HB

369

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: January 28, 1998 **FURTHER REFERRALS:** **Finance**

Date of Committee Action: 4/7/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 369**

HOUSE BILL NO. 369 **MEDICAID COVER/HEALTHY FAMILIES AK PROGRA**

"An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care case management and managed care services as optional services and to premiums and cost-sharing contributions under the Medicaid program; establishing the Healthy Families Alaska program; and providing for an effective date."

recommends it be replaced with the following committee substitute _____ [ ] the same title [X] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[X] fiscal note(s) (4) H+SS _____ [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
C Bunde	✓			
Bryant Morton	✓			
				✓
Ann Brice				✓

CHAIR'S SIGNATURE C. Bunde _____

0-GH2008\E
Lauterbach
3/26/98

CS FOR HOUSE BILL NO. 369(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to Medicaid coverage for certain eligible children; relating to premiums and cost-sharing contributions under the Medicaid program; 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 by adding a new paragraph to read:

(12) persons under age 19 who are not covered under (a) of this section and whose household income does not exceed 200 percent of the federal poverty guideline as defined by the federal office of management and budget and revised under 42 U.S.C. 9902(2).

* **Sec. 2.** AS 47.07.020 is amended by adding a new subsection to read:

(i) The department may allow a person under 19 years of age who is determined to be eligible for benefits under this chapter to remain eligible for those benefits for up to 11 calendar months following the month that the person is determined eligible for benefits or until the person is 19 years old, whichever occurs

earlier.

* **Sec. 3.** AS 47.07.042(a) is amended to read:

(a) Except as provided in **(b) - (d)** [(b) AND (c)] of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements [OR SIMILAR CHARGES] on persons eligible for assistance under this chapter to the maximum extent allowed under federal law and regulations. The plan must provide that health care providers shall collect the allowable charge. The department shall reduce payments to each provider by the amount of the allowable charge. A provider may not deny services because a recipient is unable to share costs, but an inability to share costs imposed under this section does not relieve the recipient of liability for the costs.

* **Sec. 4.** AS 47.07.042 is amended by adding a new subsection 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)(12) and whose household income is between 150 and 200 percent of the federal poverty guideline. 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. 5.** TRANSITION: REGULATIONS. Notwithstanding sec. 7 of this Act, the Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of secs. 1 - 4 of this Act.

* **Sec. 6.** Section 5 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect July 1, 1998.

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CS HB 369 (HESS)

evision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to Medicaid coverage for certain eligible children;
BRU: Medical Assistance
Component: Medicaid Non-Facility
Sponsor: House Rules by Request of the Governor
COMPONENT SERIAL NO. 229
Requestor: House (HESS)
See also (SN#): 2260, 960,230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	4,199.7	5,310.2	5,681.9	6,079.6	6,505.2	6,960.6
MISCELLANEOUS						
TOTAL OPERATING	**4,199.7**	**5,310.2**	**5,681.9**	**6,079.6**	**6,505.2**	**6,960.6**
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	3,017.9	3,815.9	4,083.0	4,368.8	4,674.6	5,001.9
1003 GF Match	1,181.8	1,494.3	1,598.9	1,710.8	1,830.6	1,958.7
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	**4,199.7**	**5,310.2**	**5,681.9**	**6,079.6**	**6,505.2**	**6,960.6**

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Balanced Budget Act of 1997 recently passed by Congress creates a new Title XXI of the Social Security Act which allows States to use the new funds appropriated to either expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase health coverage, or both. The allocation of funds is made in the same proportion of the ratio of the number of low-income children without insurance and the geographic variations in health costs. Alaska's allocation is $5.6 million with a federal match rate of 71.86%. No more than 10% of the funding can be applied to administrative support and outreach. Incremental funding expanding the Medicaid program for children up to 200% of the federal poverty level and pregnant women is requested.

The direct services costs related to the "Smart Start" initiative were estimated using a model that estimates the funding needed to provide Medicaid coverage to all uninsured Children up to 200% of the Federal Poverty Level. The model is based on a number of assumptions pertaining to the size and composition of the uninsured population in Alaska, the rates of anticipated participation in a medical insurance program by this population, and the costs associated with

Prepared by: Randy Super
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Division: Medical Assistance
Date: 04/08/98

Approved by Commissioner: Karen Perdue, Commissioner
Date: 4/8/98
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

providing coverage for Medicaid services to these program participants. Specific assumptions used are:

Variables	Assumed Value
Costs per Participant Estimates:	
Cost per Child Age 0-18	$1,908
Childrens' Health Insurance Progam & Medicaid Matching Rates:	
Childrens Health Insurance - FMAP Rate	71.9%
Childrens Health Insurance - State GF Match Rate	28.1%
Medicaid FMAP	59.8%
Medicaid State GF Match Rate	40.2%
Children Health Insurance Program Funding:	
Childrens Health Insurance - Alaska Allotment (est)	5,664,899
State Childrens Health Insurance Match	2,218,345
Total Childrens Health Insurance Funds	7,883,244
Native Children Participation and IHS Utilization:	
% of Eligible Children Below 100% of FPL Who are Native	41.0%
% of Eligible Children Below 150% of FPL Who are Native	38.3%
% of Eligible Children Below 200% of FPL Who are Native	35.6%
% of Native Children Who Use IHS Services	60.0%
Estimated Program Participation Rates:	
Participation Rate - All Children Year 1	74.0%
Year 2 and beyond	80.0%

In addition to the specific assumptions, the model relies on the results of an analysis by Employee Benefits Research Institute (EBRI) which provided an estimate of the distribution of the uninsured Alaska population by Federal Poverty Level (FPL) and number of insured who fall into each FPL category. The results of that analysis are summarized below.

Employee Benefit Research Institute - 0 thru 18
Uninsured Children Estimate

Poverty Rate	Total
0-99%	5,553
100-149%	3,679
150-199%	2,357
200-249%	3,020
250-299%	2,597
300-349%	1,185
350-399%	1,529
400% & Up	3,571
Total Uninsured Alaskan Children	23,491

The funding model calculates the cumulative number of "Smart Start" participants based on the estimated number of children who fall into FPL categories between 0% and 199%. The total estimated number of uninsured children who fall below 200% of FPL is 11,589. An extimated 5,553 of the uninsured children are would be enrolled in the Medicaid program if they applied. The 6,036 balance of uninsured children are targeted under this proposal. This number is subsequently multiplied by the Participation Rate for All Children to yield an adjusted estimate of the children who would likely participate in the program in Year 1. This result is then multiplied by two factors, the "% of Eligible Children who are Native" and the "% of Native Children Using IHS" to estimate the total number of uninsured Native children who are anticipated to use the services of IHS providers under the program. A final calculation subtracts that number (uninsured Native children using IHS services) from the estimated total number of participating children to yield the number of children who would get services from non-IHS providers.

ANALYSIS (cont.):

The costs per eligible child are based on an analysis of recent spending data from the Medicaid Management Information System for services provided AFDC children adjusted to reflect estimated costs for these same services in FY99. The estimated numbers of participating Native and non-Native children are multiplied by the projected cost per eligible child to provide a total cost of coverage for each of these groups. The model estimates that all services provided to eligible Native children who use IHS providers will qualify for reimbursement that is 100% federally funded. Funding for the services to the remaining population of children is under the Children's Health Insurance Program (Title XXI). For services to the remaining non-IHS children between 100% and 200% FPL, the State's allocation under Title XXI is used as the funding source at an enhanced match rate of 28.14% GF and 71.86% FFP.

There are increased Medicaid program costs that are anticipated to result from the outreach efforts required as part of a Title XXI program. As previously identifited, there are an estimated 5,553 uninsured children who fall below 100% of poverty and who would be eligible for Medicaid if they applied. Through the outreach effort required under Title XXI, the Division anticipates that about 40% of these uninsured children will participate as new eligibles under Title XIX Medicaid. The model assumes that direct services to children who fall under 100% of FPL will be financed under the Medicaid program and the total costs for these services will be financed at the Medicaid match rate of 40.2% GF and 59.8% FMAP. However, the additional program costs for serving these new children are not reflected in this fiscal note.

In preparing this fiscal note an implementation date beginning October 1, 1998 was assumed for the enrollment of the first child. Enrollment is projected to increase at a monthly rate of 8.7% durning the first year, ending the year with a total enrollment of a projected 4,092 children.

Using the above assumptions, the funding model estimates that Title XXI Medicaid coverage for 4,092 participating children will require $8,768.0 in total expenditures ($2,063.3 SGFM / $6,704.7 Fed Funds) for services and administration.

Distribution of "Smart Start" related funding is based on analyses of Medicaid spending for medical services provided to AFDC Children. The historical expenditure data used came from the Medicaid Management Information System monthly MR-O-91T report which is a summary of Medicaid spending by Medicaid Category of Assistance and colocation code. The expenditures used were cumulative dates of payment for the period July, 1996 through October, 1997. Distributions between the colocation codes were calculated separately for each of the Medicaid Program components (Medicaid Non-Facilities, Medicaid Facilities, and Medicaid Indian Health Services). No distributions were made for either AFDC Children to Medicaid Waivered Services as no spending occurred during the observed period in that component for these groups.

The total projected FY99 expenditures for direct services was multiplied by the percentage distribution between the components, and that result was multiplied by the percentage distribution across each relevant colocation code to determine the amount of direct services to be allocated to each colocation code.

	Total Funds	Federal	GFM
Medicaid Facilities	2,032.0	1,460.2	571.8
Medicaid Non-Facilities	4,199.7	3,017.9	1,181.8
Indian Health Service	1,575.6	1,575.6	
Totals	7,807.3	6,053.7	1,753.6

Note:
Costs per Child are based on FY97 date-of payment data. Costs exclude Indian Health Services, State Programs, API Disproportionate Share Facilities payments, and Medical Assistance Administration. The denominator is the number of eligible non-disabled children (52,154) as of June 1, 1997. The cost was then adjusted to reflect anticipated FY99 cost by multiplying times 1.06.

ANALYSIS (cont.):

FORMULAS

"Uninsured" = "Estimated Uninsured by Federal Poverty Level" (Employee Benefits Research Institute) X Participation Rate (Children)

"State GF" *Native Children*

The model shows no State General Fund expenditures for Native Children who access IHS-funded services. All funding for services to this estimated population are 100% federally reimbursed

Other Children

This part of the uninsured children population accesses medicaid services.

Uninsured Children below 100% of the Federal Poverty Level

The estimated General Fund costs of covering non-native children up to 100% of the federal poverty level is calculated by assuming the State will participate at the current State Medicaid Match Rate of 40.2%.

Uninsured Children between 100% & 200% of the Federal Poverty Level

For the population of children between 100% and 200% of FPL, the model uses a formula that first calculates the total marginal cost of covering the additional children in each FPL category, calculates the federal portion this amount by multiplying by the CHI FMAP rate [71.2%], and compares this result with the total Alaska CHI Allotment ($5,621,510). If the federal portion of the marginal need is less than the Allotment amount, then the CHI GF Match rate is used to calculate the State general fund needed to fund the marginal costs above above 99% FPL. If the federal portion of the marginal need is greater than the State's CHI Allotment, then the difference between Total amount and the sum of the Total amount for below 100% FPL and total CHI Funds. This difference is then multiplied by the Medicaid State GF match rate to determine the remaining GF needed.

"Federal" *Native Children*

IHS-funded services are 100% federally reimbursed.

Other Children

Uninsured Children below 100% of the Federal Poverty Level

The estimated Federal portion of covering non-native children up to 100% FPL is calculated using the Alaska Medicaid FMAP rate of 59.2%.

Uninsured Children between 100% & 200% of the Federal Poverty Level

Federal funds are calculated by subtracting the State GF amount for each FPL category from the Total amount.

"Total" = "Uninsured' X 'Cost per Child - 0-18' X 1.1 Administrative Cost Factor"

ANALYSIS (cont.):

The following distributes the Child Health Program Expenditures by source of funds by administration and program services. The administration and program services are further allocated between Title XIX Medicaid, Title XXI Child Health Initiative and Indian Health Service.

Fiscal Year 1999: Projected Child Health Program Title XXI Expenditures - 200% FPL

Family Income Above Current Medicaid Standards	Native Children to 200% FPL	Other Children to 200% FPL	All Children to 200% FPL	
Uninsured	751	3,341	4,092	
State GF	$ -	$ 2,063,301	$ 2,063,301	
Federal	$ 1,575,591	$ 5,129,141	$ 6,704,732	
Total	$ 1,575,591	$ 7,192,443	$ 8,768,033	*1

Source of Funds Analysis

	GFM	FMAP	IHS	TOTALS
Title XIX - Medicaid	$ 90,000	$ 90,000	$ -	$ 180,000
Title XXI - Child Health Ins.	$ 1,973,301	$ 5,039,141	$ -	$ 7,012,443
Title XIX - IHS	$ -	$ -	$ 1,575,591	$ 1,575,591
Totals	$ 2,063,301	$ 5,129,141	$ 1,575,591	$ 8,768,033
Administration				
Title XIX - Medicaid	$ 90,000	$ 90,000	$ -	$ 180,000
Title XXI - Child Health Ins.	$ 219,698	$ 561,033	$ -	$ 780,730
Title XIX - IHS	$ -	$ -	$ -	$ -
Admin Totals	$ 309,698	$ 651,033	$ -	$ 960,730 *2
Program				
Title XIX - Medicaid	$ -	$ -	$ -	$ -
Title XXI - Child Health Ins.	$ 1,753,604	$ 4,478,108	$ -	$ 6,231,712
Title XIX - IHS	$ -	$ -	$ 1,575,591	$ 1,575,591
Program Totals	$ 1,753,604	$ 4,478,108	$ 1,575,591	$ 7,807,303

Notes: *1 10% Administration is included in estimated total costs for children

*2. IHS fund is only available for direct program services.

The Division has assumed the following for calculation of the period FY00-04:
Alaska's Federal Medical Assistance Percentage (FMAP) will continue after FY2000 at the enhanced rate of 59.8% because Alaska's Congressional delegation will be effective at securing reauthorization due to enactment of this legislation. It is also assumed that the enhanced federal participation for the Title XXI funding will remain at the same 71.86% through FY04. The fiscal note also assumes an average of a 7% expenditure growth from fiscal year to fiscal year. This growth takes into account changes in the cost of medical services as well as changes in the utilization of medical services by both the clients and providers for the Child Health Initiative.

The details of the SMART START for Alaska's Families program are contained in the document "A Blueprint for Assuring Adequate Access to Health Care for Alaska's Uninsured Children and Pregnant Women." Copies are available at the Commissioner's Offices by calling in Juneau (907-465-3030) and Anchorage (907-269-7800).

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CS HB 369 (HESS)

evision Date:
Title: An Act relating to Medicaid coverage for certain eligible children;
Sponsor: House Rules by Request of the Governor
Requestor: House (HESS)

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Indian Health Service
COMPONENT SERIAL NO. 960
See also (SN#): 2260,230,229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,575.6	1,992.0	2,131.4	2,280.6	2,440.3	2,611.1
MISCELLANEOUS						
TOTAL OPERATING	1,575.6	1,992.0	2,131.4	2,280.6	2,440.3	2,611.1
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,575.6	1,992.0	2,131.4	2,280.6	2,440.3	2,611.1
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	1,575.6	1,992.0	2,131.4	2,280.6	2,440.3	2,611.1

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: 50.0

ANALYSIS: (Attach a separate page if necessary)

The Balanced Budget Act of 1997 recently passed by Congress creates a new Title XXI of the Social Security Act which allows States to use the new funds appropriated to either expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase health coverage, or both. The allocation of funds is made in the same proportion of the ratio of the number of low-income children without insurance and the geographic variations in health costs. Alaska's allocation is $5.6 million with a federal match rate of 71.86%. No more than 10% of the funding can be applied to administrative support and outreach. Incremental funding expanding the Medicaid program for children up to 200% of the federal poverty level and pregnant women is requested.

The direct services costs related to the "Smart Start" initiative were estimated using a model that estimates the funding needed to provide Medicaid coverage to all uninsured Children up to 200% of the Federal Poverty Level. The model is based on a number of assumptions pertaining to the size and composition of the uninsured population in Alaska, the rates of anticipated participation in a medical insurance program by this population, and the costs associated with

Prepared by: Randy Super
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Phone: 456-5833
Date: 04/08/98

Approved by Commissioner: Karen Perdue; Commissioner
Agency: Department of Health & Social Services
Date: 4/8/98

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FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CS HB 369 (HESS)

evision Date:
Title: An Act relating to Medicaid coverage for certain eligible children;
Sponsor: House Rules by Request of the Governor
Requestor: House (HESS)

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Facilities
COMPONENT SERIAL NO. 230
See also (SN#): 2260,960,229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	2,032.0	2,568.4	2,748.2	2,940.6	3,146.4	3,366.7
MISCELLANEOUS						
TOTAL OPERATING	2,032.0	2,568.4	2,748.2	2,940.6	3,146.4	3,366.7
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,460.2	1,845.6	1,974.9	2,113.1	2,261.0	2,419.3
1003 GF Match	571.8	722.8	773.3	827.5	885.4	947.4
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	2,032.0	2,568.4	2,748.2	2,940.6	3,146.4	3,366.7

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Balanced Budget Act of 1997 recently passed by Congress creates a new Title XXI of the Social Security Act which allows States to use the new funds appropriated to either expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase health coverage, or both. The allocation of funds is made in the same proportion of the ratio of the number of low-income children without insurance and the geographic variations in health costs. Alaska's allocation is $5.6 million with a federal match rate of 71.86%. No more than 10% of the funding can be applied to administrative support and outreach. Incremental funding expanding the Medicaid program for children up to 200% of the federal poverty level and pregnant women is requested.

The direct services costs related to the "Smart Start" initiative were estimated using a model that estimates the funding needed to provide Medicaid coverage to all uninsured Children up to 200% of the Federal Poverty Level. The model is based on a number of assumptions pertaining to the size and composition of the uninsured population in Alaska, the rates of anticipated participation in a medical insurance program by this population, and the costs associated with

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Approved by Commissioner: Karen Perdue, Commissioner
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FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CS HB 369 (HESS)

evision Date:
Title: An Act relating to Medicaid coverage for certain eligible children;
Sponsor: House Rules by Request of the Governor
Requestor: House (HESS)

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Children's Health Eligibility
COMPONENT SERIAL NO. 2260
See also (SN#): 960,230,229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	960.7	987.1	1,057.2	1,132.2	1,212.6	1,298.7
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	960.7	987.1	1,057.2	1,132.2	1,212.6	1,298.7
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	651.0	709.3	759.7	813.6	871.4	933.2
1003 GF Match	309.7	277.8	297.5	318.6	341.2	365.5
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	960.7	987.1	1,057.2	1,132.2	1,212.6	1,298.7

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Balanced Budget Act of 1997 recently passed by Congress creates a new Title XXI of the Social Security Act, which allows states to use the new funds appropriated to either expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase health coverage, or both. The allocation of funds is made in the same proportion of the ratio of the number of low income children without insurance and the geographic variations in health costs. Alaska's allocation is 5.6 million with a federal match rate of 71.86%. No more than 10% of expenditures under the Title XXI block grant can be applied to administrative support and outreach.

Program implementation requires an eligibility determination and outreach process. The Division will evaluate the options available to determine the most cost effective method to implement this function. Extension of this health care coverage will result in one time programming changes tot he state's eligibility and claims payment systems. Other one time costs will include furniture and equipment costs to support the staff processing the applications for decision.

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Date: 04/08/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 4/8/98

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ANALYSIS (cont.):

Under Federal law, initial applications processing may be performed outside of Public Assistance offices and by other State agency staff. The balance of the contractual costs are divided between contracting for this outstationed application intake and processing, and programming enchantments to the State's EIS and Claims payment systems.

The details of the SMART START for Alaska's Families program are contained in the document "A Blueprint for Assuring Adequate Access to Health Care for Alaska's Uninsured Children and Pregnant Women." Copies are available at the Commissioner's Offices by calling in Juneau (907-465-3030) and Anchorage (907-269-7800).

The Division has assumed the following for calculation of the period FY00-04:
Alaska's Federal Medical Assistance Percentage (FMAP) for administration is 50%. It is also assumed that the enhanced federal participation for the Title XXI funding for the 10% administrative activities will remain at the same 71.86% through FY04. The fiscal note also assumes an average of a 7% expenditure growth from fiscal year to fiscal year which takes into account changes in the cost of medical assistance program administration.

The following distributes the Child Health Program Expenditures by source of funds by administration and program services. The administration and program services are further allocated between Title XIX Medicaid, Title XXI Child Health Initiative and Indian Health Service.

Fiscal Year 1999: Projected Child Health Program Title XXI Expenditures - 200% FPL

Family Income Above Current Medicaid Standards	Native Children to 200% FPL	Other Children to 200% FPL	All Children to 200% FPL	
Uninsured	751	3,341	4,092	
State GF	$ -	$ 2,063,301	$ 2,063,301	
Federal	$ 1,575,591	$ 5,129,141	$ 6,704,732	
Total	$ 1,575,591	$ 7,192,443	$ 8,768,033	*1

Source of Funds Analysis

	GFM	FMAP	IHS	TOTALS	
Title XIX - Medicaid	$ 90,000	$ 90,000	$ -	$ 180,000	
Title XXI - Child Health Ins.	$ 1,973,301	$ 5,039,141	$ -	$ 7,012,443	
Title XIX - IHS	$ -	$ -	$ 1,575,591	$ 1,575,591	
Totals	$ 2,063,301	$ 5,129,141	$ 1,575,591	$ 8,768,033	
Administration					
Title XIX - Medicaid	$ 90,000	$ 90,000	$ -	$ 180,000	
Title XXI - Child Health Ins.	$ 219,698	$ 561,033	$ -	$ 780,730	
Title XIX - IHS	$ -	$ -	$ -	$ -	
Admin Totals	$ 309,698	$ 651,033	$ -	$ 960,730	*2
Program					
Title XIX - Medicaid	$ -	$ -	$ -	$ -	
Title XXI - Child Health Ins.	$ 1,753,604	$ 4,478,108	$ -	$ 6,231,712	
Title XIX - IHS	$ -	$ -	$ 1,575,591	$ 1,575,591	
Program Totals	$ 1,753,604	$ 4,478,108	$ 1,575,591	$ 7,807,303	

Notes: *1 10% Administration is included in estimated total costs for children

*2 IHS fund is only available for direct program services

TONY KNOWLES
GOVERNOR

HB 367

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 27, 1998

The Honorable Gail Phillips
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Speaker Phillips:

The state of Alaska has a unique opportunity to expand health coverage for the children and pregnant women of Alaska's working families, and to help new parents with the skills they need to raise healthy, happy kids who are prepared for a bright future. Today, I am transmitting a bill that seizes that opportunity. This legislation is part of my Smart Start for Alaska's Children initiative -- giving kids the chance for a healthy start in life.

This bill takes advantage of a new federal program to increase income eligibility for Medicaid to include children and pregnant women whose family incomes are below 200 percent of the federal poverty level. The Department of Health and Social Services estimates this new coverage will reach 11,600 children and 800 pregnant women who need, but currently cannot afford health insurance. The bill also authorizes the department to establish methods for case management and premium cost-sharing to make this new program as efficient and equitable as possible.

Especially appealing about this program is that it will cost the state no new general fund dollars because of increased federal funding for the state's Medicaid program. This bill proposes to reallocate about $7 million of general funds no longer required to match federal Medicaid dollars as the state's share for expanded children's health coverage. That $7 million will in turn leverage nearly $18 million new federal Medicaid dollars. I can think of no better use than children's health for a portion of our Medicaid savings.

This bill also formally establishes in law the Healthy Families Alaska program, which provides education and support services to pregnant women and the families of children under age five. This proven program offers home visits designed to meet the needs of parents for information, emotional support, stress management, and assistance with other negative factors that undermine parents' health habits and the care of their children. Service providers work with families to ensure children receive medical care, such as immunizations, parents receive job training and substance abuse programs if needed, and mothers receive prenatal care – the "smartest start" we can offer Alaska's children.

Programs such as expanded health care and home visits for new parents have been proven to help reduce child abuse. The state of Vermont, for instance, experienced significant drops in child abuse and neglect after adopting initiatives similar to this proposal. Because child abuse and neglect make it more likely a child will resort to violence, health care and home visitation programs that prevent abuse and neglect are considered an effective, long-term strategy for preventing future crime and the public and private costs associated with it.

I can think of nothing more valuable for us to offer Alaska's children and families than the opportunity for a physical and emotional healthy start in life. This bill offers an excellent avenue for that effort and deserves your attention and prompt action.

Sincerely,

Tony Knowles
Governor

SECTIONAL ANALYSIS HB 369/SB 266

An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care case management and managed care services as optional services and to premiums and cost sharing contributions under Medicaid; establishing the Healthy Families Alaska program; efd.

Section 1 — Adds to the Medicaid Program as new optional coverage groups children under age 19 and pregnant women with family incomes that do not exceed 200 percent of the federal poverty level. These children are added to Medicaid under the new Child Health Insurance Program (CHIP) enacted by Congress in the Balanced Budget Act of 1997.

Section 2 — Allows the department to implement continuous eligibility for up to 12 months for Medicaid eligible children under age 19.

Section 3 — Adds targeted case management for pregnant women and children under age 5 (Healthy Families Alaska), and comprehensive pregnancy-related services as new optional services for the Medicaid Program.

Section 4 — Allows the department to take advantage of new provisions of the Balanced Budget Act of 1997, that allows states to offer managed care services as a state option instead of through a Medicaid waiver. These options include Primary Care Case Management (PCCM) in which clients choose a primary care provider to receive all basic health care and who authorizes specialty care and other defined services, and contracts with managed care entities.

Section 5 — Makes technical changes to AS 47.07.042(a) consistent with changes in Section 6.

Section 6 — Grants the department the authority to require premiums or cost sharing for the new groups of pregnant women and children, added in section 1 of the bill, whose family income is between 150% and 200% of the federal poverty level.

Section 7 — Amends the definition of targeted case management related to Healthy Families Alaska.

Section 8 — Defines comprehensive pregnancy-related services to mean services in a greater amount duration or scope than is available to other recipients, or services on the options list at AS 37.07.035 that may otherwise be unavailable to adult recipients.

Section 9 — Establishes a statutory basis for the Healthy Families Alaska program.

Section 10 — Authorizes the department to adopt regulations necessary to implement this bill.

Section 11 — Immediate effective date for section 10.

Section 12 — Effective date of July 1, 1998 for all sections of the bill except 11 which is effective immediately.

CHILDREN'S HEALTH CARE:
Why Choose Medicaid
Instead of a Separate Health Insurance Program?

Under the State Child Health Insurance Program (SCHIP) federal law, states have the option to use their allotment to cover uninsured children *either* through their Medicaid program or through a child health insurance program, or a combination of both.

- If a state chooses the Medicaid option, Medicaid rules apply and a state must offer the Medicaid benefit package. If a state chooses a child health insurance program, it must offer a benefit package actuarially-equivalent to either the state's employee health plan, the federal employee health plan, or the largest HMO in the state[1].

For any state, the best option is dependent on many factors and the decision should be based on the following criteria:

- minimizing state general fund costs and maximizing the number of children covered,
- the cost and ease of administrating the program, and
- providing a benefit package that is most appropriate for children.

The Cost and Number of Children Covered

Using Alaska's SCHIP allotment to extend Medicaid coverage will stretch the State's general funds further and cover many more children.

- Between 25 and 40 percent of the SCHIP eligible children will be Alaska Native and by law must be included in any SCHIP plan. Under a Medicaid expansion for SCHIP, services provided to Alaska Native children by I.H.S. or tribal providers will be paid with 100 percent federal funds *outside the State's SCHIP allotment*. Under a separate insurance program, costs for Alaska Native children will come out of the state allotment at a 72 percent federal match. A Medicaid SCHIP expansion takes advantage of the special funding for Alaska Natives.

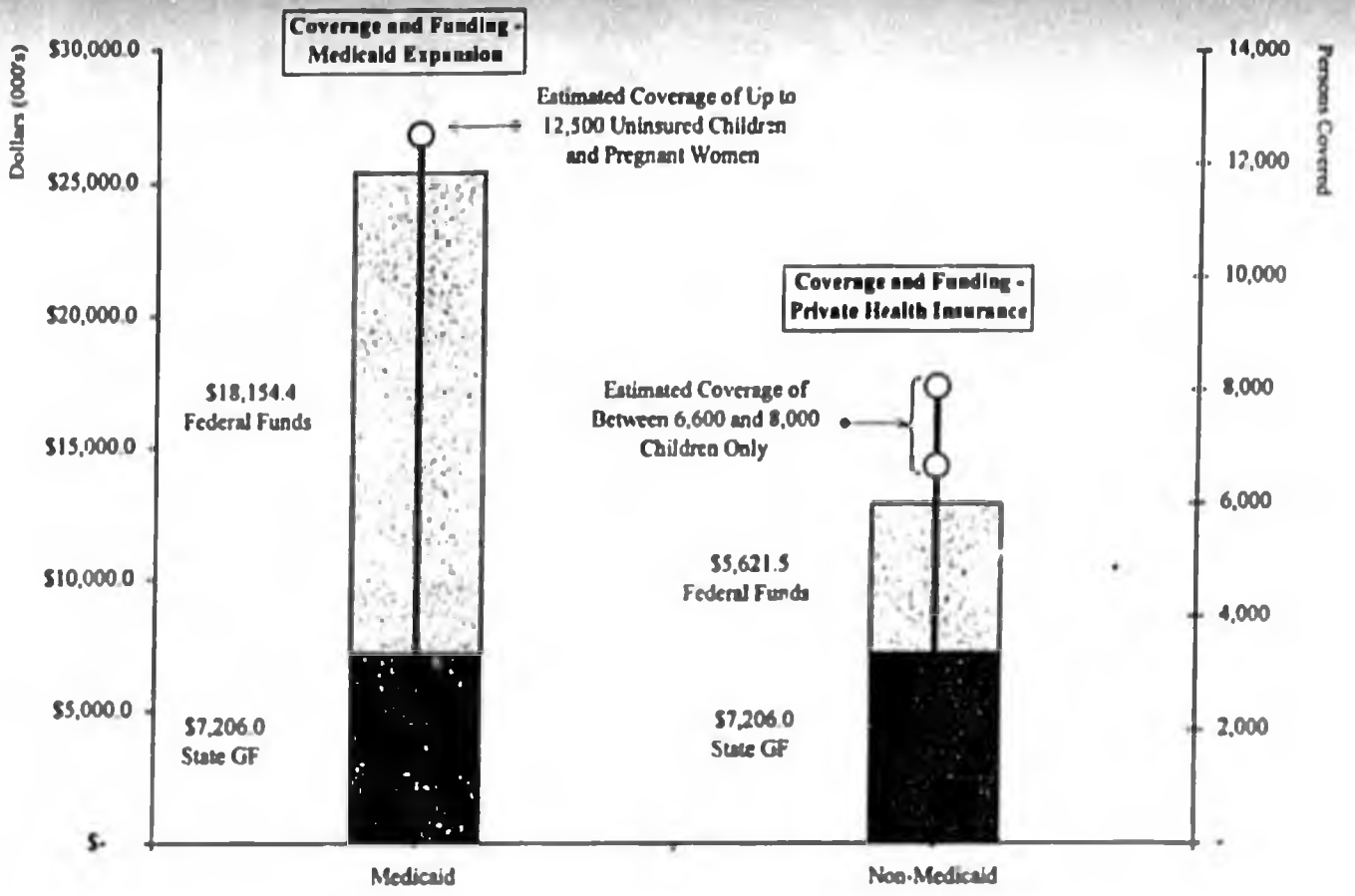
- Based on preliminary information gathered by the Division of Medical Assistance[2], comparable private health plans appear to be more costly than the average cost for a Medicaid child. The division compared the per child cost for a Medicaid expansion, estimated at $1,908, to what the Medicaid benefit package would cost in the current private market. These preliminary estimates suggest that the comparable (Medicaid) package in the current private market would cost at least $400 more per year than the average cost for a Medicaid child.

- The Governor's Smart Start proposal to invest $7.2 million in general funds will cover 11,600 uninsured children and 800 pregnant women. Under a separate insurance program, only an estimated 6,600 to 8,000 children (and no pregnant women) would be covered with same general fund investment.

---

[1] The HMO option is not currently applicable since there are no HMOs licensed to sell health plans in Alaska.

[2] The Division of Medical Assistance continues to seek information from insurers on private insurance options but to date, have not received any information that suggests that less costly options exist in Alaska's private market.



The Cost and Ease of Administering the Program

Extending Medicaid, as compared to creating a child health insurance program, minimizes new administrative and cost management functions.

- Implementation of a new child health insurance program would require duplication of many administrative components which already exist in the Medicaid program. A further consideration is that start-up costs cannot be funded with SCHIP funds as administrative costs are limited to 10 percent of *actual* expenditures on children.

- As a condition of receipt of federal funds, each child who applies for SCHIP must be screened by the State for Medicaid eligibility. Therefore, eligibility determination in a child health insurance program is still linked to the Medicaid program.

- Most health care providers are already enrolled and familiar with the Medicaid program.

- Extending Medicaid to additional children can be readily implemented[1].

An Appropriate Benefit Package for Children

[1]A Medicaid expansion could be implemented within 2-3 months after passage of the enabling legislation. The federal child health initiative funding was available as of October 1, 1997.

The Medicaid benefit package provides an appropriate benefit package for children including preventive services such as well-child exams and immunizations which are *not* covered by most private insurance plans.

- The preventive health services offered under Medicaid make this approach a better fit in addressing issues in Alaska like our declining child immunization levels.

- The benefit package for either Medicaid or a child health insurance program is stipulated in federal law, therefore, reducing services in the benefit package as an approach to lowering premium costs is largely precluded.

Conclusion

Given the data available to the Alaska Department of Health and Social Services at this time, extending Medicaid to uninsured low-income children represents the best financial and least burdensome approach to providing health coverage. The department is continuing to seek additional information and cost estimates by meeting with private insurers and health care providers and securing the analysis and consultation of national experts.

SMART START

FOR ALASKA'S CHILDREN

"CHILDREN'S HEALTH CARE INITIATIVE"

December 4, 1997

SMART START

FOR ALASKA'S CHILDREN

Children's Health Care Initiative

Initiative Goal and Objectives

- The overall goal of the **Smart Start** for Alaska's Children: *Children's Health Care Initiative* is to assure adequate health care coverage for all children and pregnant women.

- The objectives of the *Children's Health Care Initiative* include:

  ⇒ **Make health care coverage available to all children and pregnant women in Alaska with annual incomes below 200 percent of Federal Poverty Level (FPL).**

  ⇒ **Identify and work to eliminate barriers that keep moderate income Alaskan families from purchasing health insurance for their children.**

  ⇒ **Assure that affordable child-only health plans are available for Alaskan families to purchase.**

  ⇒ **Ensure that every pregnant woman and child has access to preventive health services like prenatal care and immunizations.**

Why Assure Coverage NOW?

- The recently enacted Balanced Budget Act of 1997 changed the amount that the federal government pays for Alaska's Medicaid program from 50% to 59.8%. This change means that the federal government now pays more of the costs of Alaska's Medicaid program. This change frees up State funds already committed to the State health care program for the poor (Medicaid) enabling a reinvestment to expand coverage for uninsured children and pregnant women.

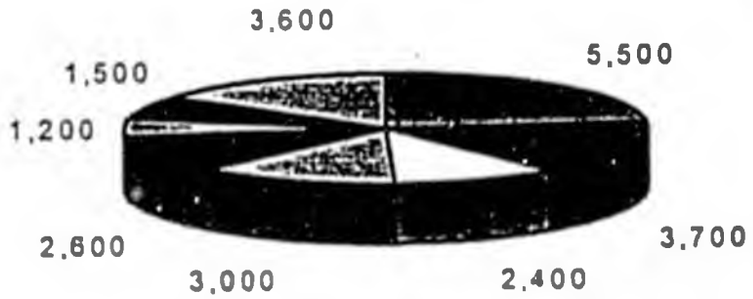
- Also in the Balanced Budget Act, Congress made available an additional $5.6 million to Alaska for expending health coverage to children. Although some State expenditure is required, for every State dollar spent, the federal government pays nearly $3 on behalf of Alaska's children.

- The State of Alaska has slipped well behind most other states in assuring that low-income families have options for providing coverage for their children.

Number of Uninsured Children and Pregnant Women

- Approximately 23,500 Alaskan children are without basic health care coverage. Of those, about half are in families with incomes below 200 percent of the Federal Poverty Level (FPL), or below $33,340 for a family of three.
- Approximately 800 pregnant women in families with incomes 200 percent of the FPL are without basic health care coverage.
- National data suggest that the percentage of uninsured children has grown dramatically in recent years.
- Contributing significantly to the trend is the decline in employer financial support for health care coverage for their employees' dependents.

Graph 2. Uninsured Alaskan Children Ages 0-18, by Poverty Status Merged Data Years 1994-1996

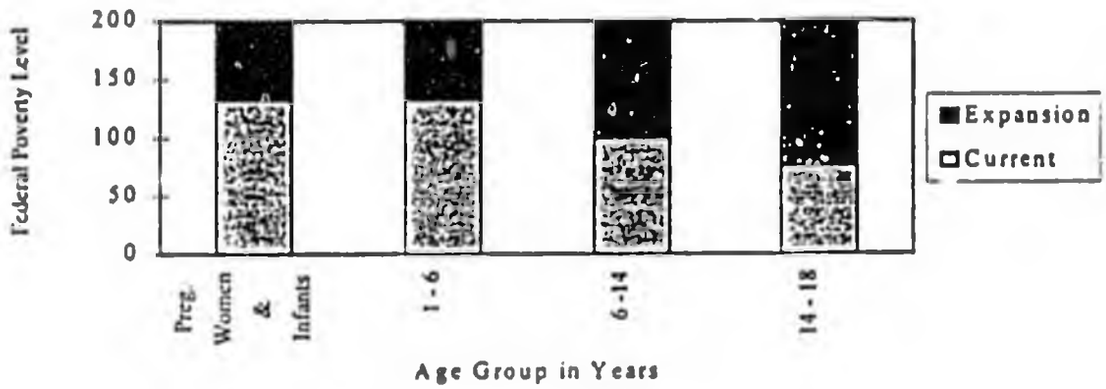


How the Lack of Health Care Coverage Affects Children

- Compared to privately insured children, children without health insurance are 6 times more likely to go without needed medical care, 5 times more likely to use the hospital emergency room as a regular source of care, and 4 times more likely to have necessary care.
- There are significant potential losses connected to periods of uninsurance for children. According to an article in the Journal of the American Medical Association, if a child develops a chronic health problem while uninsured, it can affect that child's health and well being for decades to come.

- Once an uninsured pregnant women is determined eligible, she is covered through her pregnancy and for two months following her delivery. An eligible uninsured child will retain their eligibility for six consecutive months.

Graph 4. Populations Served Under Current Medicaid Program and through Expansion



How will Eligibility be Determined and how will Families Hear about the Program?

- Applicants for the *Children's Health Care Program* will complete a simple application form which they can fill out and mail in to determine program eligibility. There will be multiple access points in local community agencies, doctor's offices, and other convenient locations for families.

- The *Children's Health Care Program* will have an extensive information and outreach component.

What will be in the Benefit Package?

- The *Children's Health Care Program* will offer all of the basic health care services a child would need with a special emphasis on preventive services aimed at detecting health care concerns before they become problems.

What Costs will Families be Responsible for?

- Families will be required to contribute to the cost of their coverage to the extent they are able.

Will Families be Expected to Choose a Primary Care Practitioner for their Children?

- In areas of the state where Primary Care Practitioners (PCPs) are available, enrollees will be asked to choose a PCP.

Which Providers will Participate in the Children's Health Care Program and Which Rules Apply?

- Qualified providers will be encouraged to voluntarily enroll in the *Children's Health Care Program*. Additionally, program participants will choose a Primary Care Practitioner (PCP) when they enroll. The PCP

- Some stategies to be considered include, but are not limited to:

  ◊ creating a public or private purchasing cooperative and use the State's clout in the marketplace to make available low-cost health plans, and give families the option of using the child's permanent fund dividend to pay part of the premium has been considered by other states and

  ◊ creating incentives in the private insurance marketplace for affordable child-only health plans.

More Information?

- To learn more about the "Smart Start for Alaska's Children", call Theresa Tanoury (in Juneau at 907-465-3030) or Diane DiSanto (in Anchorage at 907-269-7800) in the Commissioner's Office, Alaska Department of Health and Social Services.
- To get a copy of the *Children's Health Care Initiative* Blueprint and/or to get on the mailing list to receive periodic updates, call Claudette Shales in the Alaska Division of Medical Assistance in Juneau (907-465-3355).
- A copy of the *Children's Health Care Initiative* Blueprint is also available at the DHSS Homepage as well as a separate website:

  http://health.hss.state.ak.us
  http://health.hss.state.ak.us/Blueptl l.htm

FISCAL NOTE

STATE OF ALASKA **BILL NO. HB 369**
1998 LEGISLATIVE SESSION

evision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care
BRU: Medical Assistance
Componant: Indian Health Service
Sponsor: House Rules by Request of the Governor
COMPONENT SERIAL NO. 960
Requestor: House (HESS)
See also (SN#): 2260,230,229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	5,088.1	5,444.3	5,825.4	6,233.2	6,669.5	7,136.3
MISCELLANEOUS						
TOTAL OPERATING	5,088.1	5,444.3	5,825.4	6,233.2	6,669.5	7,136.3
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	5,088.1	5,444.3	5,825.4	6,233.2	6,669.5	7,136.3
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	5,088.1	5,444.3	5,825.4	6,233.2	6,669.5	7,136.3

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Balanced Budget Act of 1997 recently passed by Congress creates a new Title XXI of the Social Security Act which allows States to use the new funds appropriated to either expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase health coverage, or both. The allocation of funds is made in the same proportion of the ratio of the number of low-income children without insurance and the geographic variations in health costs. Alaska's allocation is $5.6 million with a federal match rate of 71.86%. No more than 10% of the funding can be applied to administrative support and outreach. Incremental funding expanding the Medicaid program for children up to 200% of the federal poverty level and pregnant women is requested.

The direct services costs related to the "Smart Start" initiative were estimated using a model that estimates the funding needed to provide Medicaid coverage to all uninsured Children and Pregnant Women up to 200% of the Federal Poverty Level. The model is based on a number of assumptions pertaining to the size and composition of the uninsured.

3/18/98
Prepared by: Randy Super
Phone: 456-5833
Division: Medical Assistance
Date: 03/18/98

Approved by Commissioner: Karen Perdue, Commissioner
Date: 3/20/98
Agency: Department of Health & Social Services

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FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. HB 369

evision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care
BRU: Medical Assistance
Component: Medicaid Facilities
Sponsor: House Rules by Request of the Governor
COMPONENT SERIAL NO. 230
Requestor: House (HESS)
See also (SN#): 2260,960,229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	7,521.7	7,840.7	8,173.4	8,520.2	8,881.9	9,259.0
MISCELLANEOUS						
TOTAL OPERATING	7,521.7	7,840.7	8,173.4	8,520.2	8,881.9	9,259.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	4,926.7	5,123.7	5,328.7	5,541.9	5,763.5	5,994.1
1003 GF Match	2,595.0	2,717.0	2,844.7	2,978.3	3,118.4	3,264.9
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	7,521.7	7,840.7	8,173.4	8,520.2	8,881.9	9,259.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

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The direct services costs related to the "Smart Start" initiative were estimated using a model that estimates the funding needed to provide Medicaid coverage to all uninsured Children and Pregnant Women up to 200% of the Federal Poverty Level. The model is based on a number of assumptions pertaining to the size and composition of the uninsured

3/18/98
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FISCAL NOTE

STATE OF ALASKA — **BILL NO. HB 369**

1998 LEGISLATIVE SESSION

evision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care
BRU: Medical Assistance
Component: Medicaid Non-Facility
Sponsor: House Rules by Request of the Governor
COMPONENT SERIAL NO. 229
Requestor: House (HESS)
See also (SN#): 2260, 960,230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	10,457.1	10,900.6	11,363.1	11,845.3	12,348.1	12,872.4
MISCELLANEOUS						
TOTAL OPERATING	10,457.1	10,900.6	11,363.1	11,845.3	12,348.1	12,872.4
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	6,849.4	7,123.3	7,408.3	7,704.6	8,012.8	8,333.3
1003 GF Match	3,607.7	3,777.3	3,954.8	4,140.7	4,335.3	4,539.1
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	10,457.1	10,900.6	11,363.1	11,845.3	12,348.1	12,872.4

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

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3/17/98
Prepared by: Randy Super — Phone: 465-5833
Division: Medical Assistance — Date: 03/18/98

Approved by Commissioner: Karen Perdue, Commissioner — Date: 3/20/98
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

population in Alaska, the rates of anticipated participation in a medical insurance program by this population, and the costs associated with providing coverage for Medicaid services to these program participants. Specific assumptions used are:

Variables	Assumed Value
Costs per Participant Estimates:	
Cost per Child Age 0-18	1,908
Cost per Pregnant Woman	6,840
Childrens' Health Insurance Progam & Medicaid Matching Rates:	
Childrens Health Insurance - FMAP Rate	71.9%
Childrens Health Insurance - State GF Match Rate	28.1%
Medicaid FMAP	59.8%
Medicaid State GF Match Rate	40.2%
Children Health Insurance Program Funding:	
Childrens Health Insurance - Alaska Allotment (est)	5,664,899
State Childrens Health Insurance Match	2,218,345
Total Childrens Health Insurance Funds	7,883,244
Native Children Participation and IHS Utilization:	
% of Eligible Children Below 100% of FPL Who are Native	41.0%
% of Eligible Children Below 150% of FPL Who are Native	38.3%
% of Eligible Children Below 200% of FPL Who are Native	35.6%
% of Native Children Who Use IHS Services	60.0%
Estimated Program Participation Rates:	
Participation Rate - All Children	80.1%
Participation Rate - Pregnant Women	86.8%
Number of Uninsured Pregnant Women by Federal Poverty Level	
Uninsured Pregnant Women Below 100% of FPL -	
Additional Uninsured Pregnant Women Below 150% of FPL	500
Additional Uninsured Pregnant Women Below 200% of FPL	400
Percent of Uninsured Pregnant Women Who are Native:	
% Native Uninsured Pregnant Women	26.4%

In addition to the specific assumptions, the model relies on the results of an analysis by Employee Benefits Research Institute (EBRI) which provided an estimate of the distribution of the uninsured Alaska population by Federal Poverty Level (FPL) and number of insured who fall into each FPL category. The results of that analysis are summarized below.

Employee Benefit Research Institute - 0 thru 18
Uninsured Children Estimate

Poverty Rate	Total
0-99%	5,553
100-149%	3,679
150-199%	2,357
200-249%	3,020
250-299%	2,597
300-349%	1,185
350-399%	1,529
400% & Up	3,571
Total Uninsured Alaskan Children	23,491

ANALYSIS (cont.):

The funding model calculates the cumulative number of "Smart Start" participants based on the estimated number of children who fall into FPL categories between 0% and 199%. The total estimated number of uninsured children who fall below 200% of FPL is 11,589. This number is subsequently multiplied by the Participation Rate for All Children to yield an adjusted estimate of the children who would likely participate in the program. This result is then multiplied by two factors, the "% of Eligible Children who are Native" and the "% of Native Children Using IHS" to estimate the total number of uninsured Native children who are anticipated to use the services of IHS providers under the program. A final calculation subtracts that number (uninsured Native children using IHS services) from the estimated total number of participating children to yield the number of children who would get services from non-IHS providers.

The costs per eligible child are based on an analysis of recent spending data from the Medicaid Management Information System for services provided AFDC children adjusted to reflect estimated costs for these same services in FY99. The estimated numbers of participating Native and non-Native children are multiplied by the projected cost per eligible child to provide a total cost of coverage for each of these groups. The model estimates that all services provided to eligible Native children who use IHS providers will qualify for reimbursement that is 100% federally funded. Funding for the services to the remaining population of children is divided between that available under Medicaid (Title XIX) and under the Children's Health Insurance Program (Title XXI). The model assumes that direct services to children who fall under 100% of FPL will be financed under the Medicaid program and the total costs for these services will be financed at the Medicaid match rate of 40.2% GF and 59.8% FMAP. For services to the remaining non-IHS children between 100% and 200% FPL, the State's allocation under Title XXI is used as the funding source at an enhanced match rate of 28.14% GF and 71.86% FFP.

Using the above assumptions, the funding model estimates that Medicaid coverage for 9,283 participating children and 781 participating pregnant women will require $25,372.4 in total expenditures for services and administration ($7,200.0 SGFM / $18,172.4 Fed Funds).

Distribution of "Smart Start" related funding is based on analyses of Medicaid spending for medical services provided to AFDC Children and Pregnant Women (Medicaid Eligibility subtype 11). The historical expenditure data used came from the Medicaid Management Information System monthly MR-O-91T report which is a summary of Medicaid spending by Medicaid Category of Assistance and colocation code. The expenditures used were cumulative dates of payment for the period July, 1996 through October, 1997. Distributions between the colocation codes were calculated separately for each of the Medicaid Program components (Medicaid Non-Facilities, Medicaid Facilities, and Medicaid Indian Health Services). No distributions were made for either AFDC Children or Pregnant Women to Medicaid Waivered Services as no spending occurred during the observed period in that component for these groups.

The total projected FY99 expenditures for direct services was multiplied by the percentage distribution between the components, and that result was multiplied by the percentage distribution across each relevant colocation code to determine the amount of direct services to be allocated to each colocation code.

Projected direct services expenditures for the Smart Start children's health component within the FY99 Medicaid Program:

	Total Funds	Federal	GFM
Medicaid Facilities	7,521.7	4,926.7	2,595.0
Medicaid Non-Facilities	10,457.1	6,849.4	3,607.7
Indian Health Service	5,088.1	5,088.1	
Totals	23,066.9	16,864.2	6,202.7

Note:
Costs per Child are based on FY97 date-of payment data. Costs exclude Indian Health Services, State Programs, API Disproportionate Share Facilities payments, and Medical Assistance Administration. The denominator is the number of eligible non-disabled children (52,154) as of June 1, 1997. The cost was then adjusted to reflect anticipated FY99 cost by multiplying by 1.06.

ANALYSIS (cont.):

FORMULAS

"Uninsured" = "Estimated Uninsured by Federal Poverty Level" (Employee Benefits Research Institute) X Participation Rate (Children or Pregnant Women)

"State GF" *Native Children*

The model shows no State General Fund expenditures for Native Children who access IHS-funded services. All funding for services to this estimated population are 100% federally reimbursed

Other Children

This part of the uninsured children population accesses medicaid services.

Uninsured Children below 100% of the Federal Poverty Level

The estimated General Fund costs of covering non-native children up to 100% of the federal poverty level is calculated by assuming the State will participate at the current State Medicaid Match Rate of 40.2%.

Uninsured Children between 100% & 200% of the Federal Poverty Level

For the population of children between 100% and 200% of FPL, the model uses a formula that first calculates the total marginal cost of covering the additional children in each FPL category, calculates the federal portion this amount by multiplying by the CHI FMAP rate [71.2%], and compares this result with the total Alaska CHI Allotment ($5,621,510). If the federal portion of the marginal need is less than the Allotment amount, then the CHI GF Match rate is used to calculate the State general fund needed to fund the marginal costs above above 99% FPL. If the federal portion of the marginal need is greater than the State's CHI Allotment, then the difference between Total amount and the sum of the Total amount for below 100% FPL and total CHI Funds. This difference is then multiplied by the Medicaid State GF match rate to determine the remaining GF needed.

"Federal" *Native Children*

IHS-funded services are 100% federally reimbursed.

Other Children

Uninsured Children below 100% of the Federal Poverty Level

The estimated Federal portion of covering non-native children up to 100% FPL is calculated using the Alaska Medicaid FMAP rate of 59.2%.

Uninsured Children between 100% & 200% of the Federal Poverty Level

Federal funds are calculated by subtracting the State GF amount for each FPL category from the Total amount.

"Total" = "Uninsured" X "Cost per Child - 0-18" X 1.1 Administrative Cost Factor"

ANALYSIS (cont.):

The following distributes the Child Health Program Expenditures by source of funds by administration and program services. The administration and program services are further allocated between Title XIX Medicaid, Title XXI Child Health Initiative and Indian Health Service.

Projected Child Health Program Expenditures

Family Income		Children 0-18	Pregnant Women	TOTAL	
<200% FPL	Uninsured	9,283	781	10,064	
	State GF	$ 5,209,749	$ 1,989,017	$ 7,198,766	
	Federal	$ 14,282,320	$ 3,891,280	$ 18,173,600	
	Total	$ 19,492,070	$ 5,880,297	$ 25,372,366	*1

Source of Funds Analysis

	GFM	FMAP	IHS	TOTALS	
Title XIX - Medicaid	$ 4,981,621	$ 7,419,386	$ -	$ 12,401,007	
Title XXI - Child Health Ins.	$ 2,218,345	$ 5,664,899	$ -	$ 7,883,244	
Title XIX - IHS	$ -	$ -	$ 5,088,115	$ 5,088,115	
Totals	$ 7,199,966	$ 13,084,285	$ 5,088,115	$ 25,372,366	

Administration

Title XIX - Medicaid	$ 795,619	$ 793,219	$ -	$ 1,588,838	*2
Title XXI - Child Health Ins.	$ 201,668	$ 514,991	$ -	$ 716,659	
Title XIX - IHS	$ -	$ -	$ -	$ -	
Admin Totals	$ 997,287	$ 1,308,210	$ -	$ 2,305,497	

Program

Title XIX - Medicaid	$ 4,186,002	$ 6,626,167	$ -	$ 10,812,169	
Title XXI - Child Health Ins.	$ 2,016,677	$ 5,149,908	$ -	$ 7,166,585	
Title XIX - IHS	$ -	$ -	$ 5,088,115	$ 5,088,115	
Program Totals	$ 6,202,679	$ 11,776,075	$ 5,088,115	$ 23,066,869	

Notes:

*1 10% Administration is included in estimated total costs for children & pregnant women

*2 IHS fund is only available for direct program services. Title XIX Medicaid Administration was increased to compensate at the administation match rate of 50-50.

The Division has assumed the following for calculation of the period FY00-04:
Alaska's Federal Medical Assistance Percentage (FMAP) will continue after FY2000 at the enhanced rate of 59.8% because Alaska's Congressional delegation will be effective at securing reauthorization due to enactment of this legislation. It is also assumed that the enhanced federal participation for the Title XXI funding will remain at the same 71.86% through FY04. The fiscal note also assumes an average of a 5% expenditure growth from fiscal year to fiscal year. This growth takes into account changes in the cost of medical services as well as changes in the utilization of medical services by both the clients and providers for the Child Health Initiative.

The details of the SMART START for Alaska's Families program are contained in the document "A Blueprint for Assuring Adequate Access to Health Care for Alaska's Uninsured Children and Pregnant Women." Copies are available at the Commissioner's Offices by calling in Juneau (907-465-3030) and Anchorage (907-269-7800).

FISCAL NOTE

STATE OF ALASKA **BILL NO.** HB 369
1998 LEGISLATIVE SESSION

evision Date:
Title: An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care
Sponsor: House Rules by Request of the Governor
Requestor: House (HESS)

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Children's Health Eligibility
COMPONENT SERIAL NO. 2260
See also (SN#): 960,230,229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	2,305.5	2,418.3	2,539.1	2,668.5	2,807.1	2,955.5
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	2,305.5	2,418.3	2,539.1	2,668.5	2,807.1	2,955.5
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

	FY99	FY00	FY01	FY02	FY03	FY04
1002 Federal Receipts	1,308.2	1,364.5	1,424.8	1,489.4	1,558.6	1,632.7
1003 GF Match	997.3	1,053.8	1,114.3	1,179.1	1,248.5	1,322.8
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	2,305.5	2,418.3	2,539.1	2,668.5	2,807.1	2,955.5

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Balanced Budget Act of 1997 recently passed by Congress creates a new Title XXI of the Social Security Act, which allows states to use the new funds appropriated to either expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase health coverage, or both. The allocation of funds is made in the same proportion of the ratio of the number of low income children without insurance and the geographic variations in health costs. Alaska's allocation is 5.6 million with a federal match rate of 71.66%. No more than 10% of expenditures under the Title XXI block grant can be applied to administrative support and outreach.

Program implementation requires an eligibility determination and outreach process. The Division will evaluate the options available to determine the most cost effective method to implement this function. Extension of this health care coverage will result in the state's claims payment system processing an estimated 140,000 claims for medical services provided to these clients which will increase our fees by $456.4. The balance of the contractual costs are divided between

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Division: Medical Assistance
Phone: 465-5833
Date: 03/18/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 3/20/98

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ANALYSIS (cont.):

programming enhancements to the state's eligibility information system and the state's claims payment systems.

Under Federal law, initial applications processing may be performed outside of Public Assistance offices and by other State agency staff. The balance of the contractual costs are divided between contracting for this outstationed application intake and processing, and programming enchantments to the State's EIS and Claims payment systems.

The details of the SMART START for Alaska's Families program are contained in the document "A Blueprint for Assuring Adequate Access to Health Care for Alaska's Uninsured Children and Pregnant Women." Copies are available at the Commissioner's Offices by calling in Juneau (907-465-3030) and Anchorage (907-269-7800).

The Division has assumed the following for calculation of the period FY00-04:
Alaska's Federal Medical Assistance Percentage (FMAP) for administration is 50%. It is also assumed that the enhanced federal participation for the Title XXI funding for the 10% administrative activities will remain at the same 71.86% through FY04. The fiscal note also assumes an average of a 7% expenditure growth from fiscal year to fiscal year which takes into account changes in the cost of medical assistance program administration.

The following distributes the Child Health Program Expenditures by source of funds by administration and program services. The administration and program services are further allocated between Title XIX Medicaid, Title XXI Child Health Initiative and Indian Health Service.

Projected Child Health Program Expenditures

Family Income		Children 0-18	Pregnant Women	TOTAL	
<200% FPL	Uninsured	9,283	781	10,064	
	State GF	$ 5,209,749	$ 1,989,017	$ 7,198,766	
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	Total	$ 19,492,070	$ 5,880,297	$ 25,372,366	*1

Source of Funds Analysis

	GFM	FMAP	IHS	TOTALS
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Title XXI - Child Health Ins	$ 2,218,345	$ 5,664,899	$ -	$ 7,883,244
Title XIX - IHS	$ -	$ -	$ 5,088,115	$ 5,088,115
Totals	$ 7,199,966	$ 13,084,285	$ 5,088,115	$ 25,372,366

Administration

Title XIX - Medicaid	$ 795,619	$ 793,219	$ -	$ 1,588,838 *2
Title XXI - Child Health Ins	$ 201,668	$ 514,991	$ -	$ 716,659
Title XIX - IHS	$ -	$ -	$ -	$ -
Admin Totals	$ 997,287	$ 1,308,210	$ -	$ 2,305,497

Program

Title XIX - Medicaid	$ 4,186,002	$ 6,626,167	$ -	$ 10,812,169
Title XXI - Child Health Ins	$ 2,016,677	$ 5,149,908	$ -	$ 7,166,585
Title XIX - IHS	$ -	$ -	$ 5,088,115	$ 5,088,115
Program Totals	$ 6,202,679	$ 11,776,075	$ 5,088,115	$ 23,066,870

Notes: *1 10% Administration is included in estimated total costs for children & pregnant women

*2 IHS fund is only available for direct program services. Title XIX Medicaid Administration was increased to compensate at the administration match rate of 50-50

FISCAL NOTE

No: 2

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Bill Version: HB 369
(H) Publish Date: 1/28/98

Revision Date:
Title: Medicaid coverage for certain eligible children and pregnant women
Sponsor: Rules
Requestor: Governor

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: Healthy Families Alaska
COMPONENT SERIAL NO. 2160
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

This bill would establish the Healthy Families Alaska program in statute and provide for an effective date. The program actually began in SFY 95 with $200.0 of general funds appropriated to the Division of Public Health for the specific purpose of establishing a Healthy Families model home visitation program in Alaska. In the interim years, additional state and federal funding has allowed the program to expand to seven additional sites. A $1750.0 funding increase which will replace expiring fund sources (MHTAAR, Federal funds, etc.), allow for the natural growth of existing grantee programs, fund the previously federally funded Kenai Parent Support program (which is administered by state PHN staff), and add three new programs is included in the Governor's FY 99 budget request.

Details regarding the goals of the program, how it is delivered, the costs per family with potential cost savings related to avoiding out of home placements for children who are ultimately abused and neglected, is attached to this form.

Prepared by: Peter M. Nakamura, MD, MPH
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Division: Public Health
Date: 12/17/97
Approved by Commissioner: Karen Perdue, Commissioner
Date: 12/18/97
Agency: Department of Health & Social Services

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(Rev 10/96) ZERO FISCAL NOTE - H&SS - HEALTHY FAMILIES AK

Healthy Families Alaska Budget Analysis

The Healthy Families Alaska (HFAK) Program is a voluntary home visitation program targeted to pregnant women and parents of newborns who are at risk for child abuse and neglect. The program:

- is based on the Healthy Families America model promoted by the National committee to prevent Child Abuse
- works with families long term (three to five years) to reduce stressors in the family that place the children at risk
- builds family capacity to provide a safe and nurturing environment for the children
- utilizes providers and agencies within the community to provide needed services and
- is available in only eight communities statewide currently.

Staff of the local programs attempt to screen all pregnant women or mothers of newborns in their service area. If the screening indicates the presence of certain stressors, a complete assessment is done. If the assessment reveals that the family has a number of the stressors that are known to increase the risk of child abuse and neglect, the family is offered services. If the family chooses to participate, they receive at least weekly visits at first, more if the family needs the extra support. As the family increases it's ability to safely care for and nurture the child(ren), visits decrease in frequency. At whatever point the family has resolved some of the stressors and/or developed adequate support systems and coping mechanisms to deal with the stress, usually 3-5 years, the family graduates from the program. Thus, programs will continue to grow in size for 3-5 years, until the number of families completing the program equals the number of new families being enrolled due to additional pregnancies/births in the targeted service area.

The primary goal of the program is to assist families at risk of abusing or neglecting their children in accessing the services they need to reduce the major stressors in their lives that lead to serious child abuse and neglect when left unresolved. A survey of 263 families completed in SFY 96 indicated that 21% of the primary caregivers, usually the mother, had substance abuse problems, 13% had psychiatric disorders, 16% had experienced Domestic Violence and 33% were socially isolated. The majority of the families experienced several of the stressors, thus decreasing significantly their ability to parent successfully. Alaska's very high overall child abuse numbers and ranking in the nation in terms of neglect, physical abuse and sexual abuse of children verifies that when families are left on their own to manage the overwhelming stressors in their lives, the children suffer greatly. HFAK provides a support system to new parents to deal with the stressors and thereby, potentially avoiding abusing or neglecting their children.

The HFAK program began in Alaska in SFY 1995, with the award of the first grant to Catholic Community Services. New programs have been added at the rate of 2-3 per year and as of July 1, 1997, six fully funded grantee programs, one supplementary funded grantee and one program with services delivered by the state Public Health Nurses in Kenai were operational. No new programs will be added during SFY 98 Also, because last year's funding request was not fully funded, available funding is not adequate to maintain growth in the existing programs. It is expected that most programs will need to close enrollment to new families sometime during the fiscal year and only enroll new families when a current family either moves or terminates service. It is expected these numbers will be low because family satisfaction with the program is high and very few families have been enrolled long enough to be completing the program.

The $2,000.0 increment included in the Smart Start Initiative for SFY 99 is needed to replace $410.0 funding that expires at the end of SFY 98 (MHTAAR etc.), provide $843.0 in grantee funding needed to allow existing programs to continue their natural growth, and establish three new sites @ approximately $150.0 per site. Additionally, $290.7 is needed to cover the personal services costs for the state PHN staff who deliver the Kenai Parent Support Program and the HFAK Program Coordinator/Technical Assistance position, which was previously funded with federal grant dollars. $7.0 in the contractual and supply lines provides operational dollars for the Kenai program and communication support between programs and the granting agency.

The Child Welfare League of America showed Alaska as having 37.8 cases of substantiated abuse for every 1,000 children in the state, the highest rate in the nation. Overall costs for HFAK to serve a family for one year to prevent this abuse and neglect costs approximately $4.0. When one compares this cost with the $7.8/yr. cost for foster care alone, when a child has to be removed as a result of abuse, the financial return on the investment is significant. This figure does not include any of the costs related to investigating the case, medical care for injuries resulting from the abuse or mental health services and follow-up, which can easily double or quadruple the annual costs per child. If these additional costs are considered, the return on a one dollar per year investment in HFAK can be as high as three to five dollars per year. If in later adolescence a child who was abused or neglected requires confinement to a juvenile facility at a cost of approximately $60.0/yr., the savings is much more dramatic. The human costs, to the children, the parents and society, when abuse or neglect occurs are immeasurable. Children who experience abuse or neglect for prolonged periods at young ages never recover emotionally or intellectually. As a result they frequently have difficulty functioning throughout their lives and often need additional public resources through the adult justice system and/or services to the emotionally and mentally ill throughout their life.

The programs are currently serving approximately 400 families. It is expected that by the end of SFY 99, with the SFY 98 funding and this increment, the number of families served will be between 700 and 800 families. The variance is a result of the severity of the stress in the lives of the families being served. It is expected that a family support worker, with a varied caseload of low, moderate and high risk families, can carry a caseload of 10-15 families. In

some communities the programs are experiencing caseloads of mostly high risk families and as a result of the need of these families, may only be able to carry caseloads of 5-10 families, dramatically reducing the overall number of families that can be served. It is estimated that approximately 20% of the births annually in each state in are in families stressed to the point they could be at risk for abusing or neglecting their children. In Alaska that means that at a minimum, 2,000 families per year could need services. Due to the demographics of Alaska and our high rates of abuse and neglect, we would expect the percentage of families in need of service to be above the 20% rate. The funding being requested for SFY 99 will provide services to only a small portion of the families in the state in need of this support.

The first families were enrolled in the HFAK program in mid 1995, therefore, only a fraction of the families have been enrolled for longer than one year. The success of the program will only be able to be measured conclusively over time. However, early indicators show encouraging results. They show caregivers enrolling in substance abuse programs to deal with their addictions, homeless families getting stable housing, mothers enrolling in educational programs to increase their ability to become financially self-sufficient and partners of the women giving birth finding employment as a part of the family building on their strengths and getting support to utilize the services they need to be self-sufficient overall and to nurture their children over time. Some preliminary outcome information will be available during SFY 98. A comprehensive data/evaluation component has been implemented for the HFAK program and the amount and quality of the outcome data will increase consistently over time as the numbers increase and results are input and analyzed.

- 23,000 Alaskan children are without health insurance; HB 369 covers 11,600 kids for less than $600 per child per year in state general funds.

- Expands Medicaid coverage for children with family incomes up to 200% of the Federal Poverty Level (annual income of $33,340 for a family of three). This will allow the state to take advantage of new federal Child Health Insurance Program (CHIP) funding appropriated to states for health care coverage for uninsured children.

- A Medicaid CHIP expansion allows Alaska to maximize federal funding available for Alaskan Native children served by native health care facilities.

- A $7.2 million general fund investment yields an additional $18 million federal funds for health care benefits.

- Adding 800 pregnant women to the Medicaid assures that Alaska's children receive a healthy start through early access to prenatal care.

- Medicaid benefit package is good for children because it includes well child services and immunizations. Comparable private insurance package costs more.

- Forty-one states exceed Alaska's coverage for pregnant women and children.

- Health coverage helps families become more self-sufficient.

CHILD HEALTH INSURANCE PROGRAM (CHIP)

- **WHO IS ELIGIBLE:** children under age 19, ineligible for Medicaid, not covered by health insurance, whose family income does not exceed 200% of the federal poverty level, not an inmate in a public institution, or dependent of a family member with benefits from public agency employment. Children with a pre-existing condition cannot be excluded; Alaskan Native children must be included. Any child applicant eligible for Medicaid must be enrolled in Medicaid.

- **BENEFITS:** State option: provide health insurance, expand Medicaid, or a combination of both.

- *Health Insurance* coverage must be equivalent to one of the following plans: the standard Blue Cross PPO plan for federal employees, the state employee plan, or an HMO plan; or a different benefit package that includes basic services that has an aggregate actuarial equivalent to one of the latter specified plans.

- *Medicaid Coverage* includes: the state has income and asset rules no more restrictive than those in place on June 1, 1997, a state can choose to expand coverage immediately for children born after October 1, 1983, and a state can allow 12 month continuous eligibility of children.

- **FUNDING:** $24 billion has been appropriated for 5 years of the program; Alaska's allotment for Federal Fiscal Year 1998 is $5,664,899. Enhanced Federal Medical Assistance Percentage (FMAP) expenditures can be used for health insurance, outreach activities, and administration. The FMAP for Alaska is 71.86%.

- Funds will remain available for three years as long as a state has an approved CHIP state plan in place; the Secretary will give unspent funds to other states who have spent their allotment. A plan must be approved by September 30, 1998 in order to retain the FFY 98 allotment; states are to submit plans by June 1, 1998 in order to allow sufficient time for approval.

- Administration of the plan is limited to 10% of expenditures, and include outreach, data collection, performance measurement and the required annual assessment.

- **CHIP STATE PLAN:** include a description of children with health coverage, state efforts to provide health coverage, how the plan will coordinate with efforts to increase coverage of children with health insurance, methods of delivery, utilization control, eligibility criteria, outreach activities, and methods of assuring appropriate care and access.

- **COST SHARING:** for families below 150% of the FPL, enrollment fee, premium or similar charge must be related to income, and deductible and cost sharing cannot exceed a "nominal" amount. For families with higher income, cost sharing can be imposed on a sliding scale fee but may not exceed 5% of the family's annual income. If child health services are provided through Medicaid, cost sharing is not allowed because of Medicaid rules.

Summary

Meeting Between Knowles Administration Representatives and Health Insurers Regarding the Children's Health Insurance Program

February 13, 1998
Anchorage

State/HCFA Participants: *Commissioner Karen Perdue, Jeff Bush, Alison Elgee, Bob Labbe, Marianne Burke, Nancy Cornwell.*

Industry Participants: *Mike Wiggins, NYLCare; Jeffrey Davis, Blue Cross/Blue Shield of Alaska, Cleo O'Rourke, (Great West) One Health Plan of Washington, Inc.; Patrick Carmody, Mutual of Omaha.*

State Children's Health Insurance Program (S-CHIP): Legal Guidelines and Requirements. *Elizabeth Trias, CHIP Coordinator, Region 10, Health Care Financing Administration explained the federal requirements and options available to the State of Alaska. Bob Labbe, Director, Alaska Division of Medical Assistance briefly reviewed the State's cost under a Medicaid CHIP program.*

Trends in Employer-Financed Health Coverage. *Nancy Cornwell, Alaska Division of Medical Assistance, briefly reviewed some national data which show a significant decline in employer-financed dependent coverage, particularly for low-income workers. Each of the insurers present explained their companies have experienced a significant decline in the financial contributions made by employers for dependent coverage.*

General Conclusions. *The following general conclusions were made related to the families expected to be covered under the Governor's Smart Start (Medicaid) coverage expansion.*

These families are poor or very low income. They live on tight budgets, and health care coverage is not their highest priority unless they have a child with high health care needs, for example, a chronically ill or disabled child. It is reasonable to assume that given the demands on their budgets for food, housing, clothing, child care, and other basic needs, that their ability to pay their portion of a health premium in an employer-supported benefit program is very limited (assuming their employer makes a plan available to them at all). With the understanding that most employers are increasingly requiring their employees to contribute a portion of their premium and other cost-sharing, particularly for dependents, it is reasonable to assume that these poor and low-income employees are MOST likely to participate in an employer-sponsored program for

their dependents when they a child with have high health care needs. In contrast, parents with healthy children are less likely to make the budget sacrifices on an ongoing basis if their child has no few health care needs.

If these poor and low-income families do not have access to an employer-sponsored benefit plan, and they are purchasing an individual plan for their child in Alaska's insurance market, they have a limited number of insurers to choose from. By far the largest, Blue Cross of Washington and Alaska, offers their Traditional Program (under 30, non-smoker) for the annual premium ($1,560) and ($200) deductible cost to a family for the for one child is $1,760. Again, given the tight budgets that these families exist on, it is reasonable to assume that most families at these income levels do not purchase individual policies for their children unless they are high health care needs.

Families at these income levels often have few assets so they are less concerned than higher income families about losing their assets as a result of a catastrophic health prob'em and the accompanying medical bills.

For families in these income levels, a parent may decide to take a particular job solely because the employer covers most or all of the cost for dependent coverage. If the employee's motivation is access to employer-financed dependent coverage, it should be anticipated that the parent's decision to stay with the employer will be driven by their child's health care problems and that they are prepared to wait through the pre-existing exclusion period in order to get their child's health care bills covered.

For the reasons stated above, the insurers who attended this meeting agreed that the poor and low-income Alaskan children who are expected to be eligible under the Governor's coverage expansion are not attractive as potential subscribers.

Future Meeting. *Marianne Burke, Director, Division of Insurance, reminded the group that these insurers would be in Alaska in late summer for unrelated meetings and that would be a good opportunity to reconvene the participants of this meeting.*

WHY MEDICAID

Leverage more federal funds because Alaska Native children served by IHS are reimbursed at 100% federal. Of the 11,600 children to cover, 4,500 are Native.

Medicaid Benefit package is good one for children because it includes well child services and immunizations. Comparable private insurance package costs more.

Medicaid administrative structure in place. Can use existing payment system, and network of Medicaid providers.

CHILDREN'S HEALTH CARE:
Why Choose Medicaid
Instead of a Separate Health Insurance Program?

Under the State Child Health Insurance Program (SCHIP) federal law, states have the option to use their allotment to cover uninsured children *either* through their Medicaid program or through a child health insurance program, or a combination of both.

- If a state chooses the Medicaid option, Medicaid rules apply and a state must offer the Medicaid benefit package. If a state chooses a child health insurance program, it must offer a benefit package actuarially-equivalent to either the state's employee health plan, the federal employee health plan, or the largest HMO in the state[1].

For any state, the best option is dependent on many factors and the decision should be based on the following criteria:

- minimizing state general fund costs and maximizing the number of children covered,
- the cost and ease of administrating the program, and
- providing a benefit package that is most appropriate for children.

The Cost and Number of Children Covered

Using Alaska's SCHIP allotment to extend Medicaid coverage will stretch the State's general funds further and cover many more children.

- Between 25 and 40 percent of the SCHIP eligible children will be Alaska Native and by law must be included in any SCHIP plan. Under a Medicaid expansion for SCHIP, services provided to Alaska Native children by I.H.S. or tribal providers will be paid with 100 percent federal funds *outside the State's SCHIP allotment*. Under a separate insurance program, costs for Alaska Native children will come out of the state allotment at a 72 percent federal match. A Medicaid SCHIP expansion takes advantage of the special funding for Alaska Natives.

- Based on preliminary information gathered by the Division of Medical Assistance[2], comparable private health plans appear to be more costly than the average cost for a Medicaid child. The division compared the per child cost for a Medicaid expansion estimated at $1,908, to what the Medicaid benefit package would cost in the current private market. These preliminary estimates suggest that the comparable (Medicaid) package in the current private market would cost at least $400 more per year than the average cost for a Medicaid child.

- The Governor's Smart Start proposal to invest $7.2 million in general funds will cover 11,600 uninsured children and 800 pregnant women. Under a separate insurance program, only an estimated 6,600 to 8,000 children (and no pregnant women) would be covered with same general fund investment.

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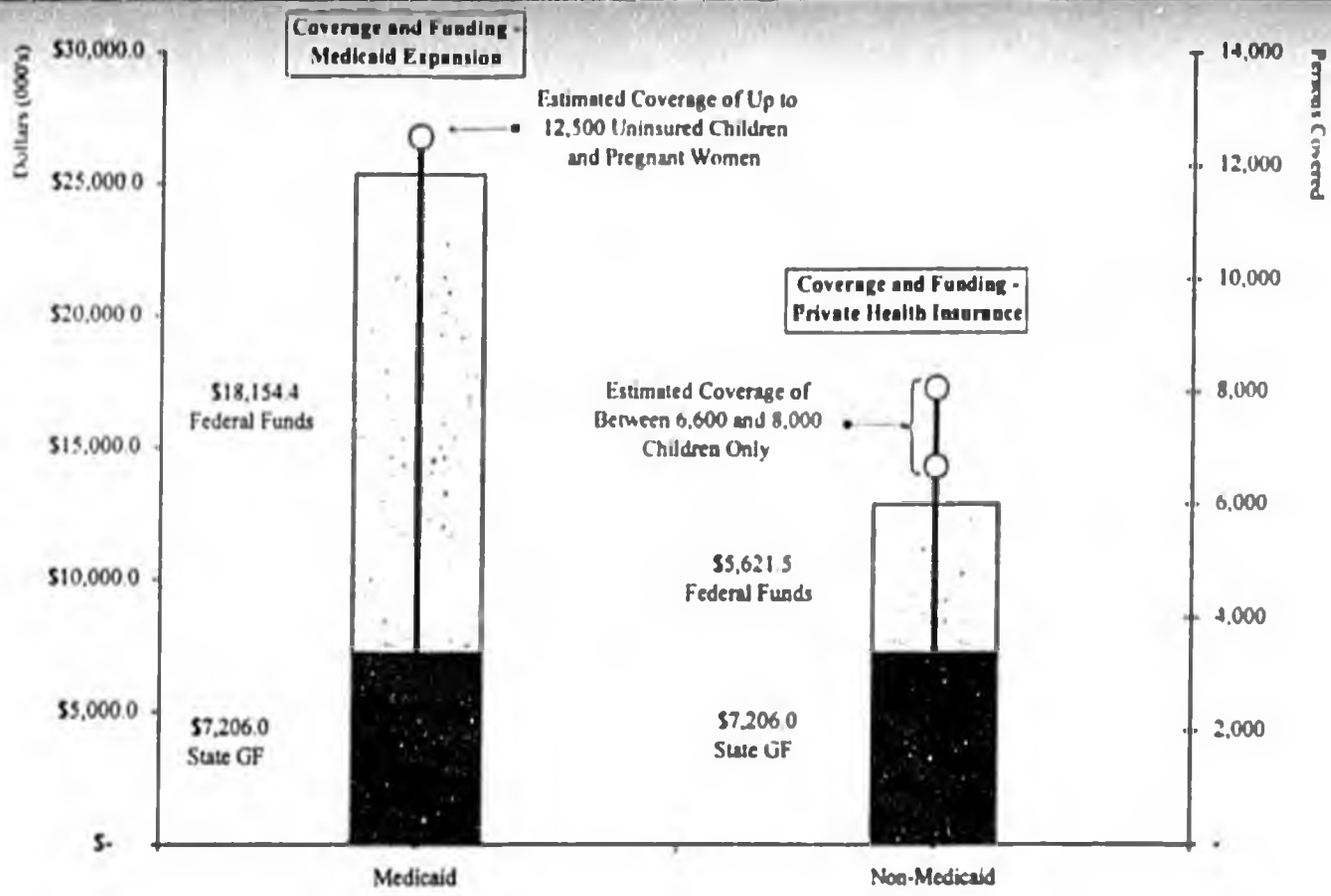
[1] The HMO option is not currently applicable since there are no HMOs licensed to sell health plans in Alaska.

[2] The Division of Medical Assistance continues to seek information from insurers on private insurance options but to date, have not received any information that suggests that less costly options exist in Alaska's private market.



The Cost and Ease of Administering the Program

Extending Medicaid, as compared to creating a child health insurance program, minimizes new administrative and cost management functions.

- Implementation of a new child health insurance program would require duplication of many administrative components which already exist in the Medicaid program. A further consideration is that start-up costs cannot be funded with SCHIP funds as administrative costs are limited to 10 percent of *actual* expenditures on children.

- As a condition of receipt of federal funds, each child who applies for SCHIP must be screened by the State for Medicaid eligibility. Therefore, eligibility determination in a child health insurance program is still linked to the Medicaid program.

- Most health care providers are already enrolled and familiar with the Medicaid program.

- Extending Medicaid to additional children can be readily implemented[3].

An Appropriate Benefit Package for Children

[3] A Medicaid expansion could be implemented within 2-3 months after passage of the enabling legislation. The federal child health initiative funding was available as of October 1, 1997.

The Medicaid benefit package provides an appropriate benefit package for children including preventive services such as well-child exams and immunizations which are *not* covered by most private insurance plans.

- The preventive health services offered under Medicaid make this approach a better fit in addressing issues in Alaska like our declining child immunization levels.

- The benefit package for either Medicaid or a child health insurance program is stipulated in federal law, therefore, reducing services in the benefit package as an approach to lowering premium costs is largely precluded.

Conclusion

Given the data available to the Alaska Department of Health and Social Services at this time, extending Medicaid to uninsured low-income children represents the best financial and least burdensome approach to providing health coverage. The department is continuing to seek additional information and cost estimates by meeting with private insurers and health care providers and securing the analysis and consultation of national experts.

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

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MEMORANDUM

DATE: February 23, 1998

TO: Karen Perdue, Commissioner
Department of Health and Social Services

FROM: Bob Labbe, Director
Division of Medical Assistance

SUBJECT: Crowd-out

Attached is a memorandum from Deborah Chollet of the Alpha Center in which she provides an assessment of issues related to "crowd-out." She defines crowd-out as the "reduction in private effort to purchase private health insurance because of eligibility for public program coverage." I've summarized the key points:

- Only a few studies of crowd-out have been done and the results are inclusive.
- Estimates of crowd-out are greater when the program enrolls higher income adults than when it enrolls only children.
- Few people who would qualify for public insurance have access to affordable private coverage.
- States that have already expanded public coverage to low and middle income children (below 200%FPL) have not found crowd-out to be a problem. They believe:
    - Lower income workers typically have either steady but low wage jobs, or are periodically unemployed due to lay off or seasonal work; and that
    - These workers generally do not have ongoing access to employer based coverage.
- To prevent crowd-out some states have limited eligibility for public health insurance to those who don't have insurance.

Conclusion

Ms. Chollet's assessment supports our conclusion that crowd-out will not be a significant issue when we expand Medicaid coverage as the Governor has proposed in **Smart Start.**

Attachment

ALPHA CENTER

MEMORANDUM

TO: Bob Labbe, Director
Division of Medical Assistance
Department of Health and Social Services, State of Alaska

FROM: Deborah Chollet, Ph.D.
Vice President

SUBJECT: Issue of crowd-out

DATE: February 10, 1998

This memorandum responds to your request for a summary of the issue of crowd-out in public insurance programs. It addresses four aspects of the issue:

- What is crowd-out?
- How big is the problem of crowd-out?
- State program features to deter crowd-out; and
- State programs to buy employer-based coverage as one way potentially to mitigate crowd-out.

As you are aware, in states that are considering extending public health insurance eligibility to children and adults with income above poverty, concern about the potential for crowd-out has grown. Most recently, this concern underlies the federal requirement that states explicitly propose how children's health insurance programs will deter crowd-out in order to qualify for federal funds under Title XXI.

What is crowd-out?

Crowd-out is defined as a reduction in private effort to purchase private health insurance because of eligibility for public program coverage. In theory, crowd-out can result from any of four types of reduced effort:

(1) individuals may stop buying nongroup (individual) health insurance for themselves or their dependents, when it is available and affordable to them;

(2) individuals may stop making required contributions to employer-sponsored insurance for themselves or their dependents, when group insurance is available and affordable to them;

(3) employers may increase the level of employee contributions that they require, presuming that lower-wage employees have access to public coverage or subsidies; or

(4) employers may terminate the group health insurance plan altogether or some employees' eligibility for the group plan, presuming both that lower-wage employees have access to public coverage and that higher-wage employees can buy individual private health insurance.

Most states' concerns about crowd-out focus on the potential for workers or their employers to substitute public coverage for employer-group coverage (issues 2 through 4, above). In general, policy makers are less concerned about the possibility that individuals would substitute public coverage for individual insurance because few people who would qualify for public insurance would find individual insurance affordable. In some states, as public program eligibility begins to reach middle-income families without group coverage, concern about public programs crowding out individual insurance purchase may grow.

How big is the problem of crowd-out?

The research literature measuring the magnitude of crowd-out is thin and offers conflicting estimates of how great crowd-out might be when more people are made eligible for public insurance programs. Estimates of crowd-out range from quite large (in one study, researchers estimated that as many as 50 percent of new Medicaid enrollees would otherwise have been privately insured) to zero. In considering the usefulness of this literature to public policy makers, two aspects are of particular importance:

(1) The differences among estimates appear (in part) to be driven by the population subgroup being studied. Estimates of crowd-out are greater when

the program enrolls adults at higher income levels than when it enrolls only children or families with lower levels of income.

(2) The reliability of the estimates is unknown. None of the available estimates is based on actual observation of employer or individual behavior. Instead, all of the research to date compares population groups that are broadly similar (for example, women with similar annual income, age, employment and education levels) over time. None of these studies control for whether workers who enroll in public insurance programs have access to affordable employer-sponsored insurance.

Because these studies are inconclusive, public policy makers must base their decisions about whether a specific proposal would cause crowd-out on an appraisal of whether private health insurance is available, affordable and stable for most people who would become eligible for public coverage. No research to date is adequate to inform public policy makers about whether or how employers might adjust group health benefits in response to wider eligibility for public programs.

State program measures to deter crowd-out

In a recent monograph prepared for the Robert Wood Johnson Foundation's *State Initiatives in Health Care Reform* Program (attached), we reviewed sixteen states' public insurance programs, including:

- public programs for children,
- public programs that enroll adults and children, and
- Medicaid programs that have expanded eligibility under Section 1115 waivers.

In states that had expanded public health insurance not just to people in poverty but also to people with incomes as high as 200 percent of poverty or more, officials had differing views about the relative importance of crowd-out as an issue for the programs. In states that had developed programs only for low- or middle-income children or that had extended program eligibility to only the near-poor population (under 185 percent of poverty), officials were unconcerned about crowd-out. In these states, officials presume

that people with such low income have few or no options for finding group insurance. In families with such low income, workers typically are either (1) steadily employed, but at very low wages; or (2) periodically unemployed due to lay-offs or seasonal work opportunities. In either case, few of these workers are likely to have ongoing access to employer-based coverage.

Insurance programs that target populations up to 400 percent of poverty generally devote more attention to crowd-out than programs that cap eligibility at 200 percent of poverty or less, especially when they enroll adults as well as children. In states with programs that enroll low-income adults or that extend eligibility to middle-income populations, the potential for crowd-out is believed to be greater, and these programs are designed with various features to deter crowd-out. These features are of two major types:

(1) *Measures designed primarily to address other program issues but which also discourage crowd-out.* These include:

- program limits on enrollee assets and age, as well as income;
- requiring enrollees to pay premiums; and
- limited program benefits (for example, no coverage for hospitalizations).

These measures typically are imposed to address public funding constraints, not because the program is particularly concerned about crowd-out. However, they deter crowd-out *de facto* by targeting public programs to families and individuals who are less likely to have private insurance options.

(2) *Measures designed explicitly to address crowd-out.* These include:

- requirements that applicants be uninsured or underinsured;
- requirements that applicants be without insurance for some minimum spell; and
- requirements that applicants have no access to employer-based insurance.

Restrictions intended explicitly to deter crowd-out may seem necessary from the viewpoint of protecting the resources of public programs, but they can cause serious problems of equity and efficiency. Waiting periods, in particular, cause problems of equity because not all uninsured families with the same financial resources qualify for public coverage (some must wait), and because families that have made an effort to find and buy insurance must wait longer for public coverage than families that never tried. Problems of efficiency arise because families are forced to weather gaps in coverage to qualify for the public program. Gaps in coverage are a problem that the program ideally would solve, not require.

In addition, for all programs that require minimum spells without coverage or ineligibility for private coverage, enforcement is a problem. Verifying applicants' declarations that they are uninsured or underinsured is time-consuming and costly. Among the states that we reviewed, state-only children's programs were especially reluctant to invest resources to verify applicant declarations. Most state-only programs that include adults had found that verifying all applicant declarations was too costly to implement or to continue. In general, Medicaid expansion programs were the most likely to attempt to verify minimum spells without access to employer-based coverage. However, even these programs more often rely on partial and/or random audits to enforce restrictions than on systematic verification of applicant declarations.

With respect to their proposed Title XXI programs, two states -- California and Colorado -- have adjusted their use of waiting periods in an effort to minimize the equity and efficiency problems that they entail.

- California proposed a 3-month waiting period for any child who had been covered by an employer-sponsored plan. Children who had been covered in the nongroup (individual) market are not subject to the waiting period, nor are children of parents who lose coverage involuntarily (through job loss of termination of the group plan).

- Colorado also proposed a 3-month waiting period for children who were covered by an employer-sponsored plan, but (as in Minnesota's MinnesotaCare program) only if the employer pays at least 50 percent of the premium for dependents. As in California, the waiting period does not apply if prior coverage was nongroup, or if the parent loses coverage involuntarily.

Like research studies that attempt to measure crowd-out from available national data, studies that have attempted to evaluate the effectiveness of restrictions to reduce crowd-out are compromised by the quality of available information. However, evaluation studies conducted in a number of states with varying programs and restrictions on eligibility all have indicated that the potential crowd-out caused by the programs is small. Most program officials and policymakers also believe that their programs reach target populations with reasonable efficiency and that crowd-out is not a serious problem.

State programs to buy employer-based coverage

We identified two states (New York and Oregon) that have programs to assist employees in purchasing employer coverage when it is available. In principle, such programs would discourage crowd-out by maximizing available employer-based coverage. However, crowd-out still can occur if employers respond to available public contributions for coverage over time by reducing employer payments for coverage (substituting public funding for employer funding). In addition, a premium subsidy program may have trouble constraining its budget if the program becomes liable for any level of premium cost that the employer does not pay.

New York's program, an older pilot program to insure adults, is exclusively an employer-premium subsidy program for workers who (1) have access to employer coverage, and (2) have family income less than 200 percent of poverty. The program limited its total cost by closing new enrollment, and at this time, no new enrollment is contemplated. Because the program was experimental and ultimately enrolled very few workers, it is unlikely that crowd-out was ever a significant problem.

Oregon's new Family Health Insurance Assistance Program (FHIAP) is designed to enroll workers and dependents who (1) have income less than 200 percent of poverty, and (2) are without insurance for 12 months. The program screens applicants for available employer coverage. FHIAP will pay the applicant's employee contribution to enroll in the employer plan if it costs less than the average cost of FHIAP coverage. FHIAP is a new program, and at this writing, has processed few if any applicants pending the design of Oregon's Title XXI program for children. FHIAP's restrictions on income for eligibility and its 12-month waiting period both suggest that crowd-out will not be a significant problem. However, FHIAP's design suggests equity problems (families that succeed in finding or buying health insurance cannot qualify as soon as families that never try). In addition, over time, FHIAP may pay employee premiums for fewer and fewer applicants if FHIAP is able to control its costs more successfully than employers do.

I hope that this information is useful to you. Please do not hesitate to call on me or on other Alpha Center staff if we might be of further assistance to you in considering this issue.

Attachment: *Deterring Crowd-out in Public Insurance Programs: State Policies and Experience* (Alpha Center, October 1997).

cc: Nancy Barrand, Robert Wood Johnson Foundation, *State Initiatives in Health Care Reform* Program
W. David Helms, Ph.D.
Anne Gauthier

NATIONAL ASSOCIATION OF SOCIAL WORKERS
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Testimony Regarding

HB 369 - MEDICAID COVERAGE/HEALTHY FAMILIES ALASKA PROGRAM

Before the
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
ALASKA HOUSE OF REPRESENTATIVES
April 7, 1998

Presented by
Angela M. Salerno, ACSW
Executive Director,
National Association of Social Workers Alaska Chapter

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

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The National Association of Social Workers (NASW) is the world's largest organization of professional social workers. NASW's 155,000 members nationwide and 500 in Alaska work in a wide range of settings at all levels in the public and private sectors. Professional social workers focus on vulnerable populations and promote state and federal policies which enhance the lives of the people we serve.

NASW strongly supports HB 369 and urges its passage.

- Advocates for young children are unified by the common core of knowledge that children require special attention to begin the developmental process in an optimal fashion. HB 369 will expand Medicaid coverage to poor children and pregnant women with family income of up to 200 percent of the federal poverty level. Under the proposed new eligibility guidelines, a family of four with an income of roughly $40,000 a year would be covered. If passed, the bill will ensure that 11,000 poor children will have the benefit of preventative health care, and 800 more poor women will receive crucial pre-natal care.

- Studies have shown that without health insurance, children are six times more likely to go without needed medical care; five times more likely to use the hospital emergency room as a regular source of care and four times more likely to have necessary care delayed. Uninsured women often receive inadequate prenatal care and deliver low-birth weight babies who require special care.

- Currently, 41 states provide better Medicaid coverage than Alaska. By expanding Medicaid eligibility, the state of Alaska could provide a child with health coverage for just $562 per year in general funds. Existing cost management tools such as utilization review and prior authorization as well as case management provided by Primary Care Practitioners will be extended to manage the cost of this program.

- As more families move from welfare to work, it is appropriate to assist them in becoming self-sufficient by making affordable health care coverage available to their children. Many lower wage jobs in Alaska do not offer health benefits. Coverage under this initiative will allow families receiving public assistance to take jobs and still provide health security to their children.

- HB 369 will institutionalize in law the Healthy Families Program in Alaska. Research over the last two decades has consistently confirmed that providing education and support services to parents around the time of a baby's birth--and continuing for months or years afterwards--significantly reduces the risk of child abuse and contributes to positive, healthy, child-rearing practices. Families receiving this type of intensive home visitor service also show other positive changes such as consistent use of preventive health services, increased high school completion rates (for teen parents), higher employment rates, lower welfare use, and fewer pregnancies. Child abuse prevention programs save money. For every $3 spent on prevention, we save at least $6 that might have been spent on child welfare services, special education services, medical care, foster care, counseling, and housing juvenile offenders.

Thank you for the opportunity to provide testimony on this matter.

NAMI Alaska – Children's Committee

We care about children with mental disorders

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March 1, 1998

Honorable Con Bunde, Chair
Health, Education & Social Services
House of Representatives, State Capitol
Juneau, AK 99801-1182

Dear Representative Bunde:

We strongly support the Governor's *Smart Start* program and urge that it be fully funded as proposed. This new federal funding gives Alaska the opportunity to catch up to the more modern and cost effective programs that have been proven in other parts of the nation.

The following comments are in support of the *Smart Start* program, but we also recommend policy changes that would cost little, if anything, while making programs more responsive and cost-effective.

1. The Children's Health Insurance program should use Medicaid to provide insurance coverage.

Medicaid provides the broad coverage of services needed for prevention and early intervention programs, the administrative structure is in place to reduce overhead costs, and it provides a more uniform way to provide coverage for public programs.

The expansion of the Medicaid program to at least 200 percent of the federal poverty level would allow leveraging of federal funds with 100 percent federal pass-through for Alaska Native children.

We note that a number of states are providing coverage to pregnant women and children through age 19 at 300 percent of the federal poverty levels, which further leverages the federal funding. By making more children eligible, these states are able to develop more assertive prevention and early intervention programs — which have proven very cost-effective. Alaska should join the rest of the nation in using the "best practices" recommendations of the national multidisciplinary research.

Should the legislature select an alternative other than Medicaid, please be sure that it provides coverage to at least as many children and with as broad a coverage of services as Medicaid.

Other comments on the legislation pertaining to Medicaid:

a. We note that the proposed legislation still uses the term "*severely* emotionally disturbed," while the Center for Mental Health Services (CMHS) regulations use "*seriously* emotionally disturbed." Since the federal regulations require the state mental health agencies to report statistics based on the CMHS regulations, it would help everyone if Alaska's Medicaid law used the CMHS term and definition.
b. We did not note in the proposed legislation any mention of "presumptive eligibility," which can greatly expedite services for children. We understand that this has been authorized in the past for pregnant women, but can now be authorized for all children. If not already done, please authorize the Department to grant authority to Medicaid providers to make presumptive eligibility determinations.

2. We strongly support the expansion of the *Healthy Families Alaska, Infant Learning,* and the *Head Start* programs. However, it is time that these complimentary programs were merged into one program for the whole child.

The *Healthy Families* type of program was piloted in the early 1980s with good results in reducing low-birth weight babies, increasing immunizations, and reducing abuse and neglect (all are risk factors for both mental and physical disorders). The *Healthy Family Hawaii* program reports that among enrollees they have increased immunization rates to 90 percent and reduced the child-abuse recidivism rates to 3.3 percent. They also offer mental and physical health screenings.

The *Head Start* program has been active since the 1960s, and reports excellent cost-benefit ratios. In 1995 Congress authorized expansion of this program to include in-home services for low-income families from pregnancy to three years of age while retaining the in-home and center-based services for three-to-five year olds. The research demonstrates that the zero-to-three program permanently increases the IQ levels of at-risk children to the normal range by the time they enter school, while control groups of children, who did not receive services, remain in the lower 20 percentile. This program lowers future special-education costs and is a part of "school readiness" programs. The program also offers screenings for mental and physical disorders.

The *Infant Learning* program in Alaska provides help for infants that have a developmental delay. In Alaska, infants at-risk of developing a mental disorder have not been offered help, although research has demonstrated that many children, whose brains have not fully developed due to perinatal injury, can be significantly helped with special stimulation in the first three years of life. Boston Pediatric Hospital had the grant for crack babies, and was able to take "throw away" babies that had large areas of the brain that had not fully developed and help them to the extent that they reported to Congress that 85 percent would lead normal lives. I understand that some areas are now making the *Infant Learning* program mandatory for infants at-risk because of such risk factors as very low-birth weight, the mother had flu or other illness during the second trimester of pregnancy, multiple births or other potential causes of anoxia, and AB/O and Rh factor blood disorders.

As valuable as these programs are, by themselves they promote agencies that provide fragments of needed services with no one having a responsibility for the whole child and their family. Because they are run by agencies that are small businesses, the agencies becomes dedicated to developing and defending their program and budgets, rather than to meeting the needs of the child and family. They are "program oriented" rather than "child and family oriented." The orientation needs to be changed so that the agency is evaluated on the beneficial outcomes that they achieve for children.

Recently over 100 national advocacy, professional organizations, and businesses joined forces for the *I AM Your Child* program. Information about this program is available on Internet at <www.iamyourchild.org>. This program is for the *whole baby* from prenatal care to age three, although they mention preconception care.

In Alaska we urge that the program be from preconception care to age three. Preconception care is an important step in reducing the risks for spina bifida, alcohol related neurological disorders, schizophrenia, depression and other physical and mental disorders. While a public education program may be all that the agency does, public education is needed in Alaska. Schools in Alaska do not have structured health education classes from K through 12 (as recommended by the Institute of Medicine), hence, we are raising generations that do not have the knowledge to make healthy choices. An effort needs to be made to compensate for this.

On April 30, 1998, the *I AM Your Child Campaign*, the National Governors' Association, the Committee for Economic Development and Kaiser Permanente are sponsoring a Leadership Summit in New York to explore how corporations and state governments can promote early childhood development. Over 100 national advocacy and professional organizations endorse this program. Alaska should be a participant.

While it may be too late for this legislature to implement the *I Am Your Child Campaign*, it can expand funding for the existing programs as proposed by the Governor.

and give direction to the Governor to merge programs and join in the nationwide program for early childhood development. The local agency responsible for the merged programs should be given the responsibility for the needs of the child and family, so that they are child and family oriented.

We also note that the US Department of Education has been talking about school readiness programs and the Center for Mental Health Services recently approved a number of demonstration grants for Zero-to-Seven programs. Alaska needs to take advantage of the funding streams from all sources and merge them into programs that best serve the whole child and their families.

We also note that the American Academy of Child and Adolescent Psychiatry recently published guidelines for the diagnosis of psychiatric disorders in infants and toddlers. Hence, the tools are available to significantly help children and reduce future costs, but the state needs to tie the delivery of services into an integrated system.

The Legislature should require the Department to develop these programs in a manner that makes optimum use of all public and private human and economic resources. Alaska should use its resources to leverage the development of local skills and services for the benefit of all residents.

3. Managed-care for children needs to be based on a series of successful demonstration programs.

Managed care has been expanding rapidly and under a variety of models. *NAMI Alaska* has endorsed the principles that the Department of Health and Social Services announced for their model children's managed-care demonstration program for seriously emotionally disturbed children. The Center for Mental Health Services has also published principles developed by the national Federation of Families for Children's Mental Health and the national office of NAMI has published their principles. All of these principles ought to be merged for use in Alaska. The family advocacy groups and professional societies should be involved in developing the final set of principles for Alaska.

We would urge that the demonstration programs in Alaska be based on whole-child concepts that manage all public programs for physical and mental health and social services for the good of the child and their family — not just for children who have deteriorated to a seriously emotionally disturbed level. Early identification and treatment is cost-effective.

The Department's proposal for an independent, locally-controlled, non-profit managed-care agency still looks like the best proposal to-date, if it is expanded to include all publicly funded health and social services. If we had such an agency, it would also be possible to plan for the optimum use of all public and private human and economic resources. In this way the community could develop more private providers, rather than sticking with the monopolies that the current practices promote.

The Alaska demonstration programs should be based on the "best practices" recommendations from the 29 existing national demonstration programs.

4. The Legislature should give direction to the Department of Education to implement an early identification program from age three to twenty-two for mental disorders.

According to the material from the Governor's Council, IDEA requires schools to identify all children with physical and mental disabilities. Yet, according to the University of Alaska Fairbanks' survey of schools, only one child in 34 who had a mental disorder actually was identified and receiving services.

From a humanitarian standpoint early identification and treatment can significantly reduce chronic disabilities and allow more children to develop to their full intellectual capabilities. Besides these humanitarian considerations, the schools are creating a huge legal liability by allowing children to develop disabilities unnecessarily.

For example, a recent study of schizophrenia, one of the most devastating and costly disorders, found that 87 percent of the people with this disorder fully recovered if they were treated with the new atypical anti-psychotics within six months of on-set. Without early treatment 70 percent will deteriorate to the point that they will need life-long support.

Bipolar disorders are another devastating and costly disorder. This disorder has a "kindling effect" with one episode creating physical changes in the brain that make another episode more likely. Studies of grade school children with AD/HD found a prevalence rate of about 5 percent, but 24 percent of these children also have, or will soon develop, a bipolar disorder. Currently most of these victims of bipolar disorder don't receive treatment until they have developed substantial life-long disabilities.

To help with the early identification and treatment programs, the members if the American Academy of Child and Adolescent Psychiatry have developed screening tools for age 3 to 6, 6 to 12, and 12 to 18. These tools use forms for both the teacher and parents to complete, and they have been tested so they are reliable. Teachers and parents are the ones who observe the child over long periods of time and under a variety of circumstances. The Child Find programs are important, but they alone cannot meet the need.

Once the child has been identified they need to be referred to mental health professionals who are trained in the diagnosis and treatment of childhood mental disorders. While this may start with the family physician, the recommended "best practices" from the American Academy of Pediatrics' *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*, 1996, is to refer children with emotional or behavioral problems to professional trained in childhood mental disorders.

Hence, new tools have been made available to help with early identification and treatment programs, and with the increased Medicaid funding they are even more practical.

5. The Legislature should give direction to the Department of Health and Social Services to become involved in the national programs to improve cost-effective services for children.

Since 1984 the "devolution revolution" has given the states unprecedented opportunities to use innovative approaches to providing services. Many states are shifting money from caring for people after they become disabled or in trouble with the law into risk reduction programs. Where prevention and early intervention programs have been used, they are producing excellent results.

The Center for Mental Health Services funds 29 demonstration programs in 12 states into managed care alone. They require outcome evaluations that provide valuable insights into what works and what does not. Unfortunately, Alaska has not participated in these programs, nor does it use the recommendations. Hence, Alaska is repeating costly errors unnecessarily.

Additionally, three universities, Georgetown, South Florida, and Portland State, are funded to do services research to improve cost-effective services for children. Alaska ought to be developing best practices based on their findings.

Most of Alaska's problems are within the authority of the state to solve. But Alaska has fallen behind the more progressive states and it shows up in the rates of suicide, substance abuse, school drop outs, child abuse and neglect, and rates of disability from mental disorders.

6. The Legislature should give strong direction to the University of Alaska, Anchorage to develop an epidemiological and services research program using the funds available from the National Institutes of Health.

Ten years ago the Legislature gave seed money to the university to start such a program, but the money was used for other purposes. I was told that the university did not have personnel with adequate credentials to do national level research.

Over the past ten years we have made numerous unsuccessful attempts to get a research program underway in Alaska. We have even participated in teleconferences with the University of Washington and state DHSS personnel. The University of Washington is Alaska's federally designated regional university research center. As such, they say they would provide trained personnel to design and conduct the needed research, if someone in Alaska would request their services and provide logistical support.

The National Institute of Mental Health list the available research grants on Internet and some specifically mention Alaska Natives. Their priority populations are children, rural

residents, Alaska Natives, and people with AIDS and tuberculoses. They also say that there is enough continuing money available to fund one person in Alaska to head up the research program even if the work is contracted to the University of Washington.

I have concluded that the University of Alaska is trying to build its own empire, at the expense of Alaska's residents.

Clearly the money and trained people are available to conduct modern epidemiological and services research in Alaska. Setting priorities for this research should involve the various boards and commissions and professional societies, and should not be left to the University's discretion.

It is time for the Legislature to give the University strong direction

In conclusion, we strongly support the Governor's proposal for the *Smart Start* program with the changes discussed above. A strong early-childhood program (preconception to three years of age) coupled with a strong early identification and treatment program from age 3 to 22 can greatly reduce the disabilities from mental disorders, and the associated rates of teen alcoholism, teen pregnancy, school drop out rates, and teens in the juvenile justice system. In the long-run these programs will pay big dividends in reduced costs to state programs for adults and provide a more productive society.

While all of the needed changes cannot be made this year, we urge that all of the new money be dedicated to children. Please enlarge the programs as recommended by the Governor, but give him the direction to use the national multidisciplinary research and grant programs to reform the programs in Alaska.

Sincerely,

Dick Wilson

Dick Wilson
Chair, Children's Committee

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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January 30, 1998

Honorable Con Bunde, Chairman
House Health, Education and
Social Services Committee
State Capitol Room 104
Juneau, AK 99801-1182

Dear Representative Bunde,

The Department of Health and Social Services respectfully requests a hearing in the House Health, Education and Social Services Committee on House Bill 369 "An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care case management and managed care services as optional services and to premiums an cost-sharing contributions under the Medicaid program; establishing the Healthy Families Alaska program; and providing for an effective date."

This bill was introduced by the Rules Committee at the request of the Governor. Fiscal notes were submitted at the time of introduction.

This bill will expand the availability of health coverage for eligible children and pregnant women in accordance with the recently passed federal child health care initiative. In addition, the bill will provide a statutory framework for the Healthy Families Alaska program.

The Department of Health and Social Services is prepared to provide the committee with a detailed presentation on the bill. Your favorable consideration of this request will be most appreciated.

Sincerely,

Elmer A. Lindstrom
Special Assistant to the Commissioner

cc: Bob Labbe, Director, Medical Assistance
Pat Pourchot, Office of the Governor

06-P38LH