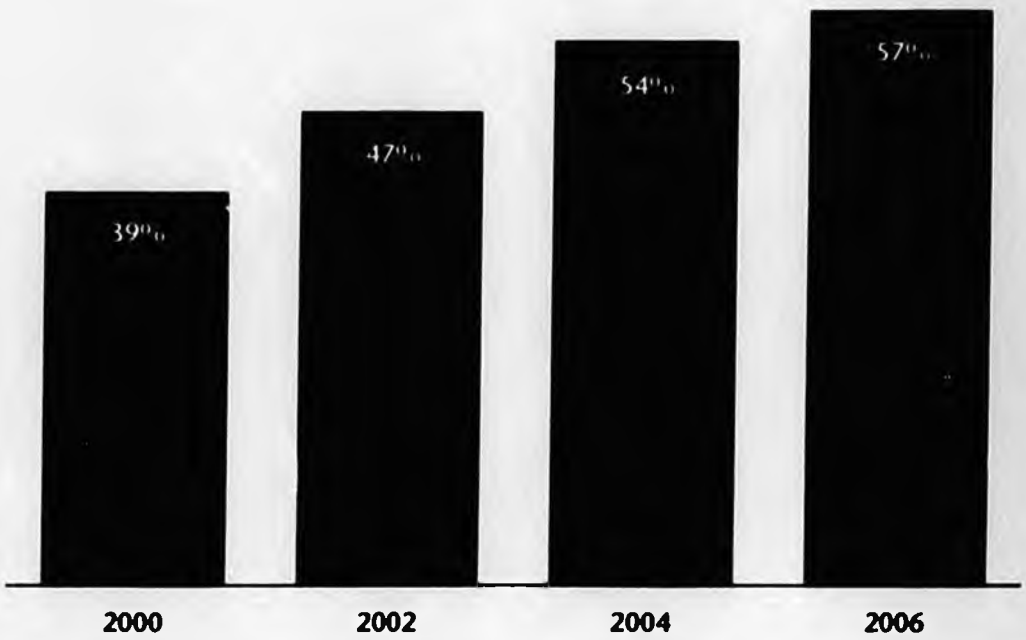
Had a Sigmoidoscopy or Colonoscopy

in the Past 5 Years, Percent of Adults Ages 50+



Percent of Adults Ages 50+ by Race/Ethnicity (Confidence Interval):				
White	39% (37% - 42%)	48% (45% - 50%)	55% (52% - 57%)	58% (56% - 60%)
Black	54% (41% - 67%)	49% (34% - 63%)	54% (41% - 66%)	60% (51% - 69%)
Hispanic	30% (20% - 40%)	35% (24% - 45%)	51% (41% - 61%)	49% (40% - 58%)
Asian	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data

Source: Massachusetts Department of Public Health (DPH) results from the Behavioral Risk Factor Surveillance System (BRFSS) for 2000, 2002, 2004, and 2006. The BRFSS survey is conducted throughout the year.

The number of Massachusetts residents ages 50 and over that reported having a sigmoidoscopy or colonoscopy to screen for colorectal cancer has increased significantly since 2000.

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Publication Number: 1542

Cover Logo Design by Harry O. Lehr, Jr.

Alaska State Legislature

Senator Hollis French
Senator Johnny Ellis
Senator Bill Wielechowski

Contact: Senator French
716 West 4th Avenue, Suite 420
Anchorage, Alaska 99501
Phone: (907) 465-3892
Fax: (907) 465-6595

Jan. 2008 - Changes in the CS for Senate Bill 160

The following modifications have been made after substantial public comment on the legislation:

- The Health Care Board will provide recommendations on what plan types should be available through the clearinghouse, but they will not decide what benefits are or aren't included. The bill will require that all accountable health care plans include:
  - Preventative and primary care
  - Emergency Services
  - Hospitalization
  - Ambulatory patient services
  - Prescription Drugs
  - Mental health services

- The Health Care Board will review potential cost saving options and give recommendations to the legislature and department of Health and Social Services through an annual report. The board will also review options for maximizing federal funds for the program.

- The Health Care Board will set criteria and compare different health plans by the financial outline they set forth for participants, allowing individuals to compare options side by side.

- Employers who arrange for employees to purchase coverage using pre-tax dollars, through establishing Section 125 cafeteria plans, won't be subject to the employer levy.

- A right to a hearing will ensure that anyone who cannot afford coverage, under the plans framework, won't be required to acquire coverage under the mandate.

- Young adult plans will have different financial criteria, allowing for plans that have annual benefit caps but lower co-pays, deductibles and out of pocket expense limits. This element will make premiums more affordable for a percentage of the population that doesn't usually require much care.

- The bill will clarify that employers can send employees to the clearinghouse with vouchers they fund, covering all or a portion of health care costs.

- Illegal residents won't receive state subsidized health coverage under the bill.

- An open season will occur at least once a year, where individuals can switch plan types and providers. New entrants to the market can purchase coverage at any time.

- Individuals who can no longer afford the plan they are enrolled in due to unforeseeable circumstances can apply to transfer to a different plan at any time, independent of the open season.

- Individuals who are only qualified for coverage through ACHIA will be granted larger needs based vouchers that will make the fiscal impact of purchasing a plan equivalent to purchasing traditional coverage through the clearinghouse.

- One registered nurse and the Commissioner of Health and Social Services were added to the Health Care Board.

- New Alaska residents will have to wait for one year before receiving needs based vouchers, much like the Permanent Fund currently requires. These new residents will not have an obligation to have health coverage during that time.

- IHS recipients have the option of utilizing the clearinghouse for health care benefits, but won't need additional coverage to fulfill the individual responsibility clause.

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Detailed Bill Summary

SECTION 1 of the bill – Findings

SECTION 2 of the bill - Provides the framework for the bill

Sec. 21.54.200: Establishes the health care program

This section lays out what the legislation will accomplish.

- it ensures that all state residents can afford quality health coverage that suits their particular needs
- it requires that health coverage is meaningful, as discussed later in AS 21.54.250
- it reduces unsustainable health care cost increases, through encouraging primary care and prevention
- it centers on consumer choice by providing a framework for competition, where insurance plans must compete to acquire and retain customers

Sec. 21.54.210: Establishes the Alaska Health Care Board

This section establishes the Alaska Health Care Board under the Department of Health and Social Services. The board will have 13 voting members, and will include:

- two representatives from the insurance industry
- one representative that works for a large business
- one representative that works for a small business
- two representatives from Alaska hospitals
- one representative of a labor organization
- two licensed Alaska physicians
- two consumer advocates
- one registered nurse
- the commissioner of Health and Social Services, or their designee

Each member, except the commissioner, serves a 3 year term and are subject to appointment and reappointment by the Governor. Members will be entitled to standard per diem and transportation costs under AS 39.20.180. The board will select a chair and a vice chair, and a majority of the board will be considered a quorum for transacting business.

Sec. 21.54.220: Defines the powers and duties of the Alaska Health Care Board

The board oversees two of the main elements in this bill: the health care Clearinghouse and the health care fund, the function of which are described in later sections of the bill.

In particular, the board will:

- ensure that a variety of plans are available in the clearinghouse, where individuals make plan selections based on their personal needs
- help educate the public about different plan options, and ensure that residents are enrolled in a health benefit plan
- establish enrollment criteria and procedures for individuals, and provide for an annual open season when customers can change their plan selections.

For more information, contact Sen. French's office:
Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

In particular, the board will *(continued)*:

- The board will hear complaints or objections to decisions made by the program or clearinghouse. Individuals who feel aggrieved by a decision of the board are entitled to a hearing
- Establish criteria and implement the voucher system, which will be discussed in a later section

Sec. 21.54.230: Alaska Health Care Clearinghouse
The health care clearinghouse will be the 'place' where Alaskans are connected up with private health plans that suit their needs. The clearinghouse will disseminate information about health insurance and the plans that are 'certified' to fulfill the essential health care services criteria, as defined later in the bill.

The Clearinghouse will be the place where individuals with health care vouchers make plan selections and are connected up with quality insurance products.

Sec. 21.54.240: Establishes the Voucher system, and includes the individual responsibility clause
This section ensures that all Alaskans can afford quality health coverage. It begins in (a) with the individual responsibility clause, which requires that all Alaskans have health coverage that provides essential health care services. This requirement will only affect those who don't currently have coverage: (1) – (7) outline specific examples of individuals who will be exempt from the individual responsibility clause. Excepted from the requirement are individuals who receive benefits under employer plans or publicly funded programs, including IHS recipients.

Subsections (b) through (e) describe the sliding scale voucher system which makes health coverage affordable for all legal residents. Sliding scale vouchers are issued to individuals in households based on the federal government's federal poverty level criteria (FPL), which sets a poverty line annually based on household size. This year the FPL has been set at $13,000 of gross income a year for an individual, or $26,500 per year for a family of four.

Subsection (c) provides a guarantee that anyone who falls below the federal poverty line won't have to pay for health coverage.

Subsection (d) provides vouchers, on a sliding scale, to individuals in households that earn between 100% and 300% of the FPL. Using the numbers from above, this means that an individual who earns between $13,000 and $39,000 a year or a family of four that has a household income between $26,500 and $79,500 will be eligible for a sliding scale voucher that makes health insurance affordable. The amount of these vouchers will be set by the board, and will vary, with more assistance going to those who earn less.

Subsection (e) requires that all individuals over 300% of the FPL acquire health coverage. While these individuals will not receive needs based vouchers, they will be eligible to receive specified beneficiary vouchers, which are discussed in a later section of the bill.

For more information, contact Sen. French's office:
Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us

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SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Subsection (b) provides larger vouchers to individuals who only qualify for ACHIA coverage, making the cost of coverage equal to that available in the normal market. These vouchers will be issued to people who earn up to 450% of the FPL.

Subsection (f) ensures that only legal residents of Alaska receive needs based vouchers.

Sec. 21.54.250: Defines essential health care services
This section defines the benefits that all health insurance plans sold through the clearinghouse must include. Insurance plans will include coverage for:

- preventative and primary care
- emergency services
- inpatient services and hospital treatment
- ambulatory patient services
- prescription drug coverage
- mental health services

Sec. 21.54.260: Relates to employer provided health coverage
(a) and (b) are included to make it clear that nothing in this legislation changes employer based health coverage for companies that elect to provide it.

(c) and (d) relate to the employer levy, which ensures that all employers contribute to the health of employees around the state. This tax is only levied against employers who don't offer health coverage, and the amount depends on employer size. For businesses with 0-10 full time employees, no levy is taken regardless of whether the employer offers coverage. For employers with 10-20 employees, the tax is 1% of gross payroll. For employers with 20 or more employees, the tax is 2%. If an employer either a) offers to pay 33% of premium costs or b) successfully enrolls 25% of employees in an employer sponsored plan they will be exempt from this tax. In addition, if an employer establishes a so-called 'Section 125' cafeteria plan that allows employees to purchase health coverage with pre-federal tax dollars, the employer will be exempt from this levy.

Sec. 21.54.270: Relates to the structure of insurance plans available in the clearinghouse
This section requires that plans provide coverage for essential health care services, as described in 21.54.250. (b) in this section mandates that an insurance company not turn down an individual looking for coverage.

Subsection (c) makes clear that health insurance plans can have varied levels of deductibles, co-pays, co-insurance and out of pocket maximums. They can include high deductible health care plans, and benefit levels can be different for in network and out of network providers. In addition, this subsection encourages lower cost plans that are especially designed for young adults, ages 18-30, which have different terms than are found in normal plans.

Subsection (d) increases the length of time that a child must be covered under a clearinghouse plan to 25 years of age, or until 2 years after the dependent no longer resides with the family.

For more information, contact Sen. French's office:
Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us
www.healthyalaskans.com

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Sec. 21.54.280: Establishes the Alaska Health Fund and Specified Beneficiary vouchers
The health fund is established as a separate trust fund of the state, and will include:

- state money and appropriations
- federal money, pursued through a variety of routes including 1115a waivers
- employer levy established in 21.54.260
- health care premiums received and appropriated to the fund
- money from any source that is given with purposes consistent with the purpose of the program

(b) establishes specified beneficiary vouchers, which gives an employer, employers or individuals the ability to contribute to the health premium of a given individual, through a voucher.

Sec. 21.54.290: Disputes and appeals
This section gives an individual the opportunity for a hearing if they are denied health coverage by a certified plan, or if a plan fails to deliver essential health care services. In addition, if a person feels adversely affected or aggrieved by a decision of the board or clearinghouse, they have the right to a hearing.

Sec. 21.54.300: Reporting
This section provides for an annual report by the health care board that includes statistics relating to how the health reform program is performing. In addition, the board will also give an evaluation and recommendations on a variety of important health reform topics, including the use of electronic health records, S-CHIP, the effect of mandated benefits, prescription drug bargaining, ways to maximize federal health care dollars, recruitment and retention of medical professionals, evidenced based treatment procedures, Medicaid effectiveness and more.

Sec. 21.54.310: Regulations
This section requires that the board establish regulations under the Administrative Procedure Act.

The remainder of the bill deals with definitions, transitional provisions and effective dates.

For more information, contact Sen. French's office:
Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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February 21, 2008

The Honorable Bettye Davis, Chair
Senate Health, Education, and
Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

I testified on February 18 before the Senate HES committee regarding Senate Bill 160, providing for Universal Health Care. The subsequent press release from the Senate majority press office indicated that the department had changed its position on this legislation. I need to clarify the Department of Health and Social Services' position on Senate Bill 160.

As I testified, "I am here on behalf of the department in support of this bill in the attempt to make health care a reality for Alaskans." Thus, we are in support of the *effort* to ensure Alaskans have access to health care.

However, the department has not changed its position on the legislation, which remains the same as Commissioner Karleen Jackson testified last summer.

The Department of Health and Social Services supports the **concept** in SB160 of health care for all Alaska citizens, but we recognize that health insurance and access to health care are two different things. As I later testified, "We must work concurrently to ensure there are providers available and willing to accept those seeking services. As Senator French has brought up, health insurance alone does not guarantee that those seeking services will receive it if there are no providers."

The Department believes that the State needs to have the health care infrastructure in place first to support increased utilization of health care, before we mandate coverage. And we are not sure if requiring everyone to have insurance, and having the state subsidize the effort, is the answer.

I apologize for the miscommunication in relaying the Department's position.

Sincerely,

William J. Streur
Deputy Commissioner for Medicaid and
Health Care Policy

cc: Senator Hollis French, Capitol Building, Room 417
Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506
Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Sherry Hill, Assistant Commissioner for Public Affairs
Wilda Laughlin, Special Assistant
Mike Tibbles, Governor's Chief of Staff
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant

SB

170

ALASKA STATE LEGISLATURE

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Chair
Senate State Affairs
Administrative Regulation Review

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Senate Judiciary Committee
Senate Resources Committee

SENATOR LESIL MCGUIRE

MEMORANDUM

To: Senator Bettye Davis
Senate Health, Education & Social Services Committee Chair

From: Senator Lesil McGuire Lesil McGuire

Date: February 4, 2008

Re: Request for hearing, SB 170 – *Insurance Coverage for Well-Baby Exams*

I respectfully request that SB 170 – *Insurance Coverage for Well-Baby Exams* be scheduled for a hearing at your earliest convenience. Attached you will find the most current version of the resolution, fiscal note, sponsor statement, and backup information.

If you have any questions or concerns please feel free to contact me personally, or my staff, Trevor Fulton at x3579. Thank you for your time and consideration.

ALASKA STATE LEGISLATURE

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SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SB170 – Well Baby Exams

Infancy is perhaps the most critical period in a child's life. Routine medical checkups during this vulnerable stage are necessary in order to monitor and assess a baby's normal, healthy development. These checkups – commonly referred to as "well-baby" exams – not only provide a professional medical assessment of a newborn's health and development, but they also provide the opportunity to educate parents in proper child care.

SB 170 would require health insurance carriers in the State of Alaska to include in their standard coverage for dependents "well-baby" exams. These exams, considered a part of routine pediatric health supervision, are estimated to cost between $125 and $250 per visit. The American Academy of Pediatrics recommends a schedule that includes 10 exams in the first 24 months of a baby's life. A typical "well-baby" exam includes monitoring development and growth rates, hearing, vision, language skills, motor development, diet, general and preventative health care, immunizations, and infectious diseases.

There is evidence to suggest that preventative healthcare coupled with early detection of health related problems not only improves health outcomes but is also cost-effective over the long run. Although "well-baby" exams may increase short-term costs to insurance providers, they inevitably save money in the long run. By averting severe and more costly health problems, including serious illness and emergency care, "well-baby" exams make sense.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 170(L&C)
(S) Publish Date: 5/10/07

Revision Date/Time (Note if correction):
Dept. Affected: Commerce

Title: Insurance Coverage for Well-Baby Exams
RDU: Insurance (116)
Component: Insurance

Sponsor: McGuire
Requester: Senate Labor & Commerce
Component No.: 354

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)*

This legislation would require health care insurers to provide insurance coverage for well baby exams. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director
Phone: 907-269-7900
Division: Insurance
Date/Time: 05/08/2007 2:36PM

Approved by: Emil R. Notti, Commissioner
Date: 5/8/2007
Agency: Commerce, Community, and Economic Development

75 Years of Caring 1930-2005

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Alaska Chapter

Alaska Chapter Executive Committee

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January 29, 2008

The Honorable Lesil McGuire
State Capitol, Room
Juneau, AK 99801-1182

RE: SB 170 Well Baby Exams

Dear Senator McGuire

I am writing to add support for SB 170 that would require insurance carriers to provide well baby coverage for the first 2 years of life. The American Academy of Pediatrics has long been an advocate of routine well visits. Preventative care has been shown to be very cost effective in that early screening allows for early intervention, when problems are small and easily remedied. Regular visits also improve immunization rates. I have included a link to the AAP's Well Visit Periodicity Schedule below. (If you are not able to access this it can also be found in *Pediatrics* December 2007 page 1376-1377)

http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1

Thank you for your continued concern and interest for the well being of Alaska's children

Sincerely yours

Jody Butto MD FAAP
President Alaska Chapter AAP

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures
Prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
Age	Prenatal	Newborn	3-5 d	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY																																
Initial/interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/height and weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for length		●	●	●	●	●	●	●	●	●	●																					
Body mass index												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood pressure		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental screening								●			●		●																			
Autism screening											●	●																				
Developmental surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/behavioral assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and drug use assessment																						★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES																																
Newborn metabolic/hemoglobin screening		←—	●	——	—→																											
Immunization		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or hemoglobin						★			●		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead screening							★	★	● or ★		★	● or ★		★	★	★	★															
Tuberculin test				★			★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia screening												★			★		★		★		★	★	★	★	★	★	★	★	←—	——	●	—→
STI screening																						★	★	★	★	★	★	★	★	★	★	★
Cervical dysplasia screening																						★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

[illegible]

● = to be performed ★ = risk assessment to be performed, with appropriate action to follow, if positive ←●→ = range during which a service may be provided, with the symbol indicating the preferred age

LEGAL SERVICES

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

MEMORANDUM May 11, 2007

SUBJECT: Effect of mandatory insurance coverage on state health benefit plan (SB 170, Work Order No. 25-LS0868/C)

TO: Senator Lesil McGuire
Attn: Marit Carlson-Vandort

FROM: Dennis C. Bailey
Legislative Counsel

This memorandum is a follow up to our conversations and my discussions with the Linda Hall and Katie Campbell at the division of insurance regarding applicability of the statutorily mandated insurance benefit for well baby exams to the state's health benefit plan.

The mandated coverage for well baby exams in the draft bill applies to "health care insurers." The other mandated coverages set out elsewhere in AS 21.42 also refer to "health care insurers."[1] A "health care insurer" for purposes of AS 21.42 is defined by AS 21.54.500(17), which provides:

> (17) "health care insurer" means a person transacting the business of health care insurance, including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, a multiple employer welfare arrangement, a church plan, and a governmental plan, except for a nonfederal governmental plan that elects to be excluded under 42 U.S.C. 300gg-21(b)(2) (Health Care Portability and Accountability Act of 1996);

Applying the definition of a health insurer in AS 21.54.500(17) to the subject of mandated coverage, I understand that the division of insurance has concluded that the mandated coverages under AS 21.42 do not apply to the state's health care plan (in part) for the following reasons.

- The state is not an "insurer." Under AS 21.90.900(27), an "insurer" includes a person engaged as indemnitor, surety, or contractor in the business of entering

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[1] *See*, e.g., AS 21.42.345 - 21.42.400. Some exclude fraternal benefit societies. Also, some refer to a "health care insurance plan" as defined in AS 21.42.500 by reference to AS 21.54.500 to mean "a health care insurance policy or contract by a health care insurer. . . ."

into contracts of insurance or of annuity. The state, while providing health care insurance to its employees, is not acting as an indemnitor. The state operates a self-funded plan where indemnity is not involved.

- The state is not in the business of entering into contracts of insurance. Under AS 21.90.900(25), "insurance" means a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies.

- Under the definition of health care insurer the state is not a "person." Under AS 01.10.060(8), "person" includes a corporation, company, partnership, firm, association, organization, business trust, or society, as well as a natural person. The state does not fall within these categories.

- The state does not "transact the business of health care" by offering a governmental plan for health insurance.

- ERISA[2] does not apply to governmental employee benefit plans. *See* 29 U.S.C. 1003(b).

The bases for the division's conclusions may be a subject for debate,[3] but appear to provide a rational basis for the department's conclusion.

In summary, the state is not considered a health care insurer under the statutory definition of a health care insurer. Therefore the mandated benefit for well baby exams contemplated in the bill would not apply to the state's health care plan.[4] Mandated benefits do apply to private health care insurance policies.

The area of health care insurance is particularly complex, especially when combined with the federal preemption considerations raised by ERISA. I routinely suggest consultation with the division of insurance for review of insurance bill drafts in order to take advantage of the division's expertise.

If I may be of further assistance, please advise.

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[2] Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

[3] The definition in AS 21.54.500(17) has at least one difficulty because it refers to "a person" and includes categories of insurance that are not "persons," e.g. governmental plans. Further, the term that allows a governmental plan to opt out under 29 U.S.C. 300gg-21(b)(2) creates additional confusion. An analysis of these issues is beyond the scope of this memorandum.

[4] I understand that most state employees do not receive health coverage through the state's health care plan. Instead, they receive coverage through union trust plans.

LEGISLATIVE RESEARCH REPORT

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INSURANCE COVERAGE FOR WELL-CHILD EXAMS

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You asked about health insurance coverage for "well-child" examinations. Specifically, you wanted the following information:

- The number of states that require insurance companies to provide coverage for well-child exams;
- Provisions of those requirements, including the number and frequency of exams required to be covered and the obligations, if any, that such laws place upon the insured;
- Research showing the health impacts of well-child examinations; and
- Potential impacts to Alaska of requiring coverage of well-child exams including benefits, negative consequences, and impacts on the uninsured.

SUMMARY

Since being incorporated into the U.S. health system in the 1930s, routine pediatric health supervision—commonly known as "well-child" care or well-child exams—has become a cornerstone of the nation's preventive healthcare.[1] At least twenty-one states require commercial insurance companies to cover some level of well-child care; however, among these states the health services and the number of exams that must be covered vary widely.

Despite the efforts of government agencies and others in recent years, high quality clinical research into the effectiveness of well-child exams is relatively scarce. This circumstance creates difficulties for healthcare providers, policy-makers, and parents when weighing the costs and benefits of providing or funding well-child care. Clearly, for certain population groups—in particular children of low-income families, who are most likely to suffer from chronic illness—certain aspects of well-child exams appear highly beneficial. Beyond immunizations, however, the battery of well-child services suggested in the schedules recommended by groups like the American Academy of Pediatrics (AAP), when delivered to healthy children, may incur costs unnecessarily and further strain an already burdened healthcare system.

Two things are true of nearly all state insurance mandates: they provide increased access to services and protection to consumers, and they raise premium costs. The question with regard to mandating well-child coverage in Alaska, then, is as follows: would the benefits gained by expanding preventive services outweigh potential increases in insurance premiums and the associated possible loss of coverage? Unfortunately, with the data available to us, we cannot conclusively answer this question. There exists wide consensus that certain preventive interventions improve health outcomes while remaining cost-effective—particularly when those services are targeted to population groups at increased risk for chronic illnesses. With the limited data available to us, however, it is not possible to determine the overall impact of mandating all well-child care services recommended by the AAP and others.

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[1] In this report the terms "well-child" and "well-baby" exams or care are used interchangeably. Significant variation exists in the composition of these exams among various jurisdictions and healthcare providers. In general, the visits include a mixture of health interventions delivered by a pediatrician or other healthcare provider according to a specified schedule throughout childhood. The interventions most commonly include behavioral counseling (sleep positioning, violence prevention, etc.), health screening (testing for iron deficiency, vision impairment, etc.), and delivery of prophylaxis (immunization, vitamin supplementation, etc.)

It is clear that mandating commercial insurance companies to cover well-child care would directly result in increased preventive care for only a portion of the state's children. About 47 percent of Alaskan children either receive public insurance benefits, which include access to robust well-child care, or are uninsured. The remaining 53 percent receive employer-based or some other form of private insurance. Although this is the type of insurance that a mandate would impact, a majority of such plans may already cover some aspects of well-child care (most often immunization and physical exams, at a minimum). With the data to which we have access, it is not possible to determine the number of children who would receive access to "new benefits" through a well-child mandate.[2]

Denali KidCare, Alaska's combination Medicaid and State Children's Health Insurance (SCHIP) program, provides access to comprehensive well-child benefits for low-income children as required by the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). The services in this program are generally more comprehensive than those provided by private insurers, yet research has shown that Medicaid's coverage of children is, on average, less expensive than private coverage. However, like many other states, Alaska struggles to enroll all of its eligible children. Particularly troublesome is that data from the U.S. Census Bureau show that the very young children (ages 0-6 years) of the lowest income families (under 100 percent of the federal poverty threshold) are also the least likely to be enrolled. Although the federal government is now requiring that states increase efforts to meet an 80 percent participation threshold, enrollment is not the sole issue. Of the Alaska children who are enrolled in Denali KidCare, only about half receive the well-child exams to which they are entitled. This lack of utilization is likely the result of a number of factors, including lack of access to healthcare providers and parents being unaware of available benefits. The combination of under-enrollment and low utilization of benefits means that there are thousands of Alaska children who currently qualify for well-child benefits, but do not receive those services.

Other states appear to have successfully increased delivery of well-child services by combining public insurance with private coverage of cost-effective services that have shown to improve health outcomes. Five of the seven states that currently exceed the federal goal of enrolling 80 percent of eligible children for EPSDT benefits have expanded both initial eligibility requirements for public insurance (at least 200 percent of federal poverty guidelines) and mandates for commercial well-child coverage.

Regardless of the strategies pursued, when considering mandating coverage of well-child care, Alaska-specific actuarial analyses of the cost-effectiveness of delivering individual preventive services to specific population groups may be the best means of determining which benefits would best serve the state's children.

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[2] The number of children who would receive new benefits depends largely on two factors as follows: the services to which children currently have access, which we cannot determine largely due to confidentiality provisions of insurance carriers and state regulators, and the specific mandates that may be enacted in law.

PRIVATE INSURANCE COVERAGE OF WELL-CHILD EXAMS IN THE STATES

At least twenty-one states require private health insurance plans to include coverage of well-child exams based on the "Recommendations for Preventive Pediatric Healthcare," or "periodicity schedule," published by the American Academy of Pediatrics (AAP).[3] Few of these states, however, require coverage of all of the procedures in the complete periodicity table. Indeed, states vary widely in the number and types of procedures covered, the years for which coverage is required, and whether the exams are exempt from deductible, co-pay, and coinsurance charges. For instance, New York requires very broad coverage of the AAP recommendations from birth to age twenty and exempts the costs for those exams from deductibles and coinsurance. By contrast, Montana requires coverage only through age three and allows companies to charge a co-pay and coinsurance for related exams and treatments.[4]

Other than deductibles, co-pays, and coinsurance, we located no requirements of or obligations placed upon the insured as a result of laws requiring coverage of well-child exams. Specifically, we found no requirement that insured parents make use of well-child benefits.

RESEARCH ON WELL-CHILD EXAMS

Assessing the overall effectiveness of well-child exams is complicated by a number factors. First, we were unable to locate high quality evidence-based studies of the impact of the exams as whole—that is, the specific combination of screening, preventive treatment, and counseling that are generally included in these exams. Indeed, with the notable exception of childhood immunizations, rigorous research designs such as randomized clinical trials have rarely been applied to individual components of the exams, much less for the well-child regimen as a whole. Second, even where a particular service can be shown to provide benefits, those benefits may not justify the costs for delivering that service to all children.

THE EVIDENCE BASE

The U.S. Department of Health and Human Service established the U.S. Preventive Services Task Force (USPSTF) in 1984 to give health care professionals advice about which forms of preventive care should be routinely offered to patients who exhibit no symptoms of illness.[5] In order to be recommended by the USPSTF, a given service must first undergo rigorous, impartial

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[3] Those states are Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Mexico, New York, Ohio, Oklahoma, Rhode Island, Texas, Virginia, and Wisconsin. Additional states require coverage of individual procedures—metabolic testing and hearing screening, for example—but do not compel coverage of the comprehensive exams recommended by the AAP. We include a copy of the AAP periodicity table as Attachment A.

[4] We include a table prepared by the AAP, which provides details on states' requirements for coverage of well-child exams, as Attachment B. Jody Ruskamp-Hatz, Senior Policy Specialist, National Conference of State Legislatures, (303) 856-1521, provided this table. According to Ms. Ruskamp-Hatz, most laws requiring coverage of well-child exams were enacted due to the advocacy of the AAP for the "Child Health Insurance Reform Plan" (CHIRP).

[5] Extensive information about the USPSTF and its recommendations are available online at *http://www.ahrq.gov/clinic/cps3dix.htm#pediatric*

assessments of the scientific evidence of its effectiveness. Since its inception, the Task Force has been widely viewed as the "gold standard" for definitevly establishing the importance of including prevention in primary health care; however, due to the very high standards of evidence required, relatively few services have received the recommendation of USPSTF for delivery to asymptomatic children who are at average risk for illness. Table 1 compares the recommendations of the USPSTF to those of the "well-child" periodicity schedule of the AAP for a child of twelve months.[6]

[6] Clearly, both the AAP and the USPSTF promote the value of preventive medicine, and the variations among their recommendations may not reflect disagreements between the two groups, but rather result from the organizations' differing missions and methods. The USPSTF is widely recognized as having among the most stringent evidence-based standards in reviewing preventive health services prior to recommending those services be administered widely. By contrast, although the AAP supports its recommendations with some degree of clinical evidence, the organization uses an "expert consensus" method. In addition, the AAP may be more concerned with establishing a "continuum of care" for *individual* patients through frequent and comprehensive exams than with absolute clinical certainty of the value of a service to the *entire population*.

Table 1: Comparison of USPSTF and AAP Preventive Services Recommendations for a Child of Twelve Months

Service[1]	AAP		USPSTF	
	Patient Risk Factors[2]			
	Average	Increased	Average	Increased
Anemia (iron deficiency) Screening	X		I	B
Developmental/Behavioral Assessment	X			
Hearing Screening	X		I[3]	
Hereditary/Metabolic Screening	X		Currently being updated	
Hip Displaysia Screening			I	
Immunization	X		X[4]	
Injury Prevention	X			
Lead Screening		X	D	I
Nutrition Counseling[5]	X			
Oral Fluoride Supplementation			B	
Physical Activity Counseling			I	
Skin Cancer Counseling			I	
Tuberculin Test		X		
Urinalysis	X			
Violence Prevention	X		I	
Vision Screening	X		B	

Legend: American Academy of Pediatrics (AAP): **X** - Recommended; U.S. Preventive Services Task Force (USPSTF) "grading" system: **A** - Strongly recommended; **B** - Recommended; **C** - No recommendation; **D** - Not recommended; **I** - Insufficient evidence to make determination.

Notes: The AAP and the USPSTF both promote the value of preventive medicine. Differences among their recommendations may not reflect disagreements between the two groups, but rather may result from the organizations' differing missions and methods. The USPSTF is widely recognized as having among the most stringent standards in reviewing preventive health services prior to recommending those services be administered widely. By contrast, the AAP may be more concerned with establishing a "continuum of care" for individual patients through frequent and comprehensive exams.

1) These are the services that one or both of the groups recommend for asymptomatic children at age 1 (twelve months). A blank space in the AAP columns indicates this service was not included in the group's schedule of preventive services. A blank in the USPSTF columns indicates that the task force has not issued an opinion on the service. Recommended services vary by age for both organizations.

2) Each organization publishes guidance regarding increased risk factors for children of various ages. For instance, the USPSTF considers status as a recent immigrant and low birth-weight and premature birth to be risk factors for anemia.

3) The USPSTF does, however, recommend hearing screening at birth.

4) Although it issues no immunization recommendations, the USPSTF endorses the joint recommendation of the AAP and the Centers for Disease Control, which is widely accepted as the official immunization schedule of the U.S.

5) The USPSTF recognizes the importance of nutrition and has reviewed data on the health risks of obesity in children, however, this is an example of a service for which there is insufficient evidence showing the positive and negative results of counseling. As a result, the organization has not issued a recommendation for nutritional counseling and has found insufficient evidence ("I") for obesity screening in children aged 6 and older.

Sources: American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, online at http://aapgrassroots.aappublications.org/cgi/content/full/pediatrics;105/3/645; U.S. Preventive Services Task Force

The differences between the recommendations of the USPSTF and the AAP are illustrative of the environment of confusing and often conflicting information in which healthcare providers, policymakers, and others are operating with regard to well-child exams. A group of researchers

who reviewed numerous studies in an attempt to assess the value and efficacy of well-child exams found that

> taken together, the literature evaluating the effectiveness of well-child care is perhaps more remarkable for its limitations that for its findings.[7]

Those words were written in 1989. Despite the efforts of the USPSTF and others in the intervening years, it does not appear that the situation has improved significantly.

A 2004 study that reviewed the well-child recommendations of seven major North American health organizations found hundreds of discrete recommendations, and forty-two separate preventive interventions for children that were variously recommended by two or more of the organizations studied.[8] Despite the dozens of recommended services, the researchers reported that they found "limited direct evidence" to support the recommendations. Although delivering preventive services, even in the absence of clinical data may appear benign, perhaps even wise, these researchers concluded otherwise, as follows:

> Because a large number of interventions are routinely recommended and often mandated and because the implementation of any recommendation may cause harm (including the displacement of other beneficial activities), these recommendations should be based on the strongest possible evidence. When recommendations are made, supporting evidence should be clearly stated.[9]

Governments at all levels may have to take more active roles in developing the evidence base for well-child exams. In the meantime, however, scarce data, and the discrepancies in recommendations from well-respected organizations, require that healthcare providers, policy-makers, and parents make often difficult decisions in prioritizing limited healthcare resources.

WEIGHING COSTS AND BENEFITS

Critically discussing the costs of well-child exams in public arenas is often challenging because if a given service has a chance of improving the health of children it is difficult to deny that service, even where evidence of its efficacy is relatively weak. Nonetheless, in an age of rapidly increasing healthcare costs and intense competition for healthcare dollars, policy-makers and others may have little choice but to prioritize services according to their costs and benefits in relation to other services. This is particularly true in light of the fact that governmental well-child policies impact not only those who are covered by Medicaid and other public health programs, but also the insurance companies that are "mandated" to provide coverage of well-baby visits in nearly half of the states and, ultimately the consumer who may bear increased costs in a number of ways. Moyer and Butler emphasized this point in the following discussion:[10]

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[7] Judith L. Wagner, Roger C. Herdman, and David W. Alberts, "Well-Child Care: How Much is Enough?" *Health Affairs*, Vol. 8, No. 3; Fall 1989. We include a copy of this article as Attachment C.

[8] Virginia A. Moyer, M.D., M.P.H., and Margaret Butler, B.A., "Gaps in the Evidence for Well-Child Care: A Challenge to Our Profession." *Pediatrics*, Vol. 114, No. 8, Dec. 2004. We include a copy of this article as Attachment D.

[9] Moyer and Butler, p. 1511.

[10] Moyer and Butler, pp. 1516-1517.

> The costs and potential adverse effects of the recommended aspects of well-child care have not been evaluated adequately. Costs include not only the direct costs of physician and staff time, laboratory costs, and costs of agents used in prophylaxis but also costs to parents, such as time lost from work and costs of transportation.

As the authors say, these costs become increasingly burdensome if they cannot be justified by the benefits produced, particularly in light of the increased demands the exams place on the healthcare system:

> When ineffective or less effective interventions displace more effective interventions, children are deprived of the more effective interventions. Although time per [healthcare] visit has increased, the average remains [approximately] 15 minutes . . . it would require 7 to 8 hours per working day for a primary care physician to provide the preventive services recommended by the USPSTF, making it unfeasible to provide even this limited list of preventive services within the current structure of practice.

MEASURES OF COSTS AND BENEFITS[11]

There are a number of ways in which to weigh costs and benefits of health policy, the most comprehensive of which are quite complex, often requiring analysis by an actuary specializing in healthcare. Perhaps the most common of these methods are variations of "cost analysis," "cost-benefit analysis," and cost-effectiveness analysis," which are briefly defined as follows:

> **Cost analysis**—calculates the net cost of a policy by subtracting the value of illnesses prevented by the policy from the cost of implementing that policy (the "cost of prevention"). When a policy has a negative cost—that is, the value of illness prevented is greater than the cost of prevention—the intervention is said to be a cost-saving policy.
>
> **Cost-benefit analysis**—compares the cost of a policy to improvements in health as measured in dollars by subtracting the dollar value of health improvements from the cost of prevention.[12] Frequently, results of these analyses are expressed as a cost-benefit ratio with benefits on top and costs on the bottom (dollar value of health improvement / cost of prevention). A policy is generally viewed as worthwhile if the cost-benefit ratio is greater than one, which indicates the benefits are greater than the costs.
>
> **Cost-effectiveness analysis**—allows comparison of health policies by dividing the value of the health improvement achieved by the policy by the net cost of that

[11] The following two sections are summarized from "What Policymakers Need to Know About Cost Effectiveness," *Partnership for Prevention*, 2001. Partnership for Prevention identifies itself as a membership organization of businesses, nonprofit organizations and government agencies advancing policies and practices to prevent disease and improve the health of all Americans. We include this document as Attachment E. Further information is available on the group's website at *http://prevent.org/content/view/5/20/*

[12] This method of cost-benefit analysis is specific to healthcare. The dollar value of health improvements is a measure that includes a degree of subjectivity and, at times, controversy. In depth discussion of such measures are outside the scope of this report. Additional information on measuring the economic burden of illness is included in Attachment E.

policy. This calculation creates a figure that can represent the value of a number of designated outcomes. For example, the analysis could be designed to compare the relative value of *deaths averted* for two screening procedures, the *per year* savings of those interventions, or the *per injection* value of several vaccines. Therefore, unlike cost analysis and cost-benefit analysis, cost-effectiveness analysis is designed to show which policies require fewer resources to achieve health benefits *compared to other interventions*, but does not necessarily indicate whether a policy produces net savings.

In general, it appears that cost-benefit analyses of well-child exam services, particularly those that are not supported by convincing clinical evidence, provide policymakers with the most useful information with which to make an "apples-to-apples" comparison of the relative value of interventions.

THE COST OF INSURANCE MANDATES

There exists fairly wide consensus that governmental mandates that commercial insurance policies include coverage of specific benefits raises the cost of insurance to consumers. There is no consensus, however, on the amount of increases such mandates generate. In 2003, the U.S. General Accounting Office (GAO) reviewed studies of the costs of state mandates. The GAO found wide variation in published estimates of increases in premiums attributable to mandates, from a 3.4 percent increase in premiums in Maryland, to a study in Virginia that claimed mandates accounted for nearly thirty percent of premiums. Some of this variation can be explained by the fact that the number and type of mandates varies among the states. In addition, some studies of mandates did not consider the fact that many state mandated benefits would be offered by insurance companies—either as an option or as a standard service—in the absence of mandates. In such cases, state mandate laws cannot be said to be responsible for the full portion of the premiums that are attributable to the service mandated. In studies that evaluated the marginal costs of mandates—those that likely would not be offered in the absence of a mandate—premium increases due to mandates were typically less than ten percent.[13]

Research specifically into increases in premiums due to mandating well-child exams appears to be relatively rare. One study by the Council for Affordable Health Insurance claims that well-child mandates represent one percent to three percent of premiums in the states that require such coverage. This study did not take into account whether such services would be provided absent a mandate; neither, however, does the study's definition of well-child care appear to include all of the services recommended by the AAP periodicity table.[14] One of the primary concerns with mandates is that they may actually reduce coverage for certain consumers by raising premiums to the extent that individuals or employers are forced to reduce or eliminate coverage. Although premiums in the state would likely increase to some degree, in the absence of additional data we are unable to determine what impact a well-child exam mandate would likely have on the level of insurance coverage in Alaska.

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[13] The GAO report is available online at *http://www.gao.gov/new.items/d031133.pdf*

[14] The Council for Affordable Health Insurance is a research and advocacy group made up of insurance carriers. Its report on mandates is available online at *http://www.cahi.org/index.asp*

IMPACTS OF REQUIRING COVERAGE OF WELL-CHILD EXAMS IN ALASKA

In general, it appears that health insurance "mandates" are both beneficial and costly to consumers. Mandates are popular because they provide consumers greater access to services, particularly preventive services, which commercial insurers may not otherwise cover. This expanded coverage should lead to avoidance or earlier detection of health issues, which may produce long-term savings in health spending and increased quality of life. However, opponents of mandates point to studies showing that mandated benefits increase costs to consumers, forcing employers and individuals to reduce their level of coverage or even forego insurance altogether, resulting in fewer insured individuals.[15] The question with regard to mandating well-child coverage in Alaska, then, is as follows: **would the benefits gained by expanding preventive services outweigh potential increases in insurance premiums and the associated possible loss of coverage?**

Unfortunately, with the data available to us, we cannot conclusively answer this question. To be clear, there exists wide consensus that certain preventive services improve health outcomes. Some of these services likely prove to be sound investments for healthcare dollars because they avert costly treatments for chronic illnesses. This is particularly true of services targeted to population groups who are at increased risks for certain illnesses. Nonetheless, with the exception of childhood immunization, we find no source to state with certainty that mandating commercial insurance coverage of the combination of services suggested by groups such as the AAP will provide benefits (improved health outcomes and long-term cost savings) that will outweigh increases in premiums and the potential loss of health coverage for some number of residents that may result. To address these questions fully, you may wish to consult an actuary specializing in healthcare policy.

CURRENT WELL-CHILD COVERAGE IN ALASKA

The extent of well-child exam coverage for Alaska children currently depends on several factors including **healthcare coverage status, whether parents take advantage of the well-child benefits that are available to them, and family income level**. Table 2 shows the status and type of healthcare coverage for Alaskans compared to the national average for children aged 0 to 18 years.

[15] We include, as Attachment F, "Mandated Health Insurance Benefits: Tradeoffs Among Benefits Coverage, and Costs?" *California Health Policy Roundtable* (a *Kaiser Family Foundation* funded organization) July 2002.

Table 2: Type of Healthcare Coverage of Children Aged 0-18 in Alaska and the U.S., 2004				
Type of Coverage	Alaska		United States	
	Individuals	Percent	Individuals	Percent
Employer	96,160	49.3%	43,899,504	56.4%
Individual	7,210	3.7%	3,502,620	4.5%
Medicaid	60,210	30.8%	20,470,868	26.3%
Other Public	13,790	7.1%	1,089,704	1.4%
Uninsured	17,880	9.2%	8,873,304	11.4%
Total	195,240	100.0%	77,836,000	100.0%

Notes: Percent figures do not sum to 100 percent due to rounding. Alaska's proportion of children covered by "other public" insurance exceeds that of the U.S. population due in large part to children covered by the Indian Health Service.
Source: Kaiser Family Foundation, from U.S. Census data; available online at *http://www.statehealthfact.org*.

Our analysis of the data in Table 2 indicates that the pool of children who would be impacted by mandating well-baby coverage is somewhat limited. Well-child benefits are currently available to those covered by Medicaid and "other public" insurance, which includes the Indian Health Service, primarily under the federally mandated Early and Periodic Screening Diagnosis and Treatment program (EPSDT). (We discuss this program in greater detail below.) Mandating commercial coverage would provide no new benefits to the uninsured. Therefore, the remaining pool of approximately 103,000 children—those covered by employer-based or individual insurance—represents about 53 percent of all children aged 18 or younger. This is not to say, however, that 53 percent of Alaskan children would substantially benefit from mandated well-child coverage, because a number of the state's insurers already provide some level of well-child benefits. For instance, Premera Blue Cross, which, according to the Department of Commerce Community and Economic Development, Division of Insurance, underwrites about 78 percent of the comprehensive health insurance policies in the state, includes immunizations and preventive office visits in its group plans.[16] Such coverage is limited, however, and it is unclear exactly which well-child services are covered or how many exams are allowed annually.[17] Nonetheless, it is clear that only a minority of Alaska children who currently receive no well-child benefits would begin receiving such benefits were they to be mandated by the state. However, the care of children who currently receive benefits may improve under such a mandate as a number of studies have shown that private preventive coverage is generally less than comprehensive, and are generally inferior to those required under Medicaid (EPSDT). We explore this issue further in our discussion of EPSDT below.

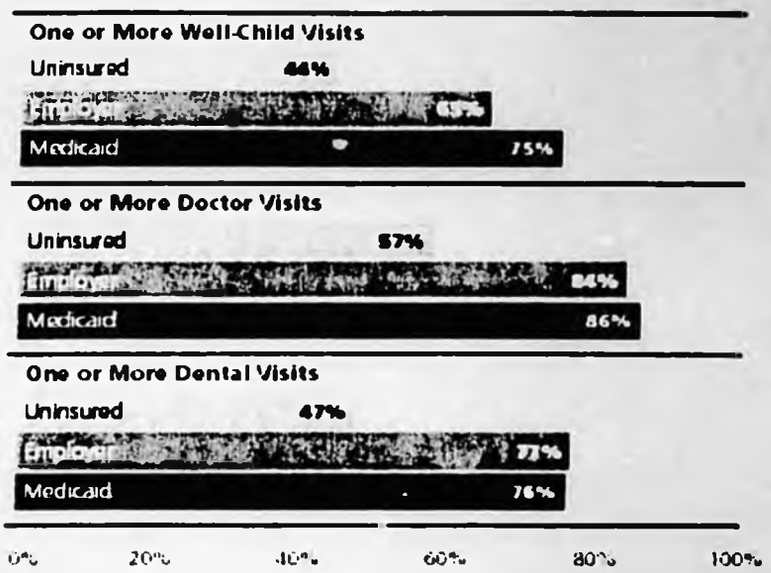
[16] Except for group plans with over 200 members, for which such services are an optional benefit. Information on Premera Blue Cross group plans is available online through *http://www.premera.com*.

[17] Insurance companies operating in Alaska are not required to disclose details of policy agreements, except to regulators who are required to keep such information confidential. We, therefore, have no means of determining exactly how many Alaskans with private insurance are entitled to well-child benefits.

"UPTAKE" OF WELL-CHILD BENEFITS

Research has demonstrated that even when well-child benefits are available, many parents do not take advantage of them, nor do parents typically adhere to recommended exam schedules as their children age. This is a cause for particular concern with regard to low-income families, whose children are more likely to be in poor health, are more likely to have special healthcare needs, and are at greater risk for long-term disability than children in families with higher incomes. In short, these are precisely the children who could benefit most from well-child exams.[18] Figure 1 illustrates the "uptake" of healthcare services by low-income children in 2002.

Figure 1: The Use of Healthcare Services by Insurance Status for Low-Income Children in the U.S., 2002



Source: Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," Health Policy Forum Issue Brief No. 819; November 20, 2006.

[18] Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," *Health Policy Forum Issue Brief*, George Washington University, No. 819, November 20, 2006. We include a copy of this document as Attachment G.

Figure 2 shows that even within the coverage group most likely to receive well-child care—those on Medicaid—uptake of available services diminishes rapidly as children age.[19]

Figure 2: Percentage of Children Receiving Medicaid-Funded Well-Child Screening by Age Group in the U.S., 2003

Source: Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," Health Policy Forum Issue Brief No. 819; November 20, 2006.

The above figures suggest that a significant portion of Alaskan children who would benefit most from mandated coverage of well-child care—that is, children from low-income families who are covered by commercial insurance that does not already provide such coverage—would not receive that care or would receive it only for a few years.

INCOME AS A FACTOR IN COVERAGE

Household income is perhaps the single most predictive factor of health insurance coverage and, therefore, for receipt of well-child exams. Because low-income children are less likely to be insured, they are also, as Figure 1 illustrates, less likely to receive well-child care. Table 3 provides further evidence that the uneven distribution of insurance coverage across income levels is such that the children who need preventive care most may not be receiving it.[20]

[19] These figures are from Provost Peters

[20] Population data are from 2005. Certain poverty data are from 2004. Because population and poverty data may be from different years, and due to the impact of sampling error and other statistical complexities, these data should be seen as estimates only. For the same reasons, and because we used data from different sources, the count of "uninsured," and certain other figures in this table may not precisely match other information in this report. We believe, however, that the proportions of children in certain age groups and of the uninsured are reliable estimates.

Table 3: Insurance Status by Age and Income Level in Alaska, 2004-2005[21]										
Ages	Insurance Status	Number of Children	Number of Children in Specified Family Income Groups (Expressed as a Percentage of Federal Poverty Threshold)[1]							
			Below 100%	% of Un-insured	100% to 150%	% of Un-insured	150% to 200%	% of Un-insured	200% and above	% of Un-insured
0 to 18 Years	Total	194,207	23,033		25,050		21,868		124,256	
	Insured	174,587	16,071		22,604		18,831		117,081	
	Uninsured	19,620	6,963	**35.5%**	2,446	**12.5%**	3,037	**15.5%**	7,175	**36.6%**
0 to 6 Years	Total	69,816	8,966		8,895		9,692		42,264	
	Insured	62,988	5,529		8,055		8,836		40,568	
	Uninsured	6,828	3,437	**50.3%**	839	**12.3%**	856	**12.5%**	1,696	**24.8%**
7 to 12 Years	Total	63,461	8,463		6,405		7,317		41,276	
	Insured	57,683	6,882		5,636		6,650		38,514	
	Uninsured	5,779	1,581	**27.4%**	769	**13.3%**	667	**11.5%**	2,762	**47.8%**
13 to 18 Years	Total	60,929	5,604		9,750		4,859		40,716	
	Insured	53,916	3,660		8,912		3,344		38,000	
	Uninsured	7,013	1,945	**27.7%**	838	**11.9%**	1,515	**21.6%**	2,716	**38.7%**

Notes and Sources: 1) The "Federal Poverty Threshold" is a complex statistical measure used by the U.S. Census Bureau to report population, economic, and demographic data. This measure differs somewhat from the Federal Poverty Guidelines, which is an administrative calculation used to establish eligibility for need-based programs. This table should be viewed as estimates of Alaskan children at certain general income levels rather than an indication of who may qualify for specific income-based assistance programs. Additional information on the differences between poverty guidelines and thresholds is available online at *http://aspe.hhs.gov/poverty/faq.shtml#differences*.

The figures in this table are from the U.S. Census Bureau, "Current Population Survey" of 2005. Certain poverty data are from 2004. Because population and poverty data may be from different years, and due to the impact of sampling error and other statistical complexities, these data should be seen as estimates only. For the same reasons, and because we used data from different sources, some figures in this table may not precisely match other information in this report. The public database for "Current Population Survey" information from several years is available online at *http://www.census.gov/hhes/www/cpstc/cps_table_creator.html*.

There are a number of striking aspects of the data in Table 3. First, over one-third of all children with family incomes below 100 percent of federal poverty threshold are uninsured. This compares to an overall uninsured rate for children in Alaska of about 9.2 percent (see Table 2). Even more alarming, about half of all children from birth to age 6 living in poverty do not have insurance. The research we reviewed indicates that this is the precise group for which society

[21] This table used the "Federal Poverty Threshold," which is a statistical measure used by the U.S. Census Bureau to report population, economic, and demographic data. This calculation differs somewhat from the Federal Poverty Guidelines, which are administrative measures used to establish eligibility for need-based programs. This table should be viewed as estimates of Alaskan children at certain general income levels rather than an indication of who may qualify for specific income-based assistance programs. Additional information on the differences between poverty guidelines and thresholds is available online at http://aspe.hhs.gov/poverty/faq.shtml#differences

will likely face the greatest expense for corrective healthcare.[22] Perhaps the most remarkable aspect of these data is the fact that *a significant portion of all uninsured children in Alaska may qualify for well-child benefits under* ***current*** *public assistance eligibility criteria*.

MEDICAID EPSDT COVERAGE[23]

As you know, the primary public insurance program for children in Alaska is Denali KidCare (DKC).[24] Because DKC is funded in part by Medicaid, federal provisions require implementation of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). This program requires comprehensive well-child services for Medicaid eligible children, which must include the following:

- Screening Services;
- Comprehensive health and developmental history;
- Comprehensive unclothed physical exams;
- Appropriate immunizations;
- Laboratory tests;
- Lead toxicity screening;
- Health education;
- Vision, hearing and dental services; and
- Other necessary diagnoses, treatments and other measures as prescribed by law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Overall EPSDT benefits must meet "reasonable standards of medical practice" as suggested by recognized medical organizations in child health care.[25] In Alaska, these services are recommended at the following ages:

- Birth, 2, 4, 6, 9, 12, 15, 18 and 24 months;
- Aged 3, 4, 5, and 6 years;
- At least every other year after age 6.[26]

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[22] See, for example, Eileen Salinsky. "Clinical Preventive Services: When is the Juice Worth the Squeeze?," *National Health Policy Forum Issue Brief*, George Washington University, No. 806, August 24, 2005. We include a copy of this document as Attachment H.

[23] A comprehensive review of Medicaid and EPSDT coverage is outside the scope of this report. We provide this information only as an indicator of the current status of well-child care in the state and of the potential to expand this care under public insurance in lieu of, or in combination with requiring coverage of well-child exams by commercial insurers.

[24] Denali KidCare is the name given to the state's public insurance program that is funded in part by Medicaid and the State Children's Health Insurance Program (SCHIP). Further information on Denali KidCare is available online at *http://www.hss.state.ak.us/dhcs/DenaliKidCare/default.htm*.

[25] Further information on EPSDT requirements is available from the Centers for Medicare and Medicaid Services online at *http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/*.

[26] "Alaska Medicaid Recipient Services." Alaska Department of Health and Social Services, Division of Healthcare Services, p. 15, available online at *http://www.hss.state.ak.us/dhcs/PDF/MedicaidRecipientHandbook1.pdf*.

A number of studies have found that the comprehensive requirements of EPSDT generally provide greater well-child benefits than those of commercial insurance policies, which tend to restrict or deny certain services.[27] In Alaska, however, those who are eligible are not fully utilizing this benefit. According to the fiscal year 2005 "Annual EPSDT Participation Report," only 50.75 percent of "total eligibles who should receive at least one initial or periodic screen" actually received that service.[28] Although the federal government is now requiring states to implement programs to increase participation rates, those efforts have not yet been widely successful. Just seven states have met the federal participation goal of 80 percent. Each of those states has initial income eligibility guidelines of at least 200 percent of the federal poverty guideline ($4,167 per month for a family of four in Alaska in 2006).[29] The barriers to participation are manifold, but include low provider participation rates due to inadequate reimbursement for services, lack of parental awareness of the benefits available, and the overall scarcity of healthcare services in many parts of Alaska.

In general, it appears that the number of children who would be impacted by increased efforts to raise participation rates among those currently eligible for EPSDT services may exceed the increases that are possible strictly from mandating commercial coverage of well-child exams. According to data from the U.S. Census Bureau, expanding Denali KidCare income guidelines to 200 percent of federal poverty guidelines would likely increase by several thousand the number of uninsured children who are eligible for services.[30] However, increased education about available benefits and expanding eligibility do little to address the shortage of healthcare providers in certain areas of the state. Although we located no Alaska-specific research in this regard, the healthcare system in many parts of the state likely could not sustain substantial increases in comprehensive EPSDT services. In addition, expanding publicly funded services will clearly increase a Medicaid budget that is already seen by many as being too costly and growing at too fast a rate. It is worth noting, however, that the national average annual per capita spending on children in Medicaid is, at $1,315, about one-third that of other enrollees at $4,011. Also, historic costs per child are less, on average, for Medicaid than for private insurance.[31]

As you know, Chapter 34 SLA 2003 reduced the household income limits for uninsured children and pregnant women from 200 percent of the federal poverty guidelines for Alaska to 175 percent of the guidelines, and converted that percentage into dollar amounts. As a result of this change, fewer children and pregnant women were eligible for Denali KidCare. The federal poverty guidelines typically increase over time, so the income limits, which are fixed at 175 percent of the 2003 guidelines, are only about 160 percent of the 2006 guidelines and 155 percent of the 2007 guidelines. If the federal poverty guidelines continue to increase, Alaska's income guidelines for Denali KidCare will continue to fall as a percentage of the federal poverty guidelines, thereby excluding additional residents from coverage.

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[27] See, for example, pp. 4-5 of Provost Peters.

[28] This report is available online at *http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp*.

[29] Those states are Georgia, Iowa, Minnesota, Nevada, New York, and Vermont. For further information, see Provost Peters, p. 24. Federal poverty guidelines for Alaska are as of April 1, 2006.

[30] As you know, companion bills currently before the Legislature, SB 87 and HB 140, seek to expand Denali KidCare eligibility guidelines.

[31] Provost Peters, p. 17.

CONCLUSION

The policy question of whether to mandate commercial insurance coverage of well-child visits in Alaska is a highly complex one. A comprehensive review of the question would include an actuarial analysis of the cost-effectiveness of requiring such coverage. Such a review may also include considering ways to expand public health coverage and use of well-child exams for both the currently eligible population and those below a certain level of income not currently receiving such benefits. Other states that have mandated benefits require an exam schedule that is based on, but is more limited than, that suggested by the American Association of Pediatrics. Some mix of these strategies may provide the preventive care Alaskan children need—particularly those in low-income families—while avoiding driving healthcare policy premiums and the Medicaid budget to unacceptably high levels.

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

LIST OF ATTACHMENTS

Attachment A

"Recommendations for Preventive Pediatric Healthcare," *American Academy of Pediatrics* (AAP)

Attachment B

American Academy of Pediatrics, "CHIRP-Child Health Insurance Reform Plan," a table of state laws mandating well-child exams, provided by Jody Ruskamp-Hatz, Senior Policy Specialist, *National Conference of State Legislatures*

Attachment C

Judith L. Wagner, Roger C. Herdman, and David W. Alberts, "Well-Child Care: How Much is Enough?" *Health Affairs*, Vol. 8, No. 3; Fall 1989

Attachment D

Virginia A. Moyer, M.D., M.P.H., and Margaret Butler, B.A., "Gaps in the Evidence for Well-Child Care: A Challenge to Our Profession," *Pediatrics*, Vol. 114, No. 8; Dec. 2004

Attachment E

"What Policymakers Need to Know About Cost Effectiveness," *Partnership for Prevention*, 2001

Attachment F

"Mandated Health Insurance Benefits: Tradeoffs Among Benefits Coverage, and Costs?" *California Health Policy Roundtable* (a *Kaiser Family Foundation* funded organization), July 2002

Attachment G

Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," *Health Policy Forum Issue Brief*, George Washington University, No. 819; November 20, 2006

Attachment H

Eileen Salinsky, "Clinical Preventive Services: When is the Juice Worth the Squeeze?," *National Health Policy Forum Issue Brief*, George Washington University, No. 806; August 24, 2005

AVAILABLE UPON REQUEST FROM TREVOR IN SEN. MCGUIRE'S OFFICE x 3579

NFIB
The Voice of Small Business®

Alaska

February 7, 2007

The Honorable Lesil McGuire
Alaska State Capitol Building
Juneau, Alaska 99801

RE: Senate Bill 170 – Mandatory Health Insurance Coverage for Well Baby Visits

Dear Senator McGuire,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 170. The National Federation of Independent Business is the largest small-business advocacy group in the state.

While we understand the concern with health insurance coverage for well baby visits, we must oppose mandatory benefits, especially when directed to a specific health benefit. Small businesses in Alaska budget a portion of their revenues to employee compensation, which includes the cost of health insurance. The distribution of those funds should be left to discussions between employees and employers, without the interference of the state. Mandating this benefit limits the options of employee health insurance programs.

The design of employee health insurance programs should not be determined by the legislature for private employers. Such action is nothing less than an unfunded mandate on small Alaskan employers and their employees. Such benefit mandates can increase the cost of health insurance and may have the ultimate effect of pricing health insurance out of the reach of small employers and their employees.

I enclosed a report done by NFIB in 2007 on the purchasing of health insurance by small businesses. Among its findings is that a significant number of new small businesses are choosing not to offer health benefits. Also it shows a move to defined benefit approach by offering a fixed payment to reimburse employees who purchase their own coverage. We believe the cost of mandated benefits leads to these strategies to contain added employer costs.

Sincerely,

Dennis L. DeWitt
Alaska State Director
National Federation of Independent Business

cc: Senate Health, Education, and Social Services Committee

National Federation of Independent Business – ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

Legislative Research Services

Alaska State Legislature
Legislative Affairs Agency
Division of Legal and Research Services

State Capitol, Juneau, AK 99801
Phone: 907-465-3991
Fax: 907-465-3908

February 8, 2008

Memorandum

TO: Senator Lesil McGuire

FROM: Chuck Burnham, Legislative Analyst

RE: Well-Child Exam Benefits
LRS Request 08.121

You asked whether the ten largest providers of health insurance in Alaska provide well-child exams as a standard benefit.

Table 1 contains the information we have thus far obtained for seven of the ten largest "accident and health" insurers in the state.[1] Collectively, these seven companies wrote 361,397 of the 419,735, or about 86.1 percent, of the applicable premiums in Alaska in 2006. Three of these seven companies—Premera Blue Cross, Principal Life, and Great West Life & Annuity—provide well-child exams as a standard benefit in their group health plans. These three companies collectively accounted for 272,607, or about 65%, of all Alaska accident and group health premiums written in 2006.

Four of the seven companies for which we have information do not provide well-child exams as a standard benefit; however, two of these companies do not offer plans under which children who might receive such exams would be covered. According to a representative of Symetra Life, that company offers only supplemental insurance and other "non-traditional" group health plans, and does not carry comprehensive health plan products in Alaska. Hartford Life of America offers health plans in Alaska only to retirees. Together, these two companies wrote 18,108, or approximately 4.3 percent, of the state's group health premiums in 2006.

Two companies—Aetna and Golden Rule—provide comprehensive health plans that do not universally provide well-child exams as a standard benefit. A representative with Aetna told us that well-child exams are included as a standard benefit in "most" of its group plans. Golden Rule offers well-child exams as part of its "enhanced care package," which requires an additional premium be paid. Collectively, these two companies wrote 36,097, or about 8.6 percent, of group accident and health plans in 2006. It is unclear what precise portion of these plans, particularly those offered by Aetna, include well-child exams.[2]

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[1] We directly contacted nine of these insurers, including Premera Blue Cross, Principal Life Insurance, Aetna Life Insurance, United Healthcare Insurance, Symetra Life Insurance, Great West Life & Annuity Insurance, The Mega Life & Health Insurance, Hartford Life & Accident Insurance, and Unum Life Insurance of America. Golden Rule Insurance publishes information on well-child benefits on its website. We have not received responses from Mega Life & Health Insurance, United Healthcare Insurance, or Unum Life Insurance of America. We will provide information for these companies when it becomes available.

[2] As you know, many of the practices of insurance companies in Alaska are deemed proprietary and are provided confidentiality protection under state law.

Table 1: Provision of Well-Child Exams as a Standard Benefit by Alaska Health Insurers

Insurance Company	Well-Child Exams Standard?	Group Accident & Health Market Share, 2006 (419,735 total premiums)		Notes
		Premiums Written	Percent of Total Premiums	
Premera Blue Cross	Yes	230,664	55.0%	
Principal Life	Yes	31,657	7.5%	
Aetna Life	No	29,147	6.9%	Well-child benefits are standard in "most" Aetna group plans.
United Healthcare	Information not yet available	21,744	5.2%	
Symetra Life	No	11,550	2.8%	This company provides primarily supplemental health benefits, and does not offer "traditional" comprehensive group health plans in Alaska.
Great West Life & Annuity	Yes	10,286	2.5%	
Mega Life & Health	Information not yet available	7,711	1.8%	
Golden Rule	No	6,950	1.7%	Well-child benefits are part of the "enhanced care package," which requires additional premiums be paid.
Hartford Life & Accident	No	6,558	1.6%	In Alaska, this company provides health plans only to retirees.
Unum Life of America	Information not yet available	5,130	1.2%	
	Total	361,397	86.1%	

Sources: Personal communication with insurance company representatives; Golden Rule Insurance Co. website at *http://www.goldenrule.com/*; and Alaska Department of Commerce, Community, and Economic Development, Division of Insurance, 2006 (Fiscal Year 2007) *Annual Report*, online at *http://www.dced.state.ak.us/insurance/report.htm* .

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Article 1. The Insurance Contract.

Sec. 21.42.010. Applicability. AS 21.42.010 — 21.42.500 do not apply to

(1) reinsurance;

(2) policies or contracts not issued for delivery in this state or delivered in this state, except as provided in AS 21.42.120;

(3) wet marine and transportation insurance;

(4) title insurance, except that AS 21.42.080, 21.42.120, 21.42.130, 21.42.180, 21.42.190 and 21.42.230 do apply. (§ 1 ch 120 SLA 1966)

Revisor's notes. — In the introductory language of this section, in 2006, "AS 21.42.010 — 21.42.500 do not" was substituted for "this chapter does not" to reflect the addition of AS 21.42.700 — 21.42.705 to this chapter by § 1, ch. 39, SLA 2006.

Sec. 21.42.020. Insurable interest: life, annuity, or health. (a) A person of competent legal capacity may procure or effect an insurance contract on the life or body of the person for the benefit of any person. A person may not procure or cause to be procured an insurance contract upon the life or body of another person unless the benefits under the contract are payable to the individual insured, the personal representatives of the individual insured, or to a person having, at the time the contract was made, an insurable interest in the individual insured.

(b) If the beneficiary, assignee, or other payee under a contract made in violation of this section receives from the insurer any benefits from the contract upon the death, disablement, or injury of the person insured, the person insured or the executor or administrator of the person insured may maintain an action to recover the benefits from the person receiving them.

(c) Notwithstanding the other provisions of this section, a charitable organization may obtain, by procurement, assignment, or otherwise, life or health insurance on an insured who consents to the issuance of the insurance. In this subsection, "charitable organiza-

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 13, 2008

Honorable Bettye Davis, Chair Senate Health, Education, and Social Services Committee
State Capitol, Room 30
Juneau, AK 99801-1182

Transmitted by email:
Senator_Bettye_Davis@egis.state.ak.us

RE: CSSB107

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA continues to oppose SB107 and its current version CS SB107. Attached is a copy of Dr. Gower's written testimony presented last year to the Senate Labor and Commerce Committee. Dr. Gower in now the immediate Past President of ASMA and I am the current ASMA President. His comments remain pertinent and are thereby offered again.

It needs to be noted that naturopaths do not provide any portion of a solution to access to care issues for Medicare beneficiaries. At this time, it is ASMA's understanding that the Medicare program does not recognize naturopaths for reimbursement purposes as it does for general internal medicine specialists who are in such short supply in Alaska.

ASMA urges you to oppose CS SB107.

Sincerely,

By: J. Ross Tanner, DO, President
For: Alaska State Medical Association

cc: Members, Senate Health Education, and Social Services Committee

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

April 17, 2007

Honorable Johnny Ellis, Chair Senate Labor and Commerce Committee
State Capitol, Room 9
Juneau, AK 99801-1182
RE: SB107 – Naturopathic Scope of Practice Transmitted By Fax: 907-465-2529

Dear Senator Ellis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA opposes SB107 and urges you to oppose it as well. Training for naturopaths is less rigorous than for medical doctors in both length and depth of study. Its emphasis on natural healing does not allow sufficient time for its students to fully learn the accepted pathology, physiology, and pharmacology necessary to treat most medical conditions. To allow naturopaths to prescribe drugs and perform "minor" surgery is unsafe for Alaskan patients.

It needs to be pointed out that there is no such thing as "minor" surgery. For example, suturing simple lacerations and removing simple moles often requires complex surgical techniques and knowledge. The decisions involved with selecting optimal closure techniques or biopsy type (and the associated risks of each) are not mastered after a short course of study. While it may seem simple to biopsy a mole, it is much more complex to determine what type of biopsy is best for which lesions, or to assess which lesions could be cancerous and at higher risk of spreading if diagnosed or biopsied incorrectly. As surgeons are quick to point out: there is no such thing as "minor surgery" there are just minor surgeons....

In 2004, many of the same issues were presented via SB306 in its initial version. At the end of the 23rd Legislature, SB306 was enacted with not expanding any scope of practice for naturopaths. It did, however, create a task force, "Task Force on Naturopath Scope of Practice". That task force did not produce a report and thus left undone its important investigative elements. Those elements being comparing the education and training of naturopaths to medical doctors; investigating what an appropriate scope of practice would be for naturopaths, for prescription of drugs; investigating what an appropriate scope of practice for naturopaths would be for minor surgery and other non-pharmacological treatments; examine the potential structure and operation of any collaborative protocols and agreements for naturopaths with other licensed practitioners; investigate the liability issues involved with any collaborative arrangements; and to investigate any other issues found to be relevant by the task force. These same issues remain and need to be thoroughly investigated before any consideration is given to acting on this bill.

ASMA strongly feels that its resources as well as the Legislature's resources should be spent in finding solutions for Alaska's current acute shortage in physicians estimated to be a 30% shortage at this time. Spending time and resources exploring and debating expanded scope of practice for naturopaths will slow the efforts to recruit the highly trained physicians in sufficient numbers that we need today and in the future.

ASMA urges you to oppose SB107.

Sincerely,

By: Roland Gower, MD, President
For: The Alaska State Medical Association

cc: Members, Senate Labor and Commerce Committee

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 11, 2008

Honorable Bettye Davis, Chair Senate Health, Education and Social Services Committee
State Capitol, Room 30
Juneau, AK 99801-1182

RE: CS SB170 - Well Baby Exams

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

CS SB170 provides for mandatory health insurance coverage for the cost of well-baby exams. Monitoring a child's medical metrics in the first 24 months of life is critical to the preventative healthcare and the early detection of health problems. This is good medicine and ASMA supports the enactment of CS SB170.

ASMA urges you to support the enactment of CS SB170.

Sincerely,

J. Ross Tanner, DO, President

HI

Trevor Fulton

From: mandsagr [mandsagr@alaska.net]
Sent: Thursday, February 07, 2008 8:45 PM
To: Sen. Lesil McGuire
Subject: SB 170

Dear Sen. McGuire,
Thank you so much for sponsoring this legislation. As you have noted in your sponsor statement, the value of "well baby" exams is supported by the professional pediatric and developmental literature. The Academy of Pediatrics recommends 10 visits in the first 2 years of life for all babies, and has recommended this as "standard of care" for many years.

I have never understood why some insurance carriers do not include coverage of well child exams in their standard policies. This bill will correct that problem.

As a pediatrician in this state for 22 years, I have numerous personal examples of the value of well child exams. Problems can be found early, parental support and education gets provided, nutrition status gets assessed, and developmental issues are found early. Babies are unable to speak for themselves. We need to do it for them.

Thank you for sponsoring this legislation. If I can assist in any way, please let me know.

Richard Mandsager MD
Executive Director, The Children's Hospital at Providence
907-743-8450
Richard.mandsager@providence.org

Trevor Fulton

From: Joy Neyhart [jmneyhart@alaska.net]
Sent: Thursday, February 07, 2008 9:08 PM
To: Senator_Lesil_McGuire@legis.state.ak
Cc: George Brown; Grisco Mary Civ 3 MDOS/SGOC; brucechandler@gmail.com
Subject: SB 170

Dear Ms McGuire,

Please support SB 170 which I understand aims to require health care insurers to provide coverage for well baby exams for the first 24 months of life for the dependents of insured parents. This would provide a significant benefit to all Alaska state and City and Borough of Juneau employees, especially school district employees, many of whom do not currently enjoy this coverage.

As a board certified pediatrician I know how important preventative health care services are for infants and toddlers. Each preventative care visit is more than a physical exam. Developmental screenings are performed and appropriate referrals are generated for any infant or young child who shows signs of developmental or language delay. Early detection and appropriate treatment of developmental and language delay significantly improves school readiness and functional ability of children with delays.

Preventative health care visits are also invaluable opportunities to provide education to parents, especially young or inexperienced parents, regarding dental health, nutrition, injury and accident prevention, the importance of reading aloud to young children, and immunizations. This list is in no way exhaustive.

If you have specific questions or concerns regarding these important preventative health care services, please do not hesitate to contact me.

Sincerely,

Joy M. Neyhart
PRIVATE PRACTICE PEDIATRICIAN
3268 Hospital Drive, Ste D
Juneau, AK 99801

907 463 1210

Trevor Fulton

From: Pittz, Shirley K (HSS) [shirley.pittz@alaska.gov]
Sent: Sunday, February 10, 2008 7:39 PM
To: Trevor Fulton
Cc: Lesmann, Mike (HSS)
Subject: RE: URGENT: SB 170 - Well Baby Exams

Trevor-
In addition to the identification of any health issues a child may be having, one of the main goals of routine preventive health care is to make sure a child is developing normally. Research clearly indicates that effective early intervention for developmental delay as well as social emotional issues is effective in ameliorating levels of delay and the need for more intensive services later on. This is not only better for children and their families, but it also saves the resources that will be needed later on if issues are not identified early. We provide well-child exams for our children on Medicaid and Denali Kidcare. Children with insurance should be able to access the same level of care. This is an important bill and one that can make a difference for many Alaskan families.

Shirley Pittz, Early Childhood Comprehensive Systems Coordinator
(907) 269-8923
(907) 269-3988 Fax
Please note my email has changed..... ***shirley.pittz@alaska.gov***

From: Trevor Fulton [mailto:Trevor_Fulton@legis.state.ak.us]
Sent: Thursday, February 07, 2008 2:48 PM
To: Pittz, Shirley K (HSS)
Subject: URGENT: SB 170 - Well Baby Exams

Shirley,

As per our conversation earlier, here is a copy of that bill and sponsor statement. As with all things legislative, time is of the essence, so I thank you in advance for yours.

Sincerely,

- Trevor

From: Trevor Fulton
Sent: Thursday, February 07, 2008 2:17 PM
To: 'jtower@alaska.com'
Subject: URGENT: SB 170 - Well Baby Exams

All,

Public Testimony for SB 170

Online
Dr. Judy Butto
Anchorage Pediatric Group
President, American Academy of Pediatrics – Alaska Chapter

In person
Dr. George Brown
Glacier Pediatrics

Stephanie Birch
Section Chief for Women's, Children's and Family Health
Division of Public Health, DHSS

Katie Campbell
Alaska Division of Insurance

SB

179

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
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Senator_Bettye_Davis@legis.state.ak.us
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Senator Bettye Davis

SENATE HESS HEARING
MARCH 31, 2008

RE: Senate Bill No. 179( ), 25-LS0936\M (3/26/08)

"An Act requiring family health care insurance coverage for dependent children who are less than 26 years of age."

Enclosed is the hearing package for the Senate HESS Committee on SB 179 regarding family health care insurance coverage for dependent children who are less than 26 years of age. Included is new version "M" which shortened the title change from the L&C version passed 3/26/08.

Attached are the following:

1. Sponsor Statement
2. Current version of SB 179
3. Fiscal Note
4. Additional documentation
5. People to testify by teleconference - representative of NCSL and others as available

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Senator Bettye Davis

Senate Bill 179( ), 25-LS0936\M

"An Act requiring family health care insurance coverage for dependent children who are less than 26 years of age."

SPONSOR STATEMENT

SB 179 mandates family private health insurance coverage by qualifying insurers for dependent children through age 25. It prohibits a health care insurer from denying or removing enrollment or eliminating coverage under age 26.

Young adults, ages 19-29, are one of the largest growing segments of the U.S. population without health insurance. In 2004 almost 14 million young adults lacked coverage, an increase of 2.5 million since 2000. This rapid change is due in part to their losing coverage under their parents' policies at 19, or Medicaid, or State Children's Health Insurance Program, or graduation from high school or college. Almost half of college graduates and high graduates will be uninsured for a substantial time after graduation.

Age 19 is a crucial year in health insurance coverage. Both public and private insurance plans treat this age as a turning point for insurance coverage. Even if youth go on to college, parents' insurance plans often stop before graduation. Almost all private universities and about one fourth of public universities require health insurance as a condition of enrollment. Forty percent of part-time students and non-students, and 20% of full-time students ages 19-23 are uninsured.

Insurance coverage is important for this generally healthy group of young adults who should be encouraged to start taking responsibility for their own health care. It has been found that 14% of adults 18-29 are obese, an increase of 70% in the 1990s, - the fastest rate of increase among all adults. There are 3.5 million pregnancies each year among the 21 million women ages 19-29. One-third of all diagnoses of HIV are made among young adults. Emergency room visits are far more common among young adults than children or older adults. Most young adults have no regular doctor, no link to the health care system, and more than one-third of those who do require medical attention are often saddled with debt and collection agencies.

States are taking action to mandate coverage for young adults, often allowing for targeted policy options. For example, in 2006 New Jersey required most group health plans to cover single adult dependents up to age 30. Massachusetts as part of its expanded health insurance law in 2006 considered dependents for insurance purposes up to age 25 or for two years after they are no longer claimed on their parents' tax returns. Since 1994 Utah has required coverage through age 26, and New Mexico provides coverage for unmarried dependents up to age 25, regardless of school enrollment. Texas in 2003 allowed full-time students up to be covered by their parents' insurance plans to age 25. It is not uncommon, or unreasonable, therefore, that Senate Bill 179 requires offering family health insurance coverage to dependent children up to age 26.

25-LS0936\M
Bailey
3/26/08

CS FOR SENATE BILL NO. 179( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to family health care insurance for dependent children who are less than 26 years of age."

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

* Section 1. AS 21.42.345 is amended by adding a new subsection to read:

(e) A health care insurer who provides health care insurance coverage of a child through family health care insurance may not deny enrollment and may not disenroll or eliminate coverage for a dependent child of the insured who is less than 26 years of age.

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FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 179
() Publish Date:

ID(File name) SB179-DHSS-MS-02-26-08
Title DEPENDENT HEALTH INSURANCE; AGE LIMIT
Dept. Affected: Health & Social Services
RDU Health Care Services
Component Medicaid Services

Sponsor DAVIS
Requester SENATE (L&C)
Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	•		•	•	•	•	•
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	•		•	•	•	•	•
Miscellaneous							
TOTAL OPERATING	•	**0.0**	•	•	•	•	•
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							
FUND SOURCE		(Thousands of Dollars)					
1002 Federal Receipts	•		•	•	•	•	•
1003 GF Match	•		•	•	•	•	•
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	•	**0.0**	•	•	•	•	•

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

The fiscal impact is indeterminate. SB 179 would mandate private health insurance coverage for dependent children through age 25. Because Medicaid is the payer of last resort, this could result in savings to the Medicaid program if older dependent children who are not currently covered by third party insurance gain that coverage. However, these savings could be reduced if mandatory coverage of older dependents increases the cost of health insurance and leads employers or individuals to drop dependent coverage.

Prepared by: William J. Streur, Deputy Commissioner
Phone 334-2520
Division Health Care Services
Date/Time 02/25/2008
Approved by: Karleen Jackson, Commissioner
Date 02/27/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)