Don Burrell

From: Ginger Blaisdell
Sent: Wednesday, March 12, 2008 9:37 AM
To: Don Burrell
Subject: Emailing: Welcome To ASPAN

ASPAN American Society of PeriAnesthesia Nurses

Home
Contact Us

PeriAnesthesia Nurse Awareness Week (PANAW)

February 4 - 10, 2008

PERIANESTHESIA NURSING focuses on the care of patients undergoing surgery and invasive procedures that require sedation, analgesia, and anesthesia. To practice perianesthesia nursing, specialty nurses must have comprehensive knowledge and competencies that are grounded in perianesthesia-specific scientific theory. Because of the expertise and dedication of the perianesthesia nurse, each year during the first full week of February, PeriAnesthesia Nurse Awareness Week (PANAW) is celebrated. Do your part in getting the word out about perianesthesia nursing by supporting the efforts of ASPAN during PANAW.

PANAW Resources

2008 PANAW Promotional Items Catalog
Working with the Media
How to obtain a Proclamation
2008 Proclamation
2008 PANAW Press Release

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ASPAN's Core Ideology

CORE PURPOSE

To advance the unique specialty of perianesthesia nursing.

Core Values
Honesty, truthfulness, fair, pride, respect, diversity, ethical, stewardship, mentoring, passion and family/community.

Value Discipline
ASPAN's image, reputation and identity of excellence must become that of eminent influence. The association will be branded as being the leading advocate and spokesperson for perianesthesia nursing.

ASPAN's Envisioned Future

Big Audacious Goal
ASPAN will be recognized by the healthcare community worldwide as the leading organization for perianesthesia nursing education, practice, standards and research.

Goal Descriptions

A. ASPAN will be its members' indispensable resource for perianesthesia education and knowledge exchange worldwide.

B. ASPAN will be the influential force for perianesthesia patient safety, public policy and practice standards.

C. ASPAN will be recognized voice and source of perianesthesia information to the public.

D. The art and science of perianesthesia nursing will be advanced through ASPAN's evidence-based practice and research activities.

Don Burrell

From: Ginger Blaisdell
Sent: Wednesday, March 12, 2008 9:36 AM
To: Don Burrell
Subject: Emailing: Welcome To ASPAN

ASPAN American Society of PeriAnesthesia Nurses

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ASPAN Facts

The American Society of PeriAnesthesia Nurses (ASPAN) is the professional specialty nursing organization representing the interests of more than 55,000 nurses practicing in all phases of preanesthesia and postanesthesia care, ambulatory surgery, and pain management.

ASPAN's Core Ideology

CORE PURPOSE

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Don Burrell

From: Ginger Blaisdell
Sent: Wednesday, March 12, 2008 9:36 AM
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Subject: Emailing: Welcome To ASPAN

Historical Information

From Fifty Years of Progress in Postanesthesia Nursing, 1940-1990

In 1980 the American Society of Post Anesthesia Nurses (ASPAN) was born of the need for education specific to perianesthesia care. ASPAN has continued to prosper with membership over 5,600 in 1989. Through ASPAN other avenues of growth have occurred which include a bimonthly journal devoted to perianesthesia nursing, a bimonthly newsletter, annual conferences, and an opportunity to become certified in this specialty of nursing.

FOUNDING DIRECTORS:

Margaret Bailey, RN
Maine

Mary Lou Barnett, RN
Minnesota

Elaine Brown, RN
Arizona

Charlene Cusick, RN
Michigan

Marie A. Darcy, RN
Florida

Alma Derway, RN
Connecticut

Jane H. Dillon, RN
New York

Betty Elliot, RN
Alabama

Hallie J. Ennis, RN
Oklahoma

Judy Ferrey, RN
Georgia

Jovita Keane Gilligan, RN
Ohio

Anita Kay Kubin, RN
Texas

Jeanne R. Maher, RN
Illinois

Coleen C. Meyer, RN
Kansas

Ina F. Pipkin, BSN, RN
Washington

Mary Ruszovan, RN
California

Marilyn Schneider Glaser, BSN, MS, RN
Maryland/D.C.

Mary Ann Seinar, RN
Pennsylvania

Marge Wareham, RN
New Jersey

PACU Progress in the ...

1940s **1970s**
1950s **1980s**

1960s 1990s

PACU Progress in the 1940s
The birth of Post Anesthesia Care Units (PACU, formerly known as Recovery Rooms) in the 1940s was the result of the necessity to centralize patients, equipment and personnel for the immediate and efficient postoperative treatment required. More extensive and complicated surgeries were being performed and the need for adequate and more detailed postoperative care increased. Surgery patients were cared for postoperatively in all nursing areas of the hospitals. During these years the medical and nursing staffs were at a minimum and most hospitals were not blessed with an abundance of equipment. To combat these problems, it was deemed necessary to introduce an area with specially prepared nurses to care for the newly operated patient.

PACU Progress in the 1950s
The 1950s ushered in an era of great progress in PACUs. Many hospitals realized the necessity for larger and more efficient facilities. This resulted in remodeling of the older units and special planning for the units in the construction of new hospital buildings. New "respirators" and blood pressure manometers were perfected and purchased by the more aggressive administrations.

At the close of the decade the need for increased staff was being addressed by administrators, and nurses were searching for more sources of education specific to their specialty.

PACU Progress in the 1960s
The 1960s were a time of growth and change within the postanesthesia arena throughout the country. Conceptually, postanesthesia rooms had been incorporated in most hospitals by 1960. It was apparent that these areas should be in close proximity to the operating suites.

PACU Progress in the 1970s
The decade of the 1970s was one of modernization and mechanization of both hospitals and their PACUs. More monitoring devices were introduced and computers were coming into use in some phases of hospital procedures, especially in the business office. Bed capacity increased markedly.

With the increase in PACU beds came increases in nursing staff and in many instances an increase in the number of hours the PACUs were open for patient care. The 1970s were years of rapid invention and manufacture of monitoring equipment of all varieties. Plastic and disposable items proliferated, making some aspects of PACU nursing easier.

PACU Progress in the 1980s
By the early 1980s exciting things were appearing in PACUs. New equipment and technology to improve patient care were being introduced. Computers were being installed and utilized in 23 of the 39 hospital PACUs questioned in one survey. Monitoring equipment was becoming an important adjunct to meeting standards of care. Forty percent of all PACU patients were being monitored with ECG monitors. Monitors with the ECG were most often used, followed closely by invasive monitoring systems.

Quality Assurance (QA) and the ASPAN Standards of Perianesthesia Nursing Practice were important as hospitals were becoming aware of the importance of risk management. Thirty-seven hospital PACUs utilized QA Programs and 32 utilized the ASPAN Standards of Perianesthesia Nursing Practice. Although care plans were available, many PACUs had not initinted these.

Ambulatory Surgery services were being established more frequently in the early 1980s as an alternative to the expense of inpatient surgery. Thirty-seven [hospitals] stated that the usual stay for the outpatient was one hour. The Ambulatory Surgery service was a separate department in 32 of the hospitals responding to the survey.

Into the 1990s
Since 1980, postanesthesia care of patients has vastly improved. Equipment has been updated to give the most accurate findings by using noninvasive and invasive monitoring. Nurses have been a part of the decision making team for purchase of equipment for their units. Input of the perianesthesia nurse is sought and equipment made to perianesthesia specifications.

Increasing numbers of hospitals use the ASPAN Standards of Perianesthesia Nursing Practice. As more practicing perianesthesia nurses learn about the American Society of PeriAnesthesia Nurses, more nurses will use the Standards.

Benefitting health care, computers have been incorporated into the hospital and ambulatory surgery setting. In the future, nursing paperwork will be converted to computer data systems, allowing nurses more time with patients and their families.

As the 1980s ended, more outpatient surgical procedures were performed, increasing PACU and ASU patient cases per day. Ambulatory surgical centers are an integral part of the health care system. Nurses who work specifically with outpatients are supported by ASPAN. These ambulatory surgical nurses share many of the concerns of nurses working with inpatient perianesthesia patients.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SCR 14
() Publish Date:

Identifier (file name):
Title SCR 14 PERIANESTHESIA NURSES WEEK: FEB 2008
Dept. Affected:
RDU
Component
Sponsor Senator Green
Requester (S) Health, Education and Social Services Committee
Component Number

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**	**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 Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

Prepared by: SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
Phone 465-3822
Division
Date/Time 3/12/08 12:00 AM
Approved by: /s/ Senator Davis, Chair
Date 3/12/2008

(Revised 10/23/2007 OMB)

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/18/08

FURTHER:

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/13/08

Health, Education and Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 14

SCR 14 PERIANESTHESIA NURSES WEEK: FEB 2008

Proclaiming February 4 - 10, 2008, as Perianesthesia Nurses Week.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[X] adopt **previous** [ ] **SCS** or [ ] **CS** SCR 14 (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[✓] Same Title
[ ] New Title
_____
HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHSS	3/12/08			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Elton	✓			
	Thomas	✓			
	Lee Sorg	✓			
CHAIR: Bettye Davis	DAVIS	✓			

SCR

17

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Chair
Senate State Affairs
Administrative Regulation Review

Member
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

Date: January 28, 2008

Re: Request for hearing, SCR 17 – *Brain Injury Awareness Month: March 2008*

I respectfully request that SCR 17 *"A Resolution relating to establishing March 2008 as brain injury awareness month"* be scheduled for a hearing at your earliest convenience. Attached you will find the most current version of the resolution and the sponsor statement.

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

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Chair
Senate State Affairs
Administrative Regulation Review

Member
Senate Judiciary Committee
Senate Resources Committee

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SCR 170 – BRAIN INJURY AWARENESS MONTH: MARCH 2008

Traumatic brain injury (TBI) is damage to the brain that results when the head is hit, strikes a stationary object, or is violently shaken. Depending on what area of the brain is injured, people with brain injuries may suffer from poor short-term memory and difficulty with organization concentration and judgment. Since the personality of a TBI survivor may also change as a result of their injury, family members often say that brain injury is one of the hardest disabilities to deal with because the survivors may look the same, but act and behave completely differently.

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

Alaska is the number one state, per capita, for brain injuries in the nation. Over 800 TBIs were reported in Alaska in 2005 and an estimated 12,000 Alaskans have suffered a traumatic brain injury.

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

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/23/08

FURTHER:

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/6/08

Health, Education & Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 17

SCR 17 BRAIN INJURY AWARENESS MONTH: MARCH 2008

Relating to establishing March 2008 as Brain Injury Awareness Month.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title
_____

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
S.HES	2/6			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

COMMITTEE ACTIONS					
	Elton	✓			
	Thomas				✓
	Dyson				✓
CHAIR: Betty, Davis	DAVIS	X			

SCR

19

ALASKA STATE LEGISLATURE

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

State Capitol, Rm. 115
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

716 W. 4th Ave, Ste. 440
Anchorage, AK 99501
(907) 269-0102
Fax: (907) 269-6122

SENATOR BILL WIELECHOWSKI

March 5, 2008

Senator Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Room 30, State Capitol
Juneau, Alaska 99801

I respectfully request a hearing on SCR 19, a resolution supporting implementation of the recommendations of the Governor's Summit on Early Learning.

Recent studies indicate that nearly half of Alaska children enter school unprepared to be successful learners, setting them up for failure before they even start kindergarten. Experts attribute this in large part to the lack of preschool education available in Alaska. Alaska is one of only 10 states without a state-funded, statewide early childhood system. Nationally the trend is towards voluntary pre-kindergarten for all children.

Study after study documents the benefits of quality preschool education, including significantly less grade repetition; major reductions in special education placements; substantially higher rates of high school graduation; dramatic increases in college attendance; substantially fewer arrests; much less reliance on public assistance; and higher rates of employment.

In addition, key workforce skills (e.g., motivation, persistence and self-control) are developed most cost-effectively and efficiently in preschool children. All of these factors combine to make returns from investments in preschool far greater than those from most public economic development projects.

Thank you for your prompt consideration of this request,

Senator Bill Wielechowski

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 115
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

Interim
716 W. 4th Ave. Ste. 540
Anchorage, AK 99501
(907) 269-0120
Fax: (907) 269-0122

Senator_Bill_Wielechowski@legis.state.ak.us

Co-chair
Joint Armed Services Committee

Member
Resources Committee
Judiciary Committee
Transportation Committee

SENATOR BILL WIELECHOWSKI

SPONSOR STATEMENT
SCR 19: Support for Alaska's Early Learners

Recent studies indicate that nearly half of Alaska children enter school unprepared to be successful learners, setting them up for failure before they even start kindergarten.

Experts attribute this in large part to the lack of preschool education available in Alaska. Alaska is one of only 10 states without a state-funded, statewide early childhood system. Nationally the trend is towards voluntary pre-kindergarten for all children.

Study after study documents the benefits of quality preschool education, including significantly less grade repetition; major reductions in special education placements; substantially higher rates of high school graduation; dramatic increases in college attendance; substantially fewer arrests; much less reliance on public assistance; and higher rates of employment.

In addition, key workforce skills (e.g., motivation, persistence and self-control) are developed most cost-effectively and efficiently in preschool children. All of these factors combine to make returns from investments in preschool far greater than those from most public economic development projects.

In 2007, Alaska was one of ten states awarded a prestigious grant from the National Governors Association to hold a Governor's Summit on Early Learning. More than 150 legislators, other policymakers and statewide leaders participated in the summit to ensure Alaska's future economy will be supported by an educated, productive workforce.

Attendees at the Summit drafted recommendations to ensure that all children, especially those most in need, have access to quality early learning opportunities.

SCR 19 calls on Governor Palin to work closely with the legislature to review and implement the recommendations of the Governor's Summit on Early Education. It also expresses support for incremental development of a statewide system of voluntary and affordable early education with options available for children and families in all communities.

Alaska
GOVERNOR'S SUMMIT ON EARLY LEARNING
2007

Recommendations

The Alaska Governor's Summit on Early Learning brought together over 150 Alaskans from a wide variety of sectors across the state to develop recommendations for Governor Sarah Palin's early learning policy agenda. Participants were asked to address these goals:

Goal A **All children, especially those most in need, have access** to early literacy and learning opportunities in their home or in out-of-home settings;
Goal B **These services are coordinated**; and
Goal C **Parents, grandparents, and extended family are engaged** in young children's learning with needed support, resources, and incentives.

After hearing from national speakers on early learning and economic development, brain research and early learning, and early learning public policy, and from Alaskan leaders, participants broke into small groups. Participants discussed how to create a **System Infrastructure** for early learning in Alaska and how to provide early learning opportunities to children **In the Home** and to children in **Programs Outside the Home**. Their top recommendations include the following:

- **Implement a voluntary Quality Rating and Improvement System (QRIS)** which is a method to assess, improve, and communicate the level of quality in early care and education settings (addresses all three goals, and is a priority in the areas of both "System Infrastructure" and "Programs Outside the Home")

- **Conduct a comprehensive public engagement campaign** to inform parents, extended families, community members, and business about the economic and social "return on investment" in the early years and what they can do to support early learning (addresses Goal C, and is a priority in the area of "In the Home")

- **Increase funding for Head Start** to enable more low-income children to participate (addresses Goal A, and is a priority in the area of "Programs Outside the Home")

- **Increase the child care assistance reimbursement rates** (addresses Goal A, and is a priority in the area of "Programs Outside the Home")

- **Increase the eligibility guidelines for child care assistance** so more families can participate in the workforce (addresses Goal A, and is a priority in the area of "Programs Outside the Home")

Supported By BEST BEGINNINGS
Alaska's Early Childhood Investment

Other Recommendations

System Infrastructure

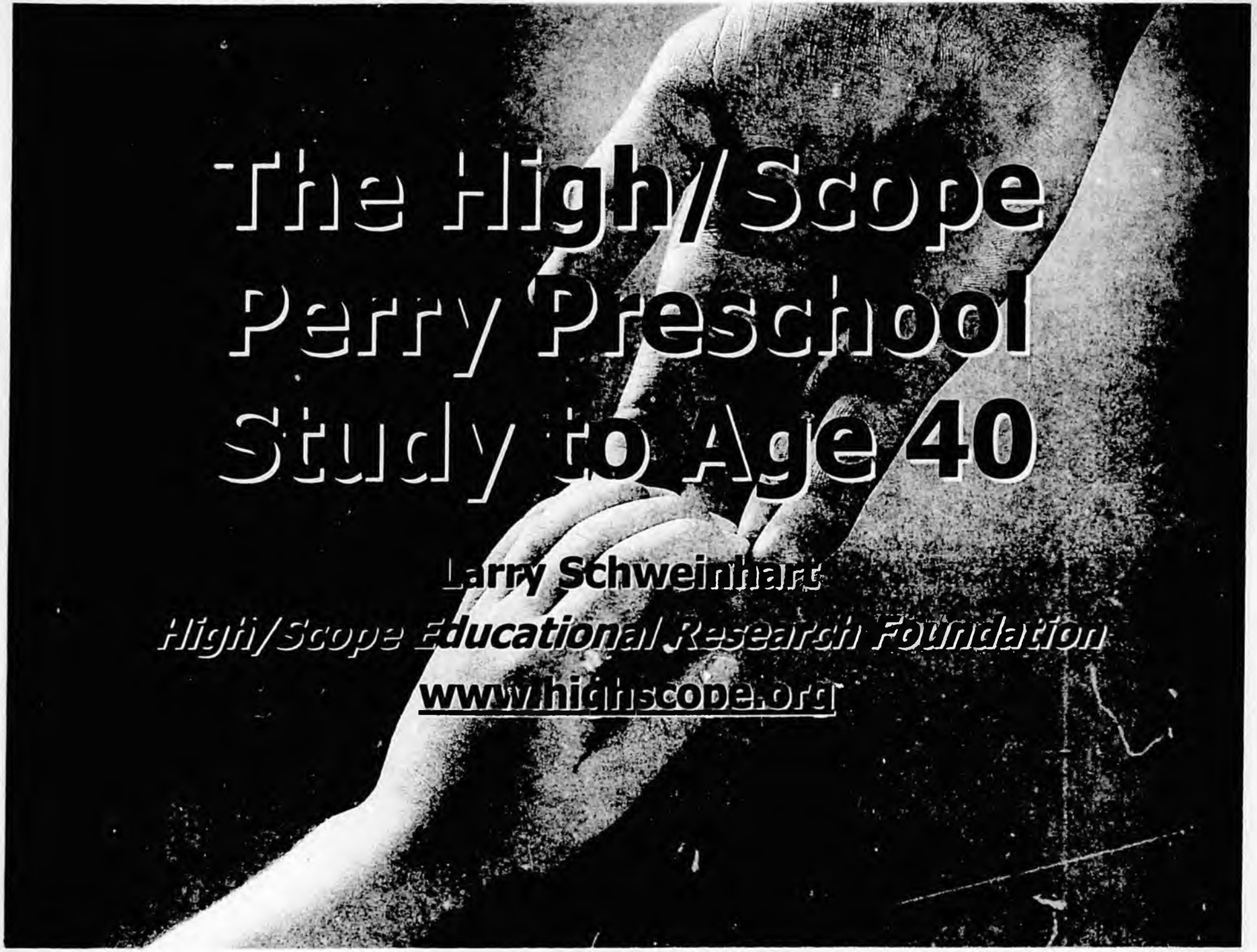
- **Provide sustainable state resources** to support early learning (examples are an early learning endowment, a formula for funding, trust fund, or savings account)
- **Develop a public-private entity** to oversee and coordinate early learning activities (examples are the Denali Commission, cabinet level structure, new department, or single coordinating office with multiple departmental linkages)
- **Develop community-level database & coordinated system** to identify services and organizations that provide early learning services across Alaska
- **Conduct community needs assessments** to develop system of support for families and children (multi-agency system and strong community buy-in)

In the Home

- **Encourage employer flexibility and financial assistance** for parents of young children, (examples are tax credits, paid parental leave, parenting resources, flexible schedules, and other family-friendly policies)
- **Provide all parents with access to home-based education and support** (examples are expansion of home visiting, parenting classes, and financial supports)
- **Develop culturally relevant materials** (listening to groups, using technology, have incentives and mechanisms to share, template to produce own materials)

Programs Outside the Home

- **Create a statewide professional development plan** that ensures there are adequate supports to build an early care and education workforce (examples are wage incentive programs and financial supports for education and training)
- **Create a liability insurance pool for child care centers and a health insurance pool for child care workers, with financial support**
- **Provide incentives to businesses** to support the creation and maintenance of quality early care and education programs



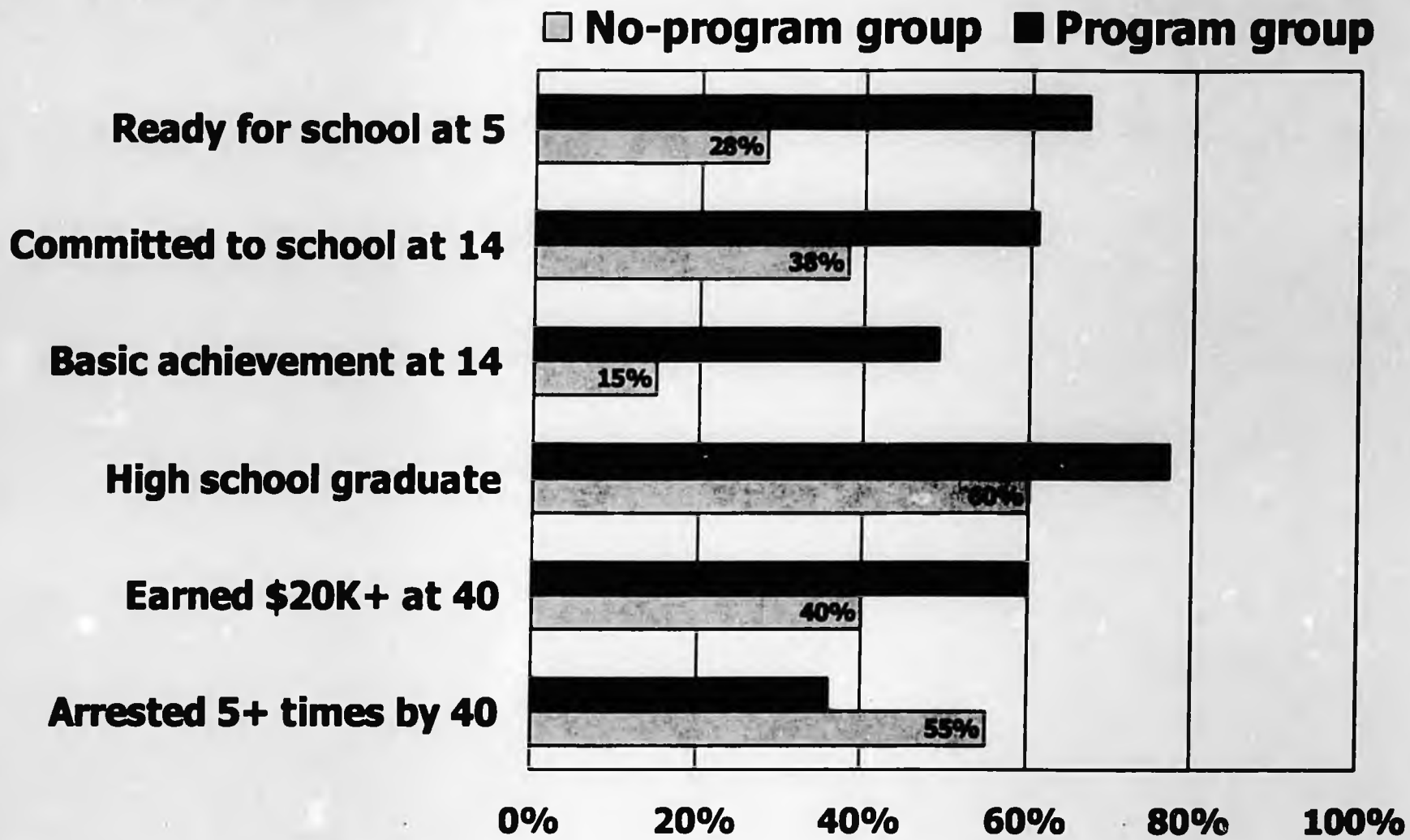
The High/Scope Perry Preschool Study to Age 40

Larry Schweinhart

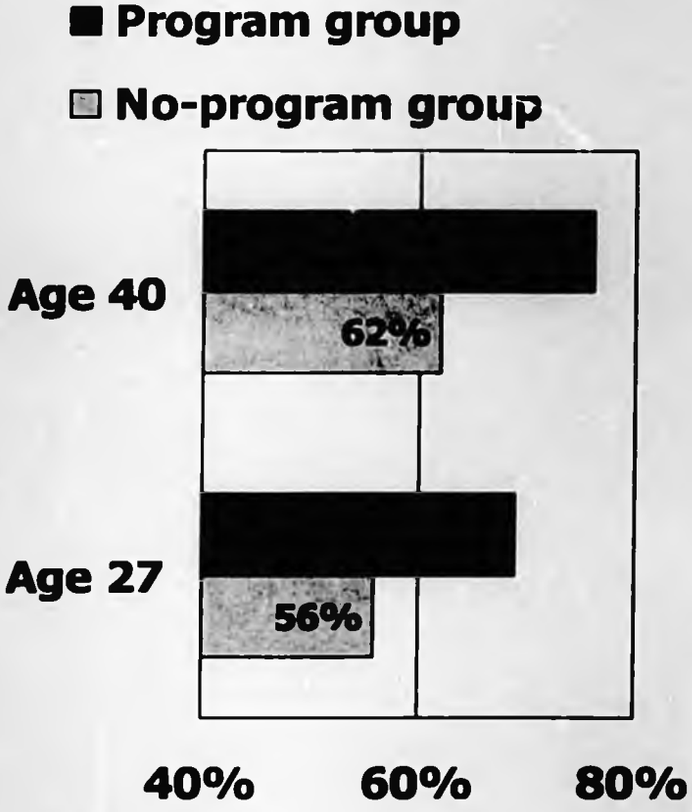
High/Scope Educational Research Foundation

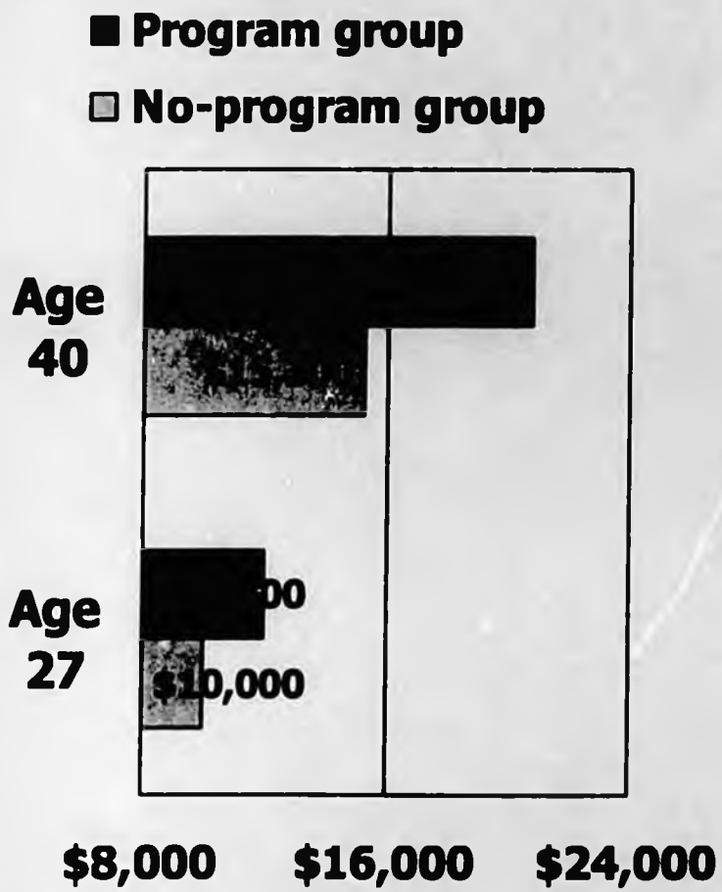
www.highscope.org

Major findings over time

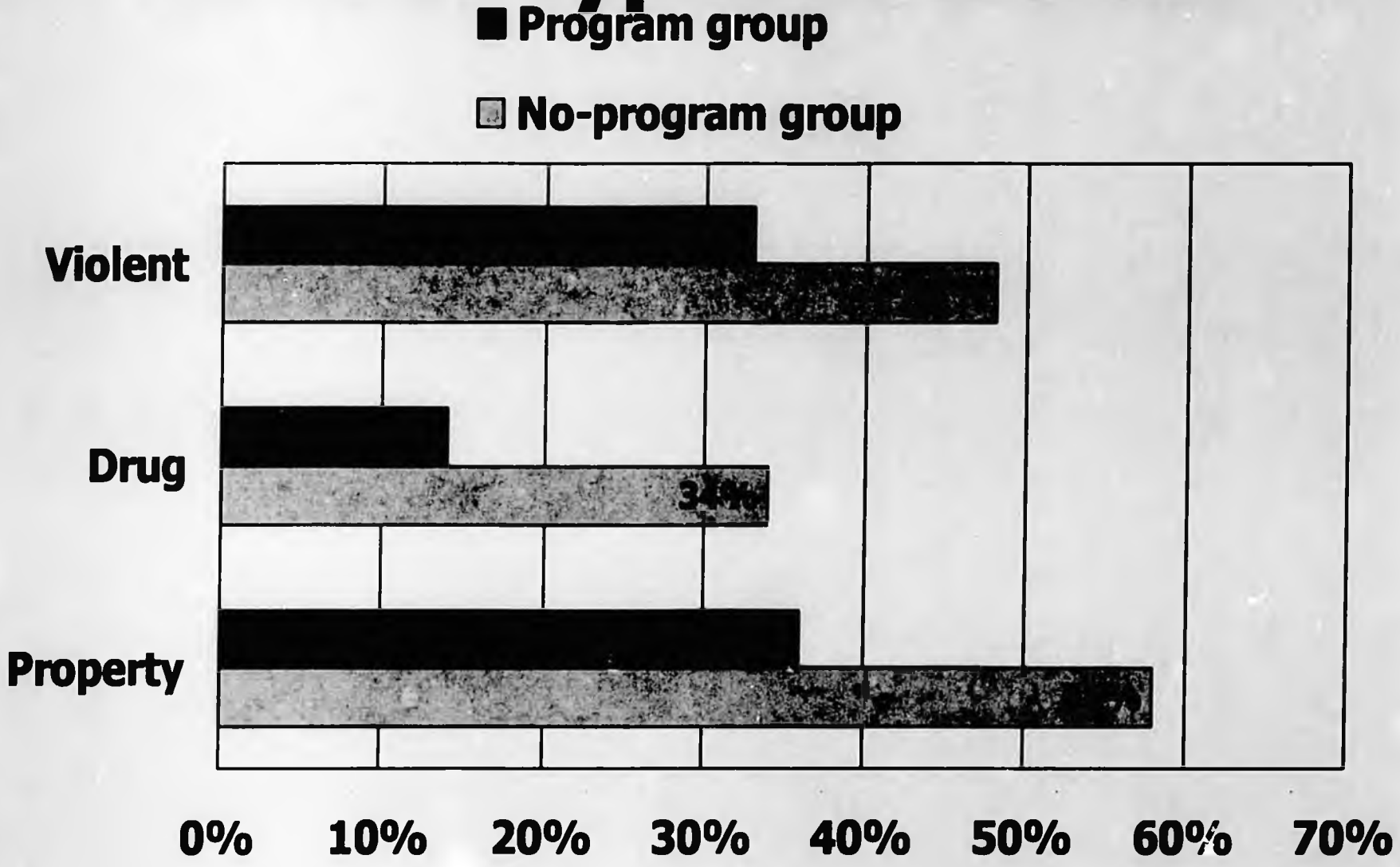


More employed, higher earnings

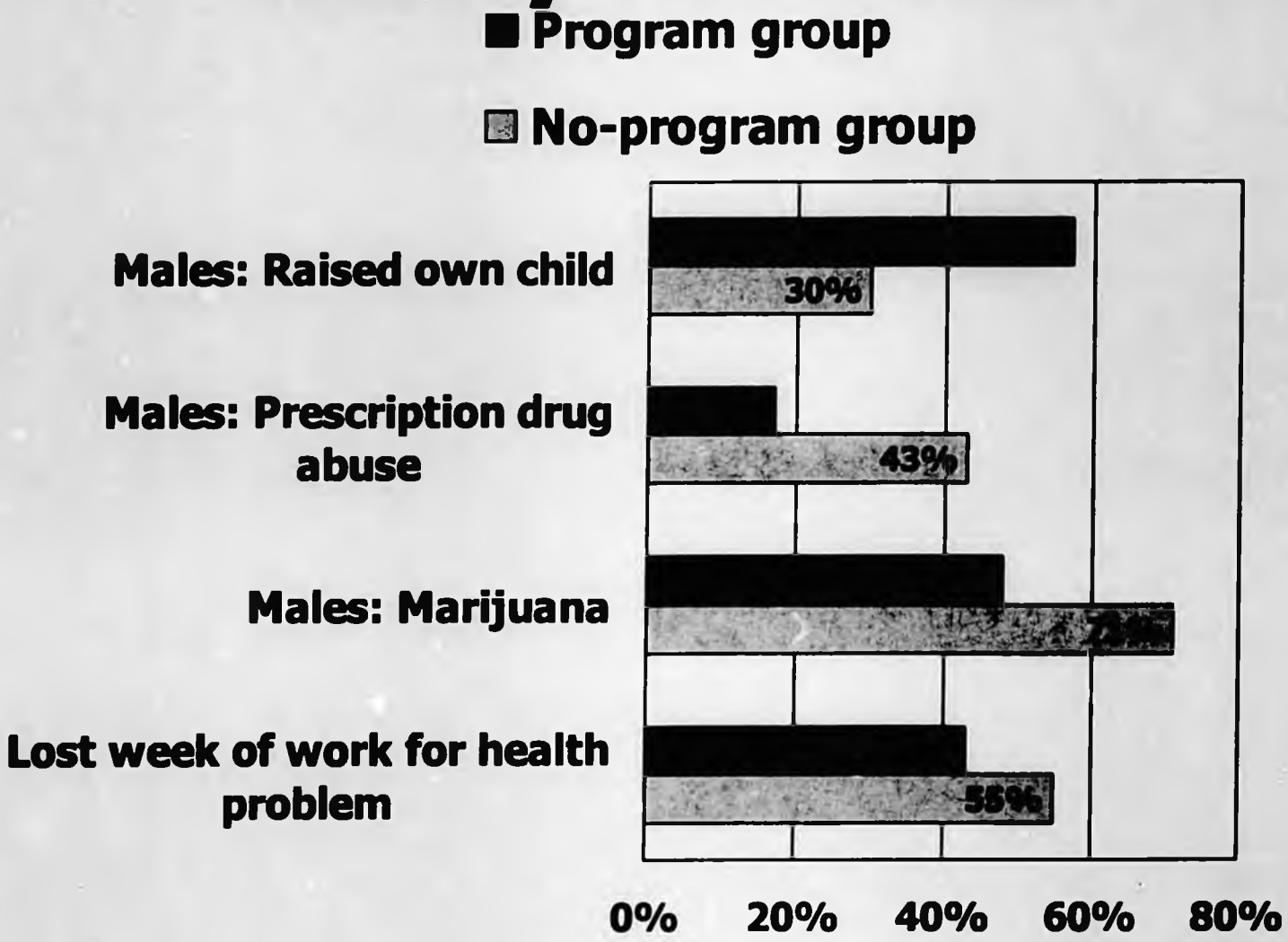




Fewer arrested for various types of crimes

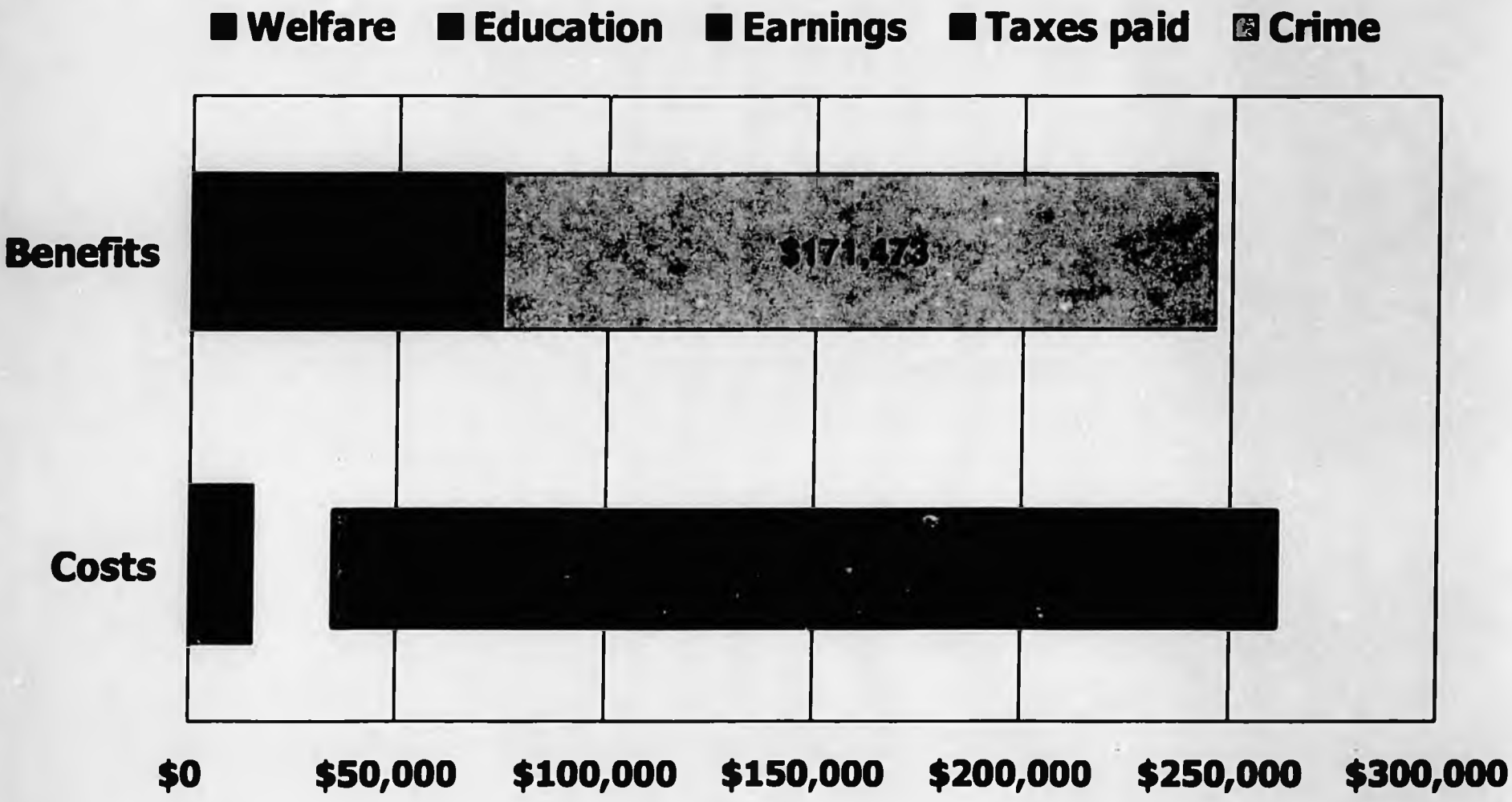


Better health and family relations



Large return on investment

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



Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 213
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

FOR YOUR IMMEDIATE ATTENTION

DATE: March 10, 2008

TO: Health, Education and Social Services Committee
(Don, Room 30)

FROM: Office of the Senate Secretary

SUBJ: Sponsor Substitute

A Sponsor Substitute has been introduced on the following bill/resolution pending in your Committee:

RETRIEVE

SENATE CONCURRENT RESOLUTION NO. 19
Relating to implementation of the recommendations of the Governor's Summit on Early Learning.

Please pull this bill/resolution folder from your files and give to the page. The bill/resolution folder will be returned to you with the Sponsor Substitute.

Thank you.

MEMO
Please Deliver Immediately

To: State of Alaska Senate HESS Committee Members
From: Susan A. Anderson, M.Ed.
Date: 10 March 2008
RE: Testimony for Senate HESS Committee meeting today at 5pm

Dear Senate HESS Committee Members,

More than 150 Alaskans generated recommendations about enhancing early learning opportunities in the State of Alaska during the *Governor's Summit on Early Learning* in December 2007.

As a participant of that forum I hope the Governor and legislature will work closely together to see that they are implemented for the future of our biggest resource – our littlest Alaskans.

Sincerely,

Susan A. Anderson, M.Ed.
Cell: 907.360.7158
Email: sanderson@gci.net

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/10/08

FURTHER:

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/11/08

Health, Education & Social Services Cmte considered SS FOR SENATE CONCURRENT RESOLUTION NO. 19

SCR 19 GOVERNOR'S SUMMIT ON EARLY LEARNING

Relating to implementation of the recommendations of the Governor's Summit on Early Learning.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Elton	✓			
	Thomas	✓			
	DYSON	✓			
CHAIR: Betty J. Davis	DAVIS	✓			

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SCR 19
() Publish Date:

Identifier (file name):
Title SCR 19 Governor's Summit on Early Learning
Dept. Affected: DHSS
RDU
Component
Sponsor Senator Wielechowski
Requester (S) Health, Education and Social Services Committee
Component Number

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**	**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 Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

Prepared by: SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
Phone 465-3822
Division
Date/Time 3/11/2008 1:00 p.m.
Approved by: /s/ Senator Davis, Chair
Date 3/11/2008

(Revised 10/23/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SCR 19
() Publish Date:

Identifier (file name):
Dept. Affected: DEED
Title SCR 19 Governor's Summit on Early Learning
RDU
Component
Sponsor Senator Wielechowski
Requester (S) Health, Education and Social Services Committee
Component Number

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**	**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 Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

Prepared by: SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
Phone 465-3822
Division
Date/Time 3/11/2008 1:00 p.m.
Approved by: /s/ Senator Davis, Chair
Date 3/11/2008

(Revised 10/23/2007 OMB)

SJR

1

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Memorandum

To: Representative Kevin Meyer, Co-Chair House Finance

From: Senator Bettye Davis BD

Date: April 18, 2007

RE: Waiving SJR 1 Medical Assistance for Children

I respectfully request that the House Finance Committee waive from Committee SJR 1 Medical Assistance for Children. SJR 1 urges our congressional delegation to support funding of the SCHIP, known as Denali KidCare here in Alaska. It has a zero fiscal note. I have included the signatures of the committee members.

K. Meyer
Rep. Kevin Meyer

Rep. Mike Chenault

Rep. Bill ~~Stolze~~ STOLTZE

Rep. Richard Foster

Rep. Richard Foster

Rep. Mike Hawker

Rep. Mike Kelly

Rep. Bill Thomas

Rep. Harry Crawford

Rep. Les Gara

Rep. Reggie Joule

Rep. Mary Nelson

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction):
Dept. Affected:
Title: SJR 1Medical Assistance for Children
RDU
Component
Sponsor: Senator Davis
Requester: (S) Health, Education & Social Services Committee
Component No.

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time						
Part-time						
Temporary						

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

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

(Revised 9/18/2006 OMB)

Center on Budget and Policy Priorities

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Revised February 22, 2007

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

By Edwin Park and Matt Broaddus

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

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

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

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

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

The SCHIP Provision Enacted in December 2006

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

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

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

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

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

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

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

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

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

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

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

A Stop-Gap Measure

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

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

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

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

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

TABLE 1

14 States Projected to Face Federal SCHIP Financing Shortfalls in 2007

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

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

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

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

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

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/7/07

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/26/07

Health, Education and Social Services Committee considered

SENATE JOINT RESOLUTION NO. 1

SJR 1 MEDICAL ASSISTANCE FOR CHILDREN

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

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
S.HES	2/25			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Elton	✓			
	Thomas	✓			
	Coaduryx	✓			
	Dyson	✓			
CHAIR:	Davis	✓			

Alaska State Legislature

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Senator Bettye Davis

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

Sponsor Statement

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

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

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

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

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

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

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

Bush FY2008 Budget:

Analysis of SCHIP and Medicaid Provisions

- SCHIP
- Medicaid

SCHIP

The State Children's Health Insurance Program (SCHIP) is set to expire at the end of fiscal year (FY) 2007 (September 30), making the reauthorization of SCHIP one of the most important health care issues that Congress will address this year. As such, the President's 2008 budget was expected to include information about future federal funding and policies for the program. But while his budget does mention SCHIP, it does so only briefly, and without much detail.

The President's budget offers the following provisions regarding SCHIP:

- **Reauthorization:** The President proposes to reauthorize SCHIP for another five years, through 2012.
- **Funding:** The President assumes that SCHIP will be reauthorized with funding at the same level it received in FY2007, approximately $5 billion per year. The President proposes to add only $4.8 billion in federal funding for SCHIP over the next five years above the baseline allotment. This level of funding is significantly less than is needed simply to continue covering current SCHIP enrollees, let alone expand coverage to any of the millions of uninsured children.

- **Limiting Eligibility:** SCHIP was created to provide health coverage to low-income, uninsured children (children in families with incomes less than twice the federal poverty level, or $34,340 for a family of three in 2007). Over the past 10 years, several states have used the flexibility built into SCHIP to provide coverage for children in families with incomes above twice the poverty level. States have also obtained waivers to extend coverage to parents, pregnant women, and other adults.

  The President's budget proposal discusses "refocusing" the program on

low-income children with family incomes below twice the poverty level, although it does not provide details about how this is to be accomplished. This proposal appears to contradict the prevailing political winds, as governors in both parties across the country are seeking to build on the success of SCHIP and Medicaid to expand coverage to more uninsured people in their states. There is no "score" attached to this proposal.

Budget Impact: The proposal for SCHIP reauthorization is estimated to cost an additional $5 billion over five years.

Families USA's Commentary on the President's SCHIP Proposals

The President's budget fails to demonstrate a strong commitment to supporting this very popular and successful program. The funding level proposed falls far short of what is needed to allow states to sustain even current enrollment in SCHIP, let alone enroll any of the nearly 7 million children who are already eligible for SCHIP or Medicaid but who remain uninsured. Moreover, the proposal ignores growing national sentiment that covering children is the right thing to do and contradicts the President's own statements about the importance of finding and enrolling the uninsured children who are already eligible for these programs. Finally, the suggestion that states should reduce their eligibility levels for children or cut parents and pregnant women from the program flies in the face of the goal of reducing the number of uninsured in this country, and it undermines what governors of both parties are attempting to accomplish with coverage expansions.

Medicaid

The President's 2008 budget for Medicaid continues a trend seen in his past budgets: proposing a laundry list of ways to shift costs from the federal government to the states and to low-income beneficiaries. In addition, the budget proposes significant changes to the rules about how Medicaid pays for prescription drugs.

Proposals to Shift Costs to the States and to Beneficiaries

- **Reduce Medicaid Administrative Match Rates:** Currently, states can receive higher reimbursements—up to 90 percent—for certain administrative costs, such as costs related to the development of information technology (IT) systems, operation of claims payment systems, and services performed by skilled medical professionals.

  The President's proposal would cut the reimbursement rate that states receive for Medicaid administrative costs to 50 percent across the board. This proposal represents a very significant reduction in federal funds to

states, since state Medicaid agencies rely on the higher administrative match to make important improvements in their Medicaid programs. The Administration has touted the virtues of health information technology investments numerous times, and investing in Medicaid data systems should be part of this effort. Moreover, implementing the DRA citizenship documentation requirement has produced many new IT burdens that states must work though, and cutting administrative reimbursement only exacerbates these burdens [legislative change].

Budget Impact: This proposal would cut $945 million in the first year and $5.3 billion over five years.

- **Eliminate Medicaid Graduate Medical Education:** The Administration's proposal would eliminate Medicaid as a source of funding for physician training through graduate medical education, reasoning that it is outside Medicaid's primary purpose of providing health care to low-income people [administrative change].

  Budget Impact: This proposal would cut $140 million in the first year and $1.8 billion over five years.

- **Restrict 1915(b)(3) Services:** Section 1915(b)(3) of the Medicaid Act allows "additional services" to be provided in Medicaid managed care programs. The President's budget proposal would issue rules clarifying allowable services under Section 1915(b)(3) [administrative change].

  Budget Impact: No cost estimate is provided.

- **Cut Duplicative Administrative Costs:** The President's budget seeks to prohibit states from billing the federal government for administrative Medicaid costs that the Administration says are already funded through the TANF block grant [legislative change].

  Budget Impact: This proposal would cut $280 million in the first year and $1.8 billion over five years.

- **Require State Reporting and Tie Grants to Performance:** The budget proposal would require states to report their performance on certain measures to CMS, and states' performance would be tied to federal Medicaid reimbursement [administrative change].

  Budget Impact: This proposal would save $0 in the first year and $330 million over five years.

- **Lower Reimbursement for Targeted Case Management:** The budget proposes to lower reimbursement for targeted case management from a

state's full Medicaid matching rate to the flat 50 percent administrative matching rate [legislative change]. Currently, many states' full Medicaid matching rates are higher than 50 percent.

Budget Impact: This proposal would cut $200 million in the first year and $1.2 billion over five years.

- **Cap Payment to Government Providers:** The budget proposes to stop certain state financing mechanisms that divert federal funds from government providers to state governments. The Administration also proposes to limit payments to government providers to no more than the cost of furnishing a particular Medicaid service to an individual [administrative change]. It is unclear how or whether this proposal differs from the proposed regulation issued by CMS in January 2007.

  Budget Impact: This proposal would cut $530 million in the first year and $5 billion over five years.

- **Cut Services for People with Disabilities:** The budget proposal would eliminate reimbursement for certain rehabilitation services for which states are now receiving funding through Medicaid [administrative changes].

  Budget Impact: This proposal would cut $230 million in the first year and $2.3 billion over five years.

- **Eliminate Certain School-Based Services:** This proposal would prohibit federal funding for transportation and administrative costs related to Medicaid services that some children receive at school [administrative change].

  Budget Impact: This proposal would cut $615 million in the first year and $3.6 billion over five years.

- **Restrict Provider Taxes:** The budget proposal would clarify and limit how Medicaid's provider tax operates [administrative change]. In 2006, Congress enacted legislation limiting the Administration's ability to restrict provider taxes, so the move to "clarify" the provider tax is another attempt by the Administration to restrict this funding mechanism.

  Budget Impact: This proposal has no costs associated with it.

- **Limit Allowable DSH Costs:** The budget would codify in regulation which costs states may claim for reimbursement under the Disproportionate Share Hospital (DSH) program [administrative change].

  Budget Impact: This proposal has no costs associated with it.

- **Third Party Liability:** The budget proposal would require states to collect payments for prenatal or pediatric services owed by third party payers, collect medical child support when the non-custodial parent has an obligation to provide health insurance, and recover Medicaid expenditures from beneficiary liability settlements [legislative change].

  Budget Impact: This proposal would save $10 million in the first year and $85 million over five years.

- **Stop "Pay and Chase":** This proposal would require states to seek reimbursement for all pharmacy claims from any applicable third party payers before allowing Medicaid to pay the claim [administrative change].

  Budget Impact: This proposal has no costs associated with it.

- **Redefine the Home Equity Limit:** The DRA allows states the option of increasing the home equity limit from $500,000 to $750,000 in order for individuals to qualify for Medicaid long-term care services. In areas of the country that have experienced inflated home prices in the last few years, even low-income individuals may have homes worth more than $500,000. This budget proposal would eliminate this state option and codify the home equity limit at $500,000, thereby making it harder for people to qualify for long-term care services under Medicaid [legislative change].

  Budget Impact: This proposal would cut $70 million in the first year and $430 million over five years.

Prescription Drug Reimbursement Proposals

In addition to shifting costs to states and beneficiaries, the President's budget contains a number of changes to how Medicaid pays for prescription drugs.

- **Multiple Source Drugs:** Building on changes contained in the DRA, this proposal would reduce the federal upper limit reimbursement for multiple-source drugs to 150 percent of the average manufacturer price of the lowest-priced drug in the group [legislative change].

  Budget Impact: This proposal would save $160 million in the first year and $1.2 billion over five years.

- **Allow Optional Managed Formularies:** The budget proposal would allow states to use "private sector management techniques" to negotiate greater discounts with prescription drug manufacturers [legislative change].

  Budget Impact: This proposal would save $160 million in the first year and $870 million over five years.

- **Replace the Best Price Rebate:** This budget proposal would replace the use of "best price" in the Medicaid drug rebate formula with a budget-neutral flat rebate [legislative change].

  Budget Impact: This proposal has no costs associated with it.

- **Require Tamper Resistant Prescription Pads:** This proposal would require providers to use "tamper resistant" prescription pads in states where hand-written prescription pads are still used [legislative change].

  Budget Impact: This proposal would save $35 million in the first year and $210 million over five years.

Proposals that Increase Federal Medicaid Spending

The President's budget does contain a few proposals that would increase federal spending on Medicaid. These include the following:

- **Extension of Transitional Medical Assistance:** The budget proposal would allow Transitional Medical Assistance (TMA) to continue through September 30, 2008. The TMA program extends Medicaid eligibility for up to 12 months after a person enters the workforce and loses TANF cash benefits.

  Budget Impact: This proposal would cost $460 million in the first year and $665 million over five years.

- **Extension of the Qualified Individuals Program:** This proposal would allow the Qualified Individuals (QI) program to continue through September 30, 2008. This program helps Medicare beneficiaries with incomes of between 120 and 135 percent of the federal poverty level and with limited financial resources pay their Medicare Part B premiums.

  Budget Impact: This proposal would cost $425 million in the first year and $425 million over five years.

- **Extension of the Refugee and Asylee Exemption:** This proposal is actually within the budget proposal for the Social Security Administration's (SSA), but it affects the Medicaid program as well. The proposal would extend the exemption period that refugees and asylees have to complete the citizenship application process from seven years to eight years. Refugees and asylees would be eligible for Medicaid during this time period.

  Budget Impact: This proposal would cost $33 million in the first year and $99 million over five years.

Miscellaneous Provisions

- **Asset Verification Demonstrations:** The Social Security Administration (SSA) runs a pilot program that uses electronic financial records to verify an applicant's assets to determine his or her eligibility for Supplemental Security Income (SSI). The budget proposal would require state Medicaid agencies to establish similar pilot programs to verify assets of Medicaid applicants in locations where the SSA pilot programs operate [legislative change].

  Budget Impact: This proposal would save $65 million in the first year and $640 million over five years.

- **Extension of the 1915(b) Waiver Period:** The budget proposes to extend the renewal period for Section 1915(b) waivers ("freedom of choice" waivers) from two ars to three years [legislative change].

  Budget Impact: This proposal has no costs associated with it.

- **HIPAA Modifications:** This proposal would ensure that people receiving Medicaid and SCHIP benefits would have protections under the Health Insurance Portability and Accountability Act (HIPAA), which increases the continuity, portability, and accessibility of health insurance [legislative change].

  Budget Impact: This proposal has no costs associated with it.

Families USA's Commentary on the President's Medicaid Proposals

The President's FY 2008 budget proposes cutting almost $26 billion from Medicaid over the next five years. If enacted, these cuts would place tremendous financial constraints on states. Although state budgets are mostly healthy, and the growth of their Medicaid programs has slowed, in the face of these new federal financial pressures, states will be hard-pressed not to make cuts to Medicaid that will reduce access to care for the people who rely on the program. Many of these proposals would restrict the types of services that can be reimbursed under Medicaid, so states will almost assuredly cut benefits, and people will lose access to critical services.

The President's FY 2008 budget contains an astonishing number of proposals that appear to be identical to items introduced in his FY 2007 budget but that were never implemented, either legislatively or administratively. However, his new proposals contain minimal detail, which makes it difficult to ascertain if they are indeed identical. The lack of detail also makes it difficult to fully

understand the implications that these proposals have for Medicaid. Many of these proposals would impose new requirements on states, cut funding, or "redefine" or "clarify" the kinds of services for which states may claim reimbursement under Medicaid.

In addition to the specific proposals discussed above, the President has mentioned another new health care reform proposal, although with little details. In his State of the Union address, the President discussed a plan to allow states to use Medicaid disproportionate share hospital (DSH) payments to fund proposals to expand health care coverage to the uninsured. Although we had hoped that the President would present more details about the plan in his budget, the "Affordable Choices" initiative is discussed only in the vaguest terms in the FY 2008 HHS budget document. These health care proposals must be "state-based" and "budget neutral" and must "not create a new entitlement." State proposals to use this public spending source would need to "avoid costly and unnecessary medical visits" and emphasize "upfront, affordable private health insurance options." Secretary Leavitt is directed to work with Congress and the states to flesh out this initiative, so details on this proposal may or may not be forthcoming.

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SJR

3

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/7/07

FURTHER: Rules

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/26/07

Health, Education and Social Services Committee considered SENATE JOINT RESOLUTION NO. 3

SJR 3 MEDICARE RATES IN ALASKA

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

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Impact	Zero	FN#
S.HES	3/26/07			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Impact	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	CORRECT	AMEND
	Elton	–			
	Thomas	✓			
	Coghill	✓			
	Dyson				✓
CHAIR: Bettye Davis	DAVIS	✓			

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Judiciary Committee
Transportation Committee

SENATOR BILL WIELECHOWSKI

SPONSOR STATEMENT
SJR 3

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

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

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

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

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

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

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

adn.com
Anchorage Daily News

Fewer primary care doctors take Medicare

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

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

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

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

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

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

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

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

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

Primary Care keeps existing patients who age into Medicare.

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

About 55,000 Alaskans are enrolled in Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Why is it such a problem here?

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

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

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