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 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

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

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Sponsor Statement

SB 13 increases and restores to original levels 12 years ago the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL). Alaska as one of the nation's wealthiest states is only one of 5-7 states which funds its SCHIP program below 200% FPL. SB 13 makes health insurance accessible to an estimated 1277 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an "enhanced" reimbursement program with up to 70% matching funds (Alaska currently receives about 66%) under the federal government's State Children's Health Insurance Program (SCHIP), which was created in 1997. Congress reauthorized the SCHIP program for five years and President Obama just signed into law on February 4, 2009 with expanded coverage for 4 million more children.

Consider the following information from the Kaiser Commission on Medicaid and the Uninsured, January, 2009:

- 44 states, including D.C., cover children in families with incomes at 200% FPL or higher.
- 33 states cover children in families with income between 200% and 250% FPL.
- 19 states including D.C., cover children in families with income at 250% or higher. 10 of these states cover children in families with income at 300% FPL or higher.
- 35 states allow premiums or enrollment fees, and 24 states have co-payments for selected services in SCHIP programs on a sliding scale of FPL.
- 46 states do not require asset tests

Denali KidCare serves an estimated 7900 Alaska children and remains one of the least costly medical assistance programs in the state at about $1,700 per child with full coverage, including dental, which is about 20% of the cost of adult senior coverage.

Early intervention and preventative care under SB 13 will greatly increase Alaska children's health and yield substantial savings to the state and public and private sector hospital emergency rooms which must admit indigent and uninsured patients for non-emergency treatment. It is estimated that

uninsured children with a medical need are five times as likely not to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost.

There are still an estimated 18,000 uninsured children in Alaska, or about 9% of the children age 18 and under. Private health care coverage for children has declined over 30% in the last ten years, and the deepening recession is pulling more children and families into the uninsured ranks. The reauthorized SCHIP program and "Stimulus Package" should help, and Alaska should do its share and take advantage of available federal matching funds by insuring its low income children up to and including 200% FPL under SB 13.

SENATE BILL NO. 13

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATORS DAVIS, Ellis, Paskvan

Introduced: 1/21/09
Referred: Health and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

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

* **Section 1.** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under

AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established

by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed **200** [175] percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed **200** [175] percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII).

* **Sec. 2.** AS 47.07.042(d) is amended to read:

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) and whose household income is between 150 and **200** [175] percent of the federal poverty line. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions.

* **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

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

MEMORANDUM January 22, 2009

SUBJECT: Sectional Summary (SB 13; Work Order No. 26-LS0076\A)

TO: Senator Betty Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends the medical assistance eligibility provisions for persons under 19 years of age and for pregnant women by increasing the household income limit from 175 to 200 percent of the federal poverty line.

Section 2. Increases the household income limit from 175 to 200 percent of the federal poverty line for requiring premiums and cost-sharing contributions from medical assistance recipients who are under 19 years of age.

Section 3. Provides for an immediate effective date.

JMM:ljw
09-039.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB013**
() Publish Date:

Identifier (file name): **SB013-DHSS-BHMS-02-01-09**
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Behavioral Health
Component: Behavioral Health Medicaid Services
Sponsor: Davis
Requester: Unknown
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	430.0	0.0	467.0	507.1	550.7	598.1	649.5
Miscellaneous							
TOTAL OPERATING	**430.0**	**0.0**	**467.0**	**507.1**	**550.7**	**598.1**	**649.5**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	284.0		305.7	330.7	359.1	390.0	423.6
1003 GF Match	146.0		161.3	176.4	191.6	208.1	226.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**430.0**	**0.0**	**467.0**	**507.1**	**550.7**	**598.1**	**649.5**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

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

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/22/08 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/1/2009
Finance Management Services

ANALYSIS CONTINUATION

prevailing federal poverty guideline (FPG) for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility.

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2010 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2010 and 2015. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2010 and 2015;, however, the program is currently funded under a continuing resolution. Title XXI funding for the balance of SFY 2009 after March 30, 2009 and for SFY 2010 will not be established until Congress takes additional action to reauthorize and fund the SCHIP program.

Expenditures for the Behavioral Health Medicaid Services component were determined based on the component's share of expenses for the affected eligibility subtypes in 2008. Behavioral Health paid about a quarter of the costs for affected DKC children in 2008. No charges for services for DKC pregnant women were paid by this component in 2008.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB013
() Publish Date:

Identifier (file name): SB013-DHSS-MS-02-01-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Davis
Requester: Unknown
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8
Miscellaneous							
TOTAL OPERATING	**2,105.0**	**0.0**	**2,286.0**	**2,482.6**	**2,696.1**	**2,928.0**	**3,179.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,448.7		1,561.0	1,689.5	1,834.8	1,992.6	2,164.0
1003 GF Match	656.3		725.1	793.1	861.3	935.4	1,015.8
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,105.0**	**0.0**	**2,286.0**	**2,482.6**	**2,696.1**	**2,928.0**	**3,179.8**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

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

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200 percent of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/22/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/1/2009
DHSS Finance Management Services

ANALYSIS CONTINUATION

prevailing federal poverty guideline (FPG) for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility.

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2010 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2010 and 2015. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2010 and 2015; however, the program is currently funded under a continuing resolution. Title XXI funding for the balance of SFY 2009 after March 30, 2009 and for SFY 2010 will not be established until Congress takes additional action to reauthorize and fund the SCHIP program.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2008. Health Care Services Medicaid paid 100% of the costs for DKC pregnant women and about three quarters of the costs for affected DKC children in 2008.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB013
() Publish Date:

Identifier (file name): SB013-DHSS-PAFS-02-04-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Public Assistance
Component: Public Assistance Field Services
Sponsor: Davis
Requester: Unknown
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	134.4		134.4	134.4	134.4	134.4	134.4
Travel							
Contractual	17.6		17.6	17.6	17.6	17.6	17.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0
Equipment	14.4						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**167.4**	**0.0**	**153.0**	**153.0**	**153.0**	**153.0**	**153.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	83.7		76.5	76.5	76.5	76.5	76.5
1003 GF Match	83.7		76.5	76.5	76.5	76.5	76.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**167.4**	**0.0**	**153.0**	**153.0**	**153.0**	**153.0**	**153.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time	**2.0**		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

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

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare(DKC) program was originally created.

This fiscal note represents the additional administrative costs needed to support the increased eligibility determination workload resulting from more pregnant women and children applying for medical assistance, using the assumptions from the companion fiscal notes for the Division of Health Care Services and the Division of Behavioral Health.

(continued on Page 2)

Prepared by: Ellie Fitzjarrald
Phone 907-465-5847
Division: Division of Public Assistance
Date/Time 2/4/09 12:00 AM

Approved by: Alison Elgee, Assistant Director
Date 2/4/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 013

ANALYSIS CONTINUATION

The eligibility decision includes verifying information and determining whether a pregnant woman or child qualifies for DKC when they apply, acting on changes, and periodically re-examining a household's eligibility.

We assume that 218 pregnant women and 1,277 children will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and that implementation will begin July 1, 2009. We estimate two additional Eligibility Technician I (Range 13) positions will be needed to manage this additional work in FY2010.

Total Administrative Costs for ET I Positions:

Personal Services: Two Eligibility Technician I Range 13 at a cost of $134.4, including benefits, for 12 months.
Contractual: Annual cost for office space, phones, etc. will be $17.6.
Commodities: Annual cost for the office supplies will be $1.0.

Additional Cost of FY2010:
Equipment/Supply: A one time cost of $14.4 for desktop computer, software, printer, and work stations will be needed for the new positions.

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
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

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

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Background of SCHIP/Denali Kid Care

- SCHIP was created in 1997 to reduce the number of uninsured children by providing subsidized insurance to children of those parents who are too poor to afford insurance but make too much to receive Medicaid coverage. About 1/3 of all children in America get health services through Medicaid or the State Children's Health Insurance Program (SCHIP), which is administered in Alaska through the Denali KidCare Program.
- The Denali KidCare Program is 70% funded by the federal government up to the state's allocated funding level. After that, the reimbursement rate declines to slightly over 50%. In fiscal year 2006 the cost of Denali KidCare was $25.9 million, of which $18.2 million was paid by the federal government.
- Denali KidCare provides health insurance for children age 18 and pregnant women who meet income guidelines. There is no cost to eligible children, teens and pregnant women. However, youth who are 18 may be required to contribute a limited amount for some services.
- Roughly 7,600 children were covered by Denali KidCare as of December, 2006.
- The cost per child of Denali KidCare is about $1,700 annually, compared to over $12,000 for an elderly person who qualifies for federal aid.
- By comparison, private health insurance for a family of three, *e.g.*, a pregnant woman with two children, is estimated at $8,000-$17,000 annually. Unlike Denali KidCare, this insurance may require a $1,000 deductible, 20% co-pay, and no vision, dental or hearing benefits.
- Alaska remains one of the lowest eligibility rates in the nation. Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL. The US and state governments' rationale for higher eligibility for children's health insurance is that it will save huge sums in transfer costs and improve health in the future through early detection and care.

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
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

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

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Repercussions of the unmet health needs of Alaska's uninsured children

---

- The number of uninsured children in Alaska is estimated to be about 18,000 or 9% of the population age 18 and under (Urban Institute and Kaiser Commission on Medicaid and the Uninsured).
- Over the last 10 years Alaska has seen a 31% decline in the number of children covered by private health insurance (Robert Wood Johnson Foundation).
- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).
- Uninsured children have much higher health risks than do covered children. The receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser, *supra*).
- Uninsured children are more likely to develop throat, eye, and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than five times as likely as insured children to have an unmet need for medical care and nine times more likely not to be examined by a regular doctor. They are also four times more likely to use emergency rooms which are much more costly than care in physicians' offices (*Pediatrics* 105, 113; "Care for Children," *New England Journal of Medicine*, 330).
- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (*Health Affairs* 23, no. 5, September-October 2004).
- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund, Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of $65-$130 billion annually.

Why Coverage for Pregnant Women is Important In Alaska

- Alaska has one of the nation's highest documented pregnancy-associated mortality ratios – 58 per 100,000 live births during 1990-1999 (DHSS). National data indicate that women who receive no prenatal care are al increased risk of pregnancy-related death.
- Only 58% of women in Alaska receive adequate prenatal care, compared with 75% nationally.
- Mothers having late or no prenatal care are more likely to have low birth weight or pre-term infants and are at increased risk fro pregnancy-related mortality and complications of childbirth (DHSS).
- The average cost of hospital care for a premature baby was $75,000 in 2001, compared with $1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about $13.1 billion annually.

adn.com
Anchorage Daily News

Print Page | Close Window

Alaska rewarded for kids' health insurance

The Associated Press
(12/21/09 21:40:13)

Alaska is among nine states being rewarded by the federal government for enrolling more uninsured children in Medicaid. Health Secretary Kathleen Sebelius said Alaska is receiving a $789,000 bonus for boosting health insurance coverage for children.

The payouts were part of the Children's Health Insurance Program reauthorization signed into law by President Barack Obama.

The amounts totaled $72.6 million in this fiscal year.

Print Page | Close Window

kaiser commission on medicaid and the uninsured

A Foundation for Health Reform:

Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009

Executive Summary

Prepared by:
Donna Cohen Ross and Marian Jarlenski
Center on Budget and Policy Priorities

and

Samantha Artiga and Caryn Marks
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

December 2009

THE HENRY J. KAISER FAMILY FOUNDATION

Executive Summary

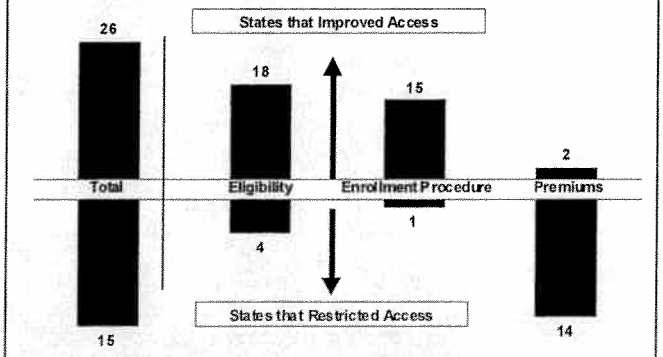
Over the past decade, substantial progress has been made on covering low-income families through Medicaid and the Children's Health Insurance Program (CHIP). However, states' ability to sustain and advance this coverage faced a difficult test in 2009. As the year began, CHIP still had not been reauthorized and states were facing the bleakest economic picture in years. Then, in early 2009, several developments, including the enactment of the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the infusion of fiscal relief through the American Recovery and Reinvestment Act (ARRA), provided key federal support to help states maintain and expand coverage. ARRA also established important protections to Medicaid eligibility and enrollment procedures that helped preserve coverage (although these did not extend to CHIP).

In 2009, health coverage programs for low-income children and parents managed not only to survive the tumultuous economic environment, but also to expand and improve access. The stabilizing force of ARRA's fiscal relief, along with its stipulations preventing states from reducing eligibility or imposing enrollment barriers in Medicaid, enabled states to avoid cuts to these aspects of their programs and move forward, making use of new resources and opportunities in CHIPRA. Based on a national survey, this report provides an overview of state actions on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and CHIP for children and parents during 2009. It finds:

More than half the states (26 states) advanced health coverage for low-income children, parents, and pregnant women in 2009 (Figure 1). These advancements included eligibility expansions, such as increases in income eligibility limits for children (9 states) and expansions to immigrant children and/or pregnant women who have been legally residing in the U.S. for less than five years under the new CHIPRA option (18 states), as well as enrollment and renewal simplifications and premium reductions.

Figure 1

Number of States Taking Action Affecting Access to Health Care Coverage, January 2009 – December 2009

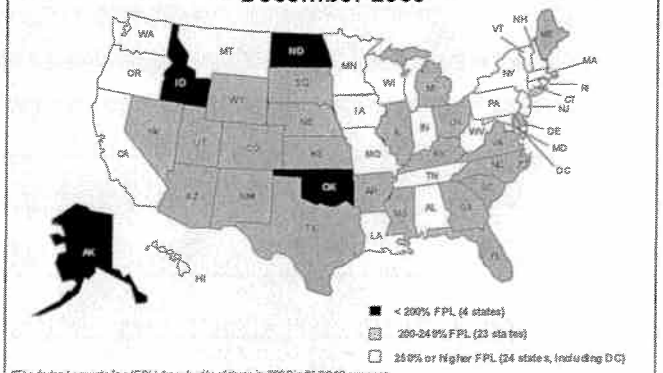


SOURCE: Based on a national survey conducted by KCMU with the Center on Budget and Policy Priorities, 2009.

Children were the main beneficiaries of expansions in 2009. Nineteen states improved children's access to coverage by increasing eligibility, simplifying procedures, and/or eliminating premiums. Reflecting this progress, currently, 47 states cover children in families with income at 200 percent of the federal poverty line ($36,620 for a family of three in 2009) or higher (Figure 2). States also continued to make strides forward in simplifying enrollment and renewal

Figure 2

Children's Eligibility for Medicaid/CHIP by Income, December 2009



*The federal poverty line (FPL) for a family of three in 2009 is $18,310 per year.
**IL uses state funds to cover children above 200% FPL. MA uses state funds to 400% FPL.
SOURCE: Based on a national survey conducted by KCMU with the Center on Budget and Policy Priorities, 2009.

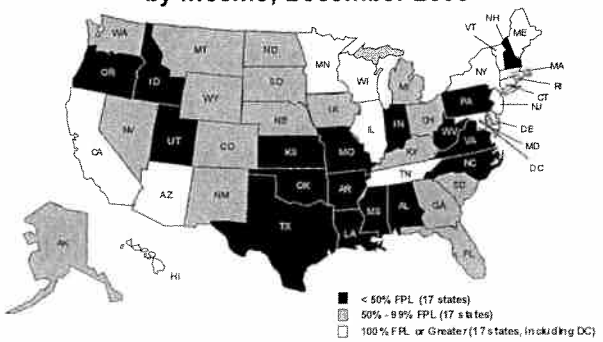
procedures for children (9 states) and by reducing CHIP premiums (2 states). Overall, of the 34 states that charge premiums for children, most do not charge families with incomes below 150 percent of the federal poverty line and the median charge for two children in a family of three with income at 200 percent of the federal poverty line remains modest at $480 per year ($40 per month), or 1.3 percent of family income.

Although most actions were positive, 15 states scaled back coverage due to budget pressures. CHIP programs bore the brunt of reductions since the eligibility and enrollment protections included in ARRA only applied to Medicaid and did not protect CHIP. No state reduced income eligibility for children. However, two states froze CHIP enrollment for some period of time in 2009 and one state reduced eligibility for low-income parents. Other actions included increases in waiting periods for CHIP, retractions in eligibility simplifications, and relatively modest increases in CHIP premiums.

Coverage for parents continues to lag significantly behind children, with disparities growing in 2009. While children's health coverage has grown stronger over time, millions of their parents remain uninsured, since, in most states, eligibility limits for parents remain extremely low. Further, because of the recent advancements for children, the gap between coverage for children and parents has become even more profound. Currently, the median income eligibility limit for children is 235 percent of the federal poverty line, compared to 64 percent of the federal poverty line for working parents. Overall, in 34 states, eligibility for working parents is limited to less than 100 percent of the federal poverty line ($18,310 for a family of three in 2009) with 17 states limiting eligibility to less than half of poverty ($9,155 per year for a family of three in 2009) (Figure 3). Additionally, in most states, it remains more difficult to enroll an eligible parent than it does to enroll an eligible child.

Figure 3

Medicaid Eligibility for Working Parents by Income, December 2009



*The federal poverty line (FPL) for a family of three in 2009 is $18,310 per year.
SOURCE: Based on a national survey conducted by KCMU with the Center on Budget and Policy Priorities, 2009.

States' commitment to provide Medicaid and CHIP coverage to low-income families and hold onto the accomplishments of 2009 will continue to be tested in 2010. States' grim budget situations are projected to persist and the fiscal support and requirements for states to maintain Medicaid eligibility and enrollment practices, which proved instrumental in helping states preserve and continue to advance coverage in 2009, are scheduled to expire. Without additional fiscal relief, states will likely begin to contemplate severe cuts to health coverage programs, which will not only jeopardize coverage for low-income families but weaken the base of coverage upon which broader health reform efforts will seek to build. Current reform proposals would build upon Medicaid to expand coverage to the millions of individuals who remain uninsured. Thus, the status of Medicaid and CHIP programs today and their ability to continue to maintain and advance coverage in the coming year will have important implications for broader reform. Continued actions to strengthen the foundation of Medicaid and CHIP coverage will be key to supporting future reform efforts.

Georgetown University Health Policy Institute
Center for Children and Families

An Overview of the CHIPRA Outreach and Enrollment Grants

On July 6, 2009, HHS Secretary Kathleen Sebelius and Medicaid Director Cindy Mann announced a request for a first round of outreach grant proposals funded through the Children's Health Insurance Program Reauthorization Act (CHIPRA). More information about the long-awaited "Request for Proposals" (RFP) can be found here.

A major goal of CHIPRA is to cover more of the millions of uninsured children who already are eligible for Medicaid or CHIP, but whose families lack information about the programs, face red-tape barriers to enrollment, or encounter unnecessary barriers when seeking to renew their children's coverage. To this end, CHIPRA gave states a range of new tools and incentives to enroll already-eligible children and also created the $100 million outreach fund.

These outreach grants can help boost awareness and encourage further simplification of the enrollment and renewal processes while targeting areas with high rates of eligible but not enrolled children and minority children who are disproportionately uninsured. Outreach, including community-based assistance, is also critical during a recession, when newly unemployed families may be particularly unlikely to know about the availability of public programs for their children.

The Centers for Medicaid and Medicare (CMS) will administer the grants. In soliciting proposals, CMS emphasizes that a strong connection must exist between outreach efforts and resultant enrollment and retention of eligible children. Data must be collected, reported, and analyzed against performance measures to determine the effectiveness of outreach efforts, and refinements to strategies must be made in real time when outcomes are not achieving the desired gains in enrollment and retention.

Legislative Background

Congress provided $100 million in CHIPRA for outreach and enrollment activities through September 2013. Of this amount, $10 million will be used for a national enrollment campaign and $10 million will be granted directly to Indian health service providers and urban Indian organizations receiving funds under Title V of the Indian Health Care Improvement Act for outreach to and enrollment of Native American children. The remaining $80 million will be granted to other eligible entities, which may include state, county, and local governments, community-based or faith-based organizations, schools, and federal safety net providers. These grants are the focus of the RFP and up to $40 million will be awarded in this first round.

As required by CHIPRA, priority for the grant awards will be given to eligible entities that target geographic areas with high rates of:

- eligible but unenrolled children, including children who reside in rural areas; or

- racial and ethnic minorities and populations with health disparities, including proposals that address cultural and linguistic barriers to enrollment.

In applying for outreach grants, eligible entities must establish that they have access to, and credibility with, ethnic or low-income populations in the communities where activities will be conducted. As stipulated in statute and reiterated in the RFP, applicants must also demonstrate the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and other punitive fears associated with receipt of benefits, as well as other cultural barriers to application and enrollment in public programs.

The Request for Proposal Process

CMS announced that it plans to award the $80 million in outreach grant funds in two or more rounds. This first round will grant up to $40 million in two-year projects ranging from $25,000 to $1,000,000. CMS anticipates awarding about 200 grants in this round.

Prospective grantees have their work cut out for them, with proposals on a fast timeline, due one month after the release of the RFP. CMS will employ a multi-phased review process that includes an objective assessment by a panel that may include private sector experts, beneficiaries, and federal policy staff, based on weighted criteria as defined in the RFP.

Key Dates

July 22, 2009 – Conference Call for Prospective Grant Applicants
July 27, 2009 – Voluntary Letter of Intent Requested (but not required)
August 6, 2009 – Electronic Submission of Application
August 10, 2009 – Mail Submission of Application
On or before September 30, 2009 – Announcement and Commencement of Grants

Grant Principles

In announcing the grants, CMS expressly stated the purpose of providing outreach money is to not only find the children who are eligible but not enrolled in Medicaid and CHIP but to ensure that they are enrolled and that they retain their coverage while eligible. The award of the grants is based on the following principles:

- ***Outreach must be results driven and connected to actual enrollment and retention of children in Medicaid and CHIP.***
- ***Grantees must provide sound data demonstrating the connection between the proposed outreach efforts and actual enrollment and retention.***
- ***Data and systems improvements that are appropriate within the context of the proposed outreach strategies will be considered for funding.***
- ***Best practices and lessons learned will be shared among grantees and successful outreach strategies that can be replicated are of particular interest.***

Eligible Entities

By law, a diverse group of entities is eligible to apply for grants. The common thread is that these organizations must have experience serving low-income children and families. Coalitions or eligible entities representing broad community partnerships with evidence of community involvement are allowed. Only one application may be submitted by a single entity in this grant round, but an eligible entity may be a member of multiple coalitions.

Eligible entities include:

- A State;
- A local government;
- An Indian tribe, tribal consortium, Indian Health Service Provider, or other tribal organization receiving funds under title V of the Indian Health Care Improvement Act;
- A federal health safety net organization such as a federally-qualified community health center or disproportionate-share hospital;
- A national, state, local or community-based public or nonprofit private organization, including those that use community health workers or have doula programs;
- A faith-based organization or consortia (subject to section 1955 of the Public Health Service Act); and
- An elementary or secondary school.

Outreach and Enrollment Strategies

Applicants are required to submit an outreach and enrollment plan. It is expected that such plans will have different components depending on the strategies proposed. For example, a proposal to establish or strengthen a community-based application and renewal assistance program will have different elements than a plan aimed at improving notices, processes, or systems to enroll or retain eligible children.

All proposals must include certain components, which include utilizing demographic data in the design of outreach projects for target populations and describing how the applicant will submit and analyze the enrollment and retention data. Also required are descriptions of each vulnerable population to be targeted and estimates of the expected numbers of uninsured children by population to be enrolled through the grant activities. Plans must describe the proposed outreach strategies and the methods that will be used to track and measure the effectiveness of each strategy in enrolling and retaining targeted Medicaid- and CHIP-eligible children. All applicants must demonstrate the ability to refine the strategies in real time based on the assessment of the effectiveness of the strategies.

Target Populations

The design of the outreach projects should target populations with high levels of uninsured children under 200 percent of the Federal Poverty Level (FPL) who may be eligible for Medicaid

or CHIP, but are not enrolled. While *target populations are not limited to the following*, proposals addressing these groups with high rates of uninsurance and issues with access to health care will be viewed favorably:

- Legal immigrants or children living in households with mixed immigration status;
- Cross-border populations;
- Children of migrant farmers;
- Hispanic children;
- Teens;
- Rural children;
- Homeless children; and
- American Indian/Alaska Native children.

Budgets, Match and Sustainability

Grant awards will range from $25,000 to $1,000,000 over the two-year period. Funds can be used for a variety of expenses including personnel, equipment, travel, and other direct costs. Applicants are cautioned to use a reasonableness test when determining a cost per new enrollee, as well as the percentage of funds attributable to administrative costs. *The outreach grants do not require a match* from the recipient, but applicants must demonstrate the ability to sustain the outreach, enrollment, and retention efforts beyond the grant period by providing a plan for sustainability. Weight will be given to applications that can show additional funding or in-kind support.

Data Reporting and Evaluation

All proposals must describe how data will be defined, collected, analyzed, and reported to assess the effectiveness of grant activities. Specific outcome measures, which may vary based on the proposed strategies, must be developed as part of the evaluation plan. Applicants must demonstrate the capacity to modify strategies when the data indicate that activities are not achieving the goals of the project. Throughout the RFP, there is a consistent and strong emphasis on data reporting, assessing progress, and redirecting efforts when needed. *The Secretary is also required to submit an annual report to Congress on the outreach and enrollment activities conducted with these funds and make the enrollment data and information collected available publicly.*

Best Practices and Lessons Learned

Applicants must participate in specific program elements to document strategies and outcomes, as well as share and report results. Grantees must commit to sharing policy documents, best practices, and lessons learned with CMS and through peer-to-peer learning and conferences. Grantees must also be willing to coordinate messages and strategies with the national outreach and enrollment campaign.

Specific Requirements for Different Types of Grantees

- ***State Applicants***

  By law, *a maintenance of effort (MOE) on outreach and enrollment expenditures is required.* If funds are granted directly to a state, it must maintain the same level of state funding for outreach and enrollment activities as expended in the prior year. In the proposed grant budget, states must submit the amount of money that was spent on Medicaid and CHIP outreach and enrollment efforts in the preceding fiscal year. This may be challenging to quantify as states have a variety of mechanisms and funding streams for supporting outreach and enrollment. States are also required to submit a certification of maintenance of effort verifying that the grant funds will not supplant existing state expenditures for Medicaid and CHIP outreach and enrollment efforts.

  Due to the responsibility that State Medicaid or CHIP agencies have in enrolling eligible children and their possession of critical data, proposals from these agencies or coalitions that include these agencies are subject to additional criteria. Depending on the proposal, such requirements may include:

  - Formal agreements with coalition grantees or enrollment facilitators (if proposed in the grant);
  - Coordination of coalition grantees for the national outreach and enrollment campaign; and
  - Evidence that the state can provide technical assistance to coalition grantees such as providing mapped census demographic data so grantees can target areas of disparities; conducting focus groups or surveys; and broadening partnerships with key entities that can be utilized by grantees.

  State applicants must demonstrate a commitment to facilitating enrollment and retention. *Of particular interest are innovative applications of technology* such as web-based applications, telephone enrollment and renewal processes, development of new simplification practices or new methods for premium payments, and other proposals including information technology and systems improvements to support outreach, enrollment, and retention.

- ***Non-State Applicants***

  In general, applicants must show that the state is supportive of their application. Non-state applicants must develop a Memorandum of Understanding (MOU) with the State Medicaid and CHIP agencies for the purposes of data collection or alternate plans to demonstrate enrollment or retention results. *In the absence of state collaboration,* applications must demonstrate the efforts will be effective in increasing enrollment among eligible children. No specific guidance is provided on how this might be accomplished.

- ***Tribes or Tribal Entities***

  While tribes and tribal organizations are eligible for grants in this solicitation, they are also eligible for the $10 million in grants targeted to Native American outreach and enrollment. Duplication of funding for activities is not allowed.

News Release

FOR IMMEDIATE RELEASE
Wednesday, September 30, 2009

Contact: HHS Press Office
(202) 690-6343

Secretary Sebelius Awards $40 Million to States to Find, Enroll Children in CHIP, Medicaid

HHS Secretary Kathleen Sebelius today announced $40 million in grants to 69 grantees in 41 states and the District of Columbia to help them find and enroll children who are uninsured but eligible for either Medicaid or the Children's Health Insurance Program (CHIP).

"Today's awards will help fulfill President Obama's pledge to assure the health and well-being of our nation's children," said Secretary Sebelius. "With millions of Americans either out of work or otherwise struggling to make ends meet during this recession, there is an even greater urgency to bring steady, reliable health care to children in these families who may have lost their coverage."

Recognizing that millions of children are eligible for Medicaid or CHIP, but are therefore needlessly uninsured, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) set aside $100 million for fiscal years 2009-2013 expressly to help find and enroll eligible children. Of the total outreach amount, $80 million will be given to states and other organizations, $10 million to Tribal organizations and $10 million for a national outreach effort. Today's awards are for a two year period ending Dec. 31, 2011, which will then be followed by a second round of $40 million in new grants.

As called for in CHIPRA, grants were awarded to applicants whose outreach, enrollment and retention efforts will target geographic areas with high rates of eligible but uninsured children, particularly those with racial and ethnic minority groups who are uninsured at higher-than-average rates. For example, 20 percent of the projects to be funded will target Hispanic children, with an emphasis on Hispanic teens, and 11 percent will focus on homeless children and seven percent will be aimed at Native American/Alaska Native children.

The vast majority of grantees will be using multiple, community-based approaches. One grantee in Missouri, for example, will work with a consortium of 35 churches in low-income, minority communities. Those parishioners will go door-to-door to locate potentially eligible children and then help those families apply for CHIP or Medicaid coverage. Another grantee will place self-service kiosks in community centers and Native American Chapter Houses (community halls) where there will also be staff available to help with applications if needed. One state school system will track children who receive free or reduced cost lunches and, with the families' permission, share that information with state health programs, which will, in turn, mail applications for CHIP and Medicaid to those families. The state will also provide one-on-one-assistance with those applications.

The grant awards require that recipients be able to show actual increases in enrollment and retention of children already in the programs. Both CHIP and Medicaid state agencies are to report to the Centers for Medicare & Medicare Services (CMS) the number of new enrollees and those who retained coverage that are directly attributable to the grant activities. Grantees are also to report activities they believe were the most effective in finding, enrolling and maintaining children in these benefit programs.

"No child in America should go without decent health care," said Cindy Mann, director of the Center for Medicaid and State Operations -- the group within CMS that will administer the grants. "With the funds we are awarding today we hope to reduce the number of children who do."

A list of grantees by state is below.

State	Grantee	Award
Arizona		
	Pima Community Access Program	$982,577
Alabama		
	Alabama Primary Care Association	$987,732
	Tombigbee Healthcare Authority	$141,167
Alaska		
	Alaska Youth and Family Network	$198,304
	Norton Sound Health Corporation	$72,999
Arkansas		
	St. Francis House NWA Inc., Community Clinic	$162,965
California		
	Providence Little Company of Mary Foundation	$317,144
	Yolo County Children's Alliance (YCCA)	$399,900
Colorado		

	Colorado Association of School Based Health Care	$499,835
	Telluride Foundation	$301,410
Connecticut		
	Community Health Center Association of Connecticut	$988,177
	Community Health Center, Inc. (CHC)	$400,584
District of Columbia		
	National Alliance for Hispanic Health	$984,144
Florida		
	Fanm Ayisyen Nan Miyami, Inc. (FANM)	$69,102
	University of South Florida	$988,177
Georgia		
	West End Medical Centers Inc.	$571,135
	Medical College of Georgia Research Institute	$986,827
Hawaii		
	Bay Clinic, Inc.	$200,000
	Hawaii Primary Care Association	$488,187
Illinois		
	Chicago Public Schools	$235,173
	Beacon Therapeutic School, Inc. of Chicago	$250,830
Idaho		
	Mountain States Group, Inc.	$287,896
Indiana		
	St. Vincent Health Inc.	$864,309
Kansas		
	Inter-Faith Ministries Wichita Inc.	$523,932
	Keys for Networking	$866,749
Louisiana		
	Louisiana State Department of Health and Hospitals	$955,681
	TECHE Action Board	$234,808
Maine		
	Maine Department of Health and Human Services	$680,249
	Maine Primary Care Association	$311,061
Maryland		
	Garrett County Health Department	$200,000
	MD Department of Health and Mental Hygiene	$988,177
Massachusetts		
	Health Care for All, Inc.	$410,815
	South End Community Health Center	$304,385
Michigan		
	Michigan Primary Care Association	$915,079
	YMCA of Greater Grand Rapids	$293,040
Minnesota		
	Portico Healthnet, Inc.	$988,177
	Vietnamese Social Services of Minnesota	$280,000
Mississippi		
	Mississippi Primary Health Care Association	$988,152
Missouri		
	Missouri Coalition for Primary Health Care	$332,173
	St. Louis Children's Hospital Foundation	$985,373
Montana		
	Montana Department of Public Health and Human Services	$971,868

Nebraska		
	One World Community Health Centers Inc.	$706,264
New Hampshire		
	Cheshire Medical Center	$143,700
New Jersey		
	Health Research and Educational Trust of New Jersey	$988,177
	New Jersey Department of Human Services, Division of Medical Assistance and Health Services	$988,177
New Mexico		
	First Nations Community Health Source	$355,000
	New Mexico Human Services Department	$957,221
New York		
	The Mary Imogene Bassett Hospital	$498,718
	Structured Employment Economic Development Corporation	$988,177
North Carolina		
	North Carolina Pediatric Society Foundation	$678,210
Ohio		
	Dayton Public Schools	$327,900
	Legal Aid Society of Greater Cincinnati	$316,418
Oklahoma		
	Oklahoma Health Care Authority	$988,177
Oregon		
	Oregon Department of Health and Human Services	$988,177
	Northeast Oregon Network of LaGrande	$465,982
Pennsylvania		
	Concern for Health Options, Information, Care & Education (CHOICE)	$200,000
	Consumer Health Coalition	$299,750
South Carolina		
	Palmetto Project, Inc.	$981,009
Texas		
	Texas Leadership Center	$988,177
	YWCA of Lubbock, TX, INC.	$384,680
Utah		
	Association for Utah Community Health	$762,580
Virginia		
	Catholic Charities USA (CCUSA)	$957,617
	Virginia Health Care Foundation	$988,154
Washington		
	HIP of Spokane County/Community Minded Enterprise (CME)	$299,766
	Puget Sound Neighborhood Health Centers Neighborcare	$150,000
West Virginia		
	West Virginia Alliance for Sustainable Families	$330,700
Wyoming		
	Wind River Health Systems Inc.	$381,895
Wisconsin		
	Wisconsin Department of Health Services	$988,177
Wyoming		
	Wyoming Department of Health	$268,889

###

Note: All HHS press releases, fact sheets and other press materials are available at http://www.hhs.gov/news.

Last revised: November 17, 2009

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

To: The Honorable Bettye Davis
Alaska Senate

From: Jennifer Saunders
Health Program
303-856-1440
Jennifer.saunders@ncsl.org

Date: February 11, 2009

Subject: SCHIP Cost Sharing Rules

Senator Davis,

We enjoyed listening to your Health and Social Services committee meeting on Monday. This memo is intended to answer the question posed about the SCHIP cost-sharing rules.

Alaska's SCHIP program is a Medicaid expansion program and therefore must comply with Medicaid's cost-sharing rules as specified under the Deficit Reduction Act of 2005. Under provisions of the Deficit Reduction Act of 2005 (DRA), states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements.

Most children under the age of 18 are exempt from premiums and from cost-sharing on most services. However, the DRA rules allow states to require co-payments for prescription drugs and use of the emergency room for non-emergency care on all children in certain circumstances. The DRA also allows states to assess premiums and cost-sharing charges on some children in families with income above the poverty line. The total amount of premiums and cost-sharing charges cannot exceed a cap of five percent of family income, which is calculated on a monthly or quarterly basis at the option of the state.

Please see the following document by the Center on Budget and Policy Priorities for more detailed information about cost-sharing and premiums in Medicaid:
Cost-sharing and Premiums in Medicaid: What Rules Apply? February 28, 2007
http://www.cbpp.org/2-28-07health.pdf

In addition, you may also find the following document by the Congressional Research Service helpful. The table on page 5 compares service-related cost-sharing rules in traditional Medicaid, the DRA options and SCHIP.
Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)

CRS Report for Congress, January 25, 2007
http://assets.opencrs.com/rpts/RS22578_20070125.pdf

The following document by the Centers for Medicare and Medicaid Services (CMS) also summarizes these Medicaid requirements and you may find the "Important Links" on the bottom of page 2 helpful.
See the CMS document here:
http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf

For more general information about cost sharing and SCHIP, please see the following CMS website:
http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp
(Scroll down to see the information under the heading "Cost Sharing.")

To create cost sharing requirements that differ from the Medicaid requirements, states can do so by submitting a waiver to and obtaining approval from the Centers for Medicare and Medicaid Services (CMS) or by creating a stand-alone SCHIP program.

If you have more specific or detailed questions regarding cost-sharing requirements under Alaska's SCHIP program, I would suggest that you contact CMS directly.

Best regards,
Jennifer Saunders

THE 2009 HHS POVERTY GUIDELINES

One Version of the [U.S.] Federal Poverty Measure

[*Federal Register* Notice, January 23, 2009 — Full text]
[Prior Poverty Guidelines and *Federal Register* References Since 1982]
[Frequently Asked Questions (FAQs)]
[Further Resources on Poverty Measurement, Poverty Lines, and Their History]
[Computations for the 2009 Poverty Guidelines]

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau** (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) Poverty thresholds since 1980 and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. The *Federal Register* notice of the 2009 poverty guidelines is available.

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under Frequently Asked Questions (FAQs). See also the discussion of this topic on the Institute for Research on Poverty's web site.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310

4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

2009 Poverty Guidelines for Alaska

Persons in family	Poverty guideline
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290
For families with more than 8 persons, add $4,680 for each additional person.	

2009 Poverty Guidelines for Hawaii

Persons in family	Poverty guideline
1	$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560
For families with more than 8 persons, add $4,300 for each additional person.	

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199–4201

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding

whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Food Stamp Program, the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility. For a more detailed list of programs that do and don't use the guidelines, see the Frequently Asked Questions (FAQs).

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in January 2009 are designated the 2009 poverty guidelines. However, the 2009 HHS poverty guidelines only reflect price changes through calendar year 2008; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2008. (The 2008 thresholds are expected to be issued in final form in August 2009; a preliminary version of the 2008 thresholds is now available from the Census Bureau.)

The computations for the 2009 poverty guidelines are available.

The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the *Federal Register* by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Go to Further Resources on Poverty Measurement, Poverty Lines, and Their History

Go to Frequently Asked Questions (FAQs).

Return to the main Poverty Guidelines, Research, and Measurement page.

Last Revised: February 27, 2009

APPENDIX F

2009 HSS Poverty Guidelines for Alaska

2009 Poverty Guidelines for Alaska	
Persons in family	**Poverty guideline**
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290
For families with more than 8 persons, add $4,680 for each additional person.	

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199–4201

Setting Income Thresholds in Medicaid/SCHIP: Which Children Should Be Eligible?

Timely Analysis of Immediate Health Policy Issues

January 2009

Genevieve Kenney and Jennifer Pelletier

Summary

As the reauthorization of the State Children's Health Insurance Program (SCHIP) is being considered, important policy questions will include where eligibility thresholds should be set for public coverage and how much latitude states should have in setting their thresholds. The original SCHIP bill targeted children with incomes below 200 percent of the federal poverty level (FPL). For families at that income level in 1996, just before SCHIP was enacted, employer-sponsored insurance (ESI) premiums for family health insurance coverage made up 16 percent of income on average for a family of four. Since then, health insurance costs have risen so much that for families at 300 percent of the FPL, ESI premiums for family coverage now make up 19 percent of income on average for a family of four. Put differently, ESI coverage is less affordable for families at 300 percent of the FPL today than it was for families at 200 percent of the FPL when SCHIP was passed. In addition, the large differences in cost of living that prevail both across and within states mean that imposing a single eligibility threshold nationally would place families in higher-cost areas at a disadvantage.

Introduction

SCHIP was designed to address gaps in health insurance coverage for children whose family incomes were too high to allow them to qualify for Medicaid but too low to afford private coverage. One of the issues that received considerable attention during the 2007 SCHIP reauthorization debate was the income level at which subsidized public coverage should be available to children through Medicaid and SCHIP.[1,2] On the one hand, some argued that SCHIP had drifted from its statutory intent by allowing children with incomes above 200 percent of the FPL to be covered in so many states, exposing the programs to an increased risk that public coverage will substitute for—or crowd out—private coverage.[3,4] On the other hand, it was argued that private premiums had grown faster than the federal poverty level since the inception of SCHIP, which in turn was placing private insurance out of reach for a growing number of moderate-income families with incomes above 200 percent of the FPL, and that cost-of-living differences across states affect how affordable health insurance premiums are for families.[5] Where eligibility thresholds are set and the extent to which states have latitude over their thresholds are important because they likely affect how effective SCHIP and Medicaid will be at filling gaps in coverage for children.

Background

The United States has experienced sharp growth in health care spending in recent decades. Between 1985 and 2005, health care spending nearly tripled in real terms, reaching $1.9 trillion in 2005.[6] Rising health care costs over this time period have numerous root causes, including advances in medical technology and increases in personal income, health sector prices, and administrative costs.[7] Increases in health care costs exert upward pressure on premiums and cost-sharing.[8] Between 2001 and 2005 alone, total annual premiums for family coverage increased nearly 30 percent per enrolled employee in private sector firms, or about $2,500.[9] Cost-sharing in the form of deductibles and copayments has also been on the rise.[10] Moreover, while no comprehensive data are available to compare cost-of-living differences for families targeted by Medicaid and SCHIP in different areas of the country, the information that is available shows that the cost of living varies substantially across areas, both within and across states.[11]

Historically, states have had flexibility to set their income eligibility limit in Medicaid/SCHIP.[12] Nationally, seven states have implemented an income limit of less than 200 percent of the FPL, 20 states have implemented an income limit at 200 percent of the FPL, and 24 states cover kids above 200 percent of the FPL. Of the states with higher income limits, 13 cover kids up to 250

Robert Wood Johnson Foundation

Urban Institute

percent of the FPL, 10 cover kids up to 300 percent of the FPL, and only one state—New Jersey—covers kids above 300 percent of the FPL with federal funds.[13] Most states that cover children with incomes above 200 percent of the FPL under Medicaid and SCHIP charge premiums for coverage, but public premiums vary substantially across states and across income levels.[14]

Despite the fact that nearly half of all states cover children with incomes above 200 percent of the FPL, the vast majority of children enrolled in these programs appear to be from low-income families. Nationally, 91 percent of children enrolled in SCHIP live in families earning 200 percent of the FPL or less.[15,16] In addition, legislation passed in 2007 to reauthorize SCHIP (H.R. 3963) would have covered an additional 3.9 million uninsured children, an estimated 80 percent of whom would have had incomes below 200 percent of the FPL; an earlier version of the bill passed by the House was even more targeted, with the share of newly-insured children who would be low-income estimated to be about 85 percent.[17]

This brief examines the extent to which increases in the costs of employer-sponsored insurance have outstripped income growth since the time that SCHIP was enacted. The implications of cost-of-living differences are also addressed.

Data and Methods

To assess how the affordability of private health insurance coverage has been changing over the past decade, we use information on the cost of employer-sponsored insurance premiums from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). The MEPS-IC includes survey information for an average of 38,500 private sector establishments per year, going back to 1996. Response rates range from 67 percent to 81 percent, with the early years of the survey experiencing lower response rates.[18] The standard errors on the premium data are small, making the annual estimates of average employer-sponsored insurance premiums very precise. For example, the standard error associated with the average total family premium in 2006 was less than 0.3 percent as large as the average premium for that year. The survey contains data on the insurance plan offered, including total premiums, employer contributions, cost sharing arrangements and information on the establishment. Data on the average premium cost for single coverage (employee only) and family coverage are available back to 1996.

The FPL for a family of four was obtained for each year from the Department of Health and Human Services (DHHS) Poverty Guidelines for the 48 contiguous states.[19] The poverty guidelines are updated each year by DHHS using the consumer price index. With the exception of Hawaii and Alaska, the same federal poverty thresholds are defined for each state.

We create ratios of average employer-sponsored insurance family premium levels to income for families of four with two different income levels: at 200 percent of the FPL and at 300 percent of the FPL.[20] We focus on changes in the average premium relative to family income for ease of presentation. We also examined alternative affordability measures including (1) the average employee premium contribution for family coverage combined with average total out-of-pocket spending on deductibles, coinsurance, and copayments[21] relative to income (to capture the direct burden on employees); (2) the average premium for family coverage relative to an adjusted income measure that includes the average premium measure (to approximate total compensation), and (3) the average nongroup premium for family coverage relative to income. We found that changes in all three alternative measures tracked closely with changes in the average premium for family coverage relative to income.

We use changes in the average employer premium for family coverage as a proxy for how the costs of private insurance coverage have been changing over time. Fully capturing how the affordability of private coverage has been changing over time would ideally rely on information on how private nongroup premiums have been changing. However, only limited information is available to estimate changes in nongroup premiums. The MEPS Household Component (MEPS-HC) contains data on nongroup premiums, which are based on small samples of respondents with nongroup family coverage, and even smaller samples that represent a family size of four.[22] Studies using the MEPS-HC data found that nongroup premiums for family coverage increased about 25 percent between 2002 and 2005 and by about 67 percent between 1996 and 2005.[23] Using the average premium growth between 2002 and 2005, we estimated the average premium cost for nongroup family coverage in 2006. While the MEPS data suggest that the nongroup premiums have not risen as fast as ESI premiums, we still found substantial growth in nongroup family premiums.[24]

To assess the implications of the area-variation in the cost of living, we use the Council for Community and Economic Research ACCRA Cost of Living Index data for the third quarter of 2008.[25] This index takes into account relative prices for a market basket of consumer goods (including grocery items, housing, utilities, transportation, health care, and miscellaneous goods and services) for a "mid-management standard of living," which is defined according to spending in the highest quintile in more than 300 urban areas across the country.[26]

Findings

On average, employer-sponsored insurance premiums for family health insurance coverage rose by 8.7 percent per year between 1996 and 2006, increasing from $4,954 in 1996 to more than double that at $11,381 in 2006.[27] At the same time, the federal poverty level rose by an average of just 2.4 percent per year. As a consequence, where family employer-sponsored insurance premiums constituted 16 and 11 percent of family income, respectively, for families at 200 and 300 percent of the FPL in 1996, by 2006, those ratios had risen to 28 and 19 percent (figure 1). Overall, the ratio of

total premiums to income rose by about 75 percent for both groups between 1996 and 2006.

Similar growth was found in the ratio of average employee ESI costs (employee contributions to premiums and total out-of-pocket costs) to income over the period, increasing from less than 8 percent of family income in 1996 to 12 percent in 2006 for families at 200 percent of the FPL and from 5 to 8 percent for families at 300 percent of the FPL.[28] Because premiums paid by employers are part of an employee's total benefit package, we also examined the share of income spent on premiums after including the value of the employer's premium contribution in the family's income. The trend using this definition of family income tracks very closely to the trend using the simpler definition, increasing from 14 percent in 1996 to 24 percent in 2006 for families at 200 percent of the FPL and from 10 to 17 percent for families at 300 percent of the FPL (data not shown). Regardless of the definition used, the ratio of ESI costs to income was higher for families with incomes at 300 percent of the FPL in 2006 than it was for families with incomes at 200 percent of the FPL in 1996, the year before SCHIP was enacted.

Growth in nongroup premiums, though not as high as that in ESI premiums, was also large. In 1996, the average nongroup premium for family coverage in the nongroup market was $3,329, representing 11 percent of income for families earning 200 percent of the FPL and 7 percent of income for families at 300 percent of the FPL. In 2006, the average nongroup premium for family coverage rose to an estimated $6,038, making up 15 percent of income for families at 200 percent of the FPL and 10 percent of income for families at 300 percent of the FPL.[29]

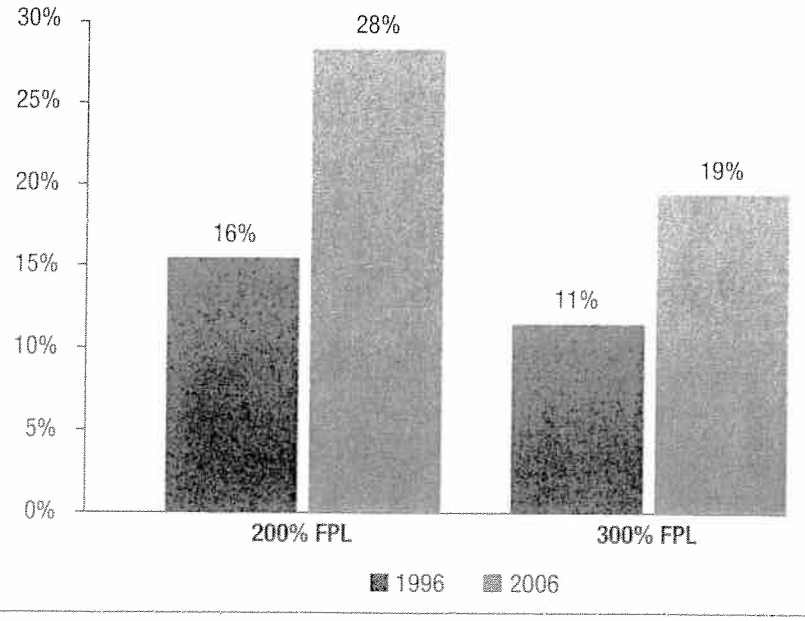
Another factor determining whether available coverage is affordable for families is the cost of living, which translates into very different effective incomes for families with the same nominal income living in different areas. For example, in 2008, families living in San Francisco and Philadelphia, two urban areas with higher than average cost of living than the other areas included in the ACCRA index, would have to earn 2.1 and 1.5 times as much, respectively, to have the same purchasing power as families living in Douglas, Georgia, the lowest cost urban area in the study (figure 2). Consequently, a family living in San Francisco or Philadelphia earning 200 percent of the FPL is much less well-off than a family earning the same income but living in Douglas, Georgia and has fewer resources available to devote to health care. Even within a given state, families face very different costs of living; families living in Philadelphia have to earn 1.4 times as much as those living in Pittsburgh while families living in San Francisco have to earn 1.6 times as much as families living in Bakersfield to have equivalent purchasing power.

Discussion

Given that health care cost growth has historically exceeded general inflation rates, capping eligibility levels for public coverage at an income level indexed to inflation rather than indexed to changes in the costs of health care premiums will likely mean that more and more moderate-income children are likely to become uninsured as their parents find that they cannot afford the increasingly high costs of private coverage. The effect of the rising premium burdens may have contributed to recent increases in the uninsured rate among children with moderate incomes. Between 2005 and 2006, the number of uninsured children rose by more than 700,000, and fully two-thirds of the increase was composed of children from families earning more than 200 percent of the FPL.[30] Over ten states have responded to the declining affordability of private coverage by enacting income eligibility expansions in the past five years.[31]

In addition, imposing a single eligibility threshold nationally, without regard for the substantial variation in purchasing power both across and within states, places families living in higher-cost areas at a disadvantage. Moreover,

Figure 1. Average Total ESI Premium for Family Coverage as a Share of Income at Selected Income Levels



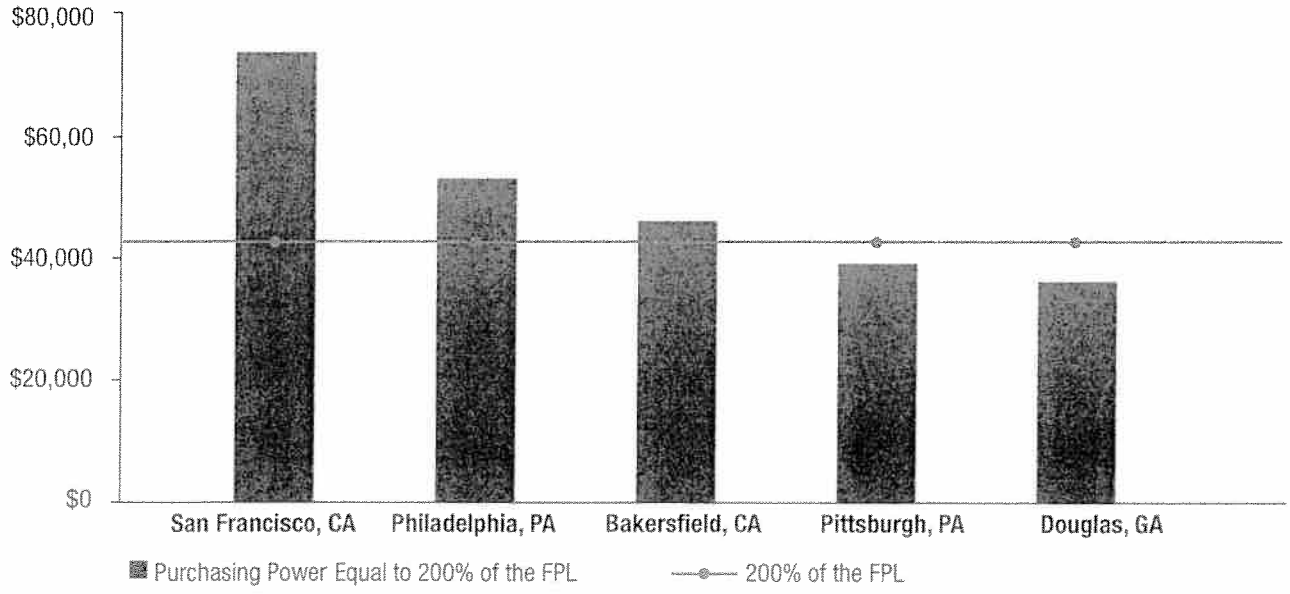
Note: Share of income evaluated for families earning exactly 200% and exactly 300% of the FPL.
Source: 1996 and 2006 Medical Expenditure Panel Survey Insurance Component. Premiums reported are for a family of four. Federal poverty level for a family of four from the Department of Health and Human Services available at http://aspe.hhs.gov/poverty/figures-fed-reg.shtml

expanding eligibility to higher income levels has been shown to have positive spillover effects on the enrollment of lower-income children who were previously eligible.[32] At the same time however, allowing states to expand public eligibility to higher income levels increases the risks that public coverage will substitute for ESI coverage and raises questions about the target efficiency of public subsidies.[33]

As states expand coverage to higher incomes, it is also important to consider whether their premium schedules adequately reflect the greater ability of higher-income families to afford coverage. It is important to note that past research has shown that premiums charged in public programs have a negative effect on enrollment, despite being much lower than premiums in the private insurance market, suggesting that even low amounts of cost sharing can deter families from enrolling their children in coverage.[34] At the same time, however, there may be room for some states to raise premium levels, especially for moderate income children, without incurring significant enrollment declines. There is substantial variation in the premiums that states charge in their Medicaid/SCHIP programs to cover families above 200 percent of the FPL—of the eleven states that cover children in SCHIP at 300 percent of the FPL, monthly premiums range from zero in the District of Columbia to over $100 in New Jersey and Missouri for one child.[35] While defining what is Affordable for families of different income levels is analytically difficult because the concept is inherently subjective, it is critical to efforts to achieve and finance universal coverage.[36]

Whereas 200 percent of the FPL might have been a reasonable eligibility threshold for coverage in many states when SCHIP was first created, that may not be the case today, particularly in high cost-of-living areas, given the large increases in health care premiums relative to income that have occurred over the past decade. In fact, this analysis suggests that ESI premiums now constitute an even higher share of family income for families at 300 percent of the FPL than they did for families at 200 percent of the FPL in 1996—that is, where health insurance premiums are concerned, 300 percent of the FPL has become what 200 percent of the FPL was over 10 years ago when SCHIP was enacted.[37] In addition, this analysis suggests that unless effective cost containment strategies are implemented that reduce the rate of increase of private premiums, pressures on public programs are going to continue to increase.

Figure 2. Income Needed for a Family of Four to Have Purchasing Power Equal to 200 Percent of the FPL in Selected Cities



Source: ACCRA Cost of Living Index, based on the data provided by Kaiser State Health Facts 2008. Income data were adapted to reflect purchasing power at 200% of the FPL by multiplying given income data (for purchasing power at 300% of the FPL) by 2/3. Federal poverty level from the Department of Health and Human Services available at hhtp://aspe.hhs.gov/poverty/figures-fed-reg.html

Notes

See Kenney, G. "The Failure of SCHIP Reauthorization: What Next?" Washington, DC: The Urban Institute. 2008. http://www.urban.org/publications/411628.html.

[2] SCHIP was established over a decade ago as part of the Balanced Budget Act of 1997. Though an optional program, all states expanded coverage under SCHIP, with an estimated 6.7 million children and 700,000 adults having coverage under SCHIP at some point during 2006. State programs vary in terms of their structure and characteristics (e.g., cost sharing arrangements and income eligibility levels), reflecting the flexibility over program design that was built into the SCHIP statute (Kenney 2008).

[3] Hederman, R. "Expanding SCHIP into AMT Territory: SCHIP Plan Would Extend Welfare to Wealthy Families." Web Memo No. 1546. Washington, DC: The Heritage Foundation. July 10, 2007; Owcharenko, N. "The SCHIP Negotiations: A Backdoor Approach to Expanding Medicaid to the Middle Class?" Web Memo No. 1716. Washington, DC: The Heritage Foundation. December 3, 2007; Winfree, P. and G. D'Angelo. "SCHIP and "Crowd-Out": The High Cost of Expanding Eligibility." Web Memo No. 1627. Washington, DC: The Heritage Foundation. September 20, 2007.

[4] When SCHIP was enacted in 1997, the statute designated children in low-income families (defined as less than 200 percent of the FPL) as the target population for SCHIP, but states had the flexibility to use disregards in setting their thresholds, and an explicit exception was made for states that already were covering children through prior Medicaid expansions above 150 percent of the FPL, who were allowed to cover children in SCHIP up to 50 percentage points greater than their Medicaid eligibility level (The Balanced Budget Act of 1997, PL-105-33).

[5] Mann, C. and M. Odeh. "The Growing Health Insurance Affordability Gap For Children and Families." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007a; Kaiser Family Foundation. "Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level." Snapshots: Health Care Costs. Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. February 2007. http://www.kff.org/insurance/snapshot/chcm021507oth.cfm

[6] Congressional Budget Office. "Technological Change and the Growth of Health Care Spending." A CBO Paper. Washington, DC: Congressional Budget Office. January 2008.

[7] Congressional Budget Office 2008.

[8] Seliger Keenan, P. "What's Driving Health Care Costs?" The Commonwealth Fund/John F. Kennedy School of Government 2004 Bipartisan Congressional Health Policy Conference Issue Brief. Washington, DC: The Commonwealth Fund. November 2004.

[9] State Health Access Data Assistance Center (SHADAC). "Squeezed: How Costs for Insuring Families are Outpacing Income." University of Minnesota: State Health Access Data Assistance Center. April 2008.

[10] Seliger Keenan 2004; Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits 2008 Annual Survey." Washington, DC: The Kaiser Family Foundation and Health Research and Educational Trust. September 2008. http://ehbs.kff.org/

[11] Kaiser State Health Facts. "Cost of Living Variation." Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. 2008. http://www.statehealthfacts.kff.org/comparetable.jsp?ind=600&cat=1; Jolliffe, D. "The Cost of Living and the Geographic Distribution of Poverty." Economic Research Service. Washington, DC: US Department of Agriculture. September 2006. http://www.ers.usda.gov/publications/err26/

[12] Before 2007, states had broad latitude to set their own eligibility levels and to use income disregards to subtract costs of child care or work expenses from a family's gross income, thereby establishing eligibility based on the family's net income; states also applied "blanket" income disregards to reach children at higher income levels, as had long been permitted for Medicaid under Section 1902(r)(2) of the Social Security Act. On August 17, 2007, the Centers for Medicare and Medicaid Services issued a letter to state health officials (SHO-#07-001) restricting states' ability to cover children in families with gross income above 250 percent of the FPL. Specifically, in order to expand income eligibility above 250 percent of the FPL, the letter required states to achieve a coverage rate of 95 percent for low-income children and to ensure that the rate of employer-sponsored coverage for children had not dropped more than two percentage points in the past five years. States were also required to impose a 12-month waiting period for children coming off of other insurance before they could enroll in SCHIP and to charge the maximum amount of cost sharing allowable by law (5 percent of family income) for children in families earning more than 250 percent of the FPL (Mann, C. and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007b). Both SCHIP reauthorization bills that passed Congress but were vetoed by the president in 2007 (H.R. 976 and H.R. 3963) would have overturned the August 17th Directive. The Directive was set to take effect on August 17, 2008 for states already covering children above 250 percent of the FPL; however, CMS has applied the new rules only to states seeking to expand coverage (including New York, Ohio, Oklahoma, Louisiana, Indiana, and Wisconsin) and not to those who had already implemented coverage expansions (Associated Press, "States Won't Be Sanctioned over Kids' Health Insurance." 2008. http://www.usatoday.com/news/health/2008-08-14-children-insurance_N.htm?csp=34).

[13] These income eligibility levels reflect those in effect as of October 2008. Several states have authorized income eligibility increases that have not yet been implemented either because of legislative delays or CMS denials of the increases (see footnote 12). In addition, four states have moved to use state-only funds to increase their income eligibility levels above the limit set in their SCHIP program. Illinois and Wisconsin use state funds to cover kids up to 300 percent of the FPL (Illinois' SCHIP eligibility level is 200 percent of the FPL; Wisconsin's is 250 percent of the FPL); Massachusetts and New York cover kids up to 400 percent of the FPL (Massachusetts' SCHIP eligibility level is 300 percent of the FPL; New York's is 250 percent of the FPL) (Georgetown Center for Children and Families. "Eligibility Levels in Medicaid & SCHIP for Children, by State as of October 1, 2008." Georgetown University Health Policy Institute. October 20, 2008).

[14] Selden, T., G. Kenney, M. Pantell, and J. Ruhter. "Cost Sharing Arrangements in Medicaid and SCHIP: Implications for Out-of-Pocket Spending Burdens." Under Review.

[15] Congressional Research Service. "REVISED: Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees, 2007." May 30, 2008. This study evaluated low-income families by their net income since that is how SCHIP eligibility is determined in most states. Some children with net income of less than 200 percent of the FPL have gross income above 200 percent of the FPL after adding back in child care and work-related expenses and other disregards.

[16] When both Medicaid and SCHIP children are considered together, the proportion of enrollees who are low-income rises to 98 percent (Author's tabulation based on SCHIP enrollment as reported in Congressional Research Service 2008 and Medicaid enrollment from Georgetown Center for Children and Families, "Number of Children Ever Enrolled in Medicaid/SCHIP by Program Type and State, FY 2007." Washington, DC: Georgetown University Health Policy Institute. 2008).

[17] Kenney, G., A. Cook, and J. Pelletier. "SCHIP Reauthorization: How Will Low-Income Kids Benefit under House and Senate Bills?" Washington, DC: Urban Institute. 2007. http://www.urban.org/publications/411545.html

[18] Establishments are pre-screened over the phone, and those that offer health insurance to their employees are mailed a complete questionnaire. Those who do not offer health insurance to their employees are only asked a few questions over the phone. Establishments that do not return the questionnaire are sent a second mailing, and those that do not return the second mailing are called to complete the information over the phone.

[19] Available at http://aspe.hhs.gov/poverty/figures-fed-reg.shtml

[20] Two-hundred percent of the FPL for a family of four translates into $31,200 in 1996 and $40,000 in 2006. Three-hundred percent of the FPL translates into $46,800 in 1996 and $60,000 in 2006.

[21] Data on out-of-pocket costs are based on Urban Institute tabulations of the Household Component of the 1996 and 2006 Medical Expenditure Panel Survey and include average out-of-pocket costs for families with ESI coverage for the entire survey year.

[22] Examining nongroup premium growth is also important when considering coverage options for this income group because few low- and moderate-income children have access to ESI coverage. (Kenney, Cook, and Pelletier. "Prospects for Reducing Uninsured Rates Among Children: How Much Can Premium Assistance Programs Help?" Urban Institute. Forthcoming).

[23] Bernard, D. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65, 1996 and 2002." Statistical Brief #72. Rockville, MD: Agency for Healthcare Research and Quality. March 2005; Bernard, D. and J. Banthin. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65: 2002 and 2005." Statistical Brief #202. Rockville, MD: Agency for Healthcare Research and Quality. April 2008.

[24] Because of the small sample sizes, the nongroup premium estimates in the MEPS have large standard errors associated with them and are therefore much less precise than the ESI premium data. For example, the standard error associated with the mean nongroup family premium for 2005 was close to 10 percent of the mean, compared to a ratio of less than 0.3 percent for the mean ESI family premium in 2006 (MEPS-IC Table I.D.1(2006); Bernard and Banthin 2008). We also looked at out-of-pocket spending when evaluating the cost of nongroup coverage but chose not to include it because the sample sizes for families of four are very small.

[25] Kaiser State Health Facts (2008) provides ACCRA data on what a family of four would need to earn in select U.S. cities to have purchasing power equal to 300 percent of the FPL. Because the focus of this brief is on children currently targeted by SCHIP, the income figures were multiplied by 2/3 in order to represent purchasing power equal to 200 percent of the FPL. Mann and Odeh (2007a) used ACCRA data and a similar method to show purchasing power for a family of three at 200 percent of the FPL.

[26] The index is based on the spending distribution across the six major categories of purchases listed on page 2 for consumers in the top income quintile in the Consumer Expenditure Survey. The distribution is relatively similar to the distribution for the lowest income quintile, which would represent lower-income families. The largest share of expenditures for both quintiles is due to housing costs, which represent 37 and 35 percent of total expenditures in the six categories of goods and services for the top and bottom quintiles, respectively. Because housing costs are highly variable across the country and constitute such a large share of expenditures in the index, the cost of living can vary greatly between cities. Transportation costs make up the second-largest share of expenditures (31 percent for the top quintile and 23 percent for the bottom quintile); groceries and utilities each constitute 10 percent of expenditures for the top quintile and 15 percent for the bottom quintile. Health care costs account for 8 percent of spending in the top quintile and 10 percent of spending in the bottom quintile (Urban Institute tabulations of the 2007 Consumer Expenditure Survey).

[27] The standard errors associated with these estimates were $32.33 in 2006 and $36.06 in 1996 (MEPS-IC Table I.D.1 from 1996 and 2006).

[28] For firms with large shares of low-wage workers (50 percent or more), the ratio of average employee premium to income is slightly higher than for all firms: For families at 200 percent of the FPL, the ratio is 6 percent in 1996 and 8 percent in 2006, and for families at 300 percent of the FPL, the ratio is 4 percent in 1996 and 5 percent in 2006 (data not shown). Employee contributions remained fairly constant over the period, constituting about a quarter of the total premium (data not shown).

[29] The premium for 2006 was estimated using the average growth rate in the nongroup premium between 2002 and 2005. The standard errors associated with these estimates are large, $241 in 1996, or 7.2 percent of the mean, and $513 in 2005, or 9.2 percent of the mean.

[30] Holahan, J. and A. Cook. "What Happened to the Insurance Coverage of Children and Adults in 2006?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. September 2007.

[31] Smith, V. and D. Rousseau. "SCHIP Program Enrollment: June 2003 Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. December 2003. http://www.kff.org/medicaid/upload/SCHIP-Program-Enrollment-June-2003-Update.pdf ; Cohen Ross, D. A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. January 2008. http://www.kff.org/medicaid/upload/7740.pdf

[32] Arjun, L. and J. Guyer. "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children." Georgetown Center for Children and Families. Washington, DC: Georgetown Health Policy Institute. 2008; Kenney, G., L. Blumberg, and J. Pelletier. "State Buy-In Programs: Prospects and Challenges." Washington, DC: Urban Institute. 2008.

[33] Winfree and D'Angelo 2007.

[34] Hadley, J., J. Reschovsky, P. Cunningham, G. Kenney, and L. Dubay. 2007. "Insurance Premiums and Insurance Coverage of Near-Poor Children." *Inquiry* 43, no. 4: 362-377; Kenney, G., J. Hadley, and F. Blavin. 2007. "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* 43, no. 4: 345-361; Kenney, G., R.A. Allison, J. Costich, J. Marton, and J. McFeeters. 2007. "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States." *Inquiry* 43, no. 4: 378-392.

[35] The cost of enrolling two children in both Missouri and New Jersey is the same as enrolling one child (Selden et al. Under Review).

[36] Blumberg, L., J. Holahan, J. Hadley, and K. Nordahl. "Setting a Standard of Affordability for Health Insurance Coverage." *Health Affairs* 26(4): w463-w473. 2007.

[37] These numbers understate the extent to which coverage has become unaffordable at 300 percent of FPL, compared to coverage at 200 percent of FPL when SCHIP was signed into law. The 1996 estimates in the text represent the cost of coverage one year before the 1997 enactment of SCHIP. The 2006 estimates, by contrast, are at least three years before the potential reauthorization of SCHIP; if SCHIP is reauthorized at its earlier possible point (2009), the year most directly analogous to 1996 would be 2008. Between 2006 and 2008, premium growth continued to outstrip increases in the FPL. According to surveys by the Kaiser Family Foundation (KFF) and the Health Research & Educational Trust (HRET), average premiums for family coverage rose by 10.5 percent from 2006 to 2008 (KFF/HRET 2008. Available at http://ehbs.kff.org/). During that same period, the FPL rose by 6 percent. Using the recent premium increase reported by KFF/HRET to project ESI premiums for 2008, ESI family coverage in 2008 consumed an average of 30 percent of family income at 200 percent of FPL and 20 percent of family income at 300 percent of FPL. If average nongroup premiums are estimated for 2008 based on the growth rate between 2002 and 2005, nongroup premiums would have constituted 17 percent of income for families at 200 percent of the FPL and 11 percent of income for families at 300 percent of the FPL.

The views expressed are those of the authors and should not be attributed to any campaign or to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgements

Genevieve Kenney is a principal research associate and Jennifer Pelletier is a research associate in the Health Policy Center of the Urban Institute.

This research was funded by the Robert Wood Johnson Foundation. The authors appreciate the excellent research assistance of Joel Ruhter and the helpful comments and suggestions of Stan Dorn, John Holahan, Bruce Lesley, Cindy Mann, Brian Quinn and Stephen Zuckerman.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.

Choose a different category...
Medicaid & CHIP

Medicaid & CHIP
- Medicaid Spending
  - Total Medicaid Spending, FY2007
  - Spending by Service, FY2007
  - Spending on Acute Care, FY2007
  - Spending on Long Term Care, FY2007
  - Growth in Medicaid Spending, FY90-FY06
  - Payments by Enrollment Group, FY2006
  - Medicaid Payments per Enrollee, FY2006
  - Federal Matching Rate and Multiplier
  - Federal/State Share of Spending, FY2007
  - Federal DSH Allotments
  - Medicaid Spending by Residence, 95-04
- State Medicaid Spending
  - State Medicaid Spending, SFY2007
- Temporary Federal Medicaid Relief
  - ARRA Medicaid Grant Funds (2 Qtrs.)
  - ARRA Medicaid Grant Funds (Total)
  - Federal DSH Allotments under ARRA
- Medicaid Budget Actions
  - Medicaid Cost Containment, FY2008
  - Medicaid Cost Containment, FY2009
  - Positive Medicaid Policy Actions, FY2008
  - Positive Medicaid Policy Actions, FY2009
- Medicare Drug Benefit: Clawback Payments
  - Baseline Dual Eligible Enrollment
  - Baseline FFS Drug Payments for Duals
  - Esimated Annual Clawback Payments
  - Per-Capita Monthly Clawback Amounts
- Medicaid Physician Fees
  - Medicaid Fee Index, 2003
  - Medicaid-to-Medicare Fee Index, 2003
  - Change in Medicaid Fees, 1998-2003
- Medicaid Enrollment
  - Total Medicaid Enrollment, FY2006
  - Medicaid Enrollment as a % of Total Pop
  - Distribution by Enrollment Group, FY2006
  - Monthly Medicaid Enrollment
  - Monthly Medicaid Enrollment - Children
  - Monthly Medicaid Enrollment - Adults
  - Monthly Medicaid Enrollment % Change
  - Monthly Enrollment % Change - Children
  - Monthly Enrollment % Change - Adults
- Children's Medicaid and SCHIP Eligibility
  - Income Eligibility-- Medicaid
  - Income Disregards -- Medicaid
  - Income Eligibility --Separate SCHIP Prog
  - Income Disregards -- SCHIP Program
- Medicaid/SCHIP Eligibility
  - Income Eligibility--Parents in Medicaid
  - Income Eligibility-- Pregnant Women
  - Income Eligibility-- Other Groups
  - Expansions for SSP Recipients
- SSI Beneficiaries
  - Total SSI Beneficiaries
  - SSI Beneficiaries as % of Population
  - Distribution of Total SSI by Age
  - Aged SSI

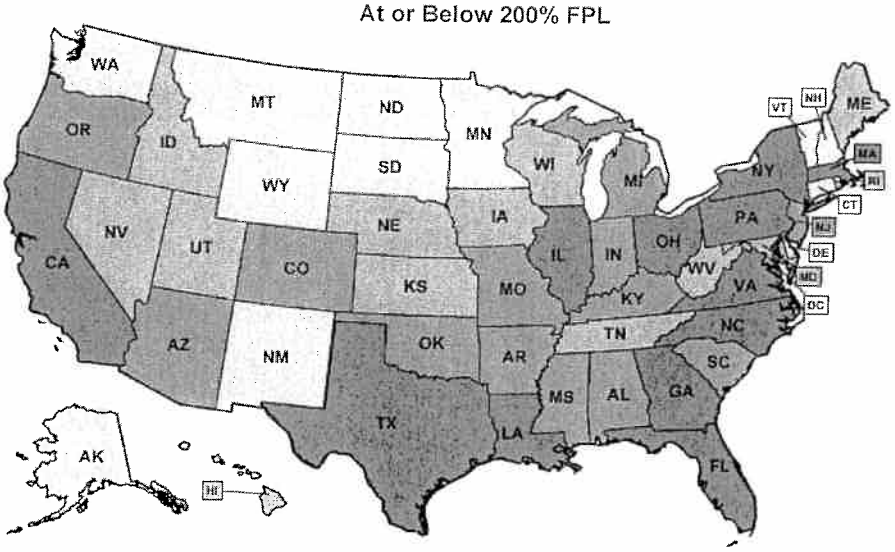
Estimated Number of Children Enrolled in SCHIP with Family Income at or Below 200% Federal Poverty Level (FPL) and Above 200% FPL , FY2008

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical) View by: # | %

Rank Order:

At or Below 200% FPL



0 - 22,679 | 23,210 - 66,602 | 67,717 - 124,954 | 142,216 - 1,371,969

	At or Below 200% FPL	Above 200% FPL	Total
United States	6,624,419	744,060	7,368,479
Alabama	110,821	NA	110,821
Alaska	18,707	NA	18,707
Arizona	112,072	NA	112,072
Arkansas	93,446	NA	93,446
California	1,371,969	320,118	1,692,087
Colorado	99,555	NA	99,555
Connecticut	4,707	17,563	22,270
Delaware	11,192	NA	11,192
District of Columbia	4,162	4,584	8,746
Florida	354,385	NA	354,385
Georgia	276,820	34,414	311,234
Hawaii	28,803	NA	28,803
Idaho	43,526	NA	43,526
Illinois	356,460	NA	356,460
Indiana	124,954	NA	124,954
Iowa	50,390	NA	50,390
Kansas	51,162	NA	51,162
Kentucky	67,717	NA	67,717

	At or Below 200% FPL	Above 200% FPL	Total
Louisiana	146,373	1,490	147,863
Maine	30,947	NA	30,947
Maryland	66,602	66,262	132,864
Massachusetts	142,216	58,734	200,950
Michigan	67,763	NA	67,763
Minnesota	5,534	87	5,621
Mississippi	84,370	NA	84,370
Missouri	110,196	25,939	136,135
Montana	22,679	NA	22,679
Nebraska	48,827	NA	48,827
Nevada	38,592	NA	38,592
New Hampshire	2,891	9,345	12,236
New Jersey	112,909	38,896	151,805
New Mexico	4,270	10,674	14,944
New York	433,047	84,209	517,256
North Carolina	251,647	6	251,653
North Dakota	7,617	NA	7,617
Ohio	251,278	NA	251,278
Oklahoma	117,507	NA	117,507
Oregon	73,686	NA	73,686
Pennsylvania	219,366	37,261	256,627
Rhode Island	23,210	2,821	26,031
South Carolina	73,620	NA	73,620
South Dakota	15,277	NA	15,277
Tennessee	55,320	8,299	63,619
Texas	731,916	NA	731,916
Utah	51,092	NA	51,092
Vermont	0	6,496	6,496
Virginia	155,289	NA	155,289
Washington	365	16,466	16,831
West Virginia	37,250	395	37,645
Wisconsin	52,940	NA	52,940
Wyoming	8,976	NA	8,976

Notes: The methods used to determine whether a child qualifies for coverage, based on his or her family income, vary from state to state. Under longstanding federal law, states must follow certain rules in determining income-eligibility, but they also have considerable flexibility regarding whether they will count or exempt certain types or amounts of income and whether they allow deductions for certain types or amounts of expenses. Typically, states **"disregard"** — that is, they do not count — a portion of earnings from a working family's income to reflect that these resources are needed to cover work-related expenses and generally are not available to cover other costs, such as the cost of purchasing health coverage. Estimates presented here reflect *net* income, taking into account each state's income disregard policy, since this is how states provide income information to CMS and is the basis on which enrollees' eligibility is determined.

The SCHIP statute defines low-income children as those at or below 200% of poverty. States use two different types of income disregards in determining eligibility for SCHIP which in turn affects the income levels reported CMS. The first type of disregard is the exclusion of particular dollar amounts or types of income, and the second occurs when a state excludes an entire block of percent-of-poverty income. For more information, see Sources.

Sources: Peterson, Chris, Domestic Social Policy Division, Congressional Research Service (CRS), January 27, 2009 memorandum based on analysis of data from the SCHIP Statistical Enrollment Data System (SEDS) provided by the Centers for Medicare and Medicaid Services (CMS).

Definitions: **NA:** Children in families with incomes above 200% poverty level were not eligible for the state's SCHIP program as of FY2008.

Federal Poverty Level (FPL) was established to help government agencies determine eligibility levels for public assistance programs such as Medicaid. FPL is represented in this resource as poverty guidelines as opposed to the slightly different poverty thresholds.

Federal Fiscal Year (FY): Unless otherwise noted, years proceeded by "FY" on statehealthfacts.org refer to the Federal Fiscal Year, which runs from October 1 through September 30. For example, FY 2009 refers to the period from October 1, 2008 through September 30, 2009.

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 8, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 415
Juneau, AK 99801-1182

RE: SB 13 (Davis)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support SB 13, authored by Senator Bettye Davis, and co-sponsored by Senators Paskvan, Ellis, Wielechowski, and French as well as Representatives Gruenberg and Tuck.

AARP is the world's largest organization of grandparents. We are concerned about health insurance coverage for everyone's grandchildren.

SB 13 will return the Denali KidCare program to the former eligibility levels at 200% of the federal poverty level. We think this is an excellent plan and should provide comprehensive and preventive health coverage for many more young Alaskans and pregnant women.

In addition, we have many retired grandparents who are raising their grandchildren. Currently there are over 5,500 grandparents responsible for raising over 8,200 young Alaskan grandchildren. Very often these grandparents are retired and dependent on Medicare for their health coverage. Denali KidCare, in many cases, is the only health insurance they can secure for their grandchildren. If these grandparents are not able to secure insurance coverage for their grandchildren, some of the children will have to leave this caring family environment and become wards of the state. We hope you realize how important Denali KidCare coverage is to these extended families that are now in one household. These grandparents are trying to provide the best care for their grandchildren. They need Denali KidCare.

Many AARP members have coverage through Medicare or their employer and they understand how important health insurance is to them; we support the efforts of this bill to provide coverage to other Alaskans who need it.

A healthy future for our children should be something everyone can agree on.

AARP requests an "AYE" vote on SB 13.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Tammie Wilson
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes
Senator Bettye Davis

[illegible] | Anchorage, Alaska 99501 | T 907.272.3663 | F 907.277.7368 | www.foodbankofalaska.org |

March 5, 2010

Representative Wes Keller
Alaska State Capital Room 13
Juneau, Alaska 99801

Dear Representative Keller,

I am writing to request your support of SB 13, which will increase the income eligibility guidelines for Denali KidCare from 175% to 200% of Alaska's federal poverty level. This change would make approximately 1,300 children and 225 pregnant women eligible for health care services.

The eligibility level for Denali KidCare is currently set at 175% of federal poverty level. This means that Alaska has one of the most restrictive eligibility criteria for child health insurance programs in the nation. 48 states and the District of Columbia now cover children at or above 200% of the federal poverty level.

Food Bank of Alaska cares about health care for children because our research shows that health care and hunger are inextricably linked. 30% of food assistance clients have no health insurance, and 58% of food assistance clients have unpaid medical bills. 35% of food assistance clients choose between paying for food and paying for health care or medication.

Providing health insurance to more Alaskan children would mean that fewer families face the agonizing choice between feeding their kids and taking them to the doctor. It is also a sound investment; research shows that children and pregnant women with preventive care, such as that received through Denali KidCare, are four times less likely to use expensive emergency room care for medical treatment. Also, the State of Alaska will be able to leverage more federal dollars, since the federal government covers almost 65% of the entire cost of Denali KidCare.

Please help Alaska join the rest of the nation in supporting health care for children and pregnant women by reestablishing Alaska legislature's original level of Denali KidCare at 200% of federal poverty level.

Sincerely,

Susannah Morgan
Executive Director

FOOD Bank
OF ALASKA

MAT-SU HEALTH FOUNDATION

950 E. Bogard Road, Suite 218 • Wasilla, AK 99654
Phone: (907) 352-2863 • Fax: (907) 352-2865
www.matsuhealthfoundation.org

Mat-Su Health Foundation Resolution in Support of Increased Denali KidCare Income Eligibility Level

WHEREAS the Mat-Su Health Foundation's mission is to enhance the health of Alaskans living in Mat-Su, and where health is in part determined by access to primary, behavioral, and dental care and preventive services;

WHEREAS the provision of health insurance is a key component of healthcare access;

WHEREAS the Mat-Su Borough is the fastest growing area of Alaska, growing from 5,188 in 1960 to 82,515 in 2008 due to both positive birth and in-migration rates; and the AK Department of Labor projects that all Mat-Su age groups will continue to grow through 2020;[i]

WHEREAS in 2006, of the 22,868 children in Mat-Su, approximately 12.9% or 2,949 were uninsured;[ii]

WHEREAS in 2006, approximately 19.5% or 1,530 children in Mat-Su living at or below 200% Federal Poverty Level (FPL) were uninsured;[iii]

WHEREAS the Average Monthly Medicaid Enrollment *decreased* from 12,073 in 2006 to 11,671 in 2007 in Mat-Su despite a *rising* rate of uninsured coupled with significant population growth;[iv]

WHEREAS in Mat-Su nearly a quarter (23.5%) of all female headed households fell below the poverty level, 51.9% of those with children under 5 years of age were living in poverty compared to 32% of similar households in AK;[v]

WHEREAS 11.3% of families with related children in Mat-Su and 11.2% of families with related children in AK have lived below the poverty level in the last 12 months;[vi]

WHEREAS 37% of Mat-Su Borough School District students ages five to 17 live in households receiving Public Assistance;[vii]

WHEREAS Mat-Su Regional Medical Center, the sole community acute care provider in Mat-Su, supplied $339,554,984 in uncompensated care from 2007 through 2009 and saw uncompensated care rates rise 10% between 2007 and 2008 and 5% between 2008 to 2009;

WHEREAS the rate of uninsured children under age 18 in Alaska is increasing—from 8.4% in 2005 to 10.3% in 2006 to 11.4% in 2007 to 13.2% in 2008;[viii]

WHEREAS results of the 2007 National Survey of Children's Health 2007 reflect that

- 46% of Alaska's children live at or below 200% FPL as compared to 40.6% nationwide;
- 12.8% of Alaskan children under age 18 were uninsured at the time of the survey versus 9.1% nationwide; and only four states have lower rates than AK
- 18% of Alaskan children under age 18 were currently uninsured or had periods of no coverage during the year versus 15.1% nationwide
- 21% of Alaskan children living at or below 99% FPL were uninsured at the time of the survey versus 15% nationwide
- 28.8% of Alaskan children living at or below 99% FPL had periods of no coverage during the year versus 24.2% nationwide

- 17% of Alaskan children living at or below 199% FPL had no coverage at the time of the survey versus 13.9% nationwide
- 25.1% of Alaskan children living at or below 199% FPL had periods of no coverage during the year versus 24.3% nationwide;[IX]

WHEREAS approximately 10,000 Alaskan children 18 years or younger and below 200% FPL are uninsured,[X] and 36,000 Alaskan children 19 years or younger and below 200% FPL rely on government health insurance to provide access to health care services;[XI]

WHEREAS Alaska has seen a 31% decline in the number of children covered by private health insurance in the past decade; [XII]

WHEREAS the cost of caring for uninsured children is passed on to other Alaskans and businesses, raising premiums and out-of-pocket expenses for everyone;[XIII]

WHEREAS uninsured children are nine times less likely to have a regular doctor, four times more likely to be taken to emergency rooms, and 25% more likely to miss school than insured children;[XIV]

WHEREAS the Denali KidCare upper income eligibility guideline was decreased in 2007 to 175% FPL from 200% FPL;

WHEREAS increasing Denali KidCare income eligibility levels to at least 200% FPL will increase health care access for children and families that meet this criterion;

WHEREAS expanding the Denali KidCare income eligibility levels would result in improved public health and overall health outcomes throughout the state for Alaskan children;

WHEREAS the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized and expands the State Children's Health Insurance Program of 1997 to allow states to implement coverage up to 300% FPL and also provides for Performance Bonuses for states enrolling additional children in Medicaid;

BE IT THEREFORE RESOLVED that the Mat-Su Health Foundation supports and advocates for the Denali KidCare income eligibility level to be increased to *at least* 200% FPL and that a cost-sharing option is considered between 200% and 300% FPL.

Approved by the Mat-Su Health Foundation Board of Directors on February 15, 2010 *(date)*

Deborah Prator

Deborah Prator, President

[i] Matanuska-Susitna Borough. Alaska Department of Labor, Division of Research & Analysis. http://laborstats.alaska.gov/cgi/databrowsing/localAreaProfileQSResults.asp?geogArea=0204000170&population=census+data=Population&B1=View+Report.

[ii] 2006 Small Area Health Insurance Estimates. U.S. Census. http://www.census.gov/did/www/sahie/data/index.html

[iii] Ibid.

[iv] Alaska Health Care Data Book, page 241. Alaska Department of Health & Social Services. November 2007.

[v] Ibid.

[vi] Ibid.

[vii] Ibid.

[viii] U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements. http://www.census.gov/hhes/www/hlthins/hlthins.html

[ix] 2007 National Survey of Children's Health. Data Resource Center. 2007. http://nschdata.org/DataQuery/SurveyQuestions.aspx?yid=2&tid=44&geoid=1

[x] U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements. http://www.census.gov/hhes/www/hlthins/hlthins.html

[xi] Ibid.

[xii] Legislative Health Care Initiatives Presentation to the Anchorage Chamber of Commerce, August 27, 2007.

[xiii] Ibid.

[xiv] Ibid.

ALASKA ASSOCIATION OF HOMES FOR CHILDREN

Alaska Baptist Family Services
Anchorage, AK

Alaska Children's Services
Anchorage, AK

Alaska Family Services
Palmer, AK

Covenant House of Alaska
Anchorage, AK

Fairbanks Native Association
Fairbanks, AK

Family Centered Services of Alaska
Fairbanks, AK

Juneau Youth Services
Juneau, AK

Kenai Peninsula Community Care Center
Kenai, AK

Maniilaq Association
Kotzebue, AK

Nome Children's Home
Nome, AK

North Slope Borough Children's Services
Barrow, AK

North Star Behavioral Health Systems
Anchorage & Palmer, AK

Presbyterian Hospitality House
Fairbanks, AK

Providence Behavioral Health Systems
Anchorage, AK

Residential Youth Care
Ketchikan, AK

The Salvation Army Booth Memorial Home
Anchorage, AK

The Boys and Girls Home of Alaska
Fairbanks, AK

Youth Advocates of Sitka
Sitka, AK

February 9, 2010

Representative Bob Herron
Representative Wes Keller
Co-Chairs, Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

Dear Representatives Herron and Keller:

Please ensure passage of SB 13, Medical Assistance Eligibility, as quickly as possible. The Department of Health and Social Services estimates that raising the income eligibility limit to 200% of the Federal Poverty Level (FPL) can provide health care to 1,277 Alaskan children currently without health insurance.

As you can see from the attached map, Alaska is one of only three states in the country that limit income eligibility for the State Child Health Insurance Program to less than 200% of the FPL. Twenty states have 200% FPL limits and all other states have eligibility above 200% FPL.

As Alaskans who consider our children as our future, we should be leading the nation in providing quality health care to them, not lagging so far behind. Let's join those states that place a greater emphasis on helping working families take care of their children! The clock is ticking. Don't make those 1,277 children wait any longer—pass SB 13 this month!

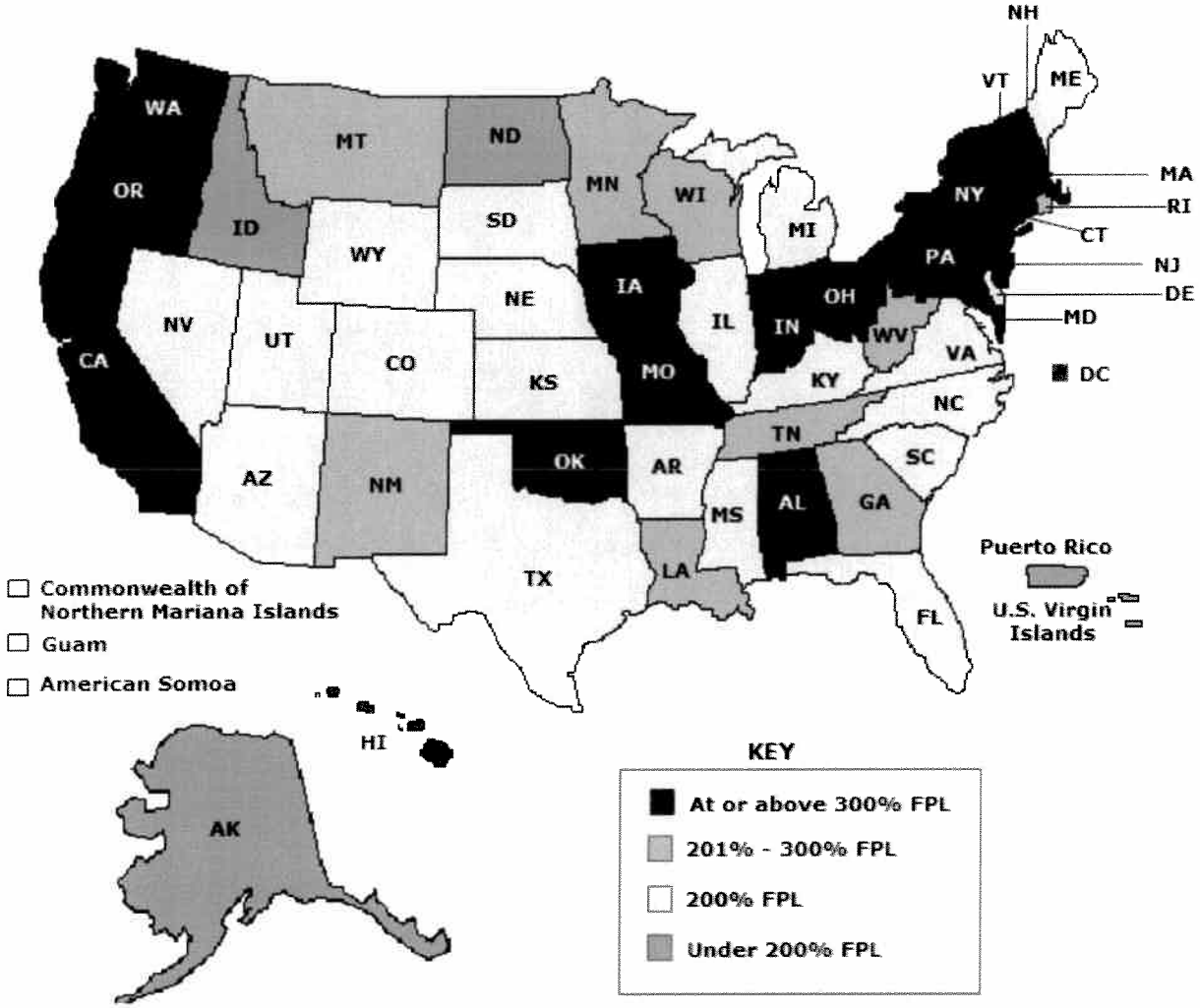
Sincerely,

Brad Ohs, President

cc.: Representative Tammie Wilson, HSS Vice Chair
Representative Bob Lynn, HSS Member
Representative Paul Seaton, HSS Member
Representative Sharon Cissna, HSS Member
Representative Lindsey Holmes, HSS Member
Representative Mike Chenault, House Speaker

Children's Health Insurance Program

Upper Income Limits as of February 1, 2010



SB 13
Tues 3/9/10

Testimony in Support of Senate Bill 13

March 8, 2010

Dear Representatives Keller and Herron and other members of the Health and Social Services Committee,

My name is Dr. Monica Gross. I am a board certified pediatrician who has practiced in Alaska since 1993. I am here in support of Senate Bill 13. This bill will strengthen Alaskan families by increasing Denali Kid Care coverage.

When children have medical insurance the entire health care emphasis changes to one that strengthens the family. Medical care is shifted from crisis-oriented care to well child and preventative care. This shift has ramifications not only for children's health, but also for family and community health.

When families don't have medical insurance kids are brought to the doctor when they are very sick and parents are really scared. Doctors respond in emergency mode- tests are ordered, drugs are prescribed and parents admonished for "waiting too long". The role of parents as the primary caregiver for their child is undermined.

When kids have medical insurance they are brought in for well child checkups and preventative care. The whole medical model shifts. Parents and doctors are a team working together to keep children healthy and prevent disease. Parents are empowered, and the important job they are doing is validated. Time is available to answer questions and counsel about age appropriate health promotion and illness prevention. This exchange sets the stage for families where children can develop and grow and become productive and healthy members of their community.

Please support Senate Bill 13.

Monica Gross M.D.

Monica Gross, M.D.
Fellow, American Academy Pediatrics
524 Main Street
Juneau, Alaska
907-586-6789

Banner Health
Tanana Valley Clinic

1001 Noble Street
Fairbanks, AK 99701
Phone 907-459-3500
Fax 907-459-3583

Representative Keller,

I am writing in support of the Denali Kid Care Funding Increase that is currently being debated in the Alaska Legislature. As a pediatrician in the Fairbanks community for over 25 years, I have seen first-hand the impact of healthcare costs on hard-working families in our state.

Although my primary role as a pediatrician is to care for the health and well-being of children, it is also imminently important that I respect the concerns of parents and consider the welfare of entire families. Many of the exams, procedures and treatments that I provide put a heavy financial burden on families, producing a mountain of medical bills to be paid out of pocket. I am repeatedly faced with this ethical dilemma and must work to reconcile the necessity of treatment with the economic consequences of my decisions. Denali Kid Care alleviates much of the financial burden on families and, in turn, enables me to effectively administer a child's medical care without the added concern of a family's hardship.

Currently, I am caring for an infant who has been producing bloody stools every few days. His parents are understandably concerned, and I have been performing tests to rule out common problems that may cause this reaction. At this point it would be appropriate for the infant to be seen by a Pediatric Gastroenterologist; however, due to the cost of seeing a specialist, the family is unable to move forward.

By increasing the eligibility percentage from 175% to 200%, Senate Bill 13 would give over 1,200 children health insurance coverage. This new eligibility standard would significantly relieve families who must compromise their children's standard of care due to financial constraints. At Tanana Valley Clinic alone, there are at minimum 40 families, in both the pediatric and OB/GYN departments, who would benefit from this increase. For many hard-working men and women who are currently just beyond the income cap to qualify for Denali Kid Care, this new bill would mean the difference between making ER visits only in dire situations and scheduling preventative visits that ultimately create healthier children. Children who receive preventative care are four times less likely to visit the emergency room; this in turn reduces the long-term cost of healthcare to the state.

When I set out to practice medicine, I did not imagine that on a daily basis my conscience would be saddled with financial concerns when caring for a sick child. However, it is the current reality. Denali Kid Care alleviates many of these concerns not only for me as a pediatrician, but more importantly for families who qualify for this service. As the economy continues to struggle and employees are laid off or faced with reduced hours and benefits, it is important that Alaska responds. This is an opportunity to extend care to over 1,200 families who would be otherwise unable to afford the healthcare that their children deserve.

Sincerely,

J. Timothy Foote, MD