding for veteran healthcare. Otherwise our state and local governments will have to cover, in many cases, the costs of medical services to our veterans.

Americans correctly believe this is a "contract" a moral obligation of our nation to those who voluntarily step forward to stand guard for America. We MUST honor this service, we must care for those injured while in service, and we must honor the contract because if we don't fewer Americans will be willing to step up to that line of defense for America.

Unfortunately both of our national political parties have played the smoke and mirrors game on veteran healthcare funding. Claims of significant increases in funding are not fully honest, as most of these increases fail to keep up with medical cost inflation and new demands as a result of the war we are now engaged in. These reports do not honestly report on the whole VA healthcare system nor candidly place this care in the context of our overall national healthcare needs or system costs.

One of the greatest problems in Alaska is that **we do not know where our veterans are**. VVA supports a volunteer group of private retired military pilots and planes that go into rural Alaska to find our veterans and "connect" them to the services they legally are due. The VA is currently serving less than 20% of our veterans. We continue to ask for state legislation (previously introduced in the House as **HB44**) allowing the voluntary registration of all Alaskan veterans though the Permanent Fund Application form. This way the Alaska Department of Military and Veterans Affairs and our Congressionally Chartered Veteran Service Organizations can find and advise our veterans on their and their families, legal rights. If we could but double the percentage of Alaskan veterans served to 40%, we would significantly increase the annual federal injection of funds and services far beyond the current $1 Billion each year veterans generate to our economy. Please consider this additional legislative item soon. **It's in Alaska's best interest** and in the best interest of thousands of our veterans and their families.

With the recent national media attention to the problems of military and veteran healthcare highlighted by a part of the facility at Walter Reed Hospital, now is the time to act. Our nation's political will is poised to correct this historic failure of our government to honor its commitments to veterans.

We are asking state legislatures, national legislative organizations, the National Conference of Mayors, the National Governor's Association and any other national organization that cares about veterans to pass a simple resolution calling for Congress to act on assured funding for veteran healthcare.

We ask you to join Senator Wielechowski and the other members of the Alaska Legislature supporting SJR11, the nine national Veteran Service Organizations, and more than 20 other states across America, in calling upon Congress to change the way veteran healthcare is funded. It is time we honored the "contract" and assured funding for veteran healthcare. Our veterans deserve nothing less.

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We want to thank the staff of the Alaska State Legislature's Joint Military and Veterans Affairs Committee Chairs who helped craft this resolution for Alaska and are delighted with its introduction.

It is an honor,

Ric Davidge
Alaska State Council President
Vietnam Veterans of America

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ALASKA STATE LEGISLATURE

Co-chair, Joint Armed Services Committee
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Resources Committee
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Judiciary Committee
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Transportation Committee

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SENATOR BILL WIELECHOWSKI

February 13, 2008

Representative Bob Roses, Chair
House Military and Veterans Affairs Committee
Room 416, State Capitol
Juneau, Alaska 99801

I respectfully request a hearing on SJR 11, a resolution supporting federal funding for veterans' health care and urging the United States Congress to ensure adequate funding for veterans' health care.

This simple resolution expresses gratitude for and recognizes the sacrifices made by veterans who suffer from medical and mental problems resulting from injuries sustained while serving in the U.S. Armed Forces. It urges the United States Congress to increase funding for veteran's health care in light of the funding inadequacies that exist today.

SJR 11 recently passed the Senate unanimously. It has the support of the Alaska chapter of Vietnam Veterans of America, the Alaska Veterans Foundation, the Anchorage chapter of the Military Order of the Purple Heart, the Alaska chapter of Veterans of Modern Warfare, and the Alaska Veterans Business Alliance.

Thank you for your speedy consideration of this request.

Sincerely,

Senator Bill Wielechowski

SJR

18

ALASKA STATE LEGISLATURE

Co-chair, Joint Armed Services Committee
•
Senate Resources Committee
•
Senate Judiciary Committee
•
Senate Transportation Committee

Session:
State Capitol, Rm. 115
Juneau, AK 99801
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SENATOR BILL WIELECHOWSKI

SJR 18: Toxic Toys
Sponsor Statement

Numerous recalls of children's toys and other products have filled the headlines in recent years. These recalls have also illuminated a weakness in consumer protection and child safety: the regulatory agency, the Consumer Product Safety Commission (CPSC) does not analyze toys or children's products for the presence of chemicals linked to harmful health and developmental impacts, like lead. SJR 18 requests the federal government to test of children's toys for these dangerous chemicals.

The CPSC conducts tests to determine if a toy presents a choking, aspiration or ingestion hazard but relies on toy and child product manufacturers to self-regulate the materials used (and thus toxicity levels) in their products.

Recalls are mostly voluntary and occur when a company alerts the agency of a problem. This past summer, millions of toys were recalled because of dangerous levels of lead paint. The only federal law applies only to lead in paint—it does not regulate it in other materials, making lead in vinyl (PVC) products (like teething rings and baby bibs) legal.

SJR 18 requests that the materials used in toys and other children's products be tested for toxicity and to make the results publicly available to protect children, the public, and workers who handle the products. Please join us in protecting our children's health.

Potential Witnesses/Sites

Kristin Ryan, Department of Environmental Conservation – Juneau

Sue [illegible]ly, Alaska Conservation Alliance – Juneau

Pam Miller, Alaska Community Action on Toxics—Anchorage

Alaska Conservation Alliance

Uniting for Alaska's Future

March 14, 2008

The Honorable Senator Wielechowski
State Capitol
Juneau, Alaska 99801

Re: SJR 18 – Child Product Safety

Dear Senator Wielechowski,

On behalf of the Alaska Conservation Alliance (ACA), a consortium of 40 Alaska-based conservation groups, I would like to express our support for SJR 18, a resolution that would encourage the President of the United States and the Consumer Products Safety Commission (CPSC) to better test toys and products intended for use by children and make that information public.

Recent headlines have brought attention to the problem of lead and other chemicals present in common toys. On Wednesday of this week the CPSC issued a recall of X Force Commander Toy Airplanes and Super Famous Toy Cars and Motorcycles for containing excessive levels of lead in paint. Last year over half of the toy recalls were due to lead and chemical contamination. Children are particularly vulnerable to exposure to lead and other chemicals because their brain, central nervous system and other vital organs are still forming. For example, even low level exposure to lead can result in lower IQ, learning disabilities, behavioral problems, slowed growth and hearing problems.

Additionally, scientific research continues to point to increased contaminant levels in Alaska due to ocean currents and deposition patterns. Subsequently, Alaskan children are not only exposed to chemicals in their toys and products but also chemicals in their environmental surroundings.

This resolution urges greater research into the toys we give our children and dissemination of that information. This will allow Alaskan parents to make better-informed decisions about which products to give their children. SJR 18 is an important first step towards raising awareness about the chemicals present in our children's toys and giving all parents the information needed to make decisions about the health and safety of their children. ACA strongly encourages the Alaska Legislature to pass SJR 18.

Sincerely,

Kate Troll
Executive Director

CC: Senator Davis, Senator Thomas, Senator Cowdery, Senator Elton, Senator Dyson

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HTS - 9503: TOYS, INCLUDING RIDING TOYS O/THAN BICYCLES; DOLLS, PUZZLES; REDUCED SCALE MODELS; PARTS AND ACCESSORIES THEREOF

U.S. Imports For Consumption

Country	2005	2006	2007	Percent Change 2006 - 2007
	In 1,000 Dollars			
China	7,298,871	7,328,765	9,239,273	26.1%
Mexico	126,436	113,137	263,215	132.7%
Denmark	113,690	129,009	162,470	25.9%
Taiwan	125,986	124,893	159,828	28.0%
Hong Kong	100,459	115,650	99,729	-13.8%
Indonesia	24,648	20,224	91,681	353.3%
Canada	81,640	66,456	66,812	0.5%
Thailand	68,692	86,744	64,853	-25.2%
Germany	48,107	45,758	53,575	17.1%
Malaysia	48,892	47,539	49,915	5.0%
Japan	43,162	39,089	43,745	11.9%
Vietnam	23,560	25,564	37,127	45.2%
Italy	24,448	19,116	35,886	87.7%
Czech Republic	14,825	16,628	20,125	21.0%
Korea	25,504	18,335	18,395	0.3%
Subtotal :	8,168,921	8,196,908	10,406,629	27.0%
All Other:	100,982	99,787	94,988	-4.8%
Total	**8,269,902**	**8,296,695**	**10,501,617**	**26.6%**

Sources: Data on this site have been compiled from tariff and trade data from the U.S. Department of Commerce and the U.S. International Trade Commission.

	2007 Toy Recalls	
AAFES	Lead Paint	"Soldier Bear"
Dollar Tree Stores	Lead Paint	Children's Toys
Jo-Ann Fabric and Craft Stores	Lead Paint	Children's Water Globes
Far East Brokers	Lead Paint	Fishing Games Sold at Grocery Stores
Bell Racing	Lead Paint	Collectible Mini Racing Helmets
Marvel Toys	Risk of Lead Exposure	Curious George Plush Dolls
Schylling Associates	Lead Paint	Collectable Toy Robot
Schylling Associates	Lead Paint	Dizzy Ducks Music Box
Schylling Associates	Lead Paint	Spinning Top
Schylling Associates	Lead Paint	Duck Family Collectable Toy
Dollar General	Lead Paint	Toy Cars
International Sourcing Ltd.	Lead Paint	Toy Dragster and Funny Car
Henry Gordy International	Lead Paint	Toy Figures
Toys "R" Us	Lead Paint	Elite Operations Toys
SimplyFun	Risk of Lead Exposure	Ribbit Board Games
Jo-Ann Stores	Lead Paint	Children's Toy Garden Tools
Fisher Price	Lead Paint	Go Diego Go Boat Toys
J.C. Penney	Lead Paint	Disney™ Winnie-the-Pooh Play Sets
Kipp Brothers	Excessive Lead	Bendable Dinosaur Toys
Toys "R" Us	Lead Paint	Children's Decorating Sets
Eveready Battery Co.	Lead Paint	Toy Flashlights
Kids II	Lead Paint	Baby Einstein Color Blocks
KB Toys	Lead Paint	Wooden Toys
Guidecraft Inc.	Lead Paint	Children's Puppet Theaters
Jo-Ann Fabric and Craft Stores	Lead Paint	Children's Toy Rakes
RC2	Lead Paint	Knights of the Sword Toys
Target	Lead Paint	Children's Toy Gardening Tools and Chairs
RC2 Corp.	Lead Paint	Additional Thomas & Friends™ Wooden Railway Toys
Fisher-Price	Lead Paint	Bongo Band Toys
Fisher-Price	Lead Paint	Geo Trax Locomotive Toys
Mattel	Lead Paint	Barbie® Accessory Toys
Schylling Associates	Lead Paint	Thomas and Friends, Curious George and Other Spinning Tops and Tin Pails
Hampton Direct	Lead Exposure Risk	Magnetic Toy Train
Mattel	Violation of Lead Safety	"Sarge" Die Cast Toy Cars
Fisher-Price	Lead Poisoning Hazard	Licensed Character Toys
AAFES	Lead Poisoning Hazard	"Soldier Bear" Toy Sets
RC2 Corp.	Lead Poisoning Hazard	Various Thomas & Friends™ Wooden Railway Toys
Gemmy Industries Corp.	Chemical Hazard	Flashing Eyeball Toys
The Boyds Collection Ltd.	Lead Poisoning Hazard	Toy Drums
AAFES	Lead Poisoning Hazard	"Soldier Bear" Toy Sets
Target	Lead Poisoning Hazard	Anima Bamboo Collection Games
Regent Products Corp.	Lead Hazard	Stuffed Ball Toys
Toys "R" Us	Lead and Laceration Hazards	"Elite Operations" Toy Sets

	2007 Child Product Recalls	
Discount School Supply	Lead Paint	Measuring Chart
Codee International Corp.	Risk of Lead Exposure	Children's Jewelry
United Scientific	Lead Paint	Horseshoe Magnets
RC2	Lead Paint	Potty Training Seats
Loppy Pillows	Lead Exposure	Slipcovers
Raymond Geddes & Co.	Lead Paint	Children's Pencil Pouches
Buy-Rite	Risk of Lead Exposure	Children's Metal Jewelry
Cherrydale Fundraising	Risk of Lead Exposure	Bracelets
Colossal Jewelry & Accessories	Risk of Lead Exposure	Children's Metal Jewelry
La Femme NY Inc.	Risk of Lead Exposure	Earring Sets
Pure Allure sold at Michael's	Children	Metal Jewelry
Discount School Supply	Lead Paint	Paint Brushes
Family Dollar Stores	Children	Metal Jewelry
FGX International	Lead Paint	Children's Sunglasses
Hobby Lobby Stores	Lead Paint	Halloween-Themed Baskets
Dollar General	Lead Paint	Children's Sunglasses
Northern Tool & Equipment	Lead Paint	"Big Red" Wagons
	Lead Paint	Pearl-like Bead Attachment Sold with Girl's Gift Sets
Amscan Inc.	Lead Paint	Halloween "Ugly Teeth"
Family Dollar Stores	Lead Paint	Halloween Pails
Dollar Tree Stores Inc.	Risk of Lead Exposure	Children's Jewelry
We( )w International	Risk of Lead Exposure	Children's Metal Jewelry
Albert's	Lead Paint	Halloween Skull Pails
Antioch Publishing	Lead Paint	Additional Bookmarks
Guidecraft Inc.	Lead Paint	Children's Puppet Theaters
J.C. Penney	Lead Paint	Deluxe Art Sets
Store®	Lead Paint	Travel Art Sets
Flaghouse Inc.	Lead Paint	Kidnastics Balance Beams
Kahoot Products Inc.	Lead Paint	Cub Scouts Totem Badges
Antioch Publishing	Lead Paint	Bookmarks and Journals
Dollar General	Risk of Lead Exposure	Key Chains
Dollar General	Lead Paint	Tumblers
TOBY N.Y.C.	Risk of Lead Exposure	Children's Metal Jewelry
Rhode Island Novelty	Risk of Lead Exposure	Metal Necklaces
Toys "R" Us	Lead Paint	Wooden Coloring Cases
Jo-Ann Fabric and Craft Stores	Violation of Lead in Paint Ban	Children's Watering Cans
Martin Designs Inc.	Lead Paint	Character Address Books and Journals
Buy-Rite	Risk of Lead Exposure	Children's Charm Bracelets
TOBY N.Y.C.	Risk of Lead Exposure	Children's Metal Jewelry
Fisher-Price	Lead Poisoning Hazard	Licensed Character Toys
Wal-Mart Stores / Uncas Manufacturing Co.	Lead Poisoning Hazard	Children's Earrings
Future Industries	Lead Poisoning Hazard	Children's Metal Jewelry
GeoCentral	Lead Poisoning Hazard	Children's Necklaces

Limited Too and Justice Stores	Lead Poisoning Hazard	Children's Metal Jewelry
Troy-Bilt	Lead Poisoning Hazard	Children's Gardening Gloves
Cardinal Distributing	Lead Poisoning Hazard	Children's Rings
Spandrel Sales and Marketing	Lead Poisoning Hazard	Children's Metal Jewelry
Cardinal Distributing	Lead Poisoning Hazard	Children's Rings
Oriental Trading Company Inc.	Lead Hazard	Children's Necklaces
Cardinal Distributing Co.	Lead Poisoning Hazard	Charm Bracelets
Dollar General	Lead Poisoning Hazard	Various Metal Key Chains
A&A Global Industries	Lead Poisoning Hazard	Children's Bracelets
Rhode Island Novelty	Lead Poisoning Hazard	Children's Mood Necklaces
Claire's Stores	Lead Poisoning Hazard	Children's Necklaces
Accessories Palace	Lead Poisoning Hazard	Children's Necklaces
H & M Recalls	Choking, Poisoning Hazards	Boy's Jackets
Discount School Supply	Lead Poisoning Hazard	Children's Two-Sided Easels
Big Lots! Stores / Lari Jewelry Company	Lead Poisoning Hazard	Children's Rings
Kmart / Crimzon Rose	Lead Poisoning Hazard	Children's Jewelry
Samara Brothers	Lead Poisoning Hazard	Boys' Jackets
DM Merchandising	Lead Poisoning Hazard	Children's Bracelets
Shalom International	Lead Poisoning Hazard	Children's Rings
U.S. Toy Co.	Lead Poisoning	Children's Butterfly Necklaces
Samara Brothers	Snaps Contain Lead	Sets