HB

140

Alaska State Legislature

House of Representatives

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Representative Les Gara

House Bill 140: The No Child Left Uninsured Act
Sponsor Statement

Currently, nearly 18,000 Alaskan children have no health insurance (Urban Institute and Kaiser Commission on Medicaid). In addition, due to changes in 2003, 3,440 children have lost coverage under the state's low income children's health insurance plan, Denali Kid Care. House Bill 140 is an efficient, low cost way to reverse this decline. It seeks to extend health coverage to all Alaska children. We believe universal health coverage for children is long overdue.

Currently, Alaska offers Denali Kid Care medical and dental insurance to pregnant women and children of families that earn roughly 160 percent of the federal poverty level for Alaska. Only two states (North Dakota and Montana) have lower a eligibility level. Most states provide coverage under their Medicaid programs to families earning up to 200 percent of the federal poverty guideline.

HB 140 raises the eligibility level for Denali Kid Care to 200 percent of the federal poverty guideline. It extends optional coverage to children of families that earn between 200 and 350 percent of the federal poverty guideline by offering coverage at a sliding scale fee of between $200 and $1,200. Families that earn above 200 percent of the federal poverty guideline would have to certify that health insurance is not offered through their work.

Currently, the federal government contributes up to 70 percent of the cost of providing this health insurance to low income children and pregnant women.

It is believed that HB 140 would serve to make health insurance available to all families that cannot afford it. At present, coverage is provided to only very low income families. HB 140 extends coverage to working families that cannot afford private insurance on their own.

We hope you will support this effort, and ask that you contact with us with any questions.

E-mail: Representative_Les_Gara@legis.state.ak.us

Alaska State Legislature

House of Representatives

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Representative Les Gara

House Bill 140: The No Child Left Uninsured Act
Sectional Analysis

Section 1

Gives short title to the act "Leave No Child Uninsured Act"

Section 2

Deletes hard income limits to qualify for Denali Kid Care and increases the income limit to 200 percent of the federal poverty guideline (FPG) as defined by the United States Department of Health and Human Services for the state of Alaska for children aged under the age of 19 and for pregnant women.

Section 3

Adds new section (AS 47.07.022) creating extended healthcare coverage to those state residents who are under the age of 19, whose household income is between 200 and 350 percent of the FPG, and whose parent or guardian certifies the child cannot be covered under a health care policy at the parent or guardian's place of work.

Allows the department to create sliding scale contribution regulations and those regulations must: include the option of using a child's and parent's permanent fund dividend and a contribution between $200 and $1,200 per person for incomes between 201 and 350 of the FPG increasing progressively as incomes progress.

In addition to the sliding scale contribution, the department shall impose a co-payment of 20 percent for medical services and prescription drug costs for a person whose income is between 250 and 350 of the FPG.

Section 4

Requires the department to accept premiums or cost-sharing contributions from recipients of the extended medical coverage.

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Section 5

Repeals previous cost sharing requirements for Denali Kid Care.

Section 6

Giving the department the latitude to begin to adopt regulations to implement this Act, but the regulations may not take effect before the effective dates for secs. 1-5 of this Act.

Section 7

Giving sec. 6 an immediate effective date

Section 8

All other sections of this Act take effect July ., 2008.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-DBH2-03-14-07
Bill Version: SS HB 140
( ) Publish Date:
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):
Title MEDICAL ASSISTANCE ELIGIBILITY
RDU Behavioral Health
Component Behavioral Health Administration

Sponsor GARA
Requester HOUSE (HES)
Component No. 2665

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services		274.6	274.6	274.6	274.6	274.6
Travel						
Contractual		6.6				
Supplies		26.4	26.4	26.4	26.4	26.4
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**307.6**	**301.0**	**301.0**	**301.0**	**301.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		153.8	150.5	150.5	150.5	150.5
1003 GF Match		153.8	150.5	150.5	150.5	150.5
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**0.0**	**307.6**	**301.0**	**301.0**	**301.0**	**301.0**

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

POSITIONS

Full-time		3	3	3	3	3
Part-time						
Temporary						

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

SS HB140 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(Continued)

Prepared by: Stacey Toner, Acting Director
Phone 465-2817
Division Behavioral Health
Date/Time 03/09/2007
Approved by: Karleen Jackson, Commissioner
Date 03/14/2007
Agency Department of Health and Social Services

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

SS HB140 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201% and 350% of the prevailing FPG, and have no insurance.

This fiscal note represents the administrative costs for utilization review for youth who have been determined eligible for extended Medicaid coverage through Denali Kid Care and who are eligible for Behavioral Health Services.

Assumptions for Extended Medicaid Coverage:

We assume that 5,106 additional children will enroll in Medicaid if the SCHIP qualifying income level is increased up to 350% Federal Poverty Guidelines. Based on the current Behavioral Health proportion (or approximately 30% of the cost of SCHIP services) approximately 1,700 of these children will be eligible for extended Medicaid coverage through DKC and will utilize Behavioral Health services.

We estimate that this will increase workload for our Utilization Review Staff who facilitate wrap-around service delivery for children and adolescents at risk of institutionalization. We also anticipate it will result in increased requests for onsite Medicaid Documentation Reviews and Technical Assistance as our providers attempt to integrate more children and adolescents into their systems. We estimate 2.0 FTE (Health Facility Surveyor I, Range 18) and 1.0 FTE (Mental Health Clinician III, Range 21) positions will be needed to manage this additional work. A Health Facility Surveyor I in our Utilization Review office can manage a workload of up to 500 cases (one child per case) per month. The Mental Health Clinician III will perform utilization reviews as well as develop, oversee, and monitor FirstHealth Medicaid claims processing. Work duties of all positions include:

Medicaid program review and evaluation

- Management of Medicaid system operations and enhancement efforts
- Management of fiscal agent contract activities
- Development of program changes, operational processes, and system enhancement to implement revised regulations
- Coordination of program developments with stakeholders
- Insures compliance with state regulations and program guidelines
- Monitors services and utilization
- Development of a provider education plan
- Maintain an effective partnership with state and federal agencies
- Evaluation of the budget and development of recommendations for program changes to insure compliance with budget constraints
- Interpretation of state and federal regulations
- Analyze legislation and develop fiscal notes
- Support MMIS development and implementation efforts
- Support the RPTC demo project
- Support PERM and the Medicaid integrity program

(Continued)

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION
Total Adminstrative Costs:

With the additional caseload, a one time cost for computers and software will be required with a cost of $2,200 for each additional staff for a total of $6,600. Annual costs for office space, phones and supplies are calculated at a cost of $8,800 per additional staff for a total of $26,400.

For the personal services allocations of this fiscal note, the fund source calculations are derived by using standard 50% Federal /50% GF Match splits for existing positions.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-DBH1-03-14-07
Bill Version: SS HB 140
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: MEDICAL ASSISTANCE ELIGIBILITY
RDU: Behavioral Health
Component: Behavioral Hlth Medicaid Svcs

Sponsor: GARA
Requester: HOUSE (HES)
Component No.: 2660

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims		3,842.4	4,172.8	4,531.7	4,921.4	5,344.6
Miscellaneous						
TOTAL OPERATING	**0.0**	**3,842.4**	**4,172.8**	**4,531.7**	**4,921.4**	**5,344.6**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		2,017.6	2,113.5	2,265.8	2,460.7	2,672.3
1003 GF Match		1,824.8	2,059.3	2,265.9	2,460.7	2,672.3
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**0.0**	**3,842.4**	**4,172.8**	**4,531.7**	**4,921.4**	**5,344.6**

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

POSITIONS

Full-time						
Part-time						
Temporary						

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

SS HB140 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

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Prepared by: Janet Clarke
Phone 465-1630
Division: Finance and Management Services
Date/Time 03/12/2007
Approved by: Karleen Jackson, Commissioner
Date 03/14/2007
Agency: Department of Health and Social Services

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

We assume that 436 additional pregnant women will enroll if their qualifying income is revised to 200% FPG, based on the difference between the number of pregnant women with incomes above 150% FPG that were enrolled in 2003, before the current statute took effect, and the number enrolled in 2006. The number of children expected to enroll in Medicaid if the SCHIP qualifying income level is increased to 200% FPG is estimated as the number of SCHIP children with incomes above 150% FPG that dropped from the program between 2003 and 2006 (2,553 children). This corresponds to 2,553 children per 50 point increment in the percent of FPG (50 points is approximately the difference between the current effective 154% FPG income limit for this group and 200%).

For this analysis, the annual cost per enrollee per year (CPEPY) to reinstate SCHIP children up to 200% FPG is based on the current annual cost per enrollee ($1,387 in 2006) for uninsured children with qualifying incomes above 150% FPG. The CPEPY to reinstate DKC pregnant women up to 200% FPG is based on the current annual cost per enrollee pregnant women with incomes above 150% FPG ($2,915 in 2006). Medicaid costs are calculated as the number of persons enrolled times the CPEPY, inflated to 2009 dollars.

SS HB140 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201 and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between $200 and $1200 per year (sliding scale based on qualifying income). In this analysis, we use an average $700 annual premium for all enrollees above 200% FPG. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SS HB140 does not impose an annual deductible.

The Deficit Reduction Act (DRA) section 6041 stipulates that co-payments cannot exceed 20% of the cost of the service claimed. Annual out-of-pocket expenses for cost sharing and premiums cannot exceed 5% of family income. We estimate that children near the 250% FPG level will reach out-of-pocket limits when costs of services approach $7,000. Because, on average, the cost per enrollee per year is expected to be lower than the average out-of-pocket limit, the ceiling on cost sharing is not a factor in calculations for this fiscal note. On an individual basis however, some children will likely reach cost-sharing limits.3 children). This

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ANALYSIS CONTINUATION

Other (DRA) limitations relevant to implementation of the provisions of section 3 include:

- No co-payments for emergency services, family planning services and supplies, and preventative services.
- No premiums or co-payments for pregnant women or the terminally ill using hospice care (no cost-sharing for children that become pregnant or use hospice care)
- Providers can deny service if the enrollee is unable to pay copays
- The State cannot terminate enrollees until premiums are at least 60 days delinquent

This fiscal analysis assumes that all co-payment and premiums are paid and that all services utilized by section 3 enrollees with incomes greater that 250% FPG are subject to cost sharing.

The number of children expected to enroll in Medicaid with incomes between 201 and 350% is based on the number of children potentially eligible for every 50 point increase in the percent of FPG. We anticipate that only 50% of eligible persons will apply and we exclude native eligibles because there is no incentive for them to seek medical insurance that requires payment of premiums and co-pays when they are already covered for most medical services through the Indian Health Service. We estimate that 851 children will enroll at income levels between 201 and 250% FPG and an additional 1,702 children will enroll between 251 and 350% FPG. All 2,553 will be required to pay premiums and 1,702 will also be responsible for co-payments for services.

The cost per enrollee per year (CPEPY) to expand coverage to children with incomes between 201% and 350% FPG is estimated as the current CPEPY for all children managed through the Denali KidCare Office (uninsured SCHIP children and certain categories of both uninsured and insured children funded through Title XIX). In 2006, that CPEPY was about $2,900. Medicaid costs are calculated as the number enrolled times the CPEPY, inflated to 2009 dollars and less 20% co-payments. Premiums are treated as SDPR and fund splits are calculated without any correction for revenue from premiums.

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ANALYSIS CONTINUATION

We assume that enrollment for all groups covered by SS HB140 will be completed rapidly on implementation of this bill, and within the 2009 fiscal year. Historically SCHIP and DKC expansion efforts have resulted in rapid growth in enrollment, up to expected targets.

The 2009 total costs estimate for SS HB140 is based on a 2006 base calculation that was adjusted annually for 5% medical inflation (average of the Anchorage CPI medical care component between 2001 and 2005). Projections for 2010 through 2013 assume an annual growth rate of 8.6% based on the projected overall Medicaid program growth between 2008 and 2012 from the *Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025.* Medical inflation and a low level of enrollment growth are incorporated into the annual growth percentage applied between 2010 and 2013.

Federal funds calculations use only the Title XIX federal match rate. Expenses for the additional SCHIP children enrolled under SS HB140 section 2 will be eligible for Title XXI funding, however Title XXI funding is not expected to cover all SCHIP costs after 2007 and the state's SCHIP allocation is not expected to increase enough to cover costs over the term of these fiscal note projections.

Behavioral Health Medicaid Services (DBH) currently pays for 1/3 of the cost of services to DKC children and none of the costs associated with DKC pregnant women. Component fund calculations for this fiscal note are based on that costs distribution (1/3 of costs of services due to added SCHIP enrollment and 1/3 of costs of services due to section 3 enrollment). Premiums will be processed through a different component (Health Care Services Medicaid) and are therefore excluded from the funds analysis for DBH.

The attached table provides a quick department-level summary of the possible Medicaid direct costs, cost sharing, and enrollment associated with this bill.

2009 Enrollment and Costs	Denali KidCare Income Standard Unfrozen		Extended Medical Assistance Coverage		Total
	Pregnant Women	SCHIP Children	Children		
	151-200% Federal Poverty Guideline	151-200% Federal Poverty Guideline	201-250% Federal Poverty Guideline	251-350% Federal Poverty Guideline	
Annual Enrollment	136	2,553	851	1,702	5,542
Average Cost per Enrollee	$2,915	$1,387	$2,900	$2,900	na
Total Cost of Medicaid Services before Cost Sharing (in 000s)	$1,471.3	$4,099.2	$2,856.9	$5,713.8	$14,141.1
Annual Premiums	$0.0	$0.0	-$255.3	-$1,531.8	-$1,787.1
Annual Co-Payments	$0.0	$0.0	$0.0	-$1,142.8	-$1,142.8
Net Cost of Medicaid Services after Cost Sharing	$1,471.3	$4,099.2	$2,601.6	$3,039.2	$11,211.2
Health Care Services Medicaid	$1,471.3	$2,732.8	$2,456.3	$4,912.6	$7,368.9
Behavioral Health Medicaid	0	$1,366.4	$1,280.8	$2,561.6	$3,842.4

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-DPA-03-14-07
Bill Version: SS HB 140
( ) Publish Date:
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: MEDICAL ASSISTANCE ELIGIBILITY
RDU: Public Assistance
Component: Public Assistance Field Svcs

Sponsor: GARA
Requester: HOUSE (HES)
Component No.: 236

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	117.5	469.9	469.9	469.9	469.9	469.9
Travel						
Contractual	14.4	57.4	57.4	57.4	57.4	57.4
Supplies	19.6	4.2	4.2	4.2	4.2	4.2
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**151.5**	**531.5**	**531.5**	**531.5**	**531.5**	**531.5**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	71.2	249.5	249.5	249.5	249.5	249.5
1003 GF Match	64.1	223.5	223.5	223.5	223.5	223.5
1004 GF	14.3	51.7	51.7	51.7	51.7	51.7
1037 GF/Mental Health						
Inter-Agency Receipts	1.9	6.8	6.8	6.8	6.8	6.8
Other(Specify Type-do not abbreviate)						
TOTAL	**151.5**	**531.5**	**531.5**	**531.5**	**531.5**	**531.5**

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

POSITIONS

Full-time	7	7	7	7	7	7
Part-time						
Temporary						

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

SS HB140 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200% of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(continued)

Prepared by: Ellie Fitzjarrald, Director — Phone 465-5847
Division: Public Assistance — Date/Time 03/14/2007
Approved by: Karleen Jackson, Commissioner — Date 03/14/2007
Agency: Department of Health and Social Services

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

SS HB140 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201% and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between $200 and $1200 per year (sliding scale based on qualifying income). Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SS HB 140 does not impose an annual deductible.

The Deficit Reduction Act (DRA) section 6041 stipulates that co-payments cannot exceed 20% of the cost of the service claimed. Annual out-of-pocket expenses for cost sharing and premiums cannot exceed 5% of family income.

This fiscal note represents the administrative costs for the eligibility determinations associated with expanding medical assistance coverage for pregnant women and children, and instituting cost sharing for certain recipients. The eligibility decision includes a finding of eligibility or ineligibility based on the household's size and monthly income at the time of application, acting on changes in a household's circumstances that are reported during the period of eligibility, and re-examining a household's eligibility every six months. This bill would also require staff to determine the amount of the household's premium payment, communicate the premium obligation to the Division of Health Care Services for collection, and confirm payment of the premium before Medicaid benefits are issued.

Assumptions for Denali Kid Care and Pregnant Women:

We assume that 436 additional pregnant women will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and 2,553 children will enroll in Medicaid if the SCHIP qualifying income level is increased to 200% FPG.

We estimate two Eligibility Technician I positions will be needed to manage this additional work. An Eligibility Technician I in our Denali Kid Care office can manage a workload of up to 1,000 cases per month, and some cases contain more than one child.

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Assumptions for Extended Medicaid Coverage:

We assume 851 children will enroll at income levels between 201% and 250% FPG and an additional 1,702 children will enroll between 251% and 350% FPG. All 2,553 will be required to pay premiums and 1,702 will also be responsible for co-payments for services.

We estimate three Eligibility Technician I positions will be needed to manage this additional work. The new extended Medicaid program increases complexity of the eligibility determination work and results in increased contact with applicants and enrollees. We assume an Eligibility Technician I will only be able to manage a caseload up to 700 cases per month.

Total Adminstrative Costs:

The increase in Medicaid applications and caseload creates the need for an Administrative Support Clerk, and an Eligibility Technician IV Supervisor to oversee the work of the five new Eligibility Technicians. These annual costs are estimated to be:
1 Administrative Clerk II $52.5 (Range 8 at a cost of $52.5, including benefits, per position).
5 Eligibility Technician I's $336.0 (Range 14 at a cost of $67.2, including benefits, per position).
1 Eligibility Technician IV $81.4 (Range 16 at a cost of $81.4, including benefits, per position).

With the additional caseload, a one time cost for computers and software will be required with a cost of $2,200 for each additional staff for a total of $15.4. Annual costs for office space, phones and supplies are calculated at a cost of $8,800 per additional staff for a total of $61.6.

It is assumed that one quarter year's funding will be needed in FY08 to hire and train staff in order to be able to accept applications and make eligibility determinations effective July 1, 2008.

For the personal services allocations of this fiscal note, the fund source calculations are derived by using standard Random Moment Time Study averages for existing eligibility workers.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-FMS-03-14-07
Bill Version: SS HB 140
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: MEDICAL ASSISTANCE ELIGIBILITY
RDU: Departmental Support Services
Component: Information Technology Services

Sponsor: GARA
Requester: HOUSE (HES)
Component No.: 2754

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	250.0					
Travel						
Contractual	30.0	65.0	80.0	31.0	31.0	31.0
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**280.0**	**65.0**	**80.0**	**31.0**	**31.0**	**31.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	140.0	32.5	40.0	15.5	15.5	15.5
1003 GF Match	140.0	32.5	40.0	15.5	15.5	15.5
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**280.0**	**65.0**	**80.0**	**31.0**	**31.0**	**31.0**

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

POSITIONS

Full-time						
Part-time						
Temporary						

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

SS HB 140 will require software changes to the Eligibility Information Management system (EIS). The changes will require four positions for six months: two information system programmers working with two additional positions testing the system for Public Assistance. No new positions are requested, instead this fiscal note will provide funding for current positions. The EIS system is a highly complex and intricate system and the changes will require high level programmers to develop and re-work the software changes necessary.

Prepared by: Janet Clarke — Phone 465-1630
Division: Finance and Management Services — Date/Time 03/09/2007
Approved by: Karleen Jackson, Commissioner — Date 03/14/2007
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

This work will include the analysis of required software changes, programming and development to implement the changes and the necessary testing to insure accuracy. These funds are required in FY08 in order to have the system operational for a July 2008 implementation date.

The contractual costs are for producing informational brochures and media advertising for education and outreach to publicize the new eligibility standards. FY08 included $30.0 for production and materials contracts to prepare for the July 2008 implementation date. FY09 contractual costs are for the television and radio broadcasting costs. FY10 includes both production/supply costs for new materials and broadcasting costs. FY11-13 have full materials costs and approximately 25% of the original broadcasting costs to reflect a reduction in the number of advertisements and outreach.

ALASKA STATE LEGISLATURE

Senator Bill Wielechowski

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Representative Les Gara

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A Primer on the "No Child Left Uninsured" Act

- The intent of this bill is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a meaningful financial contribution towards their coverage.

- The bill raises the eligibility limit for participation in Denali KidCare from $26,000/year for a single parent and child to 200% of the federal poverty level (FPL). This was the eligibility limit for the program until 2003, when SB 105 substantially lowered the limit.

- 200% of the FPL is currently $34,000/year for a single parent and child. The FPL is adjusted annually for inflation.

- This proposal puts Alaska in line with other states, 41 of which allow participation by families at or above 200% of the FPL. Seven states set the limit at or above 300% of the FPL. Alaska currently has one of the lowest eligibility rates in the nation. Only Montana and North Dakota are lower.

- This bill would also allow families with incomes up to 350% of the FPL to buy into Denali KidCare using a sliding fee scale. Many children from working families in Alaska are unable to afford private insurance and go without coverage, which results in poorer health and greater costs in the long-run.

- Premiums for coverage would range from $200 annually for a participants living at 201% of the FPL to $1,200 annually. In addition, a 20% co-pay would be required for those living at 250% and greater of the FPL. Parents and/or guardians would have to certify that eligible children do not have other insurance coverage. Those with the greatest means would reimburse the state roughly 90% of program costs.

- Several states have taken steps in recent years to ensure that all children have access to health insurance. For example, in Connecticut, uninsured children from families making 300% or more of the FPL can buy into "All Kids." In Illinois, coverage is available to any child that has been uninsured for 12 months or more, with the cost determined on a sliding scale basis. Similar proposals under are under consideration in Oregon, Wisconsin, Washington, California and New Mexico, among other states.

ALASKA STATE LEGISLATURE

Senator Bill Wielechowski

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Falling Through the Cracks:
The Unmet Health Needs of Alaska's Uninsured Children

- The number of uninsured children in Alaska is estimated to be 17,880 or 9% of the population 18 and under (Urban Institute and Kaiser Commission on Medicaid and the Uninsured).

- Over the last decade, Alaska has seen a large decline (31%) in the number of children covered by private health insurance (Robert Wood Johnson Foundation).

- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).

- Uninsured children have much higher health risks than do covered children. They receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser Commission on Medicaid and the Uninsured).

- Uninsured children are more likely to develop viral soar throats, eye and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than 5 times as likely as insured children to have an unmet need for medical care and 9 times more likely not to have a regular doctor. They are also 4 times more likely to use emergency rooms (*Pediatrics* 105 and 113; Care for Children, *New England Journal of Medicine* 330; The Urban Institute).

- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (Health Affairs 23, no. 5, September/October 2004).

- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of $65-$130 billion annually.

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Impact of the Uninsured on the Broader Population

- Hospitals often serve as primary care treatment facilities for those without access to other health care. Providence and Alaska Regional Hospitals in Anchorage report providing nearly $89 million in uncompensated care in 2004. These costs are passed on to other Alaskans, businesses and government, raising premiums and out-of-pocket expenses (Commonwealth North).

- Governor Palin has proposed a $22.7 million increment to reimburse hospitals for the uncompensated care they provide. Of this amount, $11.2 million would come from state general funds; the remaining would come from federal Medicaid dollars. This bill would reduce the need for this increment. This was not in H&S subcom. approved budget.

- The New America Foundation estimates the average family pays an additional $1,186 in medical costs to cover the cost of uncompensated health care. Another national study found that premiums for employer-sponsored family health coverage cost an extra $922 in 2005 to pay for uncompensated care.

- Some $17 billion is spent in the U.S. annually on unnecessary hospitalizations, according to a 2004 study in *Pediatrics*. The study, which surveyed parents and doctors of children admitted to the hospital, found that 13-46% of the admissions could have been avoided with better care at home or by primary care physicians.

- Nationally, individuals unable to pay medical bills are filing for bankruptcy at unprecedented rates. Between 1980 and 2001, medically driven bankruptcies increased 23 times (American Medical Association, 2005). Half of the 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause (Health Affairs, Feb. 2005).

- The pay-off from providing health insurance for low-income children is substantial. According to governing.com, "Immunizations, annual visits to a pediatrician, dental care, and screening for vision, hearing and developmental problems are all long-term money savers for the health care system as a whole." For example, every $1 spent on a mumps/measles/rubella shot, saves $26, according to Washington State Dept. of Health research.

- The National Institute of Medicine estimates that the benefit of extending insurance coverage to children is $2,410 per year. This figure is based on the value of an individual's health over future years, physical and mental development and earning potential.

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Background on Denali KidCare

- Denali KidCare provides health insurance for children through age 18 and pregnant women who meet income guidelines. There is no cost for eligible children, teens and pregnant women. However, youth who are 18 may be required to pay a limited amount for some services.

- Denali KidCare pays for doctor's visits; eye exams and glasses; dental cleanings and fillings; hearing tests and aids; hospital care; speech, physical and mental health therapy, substance abuse treatment; lab tests; prescription drugs; and other care.

- Roughly 600 children were covered by Denali KidCare as of December 2006.

- Prior to the passage of SB 105 in 2003 (which lowered the eligibility guidelines for the program) 4,992 children with family incomes between 151% and 200% of the federal poverty level (FPL) were covered. Since passage, 3,440 fewer children with family incomes between 151% and 200% of the FPL are enrolled.

- The cost per child of providing this coverage is about $1,700/year.

- In recent calls to private insurers, the cost of a health insurance plan for a family of 3 (pregnant woman with two children) ranged from $8,000-$17,000 annually. Unlike Denali KidCare, this coverage comes with a $1,000 deductible, 20% co-pay, and no vision, dental or hearing benefits.

- **Alaska has one of the lowest program eligibility rates in the nation** (160% of the FPL). Only 2 other states (Montana and North Dakota) have lower rates. Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL.

- In April 2007, Alaska's eligibility rate will decline to 154% of the FPL, bumping more low-income children (perhaps as many as 1,000) off the rolls of Denali KidCare. The eligibility

rate will continue to decline relative to the federal poverty level because it is a fixed income limit that (unlike the FPL) does not rise with inflation.

- The federal government reimburses 70% of the cost of the Denali KidCare program up to the state's allocated funding level. After that, the reimbursement rate declines to 58%.

- In fiscal year 2006, the cost of Denali KidCare (also known as the State Children's Health Insurance Program) was $25.9 million, of which $18.2 million was paid by the federal government.

Why Coverage for Pregnant Women is Important:

- Alaska has one of the nation's highest documented pregnancy-associated mortality ratios – 58 per 100,000 live births during 1990-1999 (DHSS). National data indicate that women who receive no prenatal care are at increased risk of pregnancy-related death.

- Only 58% of women in Alaska receive adequate prenatal care, compared with 75% nationally.

- Mothers having late or no prenatal care are more likely to have low birth weight or pre-term infants and are at increased risk for pregnancy-related mortality and complications of childbirth (DHSS).

- The average cost of hospital care for a premature baby was $75,000 in 2001, compared with $1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about $13.1 billion annually.

AFV labeling cost is estimated to be $258,400 ($0.38 × 680,000).

Thus, the estimated total annual non-labor cost burden associated with the Rule is $259,000 ($205 + $258,400), rounded.

William Blumenthal,

General Counsel.

[FR Doc. E7–952 Filed 1–23–07; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the HHS poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services (HHS), Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, State, or local office that is responsible for that program. Contact information for two frequently requested programs is given below:

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10–105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. To speak to a person, call (301) 443–5656. To receive a Hill-Burton information package, call 1–800–638–0742 (for callers outside Maryland) or 1–800–492–0359 (for callers in Maryland). You may also visit *http://www.hrsa.gov/hillburton/default.htm.* The Division of Facilities Compliance and Recovery notes that as set by 42 CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283 or visit *http://www.uscis.gov/files/form/I-864p.pdf.*

For information about the number of people in poverty or about the Census Bureau poverty thresholds, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Demographic Call Center Staff at (301) 763–2422 or 1–866–758–1060 (toll-free).

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–7507—or visit *http://aspe.hhs.gov/poverty/.*

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update, at least annually, the poverty guidelines, which shall be used as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines also are used as an eligibility criterion by a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2007 notice reflect the 3.2 percent price increase between calendar years 2005 and 2006. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2007 guidelines are roughly equal to the poverty thresholds for calendar year 2006 which the Census Bureau expects to publish in final form in August 2007.) The guideline figures shown represent annual income.

2007 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family	Poverty guideline
1	$10,210
2	13,690
3	17,170
4	20,650
5	24,130
6	27,610
7	31,090
8	34,570

For families with more than 8 persons, add $3,480 for each additional person.

2007 POVERTY GUIDELINES FOR ALASKA

Persons in family	Poverty guideline
1	$12,770
2	17,120
3	21,470
4	25,820
5	30,170
6	34,520
7	38,870
8	43,220

For families with more than 8 persons, add $4,350 for each additional person.

2007 POVERTY GUIDELINES FOR HAWAII

Persons in family	Poverty guideline
1	$11,750
2	15,750
3	19,750
4	23,750
5	27,750
6	31,750
7	35,750
8	39,750

For families with more than 8 persons, add $4,000 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a

Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the "OMB" (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as "income" or "family." This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions about how a particular program applies the poverty guidelines (*e.g.*, Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program.

Dated: January 17, 2007.

Michael O. Leavitt,

Secretary of Health and Human Services.

[FR Doc. 07-268 Filed 1-19-07; 8:45 am]

BILLING CODE 4151-05-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): NIOSH Occupational Health and Safety Research, Program Announcement Number (PAR) 06-484

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Time and Date: 8 a.m.-5 p.m., February 9, 2007 (Closed).

Place: 1750 New York Avenue, NW., Washington, DC 20006.

Status: The meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and ( ), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92-463.

Matters To Be Discussed: The SEP meeting will include the review, discussion, and evaluation of applications received in response to "NIOSH Occupational Health and Safety Research," PAR 06-484. The applications being reviewed include information of a confidential nature, including personal information concerning individuals associated with the applications.

Contact Person for More Information: Horace M. Stiles, DDS, PhD, MPH, Designated Federal Officer, 15111 Farm Market Road, Maypearl, Texas 76064-1902, telephone 404.498.2584.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: January 18, 2007.

Elaine L. Baker,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E7-987 Filed 1-23-07; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: 45 CFR 1304 Head Start Program Performance Standards.

OMB No. 0970-0148.

Description: Head Start Program Performance Standards require Head Start and Early Head Start Programs and Delegate Agencies to maintain program records. The Administration for Children and Families, Office of Head Start, is proposing to renew, without changes, the authority to require certain record keeping in all programs as provided for in 45 CFR part 1304 Head Start Program Performance Standards. These standards prescribe the services that Head Start and Early Head Start programs provide to enrolled children and their families.

Respondents: Head Start and Early Head Start grantees and delegate agencies.

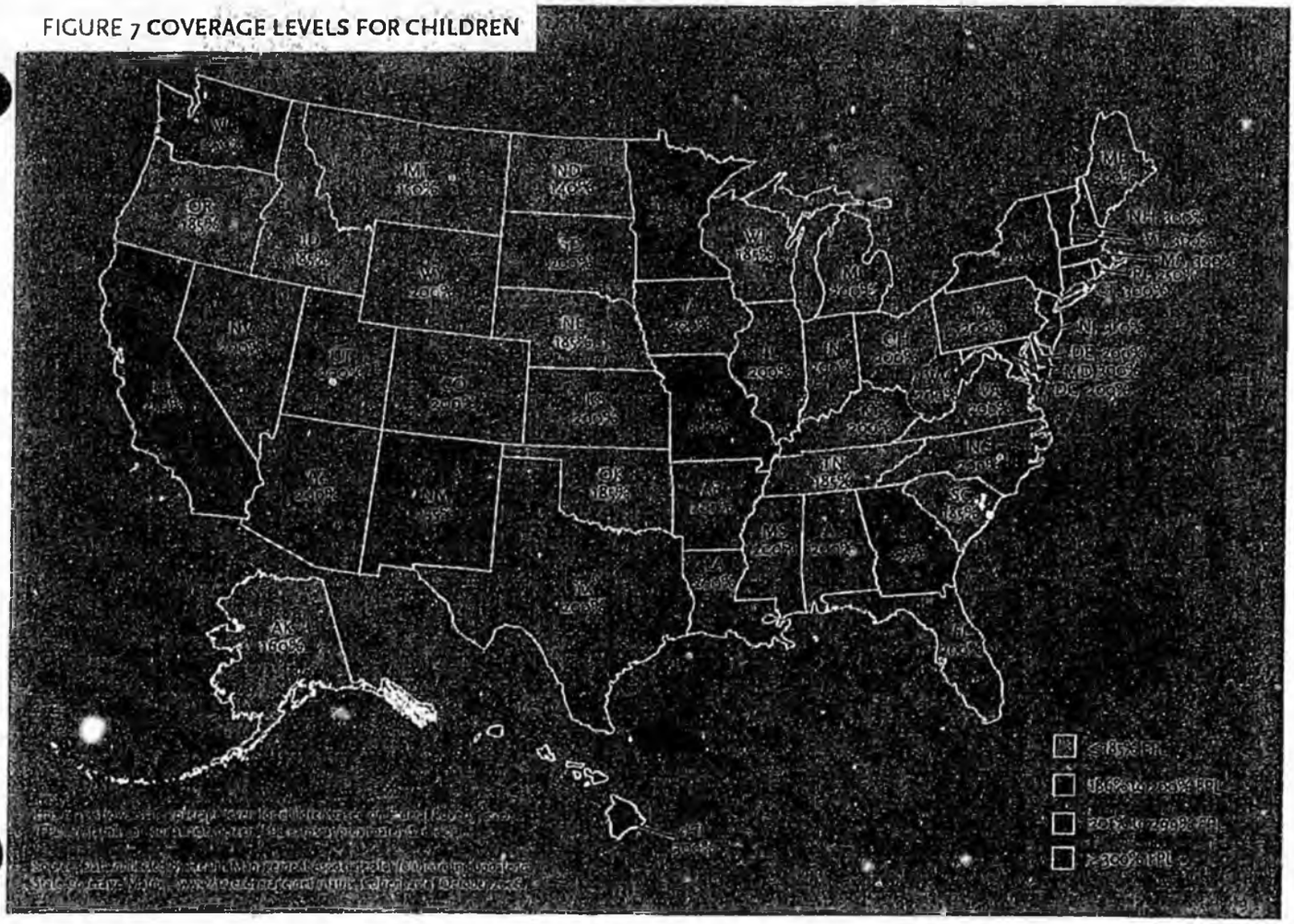
ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Standard	2,590	16	41.8	1,732,192
Estimated Total Annual Burden Hours:				1,732,192

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork

FIGURE 7 **COVERAGE LEVELS FOR CHILDREN**

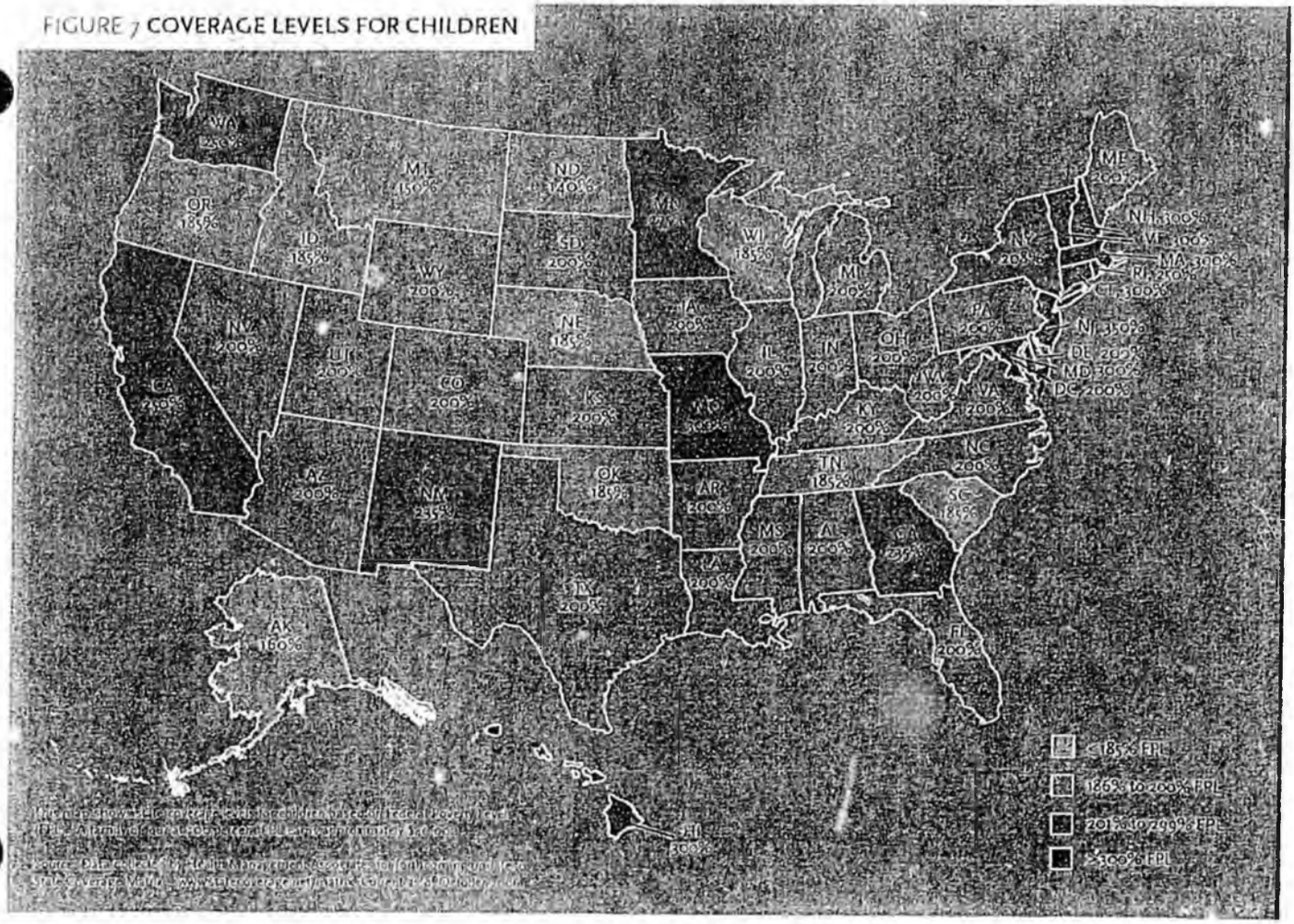


premium assistance program or an individual plan. O-EPIC is funded by state general fund revenues generated by a tobacco tax, along with federal matching funds under Title XIX and employer and employee contributions.

The Premium Assistance program, launched in November 2005, helps qualified employees in small businesses of 50 or fewer employees purchase health insurance coverage through their employer. The employer works with an insurance agent to choose a qualified private health plan to offer its employees. The Premium Assistance program pays 60 percent of the health insurance premium for qualified employees with incomes below 185 percent FPL and 85 percent of the premium for the qualified enrollee's spouse. Employees are expected to contribute 25 percent of the employee's premium and employees are expected to contribute up to 15 percent for themselves and 15 percent for their spouses.

The Individual Plan will be launched shortly and is designed as a safety net health plan for qualified individuals with incomes below 185 percent FPL and who are ineligible to participate in O-EPIC Premium Assistance. The Individual Plan includes self-employed individuals not eligible for small group health coverage; workers at small businesses who are either not eligible to participate in their employer's health plan or whose employer does not offer a qualified health plan; and unemployed individuals who are currently seeking work. The Individual Plan also provides coverage to working individuals with a disability whose income exceeds the Medicaid eligibility level but is below 200 percent FPL, and who meet "ticket to work" requirements.[33] The Individual Plan provides coverage through private managed care plans that also serve the Medicaid program; however, the benefit package is less comprehensive than Medicaid or most products offered in the commercial market.

FIGURE 7 COVERAGE LEVELS FOR CHILDREN



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National Conference *of* State Legislatures

Policy Brief

WHO'S COVERED AND WHO'S NOT?

THE STATE OF CHILDREN'S HEALTH INSURANCE: A PRIMER FOR STATE LEGISLATORS

by Michelle Herman

February 2006

The fluctuating economy, steep increases in private health insurance premiums and health care costs, and changes to public insurance programs all contribute to rising numbers of uninsured U.S. residents.[1] But the trend for children is more positive. Despite the fact that the total number of uninsured citizens is growing, the number of uninsured children decreased from 1997 to 2004, from 10.8 million to just over 8.2 million uninsured children, respectively. Even with this improvement, over 11 percent of children lack health insurance coverage. Certain groups of children are over-represented in the uninsured population: poor (below the federal poverty level, or FPL) or near-poor (between 100 percent and 200 percent of the FPL) children, those who are Hispanic or who have a non-U.S. citizen parent, and adolescents are more likely to be uninsured.

There are many reasons why children do not have health coverage. Lower-income families bear financial concerns and stresses—such as securing employment and housing—that frequently push obtaining health insurance low on their list of priorities. Even in cases where employers offer insurance coverage, premiums often are too expensive for lower-income parents. Some groups may face language and cultural barriers. Parents may not know about public health care coverage options or eligibility guidelines. Complicated application processes and strict verification requirements also may create problems.

Because they administer Medicaid and the State Children's Health Insurance Program (SCHIP), states not only have great responsibility for insuring children, they also have significant flexibility in deciding who and what to cover. The number of uninsured children has not increased as in the total U.S. population, in part because public programs have expanded to cover them. In particular, SCHIP—a federal and state partnership launched in 1997—gave states new federal funds and flexibility in program design and administration. States used this flexibility to expand coverage and develop innovative enrollment and outreach strategies. The result was an increase in enrollment of children, with significant increases occurring among low-income children: as of 2004, SCHIP had enrolled almost 4 million children.[2] SCHIP has influenced Medicaid enrollment as well; Medicaid enrollment increased for children following SCHIP implementation, and SCHIP prompted simplification reforms in Medicaid enrollment and re-enrollment processes.[3] This paper provides an overview of national children's health coverage, and what options states can use to cover uninsured kids.

WHY DO CHILDREN NEED HEALTH INSURANCE?

Health care experts unequivocally agree on the importance of covering children. Lack of health insurance is a substantial barrier to health care.[4] Uninsured children have much higher health risks than do covered children. They are more likely to go without health services, may avoid or delay care when it is needed, and are less likely to receive the proper medical care for childhood illnesses such as sore throats, earaches and asthma. Children who have health insurance are more likely to have a usual place of care and reliably receive preventive and medical services. One study found that among near-poor children, 36 percent of uninsured children had an unmet medical need, compared to 9 percent of children with public insurance and 14 percent of those with private coverage.[5] Another recent report found that almost one-third of uninsured children received no medical treatment during a one-year period between 2002 and 2003.[6]

The harmful consequences of the lack of health coverage are felt in other areas as well. As Nicole Ravenell, policy and research director at the Southern Institute on Children and Families, comments, "Health insurance is part of obtaining a good quality of life. When kids get sick or have health-related needs such as glasses, they can not concentrate in school or may miss school completely. Continued illness affects school performance and, in the long-run, can affect future workforce participation. Results from a lack of health coverage are long-term." Uninsured children face greater threats to healthy behavioral developments than do insured children, according to one study.[7] Another study discovered that uninsured children are 25 percent more likely to miss school than insured children.[8]

Covering kids improves the health care system overall because it encourages more cost-effective service utilization and closes the gaps in health service disparities. Some studies show that covered children are more likely to seek office-based or clinic care, thus saving the higher costs that might be associated with emergency department care.[9] Health care coverage also can reduce racial disparities. In a 2005 study, investigators compared unmet health care needs and having a usual source of care between uninsured black, white and Hispanic children before and after SCHIP enrollment. Before enrollment, white children were more likely to have a usual source of care and less likely to have unmet health care needs. After SCHIP enrollment, all three groups demonstrated improvements in access, continuity and quality of care. The preexisting disparities decreased across groups in access, unmet need and continuity of care.[10]

WHO'S COVERED AND WHO'S NOT?

Although the proportion of persons who are uninsured has increased in this country since 1998, the proportion of children who are uninsured slightly declined during the same period. There are 77.6 million children in the United States. As figure 1 shows, in any given year since 1997, between 8 million and 11 million children lacked health insurance.

» America's Uninsured
» The Historic Agreement
» About the Coalition
» The Organizations Involved
» In the News

America's Uninsured

According to the latest Census Bureau report, approximately 46.6 million people in the United States were uninsured in 2005 -- more than the aggregate population of 24 states plus the District of Columbia.

This number amounts to more than 15 percent of the U.S. population, or approximately one in seven Americans, and the problem is growing. Over the past two decades, the number of uninsured Americans has increased by about one million people annually, and it shows no sign of slowing down.

Being uninsured can have serious health consequences. The uninsured are often unable to receive the primary and preventive care they need -- medications to keep disease in check, mammograms and regular screenings for colon cancer, yearly visits with a primary care physician to maintain good health, and more.

The uninsured are less likely to get appropriate care when they seek it, and they have poorer health as a result. According to the Institute of Medicine, approximately 18,000 people die each year from diseases that are treatable and preventable, because they do not have health insurance.

Our nation's high number of uninsured does not merely exact a toll on those without insurance. It also impacts those who do have coverage, businesses nationwide, and the U.S. economy overall.

When the uninsured do receive health care, they often cannot afford to pay for it, so those costs are paid by others. They are passed on to privately insured people and companies offering insurance to their workers, providers who absorb costs by offering uncompensated care, and taxpayers.

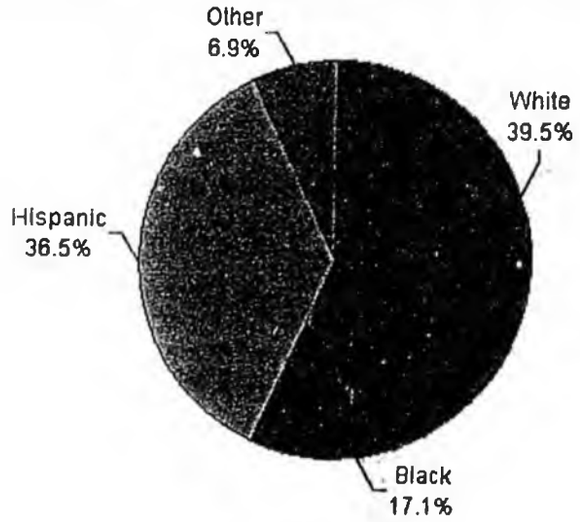
A recent study found that premiums for employer-sponsored family health coverage cost an extra $922 in 2005 to pay for uncompensated care provided to the uninsured.

Equally troubling, with health care costs rising, even more people -- many of them from hardworking, middle-class families -- will join the ranks of the uninsured if nothing is done soon to address this problem.

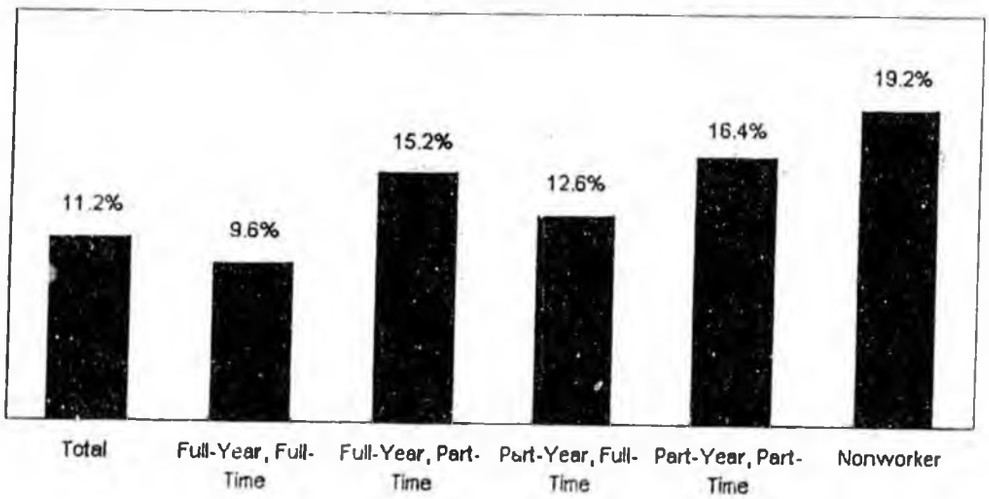
Health Coverage Coalition for the Uninsured
info@coalitionfortheuninsured.org · 202-354-6443

Fact: Nearly twenty percent of uninsured Americans – 8.3 million individuals – are children. While children are more likely to be insured than non-elderly adults, health insurance is particularly important for children. Uninsured children are more likely than insured children to lack a usual source of health care, to go without needed care and to experience worse health outcomes.

Uninsured Children by Race and Ethnic Origin, 2004

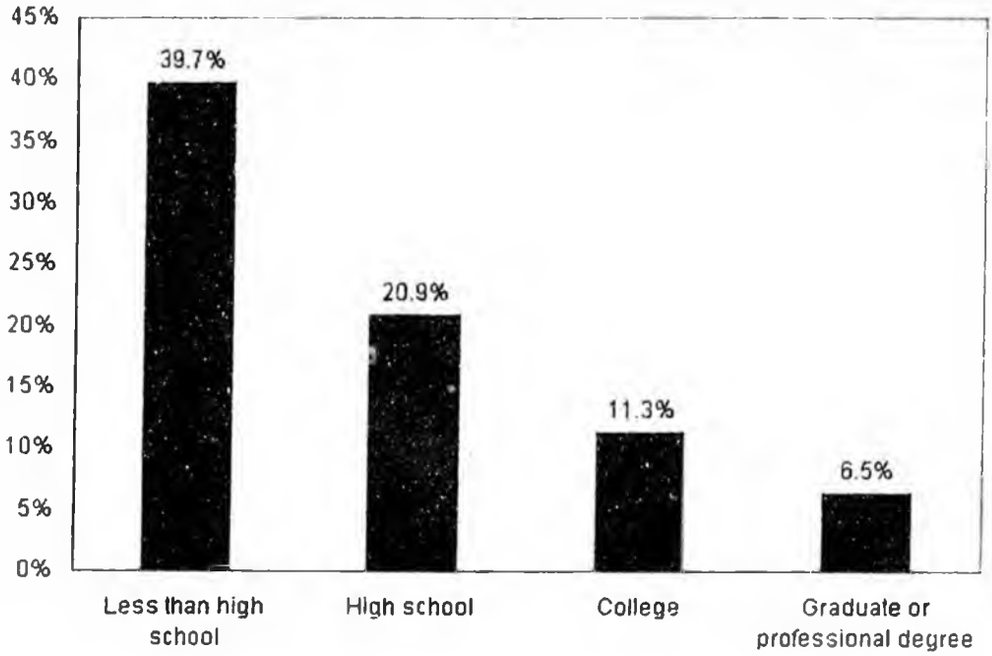


Uninsured Children by Work Status of the Family Head, 2004



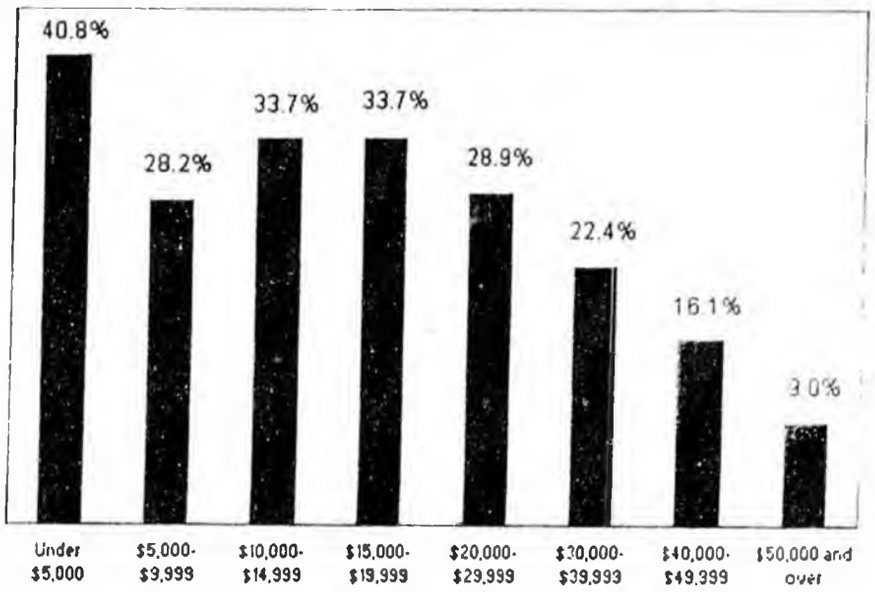
Fact: The likelihood of being insured increases as level of educational attainment rises. However, fully 40 percent of the difference in insured rates between those with no high-school diploma and those with some post-college education would disappear if the two groups were alike with respect to demographic, geographic and health status factors.

Percentage Uninsured Among Nonelderly Adults by Education, 2004



Fact: Only 9 percent of people in families with income over $50,000 per year are uninsured, compared to 40.8 percent of people with family income below $5,000.

Percentage Uninsured Among the Nonelderly Population by Family Income, 2004

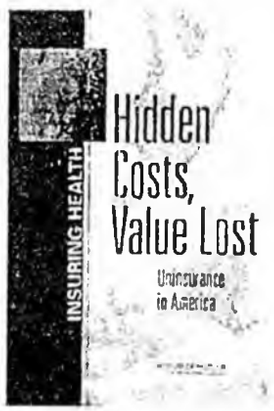


June 2003

INSTITUTE OF MEDICINE

Shaping the Future for Health

HIDDEN COSTS, VALUE LOST
UNINSURANCE IN AMERICA



Americans value health care highly, as demonstrated by our society's substantial investment in it. Our nation invests in the health of its people by directly providing health insurance for some (e.g., Medicare for people over age 65) and by offering tax subsidies to support health insurance for others. About 85 percent of the U.S. population benefits from these financial supports for health insurance. At the same time, 41 million people lack coverage every year.

The federal, state, and local governments spend substantial sums—about $30 billion annually—to compensate hospitals and clinics for services provided to the uninsured. Doctors donate services valued at another $5 billion. Despite these efforts, uninsured Americans are more likely to have poorer health and die prematurely than those who are insured.

Health care accounts for roughly 14 percent of the nation's annual gross domestic product (GDP).

WHAT DOES THE LACK OF HEALTH INSURANCE COST SOCIETY?

In its fifth report, *Hidden Costs, Value Lost: Uninsurance in America,* the IOM Committee on the Consequences of Uninsurance tallies some of the economic and social losses to the country of maintaining so many people without health insurance. It also explores the potential economic and societal benefits that could be realized if everyone had health insurance on a continuous basis, as people over age 65 currently do with Medicare.

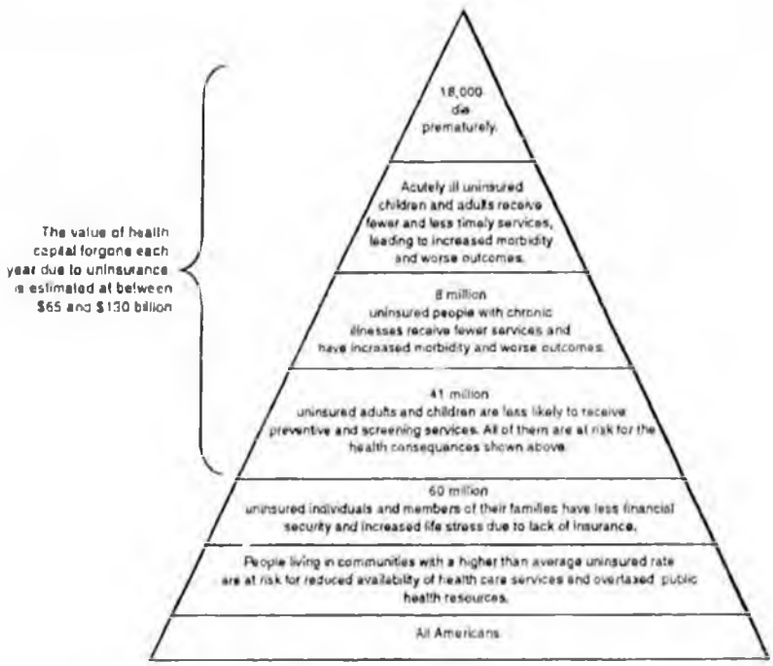
Forty-one million people are uninsured each year. 80 million Americans experience some period without coverage over 2 years.

When people lack health coverage, society's costs are substantial:

- The uninsured lose their health and die prematurely. Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated.
- Families lose peace of mind because they live with the uncertainty and anxiety of the medical and financial consequences of a serious illness or injury
- Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts in public health programs like communicable disease surveillance. These consequences can affect everyone, not just those who are uninsured.
- The economic vitality of the country is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

- Medicare, Social Security Disability, and the criminal justice system probably cost more than they would if everyone had health insurance up to age 65. For example, when an uninsured woman with diabetes turns 65 years old and gains Medicare, her condition is likely to be worse and require more intensive treatment than if she had previously been insured. Similarly, uninsured persons who are mentally ill often do not get appropriate treatment and may end up in the criminal justice system at significant but potentially avoidable costs.

The costs to society of having a large uninsured population are not primarily due to the costs of providing health services free of charge to those without coverage. Most of the cost is in the form of poorer health for the uninsured because they frequently receive too little care, too late. The pyramid illustrates the extent of loss of life, acute and chronic illness, and the pool of uninsured people who are at risk for poorer health and shorter lives. The potential economic value to be gained in better health outcomes from continuous coverage for all Americans is estimated to be between $65 to $130 billion each year, assuming the uninsured will use health care as do those who now have health insurance. It includes, but is not limited to, higher expected lifetime earnings due to improved productivity and educational and developmental outcomes.



HOW IS A VALUE PLACED ON HEALTH AND A LONGER LIFE?

The healthy years that someone expects to have over the course of a lifetime can be thought of as that person's "stock" of "health capital." The differences in health status and length of life between uninsured and otherwise similar people with health insurance represents the value of health capital lost from poorer health over the lifetime by those who lack coverage.

The range in expected annual benefits ($65-$130 billion) of insuring the uninsured comes from different assumptions about the extent to which the disparities in health status between the insured and uninsured would be eliminated by gaining coverage. To

develop these estimates, the Committee adopted an analytic strategy for placing an economic value on life and health similar to that used by public agencies such as the Environmental Protection Agency and the Department of Transportation. When agencies responsible for public health and safety regulate exposures and risks—for example, by setting fuel emissions standards and requiring seat belts and air bags in cars—they implicitly establish the value of these interventions in terms of the improved health and lives extended throughout society.

The lack of health insurance across the United States can be thought of as imposing a risk to the health and longevity of the American population. Likewise, the cost of insuring everyone continuously can be thought of in terms of the value of improved health outcomes gained as a result. The Committee's analysis of the economic benefits of insuring the uninsured is consistent with the approaches used by regulatory agencies in their quantitative analyses of costs and benefits.

HOW MUCH IS NOW SPENT ON HEALTH SERVICES FOR THE UNINSURED?

Ninety-nine billion dollars are now spent on health care services for the uninsured.

People who were uninsured for part or all of 2001 received health care services valued at about $99 billion. This total includes the amount the uninsured paid out of their own pocket, any insurance payments made if they were insured for part of the year, any worker's compensation payments for health care and any charity care received.

Uninsured children and adults are less likely to incur health expenses in a year because they are less likely to seek care than are those with health insurance. When they do receive services, the uninsured are often charged a higher price and pay a higher portion of the total cost themselves than people with coverage. For those who are uninsured for part rather than the whole year, private and public health insurance pays more than half the annual costs of services used. Still, being uninsured just for a short time can put a person at risk for poorer health outcomes and financial losses.

The burden of uncompensated (charity) care amounted to $35 billion in 2001 and is largely borne by taxpayers. The public supports 75 to 85 percent of this care through federal, state and local government programs. For example, public dollars subsidize the hospital in your community when patients are not able to pay their bills.

WILL PEOPLE WHO ARE UNINSURED USE MORE HEALTH CARE IF THEY GAIN COVERAGE?

The uninsured use fewer services and have poorer health outcomes than the insured.

Yes; total health costs for those who now lack coverage would be expected to increase from the $99 billion they now incur by an estimated $34 to $69 billion each year. This additional spending includes more appropriate use of health care that can improve health. In the absence of action to expand coverage, we can expect the existing gap in health outcomes to widen as health care interventions become ever more effective in improving health and extending life. Existing disparities between insured and uninsured people in their access to effective care will become increasingly inequitable.

IS IT WORTH IT FOR THE COUNTRY TO MAKE SURE EVERYONE HAS COVERAGE?

First, health insurance for those Americans who now lac.. it would likely yield dividends in terms of improved health of between $65 and $130 billion annually. Second, knowing health insurance is assured would reduce the stress and uncertainty about future medical care needs and financial demands for all of us. The prospect of losing insurance is a very real fear for most Americans. If having health insurance were a certainty, families' fears would be alleviated about whether they can afford health care and also meet other basic needs like buying groceries and paying the rent. Third, if everyone had cover-

Insuring the uninsured could yield $65-$130 billion in better health each year.

age, the continued viability of community health services and facilities would be more secure because of the greater financial stability of insurance-based financing.

The Committee concludes that the estimated benefits across society in healthy years of life gained by providing health insurance coverage are likely greater than the additional social costs of providing coverage to those who now lack it. Current disparities in access to and the quality of health care between uninsured and insured Americans do not reflect the ethical commitments to equality of opportunity and respect for all members of society that underpin American democracy. We are not getting the best return on our considerable national investment in health because public policies allow tens of millions of Americans to remain uninsured. It is time to insure everyone.

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For More Information...

Visit the Committee's website at **www.iom.edu/uninsured**.
Copies of *Hidden Costs, Value Lost: Uninsurance in America* are available for sale from the National Academies Press; call (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area), or visit the NAP home page at **www.nap.edu.**

This study was funded by The Robert Wood Johnson Foundation.

The Institute of Medicine is a private, nonprofit organization that provides health policy advice under a congressional charter granted to the National Academy of Sciences. For more information about the Institute of Medicine, visit the IOM home page at **www.iom.edu.**

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LEGISLATIVE RESEARCH REPORT

FEBRUARY 15, 2007

REPORT NUMBER 07.092

DENALI KIDCARE AND THE UNINSURED

PREPARED FOR REPRESENTATIVE LES GARA

BY BECKY TAYLOR, LEGISLATIVE ANALYST

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You asked a number of questions about the Denali KidCare program and the number of uninsured Alaskans. Specifically, you wished to know what the federal poverty guidelines are for Alaska and whether these guidelines are used to establish eligibility for the Denali KidCare program. You also wished to know what types of medical care are covered by the Denali KidCare program. Additionally, you were interested in the number of uninsured children and adults in Alaska and how many of these uninsured Alaskans have access to the Indian Health Service.

ELIGIBILITY FOR DENALI KIDCARE

Denali KidCare is an expansion of Alaska's Medicaid program and is funded in part by federal dollars from the State Children's Health Insurance Program (SCHIP). Denali KidCare provides health insurance coverage to eligible children and teens through 18 years of age and to eligible pregnant women. Eligibility is based on family income level and the size of the household. There are two different sets of income guidelines for the Denali KidCare program, one which applies to *children who have other health insurance* and another which applies to *uninsured children and all pregnant women*.

Income limits for *children with other health insurance* are calculated at 150 percent of the federal poverty guidelines for Alaska. As such, income limits for households with children who have other insurance change when these guidelines change.[1] Table 1 displays the 2007 federal poverty guidelines for Alaska and other states.

Table 1: 2007 Federal Poverty Guidelines

Persons in Family or Household	Annual Income		
	48 Contiguous States and D.C.	Hawaii	Alaska
1	$10,210	$11,750	$12,770
2	$13,690	$15,750	$17,120
3	$17,170	$19,750	$21,470
4	$20,650	$23,750	$25,820
5	$24,130	$27,750	$30,170
6	$27,610	$31,750	$34,520
7	$31,090	$35,750	$38,870
8	$34,570	$39,750	$43,220
For each additional person add	$3,480	$4,000	$4,350

Source: *Federal Register,* Vol. 72, No. 15, January 24, 2007, pp. 3147–3148, U.S. Department of Health and Human Services, *http://aspe.hhs.gov/poverty/07poverty.shtml.*

In 2003, state legislation reduced the household income limits for *uninsured children and all pregnant women* from 200 percent of the federal poverty guidelines for Alaska to 175 percent of the guidelines and *converted* that percentage into dollar amounts.[2] As a result of this change, fewer children and pregnant women were eligible for Denali KidCare.

The federal poverty guidelines typically increase over time, so the income limits, which are fixed at 175 percent of the 2003 guidelines, are only about 160 percent of the 2006 guidelines and 155 percent of the 2007 guidelines. If the federal poverty guidelines continue to increase, Alaska's income guidelines for Denali KidCare will continue to fall as a percentage of the federal poverty guidelines. Table 2, on the following page, compares the income limits for *uninsured children and all pregnant women* to the 2007 federal poverty guidelines and also includes estimates of what the 2007 income limits will be for *children with other health insurance.*

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[1] "Income Guidelines," Denali KidCare, Division of Health Care Services, Alaska Department of Health and Social Services, April 2006, *http://www.hss.state.ak.us/dhcs/DenaliKidCare/pov_lev.htm.* This document is based on the 2006 federal poverty guidelines for Alaska and will be adjusted in the spring of 2007 to reflect the 2007 federal poverty guidelines. We include this document as Attachment A.

[2] Chapter 34 SLA 2003 modified AS 47.07.020 (b) (13) and (14).

Table 2: Estimated 2007 Denali KidCare Income Guidelines

Household Size	2007 Federal Poverty Guidelines for Alaska	Children with Other Health Insurance[a]		Uninsured Children and All Pregnant Women[b]		
		Monthly	Yearly	Monthly	Yearly	Percent of the 2007 Federal Guidelines
1	$12,770	$1,596	$19,155	$1,635	$19,620	154%
2	$17,120	$2,140	$25,680	$2,208	$26,496	155%
3	$21,470	$2,684	$32,205	$2,782	$33,384	155%
4	$25,820	$3,228	$38,730	$3,355	$40,260	156%
5	$30,170	$3,771	$45,255	$3,928	$47,136	156%
6	$34,520	$4,315	$51,780	$4,501	$54,012	156%
7	$38,870	$4,859	$58,305	$5,074	$60,888	157%
8	$43,220	$5,403	$64,830	$5,647	$67,764	157%

Notes: We estimate the 2007 income guidelines based on how these guidelines have been determined in the past. The Department of Health and Social Services has not yet released 2007 income guidelines for the Denali KidCare program.

(a) The monthly income limit for children with other health insurance is 150 percent of the federal poverty guidelines for Alaska. These income limits change when the federal poverty guidelines change.

(b) In 2003, the monthly income limits for uninsured children and all pregnant women were fixed in AS 47.27.020 (b)(13) and (14). These income limits do not change when the federal poverty guidelines change.

Sources: Federal Poverty Guidelines *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148, U.S. Department of Health and Human Services, *http://aspe.hhs.gov/poverty/07poverty.shtml.*

"Income Guidelines," Denali KidCare, Division of Health Care Services, Alaska Department of Health and Social Services, April 2006, *http://www.hss.state.ak.us/dhcs/DenaliKidCare/pov_lev.htm.*

Alaska's income guidelines are more restrictive than those in most other states. About forty states cover children from families with household incomes up to or above 200 percent of the federal poverty guidelines under Medicaid and/or their State Children's Health Insurance Program (SCHIP). States can use federal SCHIP funds either to expand their Medicaid program, which Alaska has done, or to create a separate SCHIP program, or to adopt a combination approach.[3] Figure 1, on the following page, displays the income eligibility criteria for Medicaid/SCHIP coverage for children in other states.[4]

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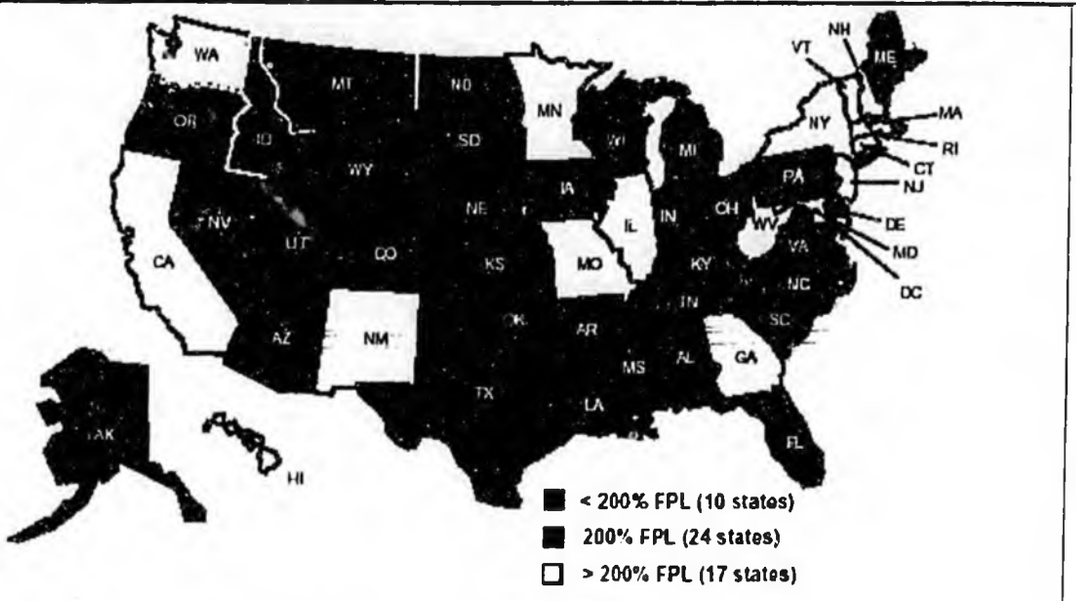
[3] Barbara Hale, Medical Assistance Administrator/SCHIP Coordinator for Alaska, points out that the SCHIP program is scheduled for reauthorization at the federal level in 2007 and that changes in the federal funding structure may impact Alaska's program. Personal communication from Barbara Hale, Medical Assistance Administrator/SCHIP Coordinator, Division of Health Care Services, Alaska Department of Health and Human Services. Ms. Hale can be reached at (907) 465-5833.

[4] This figure is taken from "State Children's Health Insurance Program (SCHIP) at a Glance," Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, January 2007, *http://www.kff.org/medicaid/7610.cfm.*

Figure 1: Children's Eligibility for Medicaid/SCHIP by Income, July 2006



*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

KAISER COMMISSION ON **Medicaid and the Uninsured**

MEDICAL COVERAGE UNDER DENALI KIDCARE

The Denali KidCare program provides comprehensive health care coverage for children, teens through age 18, and pregnant women who meet the eligibility criteria. Denali KidCare is actually comprised of several Medicaid eligibility categories administered by the State of Alaska. Because Denali KidCare is a Medicaid program, it covers the same services which are covered for all Medicaid recipients in Alaska.[5] Although other Medicaid recipients may be required to make a co-payment for services received, children under the age of 18 and pregnant women are not required to make a co-payment. Generally speaking, Medicaid appears to provide more extensive coverage of certain services for children than for adults. Medicaid recipients must obtain prior authorization for certain services such as orthodontia before receiving these services.[6]

The Denali Kid Care program covers regular prenatal checkups for eligible pregnant women, as well as two months of postpartum care. Nutrition services may also be covered for children and

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[5] Barbara Hale.

[6] "Alaska Medicaid Recipient Services," Alaska Department of Health and Social Services, revised April 2006, *http://www.hss.state.ak.us/dhcs/recipient_helpline.htm*, p. 16-17. We include this document, which provides more detailed information about covered services, as Attachment B.

pregnant women in certain situations.[7] Denali KidCare also covers complete physical exams for children under 21 years of age as part of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). According to the Alaska Department of Health and Social Services' Medicaid Recipient Handbook, these exams should include the following components:

- Height and weight measurement;
- Vision, hearing, and dental screening;
- Immunizations, if needed;
- Growth and development assessment;
- Age-related information about normal development, food, health, and safety;
- Time for parents, children and teens to have questions answered; and
- Referrals for dental care, vision exams, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), depending on the patient's age.

The Department recommends that children have a complete exam at the following ages:

- Birth, 2, 4, 6, 9, 12, 15, 18, and 24 months;
- 3, 4, 5, and 6 years; and
- at least every other year after age 6.[8]

The Denali KidCare program covers dental services for eligible children, including emergency, preventative, and routine dental services. Exams, x-rays, polishing, fluoride treatment, oral surgery, and sealants are covered, and orthodontia may also be covered under certain conditions. Unlike children, pregnant women who are over age 21 are eligible for only limited dental services necessary to relieve pain and infection.[9]

In addition to dental benefits, the program also provides recipients with access to certain vision services. Denali KidCare will cover one vision examination per calendar year and one pair of Medicaid approved glasses.[10]

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[7] "Alaska Medicaid Recipient Services," p. 9-10.

[8] "Alaska Medicaid Recipient Services," p. 15.

[9] "Alaska Medicaid Recipient Services," p. 5.

[10] "Alaska Medicaid Recipient Services," p. 13.

THE UNINSURED IN ALASKA

The Census Bureau appears to be the most widely used source of information about health insurance coverage in the United States. The Census Bureau collects health insurance data by surveying households as part of the Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS). The ASEC is a survey of about 78,000 households and includes detailed questions about health insurance coverage in the previous calendar year. According to the Census Bureau, this data can be used to examine state-level trends and differences; however, they point out that the usefulness of state level data may be limited by sampling errors.[11] Because the sample size in an individual state or category may be small, some analysts use multi-year averages when considering state-level data.

In 2005, the Census Bureau estimated that approximately 117,000 Alaskans, or 18 percent of the total population, were uninsured. Based on averages of data from 2003 to 2005, approximately 23,000 of the uninsured were children and 94,000 were adults. The ages of the uninsured in Alaska are roughly as follows:

- 22,700 uninsured Alaskans are 0-17;
- 21,000 uninsured Alaskans are 18-24;
- 44,000 uninsured Alaskans are 25-44;
- 27,800 uninsured Alaskans are 45-64; and
- 800 uninsured Alaskans are 65 and older.[12]

As you may know, the Census Bureau counts as part of the uninsured population those people who have access to the Indian Health Service but no other insurance . The Indian Health Service (IHS) is a federal program which provides medical assistance to eligible American Indians and Alaska Natives at IHS facilities and may pay the cost for selected health care services provided at non-IHS facilities.[13]

The Institute of Social and Economic Research (ISER) adjusted the Census Bureau's figures to separate those with IHS-only coverage from those with no coverage. The adjustment was based on the methods of the University of Minnesota's School of Medicine State Health Access Data Center. According to ISER's estimates, in 2004, 12.8 percent of Alaskans had no insurance coverage and another 4.2% had IHS coverage only . This suggests that roughly a quarter of the people that the Census Bureau considers to be uninsured in Alaska are covered by the Indian Health Service.

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[11] "Health Insurance: Overview," U.S. Census Bureau, Housing and Household Economic Statistics Division, last revised October 5, 2005, *http://www.census.gov/hhes/www/hlthins/overview.html*.

[12] "Available Data on Alaska's Uninsured," Health Planning & Systems Development Unit, Office of the Commissioner, Alaska Department of Health & Social Services, December 2006, *www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/assets/Data_Uninsured.ppt*. We include this presentation as Attachment C.

[13] "CPS Health Insurance Definitions," U.S. Census Bureau, Housing and Household Economic Statistics Division, last revised December 19, 2005, *http://www.census.gov/hhes/www/hlthins/hlthinstypes.html*.

The Institute of Social and Economic Research reports that between 2001 and 2003, on average, 53% of children in Alaska had private or employer-based health care coverage, 38.8% were coveraged through Medicaid, including Denali KidCare, or the Alaska Area Native Health Service, and the remaining 8.2% had no insurance. During that same time period, approximately 12% of children nationwide had no insurance.[14] It is likely that at least some of the children without health insurance are eligible for coverage under Denali KidCare.

According to ISER, Alaska probably has a smaller share of uninsured children because Alaska Native children are typically eligible for care through the Indian Health Service, and some children are covered by Denali KidCare. As the authors note, the uninsured generally suffer from poorer health and uninsured children are more likely to have development delays. The public bears the financial cost of having uninsured citizens in a number of ways, including government subsidies to hospitals to offset the costs of uncompensated care.[15]

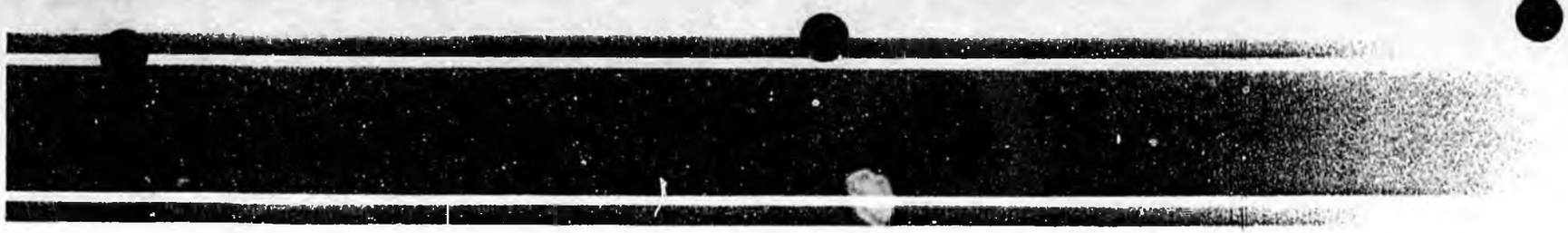
I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[14] Mark Foster and Scott Goldsmith, "Alaska's $5 Billion Health Care Bill—Who's Paying?" Institute of Social and Economic Research, University of Alaska Anchorage, UA Research Summary No. 6, March 2006, p. 4. We include this document as Attachment D.

[15] Foster and Goldsmith, p. 4.

Attachment A

"Income Guidelines," Denali KidCare, Division of Health Care Services, Alaska Department of Health and Social Services, April 2006, *http://www.hss.state.ak.us/dhcs/DenaliKidCare/pov_lev.htm*



DENALI KidCare

Household Size	Children with other Health Insurance* Monthly Income (150% FPL)	Children with no Health Insurance and Pregnant Women with or without Health Insurance ** Monthly Income
1	$1,532	$1,635
2	$2,063	$2,208
3	$2,594	$2,782
4	$3,125	$3,355
5	$3,657	$3,928
6	$4,188	$4,501
7	$4,719	$5,074
8	$5,250	$5,647
each additional	$532	$574

Note: An unborn child of a pregnant woman is counted in the household size for pregnant woman coverage.

Key Points

- Income figures are gross income (before taxes are taken out).
- Income eligibility is determined based on biological or adoptive parent income.
- Permanent Fund Dividends are not counted as income.
- A standard deduction per month for expenses related to employment may apply.
- A standard deduction per month for dependent care expense may apply.
- Child support payments may be allowed as a deduction.
- Income records and proof of deductions must be submitted with application.
- Anyone can apply for her/himself or on behalf of a child or teen.
- Children with other health insurance may still be eligible.
- Children, teens and pregnant women covered by Indian Health Service benefits may be eligible.

- ***Not sure if you're eligible? The only way to know for sure is to apply!***

Rev. 4/06

** Based on 2006 Federal Poverty Level (FPL) Guidelines for Alaska*

*** Based on 2003 Federal Poverty Level (FPL) Guidelines for Alaska frozen at the 2003 standard*

Attachment C

"Available Data on Alaska's Uninsured," Health Planning & Systems Development Unit, Office of the Commissioner, Alaska Department of Health & Social Services, December 2006, *www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/assets/Data_Uninsured.ppt.*

Available Data on Alaska's Uninsured

December 2006

Health Planning & Systems Development Unit
Office of the Commissioner
Alaska Department of Health & Social Services
Phone: 465-3091

www.hss.state.ak.us/commissioner/Healthplanning

Available Data on Alaska's Uninsured

December 2006

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Who are the Uninsured in Alaska?

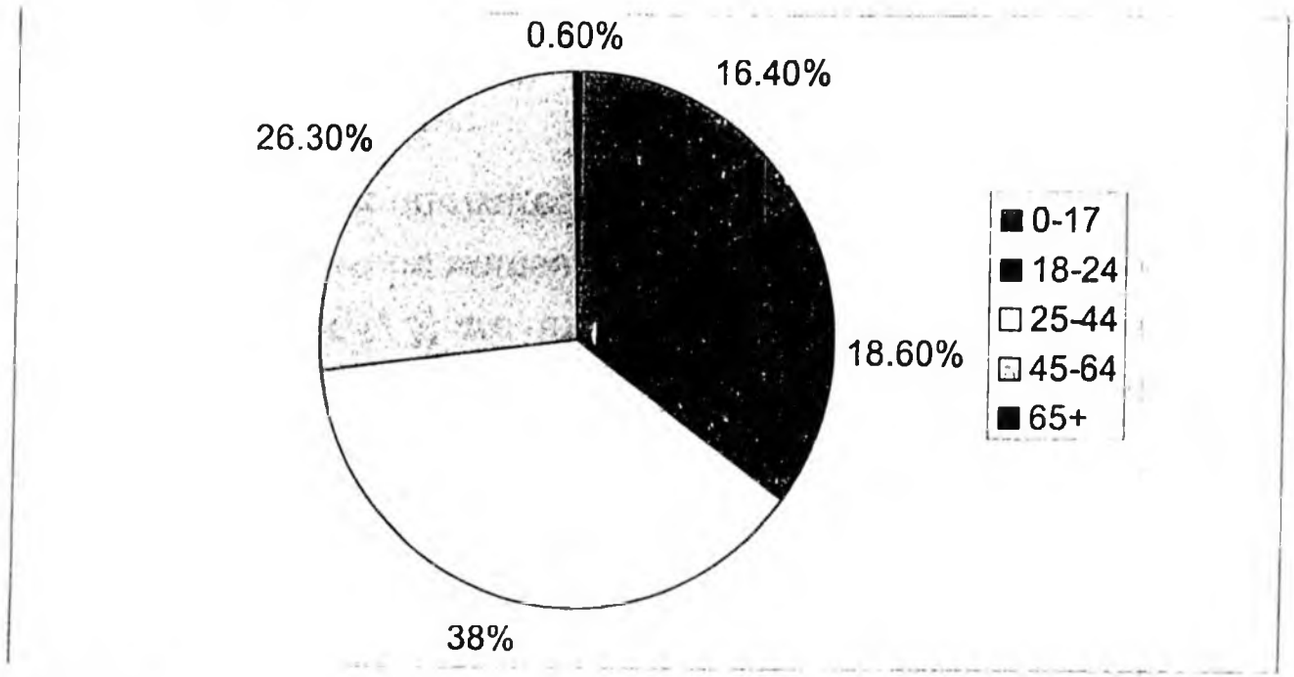
About 117,000 Alaskans (18% of the population) have been counted as uninsured in 2005.

- Young adults, males, and Alaska Natives are more likely to be uninsured.
- People who are self-employed, part-time workers, seasonal workers, and people who work for small firms are most likely to be uninsured.
- Most of the uninsured are employed; most uninsured who are not employed are children and others not in the workforce; only one in ten of the uninsured are unemployed people in the workforce.

*Current Population Survey (CPS), US Census Bureau

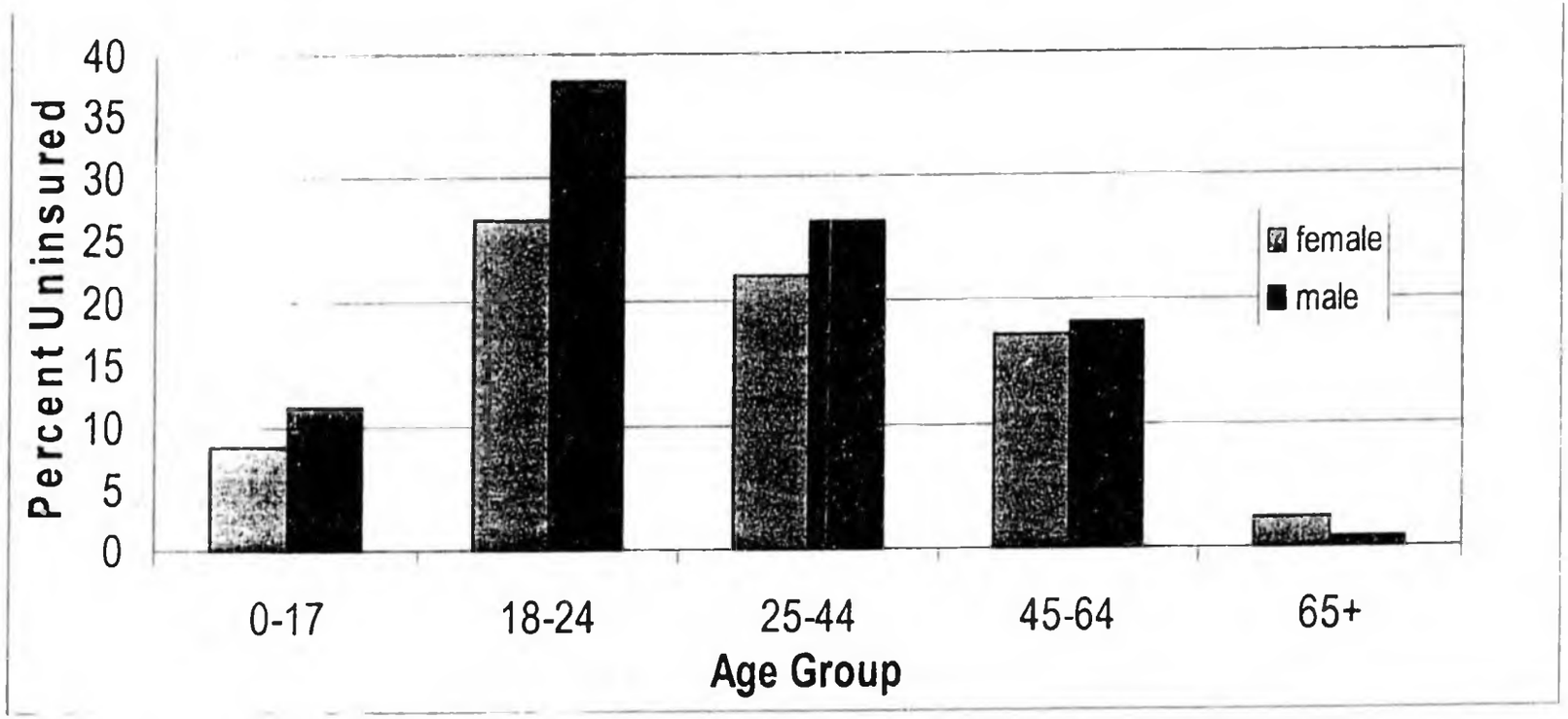
Age of the Uninsured in Alaska,
2003-2005 Average

- 22,700 Uninsured Alaskans are 0-17
- 21,000 Uninsured Alaskans are 18-24
- 44,000 Uninsured Alaskans are 25-44
- 27,800 Uninsured Alaskans are 45-64
- 800 Uninsured Alaskans are 65 and older



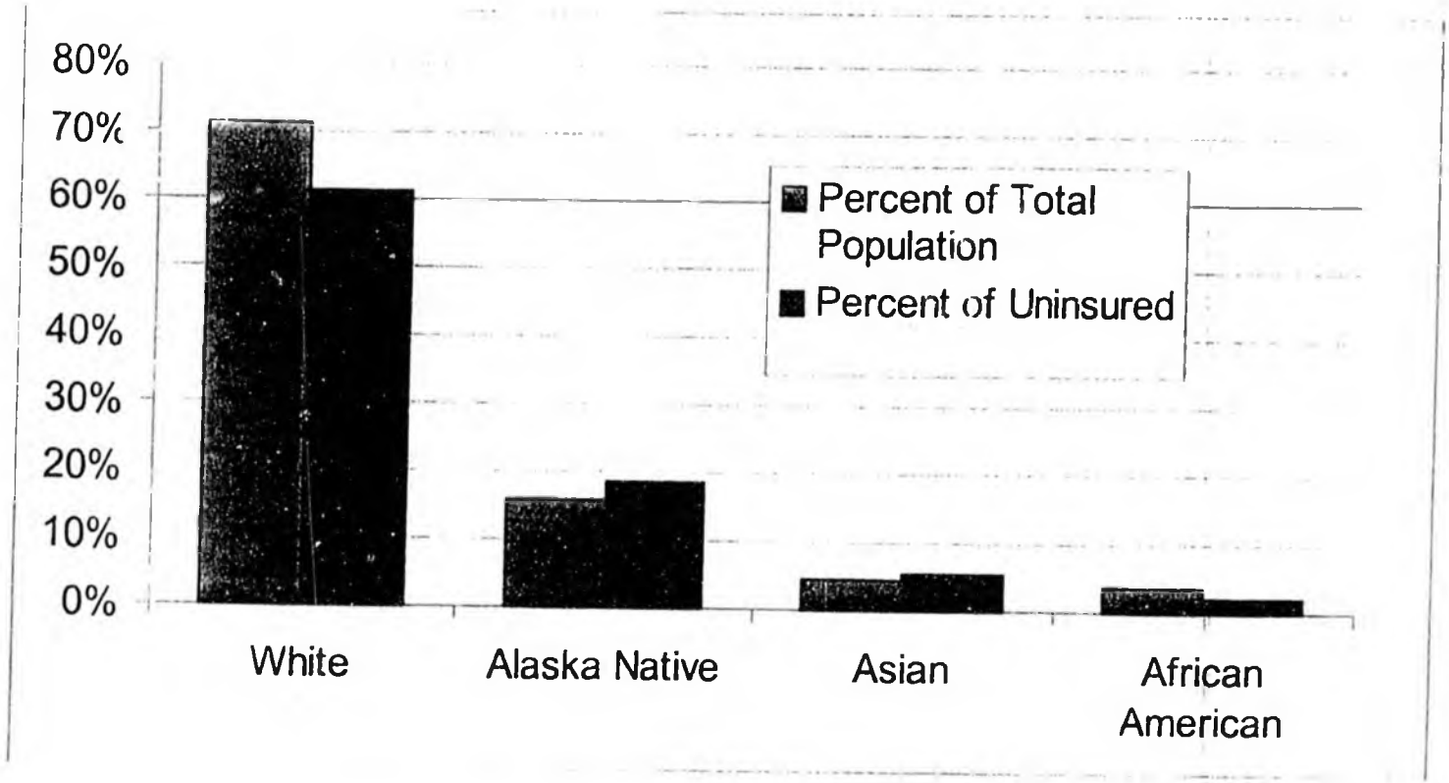
Age and Sex of the Uninsured in Alaska, 2003-2005 average

Although 18-24 year olds are about 1/5 of the uninsured, a higher proportion of 18-24 year olds (about 1/3) are uninsured than for any other age group.
Males are more likely to be uninsured – The CPS reports 16% of females and nearly 20% of males are uninsured.



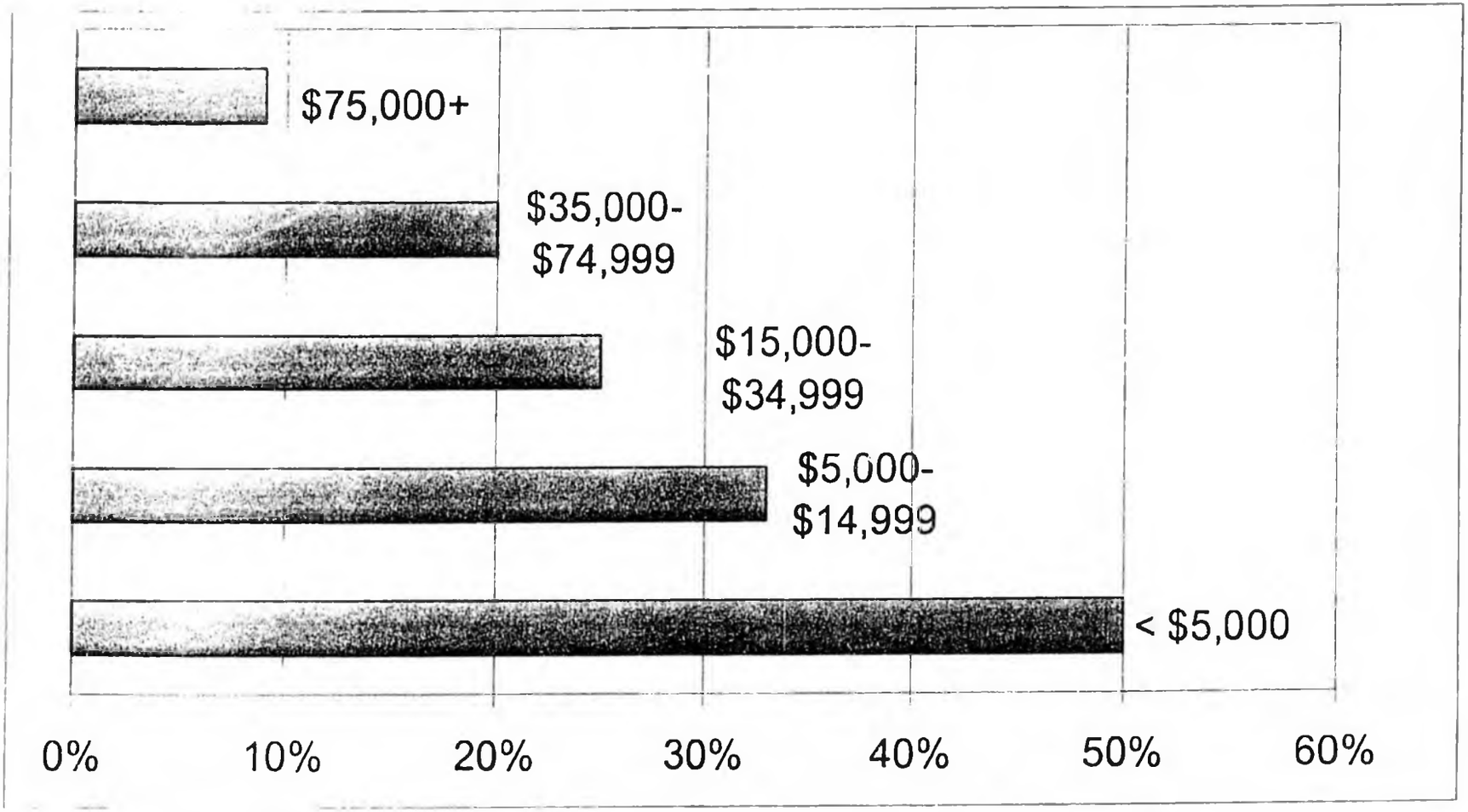
Race of the Uninsured, Alaska
2003-2005 average

Alaska Natives make up nearly 16% of the population, but account for 19% of the uninsured



Percent of Uninsured Alaskans By Household Income level

2003-2005 average

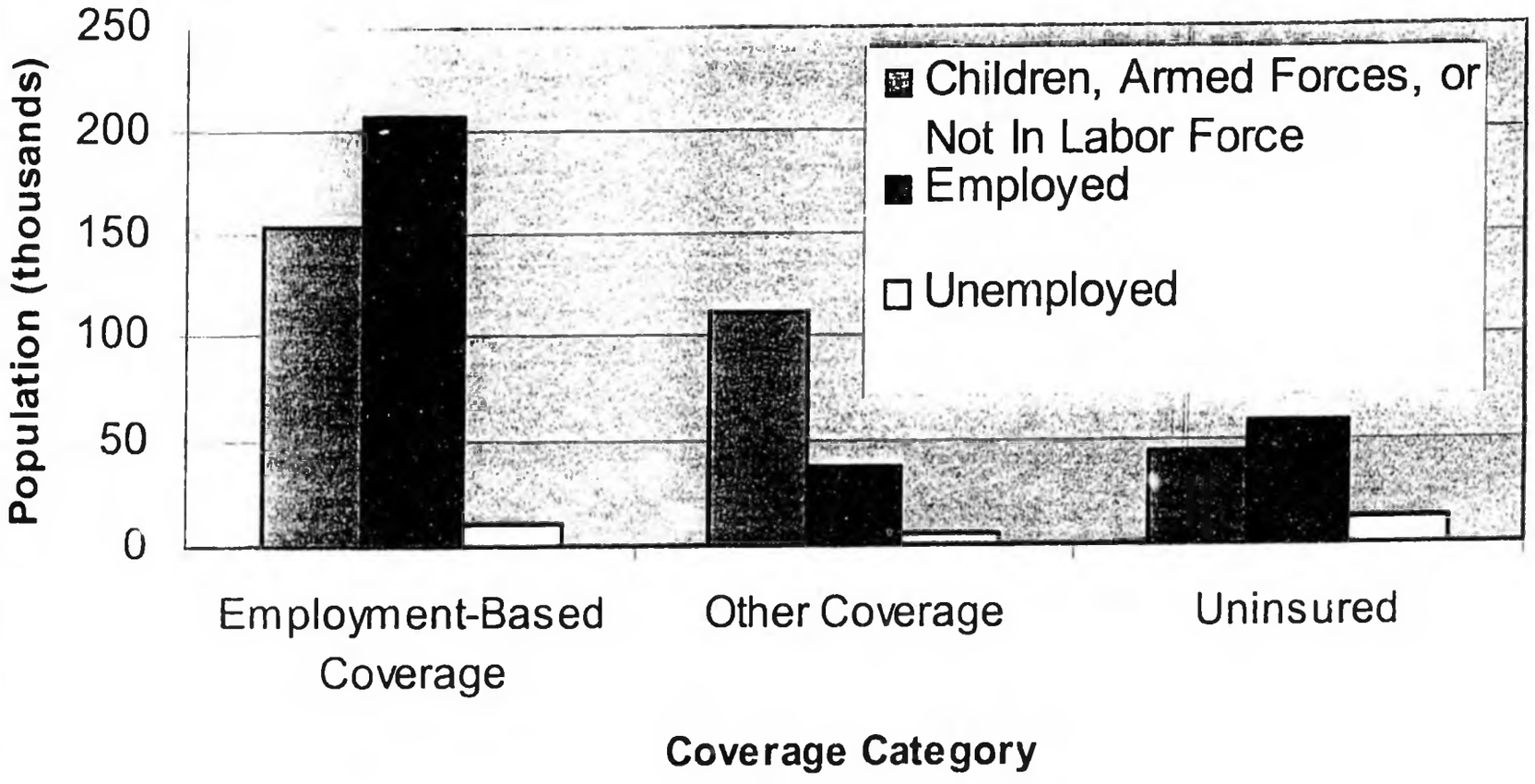


Health Insurance Coverage of Alaskans, 2003-2004

(Source: www.statehealthfacts.org, Medicaid data from CMS/USDHHS Administrative Data, other from Current Population Survey, US Bureau of the Census)

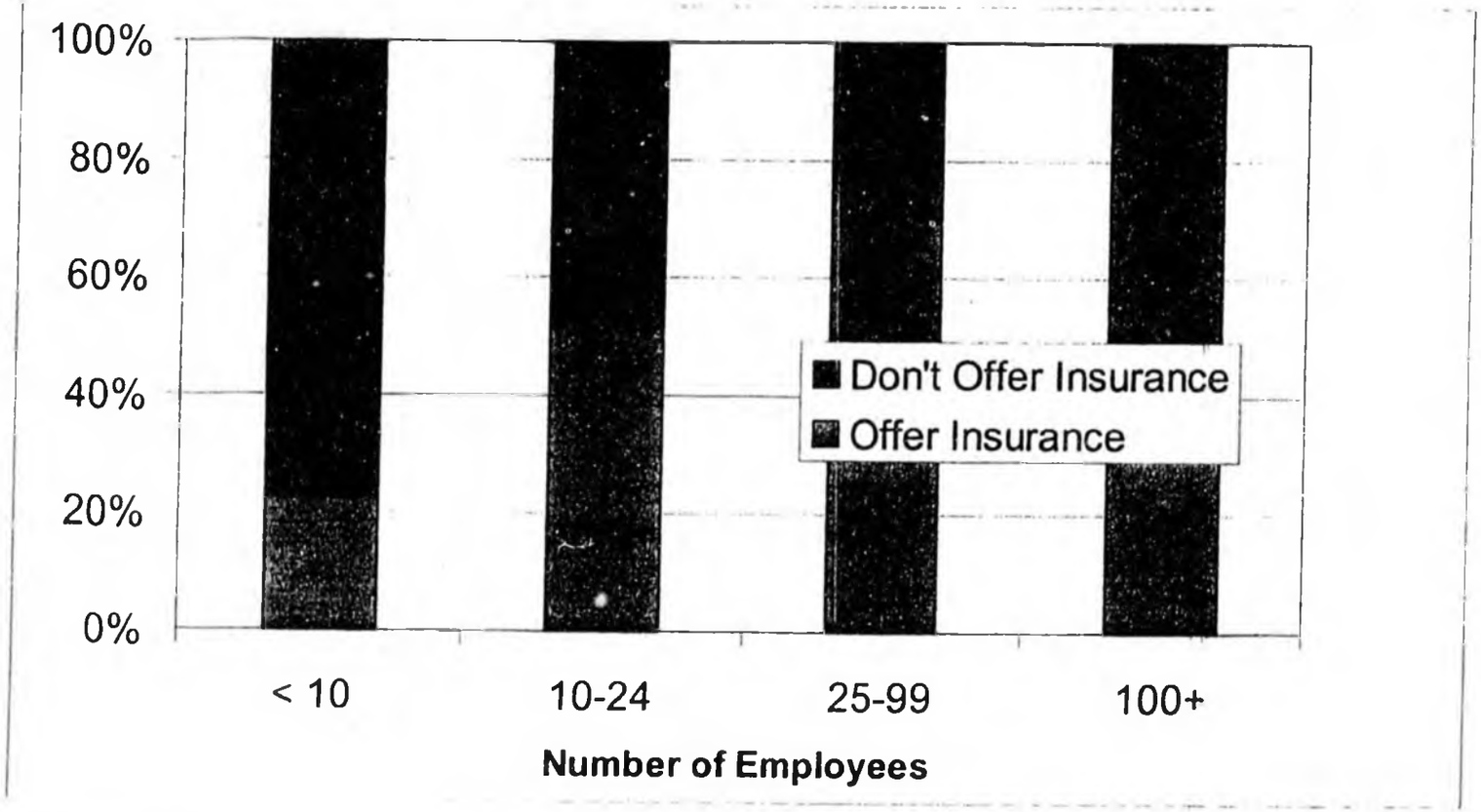
Coverage Type	Percent of Population
Employer	52%
Individual	4%
Medicaid	15%
Medicare	6%
Other Public	5%
Uninsured	**18%**
Total	100%

Health Coverage by Employment Status
(2003-2005 average)



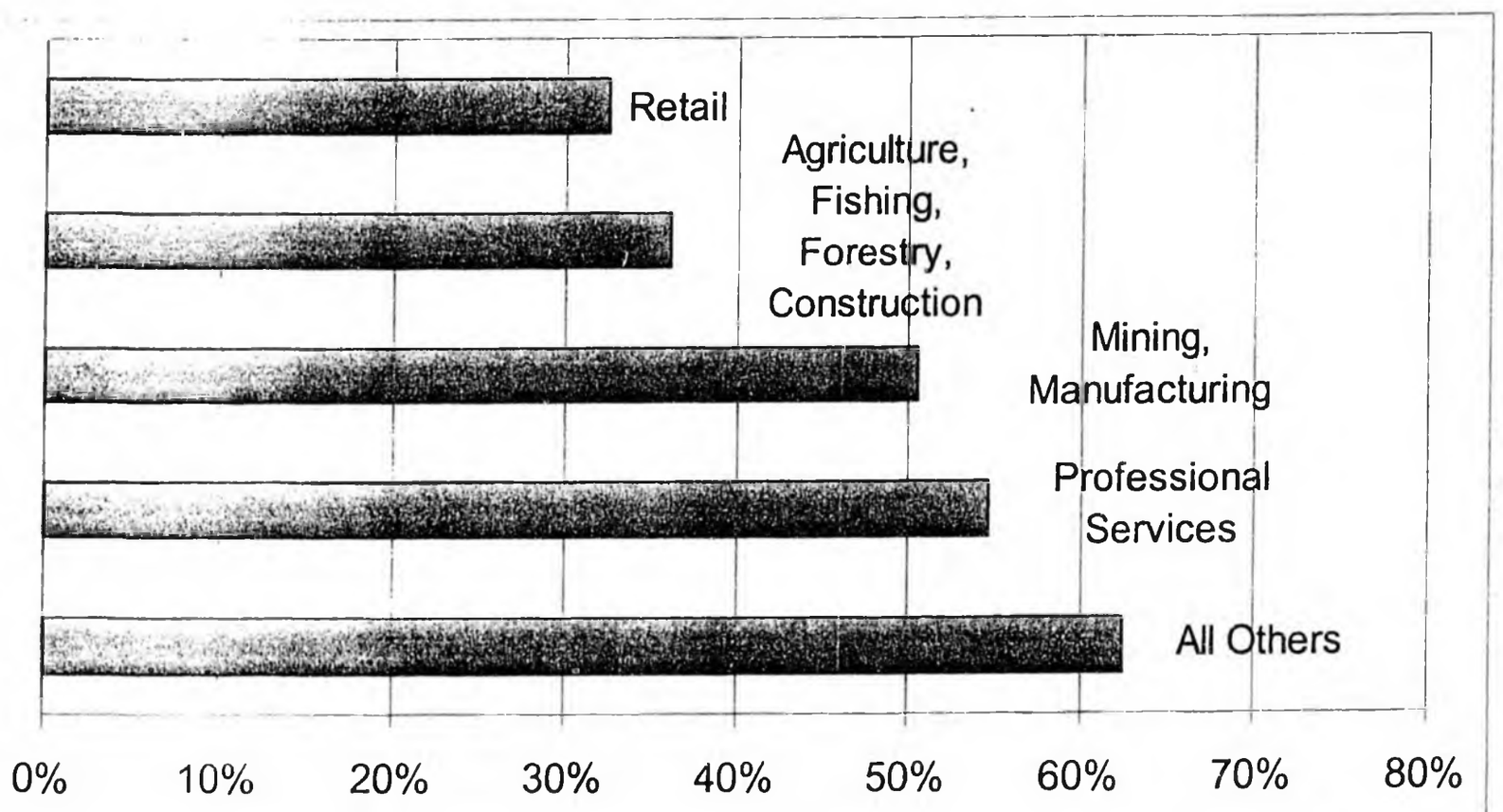
Uninsured Alaskans by Firm Size
2004

Less than one-fourth of firms with less than 10 employees offer health insurance to their employees and nearly all firms with more than 100 employees offer some type of health insurance.



Percent of Private Sector Firms Offering Health Insurance by Industry, 2004

Less than one half of all employers in Alaska offer health insurance.



Data Sources

U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2003 through 2005
(http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Agency for Healthcare Research and Policy, Medical Expenditure Panel Survey, 2004
(http://www.meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp)

Where to Find Information

For links to information about insurance, links to data and research on the uninsured, and information about the State Planning Grant:

www.hss.state.ak.us/commissioner/healthplanning/planninggrant/default.htm/

Email: infohealthplanning@health.state.ak.us

Write: Health Planning & Systems Development

PO Box 110601 Juneau AK 99811

Attachment D

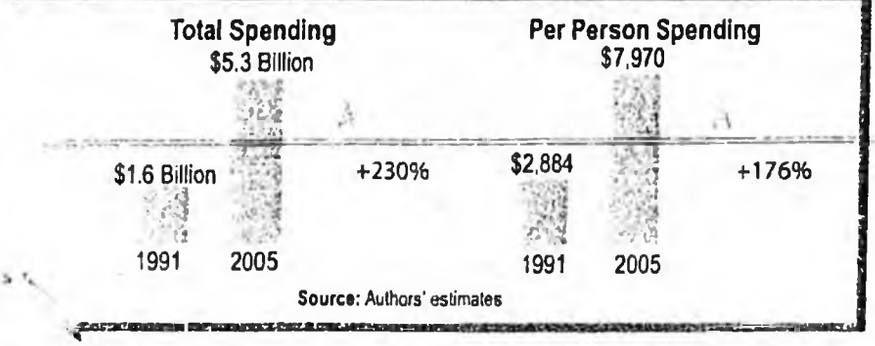
Mark Foster and Scott Goldsmith, "Alaska's $5 Billion Health Care Bill—Who's Paying?" Institute of Social and Economic Research, University of Alaska Anchorage, UA Research Summary No. 6, March 2006

Alaska's $5 Billion Health Care Bill—Who's Paying?

By Mark Foster and Scott Goldsmith

March 2006
UA Research Summary No. 6

Figure 1. Growth in Alaska Health-Care Spending, 1991-2005



Source: Authors' estimates

Spending for health care in Alaska topped $5 billion in 2005. Just how big is $5 billion? It is, for perspective, one-third the value of North Slope oil exports in 2005—a year of high oil prices. It's nearly one-sixth the value of everything Alaska's economy produced last year.

In 1991, health-care spending in Alaska was about $1.6 billion. Even after we take population growth into account, spending for health care increased 176% per Alaskan in 15 years. These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage.

The $5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 30%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

What does health-care spending buy? Stays in the hospital, visits to doctors and dentists, prescription drugs, and more, as well as program administration and public health programs. Our estimates don't include capital expenditures.[1]

Who pays the bills, and how has that burden shifted as spending increased?

• *Private and government employers spent about $2 billion for employee health-care coverage in 2005.* For comparison, they paid $11.8 billion in wages in 2005. With rising costs, businesses and governments have become increasingly likely to pay health-care bills themselves—"self-insure"—rather than pay through insurance premiums.

• *Alaska households spent just over $1 billion for health care in 2005, up from $361 million in 1991.* That includes everything individual Alaskans spent—not only their out-of-pocket costs, but also what was deducted from their paychecks to help pay for health coverage through their employers.

• *Governments spent $2.2 billion for health care programs in 2005, up from $736 million in 1991.* Medicaid spending was almost $1 billion.

Health-care spending could double again by 2013, if current trends continue. Why are costs of medical care so high, and why are they increasing faster than everything else? Why have health-care costs in Alaska stayed higher than U.S. averages, even as other costs moved closer to national levels? Are we getting better care now? Who can't afford care?

We're starting to assemble data to help answer those questions. Alaskans face some hard choices about how to control costs but still have a health-care system that provides good care and is accessible to everyone. We hope to provide some useful insights.

This publication is the first step in ISER's research on the health-care industry. It starts with our new estimates of spending and of changes since 1991, when we last looked at health-care spending.[2] But cost alone is only one part of the complicated health-care story, and here we also begin looking at:

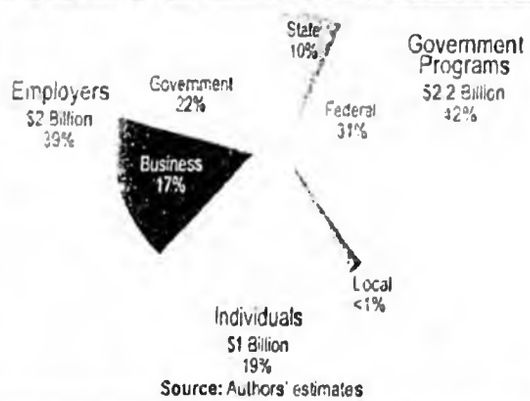
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• Who is more likely to have health insurance provided through their jobs at a reasonable cost? Single people working for big companies.

• How does use of the health care system in the U.S. compare with use in other countries? Canadians and Australians seem to use their systems about as much.

• What is driving costs? Despite what many people think, there are no simple explanations: it's a puzzle with many pieces.

Figure 2. Who Pays The Bills?
(Total 2005 Spending: $5.3 Billion)



Source: Authors' estimates

Understanding Alaska (UA) is a special series of ISER research studies examining Alaska economic development issues. The studies are paid for by the University of Alaska Foundation. UA reports are available from ISER's offices and at: www.alaskaneconomy.uaa.alaska.edu

Organization of Summary

We first describe what health-care dollars buy—what shares go to doctors, hospitals, drugs, and other expenses. Then we look in more detail at our estimates of health-care spending in 2005 and the changes since 1991. We think our estimates are a good effort to update our previous work. But the health-care industry is complex, and tracking all the spending is difficult.

After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

Pages 4, 5, and 6 discuss access to, use of, and benefits from the health-care system: who is uninsured; who has health-care coverage and how that coverage is provided; which patients get the costliest care; how Americans' use of medical care compares with use by people in other industrialized countries; and whether we've gotten healthier in exchange for more spending.

Page 7 summarizes what we know about how medical costs in Alaska differ from the U.S. average, and page 8 concludes with a discussion about the many things that may be driving health-care costs.

Keep in mind that population growth and general inflation account for part of the increase in health-care spending since 1991. Alaska's population increased from about 570,000 in 1991 to 665,000 by 2005. Also, prices for everything Americans buy also went up, by about 43% nationwide and 39% in Anchorage. But prices of medical care nearly doubled (Figure 3).

What Are We Buying?

Figure 4 shows that as of 2000, more than 70% of Alaska's health-care spending was for hospital care and visits to doctors. Prescription drugs accounted for about 9% and dental care 7%. The "other" category includes medical products, health care provided on the job and in schools, and Medicaid payments for in-home care.

Nursing home and home health care made up only 2% of health-care spending in 2000, far short of the U.S. average of 11%—and that share actually dropped between 1990 and 2000, despite fast growth in the number of Alaskans over 65. There has been a shift in how long-term care is provided in Alaska. A change in Medicaid allowed payment for in-home and assisted-living care for people who would otherwise have been cared for in nursing homes.

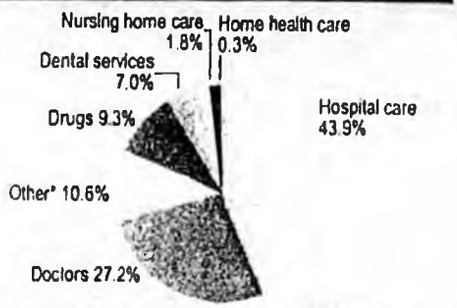
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

How Has Spending Changed?

Table 1 details who paid for health-care in 2005. Figures 5 and 6 show changes in levels and shares of spending from 1991 to 2005.

- Growth in government spending wasn't uniform. The federal government's share of spending increased (Figure 5). Costs for Medicare and Medicaid more than quadrupled and costs for the Indian Health Service doubled.

Figure 4. What Are We Buying?
(Alaska Health Care Spending, 2000)



*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.
Source: Center for Medicare and Medicaid Services

- State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.[3]

- Local government is the smallest government spender, but the local share of spending increased, mostly because of growing costs for employee health coverage.

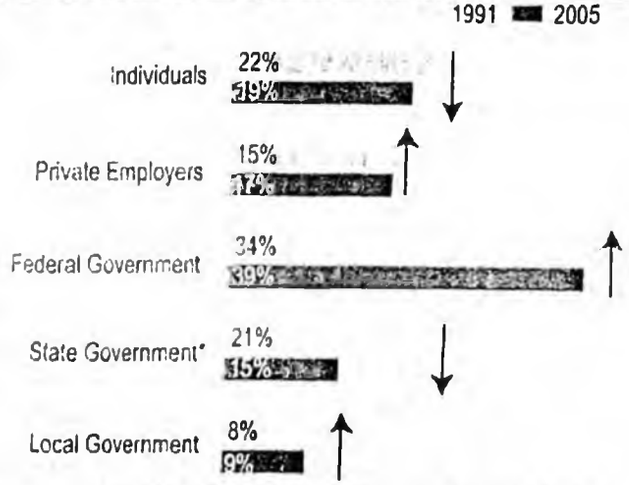
- Employers saw the fastest growth. Combined spending by private and government employers increased about 290% (Figure 6).

- Spending by individual Alaskans didn't go up as much—184%—but the $1 billion they spent in 2005 was still more than the $922 million businesses spent.

Figure 3. Increase in Consumer Price Index Anchorage and U.S., 1991-2005

*Measures price increases in a specific "market basket" that includes hospital care, visits to doctors and dentists, nursing home care, and medical supplies; also indirectly measures increases in health insurance premiums.
Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Anchorage and U.S. City Average

Figure 5. How Did Shares of Spending Change From 1991 to 2005, Among Those Who Buy Health Care?



*See endnote 3, page 8. Note: Totals may not add to 100% because of rounding.
Source: Authors' estimates

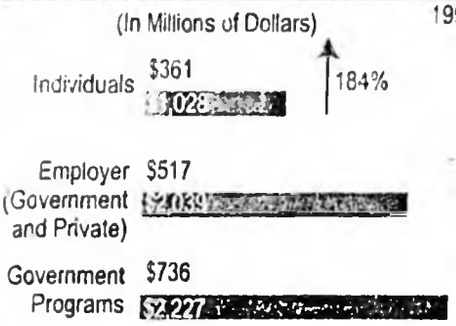
Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

Who Provides the Coverage?	Who Buys the Care? (In Million of Dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total
Individuals	**$1,028**					**$1,028**
Out-of-pocket costs	$431					
Individual policies	$276					
Payments for employer-based insurance	$320					
Employers (Including retiree coverage)		**$922**	**$454**	**$252**	**$411**	**$2,039**
Insurance Premiums		$303	$103	$72	$75	
Self-Insured Costs[a]		$485	$352	$180	$115	
Military Medical Costs					$221	
Worker's Compensation (medical benefits)		$134				
Government Health Programs			**$38**	**$535**	**$1,654**	**$2,227**
Medicare					$419	
Medicaid				$303	$667	
Other Public Programs						
Federal						
Indian Health Service Contracts					$401	
Veterans' Affairs					$105	
Community Health Centers					$29	
State						
Grant to local governments, private groups				$116		
API, Pioneers' Homes				$55		
Other State-Administered				$31		
Elementary and Secondary Schools			$3	$8	$33	
WAMI Medical Education				$2		
Department of Corrections				$21		
Local						
Health and hospital spending			$35			
Total Spending	**$1,028**	**$922**	**$492**	**$787**	**$1,950**	**$5,294**

[a]Many organizations that self-insure—that is, they pay some of their bills themselves—also still carry some insurance to help cover extraordinary risks.

Source: Authors' estimates Note: Totals may not sum because of rounding.

Figure 6. How Did Spending Change From 1991 to 2005, Among Those Who Provide Coverage?



Source: Authors estimates

Biggest Kinds of Changes

- Individual Alaskans have seen big increases not only in costs they notice most—how much they have to pay out of their own pockets—but also in less obvious costs: deductions from their paychecks to pay their share of employer-based insurance.
- Both private and government employers became much more likely to self-insure. Self-insurance costs made up about two-thirds of combined employer spending for insurance premiums and self-insurance in 2005, up from about one-third in 1991.
- Spending for Medicaid more than quadrupled (from $215 million to $970 million), so that in 2005 it alone made up nearly $1 in every $5 of health-care spending. Analysts attribute the fast growth of Medicaid nationwide to growing numbers of eligible Americans, including low-paid workers whose employers don't provide coverage and low-income seniors; to program expansion; to increasing prices of medical care; and to treatment of medical conditions at lower thresholds.

Health-Care Coverage

Most Alaskans—an estimated 87%—have some form of health-care coverage, either through private insurance or government programs.[4] Some people have more than one kind of coverage, so the percentages in Figure 7 add to more than 100%.

Around 64% of Alaskans are covered by private insurance, 38% by government programs, and nearly 13% have no coverage. Nationwide, 68% of people are covered by private insurance, 30% by government programs, and close to 16% have no coverage.

Alaskans are more likely to have coverage through the military (reflecting the state's large number of active-duty and retired military); the Indian Health Service (because Alaska Natives make up 20% of the population); and Medicaid (the joint federal-state program mainly for low-income and disabled people). Fewer Alaskans are covered by Medicare, because fewer are over 65.

We don't know characteristics of the 13% of Alaskans with no health-care coverage, but we know that nationwide the uninsured are most likely to be young adults and to have annual incomes below $25,000 (Figure 8).

Children in Alaska are more likely to have coverage than both adults in Alaska and children nationwide. Figure 9 shows that about 8% of children in Alaska had no coverage in 2003, compared with the U.S. average of nearly 12%.[5] The smaller share of uninsured children in Alaska is probably due to the fact that Alaska Native children are eligible for care through the Indian Health Service, and also to the Denali KidCare program, an extension of Medicaid that provides coverage for low-income children without other coverage.

It's outside the scope of this summary to describe all the ways that families, communities, and governments are affected because millions of Americans lack health insurance. But a recent report by the National Academy of Sciences broadly summarized those effects. It found that the uninsured are in worse health; that uninsured children are more likely to have development delays; that the direct costs of caring for uninsured Americans fall heavily on local communities; and that governments pay hospitals large public subsidies to offset their costs for uncompensated care.[6]

The 64% of Alaskans with private insurance either pay for that coverage themselves (through individual policies) or are covered through their jobs and share the costs with their employers. Figures 10, 11, and 12 show how the rising costs of medical care have affected health-insurance coverage for Alaskans working for private industry.

Figure 7 Health-Care Coverage, Alaska and U.S.

	Private Insurance	Medicaid	Medicare	Military	IHS only*	None
Alaska	63.5%	15.3%	7.3%	11.6%	4.2%	12.8%
U.S.	68.1%	12.9%	13.7%	3.7%	N/A	15.7%

*Authors' adjustment. See endnote 4, page 8.

Note: Totals are more than 100% because some people have more than one coverage.
Source: U.S. Census Bureau, Current Population Survey, 2004

Figure 8 Who Is Most Likely To Be Uninsured in U.S.?

	Percent Uninsured
By Age	
18–24	31%
65+	1%
By Annual Income	
Less than $25,000	24%
$25,000+	8.4%

Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the U.S.*, 2004

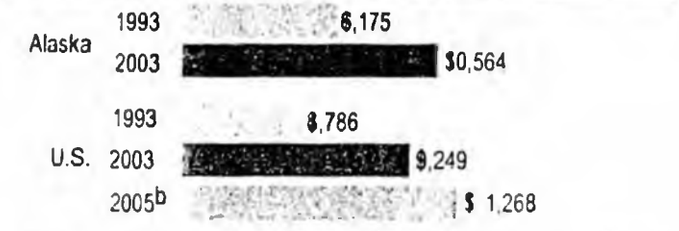
• Health insurance in Alaska was already more expensive in the 1990s and still is. In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. By 2005, those premiums had jumped to an average of $11,268 nationally (Figure 10).

• Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. But employers, especially at small firms, have been shifting more insurance costs to workers. The 2005 UBA-Ingenix Health Plan Survey found that employees of businesses nationwide paid 43% of the premiums for family coverage.

Figure 9 Health-Care Coverage for Children (18 and Under), Average 2002–04

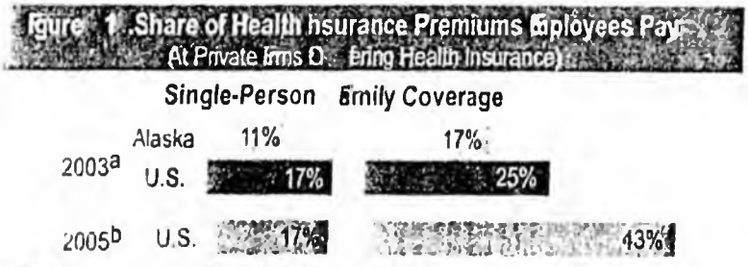
Source: American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

Figure 10 Health Insurance Premiums for Family Coverage[a], Private Firms



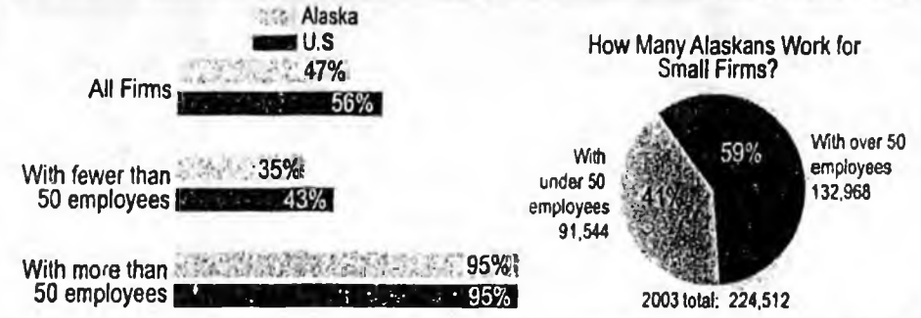
[a]Total costs shared by employer and employee. [b]Alaska figures for 2005 not available.
Sources: Medical Expenditure Panel Survey, U.S. Agency for Health Care Research and Quality, 2003; 2005 UBA/Ingenix *Health Plan Survey*

Figure 11 Share of Health Insurance Premiums Employees Pay At Private Firms Offering Health Insurance



[a]Reported in Medical Expenditure Panel Survey, 2003.
[b]Alaska 2005 figures not available; national figures from 2005 UBA/Ingenix *Health Plan Survey*

Figure 12. Private firms offering Health Insurance,* Alaska and US, 2003



* Not all workers at firms that offer insurance carry that insurance. Source: Medical Expenditure Panel Survey, 2003

• Small Alaska businesses are less likely to offer insurance coverage. Only about a third of those with fewer than 50 employees offer coverage, compared with 43% nationwide (Figure 12).

A lot of Alaskans work for small businesses. In 2003, about 91,500 of the state's 224,500 private-industry employees worked for businesses with fewer than 50 employees. That's more than 40% of all those with jobs in private industry.

Who Costs the Most and the Least?

We've talked about the costs of health care and of health-care coverage. Now we turn to the other side of the equation: who's getting the benefits of the spending?

Health-care spending in Alaska was close to $8,000 per person in 2005. But not everyone is average. The cost of care for a few is significantly higher than average, but for many it's only a few hundred dollars a year.

As a first step toward understanding who gets the benefits of health-care spending, ISER analyzed national data on the characteristics of high- and low-cost patients. That data is from a federal panel survey—that is, a survey that follows households over time.

As Figure 13 shows, just 5% of patients nationwide account for almost half of all health-care spending in any given year, while at the other extreme 50% of patients account for just 3% of spending in a year.

A lot of Americans tend to think that the most expensive patients are probably very old, or suffering from some catastrophic illness or injury, and are possibly uninsured.

The high-cost patients are older; health-care costs do go up as people age.[7] But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under $20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital for surgery, several visits to doctors, and significant spending for prescription drugs. Few of the high-cost patients—2%—are uninsured.

The low-cost patients are mostly young, averaging 28 years old. They may see a doctor or a dentist once a year, and they pay almost half their modest medicals bills out of their pockets.

Many of the low-cost group—nearly 20%—are uninsured. The share of uninsured patients in this group tracks with what the National Academy of Sciences has reported: that the uninsured often don't have any medical costs at all in a year, and among those who do, their expenses are less than half the average for people under 65.[8]

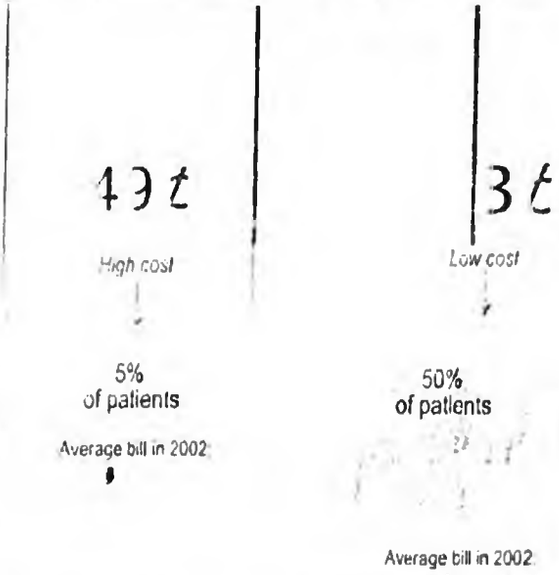
Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

Figure 13. Who Are the High-Cost and the Low-Cost Patients in the U.S.?

Distribution of Health-Care Spending on Patients, 2002

Who Are the High-Cost Patients?

- Mostly middle-aged people (average age 57), who are hospitalized for a few days, see doctors several times a year, and spend considerable money (average $3,000) on prescription drugs.
- About 40% are over 65
- They are from all income levels. A third have high incomes (family income over $20,000), and about a fifth are poor (family income under $18,000).
- Only 2% are uninsured. More than two-thirds have private insurance, and nearly a third are covered by government health programs, the most common being Medicare.
- They pay about 12% (average $2,400) of their bills out-of-pocket.



Who Are the Low-Cost Patients?

- Mostly young (average age 28), healthy people, who are likely to see a doctor and a dentist once a year and spend little (average $44) for prescription drugs.
- About 3% are over 65
- They are from all income levels, with almost the same breakdown as among high spenders: nearly a third have high incomes and about a fifth are poor.
- Nearly 20% are uninsured. About 17% are covered by government programs, most commonly Medicaid. The majority have private insurance.
- They pay about 40% (average $84) of their bills out-of-pocket.

Sources: *MEPS Statistical Bnef No. 81, May 2005 and analysis of MEPS data by Stephanie Martin of ISER*

Do We Use More Medical Care?

Americans spend more on health care than anybody else. Do Americans increase health-care costs by getting more medical care than people in other developed countries? Or conversely, do countries with national health-care systems hold down costs by rationing care?

Figure 14 compares Americans with the British, Canadians, New Zealanders, and Australians on use of, access to, and satisfaction with their health-care systems. The comparison countries all have some form of national health-care system.

Overall, the comparisons show that residents of all four countries are almost equally likely to see doctors and have diagnostic tests, and that Americans are slightly more likely to take prescription drugs.

Americans are, however, more likely to skip medical tests because of cost and less likely to get appointments the same day they call. They also seem to be somewhat less satisfied with care they get from their doctors and in the emergency room.

Figure 4 Use of Medical Care, US. and Selected Countries, 0
(Percent of Survey Respondents)

	US.	Great Britain	New Zaland	Canada	Australia
Saw at least one doctor in previous 2 years	%	95%	97%	95%	98%
Regularly take prescription drugs	%	44%	39%	43%	39%
Had blood tests, x-rays, or other diagnostic tests in past 2 years	%	71%	82%	84%	83%
Able to get doctor's appointment same day when sick	%	41%	60%	27%	54%
Skipped medical tests, treatment or follow-up because of cost	%	2%	20%	8%	18%
Rate regular doctor's care excellent or very good	%	64%	74%	68%	71%
Among those who used emergency room, share who rate emergency services fair or poor	%	23%	27%	27%	23%

Source: Commonwealth Fund International Health Policy Survey, 2004

Are We Healthier?

Another important aspect of the health-care story is what we're getting in return for the high spending. Are Alaskans healthier than in 1990?

The answer seems mixed. In 2005 the United Health Foundation ranked Alaska as among the most improved states in health outcomes since 1990. Despite that improvement, the foundation still ranks Alaska somewhere in the mid-range of states on health measures—because 15 years ago Alaska was ranked toward the bottom.[3] Figure 15 illustrates some of the improvements Alaska has made since 1990.

Rates of infectious disease (which include hepatitis, tuberculosis, and many more) went from far above the U.S. average in 1990 to significantly below by 2005. Infant mortality dropped in Alaska and throughout the country.

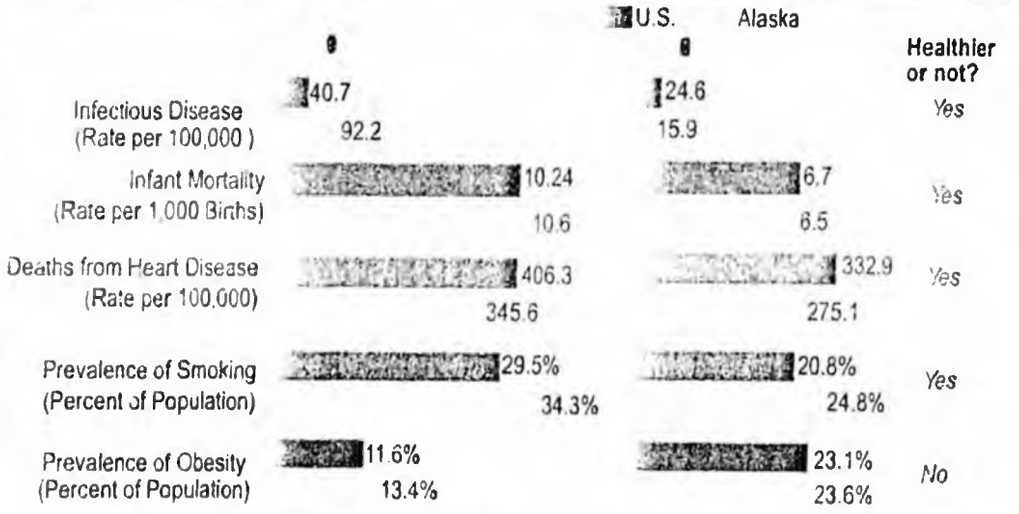
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology have also reduced infant deaths.

With improved treatments for heart disease, the rate of death from heart disease declined by 20% in Alaska since 1990, dropping slightly faster than the national rate.

Rates of smoking among Alaskans fell also, but Alaskans are still more likely to smoke than other Americans. Again, public-health campaigns to fight smoking likely contributed to the decline.

On the down side, Alaskans and other Americans are far more likely to be obese now than in 1990—and obese people are more likely to require treatment for diabetes and high blood pressure.

Figure 5 Are Alaskans Healthier Now Than in 0



Source: United Health Foundation, *America's Health Rankings 2005*

Alaska and U.S. Costs

Years ago, everything cost more in Alaska, and costs still remain high in remote areas. But in Anchorage and other urban places, the historically high costs of many things have moved closer to U.S. averages in recent times, as the population grew, local markets got bigger, and infrastructure and transportation improved.

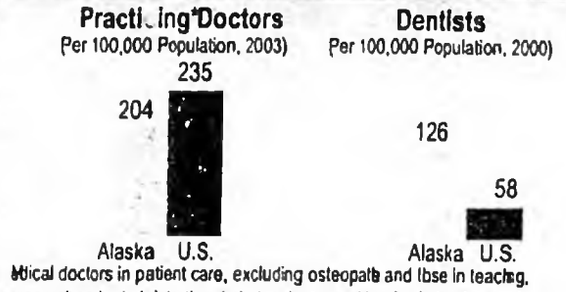
But costs of medical care haven't declined relative to U.S. averages. Overall medical costs are probably somewhere in the range of 25% higher in Alaska, but that cost difference varies quite a bit among services and procedures, and prices don't always reflect cost.

Alaska has fewer practicing doctors per capita than the nation as a whole, but about twice as many dentists—so how the supply of medical professionals may affect costs is not clear (Figure 16).

Figures 17 through 20 show some examples of cost differences, but it isn't a comprehensive picture.

- Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).
- Average costs of a visit to a doctor's office were 30% higher in Alaska in 2001. But the average is a mix of private insurance and government payments. A private insurer in Anchorage and Fairbanks paid nearly twice as much as Medicare for an office visit in 2001, as Figure 18 shows.
- Alaskans don't use as many prescription drugs as other Americans—mostly because there are fewer Alaskans over 65—but we pay more. In 2003, the average price of retail prescriptions was 25% higher in Alaska.
- Costs of hospital care went up faster in Alaska than nationwide from 2000 to 2003—so in 2003 average expenses for a day in an Alaska hospital were 42% above the U.S. average, compared with 30% in 2000.

Figure 16 How Do Numbers of Alaska Doctors and Dentists Compare with U.S. Average?



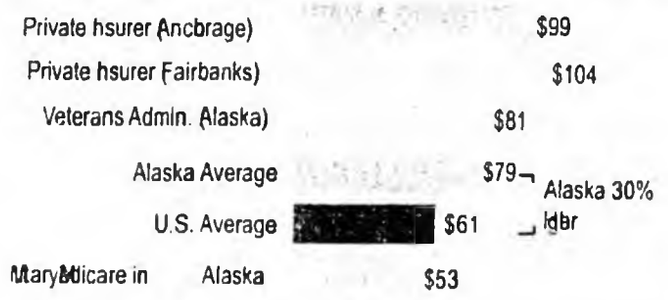
Medical doctors in patient care, excluding osteopaths and those in teaching, research and administration. Includes doctors working for federal agencies.
Sources: National Center for Health Statistics, Health United States, 2005; U.S. Department of Health and Human Services, Alaska Workforce Profile, 2000.

Figure 17 How Much Higher are Medical Costs in Alaska?
Costs Paid by Private Insurer, 2000)

	Percent Above U.S. Average
Medical/Surgical Procedures	18.1%
Dental Procedures	37.7%

Source: Ingenix data base; cited in Alaska Division of Medical Assistance, Health Care Cost Analysis, 2001

Figure 18 Costs of An Office Visit, Alaska and US, 2001
(Established Patient, 15 minutes)



Insurance coverage for active-duty and retired military personnel for medical care not available from military facilities.
Source: GAO Report GAO-01-620, July 2001

Figure 19 Prescription Use and Cost, Alaska and US, 2003

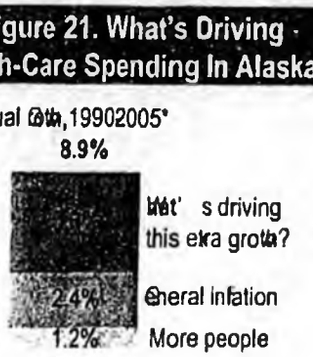
	Prescriptions Per Capita	Average Price of Retail Prescriptions	Average Cost Per Capita
United States	10.7	$52.97	$566.78
Alaska	8.3	$66.89	$421.41

Source: Kaiser Family Foundation, based on data from Verispan, LLC., Special Data Request, 2004, and U.S. Census Bureau, State Population Datasets for six Race Groups

Figure 20 Hospital Costs, Alaska and US, 2000 and 2003
(Expenses per In-Patient Day)

Source: 2003 American Hospital Association, Annual Survey

Figure 21. What's Driving Health-Care Spending In Alaska?



*Authors' estimate

What's Driving Costs? It's a Puzzle

Spending for health care in Alaska increased an average of nearly 9% a year from 1990 to 2005—and that figure doesn't reflect the big capital costs for building hospitals and clinics in the state since 1990.

More people and general inflation together account for only about 40% of that growth. So what's driving the rest?

Just about everybody has an opinion about what's pushing up medical costs, here and nationwide. Alaska has some special conditions—mostly small markets and high costs in rural areas—but other possible contributors to high costs are common to Alaska and the rest of the country.

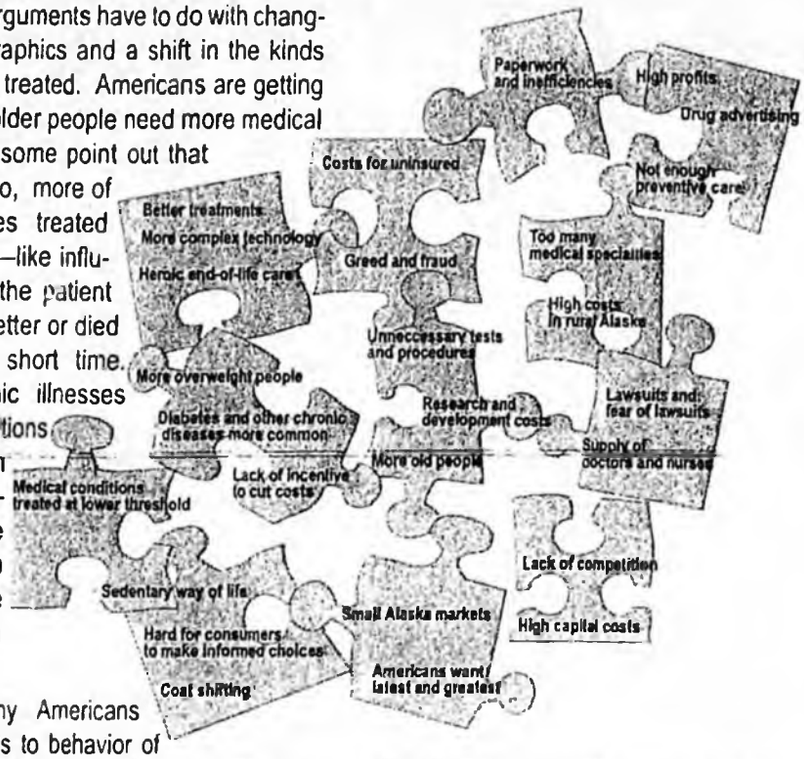
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

Other arguments related to the delivery system are that Americans get more medical care than they need, because most of the bills are still paid by health insurance. Others believe, by contrast, that costs of caring for uninsured people are responsible.

Others blame environmental factors, especially Americans eating too much and not exercising—leading to the spread of diabetes and other conditions requiring more care.

Still others say the growth has to do with changes in treatments and technology—treating conditions at lower thresholds (like the recent drop in the cholesterol level at which doctors recommend treatment); more effective but costlier treatments and prescription drugs; and more complex technology.

Other arguments have to do with changing demographics and a shift in the kinds of illnesses treated. Americans are getting older, and older people need more medical care. Also, some point out that decades ago, more of the illnesses treated were acute—like influenza—and the patient either got better or died in a fairly short time. Now, chronic illnesses and conditions—like high blood pressure—are common and require long-term treatment.



And many Americans link high costs to behavior of drug companies, the insurance industry, the medical and legal professions, and individual Americans. Such behavior would include, for instance, insurance and drug companies making high profits; doctors overbilling government programs; and patients filing lawsuits—causing doctors to practice "defensive medicine."

Probably there are other opinions we haven't discussed here. We're not endorsing any of them, but merely pointing out that many things could be contributing to rising costs—and it's a puzzle how all the pieces fit together. We will learn more as we study Alaska's health-care system. But for now, we want to emphasize that the answer to what is driving health-care costs is not simple, and finding solutions won't be simple either.

Endnotes

1. Our estimates are based on the Center for Medicare and Medicaid Services definitions of personal health care spending. See http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage. We have also included insurance costs to capture the expenses paid by employers and employees.

2. ISER *Research Summary* No. 53, "The Cost of Health Care in Alaska," December 1992.

3. The decline in state share is expected to ameliorate somewhat beginning in FY 2006, due to a decision by the 9th District Appellate Court to disallow the Fair Share program that enabled tribal hospitals to receive a higher reimbursement than non-tribal hospitals for uncompensated care.

4. U.S. Census Bureau figures from the Current Population Survey classify Alaskans with coverage only through the Indian Health Service as "uninsured." We have adjusted those figures, separating those with IHS-only coverage from the uninsured. The adjustment is based on methods of the University of Minnesota's School of Medicine, State Health Access Data Center.

5. Figures from the American Academy of Pediatrics for uninsured Alaska children are adjusted U.S. Census figures, separating children with IHS-coverage only from the "uninsured" category.

6. National Academy of Sciences. *Hidden Costs, Value Lost: Uninsurance in America*. Available at http://www.nap.edu/catalog/10719.html. Public subsidies for uncompensated care are illustrated in the State of Alaska's FY 2007 budget request, which includes $27 million to help Alaska hospitals pay for uncompensated care.

7. In 1999, for example, health-care spending for Americans ages 75 to 84 was seven times higher than for people 18 and under.

8. See note 6.

9. United Health Foundation. *America's Health Rankings 2005 edition*.

10. See Chapter 3 in ISER report, *Status of Alaska Indicators 2004*, May 2005.

About the Authors: Mark Foster is a research consultant to ISER. Scott Goldsmith is a professor of economics at ISER. The authors thank their colleagues at ISER for their help—Rosyland Frazier, Virgene Hanna, Lexi Hill, Stephanie Martin, and Kerry Pride.

Editor—Linda Leask Graphic Artist—Clemencia Merrill

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Anchorage Daily News

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Denali KidCare

Let's make sure Alaska children get the medical help they need

(Published: February 21, 2007)

This one is simple. The answer is yes.

Anchorage Rep. Les Gara and Sen. Bill Wielechow-ski have introduced legislation to provide children's health insurance coverage for more of Alaska's working families who currently go without.

Their bills would fortify Denali KidCare, a state and federally funded program started during the Knowles administration in 1999 and cut back by lawmakers in 2003.

Back in 1999, Alaska children and pregnant women in working families could qualify for coverage if their income was no more than 200 percent of the federal poverty level.

That provided medical, dental and vision coverage to thousands of children and pregnant women. As Rep. Gara points out, the program aimed to cover families caught in the uninsured gap between welfare and good-paying jobs with health benefits.

In 2003, shortsighted Republican lawmakers voted to scale back the program to a hard-number income limit that took no account of inflation and automatically cut children of working families out of the program over time. That has left an estimated 3,500 kids uninsured -- kids who would have been eligible under the 1999 rules. Supporters of this year's bills say an additional 1,000 will lose coverage in 2007.

As it stands now, a working Alaska family of four can't make more than $40,260 per year to qualify for the program. There are only two states with tighter qualification limits.

"That the richest state in the nation provides some of the lowest levels of care is just shameful," said Anchorage Sen. Hollis French. He's right.

Here's what this year's proposed No Child Left Uninsured Act would do:

• Restore coverage up to the old limit of 200 percent of the federal poverty line. That means eligibility would float with inflationary changes in the line. That makes sense. Right now, using 2007 federal poverty limit levels, a working family of four without insurance coverage would qualify for Denali KidCare up to a yearly income of $51,640.

• Expand the program to allow Alaska families earning from 201 percent to 350 percent of the federal poverty level to buy Denali KidCare coverage on a sliding scale -- from $200 a year at the bottom to $1,200 a year at the top. Families making more than 250 percent of the poverty level also would contribute a 20 percent co-pay for services.

The cost? That's not certain yet. The state estimates the cost of Denali KidCare at about $1,700 per child per year. With 7,600 youngsters enrolled, that comes to almost $13 million per year. Thankfully, the federal government reimburses states for 58 to 70 percent of the costs.

Several other cost factors apply, too. Families without insurance often have no choice but hospital emergency rooms for care. They can't afford to pay, but hospitals can't turn them away. Anchorage's Alaska Regional and Providence hospitals reported $89 million in unpaid emergency room costs in 2004. Burdens like that have prompted the governor to ask for $22 million in aid for Alaska hospitals.

An expanded Denali KidCare would ease that strain because more Alaskans could afford routine and preventive care. Instead of all Alaskans bearing the costs for unpaid care with higher prices, a public investment up front would reduce those bills. Each dollar spent on routine care saves many times that dollar in care for more serious afflictions.

Rep. Gara sums up the case well for Denali KidCare: "Cheaper, smarter and more moral than doing nothing."

BOTTOM LINE: The children of working Alaskans without insurance deserve health care. Let's make it happen.

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Anchorage Daily News

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Alaska could be leader in health care

Compass: Points of view from the community

By JOHN RILEY

(Published: February 23, 2007)

Health care is a $5 billion industry in Alaska. It impacts every part of our economy and touches each of our lives. Yet there is widespread agreement that we have a dysfunctional, inefficient system. Solutions have remained elusive. The very wealth and reach of the industry can frustrate attempts to improve it.

The Commonwealth Fund has identified the five key dimensions of high-performance health systems. We can adapt these dimensions as a blueprint to transform Alaska's health care system.

The five key dimensions are: access, affordability, high-quality care, efficient care and equity. Because the five dimensions are interrelated, successful transformation requires simultaneous efforts on each. Affordability affects access. Quality and efficiency affect cost and affordability.

Where does Alaska stand? What are possible solutions?

Access: Alaska ranks in the bottom 15 percent of states, with close to 18 percent of Alaskans uninsured.

Solutions: Expand Denali KidCare to cover children and their parents up to 300 percent of the federal poverty level. Promote partnerships between the state and employers. Assure that benefits cover primary and preventive care. Consider mandated subsidized health insurance. Strengthen community heath centers. Fund workforce training to assure an adequate supply of health professionals.

Affordability: Alaska ranks 50th of the 50 states, with average health care premiums of $4,379 for employee single coverage. The majority of this cost (88 percent) is borne by employers and passed on to consumers. The cost of living increased in Anchorage by 40 percent between 1991 and 2005 while the cost of medical care increased almost 100 percent and is projected to double again by 2013. The cost of retiree health benefits is a major factor in the crisis in unfunded pension liabilities.

Solutions: The majority of health care spending is for hospital treatment of episodic high-cost complications of preventable chronic illness. Our health care must be reorganized around primary care that provides a medical home to all patients. Care must focus on behavioral change to prevent the rising epidemic of chronic disease. Alaska ranks fifth in the U.S. with 25 percent of adults who smoke. Alaska ranks fourth in the US with 62 percent of adults who are overweight or obese. New primary care payment models must exempt preventive and primary care from deductibles.

Efficiency: The U.S. spends more than twice per capita for health care as Canada and the other developed nations. The U.S. has the highest percent of national health expenditures on insurance administration and overhead at 7.3 percent.

Solutions: Encourage public-private collaboration to achieve simplification such as the Minnesota

"Smart Buy Alliance" that purchases health insurance for 70 percent of Minnesota residents. Implement performance incentives for meeting cost efficiency indicators. Increase transparency in reporting on quality and costs.

Quality: Nationwide, less than 50 percent of patients receive the recommended care for common chronic conditions. Twenty eight percent of U.S. primary care doctors use electronic medical records, or EMRs, compared to 92 percent in New Zealand and 89 percent in the United Kingdom.

Solutions: Redesign the office visit around the provision of quality care. Electronic medical records are an essential part of quality health care delivery. Leverage Alaska's health care purchasing power to provide incentives to use EMRs, to meet quality indicators and interconnect health information systems.

Equity: Nationwide, the percent of diabetics receiving recommended care is lowest for patients who are rural, poor or uninsured. African American mortality rates are significantly higher for heart disease, diabetes and infant mortality. Alaska Native infant mortality rates are almost twice that of whites.

Solutions: We must assure access to care for the poor and minorities who currently slip through our safety net systems. Patient's health care "literacy" must be assessed and care must be responsive to it.

There are innovative health care transformations in Maine, Massachusetts, Rhode Island, New York and Minnesota. A successful approach will require improving each of the five interlocking dimensions. Strategies focused on improving only one aspect of health care are unlikely to achieve the central goal of long, healthy productive lives for Alaskans. Alaska has an opportunity to become a national leader in developing a high-performance health system. Alaska's future may depend on it.

John Riley is with the clinical faculty of the University of Alaska Anchorage and is president of the Alaska Public Health Association.

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Health

U.S. approves state's Cover All Kids program

This signals the go-ahead to expand health insurance coverage to all Pennsylvania children

Friday, February 23, 2007

By Joe Fahy and Jerome L. Sherman, Pittsburgh Post-Gazette

Federal officials have cleared the way for Pennsylvania to implement its Cover All Kids program, which aims to make affordable health insurance more available to the state's uninsured young people.

"Our pledge was to ensure that every Pennsylvania child had access to health insurance coverage," Gov. Ed Rendell said in a statement yesterday. He said that because of the federal approval, announced yesterday, Pennsylvania officials can "start to make that pledge a reality."

Annie O'Neill, Post-Gazette

U.S. Sen. Bob Casey gets some pointers on how to run an electronic toy from Asa Martin, 5, in a Children's Hospital play room yesterday. Mr. Casey was at the hospital to discuss efforts to provide health insurance for the state's children.

Click photo for larger image.

The state was notified of that approval yesterday by the U.S. Centers for Medicare and Medicaid Services, said George Hoover, deputy insurance commissioner for CHIP and adultBasic programs.

The approval expands Pennsylvania's Children's Health Insurance Program, which provides coverage to young people whose families earn too much to qualify for other assistance programs such as Medicaid. Coverage is paid through state funds, with the federal government reimbursing about 68 percent of the cost.

Mr. Rendell said the approval also bodes well for "Cover All Pennsylvanians," his proposal to provide more affordable coverage for uninsured adults.

Up to now, Pennsylvania's program only received federal reimbursement for children in families whose income is up to 200 percent of the federal poverty level, about $41,300 for a four-member family, Mr. Hoover said.

The expanded program will provide federally-subsidized coverage for families that are at up to 300 percent of the poverty level, meaning income of about $61,950 for a family of four. Those families would pay sliding scale fees for the coverage based on their incomes.

Families with incomes at 200 percent of the poverty level would pay no monthly premiums; those with higher incomes up to 300 percent of the poverty level would pay premiums ranging from about $38 to $60 per child.

Families with incomes above 300 percent of the poverty level would pay about $150 a month per child.

Enrollment in the program will begin next month, Mr. Hoover said. Young people from birth to age 19 are eligible.

State officials estimate that about 133,000 Pennsylvania children are uninsured, and all but

110,000 qualified for coverage under programs that existed prior to Cover All Kids, he said.

But officials expect more families will take advantage of the coverage with the message that it is available to families of all income levels, Mr. Hoover said.

There are some exceptions. Children in families with incomes above 200 percent of the poverty level, for example, have to be uninsured for six months to qualify.

For more information, parents can call 1-800-986-5437. They also can visit www.compass.state.pa.us to apply online.

Mr. Hoover said state officials were relieved to receive federal approval of Cover All Kids. In his budget proposal, President Bush has proposed targeting the State Children's Health Insurance Program to young people at or below 200 percent of the poverty level. He also has proposed funding levels that some consider inadequate.

The federal government currently spends about $5 billion annually on SCHIP, and the president's budget proposes $4.8 billion in new money for the program over the next five years.

But the new funds won't be enough to cover rapidly rising health care costs and new programs at the state level, according to a report released yesterday by the Center on Budget and Policy Priorities.

Jeff Nelligan, director of media affairs for the Centers for Medicare and Medicaid Services, said the president's budget focuses on SCHIP's original objective of improving health insurance coverage for children in low-income families.

During a visit to Pittsburgh yesterday, U.S. Sen. Bob Casey, D-Pa., said the president's budget proposal would hamper states' efforts to provide coverage to more children.

Speaking at Children's Hospital in Oakland, Mr. Casey praised Pennsylvania's efforts to expand coverage for young people.

Joan Benso, president and chief executive officer of Pennsylvania Partnerships for Children, called the president's budget proposal "short-sighted." But she praised approval of Cover All Kids.

"We know that children who have health insurance are less likely to get preventable diseases, are less likely to use emergency room care, and are more likely to attend school," she said. "All these things save us money as taxpayers."

(Politics Editor James O'Toole contributed. Joe Fahy can be reached at jfahy@post-gazette.com or 412-263-1722. Jerome L. Sherman can be reached at jsherman@post-gazette.com or 1-202-488-3479.)

Rep. Les Gara
State Capitol, Rm 500
Juneau, AK 99801

Fax – 907-465-3518

Dear Representative;

I whole-heartedly support your effort to expand the Denali Kid Care Program back to 200% of the poverty line. Also, allowing people to "buy in" from 200 – 300% of the poverty line is an excellent idea.

I mentioned in a previous e-mail that a co-pay, whether percentage or fixed rate per visit, would allow the program to be utilized by more people, & make it more equivalent to a private insurance plan. The children served by Denali Kid Care would not otherwise have insurance, & therefore no access to preventative health care. Furthermore, I know that a large percentage of these kids would end up obtaining their care in the Emergency Departments – like the elderly are faced with now. This just adds to everyone's health care costs.

Insurance premiums are out of reach for this financial group. As an example, I interviewed a Nurse Practitioner who works for a local health clinic, that provides her with insurance, but the premium for her one child is $450.00 per month! That's $5400.00 per year – a tremendous amount out of someone's salary. Not many people can afford this, & many children go uninsured as a result. Prisoners & people dependant on welfare have more benefits than the average worker or the elderly.

These are all hard working people, who want to provide for their families, & I feel are willing to contribute to the costs health care if it is manageable.

Denali Kid Care is money very well spent.

Thank you;

Jeff Brand, MD
2841 DeBarr Rd. Ste 32
Anchorage, AK 99508
264-1457
3/11/07

AARP Alaska

March 14, 2007

The Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
Alaska State Capitol, Room 403
Juneau, AK 99801-1182

RE: HB 140 (Gara)–Support

Dear Chair Wilson:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health, Education and Social Services Committee to support HB 140, authored by Representative Les Gara.

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

HB 140 will return the Denali KidCare program to the former eligibility levels, index those eligibility parameters to the annual increases in the federal poverty level and, for the first time, allow uninsured families above the 200% FPL to buy into the program. We think this is an excellent plan and should provide comprehensive and preventive health coverage for many more young Alaskans and pregnant women.

AARP members understand how important health insurance is to them; we support the efforts of this bill to provide coverage to other Alaskans who need it.

AARP requests an "AYE" vote on HB 140.

3601 C Street, Suite 1420| Anchorage, AK 99503| toll-free 866-227-7447| 907-341-2270 fax| toll-free 877-434-7598 TTY
Marie F. Smith, President| William D. Novelli, Chief Executive Officer| www.aarp.org/ak

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

Thank you for your consideration.

Sincerely,

Marie Darlin

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

CC: Vice-Chair Bob Roses
Representative Anna Fairclough
Representative Mark Neuman
Representative Paul Seaton
Representative Berta Gardner
Representative Sharon Cissna
Representative Les Gara

From: Nicole Thibodeau [mailto:nicole.thibodeau@covhouse.alaska.com]
Sent: Wednesday, March 14, 2007 2:38 PM
To: Rep. Peggy Wilson; Rep. Bob Roses; Rep. Anna Fairclough; Rep. Mark Neuman; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Berta Gardner
Cc: Rep. Les Gara
Subject: *****SPAM***** Support for HB 140

Dear Members of the House HESS Committee,

Covenant House Alaska urges you to support HB 140. This bill restores funding for DenaliKidCare back to 200% of the Federal Poverty Level, allows the DHSS to charge co-pays to some families who can afford it and allows families to buy into DenaliKidCare. This bill will seriously impact two distinct groups of youth that Covenant House serves.

First, there are kids under 18 whose families cannot afford health insurance, but earn too much to qualify for DenaliKidCare. Many times children from intact families come to Covenant House not as runaways, but because their parents know that Covenant House is able to provide the basic needs; food, shelter and clothing, to these children of parents who have fallen on hard times. These are usually children with working parents whose income is great enough to disqualify them from programs such as DenaliKidCare and Medicaid, but not enough that they can support their children and pay for their basic needs.

Second, there are kids over 18, independent from their families who earn too much at minimum wage jobs to qualify for DenaliKidCare or Medicaid. This describes the majority of kids who are served by Covenant House. These kids earn too much money to qualify for government funded health insurance programs, but do not earn enough to pay for health insurance and their other basic needs expenses.

Health insurance coverage is one of the basic necessities that all children and families need to be secure, healthy and successful. The burden of health insurance and medical costs alone can drive a working family to homelessness. Research shows that children without preventative health care have much higher health risks and are four times more likely to end up in hospital emergency rooms where very expensive bills are incurred, largely at the hospital and the public's expense.

By restoring funding for DenaliKidCare back up to 200% of the Federal Poverty Level and expanding Medicaid eligibility Alaska will be making a valuable investment in its children and families. Please protect Alaska's families and children by supporting HB 140. Feel free to contact me with any questions.

Sincerely,
Nicole Thibodeau

Nicole Thibodeau

Director of Advocacy
Covenant House Alaska
609 F Street
P.O. Box 104640
Anchorage, AK 99510
Tel. 907.339.4205
Fax. 907.272.1466

From: Tom Conley [mailto:prophet@ptialaska.net]
Sent: Wednesday, March 14, 2007 11:41 AM
To: Rep. Les Gara
Subject: HB 140

Dear Les, For the last couple of years the members of the Alaska Chapter of the American
Academy of Pediatrics have been advocating for a resumption of the 200% of poverty guideline for Denali
Kid Care enrollment. While the previous limit was in force access to care fc the medically indigent and many
of the working poor was markedly improved. It is therefore very gratifying to see the introduction of HB 140 which
reinstates the 200% rule and extends "discounted" coverage to those qualifying at 200-350% of the poverty
level. It is truly saddening to see inadequate provision of medical care for children in this country and particularly
in a state like Alaska which is manifestly able to afford providing such coverage. All too often the parents of those
in the captioned income groups are unable tc acquire or afford medical insurance but fail to meet the stringent
criteria necessary to qualify for medicaid. Thus their children often fail to receive preventive care in general and
early care when ill thus increasing morbidity and ultimate cost. I would urge you to give serious and favorable
consideration to HB 140 to help solve this growing problem.
Thomas L. Conley, MD, FAAP Sitka Pediatrician

Thanks for sponsoring HB 140; it is much appreciated. Tom Conley, Sitka School Board

From: Phyllis Kiehl [mailto:pkiehl@pol.net]
Sent: Saturday, March 10, 2007 12:27 PM
To: Rep. Les Gara
Subject: Re: HB 140

Thank you so much for sponsoring HB 140, the "No Child Left Uninsurec Act," supporting financial assistance for women's and children's health care coverage. At present, there are too many who cannot afford health care but do not qualify for assistance.

I am a pediatrician in Anchorage, and want to be able to provide care to those who need it, and I know that some people avoid bringing their children into the doctor's office unless they are so sick that they need emergency care. Then they end up in the ER, at increased financial cost and more ill than they might otherwise have been if they had sought care sooner.

I appreciate your support of this legislation.

Phyllis Kiehl, M.D.

STATE OF ALASKA

Sarah Palin, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

Advisory Board on Alcoholism and Drug Abuse
Alaska Mental Health Board

P.O. BOX 110608
JUNEAU, AK 99811-0608
PHONE: (907) 465-8920
FAX: 465-4410

March 14, 2007

RE: HB 140 – Eligibility for Denali KidCare
Testimony to the House HESS Committee by
Angela Salerno, Advocacy Coordinator

The Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse strongly support HB 140 and urge its passage from committee.

- **HB 140 will make health insurance accessible to more children in Alaska.** Alaska has the third lowest DKC eligibility rate in the nation. Combined with a 31% decline in the number of children covered by private health insurance in the last decade, Alaska is taking a costly risk with the health and behavioral health of its children and the well-being of families.

- **DKC covers the majority of children's behavioral health care.** Providing kids with prevention and early intervention behavioral health services are critical to their long-term mental health and the well-being of their families. In addition, access to these services will help control the mounting costs of inpatient psychiatric care.

- **DKC is a good bargain for the State of Alaska.** The federal government covers 70% of the cost of DKC. Also, those families who can afford it will make a meaningful financial contribution towards their children's health coverage.

- **DKC saves the State of Alaska money in the long run.** Children without health care get less preventative care, have much higher health risks and are four times more likely to use expensive emergency room care. Research shows that immunizations, annual visits to a doctor, dental care and screenings for vision, hearing and developmental disabilities are all long-term money savers for the health care system as a whole.

- **DKC saves all Alaskans money.** In 2004, Anchorage hospitals provided almost $89 million in uncompensated care. These costs are passed on to Alaskan business and individuals in higher insurance premiums and out of pocket health care costs.